

**Understanding how clients recently discharged  
from psychological therapy manage their  
mental health problems**

Claire Lisa Howarth

Submitted in accordance with the requirements for the degree of  
Doctor of Clinical Psychology (D. Clin. Psychol.)  
The University of Leeds  
School of Medicine  
Academic Unit of Psychiatry and Behavioural Sciences

October, 2016

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

© 2016 The University of Leeds and Claire Lisa Howarth

The right of Claire Lisa Howarth to be identified as Author of this work has been asserted by her in accordance with the Copyright, Designs and Patents Act 1988

## ACKNOWLEDGEMENTS

First of all I would like to thank the participants that took part in the research, who gave up their time to talk to me and spoke so honestly about their experiences. It was a privilege to hear their stories and to be in a profession that contributed to having such a positive impact on their lives. I would also like to thank my supervisors, Gary Latchford and Mike Lucock for their continued enthusiasm, support and feedback throughout the project. Finally, I would like to thank my wonderful husband, parents and sister for their understanding and unwavering support which provided me with the motivation to persevere when it felt like I couldn't.

**ABSTRACT**

Research has proved psychotherapy to be effective (Wampold, 2007) though longer term outcomes are less well investigated and relapse still occurs (Crown, 2002; Eaton et al, 2008). There has been little research into how mental health is managed once discharged from therapy, yet the importance of self-management has been highlighted by both professionals and service users (Barlow et al, 2002; Todd et al, 2012). This study focuses on individuals who found psychological therapy to be of benefit and aimed to explore their experiences of how they manage their mental health on a daily basis after discharge. Eight participants who had completed a minimum of six sessions of therapy within adult psychological therapy services and subjectively felt they had benefitted at the time of discharge were interviewed about their experiences. Using thematic analysis to analyse the data, five core themes were identified; ‘how therapy is helping me now’, ‘life changing’, ‘things that helped therapy to be successful’, ‘things outside therapy that are helping me now’ and ‘how therapy could be improved’. Participants maintained their mental health in similar ways irrespective of the initial presentation of symptoms, type of treatment received and the therapist they saw. Subthemes offer a deeper understanding of what people took from therapy and how the changes made are still being used to maintain mental health. Important factors included the acceptance of mental health difficulties, previous difficult life experiences, and the recognition that continued effort and distress in life are to be expected. Understanding and changing interpersonal relationships was also highlighted along with the importance of valuing yourself and not putting others’ needs before your own. Specific strategies were also commented upon including cognitive techniques as well as relaxation and mindfulness. Findings from the analysis are discussed in relation to the literature, along with the consideration of clinical implications and future research.

**ABBREVIATIONS**

ACT: Acceptance and commitment therapy

ADM: Anti-depressant medication

APTS: Adult psychological therapy service

CAMHS: Child and adolescent mental health service

CAT: Cognitive analytic therapy

CBT: Cognitive behavioural therapy

CORE-OM: Clinical outcomes in routine evaluation – outcome measure

EBP: Evidence-based practice

GP: General practitioner

GT: Grounded theory

IAPT: Improving access to psychological therapies

IPT: Interpersonal therapy

m-ADM: Maintenance anti-depressant medication

MBCT: Mindfulness based cognitive therapy

NHS: National Health Service

NICE: National Institute for Health and Care Excellence

NNT: Numbers needed to treat

OCD: Obsessive compulsive disorder

PBE: Practice-based evidence

PICT: Psychologist in clinical training

PTSD: Post-traumatic stress disorder

R&D: Research and development department

RCT: Randomised control trial

WRAP: Wellness recovery action plan

## Contents

ACKNOWLEDGEMENTS .....	3
ABSTRACT .....	4
ABBREVIATIONS .....	5
LIST OF TABLES.....	8
TABLE OF FIGURES .....	8
CHAPTER ONE: INTRODUCTION.....	9
Psychotherapy.....	9
Does it work?.....	9
Is one model more effective?.....	10
How does psychotherapy work?.....	14
Evidence-based practice .....	17
Practice-based evidence .....	19
Realities of clinical practice .....	21
Qualitative research into effective processes in therapy.....	25
Long term outcomes .....	26
Relapse .....	26
Self management.....	30
How do people stay well? .....	30
Service users' views.....	33
Summary .....	43
Aims.....	44
Principal Research Question/Aim.....	45
CHAPTER TWO: METHOD.....	46
Design .....	46
Methodological approach.....	46
Thematic Analysis .....	48
Ethics.....	52
Ethical Approval .....	52
Ethical Considerations .....	52
<i>Service User Involvement</i> .....	52
<i>Informed Consent</i> .....	53
<i>Confidentiality</i> .....	54

<i>Risk and Distress</i> .....	54
Recruitment .....	55
Participants .....	55
Inclusion Criteria .....	55
Exclusion criteria .....	57
CORE-OM.....	57
Sample size .....	58
Service Context.....	59
Recruitment Method .....	60
Data Collection .....	62
Interviews .....	62
Quality Checks for Qualitative Research.....	62
Researcher Reflexivity .....	65
CHAPTER THREE: RESULTS.....	67
Recruitment .....	67
Demographic details .....	68
Pen Portraits .....	70
QUALITATIVE ANALYSIS .....	77
Carrying out thematic analysis .....	77
Qualitative results .....	80
Core themes .....	80
Theme 1: How therapy is helping me now .....	82
Theme 2: Life changing .....	97
Theme 3: Things that helped therapy be successful .....	98
Theme 4: Things outside of therapy that are helping me now .....	101
Theme 5: How therapy could be improved .....	105
Summary .....	107
CHAPTER FOUR: DISCUSSION.....	109
Revisiting research aims .....	109
Summary of findings.....	109
Overview of themes .....	109
Theme 1: How therapy is helping me now .....	111
Theme 2: Life changing .....	116

Theme 3: Things that helped therapy to be successful .....	117
Theme 4: Things outside therapy that are helping me now .....	123
Theme 5: How therapy could be improved .....	124
Strengths and Limitations .....	125
Strengths .....	125
Limitations.....	127
Clinical Implications.....	129
Future Research .....	132
CONCLUSIONS .....	134
REFERENCES .....	136
APPENDICES .....	149
Appendix 1: CORE-OM 34 questionnaire .....	149
Appendix 2: NHS Ethical Approval .....	151
Appendix 3: R&D approval .....	153
Appendix 4: Dataset of referrals to respective services.....	156
Appendix 5: Opt in letter.....	157
Appendix 6: Information Sheet .....	159
Appendix 7: Consent Form .....	163
Appendix 8: Topic Guide .....	164
Appendix 9: Examples of NVivo analysis .....	166

### **LIST OF TABLES**

<i>Table 1: Phases of Thematic Analysis (From Braun &amp; Clark, 2006) .....</i>	<i>50</i>
<i>Table 2: A checklist for achieving a good TA (From Braun &amp; Clark, 2006).....</i>	<i>51</i>
<i>Table 3: Inclusion and exclusion criteria.....</i>	<i>57</i>
<i>Table 4: Demographic details of participants.....</i>	<i>69</i>
<i>Table 5: Examples of generating codes.....</i>	<i>78</i>

### **TABLE OF FIGURES**

<i>Figure 1: Recruitment procedure .....</i>	<i>61</i>
<i>Figure 2: Thematic Map.....</i>	<i>81</i>



## **CHAPTER ONE: INTRODUCTION**

The following study aims to understand what clients take from therapy that helps them manage their problems on a day to day basis after therapy has ended. I will present a rationale for the study, beginning by outlining the evidence for the effectiveness of psychotherapy. I will then go on to discuss the limitations of evidence-based practice and the importance of practice-based evidence in relation to clients that are seen within secondary care mental health services and the practice of therapists within them. Long term outcomes will then be discussed, considering relapse and the importance of self-management approaches and research into this area.

### **Psychotherapy**

#### **Does it work?**

There has been much research into psychotherapy over the decades considering questions such as; does it work? How does it work? Is one type of therapy more effective than another? In terms of answering the question of whether psychotherapy works; it has proved its effectiveness across a range of mental health difficulties and continues to do so. As judged by quantitative outcome measures, psychotherapy consistently produces an effect size of 0.8. This means the average score on a given measure of those receiving treatment is 0.8 of a standard deviation better than the score of those who are in a comparison group, i.e. not receiving treatment. Simply put, clients receiving treatment will score above 79% of those who are not receiving treatment (Lambert & Ogles, 2004; Wampold, 2007).

Psychotherapy has also been evaluated in terms of number needed to treat (NNT), an outcome measure commonly used in medicine. NNT is based on the number of

people needed to receive the intervention to achieve a better outcome than would have been gained should the intervention not have been received. Kraemer and Kupfer (2006) highlight an effect size of 0.8 equates to a NNT of around three; meaning three people need to receive psychotherapy in order to achieve a better outcome than not receiving psychotherapy. Though the evidence does not establish psychotherapy as a guaranteed success with all clients, it has been found to equal or be more effective than many medical treatments including the influenza vaccine, cataract surgery and taking aspirin as a prophylaxis for heart attacks (Wampold, 2007).

It is with such evidence that psychotherapy is now firmly established in the National Institute for Health and Care Excellence guidelines (NICE 2009; 2011) often as a first line of treatment. There is now widespread recognition of the efficacy of psychotherapy in the treatment of depression, anxiety and other mental health problems as a standalone treatment or alongside a pharmacological option (DeMaat et al, 2007; DeReubis et al, 2005; 2009; Dimidjian et al 2006; Barlow et al, 2000; Vocks et al, 2010; Deacon & Abramowitz, 2005).

### **Is one model more effective?**

With psychotherapy research establishing effectiveness, attention focussed on the question of whether any one type of psychotherapy model or theory has an advantage over any other. Many therapists would associate themselves with a particular model depending on their preferences, training or work environment. This created allegiances between researchers and a “battle of the brands” (Hubble, Duncan & Miller, 1999) where competition was rife to determine the ‘superior’ therapy. In line with medical research it was thought the most robust way to test superiority would be through randomized control trials (RCTs) which are often referred to as the ‘gold standard’ of research. A RCT involves randomly allocating

participants to an intervention or control group which should be explicitly described. This minimises allocation bias and allows researchers to determine if there is an effect from the intervention compared to the control group. Inclusion and exclusion criteria of participants are clearly defined and require representative samples of adequate size to enable statistical analyses of results, to determine the effectiveness of the intervention. The impact of the intervention will be determined from outcomes defined at the outset of the trial. In the case of psychotherapy the aim would be to test a treatment type. One condition would see the group receiving the type of psychotherapy being tested, whilst the control group would receive an alternative form of psychotherapy or no active treatment. Other than the difference in the intervention being received, participants should be treated equally, to reduce the likelihood other variables impacting upon the results. In 1995, The Division 12 Task Force (American Psychological Association, 1995) ranked methodological techniques employed in research studies to the extent to which they control for confounding variables and other sources of bias; they rated RCTs as the top method. NICE also states RCTs are generally to be considered the most rigorous experimental study design (NICE, Third edition, 2012).

Research has not been able to demonstrate convincingly that a specific model or therapy is most effective at treating a specific difficulty. Wampold (1997, 2001) conducted a meta-analysis comparing psychological therapies to determine influence on outcome and found that 87% of the variance was due to extra-therapeutic factors. Of the 13% that was ascribed to the treatment; 8% was attributed to the therapeutic alliance, 4% for the therapist's allegiance to and enthusiasm for the model being used and the final 1% was accounted for by the model or technique itself. Luborsky et al (2002) conducted a meta-analysis of treatments (cognitive and psychodynamic)

for common mental health problems (anxiety and depression) and found differences between them were small. Though the research figures are stark in demonstrating the equivalence of therapies, it led some to question whether there was still some evidence for certain therapies being superior for specific 'disorders'. This was particularly questioned in regards to anxiety disorders and the most common treatment for this group, cognitive behavioural therapy (Barlow, 2004). However, in a review of meta-analyses conducted by Wampold (2001, 2006), no evidence was found to demonstrate one type of treatment for anxiety disorders was more effective than any other. This has also been found to be the case for the treatment of depression (Wampold, 2007). The results of such research in the field have led to statements from Hubble et al (2010) that "the existence of specific psychological treatments for specific disorders is a myth". The most recent review of the equivalence literature is that of Marcus, O'Connell, Norris and Sawaqdeh (2014) who conducted a meta-analysis of treatment comparison studies between 1996 and 2012. They questioned whether some of the methods used by Wampold et al (2007) to analyse the data may have minimised treatment differences. The majority of the studies compared CBT to other therapies including; behaviour therapy, interpersonal therapy, acceptance and commitment therapy and psychodynamic therapy. Marcus et al (2014) found some bona fide treatments are more effective than other bona fide treatments when specific treatment outcomes are assessed at the end of therapy e.g. habit reversal therapy for tic disorders and CBT for panic disorder; with a 55% success rate compared to a 45% success rate for less effective treatments. The criteria for treatments to be considered bona fide were the treatment targeting a problem or issue that was clinically relevant as well as being tailored to the client. It must also have met two of four other criteria, consisting of 1) having a treatment manual, 2) citing a therapeutic approach that was established 3) including 'active

ingredients' that have published citations or 4) including a description that contains a reference to an established psychological process. Though there was statistical significance for primary outcomes (measures of the symptoms) being reduced in specific disorders at the end of treatment, this was not the case for all diagnoses. There was no difference overall between bona fide treatments in regards to secondary outcomes i.e. quality of life measures at the end of therapy and follow-up, which was around six months. They also reported a tentative "perhaps" for the Dodo bird hypothesis being apparent in the case of primary outcomes at follow-up. The Dodo bird hypothesis makes reference to the quote from the Dodo in Alice in Wonderland of "Everybody has won, and all must have prizes" (Carroll, 1865), which was used to illustrate research findings by Rosenzweig in 1936. Rosenzweig (1936) identified four aspects of therapy he believed to be common factors across diverse forms of therapy. The four were 1) the therapeutic relationship, 2) a rationale being provided for the client to enable them to understand their difficulties and how they could be managed, 3) change being initiated from a number of starting points and 4) the therapist's personality. The quote reflected Rosenzweig's thinking that commonalities occurred across all schools of thought and one was not more effective than another. Though the statistical limitations when analysing the present data are highlighted, Marcus et al (2014) believe there could be "Dodo disorders" and "non-Dodo disorders". In summary, Marcus et al (2014) advocate the use of specific treatments when clients seek primary symptom reduction where it has demonstrated its effectiveness i.e. panic attacks or tics. However, overall they state that a specific treatment manual is unlikely to have a major impact on the treatment outcome, particularly at follow-up; which confirms previous research in this area. This declaration highlights the move from an allegiance to one type of therapy to an eclectic approach, with many therapists now being trained in multiple modalities and

describing themselves as “integrative” (Larsson, Kaldø, & Broberg, 2009). It is therefore important that research is conducted in settings which comprise of therapists trained in multiple modalities who practice therapeutic treatments from an integrative approach as they reflect the realities of clinical practice within mental health settings. The current research reflects these realities in a secondary care mental health setting in that participants presented with varying symptoms and were seen by different therapists within the service who do not work exclusively from one treatment approach. It is from this inclusive approach that the study will be able to determine if there are themes across these factors that support people in managing their mental health once they have been discharged from therapy.

### **How does psychotherapy work?**

Thus far the questions have been answered in that psychotherapy does indeed work for a significant number of people and on the whole this is not due to a specific type of treatment, which leads to the question of how *does* it work? Lambert (1992) conducted a review of empirical studies on outcome research and proposed a four-factor model of change based upon this. The four –factor model encompasses: extra-therapeutic change factors, common factors, technique factors and expectancy factors. Estimated percentages of variance in outcome that each factor contributed to change in the therapeutic process were then apportioned. It was estimated that client and extra-therapeutic factors accounted for 40% of the change; which includes client factors such as severity of symptoms, motivation and personality and extra-therapeutic factors outside of therapy that involve change in a client’s life such as relationships, work and other life events. Relationship factors were said to account for 30%, with model/technique and client hope/expectancy each contributing 15% towards change. It is believed that these factors transcend all approaches and are

essential elements in producing effective change. A subsequent meta-analysis by Wampold (1997, 2001) produced an even higher estimate than Lambert's 40% of change being due to client and extra-therapeutic factors, finding 87% of treatment outcome being due to extra-therapeutic factors, leading Hubble et al (2010) to report their influence to be undeniable. Since the identification of the Dodo bird hypothesis in 1936, researchers have attempted to categorize the common factors, with varied results. Different authors have focussed on different domains of commonalities and in turn have produced numerous variations of the factors that lead to therapeutic success. Grencavage and Norcross (1990) reviewed a large body of literature on common factors to determine the commonalities that have been proposed. Their coding system was determined from a review of the literature, which saw them categorize common factors into five categories; client characteristics, therapist qualities, change processes, treatment structure, and relationship elements. Though the research was not without its limitations, i.e. not all research being empirically based, Grencavage and Norcross found eighty nine terms used to express common factors. The most common factor cited under the heading of client characteristics was "positive expectancies and hope for improvement". Most frequently reported under therapist qualities was a rather general "beneficial therapist qualities", however commonly cited was the therapist's ability to "cultivate hope and enhance positive expectancies within the client". The third category of change processes found an opportunity for catharsis and the "acquisition and practice of new behaviours" to be most common. Under the heading of treatment structure, the most reported factor was the use of "concrete techniques and rituals". Finally, the fifth category, therapeutic relationship saw the most frequently reported common factor to be the development of the "therapeutic relationship or working alliance". Overall, the most commonly cited factor was the development of a therapeutic alliance.

Research into the therapeutic relationship seems to be firmly established and has shown the superiority of client outcomes when working with therapists who are able to build more effective therapeutic alliances (Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Wampold & Brown, 2005). Goldfried and Davila (2005) would argue for a combination of the relationship and the technique used in therapy. They state a good therapeutic alliance increases the likelihood of the client engaging in the therapeutic techniques and the successful implementation of the techniques enhances the functioning of the alliance. This is echoed by Hill (2005) who highlights the inextricably linked nature of therapist techniques, client involvement and the therapeutic relationship. In regards to client involvement, Hill (2005) refers to clients as 'active agents' who seek out therapy and engage with therapists, utilising what they feel is helpful for them from the techniques being offered and making changes in line with these.

Gelso (2011) highlights the emerging and continuing trend of the integration of techniques and the therapeutic relationship within the research literature. Although the shift towards integration has been strengthened, Gelso (2011) highlights the importance of acknowledging the differences between technical and relational factors and striving to continue to examine their relationship, the influences upon each other as well as on treatment processes and outcomes.

It is difficult to disentangle the intertwined nature of psychotherapy factors and the impact they have on outcomes. These important factors include; the therapist giving the client a rationale for treatment and an explanation of their difficulties, the client being willing to participate in therapy and an agreement being reached regarding the tasks and goals of therapy (Hubble et al, 2010). Thus common factors demonstrate



their significance in therapeutic outcome, however, the overall question of how psychotherapy works is still in contention. An emphasis on therapy technique above other considerations such as common factors in the NICE guidelines is a cause for concern amongst practitioners such as Mollon (2009) and leads to questions regarding the clinical applicability of treatment guidelines. The concern surrounds the generalisability of RCTs to routine mental health settings, where clients present with many symptoms that fall into multiple diagnoses and are seen by therapists of varying abilities offering integrative treatment approaches. To evaluate technique alone minimises the importance of other such variables and the applicability of the findings. The current study aims to determine if there are any themes present, regardless of technique, that support individuals in managing their mental health on a day to day basis after they have been discharged from therapy. RCTs have their place in psychotherapy and have led to the development of evidence-based practices (EBP) which inform the NICE guidelines. Practitioners are recommended to follow these guidelines; the impact of which will now be discussed and evaluated in contrast to practice-based evidence (PBE) and routine clinical practice.

### **Evidence-based practice**

In terms of research investigating the impact of psychotherapy, there are two important distinctions to be made; efficacy and effectiveness. Efficacy research aims to produce conditions that produce high internal validity. It is generally in the form of a RCT, i.e. comparing the treatment being investigated to a control group or a comparison treatment which clients are randomly assigned to. Evidence-based practice (EBP) recommendations are largely based on evidence from RCTs. The therapists in RCTs are usually highly trained in the specific form of therapy being provided and the client must meet strict inclusion and exclusion criteria of the

condition the treatment is designed to address, to reduce confounding factors that may impact on the outcome of the treatment. EBP has been able to provide clinicians with evidence on which to base their decisions, advocating for improved patient outcomes, detecting harmful therapies and setting a standard for comparison work to take place. However, the conditions under which a RCT study takes place do not necessarily reflect conditions under routine practice, particularly in secondary care. These conditions include the complexities of clients' problems and co-morbidities as well as the range of therapies provided, hence the need for effectiveness research to be undertaken.

Research methods that inform the NICE guidelines for psychological therapy are largely based on RCTs. RCTs have established their rigour and salience in the medical setting where they are commonly used; offering specific treatments to target specific symptoms/diagnoses. Psychotherapy is also established in scientific research methods to evaluate its effectiveness, with RCTs being used to determine which therapeutic approach is best. This has led to the manualisation of treatments methods such as cognitive behavioural therapy (CBT) for anxiety and depression. Manualised therapy can provide details of what treatment to use, how many sessions to offer, what work to cover in each session and homework to be set. This has been endorsed by the government and the Improving Access to Psychological Therapies (IAPT) programme which was founded in 2008, enabling increased access to talking therapies. Advocates of the manualisation of therapy state they provide an aid to the teaching and usage of EBPs as well as providing the "structural and conceptual boundaries of a treatment" (Addis & Cardemil, 2006). The benefit of such methods in the case of IAPT is undoubtedly giving access to psychological therapies to individuals that previously wouldn't have received them. However, Duncan & Miller

(2006) contend the use of manuals and state they are “empirically incorrect” with evidence not demonstrating “specific therapist technical operations result in client change”. RCTs may be able to tell us what treatment is likely to work for certain diagnoses in a highly controlled condition; however the generalizability of this into routine clinical practice is called into question (Kazdin, 2008). Chambless & Crits-Christoph (2006) believe the efficacy model provides accurate outcome data as the treatment method is the only aspect psychotherapists can be trained in. Baker et al (2008) adds that research on the common factors approach does little to validate a science-based practice of clinical psychology. However, others believe effectiveness research to be more meaningful (Hunsley, Elliott & Therrien, 2013). Seligman (1995) maintained that efficacy studies are the wrong type of method to evaluate psychotherapy because of the high internal validity, i.e. it omits too many of the vital elements that are present in routine services, such as co-morbidities. This has led to acknowledgement of the importance of practice-based evidence. They investigate outcomes in routinely provided services where a range of therapies are provided by a range of therapists to a range of clients, often with complex problems. The case for practice-based evidence will now be discussed.

### **Practice-based evidence**

Effectiveness research is conducted under conditions of high external validity, whilst still aiming to maintain levels of internal validity, which practice-based evidence (PBE) stems from. The aim of effectiveness research is to assess the treatment in a ‘real-world setting’ i.e. being conducted at clinical bases that provide services. Barkham and Parry (2008) believe evidence based practice to be selective; they state a science research model needs to be inclusive of clients’ choice as well as

considering the complexity of presentations seen in clinical practice, which is accommodated by practice-based evidence (PBE).

PBE aims for “clinical realism and external validity” by including heterogeneous samples with therapists conducting their usual treatment under routine clinical/practice based conditions (Barkham et al, 2008). This therefore means clients may not have a single diagnosis, are not randomised to one specific treatment, nor may therapists be trained in one specific treatment model; which increases the generalizability of the findings across particular services and settings (Barkham and Mellor-Clark, 2003). Barkham and Parry (2008) highlight the areas PBE is able to address; whether clients improve under routine clinical conditions, the factors that may affect or predict outcome, the clients’ evaluation of the treatment and the frequency of adverse outcomes. Traditional evidence to inform practice guidelines have stemmed from a linear approach of research to reviews, then dissemination and implementation, minimising contextual influences (Leeman & Sandelowski, 2012). Whereas PBE aims to integrate these contextual influences into varying practices and service settings from the ground up, making it more relevant to clinical practice (Barkham & Mellor-Clark, 2003).

Efficacy and effectiveness research have been contrasted and whilst both have merit, the concern of efficacy research is that it does not reflect the realities of clinical practice. Some key areas for the argument of PBE in considering the realities of clinical practice have been put forward by Holmqvist, Philips and Barkham (2015), these will now be discussed in relation to the current research study.

