How Patients Guide Therapy: A Pilot Study on the Development and Reliability of the Patient Coaching Rating System (PCRS)

Abstract

Objective

Patient coaching refers to patient-initiated communication that help therapists understand therapy goals, maladaptive beliefs, personal challenges, and preferred therapeutic approaches. Despite its theoretical significance, empirical research remains limited, with a few recent studies relying on labor-intensive methods involving extensive training of judges and detailed case analysis. To support broader empirical research, this study introduces the Patient Coaching Rating System (PCRS) to assess two dimensions of patient coaching: *information coaching* (what and why) and *direction coaching* (how).

Methods

Seven judges used the PCRS to rate 22 segments from an early psychotherapy session. Each segment was rated on two dimensions—information coaching and direction coaching—using a 0–4 scale.

Results

They achieved inter-rater reliability scores of 0.86 for information coaching and 0.68 for direction coaching. While information coaching demonstrated excellent reliability, direction coaching showed moderate to good reliability, highlighting the need for further refinement of the coding manual.

Conclusions

This pilot study provides a structured method for assessing patient coaching and represents an initial step toward facilitating empirical investigation within therapy sessions.

Keywords: patient coaching; Control-Mastery Theory; rating scale; coding manual; reliability assessment

Highlights

- The study introduces the Patient Coaching Rating System (PCRS), a novel instrument designed to quantify patient-initiated communication that reveals patients' maladaptive beliefs, therapy goals, and therapy preferences, thereby enabling therapists to better understand and address patient needs.
- The PCRS emerges as an efficient tool for empirical investigation, demonstrating that patient coaching can be reliably assessed without extensive rater training or detailed transcript analysis.
- The work underscores the critical role of patient coaching in guiding therapist responsiveness and enhancing collaborative psychotherapy, with significant implications for both research and clinical practice.

Conflict of Interest

The authors declare no conflicts of interest.

Funding

No funding was received for this specific study.

Patient coaching is a central component of Control-Mastery Theory (CMT), which posits that individuals enter therapy with unconscious plans aimed at overcoming their pathogenic beliefs, which stem from traumatic experiences and the psychic processing of those experiences, and achieving adaptive personal goals [1,2]. Patient coaching refers to any patient-initiated communication intended to help the therapist understand the patient's therapy goals, obstructive beliefs, relevant adverse experiences, and preferences for how they wish to work in therapy [3]. Patient coaching is considered essential because it supports the disconfirmation of the patient's deeply held, maladaptive beliefs by preparing the therapist to respond in a way that promotes therapeutic progress. By offering implicit or explicit guidance on how they wish the therapist to respond, patients enable opportunities for corrective emotional experiences within the therapeutic relationship [4].

In addition to conscious and direct statements or requests, patients' coaching can manifest as unconscious communication that unfolds from patients' narratives that indirectly or symbolically convey their therapeutic concerns or needs. For example, a patient who feels unseen or unsupported might share stories of past relationships where their needs went unacknowledged. Through these narratives, the patient may be indirectly coaching the therapist to offer consistent attention and validation, in the hope of challenging a deeply held belief that their presence will always go unnoticed. Similarly, a patient with a fear of dependency might tell stories of being let down by people they relied on in the past. Through these stories, the patient might be indirectly coaching the therapist about their need to address—potentially through transference-oriented work—a sense that reliance on others inevitably leads to disappointment. When therapists respond in ways that align with the patient's healing goals, it reinforces the patient's motivation to let go of limiting beliefs, thereby supporting the patient's movement toward personal growth and psychological relief. Thus, patient coaching potentially facilitates therapists' responses that help disprove the

patient's dysfunctional or pathogenic beliefs and operates as a collaborative, implicit process [1]. In this way, psychotherapy is shaped to meet the patient's psychological needs, thereby advancing their progress toward healthier, more adaptive belief systems [4].