**Realities of clinical practice**

Adult psychological therapy services are designed to support people experiencing severe, complex and persistent mental health difficulties. Holmqvist et al (2015) highlight the complex nature of clients' difficulties that need to be addressed in therapy including psychiatric, relational and social factors. Research trials however, generally have strict inclusion and exclusion criteria, selecting participants who have a single diagnosis rather than a complex presentation and history. Westen, Novotny and Thompson-Brenner (2004) found in general, the amount of people excluded from participating in trials was 40-70%. Trials therefore may not accurately reflect the complexities of routine clinical practice, particularly in secondary care. For instance, Hofmeijer-Sevink, van Oppen, van Megen, Batelaan, Cath, van der Wee, van den Hout and van Balkom (2013) found of 382 individuals with a diagnosis of obsessive compulsive disorder (OCD), 55% had a current comorbid diagnosis and the lifetime prevalence of comorbidity was 78%. Westen, Novotny, and Thompson-Brenner (2004) found that Axis I disorders were co-morbid with other Axis I or Axis II disorders 90% of the time.

As the current research aims to give a true reflection of day to day practice, it is essential that all clients in the service, despite their diagnosis/diagnoses are able to be included. Clients will also be included despite their history and previous involvement with services, to accurately reflect the population of clients seen within an adult psychological therapies service. It can be argued that investigating self management and long term benefits from therapy is particularly important in relation to clients with more complex problems and a history of previous involvement with services. This is further supported by research showing high levels of relapse even

following medication or psychological therapy, which will be described in a later section.

Okiishi, Lambert, Nielsan and Ogles (2003) believe that an over emphasis on the effectiveness of a therapeutic model has led to minimal research investigating the effectiveness of therapy providers. They state the relative unimportance given to the therapist has been further reinforced by the promotion of standardised treatments and treatment manuals, which give little acknowledgement of any therapist variation and the impact this may have. Green (2008) uses the term “empty vessel fallacy” to describe research which does not consider the practitioner’s skills and practices, whereby evidence is seemingly poured into an empty vessel where no interaction would occur with the therapist. Okiishi et al (2003) conducted a study to determine the extent of variability in outcome due to the impact of individual therapists. The data consisted of 56 therapists who had seen a total of 1779 clients with similar levels of symptomology at intake and it was found that there were significant differences in outcome across therapists. The differences were not found to be due to gender, level of training, theoretical orientation or type of training; indicating that any differences due to the therapist were due to the effect of other therapist variables. It was found that the ‘better’ therapists (those with clients who saw the greatest rate of change) saw clients for a shorter amount of time. The top three therapists saw clients on average for 2.4 sessions, with a maximum of sixteen, and the bottom three therapists saw clients on average for 7.05 sessions with a maximum of fifty-four. This indicates there is something about the way the ‘better’ therapists’ work, independent of the amount of time spent with clients, that has a significant impact on outcome. Though the study was not able to explore the differences between therapists, it highlights the significant variability there is between therapists and that

this is an important area which should be considered in research studies. EBP sees highly trained therapists in a particular model deliver that intervention, however in clinical settings the evidence of therapists following EBP guidelines for treatment is less substantive. Tobin, Banker, Weisberg, and Bowers (2007) surveyed two-hundred and sixty five eating disorder professional clinicians to determine their psychotherapeutic approach. Only 6% reported adhering closely to treatment manuals, whilst the remainder indicated using both behavioural and dynamically informed interventions, suggesting clinicians use a mixture of empirically supported treatments and treatments that are not founded on randomized control trial studies. This was further supported by Wallace and von Ranson (2012) who found amongst a group of professionals delivering evidence-based treatments for eating disorders, half were providing this alongside another form of psychotherapy which generally was not evidenced-based. Webb, DeRubeis and Barber (2010) highlight a lack of studies investigating adherence or competence outcome compared to that of alliance and outcome i.e. common factors, thus they conducted a meta-analytic review of such studies where therapist adherence or competence was examined in relation to outcome. Overall, effect sizes were calculated from thirty-two adherence-outcome studies and seventeen competence-outcome studies. Results were not significant in either adherence or competence outcome i.e. they were not found to be related to patient outcome. Holmqvist et al (2015) also detail other strengths that lie in a PBE approach. They can include treatments that do not prescribe treatment length, the study of under-represented treatment methods, representing therapists who are trained in a range of methods rather than specialists in one area, as well as considering service effects, dropout and patient-treatment matching. With many therapists not being trained in one particular model and describing themselves as integrative practitioners (Larsson, Kaldo, & Broberg, 2009) or adapting therapy to

match client characteristics (Baker, McFall, & Shoham, 2009); it is vital that eclectic treatment approaches are considered and evaluated. Tasca et al (2015) note that clinicians often feel that research findings do not reflect the realities of their daily practice and therefore do not consistently use the research findings to inform their work.

Though there are many benefits to PBE, Barkham and Mellor-Clark (2003) state that no one research method can meet all requirements to be both rigorous and relevant and there must be an appreciation of multiple methods which can be brought together to provide the most effective knowledge base and outcomes for psychological therapies. In 1995, the American Psychological Association gave the highest weighting in terms of research to randomised control trials; however, a Task Force was set up in 2005 to address the issues surrounding EBP. They now defined EBP for psychology as "...the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences". Expanding upon their definition, the Task Force (APA, 2005) now endorse multiple types of research methods including single case experimental designs, qualitative research and process outcome studies. They emphasise the importance of clinical expertise, highlighting eight components including; diagnostic judgement, monitoring of patient progress and "understanding the influence of individual, cultural and contextual differences on treatment". Finally, the Task Force have taken into account the importance of patient characteristics. It recognizes the skills and experience of a clinician to consider if a client will benefit from a given therapy, acknowledging their characteristics may be different to those of the participants who took part in research trials. This creates a balanced, broader approach to research and its implementation, which the present study aims to provide. A research method that



was endorsed by the Task Force (APA, 2005) as contributing to effective psychological practice is qualitative research, which was described as offering “subjective, lived experiences of people, including participants in psychotherapy” (page 174). The value of qualitative research will now be discussed.

### **Qualitative research into effective processes in therapy**

Qualitative research is said to offer discovery, elucidating new insights and producing idiosyncratic accounts of the experiences of those participating in research (McLeod, 2012). Evaluating client experiences is said to be crucial in the understanding and improving of theoretical knowledge of the processes in therapy which lead to improved outcomes (Elliot, 2008). Research investigating client experiences of therapy using qualitative methods has grown (Fitzpatrick & Chamodraka, 2007; Jim & Pistrang, 2007; Nilsson, Svensson, Sandell, & Clinton, 2007; Ramnero & Ost, 2007; Vanaerschot & Lietaer, 2007; Rayner, Thompson & Walsh, 2011; Barnes et al, 2013) and a qualitative meta-analytic method to assess findings from qualitative studies has been conducted by Timulak (2007). Timulak (2007) aimed to identify core categories of the impact of helpful events in psychotherapy, as identified by clients, across a range of studies. The studies included a variety of diagnoses and treatment modalities engaged in by therapists. Results of the meta-analysis identified nine core categories of helpful events which are as follows; (1) awareness/insight/self-understanding; (2) behavioural change/problem solution; (3) empowerment; (4) relief; (5) exploring feelings/emotional experiencing; (6) feeling understood; (7) client involvement; (8) reassurance/support/safety; and (9) personal contact. Though some of these may overlap, they do provide the beginnings of a conceptual framework of aspects of therapy that clients report finding helpful. Timulak (2007) recommended addressing

session outcomes and overall outcomes of therapy in the context of the helpful events identified. Though the research conducted is a useful exploration of the experiences of clients of the therapy process, it is invariably retrospective, and focussed on client experiences of recent therapy. Research has not explored the next stage in a client's experience of therapy – perspectives of clients about processes *after the end* of therapy, i.e. the benefits of therapy after discharge and what clients feel they gained from therapy that is having an impact longer term; which is the focus of the present study. Given the present study will be conducted with participants who have been discharged from therapy, it is important to consider the long term outcomes of therapy including relapse rates and self management; how people stay well. These issues will now be considered.

### **Long term outcomes**

#### **Relapse**

Overall, there is a scarcity of research on long term follow up of mental health conditions and their response to treatment, particularly beyond two years; however, what research there is has demonstrated consistent findings. Crown (2002) identified that for individuals who suffer with depression; approximately 50% will chronically relapse with relapsing generally indicating a pattern of increased severity and frequency (Kendler, 2000). Other research has shown relapse rates to be between 35-85% (Eaton et al, 2008; Mueller et al, 1999).

Anti-depressant medications are effective in the treatment of moderate and severe depression; however, the prevention of symptoms are maintained only if medication is continued (Hollon et al, 2005). Even those who are considered to be in remission are kept on continuation pharmacology for a further six to twelve months to prevent the likelihood of relapse (Cuijpers et al, 2013) and those with chronic or recurrent

depression are kept on medication indefinitely (American Psychological Association, 2010). The majority of individuals who respond to anti-depressant medication relapse within a year if withdrawn (Hollon et al, 2005). Hollon et al (2006) describe three categories efficacious treatments can fall into; 1) palliative 2) curative and 3) prophylactic. Hollon et al (2006) believes medication falls into the palliative category; that they suppress the symptoms as long as they are taken, but do not treat the underlying disorder. They believe cognitive and behavioural treatments fall into the second and third categories in that they eliminate or reverse the underlying symptoms (curative) and somewhat produce lasting change; reducing future risk (prophylactic). Cuijpers et al (2013) conducted a meta-analysis of acute phase CBT for the treatment of depression that had been discontinued, compared with pharmacotherapy that was either continued or discontinued across a period of six to eighteen month follow up. The findings revealed CBT to be clearly more effective in reducing relapse, though the results draw from a limited number of studies. Steinert, Hofmann, Kruse and Leichsenring (2014), produced a meta-analysis of relapse rates beyond two years after psychotherapy for depression and the rates of relapse in psychotherapy compared to a non-psychotherapeutic condition, for example, pharmacotherapy or treatment as usual, also beyond two years. Eleven studies were included (six of which had a non-psychotherapeutic comparison condition), consisting of the data of nine-hundred and sixty six clients with a mean follow up of 4.4 years. Findings can only be seen as preliminary due to the studies differing methodology and publication bias, however, on average it was found the overall relapse rate was around 40%. Psychotherapeutic interventions resulted in significantly fewer relapse rates compared to treatment options without specific psychotherapeutic ingredients, 53.1% vs 71.1%. Hollon et al (2005) followed up patients who did not relapse the following year after treatment. Those who were

taking medication were withdrawn and compared to patients who had a history of cognitive therapy. As all patients had not relapsed within the year, they were considered to be in remission, thus a return of symptoms would constitute a new episode. It was found that those who were withdrawn from medication were more likely to experience a recurrence (53.6%) than those who had cognitive therapy, with a recurrence rate of 17.5%. DeReubis et al (2005) also found a significant reduction in relapse of 70% when the individual had cognitive therapy relative to antidepressant medication withdrawal. This is not to say that individuals who receive psychotherapy do not relapse, as research has also indicated around 50% of individuals who were considered to be recovered after psychotherapeutic treatment suffer a relapse within two years (Dobson et al, 2008; Emmelkamp, 2013; Gortner et al, 1998; Hollon et al, 2005; Shea et al, 1992; Vittengl et al, 2007). However, meta-analyses suggest that psychotherapy has a significant favourable outcome of reducing relapse compared to that of medication, clinical management and treatment as usual in the treatment of depression (Cuijpers et al, 2013) indicating psychotherapy has enduring effects beyond the end of treatment (Hollon, 2006). What is not known is how the effects of psychotherapy have a lasting effect beyond treatment, i.e. what do people take from therapy that supports them in managing their mental health, hence the importance of the current research exploring this area.

There are many ways in which psychotherapy can be deemed to have ‘worked’, ranging from outcome measures, therapists’ and significant others observations, and the clients’ subjective experience. Psychotherapy having ‘worked’ generally refers to a change that has occurred. The term ‘change’ is elusive in that there is no operational term; Roussos (2013) raises the difficulties surrounding this lack of definition due to its complex nature. There is evidence to suggest that therapists and

clients do not necessarily agree on outcomes or change from psychotherapy (Viklund, Holmqvist, & Zetterqvist Nelson, 2010), which leads to questions of how to give measured meaning to change. Jacobson, Follette, and Revenstorf (1984) define two different types of significant change to be used in quantitative psychotherapy research; reliable and clinical. Reliable change is the statistic used to assess whether an individual's score, before and after an intervention, is statistically significant based on how reliable the measure is. It is calculated by dividing the difference between the pre-intervention and post-intervention scores by the standard error of difference between the two scores. A score greater than 1.96 indicates the difference is reliable and is of a scale that would not be expected due to the unreliability of the measure being used. The question reliable changes addresses is whether the client has changed sufficiently to be confident that the change is of a magnitude beyond what could be attributed to measurement error. However, this outcome alone does not determine clinically significant change. Clinically significant change is the extent of change in an individual's score which is deemed to be clinically meaningful, i.e. it moves within the range of a 'functional' population or outside the range of a 'dysfunctional' population (Jacobson et al, 1984). Jacobson and Truax (1991), proposed three methods of calculating this; a) the client moves out of clinical range, i.e. moves two standard deviations out of the 'dysfunctional' population b) the client moves into the non-clinical range, i.e. falls within the range of the two standard deviations of the functional population or c) the client's post treatment mean is closer to the non-clinical mean than the clinical mean. Although this type of analysis may provide a quantitative measure of change in relation to questionnaire data; Hill, Chui, and Baumann, (2013) point out that quantitative methods may not capture changes that have been made and what they mean to clients, suggesting qualitative methods as a way of identifying clinically significant change.

It is important to gather the views of the client to determine what they felt worked for them and determine how this can be considered by therapists and incorporated into future work. Weinberger (2014) notes that the clients' understanding of the outcome of psychological treatment affects the likelihood of relapse. Relapse is less likely when clients attribute successful changes internally i.e. due to coping skills they have developed or their hard work during therapy. Conversely, relapse is more likely when clients attribute change to external outcomes, i.e. the therapist or therapeutic technique.

As stated earlier, Hollon et al (2006) report that pharmacology is believed to be palliative, with patients requiring extended doses for it to be considered effective. Yet psychotherapy continues to be effective, reducing the rates of relapse once psychotherapy has ended. What the research has not demonstrated are what changes the patient has made in order to prevent/reduce relapse after therapy has been completed. It would seem that psychotherapy inculcates a management of symptoms or difficulties more effectively; however, there is a lack of evidence to support how this is done beyond therapy. Self management offers some insight into how individuals manage their difficulties, which will now be considered.

### **Self management**

#### **How do people stay well?**

In recent years there has been a commitment from the Department of Health to involve service users in the delivery and evaluation of the NHS (Simpson and House, 2002). This is evident in self management approaches for mental health problems which have been service user led and developed. Attempts have been made to deliberately enhance self-management, though these have largely been standalone

management courses as opposed to strategies from within therapy sessions. For example, the Manic Depression Fellowship Course, the Expert Patient Programme, and the Rethink Self Management Course (Davidson, 2005). The Expert Patient Programme was initially developed for physical health conditions and Davidson (2005) states that it cannot be transitioned to a mental health setting without changes being made, and that there needs to be a conscious effort to “start listening to people about what works for them”. It is now recognized that individuals with serious mental illness can recover and there are specific things they can do to help themselves (Sterling, von Esenwein, Tucker, Fricks, and Druss, 2010). There are varying definitions and meanings of recovery with Todd et al (2012) noting it to be a “multifaceted, dynamic and idiosyncratic process”, demonstrating the difficulty in providing a conclusive definition for all. However, Anthony (1993) defines recovery as a way of living a fulfilling life despite limitations caused by mental health difficulties, which still allows for an idiosyncratic interpretation. Four key themes were identified by Todd et al (2012) in a focus group of service users with bipolar disorder in understanding recovery and self-management. The themes identified that 1) recovery is not about being symptom free; 2) recovery requires taking responsibility for your own wellness; 3) self management: building on existing techniques and 4) overcoming barriers to recovery: negativity, stigma and taboo. Self-management encourages service users to become active participants in their treatment, with a shift of management from a health care professional to the individual as an ‘expert of experience’ (Barlow, Wright, Sheasby, Turner and Hainsworth, 2002). The Wellness Recovery Action Planning (WRAP) is a self management programme for people with mental health difficulties and has been noted for its emphasis on individuality and responsibility, however, it has also been criticised for its detail and directiveness (Henderson, Swanson, Szmukler,

Thornicroft, and Zinkler, 2008). Research has been conducted into the area of bipolar disorder (Todd et al, 20012; Murray et al, 2010), investigating self-management strategies used, however, the self-management interventions have been criticised for being incompatible with service users' definition of what recovery means to them. It is felt there is a "prescriptive focus on treatment and over emphasis on symptom recovery" (Todd et al, 2012). Many of the self-management programmes are an intervention in themselves, rather than post therapy or what has been taken from therapy, thus will not elucidate therapy specific factors that have led to change or maintenance. Of particular importance to consider are individuals with long term mental health problems, which are more prevalent in secondary services. Hence the case for the investigation of the subjective views of clients who feel they benefitted from therapy to explore what they took from therapy in the management of their mental health on a daily basis. Andrews (2001) highlights the reoccurring nature of depression and questions whether treating the condition as episodic is helpful as opposed to managing depression as a chronic disease. Aside from the detrimental impact the reoccurrence of depression can have on individuals, there is a financial implication to repeated treatment and strain on services.

Where individuals have longer term mental health problems, it is important to understand how they manage their problems, how they can be supported in this, and how therapy can enable them to manage their problems in the longer term. This information could lead to more effective management minimising the likelihood of reoccurrence and reducing costs to the NHS. Mindfulness-based cognitive therapy (MBCT) was developed in response to the relapse/recurrence of major depression (Segal, William & Teasdale, 2002) and combines approaches from cognitive behavioural therapy and the mindfulness based stress reduction program. In two



RCTs findings were replicated for the impact of MBCT. It was found for individuals with three or more episodes of depression, MBCT plus usual care halved the rates of relapse compared with usual care over a sixty week period. However, for individuals with two prior episodes, MBCT did not reduce relapse/recurrence. Approximately two thirds relapsed in the usual care category and one third relapsed in the MBCT plus usual care category (Teasdale et al, 2000; Ma & Teasdale, 2004). More recently, Kuyken et al (2008) found relapse rates over a fifteen month period for individuals receiving MBCT was 47% compared to 60% for those receiving maintenance antidepressant medication (m-ADM). MBCT was also more effective than m-ADM in reducing psychiatric comorbidity, residual depressive symptoms and improving quality of life in physical and psychological categories. Though results are promising, it appears that to gain the most benefit from MBCT, individuals need to have relapsed a substantial amount of times, thus demonstrating other forms of psychological therapy have not been successful or improvements have not been maintained. As psychotherapy demonstrates a reduction of relapse rates compared to that of ADM (DeReubis et al, 2005; Hollon et al, 2005; Cuijpers et al, 2013), it would appear that some sort of relapse prevention work is combined across psychotherapies, however this has not been investigated, thus it cannot be categorically incorporated into therapy. Hearing from service users' themselves about what has been helpful in therapy is crucial to begin to understand what is valued and how this may impact upon session delivery.

### **Service users' views**

Failing to take into consideration service user views may lead to an increase in dropout from therapy as well as poor treatment outcomes (Brownell, Schrank, Jakaite and Larkin, 2014). Yet the scarcity of service user views on the outcome and

effectiveness of therapy continues to be highlighted (Macran, Ross, Hardy and Shapiro, 1999; Valkonen, Hänninen and Lindfors, 2011). Nilsson (2007) notes the drawback of using standardised quantitative therapy outcomes which provide predefined response categories, stating that they often do not capture the fullness of service users' views. McLeod (2001) also considers pre-determined quantitative outcomes as being based on socially constructed knowledge, therefore highlighting the importance of qualitative methods for understanding individual client perspectives. The majority of research has tended to focus on the competencies, skills and actions of the therapist as indicators of successful therapy, rather than the skills, feelings and values brought by the client (Macran et al, 1999). This generates a notion that therapy is something that is done to the client, rather than seeing the client as an active agent in their therapy.

Lucock, Barber, Jones and Lovell (2007) investigated how service users manage their problems in everyday life with results identifying five themes of self-help strategies; managing and structuring the day; empowerment; engaging others to help yourself; physical health and well being; and spirituality. The findings provide a useful insight into service user management techniques, though most of those strategies were developed independent of any type of professional help, demonstrating the agency of the individual. Carey et al (2007) conducted research to identify how change occurred in psychotherapy. Six themes emerged from qualitative analysis across a range of therapeutic modalities; motivation and readiness, perceived aspects of self, tools and strategies, learning, interaction with the therapist and the relief of talking. Motivation and readiness was viewed as important with participants feeling they needed to make change. Perceived aspects of the self were a realisation of traits within individuals that hindered or helped the

change process, e.g. being avoidant. Participants described tools and strategies that helped the change process, i.e. homework, techniques and diaries. Learning was identified as part of the change process, gaining new insight or learning having occurred without awareness. The therapeutic relationship was noted as contributing to change i.e. the therapist being non-judgemental and finally talking; though difficult for some, it provided a relief and an opportunity to share their emotions rather than just thinking about them. Overall, participants were able to say with clarity that change had occurred, however, what we do not know is how this change is maintained once therapy ends and over time. It may be that the therapy and the therapeutic relationship created a space for the client to talk, facilitating the experience of catharsis. It could be that the therapist helped the client to achieve insight and understand their problems better, which led them to being able to solve their problems more effectively. The therapist may have helped the client to understand and express their emotions or may have supported the client in developing strategies for managing difficulties in terms of their relationships or skills for managing symptoms, for example, CBT or mindfulness strategies. It is important to consider these aspects and how the client may experience the changes after therapy. It would be beneficial to consider how clients implement techniques or how changes that occurred in therapy affected their perception and way of dealing with their difficulties once therapy ended and how they maintained this. There are some similarities between these results and those discovered by Lillevoll et al (2013) who qualitatively explored what fourteen clients found helpful in a guided internet-based treatment (MoodGYM) for depression. Five themes were found, the first being 'taking action to address one's problem'. This refers to moving from a state of passivity to a state of activity, whereby the clients described wanting to move forward and make changes which drove them to seek support. This links to

motivation and readiness to change as described by Carey et al (2007). The second theme was 'the value of talking to a professional', which was described as a 'vital' part of the treatment. Although the amount of input clients wanted from a therapist varied, it was seen as very important to be able to speak to a professional, again, something that was found by Carey et al (2007). The third theme related to 'acquiring relevant knowledge' from the programme that they could relate to and learn from. Though beneficial for some, not all clients could relate to the content and felt there was a mismatch between their difficulties and felt the programme could not address these; which impacted upon the outcome. The fourth theme was 'restructuring the new knowledge' which highlighted the clients' ability to reflect on the material in the programme and adapt it to their own needs; demonstrating there was an active process of interpreting the information. The fifth theme was 'actual changes in perceptions and interaction' which related to coming to the realisation that thoughts might not be accurate representations of reality and may need questioning. Some clients also described changes in self-perception, moving towards self-acceptance and reducing their self-critical/judgemental attitude, a themes which has also been found by Berry and Hayward (2011) in regards to the impact of CBT on individuals with a diagnosis of psychosis. Lillevoll et al (2013) discovered similar themes to those of Carey et al (2007), even though their research was focussed on an internet based treatment programme with less contact from a therapist. It mirrors the commitment brought to therapy by clients and the powerful impact the working alliance and expectations have on therapy outcome. Clients' also demonstrated ownership within the therapy; they sought out the parts of the programme they felt were relevant, evaluated this information and incorporated it into their life. The themes highlight the dynamic, collaborative interaction between the client, the programme and the therapist. However, the clients' involved in the study were

mainly those who completed the treatment, therefore may provide a biased view regarding the helpfulness of treatment. Also the study was conducted shortly after the end of treatment, thus long term impact cannot be determined, hence the need for research to be conducted in understanding what people take from therapy and how they manage their mental health once treatment has been completed.

Clarke, Rees and Hardy (2004) aimed to understand clients' experiences of cognitive therapy and their explanations for how change occurred. Five clients were interviewed after having between twelve and twenty sessions of CBT for depression. Ten categories were found with three category clusters, consisting of; 'the listening therapist', 'the big idea' and 'feeling more comfortable with self'. 'The listening therapist' highlighted the emotional and interpersonal components of therapy, whereby clients' discussed an initial hesitancy about therapy moving to an increasing investment and engagement with the process, which largely centred around the relationship with the therapist. This also links to the category of safety, where clients felt they were in a safe environment to talk about their difficulties. In the category of 'the big idea', clients refer to particular therapy techniques or procedures to be important. Understanding specific CBT components of core beliefs and being able to implement techniques and attempt to solve problems outside of sessions was noted as being helpful for making change. The final category 'feeling more comfortable with self' refers to the impact therapy had upon how the client felt about themselves, for example, feeling more confident and relaxed, as well as more compassionate and tolerant with themselves. Clients also discussed responsibility in the context of spending less time worrying about areas of their life that they had little control over. Though clients' discuss individual experiences and a small sample was interviewed, some consistent themes were evident. The study highlights the value of specific

techniques, the importance of the therapeutic relationship and the change in their relationship with themselves as components for making change.

Valkonen, Hänninen and Lindfors (2011) investigated pre and post-therapy views of fourteen service users with a diagnosis of depression, who had either long-term psychodynamic psychotherapy or short-term solution-focussed therapy. Service users' views about therapy, their diagnosis and understanding of depression were gathered and interpreted within the concept of the 'inner narrative'. This provided an understanding of the service users' experience of psychotherapy in regards to the outcome of therapy, alongside their inner narrative orientation. This approach does not determine outcomes beforehand; rather, each participant's narrative is interpreted on an individual basis, with the outcome being determined by the service user. It was found that the value or utility of the psychotherapy was connected with the way the person interpreted themselves and their difficulties i.e. the outcome was related to the person's experiences; their thoughts, feelings and values. Three orientations were found; life historical, situational and moral. Those with a life historical orientation expected therapy to help them to 'repair a fragmented or broken self-narrative', which sits alongside a psychodynamic view of therapy. People with a situational orientation expected therapy to help them with present difficulties, which sits alongside solution-focussed views of therapy and those with a moral inner narrative expected therapy to help them 'clarify their future perspectives and to join in dignified and desirable cultural narratives' (pg 239). On the whole it was found that a match between the individual's inner narrative and therapeutic orientation (for example, a historical narrative and psychodynamic therapy) supported the view of psychotherapy being of value. However, there were exceptions whereby a discrepancy between the inner narrative and therapeutic approach enabled

participants to formulate a new story about themselves and their difficulties. From this approach, the value of psychotherapy was seen as one which could support the person to progress in line with their inner narrative or for their inner narrative to be changed and provide new meaning, which in turn provided relief from their difficulties. The over-arching theme from this research is the importance of the individuals' inner narrative, values and preferences interacting with the type of psychotherapy received; i.e. the service user being an active agent in their treatment. It highlights the importance of seeking the views of clients and their expectations of therapy, and providing them with enough information to allow them to make an informed choice about the type of therapy which they feel would best suit their needs. Doing so may also lead to increased satisfaction with therapy, which is a key part of the therapeutic process (Brownell et al, 2015).

Knowles et al (2014) conducted a qualitative meta-synthesis of service user views of the barriers and facilitators of engagement in computerised therapy for depression and anxiety. Service users reflected on the interpersonal reactions they had towards the computer programme, such as becoming frustrated that the system was insensitive to their difficulties, feeling that the computer cared, or continuing to engage with the programme as they 'didn't want to disappoint the computer'. The results revealed two main constructs in regards to engagement, the first centred on the wish for the programmes to have greater sensitivity towards the service user, for example, recognising the impact of depression, such as a lack of motivation. The second construct that was found related to the level of support from others whilst receiving technologically delivered therapy. Some participants found using a computer programme enforced autonomy, which was seen positively; however, for others, the level of self-discipline and responsibility on oneself to complete the

programme was 'confronting'. This demonstrates the contrasting views of service users regarding autonomy and the impact upon engagement, a theme which was also apparent in the need for human interaction. Some participants found a lack of personal contact enabled them to disclose freely, whereas for others it brought about feelings of social isolation. Participants also spoke of adapting the programme to suit their needs by only completing elements of the programme they perceived to be useful, reflecting the agency of service users whilst in therapy. What is evident from the research are the varying interpretations of the same programme which could be viewed positively or negatively. Conclusions drawn from the meta-synthesis highlight the need for programmes to be tailored to the needs of the user, to meet service user preferences by being sensitive and having personalised content to engender feelings of connection. Without gauging the needs of the service user, the programme will not encourage engagement or facilitate change. It is crucial for the views of the service user to be gathered to minimise the gap between the client and therapist in regards to various aspects of the effectiveness of the therapy process.

In regards to conducting psychotherapy research and incorporating service users perspectives, opinions and ideas within this research, Macran et al (1999) identify four levels; level one involves researchers making inferences about clients' wellbeing and uses standardised measures to assess treatment progress. Level one acknowledges the importance of client perspectives; however, the researcher determines the research questions. Level two explicitly involves clients in developing the evaluation criteria that is used in the research; however, the research question is still determined by the researcher. Level three involves clients in developing the evaluation criteria and includes them in developing the research question. They advocate that including clients at all stages should be seen as integral



to the research which is of equal importance to the inclusion of clinicians and researchers. Brownell et al (2014) investigated service user experience of an eleven week positive psychotherapy intervention for psychosis. It appears that the research was conducted at level one as defined by Macran et al (1999), as although service user views were sought; the research question and evaluation criteria were determined by the clinicians/researchers. Overall, the feedback about the experience of the programme was positive and clinicians were provided with ways they could adapt and develop the programme for future groups. However, one of the findings was particularly poignant in regards to service user involvement. As part of the programme, clinicians offered between session telephone calls; some service users found this to be helpful, however, some reported finding the calls ‘unnecessary’ and ‘disturbing’ and asked not to receive them. If the programme had been developed in conjunction with service users, the issue of whether to offer phone calls may have previously been considered or the option of discussing this as an opt-in part of the programme with group members could have been had, rather than clinicians assuming it would be helpful. This is further emphasised by Berry and Hayward (2011) who highlight the continued quietness of the service user voice, and note that when it is present in qualitative research, it has still been found to be dominated by the perspectives of the ‘professional’.

Macran et al (1999) highlighted potential reasons why clients’ perspectives have tended to be neglected which include; not being able to make reliable judgements or reporting distorted experiences due to their difficulties and clients not being skilled enough to make a competent decision about the therapy they received due to having a less differentiated view of the therapy process. These views were challenged by the authors and assertions as to why clients’ perspectives should be considered were

stated. The acknowledgement that the client is an active part of the therapeutic process highlights at the least, the equal importance of the client alongside the therapist and how critical their contributions are. Given the importance of the clients' contribution to therapy, it is essential to discover what conditions will enable engagement in therapy, from their perspective, and to discover what has been helpful so clinicians and researchers are able to replicate and evaluate this. Bendelin et al (2011) evaluated the experiences of participants who undertook a guided internet-based cognitive-behavioural programme for depression. Four core themes emerged from the qualitative analysis of participants' accounts of the treatment; working process, motivation, attitudes towards treatment and consequences of treatment. Participants' accounts were further categorised and placed into three groups; readers, strivers and doers which accounted for differences described within the change process and accounted for different perceptions of the treatment depending on expectations and outcome. For example, in relation to working process, readers were classified as working sporadically or as stating that they could not work practically with the treatment programme; which led to a less favourable view of the treatment and outcomes. However, those who were categorised as doers discussed a practical approach to the treatment, integrating it into their lives which resulted in favourable outcomes and improvement. Overall, those who took responsibility for the treatment and attributed success to themselves appeared to benefit more. It is important to consider however, if some individuals are more suited to this type of treatment where working independently with a structured and practical approach is required. Taking into consideration client preferences and their perceptions of treatment could lead to more favourable outcomes.

Overall, the research discussed surrounding service user views highlights the active part they play in the therapeutic process. Macran et al (1999) draw attention to the 'hopes, aims and intentions' clients bring to therapy, and how they evaluate the therapists' actions in relation to those. Without gaining the views of the service user, research will continue to be dominated by professional thoughts and views which limit the type of research conducted and impact upon what is offered in therapy. The present study is influenced by the researcher in the creation of the questions, however, it seeks to gain the views of clients in an area that has not been researched before and aims to understand what participants have taken from therapy in the hopes that it will lead to questions being raised about what approach is most beneficial.

### **Summary**

Although psychotherapy has proved to be effective (Lambert & Ogles, 2004; Wampold, 2007), relapse still occurs (Dobson et al, 2008; Emmelkamp, 2013; Gortner et al, 1998; Hollon et al, 2005; Shea et al, 1992; Vittengl et al, 2007). Long term outcomes are questionable and prior research has not addressed what clients have taken from therapy and how they apply it once therapy has ended. It is important to uncover the experiences of individuals who found psychological therapy to be of benefit within this client group/setting and how they manage their mental health on a daily basis. It is hoped this understanding will provide a greater insight into how clients learn to manage their symptoms or their problems more effectively after therapy, and how practice may be adapted to elicit more effective interventions, preventing the likelihood of relapse in the future.

Previously, research into the area of the effectiveness of psychotherapy has been conducted using the evidenced-based practice framework, where one model is evaluated in regards to a particular diagnosis. Although this has been helpful and has provided information about the safety of treatments and allowed for comparison in similar research; no conclusive evidence has been provided to determine one type of treatment to be more effective than another (Wampold, 2001; 2006, Luborsky et al, 2002, Marcus et al, 2014). Secondary care offers support to a complex client group with multiple diagnoses, long term difficulties and previous experience of mental health services. As this particular group has not been routinely recruited in evidenced-based practice research, there is comparatively little known about what happens in routine services that hold this level of complexity. There is therefore a need to conduct research in routine services where clients have complex, multiple diagnoses and therapists are trained in multiple modes of therapy and work integratively, to provide greater external validity of findings.

### **Aims**

As previously outlined, there is at present little understanding of what people recently discharged from psychological therapy take from therapy in order to manage their mental health problems. It is essential to gain an understanding of this to improve the long term effectiveness of psychological therapy, to enable people to maintain improvements, to reduce the likelihood of relapse and to improve quality of life. The wider implications are in reduced costs to the NHS and the economy. Service users' experience will add to the body of knowledge to understand how improvements can be maintained following therapy. It is hoped the present research will depart from an over emphasis of symptom recovery in pre-determined measures and will produce idiosyncratic experiences as to how therapy helped, as research

suggests that the perspective of the client is the strongest predictor of outcome, surpassing the views of therapists' or outside observers (Lambert, 1992). The aim of the current research is to understand what those who have found therapy helpful took from the therapy to help them manage in their day to day life.

### **Principal Research Question/Aim**

The current study is the first known research which aims to gain an understanding of how psychological therapy helps people to manage their mental health after therapy has ended.

## **CHAPTER TWO: METHOD**

### **Design**

The aim of the study was to gain an understanding of how psychological therapy helped people to manage their mental health once therapy had ended. As the research was exploratory, qualitative methods were used to gain insight into how participants' utilised their experiences from therapy on a day to day basis. Data was collected via semi-structured interviews with 8 participants who had been discharged from the Adult Psychological Therapies Service in the past 3-6 months. Qualitative data was transcribed and analysed in NVivo 10, software for qualitative data analysis, using Thematic Analysis (TA) as outlined by Braun & Clark (2006). Demographic details of participants including information of their mental health and treatment status were gathered in order to situate the sample.

### **Methodological approach**

Qualitative research methods help provide rich descriptions of phenomena, exploring participants' experiences, which moves inquiry towards more meaningful explanations (Sofaer, 1999). In regards to psychology, qualitative research aims to explore lived experience and participant defined meanings (Willig, 2008). Qualitative approaches are also described as being diverse, complex and nuanced (Holloway & Todres, 2003), which equally describes people and therapy; thus it felt appropriate to use this method to capture the intricacies of the research topic. Due to a lack of research in this particular area, a qualitative approach was also utilised to give a voice to views which have rarely been heard and form a self-defined perspective. This allowed for the development of insight and understanding into

participants experiences of the impact of therapy upon mental health once discharged, one which would not be captured through quantitative means.

Before selecting TA as the chosen approach for qualitative analysis, Grounded Theory (GT) (Strauss & Corbin, 2008) was carefully considered. The central component of GT is the opportunity to generate and build new theory, which is relevant to the research, due to the understudied nature of the topic being explored. However, in order to generate theory, emphasis is placed upon the data being free from preconceived hypotheses about possible responses from data collection with a greater focus at a conceptual explanatory level. Strauss & Corbin (2008), departed from traditional positivist ideas endorsed by the original GT (Glaser & Strauss, 1965; 1967). They moved towards social constructivist and postmodern thinking, acknowledging that the researcher and the researched co-create the theory, accepting that reality cannot be fully known but is interpreted and linked to context at that moment in time. Although this was more compatible with my thinking regarding research; it was felt that being free from preconceived hypotheses regarding the outcome of the data was not entirely possible. TA was selected upon the basis that it offers “an accessible and theoretically-flexible approach to analysing qualitative data” (Braun & Clark, 2006, pg. 2) that allows rich and detailed data to be gathered within a flexible framework. It identifies patterns within the data, which is useful in this novel area. It also acknowledges the role of the researcher’s theoretical position and their active role in making decisions when gathering and analysing the data; rather than data simply emerging from the text which fits with my beliefs when conducting research.

## **Thematic Analysis**

It has been stated that TA should be seen as a foundation for qualitative analysis and should be the first method researchers learn as it provides fundamental skills that are transferrable to many other forms of qualitative analysis (Braun & Clark, 2006). Prior to Braun and Clark's (1996) paper, there had been no clear agreement of what TA was and how to conduct it effectively. This led to patchy reporting of the method in research papers making it hard to evaluate and compare with other work.

As TA is not tied to a particular theoretical framework, it is important for evaluative purposes to identify the process and practice of the methods used. The initial three methods to be considered are; realist, constructionist and contextualist. A realist method is based on reporting the experiences and meaning of participants; their reality. The constructionist method focuses on the range of discourses in society which have an impact upon the participants' reality, events and meaning. The contextualist method acknowledges participants individual interpretations of experiences whilst considering the impact the social context has upon these interpretations. As I wanted to gain an understanding of the individual's interpretations and meanings of their world and how psychological therapy may have had an impact upon this, I felt the realist method would offer the opportunity to do this. However, I felt I would not be able to completely separate myself from considering the impact the social context has upon these interpretations as I believe we can never truly separate ourselves from this and this was acknowledged throughout data collection. Thus, overall, I felt the contextualist method offered a balance of both my aims of wanting to immerse myself in participants' accounts yet understanding these in a wider social context and my theoretical beliefs about conducting research.



Themes can be identified in two ways in TA; inductive or deductive. An inductive approach involves themes being strongly associated with the data and may have little relationship to the question posed by the researcher i.e. it is not driven by the researcher's interest in the topic area. A deductive approach is driven by the researcher's interest to gain an answer and understanding to the question posed. As I aimed to answer the question of how people manage their mental health after being discharged from psychological therapy, I felt the deductive approach was most appropriate.

A final decision to make before conducting the research is to determine at what level the themes will be identified; semantic or latent. A semantic approach offers an interpretation of meanings at an explicit/surface level; the researcher does not look beyond what the participant has said for a deeper understanding or interpretation of why this might have been said and what may have influenced them. A latent approach attempts to identify the underlying meanings and ideas of what has been said. As a psychologist in clinical training (PICT), I believe it would have been difficult to state a wholly semantic approach to identifying themes would be achievable, due to the essence of clinical work I am involved in which has a strong element of interpretative understanding. Thus, although I wished to stay close to the participants' interpretation and understandings i.e. a semantic approach; the responses were thought about at a latent level, therefore a combination of the two was utilised.

Although TA is a flexible approach, guidelines have been developed to allow a framework of how to conduct the analysis, (Braun & Clark, 2006) which is useful to a researcher using the method for the first time. The guidelines are not intended to be

a prescriptive, linear process; rather to be recursive; constantly moving back and forth between the entire data set. Please see table 1 for the phases of conducting TA.

**Table 1: Phases of Thematic Analysis (From Braun & Clark, 2006)**

<i>Phase</i>		<i>Description of the process</i>
1	Familiarizing yourself with your data	Transcribing data, reading and re-reading the data, noting down initial ideas
2	Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code
3	Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme
4	Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis
5	Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme
6	Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis

A helpful checklist was also developed to guide the process of conducting TA, beginning with transcribing, moving on to coding and analysis, the overall aim and finally the written report. This was followed to ensure a good TA had been achieved. Please see table 2 for the checklist.

**Table 2: A checklist for achieving a good TA (From Braun & Clark, 2006)**

<i>Process</i>	<i>No</i>	<i>Criteria</i>
<i>Transcription</i>	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for ‘accuracy’
<i>Coding</i>	2	Each data item has been given equal attention in the coding process
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive
	4	All relevant extracts for all each theme have been collated
	5	Themes have been checked against each other and back to the original data set
	6	Themes are internally coherent, consistent, and distinctive
<i>Analysis</i>	7	Data have been analysed, interpreted, made sense of, rather than just paraphrased or described
	8	Analysis and data match each other, the extracts illustrate the analytic claims
	9	Analysis tells a convincing and well-organized story about the data and topic
	10	A good balance between analytic narrative and illustrative extracts is provided
<i>Overall</i>	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly
<i>Written report</i>	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated
	13	There is a good fit between what you claim you do, and what you show you have done, i.e. described method and reported analysis are consistent
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis
	15	The researcher is positioned as active in the research process; themes do not just ‘emerge’

## **Ethics**

### **Ethical Approval**

Ethical approval was sought and granted from the National Health Service (NHS) Research Ethics Committee (Appendix 2) as well as the Research and Development Department of South West Yorkshire Partnership NHS Foundation Trust (Appendix 3).

### **Ethical Considerations**

#### *Service User Involvement*

All materials used within the research study, such as participant information sheets, consent forms and the interview schedule were discussed and reviewed with the service user group within APTS. This felt particularly relevant given the nature of the research being focussed on client experience and the group having direct knowledge of the service and treatment which enabled them to advise meaningfully about the materials used. Adjustments were made to the wording of the documents being sent out to participants on the basis of this feedback, for example, explaining acronyms and refreshing participants' memories of what the CORE questionnaire was that they filled in at the beginning of therapy.

I also sought feedback from the service user panel in regards to participants receiving payment for taking part in the study. Payment was discussed in being proportionate to the risk of taking part in the study and as this was low risk, the panel felt that remuneration should be towards travel expenses for coming to meet me. This suggestion was followed and participants were offered payment for their travel expenses.

The panel were also keen for more of the benefits of taking part in the research to be listed in the information sheet which were sent out as part of the recruitment procedure. I had initially been hesitant as I didn't want the letter to come across as coercing people to take part; however the panel thought it was important to be explicit in that contributing to the research would hopefully make a positive difference and have an impact upon the service.

The panel also requested more details of the interview process, in that it could take place either at the participants home or where they had therapy sessions, wherever they felt most comfortable. More explicit information was also requested in regards to any discomfort that may be elicited in the interview, how this would be managed and providing contact details of services should participants' wish to speak to someone after the interview had ended.

Also raised by the panel was the possibility of the participant bringing someone to the interview with them to make them feel more comfortable. Although I acknowledged the reasoning behind this, I explained how this may impact upon the answers that were given. We discussed informing the participant that they may bring someone with them to the venue or have someone be with them at home during the interview, however, it would be preferable if they waited in a different room, as it was important they could speak openly to me about their experiences. Meeting the panel was important in shaping the research and having feedback from experts by experience and all suggestions discussed above were incorporated into the documents.

### *Informed Consent*

Participants were provided with detailed information about the study prior to meeting with the researcher, enabling them to give informed consent. At the

interview stage, the researcher talked the participant through the consent form and they were given the opportunity to ask any questions. The right to withdraw from the interview was explained and that there would be no impact upon their care should they re-engage with the service.

### *Confidentiality*

Participants were informed that quotes may be used in the research; however, any identifiable information would be removed. Participants were given pseudonyms to protect their identity. Interviews were audio-recorded and transcribed by a University approved transcriber who signed a confidentiality agreement. Recordings were hand delivered to the transcriber to ensure their safety. Participants were informed that the therapist they had previously seen in the service was not aware of their participation in the study and the researcher was not involved in the provision of services in the department.

### *Risk and Distress*

Participants were informed that the intention of the interview was not to cause distress; however, reflecting upon their time in therapy and the reason for their referral may bring up difficult emotions and if they wanted to withdraw at any point or take a break then it was fine to do so. Participants were to be provided with a list of contact support services should they become distressed, as well as being directed to their GP if they wished to be re-referred to the service. Prior to the interview, risk was explicitly discussed. The participant was informed that if any information indicated a significant risk to themselves or others then a plan would be made between the researcher and the participant and be communicated to the relevant parties in order to safeguard themselves or others.

## **Recruitment**

### **Participants**

Data was collected from clients seen by an Adult Psychological Therapy Service (APTS) in Yorkshire, where the research took place. Information detailing referrals to other services were analysed from data collected since records were stored on Rio from 2006. Rio is a computerised care records system; it delivers administrative, clinical and case management support to health and social care practitioners. Of the 1,008 clients for which data is available, 83% had prior involvement with an adult mental health service, 41% have previously had contact with the community mental health team, 39% had contact with the single point of access/crisis team and 27% had contact with day services. Only 13% of clients had not had any previous contact with the range of services listed (see appendix 4). This demonstrates the complexity and long term nature of clients seen in secondary care services and the likelihood of them being involved with a range of other mental health services as well as previous involvement with an adult mental health team. Limiting participants by diagnosis or treatment type would minimise the practice-based evidence nature of the present study.

Participants were men and women over 18 years of age who had been discharged within the past 3-6 months after completing psychological therapy within the Wakefield Business Delivery Unit of Adult Psychological Therapies. All participants who felt they had benefitted from therapy, which was self-defined, were eligible to take part, dependent on meeting the inclusion criteria.

### **Inclusion Criteria**

- The service offers therapy for ‘working age adults’, thus the age range limits of participants were set between 18 to 65 years of age.

- Participants were recruited if they had completed a CORE-OM at the beginning of their most recent episode of therapy.
- Participants were recruited if they had a planned discharge from therapy within the past 3-6 months. This time frame is long enough to allow participants to implement what they have learnt and experience life without therapy, yet not too long so that it would lead participants to forget what they had took from therapy.
- Participants were recruited if they considered therapy to be helpful, which was self-defined. This was operationalised through the opt in letter, where participants' were invited to take part in the research if they felt they had benefitted from therapy.
- The minimum number of sessions clients must have attended is six which could include an assessment session. Research has found change to be indicated within the first four and eight weeks of therapy, with early change being a predictor of short and long term outcome in psychotherapy (Lambert et al, 2002; Lutz et al, 2006; Lutz et al, 2009; Richard & Kordy, 2000; & Howard, 1986). Thus, it was felt 6 sessions would be sufficient to be considered a reasonable dose of therapy and to capture a significant change.

As the research was conducted in a secondary care adult psychological therapy service, which is not limited to condition or therapy, the participants included reflected this. There was no exclusion criteria based on diagnosis or type of therapy to reflect the provision of services offered to clients. This is consistent with effectiveness research, which has high internal validity and reflects the complexities of routine clinical practice.



## Exclusion criteria

Participants were excluded from the research if they were currently undertaking a form of psychotherapy as this may have distorted their ability to specify what was helpful from the prior therapy. They were also excluded if they attended less than 6 sessions or if they were currently in an inpatient setting. See table 3 for a summary of the inclusion and exclusion criteria.

**Table 3: Inclusion and exclusion criteria**

<i>Inclusion criteria</i>	<i>Exclusion criteria</i>
<ul style="list-style-type: none"> <li>• 18-65 years of age</li> <li>• Planned discharge from therapy within past 3-6 months</li> <li>• Attended minimum of 6 sessions</li> <li>• CORE-OM completed at the beginning of therapy</li> <li>• Responded that they felt therapy to have been helpful</li> </ul>	<ul style="list-style-type: none"> <li>• Attended &lt; 6 sessions</li> <li>• Undertaking a form of psychotherapy</li> <li>• If currently in an inpatient setting</li> </ul>

## CORE-OM

As detailed in the inclusion criteria, the CORE-OM had to be completed at the beginning of therapy in order for participants to take part in the research. The CORE-OM (Evans et al, 2002) is a 34 item self-report measure designed to assess global psychological distress and outcomes of psychological therapy (see appendix 1). Clients respond to 34 statements regarding how they have been feeling in the past week, using a five point Likert scale ranging from ‘not at all’ to ‘most or all of the time’. The questionnaire comprises four domains; subjective well-being, problems/symptoms experienced, life functioning and risk/harm to self and others. Thus, four domain scores are produced as well as a total score, with higher scores

indicating higher distress. The total score of 136 that can be reached is grouped into categories to indicate the severity of client distress; 1-20 places clients in the 'healthy' range, 21-33 is 'low level', 34-50 is 'mild', 51-67 is 'moderate', 68-84 is 'moderate to severe' and 85+ is 'severe'. The measure has been validated and has demonstrated good internal consistency and test-retest reliability (Evans et al, 2002). The Adult Psychological Therapy Service (APTS) aims to complete the CORE-OM with clients at the beginning of therapy and after their final session to provide a quantitative measure of change. CORE-OM data were included from participants', collected at the beginning of therapy to situate the sample; identifying the range of distress the questionnaire placed them in.