The concept of "patient coaching" finds its roots in psychoanalytic ideas, where patients unconsciously shape therapeutic interactions to address unresolved conflicts and emotional needs. Freud's concept of transference [5, 6] refers to the patient's projection of feelings, desires, and relational patterns from past significant relationships onto the therapist. These projections are not merely defenses but also avenues for patients to explore unresolved conflicts and offer the therapist opportunities to respond in ways that challenge the patient's maladaptive patterns. In this context, coaching aligns with transference as patients guide therapists toward understanding their unconscious needs and relational expectations. Likewise, Klein's concept of projective identification [7] involves the unconscious projection of difficult or intolerable emotions onto the therapist, often influencing the therapist to experience or respond in specific ways. This dynamic can be seen as a form of communication, in which the patient unconsciously conveys their internal emotional state through a more reciprocal and co-created emotional experience than in Freud's classical model of transference. In the context of patient coaching, these projections serve as an indirect way for the patient to guide the therapist toward understanding their unmet emotional needs, enabling the therapist to respond in ways that support reintegration of these disowned aspects. The concept resonates with self psychology, as described by Kohut [8], where patients actively communicate their needs for the therapist to act as a self-object, providing empathy, validation, and attuned responses that repair disruptions in the self. It also aligns with relational psychoanalysis [9], which emphasizes the co-created dynamic between therapist and patient, where both influence and are influenced by the relational interaction. Patient coaching reflects this mutuality as patients, through their narratives and relational

cues, shape the therapeutic process. By engaging with the patient's implicit and explicit guidance, therapists can address relational patterns in real time, fostering emotional repair and healthier relational dynamics.

Most literature on patient coaching has been conceptual and clinical. Recently, three empirical studies examined coaching in psychotherapy through case studies. Bugas et al. [10] analysed three single-case studies, assessing verbatim therapy transcripts using Likert scale ratings. Extensively trained clinical judges reliably identified patient coaching, particularly statements about therapy goals, obstacles, and therapist assistance. Gazzillo et al. [11] examined 98 sessions from six brief psychodynamic cases, assessed by 12 trained raters. Likert scales measured coaching presence and therapist alignment. Findings indicated that accurate therapist responsiveness to coaching cues led to immediate patient improvement, demonstrating that coaching can be reliably assessed. Kealy et al. [12] investigated patient coaching and therapist responses in time-limited psychodynamic therapy. Across six sessions, two trained raters evaluated coaching clarity on a four-point scale, while therapist responsiveness was rated for receptivity and plan compatibility. Minimal therapist responsiveness, particularly in later sessions, correlated with the patient's early termination. Together, these studies support patient coaching as a measurable construct and highlight its role in shaping therapeutic outcomes but relied on raters' expertise without a training manual.

Empirical research on patient coaching is promising, yet the time required for both extensive rater training and careful transcript analysis can make research burdensome. The addition of a standard measure of patient coaching can lend expediency to future research and thus an important contribution to facilitate further empirical study. This paper introduces the Patient Coaching Rating System (PCRS), designed to measure the degree and nature of patient coaching in psychotherapy sessions. The PCRS operationalizes and assess patient coaching into two dimensions: *information coaching* and *direction coaching*. As a

preliminary effort, this study focuses specifically on establishing the interrater reliability of the PCRS as a foundation for future empirical research into the more complex dimensions of patient coaching.

Methods

Seven licensed psychologists (3 females, 4 males), recruited from the San Francisco Psychotherapy Research Group (SFPRG) participated in this study conducted in September and October 2024. Although exact ages were not collected, the sample represented a broad range of clinical experience—from early-career practitioners to highly experienced clinicians—with an average of 25.21 ± 23.86 years in practice. In terms of theoretical orientation, the majority of raters primarily endorsed integrative methods, whereas two identified with psychodynamic perspectives, thereby ensuring a relatively diverse range of clinical viewpoints. On a five-point Likert scale, their self-rated familiarity with CMT was moderate to high (M = 4.29 ± 0.95), and their familiarity with the concept of patient coaching was similarly rated as moderate to high (M = 4.14 ± 0.90). Psychotherapy session data were collected under the Protection of Human Subjects Assurance/Certification Declaration (HEW-596), with all participants providing informed consent.

Participants received an invitation email with the PCRS coding manual (see Supplemental Materials S1), which describes the two dimensions of patient coaching, structured guidelines, and coding examples. Once participants reviewed the manual, they accessed the rating survey through Qualtrics. In the survey, they were presented with 22 segments from session 3 of a 16-session short-term psychotherapy treatment. Session 3 was selected a priori as an early point in therapy where coaching communication was expected to emerge beyond mere intake information, making it suitable for testing inter-rater reliability.

Segments ranged from 160 to 450 words and were presented chronologically from the start of the session.