### **Sample size**

The number of participants to be included in qualitative research is difficult to ascertain as the literature encourages having as many participants as necessary to reach theoretical saturation, where data analysis no longer yields new information or categories. Sandelowski (1995) stated that the sample size needs to be small enough to manage the material yet large enough to provide 'a new and richly textured understanding of experience' (p. 183), yet this is always dependent on subjective judgement.

Research using thematic analysis (TA) to determine a sufficient amount of participants to reach saturation found from interviewing 60 participants, that meta themes were present in the first six interviews with saturation being reached at 12 (Guest, Bunce & Johnson, 2006). Some studies have found saturation was reached at 6 interviews (Isman, Ekéus, & Berggren, 2013; Isman, Mahmoud Warsame, Johansson, Fried, & Berggren, 2013), whereas Francis et al (2010) found saturation was reached at 17. Braun and Clark (2013) provide guidelines for the number of

participants needed in thematic analysis dependent upon the type of data collection and the size of the project. For small projects conducting interviews, which this research would be classified as; 6-10 participants are recommended (Braun & Clark, 2013). Thus it was felt 8-10 participants would be sufficient to capture themes and be manageable at this level of research.

### **Service Context**

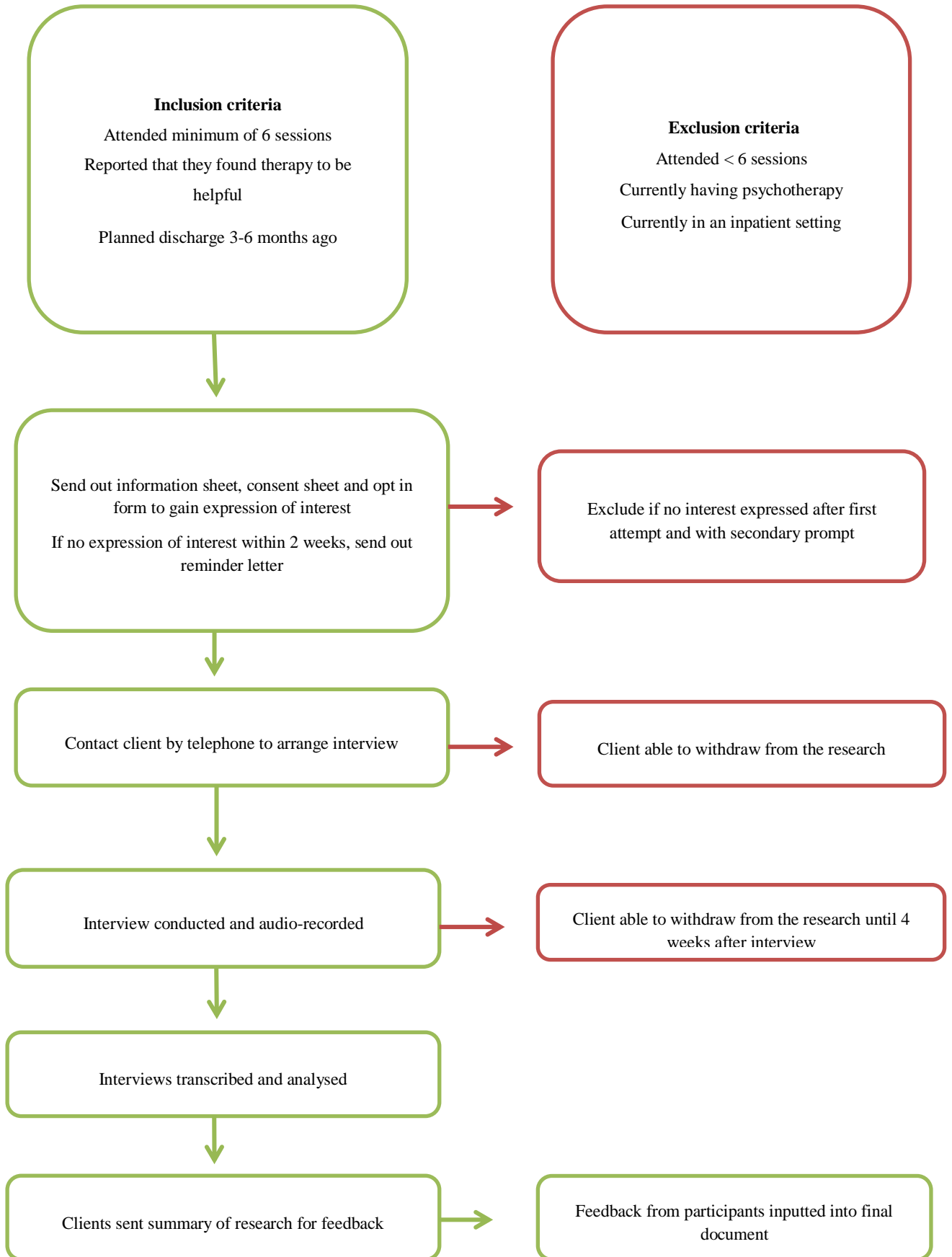
The adult psychological therapies service offers psychological therapy to people who are experiencing severe, complex and long-standing psychological and mental health difficulties. The service provides secondary care (specialist) services due to the complex nature of the difficulties people face. Participants were recruited from APTS provided by a Yorkshire NHS Trust.

Feedback was sought from therapists within the APTS team to determine the therapeutic model they aligned themselves with and currently practiced. Responses were gained from twenty four therapists across the trust, of which only two identified one particular model they practiced from. The majority of responses identified two therapeutic orientations e.g. cognitive behavioural therapy, eye movement desensitization and reprocessing, psychodynamic, mindfulness or a combination i.e. integrative/eclectic. Although most therapists have a main therapeutic orientation, the evidence demonstrates that overall, therapists do not practice just one type of therapy. The current research study therefore recruited participants from a range of therapists who aligned themselves with a range of models. As research emphasises common factors accounting for more variance in the outcomes than type of therapy (Imel & Wampold, 2008), it is likely that common factors may be found across psychological therapies including how therapy supports self-management after

discharge. This approach therefore roots itself to the reality of practice within services and is consistent with a PBE approach.

### **Recruitment Method**

A request was made to Information Services to provide a database of clients who had been discharged from psychological therapy within the Wakefield Business Delivery Unit within the past 6 months. The database was then filtered to meet the inclusion criteria for the study. Recruitment lasted from November 2015 to February 2016. An opt in form (appendix 5), information sheet (appendix 6) and consent form (appendix 7) were then posted out to gain an expression of interest, if they felt they had benefitted from therapy, with a pre-paid envelope to return. Participants were given the option to express their interest in taking part either by contacting the researcher by telephone, email or returning the opt in form. See figure 1 for recruitment procedure.

**Figure 1: Recruitment procedure**

## **Data Collection**

### **Interviews**

The topic guide (appendix 8) for the interviews was initially developed by the researcher in conjunction with feedback and guidance from supervisors. It was piloted with two colleagues known to the researcher who role played being a participant. It was also taken to the service user research panel within APTS which was also attended by the Research and Development Department (R&D). Feedback from colleagues, the service user panel and the R&D were taken into account and minor amendments were made to the wording and order of the questions.

The main body of the topic guide focussed on the participants' most recent experience of therapy and explored how they benefitted from it, the importance of it and how they implemented it in their day to day life. Also included were questions to determine if they felt any aspects of therapy were unhelpful, if they had previous experiences of accessing psychological therapy and other methods people use to manage their mental health on a daily basis. 7 out of the 8 interviews were conducted at the NHS APTS and one interview was conducted at the participant's home. The interviews were audio recorded and lasted between 40 and 90 minutes. After each interview my reflections were recorded, describing my sense of the person and of the interview. Interviews were transcribed verbatim and the reflections were referred to when analysing the interviews.

### **Quality Checks for Qualitative Research**

As previously discussed, prior to Braun & Clark's (1996) paper, there had been no clear agreement of what TA was and how to go about conducting it sufficiently which led to patchy reporting of the method, making it hard to evaluate and compare with other work. The guidelines now provided offer the potential for research to be

conducted in a deliberate, more rigorous way. Further guidelines which also provide the opportunity for increased validity and quality of qualitative research are those provided by Elliot, Fischer and Rennie (1999), who developed the 'evolving guidelines for publication of qualitative research studies in psychology and related fields'. Seven guidelines are provided, though not intended to be definitive are described in relation to the research project.

*1. Owning one's perspective*

This is described as the researcher making explicit their theoretical orientations and personal anticipations, as well as being able to recognize their personal values, interests and assumptions and how these may impact upon their understanding and interpretation of the data. This is described in the researcher reflexivity section and in the description of the approach used in TA.

*2. Situating the sample*

Situating the sample entails the author describing the participants and their life circumstances in order to enable the reader to have some context surrounding the participant's life which may be relevant to the findings. This has been provided with pen portraits of the individuals who took part in the research as well as including data from the CORE-OM completed at the beginning of therapy.

*3. Grounding in examples*

Providing examples of the data allows for the illustration of the procedures used in the study and how interpretations were developed on the basis of these. It allows for an appraisal of the understandings reached by the researcher and gives the opportunity for the reader to reach alternative meanings and understandings. The procedures used are described with examples of participants' quotes and the interpretations developed in light of these.

#### 4. *Providing credibility checks*

*Supervision* - supervision was utilised to ensure the validity of the themes and coding within the data as well as reviewing my interview technique as a whole. On the basis of feedback from the first interview conducted, it was noted that I had a tendency to assume the 'therapist role', i.e. using reflective listening and acknowledging the impact of experiences the participants had on their emotional and mental well-being. Although it was discussed that initially this may be useful to develop a relationship with the participant and put them at ease, it was something I had to be conscious of to make sure I retained my role as a researcher and gathered the information required.

*Returning to participants* - themes and outcomes of the research are checked with the participants who took part. Participants were sent a summary of the findings and were asked to comment on whether they felt the themes accurately captured their experiences. One participant, David, responded to the request for feedback on the results. David stated he found it '*very helpful*' to have taken part in the research and was '*overwhelmed to see how many people are feeling better after being helped by the staff from (NHS base)*'. He spoke of the changes his partner had noticed in him over the course of therapy and after and noted the '*high praise*' he holds for his therapist and the staff who supported him.

#### *Coherence*

Coherence refers to the understanding reached from the data. The individual accounts come together to offer an understanding which provides an overall story or framework, yet retains the nuances in the data. This has been shown by the research demonstrating overarching categories and themes, yet also including subthemes grounded in the data, which provide individual nuanced accounts of experiences.



### *5. Accomplishing general vs specific research tasks*

A general understanding of a phenomenon has been provided, i.e. how clients manage their mental health once they have been discharged from therapy. This has been based upon an appropriate range of accounts from participants, given the size of the research project. Limitations of generalising the findings to other contexts and individuals are discussed. Although a specific research task has not been undertaken i.e. a case study; the process through which the results were attained have been described thoroughly and systematically, in order for the reader to comprehend the basis for the understandings that were reached.

### *6. Resonating with reader*

The research that is presented aims to resonate with readers, by providing the material in a way which allows the reader to assess if the material accurately represents the subject matter and views of the participants, as well as expanding the readers understanding of the topic.

## **Researcher Reflexivity**

Before presenting the results, it is important to acknowledge the role of the researcher, as stated in Elliot, Fischer and Rennie's (1999) qualitative checks as 'owning one's perspective'. This provides insight into the background of the researcher which will have impacted upon the interpretation of the results. I will provide a summary of myself in order for the reader to have transparency around how my background, influences and current situation may have shaped the research process and the understandings reached from the data.

I am a 32 year old, White-British female living in West Yorkshire with my husband. I have experience of complex mental health problems within my family and the re-

occurring nature of these. I was in part motivated by the research topic in order to gain insight into how the findings could be translated to prevent relapse and help individuals to manage their mental health problems outside of the mental health setting. I feel this motivated me to want to thoroughly understand participants' individual experiences. I relished the opportunity to conduct qualitative research and to listen to stories of individuals who self-defined they had benefitted from therapy rather than from quantitative measures. I had worked in a variety of settings across mental health services and was aware only of people who were re-referred back to a service, rather than those who were managing their mental health without service input. I felt privileged to be able to hear the experiences of people who had benefitted from therapy and to gain an understanding of how therapy was still having an impact upon them.

My preferred theoretical orientation in regards to clinical work is a systemic approach. I feel this has been influenced by my family experience of mental health. I have been interested in how the family as a whole are affected and how the different understandings and approaches to mental health affect interactions and explanations. I feel this led me to want to understand the impact of the participant's mental health on their systems.

I was aware I was taking a different position to what I was used to; a researcher as opposed to a psychologist in clinical training and that my approach would have to be adapted in order to gather the most information from the interviewees. I kept a reflective journal throughout the process and made notes after each interview to refer back to when analysing the data. This, along with the use of supervision contributed to my reflexivity and acknowledgement of my role in the analysis and interpretation of the results which will now be presented.

## **CHAPTER THREE: RESULTS**

Details of the recruitment of participants will be discussed, followed by demographic details. Pen portraits of the participants will then be provided to give a broader understanding of the individuals and the context of their mental health which led them to receiving psychological therapy. Finally, the results of the thematic analysis will be presented along with direct quotes from the participants to demonstrate the themes described.

### **Recruitment**

A total of 120 people met the inclusion criteria over the recruitment period. 25 people who initially appeared to meet the criteria were excluded for a number of reasons after consulting their data; 2 individuals had passed away, 5 had been admitted to an inpatient setting, 13 had not given consent for their information to be shared with anyone other than their GP, 3 had moved out of area and 2 people had been referred back to the service. Thus a total of 95 people met the inclusion criteria and were sent out information to participate in the study. Letters were sent in batches of around 20-25, to clients over the data collection period, due to participants needing to meet the inclusion criteria of having been discharged for a total of 3-6 months. In line with the recruitment procedure, a secondary prompt was given to clients who were in the first batch of recruitment, where 25 recruitment letters were re-sent. Further prompts were not sent after this stage as the numbers needed for recruitment were reached. A total of 10 participants were recruited, however, 1 participant did not attend the interview and did not respond to further contact to re-arrange. A further participant, when contacted, stated he felt unable to take part in the research as his mental health difficulties had become more pronounced and he was due to attend an appointment with his mental health team. Thus, a total of 8

participants were recruited and interviewed. 7 out of the 8 participants responded to take part by returning the opt in form and 1 participant responded via email. Once an expression of interest was gained, participants were contacted to arrange a suitable interview time and location; which was at either the NHS base or the participant's home. 7 out of 8 participants opted to be seen at the NHS base and 1 participant opted to be seen at their home.

The participants were seen by a total of 6 therapists whose professional background included clinical psychologists, CBT therapist, psychotherapist and a psychiatrist. 2 therapists practiced from a CBT approach, one from a psychodynamic orientation and the remaining practiced integratively.

### **Demographic details**

Pseudonyms have been used throughout the research to provide anonymity and confidentiality for the participants. All participants had received previous input from psychological services with 7 out of 8 participants also having received input from the crisis team. Other services that participants' had input from were primary care mental health, psychiatric liaison and day treatment. The ethnicity of the participants was self-described. See table 4 for demographic details.

**Table 4: Demographic details of participants**

<i>Participant</i>	<i>Gender</i>	<i>Age</i>	<i>Ethnicity</i>	<i>Presenting problem</i>	<i>Rio cluster</i>	<i>Discharge</i>	<i>Number of sessions</i>
Sarah	Female	49	White-British	Depression	6. Non psychotic disorder – overvalued ideas	Planned discharge	Individual – 116 Group – 62
Helen	Female	57	White-British	Childhood abuse and neglect	6. Non psychotic disorder – overvalued ideas	Planned discharge	Individual – 17 Group – 1
David	Male	29	White-British	Not recorded	5. Non psychotic disorder (very severe)	Planned discharge	Individual – 10
Emily	Female	31	White-British	OCD	6. Non psychotic disorder – overvalued ideas	Planned discharge	Individual - 23
Jessica	Female	52	White-British	Childhood abuse and neglect	Not recorded	Planned discharge	Individual – 28
Olivia	Female	48	White-British	Childhood abuse and neglect	6. Non psychotic disorder – overvalued ideas	Unplanned discharge – Stopped attending	Individual – 10
Joanne	Female	28	White-British	Childhood abuse and neglect	4. Non psychotic disorder (severe)	Planned discharge	Individual – 27
Jamila	Female	45	Black or Black British – African	Trauma PTSD (not abuse)	Not recorded	Planned discharge	Individual - 65

**Pen Portraits****Sarah**

Sarah was 49 at the time of the interview and married. Sarah had taken part in 116 individual therapy sessions and 62 group sessions, a total from attending 2 groups. Sarah's CORE-OM score completed at the beginning of therapy placed her in the 'severe' category. From a previous relationship Sarah had two grown up children who had both been to University. Growing up, Sarah had a parent with mental health difficulties. Her parent's behaviour was frightening for Sarah, as at the time she didn't understand what was happening. This experience along with other distressing situations led to a fear of men. Sarah persevered through some challenging times, including being made homeless with her two children. Sarah always put her children's needs before her own and it was not until they left home and her focus was not solely on them, that she felt unable to cope. Sarah began to drink alcohol and self-harm as a strategy for coping. I was struck by how long Sarah had managed without support and how many difficulties she had overcome in her life and the modesty with which she described the changes she had made to her life. Sarah was warm and engaging throughout the interview and open about her experiences. Sarah felt she benefitted from therapy in a number of ways; being able to put herself first and being able to say 'no' to others requests, which led to gaining more respect from people. Sarah also felt she benefitted as she is now aware of how to manage her stress levels and having strategies to help her do so, for example, mindfulness.

**Helen**

Helen was 57 at the time of the interview; she had taken part in 17 individual therapy sessions and 1 group session. Helen's CORE-OM score completed at the beginning of therapy placed her in the 'severe' category. Helen had a difficult upbringing and had to take responsibility as a young child to care for her Mother and younger sibling which

meant that she was not able to attend school beyond primary school age. Helen endured physical and emotional abuse from her mother, protecting her sibling as best she could. Helen reported always putting others needs before her own. Despite the difficulties Helen had been through, she felt that her experiences had led her to become a more caring person, who is more able to empathise with people's experiences. Helen was not in a relationship at the time of the interview, though had a good friendship which was able to offer her support. Helen had two grown up children from her first marriage, who she is close to. Helen's second marriage, which has now ended, unfortunately became severely abusive on many levels and led Helen to have a lack of confidence in herself. I was overwhelmed by the courage Helen had shown throughout her life and was continuing to show given the present challenges she was facing. Helen displayed a passion for helping others and demonstrates this through her work where she cares for and supports people. Helen provided lots of detail about her previous experiences in life; this seemed important for her to share to demonstrate what she had overcome and where she had gotten to since therapy. Helen also described a difficult relationship with her therapist at the beginning of therapy, I was conscious I didn't want to replicate any of those initial negative experiences, which I feel is in part why this was the longest interview. I felt if I were to move Helen on, I would have ruptured the relationship. Helen described benefitting from therapy as it helped her to make sense of past experiences she had been through and create a sense of balance in her life. She also stated that without therapy she would have ended her life. Helen is now able to think about her own needs and be kinder to herself.

### **David**

David was 29 at the time of the interview; he took part in 10 individual therapy sessions. David's CORE-OM score completed at the beginning of therapy placed him in the 'low level' category. David has a son and had been married to his husband for three years.

David was busy studying for two College courses in caring for others, something he was able to do after completing therapy. He described himself as always wanting to make people laugh and cheer them up and likes to be sociable and spend time with his friends; his sense of humour was evident throughout the interview. David described being put down by others for the majority of his life, going through many chaotic experiences, and how this impacted on his mental health and led to him harming himself as a way of coping. David described how he is now fighting back and prioritising his needs. David described benefitting from mindfulness techniques as a way to manage his emotions and gaining an understanding of the internal battles he has between conflicting sides of his personality, which through therapy he was able to name.

### **Emily**

Emily was 31 at the time of the interview; she was in a relationship and was looking to buy her first house. Emily took part in 23 individual therapy sessions. Emily's CORE-OM score completed at the beginning of therapy placed her in the 'moderate to severe' category. Emily works in a College offering pastoral care to students; she had previously worked in administrative jobs, however, she found working with people was where she was at her best. Emily enjoys travelling the world and learning languages. Emily had a diagnosis of obsessive compulsive disorder and had struggled with this for a number of years which impacted significantly on her day to day functioning at work and in her social life, which led Emily to have thoughts of ending her life. Emily had an overestimated sense of responsibility and low self-esteem. I was struck by how dedicated Emily had been throughout her therapy sessions and how determined she was to overcome her difficulties using the techniques learned in therapy, despite it being very challenging. Emily took real ownership of making changes and was very proactive in seeking out opportunities to put the work into practice outside of sessions, becoming (as she described) her own teacher. Emily was articulately able to describe



her experience and often pre-empted the questions I had. She was engaging in the interview and wanted to provide as much information as she could to assist others, as she had found reading the experiences of others in self-help books so invaluable herself. Emily felt she gained her ability to “function in life” back from attending therapy and was consistently working towards making positive changes in her life.

### **Jessica**

Jessica was 48 at the time of the interview; she had taken part in 28 individual therapy sessions. Jessica’s CORE-OM score completed at the beginning of therapy placed her in the ‘moderate to severe’ category. Jessica is the eldest of her siblings; she works as a librarian, has a passion for music and plays in a band. Jessica had struggled with panic attacks and they were impacting on the functioning of her daily life. Jessica described being treated differently by her Mother compared to her siblings and that led her to believe that she was always at fault. Jessica described feeling emotions in situations but not being able to identify why she was feeling that way and not being able to articulate that emotion or manage it. Jessica initially seemed nervous in the interview, I later learned this was in part due to the fact that where the interview took place required an access code to leave. This would have previously led Jessica to experience a panic attack, however, this was something she had worked on in therapy sessions and was able to overcome. Jessica described her therapy sessions as “revolutionary” in the perspective it gave her and this led to an acceptance of prior experiences. Jessica is now able to identify her emotions and make changes to relationships to acknowledge and prioritise her feelings. Jessica enjoyed a balance of theory and practical strategies in her therapy sessions.

### **Olivia**

Olivia was forty-nine at the time of the interview and had been in a relationship for three years. Olivia took part in 10 individual therapy sessions. Olivia’s CORE-OM

score completed at the beginning of therapy placed her in the ‘moderate’ category. Olivia has two grown up children, one of whom she does not have contact with, and two grandchildren; she has a pet dog that she enjoys taking out for walks and giving her attention to. Olivia had experienced sexual and emotional abuse growing up and suffered with panic attacks. She had previously drunk alcohol as a way of blocking out the difficult experiences in her life. This has impacted on her memory, which she finds frustrating at times. Olivia described feeling angry at herself and putting herself down for a long time for the situations she experienced; however, she is now able to be kinder and more forgiving to herself. Despite the difficulties Olivia had faced, she struck me as a kind hearted individual who was working towards becoming more independent and placing value on her own opinion. Olivia was concerned about giving the right answers at the start of the interview; however, after reassurance that there was no right answer and that I was interested in her experiences, this seemed to put Olivia at ease. Olivia described feeling like a “stronger person” from having therapy and coming to accept the difficult experiences she had been through in her life. Establishing a routine was extremely helpful for Olivia, particularly in the morning, which enables her to feel prepared for the day ahead.

### **Joanne**

Joanne was 28 at the time of the interview and had participated in 27 individual therapy sessions. Joanne’s CORE-OM score completed at the beginning of therapy placed her in the ‘moderate to severe’ category. Joanne had separated from her husband and has three children. She was working towards completing a degree, something she had wanted to do for some time, and was enjoying studying and reading. Joanne described being in and out of psychological services since she was 15 years old. In the lead up to being seen in the current service, Joanne described being seen by multiple services for a limited number of sessions, then being told she was not “fit for the service”. This made

it difficult for Joanne to trust in therapy and be able to open up, as she continually felt she would work towards getting to this stage in order to be told she couldn't be seen at the service any longer. From a lack of support from previous services, Joanne was very specific in her requests when entering APTS as she wanted to ensure she would have one therapist who would see her for the duration of her sessions. This was important for Joanne to clarify in order for her to build up trust in the therapeutic relationship and in order for her to be able to share her thoughts and feelings. Joanne suffered with post-natal depression with each of her children, she struggled with flashbacks to these times in her life and the impact of the relationship she had with her husband, which led to a lack of self-worth and confidence. Joanne came across as bright and was engaging throughout the interview. She discussed conducting research as part of her University course and was hoping that others would participate in her future work as she had done in the interview. Joanne had made major life changes as a result of therapy; ending her "controlling" marriage, becoming a single parent of three children and starting a University degree. Despite the difficulties she faced, Joanne had a real enthusiasm for life and was benefitting from a different perspective due to the work she had completed in therapy.

### **Jamila**

Jamila was 45 at the time of the interview and had participated in 65 individual sessions. Jamila's CORE-OM score completed at the beginning of therapy placed her in the 'severe' category. Jamila enjoys sewing and knitting and is an avid football fan; watching it on television as well as listening on the radio. Jamila is originally from Africa but is now living in the UK. Jamila discussed the cultural differences of mental health in Africa compared to England and the impact this had upon her. Jamila stated that mental health didn't exist in African Culture; she noted that if you were to say you are sad, it meant that you were weak and your trust in God was failing as He was not

helping you to be happy. Jamila stated that the only description of it was 'madness' and people would refer to her as 'mad woman' and would segregate her. This led Jamila to feel very low and it proved difficult for her to acknowledge her feelings whilst trying to maintain her belief in God and her culture. Jamila was noticeably nervous when we first met and I hoped to make her feel at ease throughout the interview. After an initial conversation about Jamila's interests, she visibly relaxed and engaged in the interview. Jamila has a long term health condition and I was overwhelmed by her attitude towards this and of the adjustments she had made since taking part in therapy, for example, dealing with cultural beliefs about her mental health. Jamila benefitted from therapy by making practical changes to her lifestyle as well as learning to accept her circumstances, have confidence and value her own needs.

## **QUALITATIVE ANALYSIS**

An outline of how TA was carried out will be described, Helen's interview will be utilised to illustrate examples of the analysis. The findings of the analysis of the 8 interviews will then be presented.

### **Carrying out thematic analysis**

#### **Phase 1: Familiarizing yourself with your data**

Braun & Clark (2006) note the importance of immersing yourself in the data with the result of becoming familiar with the breadth and depth of the content. Once the data had been transcribed, the transcriptions were read whilst listening to the audio recordings to check for any inaccuracies. The recordings were listened to twice whilst reading through the transcripts so I could familiarise myself with the data and the transcriptions were also read separately to allow for familiarisation of the data. During this stage, the data was read in an active way, as recommended by Braun and Clark (2006), to search for patterns and meanings within the data, with notes being made to refer back to when coding. Braun and Clark (2006) note how important this phase is as it forms the basis for the rest of the analysis. Whilst listening to Helen's interview and reading the transcript, I made notes of how I understood what she was discussing, for example, acceptance, the difficulties she was still facing and the impact of the relationship with her therapist. This helped generate possible categories for coding, which could be developed and defined in further analysis and in conjunction with analysis of the other interviews.

#### **Phase 2: Generating initial codes**

Once the researcher has generated an initial list of ideas about what the data encompasses, the production of initial codes can begin, whereby data can be organised into meaningful groups. The data sets were worked through line by line and coded

through NVivo 10 software for qualitative data analysis. Codes were produced from interesting aspects of the data set and of relevance to the research question. As advised by Braun and Clark (2006), data was coded for as many potential themes or patterns as possible, the context surrounding the codes were kept and data was placed in as many different themes as it fit into. Braun and Clark (2006) note that no data set is without contradiction and tensions within and across data items do not have to be smoothed out. Table 5 provides an example of the coding process.

**Table 5: Examples of generating codes**

Sentence	Code allocated
<i>“I’ve always been the first person to put others first and the last person to put myself first. And my life pattern hasn’t been that great.”</i>	Putting others first Value of self Previous experiences Difficult experiences
<i>Well, like last week I was ill with this chest infection and I pushed myself to work but then I thought: “No, I’m not going to do that.” Now, before, I would have pushed myself to work until I collapsed, but I just thought: “No, I’m not doing it”, it doesn’t matter because it’s only once or twice a year I’m on sick and if I need to be on sick it’s because I need to get well and rested. And I went for a walk and thought: “I’m going to phone in, I’m not going to push myself now. I’m fifty-seven, I’ve worked all my life since I was sixteen, I deserve to put myself first a little bit.”</i>	Pushing self to work Change from how would have previously managed Shift in priority Making time to get well and look after self Stop pushing self Deserve to put myself first
<i>“So, I guess the outcome has been really good. I’m not saying I’m right because I’m never going to be completely right I don’t think, I don’t think I’ll ever get back to- well, what is normal?”</i>	Good outcome of therapy Long term impact of mental health and previous experiences Continued difficulties Acceptance of mental health Questioning normality

**Phase 3: Searching for themes**

This section of the analysis concentrates on the re-focussing of the data; it involves the sorting and analysis of codes and considers how they may be combined to form potential themes (see appendix 9 for examples of the analysis in NVivo). The relationship between codes, themes and different levels of themes are also thought about i.e. overarching themes and subthemes. Codes were grouped into categories of meaning, for example, ‘change from how would have previously managed’, ‘shift in priority’, ‘making time to get well and look after self’ and ‘deserve to put myself first’ were categorised as ‘valuing yourself’. Once the initial groupings of categories were produced, these were further considered and given a theme name. For example, ‘valuing yourself’ and ‘stop putting others first’ felt to me to be around how therapy was helping to gain a sense of balance in views of responsibility and was categorised as ‘Responsibility’.

**Phase 4: Reviewing themes**

Reviewing themes involves two levels of processing; how the themes and subthemes relate to each other and how they relate to the entire data set. I reviewed the transcripts and the codes given for each theme to ensure there was an identified pattern. Themes were discarded if there was too little data to support them or they weren’t relevant. Reviewing also identified when themes may collapse into each other or when they needed to be separated. For example, earlier identified themes of increasing exercise, reducing alcohol intake were collapsed into ‘Healthy Living’, and ‘Things that helped therapy to be successful’ was broken down into ‘Relationship with therapist’, ‘Structure and focus of therapy’ and ‘Commitment to change’.

**Phase 5: Defining and naming themes**

Phase 5 involves further refinement of the themes; identifying their stories and what they capture from the data, i.e. in relation to themselves and others, making sure the

names concisely represent the data. The story of each theme is also considered in the overall story of the data and in regards to the research question. My understandings and interpretations were led by the research question, however, there were also stories that were not directly linked to the research question but were relevant to include, for example, 'Things that helped therapy to be successful'.

### **Phase 6: Producing the report**

The final phase of the analysis is the production of a report which aims to tell a detailed story of the data, allowing the reader to be convinced of the validity and merit of the analysis (Braun & Clark, 2006). The report should provide evidence of the account of the story, i.e. extracts of themes and subthemes and provide an argument in relation to the research question.

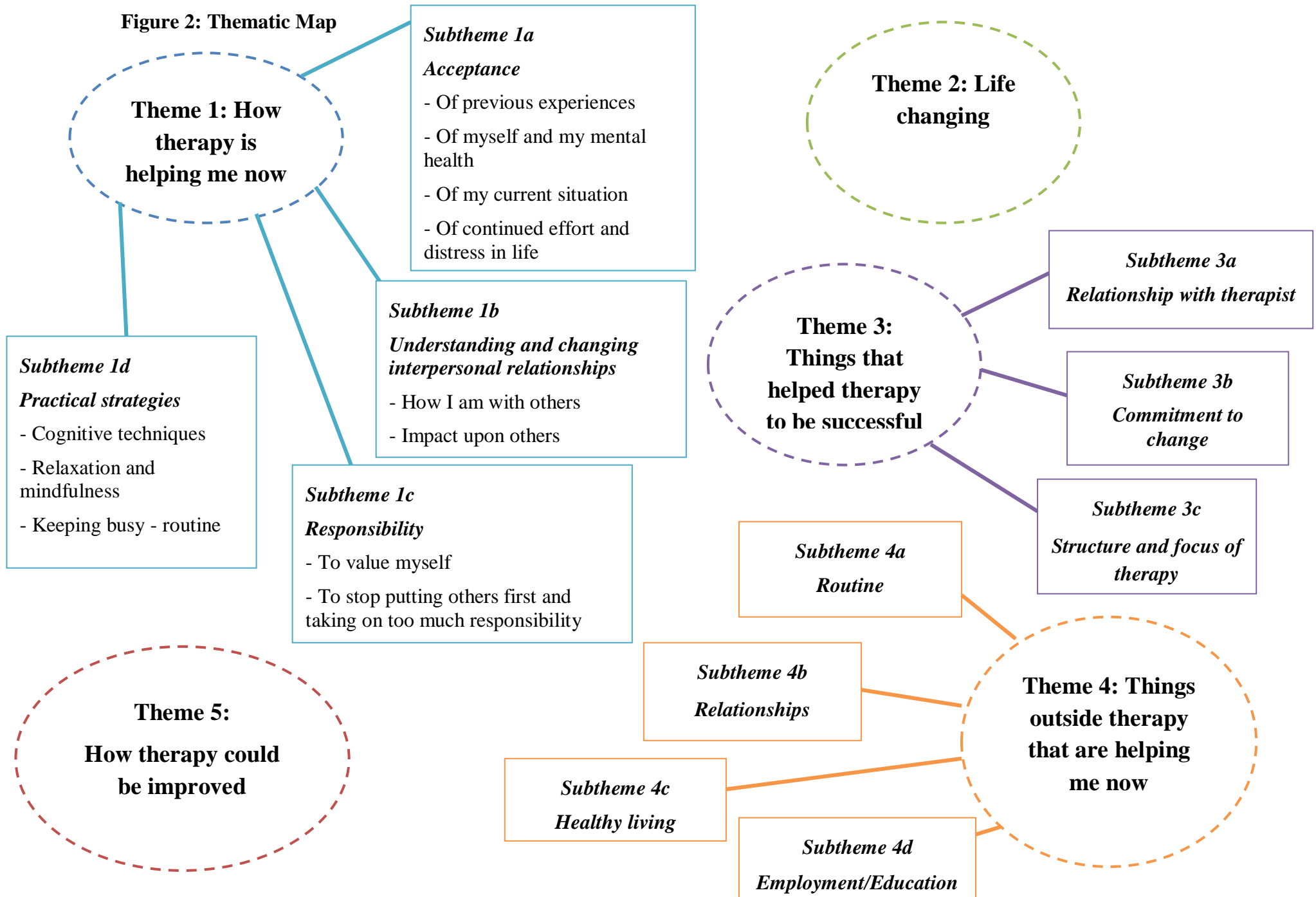
### **Qualitative results**

#### **Core themes**

Five core themes were developed from the thematic analysis; i) How therapy is helping me now, ii) Life changing, iii) Things that helped therapy to be successful, iv) Things outside of therapy that are helping me now and, v) How therapy could be improved. The core themes were broken down into subthemes and the subthemes were further categorised for ease of understanding the outcomes of the analysis. Figure 2 shows a full thematic map with core themes, subthemes and the breakdown of subthemes. Each of the themes and subthemes will be described in detail using illustrative examples from participants.



Figure 2: Thematic Map



## **Theme 1: How therapy is helping me now**

This theme captures the essence of the research question in determining whether or how therapy is helping participants' manage their mental health on a daily basis. The themes grouped around four main subthemes, giving further detail as to how therapy is now helping.

### *Subtheme 1a: Acceptance*

- **Of previous experience**

Six participants' described coming to an acceptance of their previous experiences, which generally referred to difficulties in relationships, trauma, or events that contributed to mental health problems, such as a turbulent upbringing. Accepting the experiences, i.e. not dwelling on them, letting go of the blame they felt towards themselves or the anger they held towards others, allowed them to move on and function more ably in their daily life:

*"I think it was because it was rather- rather managing your emotions and interpersonal stuff and all that and all of it, bits of all of it. It put things in perspective I think and there's no point dwelling on it now because it does- I'm allowing it to have an impact, aren't I? Still thinking about it, but it happened and I can't do anything about it, so I've just put it away and it has no impact."*  
(Sarah)

*"Coming here to understand it, I realised it wasn't actually my fault, it was something totally out of my hands- and coming here, I've realised that everything what's actually happened in my life, from being born to now, I can't [pause] blame myself."* (David)

One participant described part of the acceptance as being able to speak to others about her experiences and rather than this leading the participant to dwell on that experience, it enabled her to move on from it:

*“I can actually- I can talk about things to my friend that happened to me, which I couldn’t before, so it’s a big change and it doesn’t make me dwell on it, because there’s no reason to dwell on it- it’s done. It’s gone.” (Helen)*

It was also acknowledged that how people were reacting to their previous experiences could not change what had happened. Participants described putting their experiences to one side and not letting them dominate their emotions which enabled them to gain perspective and move on with their life. For some this was in relation to the parenting they had received as a child, whereas for others it was abusive relationships they had experienced as an adult. Not dwelling or ruminating on these experiences cleared the way for participants to look forward and move on with their lives:

*“Acceptance of that and acceptance of what happened when I was younger happened, and no matter what I’m going to do now and what I do now isn’t going to change that.” (Jessica)*

*“So, it’s best not to think too much about them and dwell on them and just say: “Okay, yeah, that happened,” but you’ve got to put that to one side and, you know, carry on, you’ve got a life to live and you’ve got to carry on and make the best of your life. Because –like I said- I still have- I’m still angry and certain parts of, you know, what’s happened but I don’t let that anger get out of control, just don’t blame and I don’t blame myself like I used to.” (Olivia)*

*Subtheme 1a: Acceptance*

- **Of myself and my mental health**

All participants spoke of how coming to an acceptance about themselves and their mental health is helpful for them on a day to day basis. It reduces some of the pressure they would place on themselves and reduces shameful feelings about their mental health difficulties, which allows them to feel comfortable being themselves and lets them move on in life:

*“I’m not hiding away, I’m not panicking anymore, I’m going and I’m being me.”*  
(David)

*“Yeah, sure. It helped me with a lot of things and things that were-it was okay to talk about it, you know, it wasn’t something shameful that you had to hide away from.”* (Olivia)

Reducing negative comparisons with others, for example, where other people were in their life and what they had achieved, and using this as a baseline of comparison for success in their lives was highlighted as a change that was helpful and continued to be so. Having realistic goals of what they were able to achieve and what they wanted to achieve in line with what they felt was important along with being more compassionate to themselves were also discussed as helpful changes in thinking:

*“With me, I was starting to compare myself with other people: I can’t look like my friends, I can’t be like my friends. I can’t be like them and they can’t be like me. I’m happy. I must agree that I am me.”* (Jamila)

*“Um, but I do notice I’m a bit more realistic now and- but I do still find especially consciously trying to be kind to myself is a big issue.”* (Jessica)

It was also recognised that mental health difficulties may still be present; however this has also come to be accepted:

*“So, I guess the outcome has been really good. I’m not saying I’m right because I’m never going to be completely right I don’t think, I don’t think I’ll ever get back to- well, what is normal?” (Helen)*

It was also accepted that some emotions around certain experiences are natural and being able to reduce the pressure they placed upon themselves to think, feel or react in a certain way, was helpful in managing their mental health. Emily and Joanne both spoke of the acceptance of some anxiety in their lives, particularly in relation to work where they had previously described trying to live a life without anxiety. Before therapy, they deemed anxiety to be negative and their experiencing of it to indicate they were not able to manage their lives successfully, that they were failing. Accepting they would feel those emotions and it was not always entirely negative, enabled them to prepare and manage their emotions or the situation more effectively and relate to themselves more compassionately, which reduced the shame they had associated with the feeling. Similarly with Joanne who placed unrealistic demands on what she should be able to achieve, who came to accept she could only do a certain amount and this was ok, which relieved the pressure she placed upon herself and the negative impact this had:

*“Um, I think in my own skin, trying to be more with the mindfulness and present in my own skin, the only time I was in my own skin previously was when the negative stuff was going on, the panic and anxiety were overwhelming, if you like, and then I couldn’t see anything. I’m trying with this –like you say- to be more balanced, um, and then when things are- when I’m more anxious generally, um, I trying to be more realistic about why I’m anxious. So, recently I had to have- I had an appointment with my appendix, about a growth being found and trying to be more realistic while accepting that I’m going to be anxious because it’s natural.” (Jessica)*

*“So have notice that when I have had a bad night’s sleep I’m much less able to think lets be rational about this, and lets actually. But because I can notice that now I go well give yourself a break you haven’t had any sleep. Whereas before I would be like but you’re a parent it doesn’t matter if you have only had one*

*hours sleep. You should still be able to bake cakes and do this and do that.”*  
(Joanne)

***Subtheme 1a: Acceptance***

- **Of continued effort and distress in life**

All eight participants spoke of coming to an acceptance that distress is a natural part of life and recognising there will be difficulties in the future:

*“The fact that distress is part of life- And it’s still something that I’m working on, I suppose. Um, how important that’s been- and it’s been quite important and revolutionary in way but I’m not sure [slight laugh] entirely. Just now I think the effects of that are coming home to roost, I guess. Um, so that sort of ‘accepting’ was massive really.”* (Jessica)

*“I think the idea again -you know I said about having some kind of, it’s good to have some kind of stress in life- I think that idea of I just wanted to walk through some perfectly non-stressful life [slight pause] but you can’t do it.”* (Emily)

As well as recognising that there is no perfect way to live your life:

*“There isn’t a normal is there? Nobody’s life is completely perfect.”* (Helen)

It was also accepted that it will take continued effort to maintain mental health during difficult times, that there will be ups and downs, yet participants were able to hold onto their ability to cope through these situations:

*“I imagine everything just helped me evolve into a better person now and I’m understanding now: “Yeah, life can be crappy, but I know I can do it.”* (David)

*“And I know that things are sometimes going to be hard, like last month, but I haven’t fallen to pieces and the worlds not ended and all that rubbish.”* (Sarah)

*“And realising that it’s okay to have bad days and it’s okay to feel stressed, everyone does and the only difference is [pause] that they’re just seeing that as*

*a normal part of life and I was just ignoring that completely. So, if the decision turns out to be wrong I just deal with it.” (Emily)*

Joanne was able to reflect that there was a danger of her thinking “*right well I’ve got the stuff that I need. I can just do whatever I want now...I’m fixed*” or conversely, that she would always have to work as hard as she was when she was in therapy “*just to be able to function*”. It was important for Joanne to “*find that middle*” and try “*to go a bit slower and not expect the world to be fixed over night*”, in order for her to continue to maintain her mental health.

As well as discussing continued effort in tackling difficult situations, Jessica discussed making sure to focus on the positive experiences in her life “*being more open to the positive side of experience rather than the negative*” and being able to acknowledge her achievements as areas of continued effort. Jamila also made reference to balancing positive and negative experiences and making sure not to discount the positive times. In accepting the negatives, participants were freed up to acknowledge the positives and give more energy to focus on them:

*“We can’t just have happy days every day, sometimes its ups and downs and it shouldn’t be ended because I’m sad because not all days I’m sad. Maybe if I’m sad- seven days, five out of seven days I’m sad and two I’m good- I must always count the blessings of the two days- two days I’ll be happy, five days I’ll be sad but the advantages and disadvantages, they’re always there.” (Jamila)*

### Subtheme 1a: Acceptance

- **Of my current situation**

Seven participants spoke of coming to an acceptance of their current situation, for example in regards to their relationships, work, housing and financial position, and how this helps them to rationalise their thoughts and feelings, taking each day as it comes:

*“But what I can do is make the best of what I’ve got and that’s what I’m going to do.” (Helen)*

*“Um, I feel as if I’ve got a roof over my head, wherever I live and I’ve got a friend, go to work and add a little money- what more do I need? I’ve got everything: I’ve got my children. I’ve got my granddaughter.” (Helen)*

*“So, I don’t mean I’m trying to keep hold of things really tightly, but I’m just trying to be more -not rationalise it, what’s the other one? - sort of, um, well be mindful and thoughtful about the reality of the situation and trying.” (Jessica)*

As well as recognising that sometimes they are not able to have control or influence over a situation:

*“Um, yeah and the sort of still trying to influence the outcome now, um, when perhaps it’s not influencable. Um, that acceptance that it is as it is.” (Jessica)*

*“So, I’ve been able to learn that whatever happens I can’t control it because it’s nothing I can personally.” (David)*

Participants spoke of appreciating the moment they are in, not attempting to make any changes or judge their life negatively, but looking for the positives and holding on to that mind-set:

*“Uh, attitude of life, I live by the day, whatever- sunlight I smile. If it’s good like this just take a good view and feel okay.” (Jamila)*



### **Subtheme 1b: Understanding and changing interpersonal relationships**

- **How I am with others**

All participants spoke of the impact of therapy on their interpersonal relationships and how this impacted upon their day to day interactions with people, friends and family; Helen felt like she was now “*understanding other people better*”. Many participants spoke of being able to have confidence in their opinions and beliefs and be able to express these to others, as Sarah stated “*...if I feel it, I should have a right to say it, even if it's right or wrong*”.

*“The interpersonal stuff, I think, that's made life easier, um [pause] I find myself- I find that I can disagree with some people sometimes, we aren't getting frustrated, angry or upset if they're not happy at what I said or, um, yeah- that's helped most I think.” (Sarah)*

The impact of how participants were with others varied; for some it meant distancing themselves from people who were not having a positive impact on their life:

*“Um, uh, I don't spend a lot of time with my mum in a one-to-one situation and one of the things that created –another benefit in a way- was to give myself some time away from my mum [pause] healthy space it was. And that's proved really a good strategy.” (Jessica)*

*“I just change friends, those who are pulling me down, making me feel sad- I just change to new ones who have positive vibrations.” (Jamila)*

For others it was recognising that it is ok to seek support from others:

*“I've got a few people now that whereas before if I had had an argument with my husband. I wouldn't have ever wanted to say anything to anybody. Because I wouldn't have wanted them to think I was struggling. But I also wouldn't want them to think anything negative of my husband. So whereas now I just think if people don't want people to think they are arse holes then they shouldn't be arse*

*holes should they? (laughs) so you know whatever. So I have got some friends that I really trust and I will say to them this has happened. I'm not sure why I am upset but would you be upset?" (Joanne)*

Some participants noticed how the changes they had made within themselves impacted upon others and enhanced their relationships:

*"Yeah, to do things that I want to do and go shopping with my daughter. Yeah, I'm finding I'm managing to see my son and my daughter more now because I like myself better. I know it sounds bad, but sometimes I think they must have felt bad because 'I don't want to go to mum, she's not-', I probably must have made them feel bad." (Helen)*

*"I stood up to my mum [slight pause] my real mum; I stood up to my dad and I told them what I thought. Me and dad are getting on fantastic now, because I stood up to him, because in the gypsy way the son stands up to the father." (David)*

*"Yeah, I've got a better relationship with my mum and dad now, because my dad used to get cross with me." (Sarah)*

### **Subtheme 1b: Understanding and changing interpersonal relationships**

- **Impact on others**

The impact on others was reflected upon as participants spoke of the impact the changes they had made, and were continuing to make in their interpersonal relationships, were having on the way others were interacting with them. Sarah noted that she was getting *"a bit more respect of people"* as she had been able to become more assertive and she was also being asked if she wanted to socialise with others; *"they'll ask me to do things with them and they'll ring me up and ask if I want to come out for a coffee."*

For some, it meant the ending of unhelpful relationships:

*“I just change to new ones who have positive vibrations-who doesn’t talk about days; who doesn’t talk about going to Hell; who doesn’t tell me I’m a sinner; who doesn’t judge me, just takes me as who I am and enjoys life.” (Jamila)*

David stated he *“got rid of everybody what were making my life crap”*. Jessica noted how the changes she had made were *“bringing around issues for others”* as she had removed herself from relationships that were making her unhappy and was no longer a *“part of their usual structure of negativity”* that other people were feeling the consequences of what she usually endured, which had led her to suggest other members of her family *“might look at some sort of help”*.

### **Subtheme 1c: Responsibility**

All participants spoke of responsibility in two ways; the responsibility to oneself, linked to valuing and looking after themselves, as well as reducing their sense of responsibility for others and situations; stopping putting others first. Putting themselves first referred to not being so hard on themselves and feeling that they deserved more from themselves (in terms of self-compassion), more from other people (respect) and more from their life in general (goals/what they wanted to achieve). This galvanised people to make changes and prioritise their needs, which improved their mental wellbeing but also had an impact on the way they were treated by others, mainly improved relationships where they felt they now gained more respect from others. Participants were able to notice unhelpful patterns in relationships and interactions, such as prioritising the happiness of others at the expense of their own and the impact this had. Changing this focus to concentrate on their own happiness led to changes in interactions, which led to participants feeling they had more authentic relationships and an increased sense of self-worth.

### Subtheme 1c: Responsibility

- **To value myself**

Sarah spoke of realising *“I’ve got to do this for myself”* and making sure *“I don’t slip back into letting people walk all over me again”* as she described, she deserved to put herself first.