Participants rated the presence and degree of patient coaching efforts for each segment according to the two PCRS dimensions. Each dimension was rated on a 0-4 scale, with higher scores indicating greater observed coaching communication. Decimal ratings were permitted between scoring anchors for finer distinctions. Participants could refer to the PCRS manual throughout the process to ensure alignment with coding criteria. Ratings were made independently for each segment, focusing solely on the specific segment content without reference to prior or subsequent segments. Participants were also informed that some segments might lack coaching, as coaching is not always present in therapeutic conversations. The entire process, including manual review, segment reading, and rating, took approximately 60-120 minutes.

The PCRS coding manual, developed by the San Francisco Psychotherapy Research Group (SFPRG), provides a structured framework for assessing patient coaching in psychotherapy sessions. The manual was initially conceptualised by senior members of SFPRG with decades of experience in CMT and psychotherapy process research. Its development spanned approximately three years and involved iterative drafting, expert review, and piloting—drawing on clinical case material, weekly team discussions (the SFPRG Friday Group), and pilot reliability exercises to refine its structure and content.

It evaluates patient coaching along two primary dimensions: information coaching and direction coaching. Information coaching captures the "what and why" of patient communication, providing essential context and goals that the patient brings to therapy. This includes goals for therapy, significant life experiences, and obstacles to goal achievement. For example, a patient may say, “I have a long list of stresses and problems, but all of them

are dwarfed by my relationship issues with my mother." Direction coaching involves the "how" of therapy, guiding the therapist toward approaches the patient believes will be helpful or unhelpful, which may include relational patterns, feedback for the therapist, and requests for therapeutic adjustments. For example, a patient may say, "It's much easier for me to feel comfortable and open up with someone when I know something about the person I'm speaking to, so I hope you will tell me a little about yourself." Some instances involve both information and direction coaching, such as, "I've been extremely shy ever since middle school (information coaching), and I hope that you will draw me out when I'm reluctant to engage (direction coaching)."

The rating system uses a 0-4 scale for both dimensions of patient coaching, with clear definitions and markers for each level. Information coaching and direction coaching are designed to be rated independently in that a high score on one dimension does not preclude or influence a high score on the other, as each dimension captures distinct aspects of patient coaching. The PCRS coding manual includes detailed guidelines, examples drawn from psychotherapy sessions, and scoring anchors to ensure consistency and reliability across raters.

Inter-rater reliability was assessed using the intraclass correlation coefficient (ICC) with a two-way random-effects model for average random raters. Data analysis was conducted using the R statistical package [13] to evaluate the reliability of the PCRS in capturing the consistency of ratings among judges for both information coaching and direction coaching dimensions.

Results

Analysis of inter-rater reliability, using a two-way random-effects ICC, showed strong reliability for Information Coaching (ICC = 0.86, 95% CI = 0.74–0.94, $p < 0.001$), reflecting

a high level of agreement among the seven judges, and moderate reliability for Direction Coaching (ICC = 0.68, 95% CI = 0.43–0.84, $p < 0.001$) [14].

Discussion

The current study introduced the PCRS and conducted a pilot test to evaluate its potential for reliably rating patient coaching in psychotherapy. High inter-rater reliability was observed for the information coaching dimension, indicating that raters were able to consistently identify patient-reported information that convey therapy goals, beliefs, and significant experiences using criteria in the PCRS manual. Moderate reliability was found for direction coaching, suggesting that patient communication in this dimension was mostly identified by raters but may require further refinement or broader examples. Overall, these results provide preliminary support for the reliability of the PCRS as a tool for assessing patient coaching in psychotherapy.

One possibility for the minor difference in reliability ratings between the two PCRS dimensions may be the greater variability in assessing direction coaching. Unlike information coaching, which often involves explicit and concrete statements of therapy goals, maladaptive beliefs, traumatic life experiences, or obstacles to achieving these goals, direction coaching can require raters to identify more implicit cues. Patients who are less aware or comfortable with expressing which techniques they would prefer may only offer indirect clues, which can challenge therapist responsiveness [12]. In addition, direction coaching is more individualised and may shift across sessions or treatment stages as patients gain increasing awareness of their needs [3, 12]. Not only does this highlight the dynamic nature of patient coaching, but it may also help in understanding subtle differences between the two dimensions represented in the PCRS, which can be addressed through refinement of the direction coaching guidelines and/or rating transcripts across sessions.