David had previously put others’ needs before his own:

*“Like everybody is underneath me, it’s a pyramid: You’ve got all your crap, you’ve got everybody who needs your help and then you’ve got you at the top, and I were at the bottom trying to help everybody else”*

Although he still cared for others, he has been able to find some time for himself and do the things he wanted to do, such as going to College, the results of which are pride in himself and recognising *“I haven’t done it for anyone else, I’ve done it for me and that’s why I’m proud of it.”*

In order to be able to make changes and value themselves, participants spoke of not being as hard on themselves *“a massive thing I learned was to stop beating myself up”* (Emily). Removing the constant consideration of others allowed participants to listen to themselves, acknowledge their feelings:

*“What about my feelings? You must also think about yourself, you must first of all love yourself. You can’t expect others to like you, to love you, if you can’t love yourself. So you must make sure that the first priority is you.”* (Jamila)

Which led people to realise they didn't deserve the way they were being *treated* "...now I think looking back: *"Well, I didn't deserve it"* (Olivia). It was recognised that this can be difficult at times. Joanne spoke of using techniques she learnt from therapy in order to help her manage this as well as gaining the support of others:

*"Erm I think I still use the searching for evidence thing quite a lot. When I find myself thinking oh I'm not I'm not coping or I'm being useless or whatever. Erm I start thinking right look back over the last five days and what have you done that says that that's not true. And erm doing it that way. Erm and the kind of noticing my moods as well and actually saying when... say it when I am struggling. Rather than just expecting everyone to know and to treat me gently. Because I'm struggling actually saying I'm struggling you need to be gentle with me."* (Joanne)

### **Subtheme 1c: Responsibility**

- **To stop putting others first and taking on too much responsibility**

Seven out of the eight participants spoke of always putting other people's needs before their own, placing other people's happiness first and the consequences this had on them. Joanne identified that it was useful for her to decide who was important in her life and be there for those people *"rather than, erm trying to be there for everybody."* Participants spoke of how they had made changes to prioritise themselves:

*"I've always been the first person to put others first and the last person to put myself first."* (Helen)

*"I were more looking after my Nana, Michael, my sister, um, even looking after people what wasn't anything to do with the family. If friends needed me, I dropped everything and I was there. And even though I was doing that and my plate were getting full, I wasn't thinking of the number one, and that's me."* (David)

Though it was acknowledged that this could be difficult, there was a sense of purpose as to why they had to make the changes:

*“I’m still finding it hard but I know I need to do it and why I need to do it, you know what I mean?” (Sarah)*

Participants also described an overvalued sense of responsibility prior to therapy. For David this was to other people; he described the shift in his relationship:

*“I’m going out and I’ve got my college work with me and I say to Michael now: ‘I’ll see you when I get home.’ I’m not wrapping him up in cotton wool now, I’m just saying: ‘Look, if you need me, text me and when I’m on a break I’ll ring you.’ But I know it’s something I’ve got to do for myself, not for everyone else like I was doing before.” (David)*

Emily described being given responsibility for the changes she made in therapy *“the onus being on me”* and this was crucial for her in being able to manage the responsibility she felt in relation to her difficulties as well as other areas of her life:

*“I think one of the things that he said that was so useful for me because the issue with the OCD is taking responsibility and taking too much responsibility for stuff, like: ‘If this house burns down it’s my fault’ .... Um, but now it’s helped not just with the OCD but obviously all the underlying issues that caused that, um, [pause] like the responsibility and the amount of responsibility I’d taken on in life.” (Emily)*

### **Subtheme 1d: Practical strategies**

Participants spoke of a variety of practical strategies they had learnt from therapy that they implemented on a day to day basis to manage their mental health. The strategies grouped into three categories; cognitive techniques, relaxation and mindfulness and keeping busy - having a routine:

- **Cognitive techniques**

Participants discussed using a range of techniques. Jessica frequently used a diary to enable her to reflect on the day's events, searching for evidence to create a balanced perspective of her experiences:

*“What I’m trying to do now is be more reflective of all situations so I can recognise that there’s really good stuff goes on, and try and recognise these things so when I do read back it’s not all negative. And try and- I’m not naturally a negative person I don’t think, but the negative is what comes up most-And I tend to discover I’ve missed the positive. So, not only keeping the diary but having the time when I do write things down and I do reflect on the day, I’m trying to be fair and really encapsulate the things that go on as well.”*  
(Jessica)

Joanne also used this technique, but rather than writing her thoughts down, completed this internally. Participants spoke of feeling able to use the techniques they had learnt from therapy on a day to day basis, as Jamila reflected *“if I’ve got problems in my life, I know how to solve the problem.”* Emily also described how she would *“do my own test and exposure”*, when she notices her OCD behaviours reappearing and how motivated she was to do this *“I remember how I was and how much better I am now and I’m not going to slip back.”*

Olivia described positive self-talk, being able to *“talk to yourself and calm yourself, reassure yourself in a way.”* Whereas Jessica referred to the ‘poison parrot’, an externalised internal critical voice, as a useful strategy and *“way of looking at things”* that helped her get some perspective on difficult situations. Through objectifying her internal voice, Jessica was able to see how unhelpful and critical she was in relating to herself and worked on an improved, more compassionate way of understanding and relating to herself.

### **Subtheme 1d: Practical strategies**

- **Relaxation and mindfulness**

Sarah described the things that *“makes you calm and helps”* which included *“doing creative things like mindfulness and colouring”* as well as reading, listening to music

and meditation. She summarised how important it was “*just doing things that make you happy*” which could also be thought of in terms of behavioural activation, doing things that give a sense of enjoyment or satisfaction. For Jamila that was watching her favourite television programmes or reading a book which she stated “*..that means that my mind will maybe be off that thing that has made me sad.*”

Mindfulness was also helpful for David and Emily. David talked of the benefits of mindfulness preventing him from getting angry and for Emily, preventing her from ruminating on worries:

*“One thing I managed to do last weekend was actually practice my mindfulness properly and I actually managed for the whole weekend not to talk about it at all.”*  
(Emily)

Helen spoke of keeping in mind what the therapist had said and giving herself permission to relax and take some time for herself:

*“I always think: “[therapist] said this, when I’m like this”- I always think about that, but it’s good because I always relate to her and what she used to say to me and she used to say: “Run a bath, do you like to have soak?”*

### **Subtheme 1d: Practical strategies**

- **Keeping busy-Routine**

As well as finding time for relaxation, participants found that keeping busy and having some routine or structure in their day was helpful in managing their mental health:

*“I’ll get myself cleaning, or I’ll do some colouring or painting or do some studying on online courses, I tend to keep my sen busy...I go out for a walk with the dog [laughs], yeah. Get up and get ready, then take the dog out. Um, and then I walk for about an hour and then I come back and have my breakfast. Yeah, that’s something I would have never done before.”* (Sarah)



*“Yeah, I’ve got a completely different routine. Um, and I find that if I stick to that, I’m alright, I can manage. That’s, that something I would attribute to DBT.”*  
(Sarah)

Jamila reported that keeping busy prevents negative thoughts from occurring:

*“So, my day must be occupied with something-because if I’m idle I start becoming sad, I think I’m a failure, just because the brain is idle and it’s not going to get you know sounds, like “You are an idiot- you are stupid, you are a failure if you never do anything.” So, I make myself very busy until ten o’clock in the night and then go to bed.”*

Olivia discussed that having a plan for the day makes her feel prepared and reduces the likelihood of anxious feelings. However, she was also able to recognise that her plans didn’t always work but she was able to tolerate that:

*“It’s focus, a lot of planning I think- um, just plan my day basically-because I find if things go wrong at what I’m planning it feels so rushed and I suffer with anxiety, you see, so that builds up and it starts everything just seems to go wrong...Now, keeping mesen [myself] busy so I can plan my things and I know what I’m doing and that gives me plenty of time to do everything. So, it al- it’s doesn’t always work, that is life.”* (Olivia)

## **Theme 2: Life changing**

Seven out of eight participants stated how therapy had changed their life, for some, to the extent that they felt had they not had therapy they wouldn’t be alive:

*“Yeah, it’s helped me a lot, it’s changed my life.”* (Sarah)

*“That if I hadn’t have done it, I’ll tell you now I wouldn’t be here. I’d have killed myself- there’s no doubt about it. But now [slight pause] I am so grateful, that’s the only way I can put it.”* (Helen)

*“If it wasn’t for [therapist] and for (NHS base), I know I’d be buried now, I’d be six feet under, I know that for a fact.”* (David)

Participants spoke of the profound and “revolutionary” (Jessica) changes they felt within themselves due to attending therapy and also highlighted the commitment they had to the sessions:

*“If it wasn’t for (NHS base) and I will always praise these- that if I wasn’t shown how to cope with it, and to show when I know I need help, I definitely wouldn’t be sat here talking. It has, it’s changed me and who I am.” (David)*

*“and back then when I was following it to the letter I was not allowing myself to touch the tap at all and go along with my daily thing, maybe touching my face or whatever [pause] I just felt so free. Um, it’s that feeling –that amazing feeling- that comes into my head and I just walk away from it.” (Emily)*

*“So, that over time has been a challenge but I know it’s different for everybody but I absolutely treasure those session because I couldn’t get a handle on it otherwise. So, I didn’t miss any sessions.” (Jessica)*

Olivia described the impact of therapy meaning that she was now no longer taking anti-depressant medication and that the sessions had given her “more motivation in life”. She also spoke of her appreciation of the therapist she saw, as did Jamila, and she described how the sessions removed “all the fear” she had felt which impacted on her ability to function.

### **Theme 3: Things that helped therapy be successful**

- **Subtheme 3a: Relationship with the therapist**

Six participants discussed the impact the relationship with their therapist had on therapy being successful. There was a striking difference between the descriptions of the relationship with the therapists. For some participants, a very tentative approach was required and when this was not apparent at the beginning of therapy, there was a rupture in the relationship:

*“She was very good then, yeah. She seemed to realise then that she was a bit, uh, ‘surlly’, as I put it and I’m sure she doesn’t mean to be, it’s just the way she speaks*

*[does little 'bossy' impression] and I'm like: "Oh my God..". You know I'm sensitive so it did upset but we got on after three weeks- she extended it for that reason, because we didn't start off very well." (Helen)*

However, for others, it was important to be given a sense of responsibility and take ownership for the changes they made which improved their confidence within themselves to be able to implement the changes after therapy had ended:

*"Yeah for me it felt like- it's the way I take things, may not be the case- but I took it as: "If you don't read this book," um, "I won't be carrying on the sessions for you." Probably it wasn't necessarily said like that but that's how I took it. And it's kind of credit to him as a teacher, in a way, that I'm able to carry this on and in a way, why could it work with him and not on my own, if that makes sense?" (Emily)*

Emily also described how much respect she had for the therapist and how the belief he had in her, gave her belief in her own life. Olivia described how the therapist she saw *"actually listened - and I felt that she really understood"* and worked in a *"low-key but authoritative way"* which supported Olivia in being able to make changes. It appeared that therapists adapted to the needs of the client and Joanne discussed being given *"lots of choices"* about the approach to take. This proved to be helpful for Joanne as she described herself as being *"terrified"* of opening up her past experiences, however, with the therapist they decided she *"needed to work on how I deal with it now"* which *"was really important."* Joanne also noted that had the trust in their relationship not been built, she *"would never have mentioned that stuff."*

### **Theme 3: Things that helped therapy be successful**

- **Subtheme 3b: Commitment to change**

Six participants discussed how committed they were to making changes, Sarah reported how she *"really wanted it to work"*, didn't miss a session in the twelve months she had support and always *"did the homework"*.

*“I just thought, for the DBT you really have to be up for it. You really want to have to tackle everything and change, because if you haven’t got that, I mean I don’t think it’s worth- when the two sort of like, didn’t turn up for sessions and stuff like that, if you miss more than two then you’ve just had it.” (Sarah)*

Jessica reported never missing any of the sessions, and Emily also described her dedication to therapy despite how difficult it was:

*“I just did everything, did every homework and followed it to the ‘T’ even though it was really difficult, it was the last resort for me and I did it because after that it was just so successful.” (Emily)*

Helen expressed her need for support *“I needed help, I knew that* “and Jamila highlighted how she wanted to change *“So I want to be feeling better, not sad, I don’t want that.”* Jessica spoke of the discipline required to persevere with therapy and how it requires effort in order to make changes:

*“I think just the discipline of [slight pause] and the thing about having time to think about it in the sessions and then obviously going away and thinking about things that had happened, using the stuff I’d learned on those things or putting those stuff into things I’ve learned has been really [pause]- but it is discipline. I think you do have to, um, consciously to it.” (Jessica)*

### **Theme 3: Things that helped therapy be successful**

- **Subtheme 3c: Structure and focus of therapy**

Six participants spoke of the approach of the therapy they received and how it was useful for them in supporting them to make a change. For some it was useful to be able to talk in detail about their experiences:

*“I think because of the intensity of it and it gets down to the ‘nitty- gritty’ of it, shows you new ways of managing your emotions.” (Sarah)*

Yet for others it was the structure and theoretical understanding which supported them:

*“Think -like with the CBT- I respond very well to structured, like: “This is the plan this is what you’re working towards, this is how to do it,” type things.”*  
(Emily)

*“I do, because everything that- when [therapist] did [slight pause], um, some elements of theory with me, um, which naturally I accept that I’m really a bit of a theorist.”* (Jessica)

Sarah reported group sessions to be helpful as they *“recapped on things all the time”*. Sarah attended two groups in the service and acknowledged how important it was for her to attend a second time. Sarah felt in attending the first group she was unable to take information in as she was consumed by feelings of fear of being in a group and with other members. However, she stated that after attending the second group *“it were just everything seemed to go in”*, which then allowed her the opportunity to take part in the sessions and implement the skills and strategies she had learnt outside of session as well. This also highlights the importance for Sarah of having further opportunity to engage in therapy and her commitment to take part in a second group; without this the continued benefit of therapy may not have proved to be as successful.

For Emily, being given the responsibility of being able to make changes for herself and recognise she had the ability to do this was vital in her managing her mental health:

*“One thing the doctor always taught me, which was great, was that it was never about him, it was about me becoming my own coach and becoming my own teacher.”* (Emily)

#### **Theme 4: Things outside of therapy that are helping me now**

The subthemes derived from this category do not appear to be clearly related to the therapy participants received, however there does seem to be some overlap. It is difficult to decipher if receiving therapy led to the enablement of things outside of

therapy that supported changes made whilst in therapy and continued to maintain mental health and wellbeing.

- **Subtheme 4a: Routine**

Seven participants spoke of how a routine prevents them from ruminating on negative thoughts and provides them with a supportive structure to manage the day:

*“Because I think if I don’t get up in a morning and, you know, brush my hair and get showered or whatever, you know, get myself sorted out, then I’m no good for the rest of the day, and maybe that’s just the personal thing for me, I don’t know, but that helps me to cope. Yeah, rather than before I used to sit and do nothing and that’s when you’ve got nothing else, you’ve got time and you’re thinking constantly about everything. Well, now I try to keep myself busy and with that.” (Olivia)*

As Jamila also reflected:

*“if I think negative, the whole day is negative, so I realise that every day I must open the fridge, make a cup of tea, eat porridge, do something like go to the corner shop to buy a newspaper.”*

Sarah discussed the importance of taking her medication as it was prescribed, was helpful to incorporate into her routine. David highlighted how having a routine and “*managing day-by-day*” provided him with the motivation to get out of bed in a morning.

Jessica mentioned the importance of planning things outside of work as she stated “*I just used to waste my weekends sat around trying to do work and watching telly and stuff*”. Now, she makes plans in advance to do things that she enjoys and emphasised that “*whatever happens I stick to that*”. As well as planning activities into a routine, Joanne noted the importance of planning in time where she didn’t have any tasks to do, although acknowledged the difficulty in trying to do this “*I try and make sure I have*

*half an hour to myself every day. Erm which is sometimes much more impossible than it sounds.”*

#### **Theme 4: Things outside of therapy that are helping me now**

- **Subtheme 4b: Relationships**

Six participants discussed the importance of relationships in helping them to manage their mental health; this was discussed in relation to friends and family members as well as support groups:

*“I started going to the foundation and there’s a group there I go to. I don’t really need it to be honest; I just like to go [laughs]. Because it’s only four or five of us and it’s just talking about what’s happening at the moment...we help each other out, we have ideas about how to deal with stuff. So I like going there.”*  
(Sarah)

David discussed the personal strength and support his relationships provided him with and how with encouragement from his partner, he was able to have more self-belief:

*“I’d be weak, I’d give in but because I’ve still got that unit (family) behind me I know I’m still weak-ish but I know I’ve still got that strength behind me....I’ve still got my strength with Michael saying: “You can do this.” And he knows when I’m having a panic attack because he says I shake, but because I’ve done it that long, I don’t notice when I shake. And Michael will just put his hand on mine and say: “You can do this.” I just feel like I can more- I just relax then.”*  
(David)

In order to gain support from others, Olivia discussed the difficult step she took in opening up to people about her difficulties. Prior to having therapy, Olivia had not shared her experiences with others and found it was “*such a relief like from when I told my mam*”. Attending therapy gave her “*the confidence to speak to other people*” and relieved the shame she had felt “*instead of it being my dirty little secret*”.

#### **Theme 4: Things outside of therapy that are helping me now**

- **Subtheme 4c: Healthy living**

Six participants made reference to healthy living which included reducing alcohol intake, exercising, spirituality and eating healthily and the positive impact this had upon their mental health:

*“Well, I eat healthily. That is because I wasn’t eating, I went quite thin, um, I went down to about ten stone and I’m about five foot seven, so that were quite slim. Um, I try not to drink so much because I think that affects my mental health.” (Helen)*

*“I’ve actually brought a food journal back in and also regular exercise, that definitely helps, definitely helps.” (Emily)*

*“My drinking has gone from a drunkard, to someone who drink casual. Also inside and also my mood. My mood swings with the drinking was really, after a night out I would be so sad and the next day, just very low.” (Jamila)*

Jamila also reported how the use of anti-depressant medication had helped her to cope. Helen noted that some of the lifestyle changes may seem to be common sense, however *“when you have a break down it’s like you can’t look after yourself”*, therefore discussing these factors are helpful:

*“I think my friend has shown me some meditation and as I say I’ve done some at the centre over the road and [slight pause] - so that idea of allowing thoughts to come in and not worrying about them, just letting them go, the same as with the cycle: you can’t stop your triggers; you can’t watch your every move, being aware of that and not worrying about it, just letting it go.” (Emily)*

Joanne highlighted the realities of being a busy Mum of three children whilst completing a degree. She manages to incorporate a healthy living approach and exercise into her routine by doing *“YouTube yoga”* rather than attending a class, which she struggles to find time for. Joanne also found that finding a way of incorporating something she enjoyed doing into her routine was helpful:



*“..so now I listen to audio books in the car. And I find that really, really good because it focuses me on listening to the book. I still can focus enough on driving but I’m not, my minds not wandering away while I’m listening to the book. Cause I always get upset that I don’t have time to read. It means that I’m still getting that reading time cause I’m generally driving for two, three hours a day so I can get through quite a few books in that time. So I find that really good.” (Joanne)*

#### **Theme 4: Things outside of therapy that are helping me now**

- **Subtheme 4d: Employment/Education**

For some participants, working or being in education helped them to manage their mental health. Helen also advocated the role of a job for people who have mental health difficulties and likened it to therapy itself:

*“I think you have to work, even if you can’t work full time. So what I like to do is work: A) because I have pocket money, and I also like to work for mental health because I think it helps take my mind off my problems, when I’m helping somebody else.” (Helen)*

*“My reading has come on, my writing has come on, um, and I didn’t think I’d be able to do it and now I’m on a course to get a qualification in caring, and that’s one job I really wanted to do ‘cause I’ve lost jobs because of dyslexia; through my bi-polar; through my depression.” (David)*

For others it was recognising that they would like to go back into employment but they weren’t quite ready, which lessened the pressure they placed on themselves:

*“I’m determined I don’t want to go back until I know that I can um [pause] cope better. Uh, because I want to be physically well enough as well as mentally well enough.” (Sarah)*

#### **Theme 5: How therapy could be improved**

Participants broadly spoke of having some follow up to therapy sessions, offering a refresher of skills and strategies. It was suggested that this would be useful in helping them maintain their mental health; Helen stated *“it would be like a lifeline.”*

*“Because I felt like it was a bit sort of stop and they dropped you [pause] yeah, because I did feel panicky and I’ve got all these skills, but what if I can’t use them someday, because you do. But I have been alright. Yeah, sometimes maybe even just a telephone conversation with one of the DBT, just to say ‘you’re alright, you’re doing fine and you can do this’. You know, yeah, that would have been helpful, I think.” (Sarah)*

Olivia and Joanne also spoke of some sort of follow up, however, also mentioned getting feedback from the particular therapist they saw for individual sessions;

*“I mean, I wouldn’t mind, you know, if they wanted to get in contact with me and just see how I were coping and that. I wouldn’t mind that at all and I would attend. Um, and maybe pick up some more strategies, tips or from them I’d probably like to know- from (therapist’s) point of view of how she thinks I’ve changed.” (Olivia)*

Jessica noted that after being discharged and not being able to access services or support is a “very un-empowering feeling” and had given a lot of thought into how there could be follow up from the service, potentially offering group sessions to go over strategies and skills:

*“You do have to- could do really with not really refresher things but sessions to-just the odd session every week- to, um, ‘give your mental system a boost’, if you like. To invigorate those things, ‘cos they’re there and they’re skills that really [pause] they are there but they need to be and could be used more effectively if they’re practised more and the length of time you got from your sessions, it’s harder just to tap back into it. Yeah, it’s something I’ve long thought about and I don’t know how easy it would actually be to do, but I do think that would be something that kept people from perhaps away coming back for longer term thing. If you had like ‘wellness’ session -[slight laugh] I don’t know quite what you’d call it- but it’s sort of mental wellbeing, um- I don’t know, not necessarily catch up with-I don’t know how it would be done if you were seeing someone else but to sort of use and revisit those skills would be really useful.” (Jessica)*

Although the majority of participants stated follow up appointments would be positive, Emily mentioned the caution she would have if any appointments would be in a group setting and the pressure she might face in feeling she had to support other people;

*“I think that could be something possibly in the future if I was having problems again but I do- I suppose I am a bit reticent about it, in terms of if I was accepted to go and try and help other people, I don’t know if- I don’t know, I’d have to think about that.” (Emily)*

Joanne also highlighted a potential reluctance to attend follow up appointments as she discussed her lack of attendance at her last two appointments due to her improved mental wellbeing, which led her to feel that she couldn’t prioritise attending the sessions any longer.

## **Summary**

Common understandings of how participants manage their mental health after being discharged from therapy were found irrespective of the varying gender, age and presenting problems of participants, type of therapy they received and therapist they saw. Participants’ spoke of the factors that helped therapy to be successful, such as the relationship with the therapist and their commitment to change, and themes of what they took from therapy that are still helpful after discharge in managing their mental health. Acceptance of their mental health and experiences were important as this allowed participants’ to let go of the blame they felt towards themselves or the anger they held towards others, which aided them in moving on and functioning more ably in their daily life. An understanding and change in interpersonal relationships linked with participants’ valuing themselves and minimised prioritising others’ needs before their own which led to increased self respect and confidence. The impact of making these changes was described as ‘life changing’, highlighting the significance of the changes that occurred and which are continuing to do so. Factors outside of therapy are also

important in maintaining mental health, such as developing a routine and leading a healthy lifestyle. Finally, areas of improvement in therapy were discussed, in particular in relation to follow up appointments as a means of empowering clients to self manage their mental health by offering the chance to refresh strategies and techniques that have been helpful.

## **CHAPTER FOUR: DISCUSSION**

The results will be summarised and discussed in relation to the existing literature. The implications for clinical practice will be considered, as well as strengths and limitations of the study. Finally, areas of future research will be discussed, followed by overall conclusions.

### **Revisiting research aims**

The aim of the current study was to explore how clients recently discharged from psychological therapy manage their mental health. Semi structured interviews were completed with eight participants who had been discharged from adult psychological therapy services within the past three-six months after completing a minimum of six sessions. The data were then analysed using thematic analysis.

### **Summary of findings**

Results from the qualitative analysis produced five overall themes; ‘how therapy is helping me now’, ‘life changing’, ‘things that helped therapy to be successful’, ‘things outside therapy that are helping me now’ and ‘how therapy could be improved’. Two of the themes, ‘how therapy is helping me now’ and ‘things outside therapy that are helping me now’ were in direct response to the topic guide questions, however, the other three themes were generated independent of the interview questions. Themes and subthemes will now be discussed in relation to the literature.

### **Overview of themes**

In aiming to discover how people manage their mental health on a day to day basis after they had been discharged from therapy, eight participants were interviewed. Common themes in the management of mental health after discharge were found despite

participants being included who were both men and women, were of different ages, had a variety of presenting difficulties and had undergone different types of therapy with different therapists. Generally, how participants managed their mental health after discharge was similar, though certain aspects of self-management could be identified as being linked to a particular therapy, particularly in 'practical strategies'. An example of this was completing thought diaries, searching for evidence and completing exposure tasks which came from a CBT approach. However, this was not the sole indicator of being able to manage mental health problems, as a combination of elements were discussed by all participants.

The research found similar findings to Carey et al (2007) as discussed earlier, who investigated what psychological change is and how it occurs; which was also conducted with a sample of people who were included despite having different types of therapy, varying diagnoses and seeing different therapists. It appears that some of the aspects of therapy that enabled change to occur whilst in therapy by Carey et al (2007) were described as being helpful after therapy in the present study. Themes that highlighted how change occurs were also discussed by participants in the present study, which included motivation and readiness, perceived aspects of the self, tools and strategies and interaction with the therapist.

How people benefit from psychological therapy in the long term and how they are able to maintain their mental health on a day to day basis, are again due to features which are trans-theoretical/diagnostic. Although factors could be identified as being specific to a certain type of model, for example; 'acceptance' of one's self and 'commitment to change' (ACT), improving 'interpersonal relationships' (Interpersonal

psychotherapy/CAT) and being able to change maladaptive thoughts (CBT); these elements were discussed across therapies. This indicates that therapists used an integrative approach and a combination of these ingredients were found to be useful by participants in helping them to self-manage their mental health once discharged from therapy, rather than a single approach. The individual themes will now be discussed.

### **Theme 1: How therapy is helping me now**

Participants discussed the varying ways in which therapy was helping them on a day to day basis to manage their mental health and could be understood through the four subthemes of ‘acceptance’, ‘understanding and changing interpersonal relationships’, ‘responsibility’ and ‘practical strategies’.

#### *Acceptance*

Participants’ views of acceptance were further broken down into four categories; ‘Of previous experiences’, ‘Of myself and my mental health’, ‘Of my current situation’ and ‘Of continued effort and distress in life’. It appeared that for participants to make changes and move forward with their life, an acceptance of the past was helpful in facilitating this as it proved to relieve the pressure and blame that participants placed upon themselves for what they had been through. This is in keeping with the principles of Acceptance and Commitment Therapy (Harris, 2009), which emphasises accepting what is out of your personal control and teaches psychological skills to support individuals in dealing with painful thoughts and emotions and to reduce the influence and impact they have. No participants’ explicitly mentioned having this type of therapy, however, it seems that these principles transcended a range of therapies and proved to be beneficial. There was also an acceptance and awareness that there would be difficulties in the future and that distress in life was something everybody faced and could not be avoided. This helped participants feel more prepared and equipped to deal

with difficult situations and acknowledge that they would have to continue to face these situations in the future. This reflects the impact of ‘helpful events’ whilst in psychotherapy as found by Timulak (2007). These helpful events as described by clients’ whilst in therapy, such as exploring feelings, the continued effect of awareness and self-understanding leading to feelings of empowerment and finding solutions to problems after therapy had ended were found to be prevalent factors for participants in the current study, once therapy had been ended. They were also factors that were continuing to be utilised on a daily basis and supporting the management of mental health, demonstrating the longer term impact of such events. Increasing self-acceptance and reducing self-criticism were also concepts found by Lillevoll et al (2013); Barry and Hayward (2011) and Clarke et al (2004) to be helpful whilst in therapy. This was the case for individuals with a diagnosis of depression and psychosis receiving CBT; delivered on a one to one basis, as well as guided internet-based treatment. It appears this acceptance is a recurring theme and something that the present participants continued to utilise after therapy had ended. The acceptance of themselves and their mental health in their lives, allowed participants’ to acknowledge that they are able to live a rewarding life alongside any difficulties they may have, which supports Anthony’s (1993) definition of recovery as a way of living a fulfilling life despite limitations caused by mental health difficulties. It also supports the previously discussed findings of Todd et al (2012), who explored the understandings of recovery and self-management amongst service users with bipolar disorder. That research found recovery was conceptualised as not being about being symptom free, but rather of taking responsibility for your own wellness, which links to the current findings of an acceptance of mental health, distress in life and continued effort to maintain mental health.



*Understanding and changing interpersonal relationships*

This subtheme was further divided into two categories ‘How I am with others’ and ‘Impact upon others’. The change in the way participants’ interacted with others after being discharged from therapy was discussed throughout the interviews. For some, this meant distancing themselves from people who were not having a positive impact on their life, and for others it was about seeking support and being able to rely on someone apart from themselves. Lakey and Orehek (2011) discuss the link between perceived social support and the positive impact it has upon mental health. Social support is said to protect people from the negative effects of stress, also known as stress buffering. Research has demonstrated the link between life stress and poor mental health to be stronger for people who have low levels of social support compared to those who have high levels of social support. It has also been found to reduce medical morbidity and mortality as well as helping to protect against developing trauma-related difficulties and decreasing the functional consequences of trauma-induced diagnoses, such as posttraumatic stress disorder (Southwick, Vythilingam, & Charney, 2005).

Therapy offered participants the opportunity to reflect on their experiences with others and how they felt in their interactions with them. The majority of participants tested out making changes in these interactions whilst in therapy; however, it was something that was still ongoing since being discharged. Interpersonal relationships are discussed from the perspective of cognitive analytic therapy, whereby early interpersonal relationships are seen as being fundamental to the development of the self and the patterns of roles in relationships (Ryle & Kerr, 2002). Gaining an awareness of these roles and their functionality allows for the development of strategies to change how you relate to yourself as well as others, and with this, improve mental wellbeing. The theme of understanding and changing interpersonal relationships also links to the theme of

responsibility and valuing themselves. The ability to prioritise and value themselves enabled participants' to acknowledge that their feelings, needs and wants were as important as others. This gave them the confidence to be able to identify when relationships weren't meeting their needs and to make changes to them, though it was something that was identified as being difficult and an ongoing process. The impact upon others again varied between participants. For some, this meant that they were no longer involved in the participants' life or they were feeling the impact of a reduction in interactions and coming to term with the repercussions of this. For others, the impact was noted by the participants in their interactions, for example, an increase in respect for them and wanting to spend time with them as they were now valuing themselves more and not letting others hold all the power in the relationship.

### *Responsibility*

A fundamental part of how participants' manage their mental health after being discharged from therapy and what they felt gave them the confidence to be able to implement changes can be understood from this theme. It was divided further into two categories 'To value myself' and 'To stop putting others first and taking too much responsibility'. An overvalued sense of responsibility and prioritisation of others needs before their own led to low self-esteem and a lack of confidence in participants. What people were implementing after being discharged from therapy was making time for themselves, doing things they wanted to and saying 'no' to others which stemmed from learning to value and prioritise themselves. There is some overlap with the 'understanding and changing interpersonal relationships' theme. Participants' were able to understand their relationships better and make changes, moving away from unhelpful interpersonal relationship patterns to more helpful ones, which mirrors the understandings and strategies used in Cognitive Analytic Therapy (CAT). CAT (Ryle & Kerr, 2002) looks at patterns of relating and the effect these patterns have on

relationships with others and the relationships we have with ourselves. It appears that these elements were helpful in participants maintaining their mental health, though were not explicitly delivered in a cognitive analytic approach.

### *Practical strategies*

A variety of strategies to manage mental health on a daily basis after discharge were discussed and were grouped into three categories; 'cognitive techniques', 'relaxation and mindfulness' and 'keeping busy-routine'. In regards to cognitive strategies, a number were used including; positive self-talk, reality checking, searching for evidence of thoughts and beliefs and using diaries. It seemed that the majority of people had been taught the techniques whilst they were in therapy and had had positive experiences from using them, which increased their confidence in using them again once they had been discharged from therapy. Findings from Carey et al (2007) who identified how change occurred in psychotherapy across a range of modalities, highlighted six themes, one of which was 'tools and strategies'. Homework, techniques and diaries were noted amongst others as supporting change. This was also found to be the case from the findings of Clarke, Rees and Hardy (2004) who explored client views of the change processes in cognitive therapy. The tools were said to provide clients with strategies to solve problems they hadn't previously been able to. Current findings suggest they continue to be used after therapy has ended in the management of mental health. Relaxation and mindfulness also support the category of 'tools and strategies'. Participants' were able to use these techniques after being discharged in situations that were stressful and felt like they would help them to calm themselves and manage effectively. However, some participants' spoke of them as a maintenance strategy, something that they practiced daily to maintain equilibrium. Keeping a routine and being busy were also spoke of in terms of maintenance factors. Though routine is also discussed in 'things outside of therapy that are helping me now', a distinction was made

by participants between what they had taken from therapy and were still incorporating into their life and what things they had done outside of therapy. It is difficult to completely disentangle the two as it may have been that through attending therapy, people were able to build a routine. Braun and Clark (2006) acknowledge the realities of qualitative data, and state that there may be tensions and inconsistencies within and across data items which don't have to be smoothed out.

### **Theme 2: Life changing**

The impact of therapy as described by participants was 'life changing', with some stating they did not believe they would still be alive had they not received psychological treatment. Participants' generally used this term in relation to the positive experience of therapy as a whole, rather than specifying particular moments in therapy. Some participants identified how therapy changed their life as they were now able to identify when they needed help. Previously participants' had dismissed their needs as they didn't value themselves enough to feel they deserved support, or they felt they should be able to manage and not doing so was a sign of their failure. It seems participants' had reached a point where they felt they could no longer carry on living their life the way they were. Therapy provided them with the skills to be able to manage their mental health, which they previously didn't have, which was described as accounting for changing who they were. Some participants referred to a new found ability to function in their day to day life. The fear they previously felt, which prevented them from engaging in life was either reduced or no longer present. Increasing motivation to engage in life as a whole was also discussed as well as no longer taking anti-depressant medication. This was seen as a life changing experience as they were no longer dependent on medication to manage their mental health; they felt enough change had occurred as a result of therapy and they were now equipped to manage their mental health independently. It could be that the success of change and beneficial impact

described from having therapy and seeing changes whilst still undergoing therapy may be a contributing factor to the maintenance and confidence of managing mental health after being discharged from therapy.

### **Theme 3: Things that helped therapy to be successful**

#### *Relationship with therapist*

Three subthemes were identified as contributing towards things that helped therapy to be successful: 'relationship with therapist', 'commitment to change' and 'structure and focus of therapy'. The relationship with the therapist helped participants' to open up and in most cases talk about experiences they previously hadn't been able to share with anyone. The notion of the strength of the alliance between therapist and client and the impact this has upon change is well documented and was described in 1979 by Bordin. He reported that the effectiveness of therapy was in part, if not entirely based on the strength of the working alliance. The evidence on alliance is as convincing in the present day, with decades of research indicating the curative component the therapeutic relationship has on psychotherapy outcome (Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Wampold & Brown, 2005).

The type of relationship that was described as helpful by participants varied. For some, a gentle approach where the therapist came alongside the participant was most needed, whereas for others, being given a sense of responsibility and ownership for making changes independent of the therapist was most helpful. This reflects the findings from Carey et al (2007) who identified six themes that contributed towards change in psychotherapy, one of which was the interaction with the therapist. It was found that the therapist having no personal connection to the participant and not placing any judgement on the individual was helpful in allowing the client to be open and honest

about their situation. The varying styles of therapeutic relationships being identified as helpful were also reflected in the research of Carey et al (2007). Some participants stated how important it was to share the journey with someone, for others it was helpful for them to feel they were on their own, with the therapist offering a supportive role and others described wanting to be told what to do. Having a sense of responsibility for the outcome of psychological treatment is said to have an impact on the likelihood of relapse. Weinberger (2014) suggested that relapse is less likely to occur when clients attribute successful changes internally i.e. due to coping skills they have developed or their hard work during therapy. Conversely, relapse is more likely when clients attribute change to external outcomes, i.e. the therapist or therapeutic technique. Participants' often spoke of making changes for themselves, which links in with the 'valuing myself' theme, but this could stem from empowerment that was instilled in them from the therapeutic relationship. This has also previously been acknowledged by participants as contributing towards change, where they identified that the change was attributed to their own hard work rather than the therapist (Carey et al, 2007). The relationship with the therapist has previously been discussed as facilitating the therapy process and seen as a helpful aspect in the individual being able to make changes (Clarke, Rees & Hardy, 2004). Even participants who engaged in internet-based treatment described a relationship with the computer (Knowles et al, 2014) and the impact this had upon their engagement and impact upon outcome. For some a computer programme provided the autonomy to encourage them to make changes for themselves, whereas for others it led to feelings of social isolation. This demonstrates the varying impact the perceptions of the client has on the outcome of therapy and how treatment should be individually tailored to meet the varying needs to ensure the best possible outcome. The difference in expectations and personal preferences regarding the therapeutic relationship was captured in the present study. In one instance a rupture in the relationship at the

beginning of therapy due to the therapeutic relationship style not matching that of the participant's expectations was discussed, which led to the participant not feeling understood. Bordin (1979) reported the likelihood of change to be a fit between the demands of the working alliance and a match between the personal characteristics of the therapist and client. Stiles, Honos-Wedd & Surko (1998) refer to the term 'responsiveness' as a means of bringing about change in psychotherapy. They described responsiveness as a behaviour that is affected by the emerging perceptions of characteristics and behaviours between client and therapist and how they each respond to these, indicating a dynamic relationship. In this instance, it seems a lack of initial responsiveness led to a rupture in the relationship. Safran, Muran & Eubanks-Carter (2011) stated ruptures in alliance to be due to three elements; 1) Disagreements about the task, 2) Disagreements about the treatment goals, or 3) Strains in the client-therapist bond. They indicated six methods for repairing the rupture; 1) Repeating the therapeutic rationale, 2) Changing task or goals, 3) Clarifying misunderstandings at a surface level, 4) Exploring relational themes associated with the rupture, 5) Linking the alliance rupture to common patterns within the clients' life or 6) New relational experiences. It appeared that in the participant's case, there were strains in the therapist and client bond and the relationship was repaired with the therapist being responsive to the needs of the client by making adjustments to the approach and clarifying misunderstandings at a surface level. The participant described attributes in the therapist which were associated with negative relationships she had in the past and they were discussed and modified to enable the relationship to progress. Therapists adapting to clients' characteristics is endorsed by the Task Force (APA, 2005). The American Psychological Association 2005 Presidential Task Force on Evidence-Based Practice (APA, 2005), produced a report which highlights the commitment to a full range of evidence that promotes psychological practice and policy. Highlighted within this report is the

acknowledgement of the importance of clinical expertise in identifying and incorporating evidenced based practice in conjunction with clinical data, i.e. integrating information gathered about the clients over the sessions. Therapists' adapting sessions to fit with client preferences and characteristics increase the likelihood of delivering a service where the client is able to achieve their goals in therapy, which appears to have taken place from the experiences described by participants.

The relationship with the therapist can be described as a common factor as a means of facilitating successful therapy, which participants' state as providing the base for work to begin and changes to be made. Wampold (2015) states that rather than common factors being known as therapeutic elements related to all psychotherapies; they collectively shape a model about the mechanisms of change. Wampold (2015) proposes the contextual model as "providing alternative explanations for the benefits of psychotherapy to ones that emphasize specific ingredients" (page 271). The model begins with the alliance between therapist and client on which three pathways are built; 1) the real relationship, 2) expectations, and 3) specific ingredients. The 'real relationship' is one that is genuine and is a fit between client and therapist. Expectations consist of the beliefs the client has about their difficulties, with psychotherapy offering an explanation that is adaptive, in that it provides means to support the client in overcoming or coping with the difficulties. The specific ingredients are said to be a treatment that the client finds acceptable as a means of managing their difficulties, creating expectations that the client will experience less distress. From a strong alliance, expectations that the treatment will be successful can be built, which encourages the likelihood of clients participating in 'healthy actions'. It appears that these factors were present in therapy in the present study and were factors which enabled the continued self-management of mental health once discharged from therapy. Participants spoke of



internalising the therapists' advice and of the confidence they had from making successful changes in therapy ('healthy actions') that encouraged them to continue to build upon these experiences outside of therapy. Therefore, no one element can be specifically highlighted as contributing towards the management of mental health and it is a combination of the individual themes that support participants in staying well.

#### *Commitment to change*

Attending sessions, completing homework and wanting to make a change were some of the factors that participants' noted as contributing towards helping therapy to be successful and demonstrated a 'commitment to change'. This was also reflected in previous research conducted by Lillevoll et al (2013) where helpful factors from guided internet-based CBT were explored. Clients described wanting to move forward and make changes which highlighted their motivation to seek support and invest in the therapy. There has been much research conducted into the area of motivation to change, in particular The Transtheoretical Model (TMM) (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992). The TTM identified five stages of change that people progress through when seeking to make a change to their behaviour; precontemplation, contemplation, preparation, action and maintenance. Although the stages of change are not always linear, it appeared that participants' fitted into the preparation and action phase whilst in therapy i.e. intending to take action and modifying their behaviour as opposed to having no intention to change or not yet making a commitment to take action. Prochaska, Norcross & DiClemente (2013) suggest that clients in psychotherapy in the action stage are far more likely to achieve quicker and better outcomes. Therefore it could be that participants' being in these stages enabled them to benefit more from therapy and maintain the changes once discharged. Prochaska et al (2013) describe eight processes of change in psychotherapy; 1. Consciousness raising, 2. Self re-evaluation, 3. Emotional arousal, 4. Social liberation,

5. Self liberation, 6. Counterconditioning, 7. Stimulus control and 8. Contingency management. It seems that participants' have moved through these processes and are now in the eighth process of change where they are rewarding themselves and being rewarded by others for making changes whilst having contingency contracts in place. It would be interesting to have further information regarding participants' motivation to change in relation to their previous experiences of therapy. One participant had undergone two lots of therapy from the service and although indicated she had wanted to make a change in her first spell of therapy, felt unable to because of her worries of being in a group environment. It was only through experiencing the setting and being able to attend a further group that she was able to put these worries aside and engage in the sessions and implement changes. Therefore, although the participant indicated she was in the preparation/action phase at the initial group, this was not enough to support her in making changes. This also raises interesting questions regarding the process of change and indicators of when change will occur and what this means for the impact of therapy and its longevity. Some research has indicated the effect of early response in psychotherapy to be indicative of better intermediate and long-term outcomes (Fennel & Teasdale, 1987; Renaud et al, 1998; Ilardi & Craighead, 1994; Bradford et al, 2011). Although the debate between the change being between specific theory techniques or common factors continues, in relation to demonstrating improved outcomes, this does not fit the example in the present study. This is important to consider if therapists use early response as an indicator of outcome and in considering the management of complex mental health problems as a chronic disease rather than something that can be treated in a single episode of care as discussed by Andrews (2001).

#### *Structure and focus of therapy*

There was discussion concerning the approach of therapy and how useful this was in enabling participants' to make changes. For some this meant talking through the detail

of their experiences, to allow them to minimize the impact it had upon them, whereas for others it was being able to have a choice not to have to focus on the detail and being able to concentrate on the impact it was having in the present. Having structure and a theoretical understanding of the approach was also noted as being helpful as was attending a group. The structure and focus of therapy may well overlap with the therapist relationship as the difficulty to separate the two have previously been noted (Goldfried and Davila, 2005; Hill, 2005).

#### **Theme 4: Things outside therapy that are helping me now**

The subthemes that emerged for this theme were deemed to be separate to the skills or strategies learnt from therapy; however, it cannot be said with certainty that therapy didn't influence these changes. There are a number of factors that help a person manage their mental health problems, some of which will be derived from therapy, others will be very separate and some will be indirectly related. It is also important to consider the difficulties for clients to be clear as to what the influences are and how they came to do the things that help them.

Structuring the day with routine, seeking support from relationships, living a healthier lifestyle and gaining employment or working towards a qualification were said to be supporting participants' in the management of their mental health on a daily basis. These support findings from Lucock et al (2007) who investigated how service users manage their problems in everyday life, identifying five themes: self-help strategies; managing and structuring the day; empowerment; engaging others to help yourself; physical health and well being; and spirituality. Though both the current research and that of Lucock et al (2007) found these strategies to be independent of therapy, it demonstrates how important the themes are in the maintenance of mental health outside

of therapy and could prove to be essential in providing the basis for things learnt from therapy to continue to be implemented.

### **Theme 5: How therapy could be improved**

It was suggested that having follow up review sessions or a group that could offer refresher sessions incorporating strategies to support people post discharge would be helpful in preventing relapse and empowering individuals to maintain their mental health. Some participants' described feeling panicky that therapy was ending and were uncertain of their ability to remember and implement the strategies that they were taught. Though these feelings can be described as being typical towards therapy ending (Schlesinger, 2014), a review appointment or the option of a group may empower individuals to continue without input. It may also provide those who are struggling with enough support to bolster their use of tools and strategies, preventing further distress and relapse or re-admission to the service. This supports the findings from Todd et al (2012) regarding understandings of recovery and self-management as being to build on existing techniques. It was found that for clients with bipolar disorder, regardless of where they were in their recovery journey, support with self-management was desired. The clients who were relatively new to self-management highlighted wanting to learn new strategies and techniques, however, those who had used self-management resources before requested an opportunity to have advice tailored to their current needs. Coulumbe et al (2015) developed a mental health self-management questionnaire (MHSQ) to establish the role of self-management in recovery and for monitoring the efficacy of self-management support programmes. The MHSQ resulted in being composed of three subscales: clinical (getting help and using resources), empowerment (building upon strengths and positive self-concept to gain control) and vitality (active and healthy lifestyle). Again, the notion of building upon strengths was found. Having the option to attend a review or group may increase the positive self-concept to gain

control either by clients deciding not to attend as they do not feel it is necessary or taking control by deciding to attend to refresh their understandings.

## **Strengths and Limitations**

### **Strengths**

#### *Contribution to the literature*

This is the first study that has qualitatively explored how clients, who felt that they benefitted from psychological therapy, managed their mental health once they had been discharged from an adult psychological therapy service. It adds to the literature surrounding self-management, but from the unique perspective of what the participant took from therapy that they are still using on a day to day basis. A strength of the research is the approach of the question in itself. Previous research has investigated whether therapy has been helpful, however, the current research establishes this and investigates the impact of how it is helping them and the impact of this now. The qualitative approach gave a voice to views which have rarely been heard and form a self-defined perspective. This allowed for the development of insight and understanding into participants' experiences of the utilisation of therapy on a day to day basis.

#### *Recruitment process and sample*

Participants' were recruited from a self-defined perspective, it was a conscious decision not to determine the sample from the pre-defined measures which are collected during therapy (the CORE-OM) and instead use the measure collected at the beginning of therapy to situate the sample, a quality check recommended by Elliot et al (1999). This allowed participants' to self-select on the basis that they perceived they had benefitted from therapy, rather than selecting those who had changed on an objective measure.

As previously discussed, the study was based in a routine psychological therapies service. The strengths of this approach and of the study were conducting research in a 'real-world setting', increasing its relevance to routine practice and the patients seen in those settings. In terms of the sample, this meant that participants' were not excluded on the basis of diagnosis or treatment type and they were seen by therapists' conducting their usual treatment under routine clinical/practice based conditions, which increases 'clinical realism and external validity' (Barkham, Stiles, Connell, Leach, Lucock, Mellor-Clark, Bower, King, Shapiro, Hardy, Greenberg, & Angus, 2008).

#### *Quality checks*

As outlined in the 'Method' section, in 1996, Braun & Clark provided guidelines that allowed TA to be conducted in a deliberate, more rigorous way and allowed researchers to state their position in relation to the interpretation of results. The stance taken in regards to data analysis, along with 'Researcher reflexivity' section were discussed to allow for transparency to readers and to own one's perspective. The credibility checks guidelines by Elliot et al (1999) were also followed which provided increased validity and quality of the qualitative research.

#### *Service user involvement*

Service users were consulted in the development of the research and with their feedback; changes were made to recruitment information and the process of the interview. This improved the accessibility of information given to participants and ensured the implications for taking part in the research were clear. This allowed participants to make an informed decision about taking part in the research. It was helpful to gain the insight of people who had received therapy from the service, as they were able to offer important reflections on the wording of documents and the interview, ensuring they were thoughtful and sensitive.

**Limitations***Recruitment process and sample*

Participants' were selected on the basis of completing a CORE-OM at the beginning of therapy, in order to situate the sample. Although the service aims to complete the questionnaires at the beginning and end of therapy, they are not always recorded and it may have led to the sample being restricted.

Six out of eight participants were White-British females between the ages of 27 and 59, which may have led to results which are less able to be generalised. The sample of participants were self-selecting and self-defined in terms of benefitting from therapy, which is likely to produce a degree of bias. The decision to participate in the study may reflect inherent bias or traits within participants which can impact on the representativeness of the sample. The participants were also recruited from one service, which although may be useful in detecting themes across the specific area in what participants found helpful, it is not able to generalise to other services. It could be that the therapists from the particular service work in similar ways. It would be useful to widen the recruitment to other APTS to determine if themes are consistent across areas, and with other therapists. Similarly, it would be useful to increase the number of participants recruited to increase the generalisability of results.

Though results were posted out to all participants with a request for their feedback, only one participant responded. It would have been interesting to see if more participants felt the results and outcomes of the study reflected their experiences as well as adding to increase the credibility checks of the study.