In developing the PCRS, we opted to assess patient coaching independently of the Plan Formulation Method (PFM) [15]. Although the PFM provides a reliable framework to identify a patient's therapeutic goals, pathogenic beliefs, and necessary interventions early in therapy, it is a time-intensive process for researchers. By making the PCRS independent of the PFM, we aimed to create a versatile tool that simplifies coding and broadens applicability across various research and clinical settings. However, this approach has limitations; without a predefined case formulation, raters might overlook nuanced coaching, particularly in cases where unexpected or contradictory elements arise. While our pilot findings indicate that reliable coding is feasible without the PFM, future research could explore whether adding brief case summaries improves raters' ability to detect and interpret coaching communication.

This study has several limitations. First, ratings were based on a single psychotherapy session from one therapeutic approach, which may not capture the full range of patient coaching across modalities or populations. While findings support the PCRS's reliability, future research should assess its reliability and validity across different therapists, settings, and patients. Additionally, although judges varied in experience, they all had moderate to high familiarity with CMT and patient coaching. Including raters unfamiliar with these concepts, such as trainees or researchers with limited field experience, could offer insights into the tool's usability for a broader audience. This study also did not examine validity, which is essential to confirm that the PCRS accurately measures patient coaching.

This pilot study demonstrated that the PCRS can be reliably scored, with robust inter-rater reliability for information coaching and moderate to good reliability for direction coaching. These findings support the PCRS's potential as an efficient tool for quantifying patient coaching and open avenues for empirical research. However, immediate refinements should target the direction coaching dimension. Further research should explore the instrument's validity (e.g., concurrent, discriminant, predictive) and its relationships with

established measures. Additionally, investigating how patient coaching relates to therapist responsiveness, rupture-repair cycles, treatment outcomes, and cultural influences on coaching dynamics will broaden the PCRS's applicability across clinical and research contexts.

References

1. Weiss, J. (1993). *How psychotherapy works.* New York, Guilford Press.
2. Weiss, J. (1997). The role of pathogenic beliefs in psychic reality. *Psychoanalytic Psychology, 14(3),* 427–444. https://doi.org/10.1037/h0079619
3. Bugas, J., & Silberschatz, G. (2000). How patients coach their therapists in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 37(1),* 64–70. https://doi.org/10.1037/h0087676
4. Silberschatz, G. (2008). How patients work on their plans and test their therapists in psychotherapy. *Smith College Studies in Social Work, 78(2-3),* 275–286. https://doi.org/10.1080/00377310802114528
5. Freud, S. (1912). The dynamics of transference. In *Collected Papers* (Vol. 2, pp. 312–322). London, Hogarth Press.
6. Freud, S. (1914). Remembering, repeating and working-through (Further recommendations on the technique of psychoanalysis II). In *Collected Papers* (Vol. 2, pp. 145–156). London, Hogarth Press.
7. Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psychoanalysis, 27*, 99–110.
8. Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. New York, International Universities Press.

9. Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration*. Cambridge, MA, Harvard University Press.
10. Bugas, J., McCollum, J., Kealy, D., Silberschatz, G., Curtis, J. T., & Reid, J. (2023). Identifying patient verbal coaching in psychotherapy. *Counselling and Psychotherapy Research, 23(1),* 247-257. https://doi.org/10.1002/capr.12495
11. Gazzillo, F., Mannocchi, C., Curtis, J., Biuso, G. S., De Luca, E., Fimiani, R., Fiorenza, E., Genova, F., La Stella, M., Leonardi, J., Rodomonti, M., & Silberschatz, G. (2024). Passing patients' tests and following patients' coaching communications in psychotherapy: an empirical study. *Counselling Psychology Quarterly,* 1–27. https://doi.org/10.1080/09515070.2024.2354283
12. Kealy, D., McCollum, J., Curtis, J. T., Silberschatz, G., & Luo, X. (2022). Failure to respond to the patient's coaching: A case study of premature termination in psychodynamic psychotherapy. In *Therapeutic Failures in Psychotherapy* (pp. 73-97). London, Routledge.
13. R Core Team (2020). *R: A language and environment for statistical computing*. Vienna, R Foundation for Statistical Computing. https://www.R-project.org/
14. Koo, T. K., & Li, M. Y. (2016). A guideline of selecting and reporting intraclass correlation coefficients for reliability research. *Journal of chiropractic medicine*, *15*(2), 155-163. https://doi.org/10.1016/j.jcm.2016.02.012
15. Curtis, J. T., & Silberschatz, G. (2007). Plan formulation method. In T. D. Eells (Ed.), Handbook of psychotherapy case formulation (2nd ed., pp. 198–220). New York, Guilford Press.