Though not specifically answering the research aim, it may have been useful to include therapists' views about their perceptions of the clients' likelihood of maintaining their mental health and utilising therapy on a day to day basis. Although some participants' were able to name the type of therapy they had, this was not asked of them. It may have been useful to know this in order to determine if different approaches were being used to manage mental health dependent on the type of treatment received. However, as previously highlighted, therapists' rated their therapeutic modality as 'integrative', therefore, if the type of therapy was recorded, it may not have been done exclusively.

#### *Researcher bias*

Although steps were taken to reduce researcher bias; stating my position in regards to the TA conducted and completing the quality checks as set out by Elliot et al (1999); keeping a reflective journal, utilising supervision and stating 'researcher reflexivity', it is important to acknowledge that researcher bias can never be eliminated. I feel being a psychologist in clinical training afforded me strengths in the interview process, in that I was able to empathise with participants' and build a rapport, as well as have an understanding of the mental health system and the therapy process. However, it may have also influenced the way I responded to participants' and the phrasing of questions I asked. I was made aware of my tendency to take the clinician role when having supervision after the first interview I conducted. I then made a conscious effort to maintain the role of a researcher by adapting the language I used and reducing my tendency to offer interpretations of participants' experiences.

#### *Quality checks*

One participant responded with feedback about taking part in the study, it would have been interesting to gather further feedback to gain the views of the remainder of the participants who took part.



*Retrospective views*

It has to be acknowledged that participants were asked for information retrospectively, which cannot guarantee accuracy. Also, the information provided by participants stating therapy to be useful, may not necessarily be the case. The information provided by participants was their construction of reality and described in a way that enabled them to make meaning from their lives. Research into psychological debriefing found trauma victims to state the intervention was helpful at the time, however, only through longer term follow up was it in fact found to be damaging and ineffective (Mayou, Ehlers & Hobbs, 2000). Therefore, though there are multiple versions of ‘reality’ and the participants’ experiences are validated and valued, we have to be aware of the fact that we are all subject to bias and presuming mistaken causality.

**Clinical Implications***Therapy*

The results of the research will be fed back to the therapists within the service to consider how it might inform their practice. In terms of the impact upon the delivery of therapy, there appears to be different phases that were reached in order to make changes whilst in therapy and maintain them in the management of mental health once discharged. The initial phase to the delivery of effective therapy was in the ‘relationship with the therapist’, the client demonstrating ‘commitment to change’ and the ‘structure and approach of therapy’ being a fit for the client. The value of such has been demonstrated in previous literature and is reinforced in the present study. This is crucial for therapists to consider as a base for all work to be effective.

In terms of the next steps in the delivery of therapy, it is difficult to say whether the ‘practical strategies’ that were used enabled the wider global psychological improvements of acceptance, interpersonal relationship and responsibility or whether it was coming to an understanding of these components and seeing change that

encouraged the use of ‘practical strategies’. What is certain is the importance of these global psychological themes of acceptance, understanding and changing interpersonal relationships and responsibility and how crucial they are in enabling participants’ to make significant, sustained changes to their mental wellbeing. It would be useful to incorporate these into the assessment of mental wellbeing as measures of functioning as opposed to a change in symptoms. It would also be valuable to have a specific focus on these areas in the delivery of therapy.

Also of significance in the delivery of therapy is the consideration of ‘things outside of therapy’. Participants’ noted the importance of these subthemes in the maintenance of their mental health outside of therapy. It could prove useful to assess these elements as a matter of course within the assessment process and work on building these areas into the therapeutic work.

#### *Outcome measure*

As discussed above, it may be useful to develop an outcome measure based on the global psychological functions found as helpful aspects of making change within therapy and maintaining or improving change outside of therapy. Participants’ identified many aspects of change that weren’t about symptomatic change. The development of a measure could provide a meaningful measure of change as opposed to a reduction in symptoms and could highlight what recovery actually means to clients, for example, accepting their previous difficult experiences in life. Assessing these areas may help to assess where clients’ are in their recovery and may indicate the likelihood of relapse.

#### *Information giving*

It may prove to be useful to provide information in the form of a leaflet to individuals at the start of therapy to build an awareness of the realities of engaging in therapy and the likely outcome from the perspective of service users. For example; including

information about the importance of being ready to make a commitment to change and to engage in the sessions, which helps make the most out of therapy. Also, the acknowledgement that distress is a part of life and in the majority of cases, it will take continued effort to maintain mental health once discharged from therapy, however, also highlighting the potential positive impact it can have.

#### *Follow up appointments*

The majority of participants' discussed how useful it would be to have some sort of follow up from the service, whether this is a phone call for a review, an individual appointment or a group session where skills and strategies could be refreshed. Participants' highlighted the difficulty of therapy ending and thought some sort of follow up session/s would decrease the likelihood of referrals to the service in the long term, which the relapse literature would support. It may also be useful to have relapse prevention plans incorporated into the sessions; however, the lack of attendance towards the end of therapy has been discussed by participants and is something to be mindful of. Offering review appointments or group sessions after discharge may offer the opportunity to prevent relapse and empower individuals to maintain their mental health, knowing that support is available should they need it.

Child and adolescent mental health services (CAMHS) have developed a discharge passport which varies from trust to trust, however the majority offer clients a return to the service within a given time frame, in which they can contact the previously seen clinician to discuss concerns or self-refer for a further face to face appointment. It would be worth considering developing a 'keeping you well' booklet or document incorporating the results from the participants' as to what things they took from therapy that maintain their mental health as well as things outside therapy that support their

mental health. The booklet could provide information about healthy living, quotes from service users about the acknowledgement that it will take continued effort to maintain their mental health and what things support them. A list of other support services such as voluntary sector services could also be included as well as self-help links. The booklet could be developed in conjunction with service users to serve as a self-management tool.

The possibility of offering ‘wellness sessions’, as described by Jessica, are worth considering to reduce the likelihood of relapse and referral back into the service. Although the service sees a high level of complexity and difference in service users who undertake a variety of therapies, the research demonstrates themes that run across diagnoses and therapies and could form the basis of perhaps a rolling course of sessions. These could be offered to people who have been discharged, where they could either attend a block course or select specific sessions that they feel would be helpful and relevant to their needs.

### **Future Research**

The current study explored how clients recently discharged from psychological therapy manage their mental health on a daily basis, which highlighted elements from therapy and outside of therapy which support them in the longer term. How clients’ utilise therapy once they have been discharged is an understudied area and would benefit from replication with a larger sample; increasing the diversity within the sample, the therapists’ that were seen and the treatment modalities offered. It would be interesting to investigate themes as a whole across a wider sample, as well as categories based on type of therapy and therapist seen, to see if searching by these specifications has any impact on the results. As the theme ‘things that helped therapy be successful’ was produced, it

would also be interesting to compare these factors to a further understudied population, those who did not respond to therapy. It could prove useful to see if there is any correlation between the reasons for therapy not being successful and the reasons that helped therapy to be successful. Not responding to therapy could be due to a lack of the helpful factors or other factors that have not been considered. It would also be useful to continue the study over a prolonged period of time, to investigate how this has an impact on longer term follow up and consider the factors that may have led to relapse or that enabled them to continue to self-manage.

There is also the potential for quantitative research to be undertaken and incorporated to explore the notion of benefitting from therapy. It may be that future studies could ascertain the association between subjective accounts of benefitting from therapy compared to objective measures that are used within the service, such as the CORE-OM. Further research into the area may highlight similarities or differences between the two measures, leading to the development of different measures or a different process for assessing change and the benefit of therapy.

Future work could include the development of an outcome measure that assesses the components found that indicate how change was enabled within therapy and how it was maintained or improved outside of therapy. This may lead to a meaningful measure assessing global psychological functions and may indicate the likelihood of relapse. Research could also be conducted into the development of a 'keeping you well' booklet and the impact of this on participants' in terms of support, self-management and the likelihood of relapse or contact with the service. The same applies to the development and evaluation of 'wellness sessions' should they be taken forward.

## CONCLUSIONS

- The research has demonstrated that despite the complexity, presenting problem of the individual and type of therapy received, there are commonalities of changes in therapy that are utilised on a daily basis afterwards, alongside external factors outside of therapy that help participants' to stay well and manage their mental health. This offers a trans-theoretical approach of individuals managing their mental health.
- The study highlights the importance of therapy and the 'life changing' impact it can have on individuals.
- The results include requests from participants for some sort of follow up or review from the service to support them in maintaining their mental health.
- Participants' discussed the importance of the relationship with the therapist, their commitment to change and the structure and focus of therapy as important factors that enabled therapy to be successful, which confirms previous research into this area.
- A number of complex processes occur as a result of therapy that allow participants' to manage their mental health on a daily basis, including an acceptance of themselves and what they have been through. It was also recognised that distress is a natural part of life and that it will take continued effort to manage mental health under these circumstances. The importance of valuing yourself and making yourself a priority was highlighted and the impact this had on relationships with others. The increased understanding of interpersonal relationships with others and themselves, what patterns of

interactions were helpful or not enabled changes to be made to increase positive ways of relating.

- How clients' manage their mental health on a daily basis once discharged from therapy is an understudied area and warrants further research.
- The development of an outcome measure or 'wellness sessions', incorporating these themes may provide a meaningful concept of change and recovery.

In setting out to understand how clients' manage their mental health after therapy, a narrative account was given by participants' that detailed the journey from factors that assisted the process of therapy at the time, to what was taken from therapy, factors outside of therapy and how therapy could be improved. The study provides an understanding of the role of psychological therapy in enduring change and self-management after discharge. Important themes were acceptance of previous difficult experiences, mental health and distress in life, understanding and changing interpersonal relationships as well as strategies and techniques. Psychotherapy aims to bring about and maintain change. Irrespective of the varying gender, age and presenting problems of participants, type of therapy received and therapist they saw, all participants' made reference to the fact that therapy was 'life changing', demonstrating the profound and transtheoretical nature of change and self-management. The processes and factors identified as important by participants stayed with them after therapy and helped them manage their continued problems. These should be taken into account in order to improve therapy, reduce relapse and increase the likelihood of continued improvement after discharge. It is hoped that from this more clients will leave therapy as Helen did feeling as though "*it changed my life*".

## REFERENCES

- Addis, M.E., Cardemil, E.V., Duncan, B.L., Miller, S.D. (2006). Does Manualization Improve Therapy Outcomes? In Norcross, John C. (Ed); Beutler, Larry E. (Ed); Levant, Ronald F. (Ed), (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*, (pp. 131-160). Washington, DC, US: American Psychological Association.
- Andrews, G. (2001). Should depression be managed as a chronic disease? *BMJ*, 322, 419-421.
- APA Presidential Task Force. (2006). Evidence-based practice in psychology. *The American Psychologist*, 61(4), 271-285.
- Baker, T.B., McFall, R.M., & Shoham, V. (2009). Current Status and Future Prospects of Clinical Psychology: Toward a Scientifically Principled Approach to Mental and Behavioural Health Care. *Association for Psychological Science*, 9(2).
- Barkham, M., & Mellor-Clark, J. (2003). Bridging evidence-based practice and practice-based evidence: developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology & Psychotherapy*, 10(6), 319-327.
- Barkham, M., & Parry, G. (2008). Balancing rigour and relevance in guideline development for depression: the case for comprehensive cohort studies. *Psychol Psychother*, 81(Pt 4), 399-417.
- Barkham, M., Stiles, W. B., Connell, J., & Mellor-Clark, J. (2012). Psychological treatment outcomes in routine NHS services: what do we mean by treatment effectiveness? *Psychol Psychother*, 85(1), 1-16.
- Barkham, M., Stiles, W.B., Connell, J., Twigg, E., Leach, C., Lucock, M., Mellor-Clark, J., Bower, P., King, M., Shapiro, A.D., Hardy, G.E., Greenberg, L., and Angus, L. (2008). Effects of psychological therapies in randomized trials and practice-based studies. *British Journal of Clinical Psychology*, 47, 397-415.
- Barlow, J., Wright, C., Sheasby, J., Turner, A., and Hainsworth, J. (2002). Self-management approaches for people with chronic conditions: a review. *Patient Education and Counselling*, 48, 177-187.
- Barnes, M., Sherlock, S., Thomas, L., Kessler, D., Kuyken, W., Owen-Smith, A., Lewis, G., Wiles, N., and Turner, K. (2013). No pain, no gain: Depressed clients' experiences of cognitive behavioural therapy. *British Journal of Clinical Psychology*, 52, 347-364.



- Berry, C., & Hayward, M. (2011). What can qualitative research tell us about service user perspectives of CBT for psychosis? A synthesis of current evidence. *Behavioural and Cognitive Psychotherapy*, 39, 487-494.
- Bendelin, N., Hesser, H., Dahl, J., Carlbring, P., Nelson, K.Z., & Andersson, G. (2011). Experiences of guided internet-based cognitive-behavioural treatment for depression: A qualitative study. *BMC Psychiatry*, 11, 107.
- Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, 16(3), 252-261.
- Bradford, A., Cully, J., Rhoades, H., Kunik, M., Kraus-Schuman, C., Wilson, N., & Stanley, M. (2011). Early Response to Psychotherapy and Long-term Change in Worry Symptoms in Older Adults with Generalized Anxiety Disorder. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry*, 19(4), 347-356.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.
- Brownell, T., Schrank, B., Jakaite, Z., Larkin, C., & Slade, M. (2015). Mental health service user experiences of positive psychotherapy. *Journal of Clinical Psychology*, 71(1), 85-92.
- Carey, T. A., Carey, M., Stalker, K., Mullan, R. J., Murray, L. K., & Spratt, M. B. (2007). Psychological change from the inside looking out: A qualitative investigation. *Counselling and Psychotherapy Research*, 7(3), 178-187.
- Carroll, L. (1865) *Alice's Adventures in Wonderland*. London, England: Macmillan Publishing Co.
- Castonguay, L. G., & Muran, J. C. (2015). Fostering collaboration between researchers and clinicians through building practice-oriented research: an introduction. *Psychotherapy Research*, 25(1), 1-5.
- Clarke, H., Rees, A., & Hardy, G.E. (2004). The big idea: Clients' perspectives of change processes in cognitive therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 77, 67-89.

- Clinton, D.N. (1996). Why do eating disorder patients drop out? *Psychotherapy and Psychosomatics*, 65, 29-35.
- Coulombe, S., Radziszewski, S., Trépanier, S.G., Provencher, H., Roberge, P., Hudon, C., Meunier, S., Provencher, M.D. and Houle, J., (2015). Mental health self-management questionnaire: Development and psychometric properties. *Journal of affective disorders*, 181, pp.41-49.
- Crown, W.H., Finkelstein, S., Berndt, E.R., Ling, D., Poret, A.W., and Rush, A.J. (2002). The impact of treatment-resistant depression on health care utilization and costs. *Journal of Clinical Psychiatry*; 63(11), 963–971.
- Cuijpers, P., Hollon, S. D., van Straten, A., Bockting, C., Berking, M., & Andersson, G. (2013). Does cognitive behaviour therapy have an enduring effect that is superior to keeping patients on continuation pharmacotherapy? A meta-analysis. *BMJ Open*, 3(4).
- Davidson, L. (2005). Recovery, self management and the expert patient – Changing the culture of mental health from a UK perspective. *Journal of Mental Health*, 14(1), 25-35.
- De Maat, S., Dekker, J., Schoevers, R., & De Jonghe, F. (2006). Relative efficacy of psychotherapy and pharmacotherapy in the treatment of depression: A meta-analysis. *Psychotherapy Research*, 16(5), 566-578.
- DeRubeis, R. J., Hollon, S. D., Amsterdam, J. D., Shelton, R. C., Young, P. R., Salomon, R. M., et al. (2005). Cognitive therapy vs. medications in the treatment of moderate to severe depression. *Archives of General Psychiatry*, 62, 409–416.
- Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmaling, K. B., Kohlenberg, R. J., Addis, M. E., et al. (2006). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *Journal of Consulting and Clinical Psychology*, 74, 638-670.
- Dobson, K. S., Hollon, S. D., Dimidjian, S., Schmaling, K. B., Kohlenberg, R. J., Gallop, R. J., Rizvi, S. L., Gollan, J. K., Dunner, D. L. & Jacobson, N. S. (2008). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the prevention of relapse and recurrence in major depression. *Journal of Consulting and Clinical Psychology*, 76, 468-77.
- Duncan, B., & Miller, S. (2006) Treatment Manuals Do Not Improve Outcomes. In Norcorss, J., Levant, R., & Beutler, L. (Eds) *Evidence-based practices in mental health*. Washington, D.C.: APA Press.

- Eaton, W. W., Shao, H., Nestadt, G., Lee, B. H., Bienvenu, O. J., & Zandi, P. (2008). Population-Based Study of First Onset and Chronicity in Major Depressive Disorder. *Archives of General Psychiatry*, 65(5), 513–520.
- Elliot, R. (2008). Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research*, 18(3), 239-242.
- Elliot, R., Fischer, C.T., and Rennie, D.L. (1999). Evolving guidelines for the publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), 215-229.
- Evans, C., Connell, J., Barkham, M., et al (2002) Towards a standardised brief outcome measure: psychometric properties and utility of the CORE–OM. *British Journal of Psychiatry*, 180, 51– 60.
- Fennel, M.J.V., & Teasdale, J.D. (1987). Cognitive therapy for depression: Individual differences and the process of change. *Cognitive Therapy and Research*, 11(2), 253–271.
- Fitzpatrick, M.R., Chamodraka, M. (2007). Participant critical events: a method for identifying and isolating significant therapeutic incidents. *Psychotherapy Research*, 17, 622-627.
- Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*, 25, 1229–1245.
- Gillard, S., Simons, L., Turner, K., Lucock, M., & Edwards, C. (2012) Patient and public involvement in the coproduction of knowledge: reflection on the analysis of qualitative data in a mental health study. *Qualitative Health Research*, 22, 1126-1137.
- Glaser, B.G. and Strauss, A.L. (1965). *Awareness of dying*. Chicago: Aldine.
- Glaser, B.G. and Strauss, A.L. (1967). *The discovery of grounded theory*. Chicago: Adline.
- Goldfried, M. R. (2013). What should we expect from psychotherapy? *Clinical Psychology Review*, 33(7), 862-869.
- Goldfried, M.R., & Davilo, J. (2005). The role of relationship and technique in therapeutic change. *Psychotherapy: Theory, Research, Practice, Training*. 42(4), 421-430.

- Gortner, E.T., Gollan, J.K., Dobson, K.S., & Jacobson, N.S. (1998). Cognitive-behavioural treatment for depression: relapse prevention. *Journal of Consulting and Clinical Psychology*, 66(2), 377-84.
- Green, L. W. (2008). Making research relevant: If it is an evidence-based practice, where's the practice-based evidence? *Family Practice*, 25(Suppl. 1), 20–24.
- Grencavage, L. M., Norcross, J.C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice*, Vol 21(5).
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59-82.
- Harris, R. (2009). *Act Made Simple: An Easy-to-Read Primer on Acceptance and Commitment Therapy*. UK: New Harbinger Publications.
- Henderson, C., Swanson, J. W., Szmukler, G., Thornicroft, G., & Zinkler, M. (2008). A typology of advance statements in mental health care. *Psychiatric Services*, 59(1), 63 - 71.
- Hofmeijer-Sevink, M.K., van Oppen, P., van Megen, H.J., Batelaan, N.M., Cath, D.C., van der Wee, N.J.A., van Balkom, A.J., and van den Hout, M.A. (2013). Clinical relevance of comorbidity in obsessive compulsive disorder: The Netherlands OCD Association study. *Journal of Affective Disorders*, 150, 847-854.
- Hollon, S.D., DeRubeis, R.J., Shelton, R.C., Amsterdam, J.D., Salomon, R.M., O'Reardon, J.P., Lovett, M.L., Young, P.R., Haman, K.L., Freeman, B.B., & Gallop, R. (2005). Prevention of relapse following cognitive therapy vs medications in moderate to severe depression. *Archives of General Psychiatry*, 62(4), 417-22.
- Hollon, S. D., Stewart, M. O., & Strunk, D. (2006). Enduring effects for cognitive behavior therapy in the treatment of depression and anxiety. *Annu Rev Psychol*, 57, 285-315.
- Holloway, I. & Todres, L. (2003). The status of method: flexibility, consistency and coherence. *Qualitative Research*, 3(3), 345-357.
- Holmqvist, R., Phillips, B., and Barkham, M. (2015). Developing practise-based evidence: Benefits, challenges and tensions. *Psychotherapy research*, 25(1), 20-31.
- Hubble, M.A., Duncan, B.L., Miller, S.D., Wampold, B.E. (2010). In: *The Heart and soul of change* (2<sup>nd</sup> ed). Delivering what works in therapy. American Psychological Association, Washington.

- Hunsley, J., Elliot, K., & Therrien, Z. (2013). *The efficacy and effectiveness of psychological treatments*. The Canadian Psychological Association, Ontario.
- Ilardi, S.S., & Craighead, W.E. (1994). The role of non-specific factors in cognitive-behaviour therapy for depression. *Clinical Psychology: Science and Practice*, 1, 138–156.
- Imel, Z. E., & Wampold, B. E. (2008). The common factors of psychotherapy. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed.). New York: Wiley.
- Isman, E., Ekéus, C., & Berggren, V. (2013). Perceptions and experiences of female genital mutilation after immigration to Sweden: An explorative study. *Sexual & Reproductive Healthcare*, 4, 93–98.
- Isman, E., Mahmoud Warsame, A., Johansson, A., Fried, S., & Berggren, V. (2013). Midwives' experiences in providing care and counselling to women with female genital mutilation (FGM) related problems. *Obstetrics and Gynecology International*, 2013. Article ID: 785148.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of consulting and clinical psychology*, 59(1), 12–9.
- Jacobson, N. S., Follette, W. C. & Revenstorff, D. (1984). Psychotherapy outcome research: methods for reporting variability and evaluating clinical significance. *Behaviour Therapy*, 15: 336-352.
- Jim, J; Pistrang, N; (2007) Culture and the therapeutic relationship: perspectives from Chinese clients. *Psychotherapy Research* , 17 (4) 461 - 473.
- Kazdin, A.E. (2008). Evidence-Based Treatment and Practice: New Opportunities to Bridge Clinical Research and Practice, Enhance the Knowledge Base, and Improve Patient Care. *The American Psychologist*, 63(3), 146-159.
- Knowles, S.E., Toms, G., Sanders, C., Bee, P., Lovell, K., Rennick-Egglestone, S., Coyle, D., Kennedy, C.M., Littlewood, E., Kessler, D., Gilbody, S., Bower, P. (2014). Qualitative meta-synthesis of user experience of computerised therapy for depression and anxiety. *PLoS ONE*, 9(1), e84323.
- Kraemer, H.C., & Kupfer, D.J. (2006). Size of treatment effects and their importance to clinical research and practice. *Biological Psychiatry*, 59(11), 990-996.

- Kuyken, W., Byford, S., Taylor, R.S., Watkins, E., Holden, E., White, K., Barrett, B., Byng, R., Evans, A., Mullan, E., Teasdale, J.D.(2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *Journal of Consulting and Clinical Psychology*, 76(6), 966-78.
- Lakey, B., & Orehek, E. (2011). Relational Regulation Theory: A new approach to explain the link between perceived social support and mental health. *Psychological Review*, 118(3), 482-495.
- Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In Norcross, J.C., & Goldfried, M.R. (Eds.), *Handbook of psychotherapy integration* (pp. 94–129) New York: Basic Books.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed.). New York: John Wiley & Sons.
- Lambert, M. J., Whipple, J. L., Bishop, M. J., Vermeersch, D. A., Gray, G. V., & Finch, A. E. (2002). Comparison of empirically-derived and rationally-derived methods for identifying patients at risk for treatment failure. *Clinical Psychology & Psychotherapy*, 9(3), 149-164.
- Larsson, B. P. M., Kaldø, V., & Broberg, A. G. (2009). Similarities and differences between practitioners of psychotherapy in Sweden: A comparison of attitudes between psychodynamic, cognitive, cognitive-behavioral, and integrative therapists. *Journal of Psychotherapy Integration*, 19(1), 34-66.
- Leeman, J., and Sandelowski, M. (2012). Practice-based evidence and qualitative enquiry. *Journal of Nursing Scholarship*, 44(2), 171-179.
- Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2013). Why many clinical psychologists are resistant to evidence-based practice: root causes and constructive remedies. *Clinical Psychology Review*, 33(7), 883-900.
- Lillevoll, K., Wilhelmsen, M., Kolstrup, N., Høifødt, R.S., Waterloo, K., Eisemann, M., & Risør, M.B. (2013). Patients' experiences of helpfulness in guided internet-based treatment for depression: Qualitative study of integrated therapeutic dimensions. *Journal of Medical Internet Research*, 15(6), e126.
- Llewelyn, S. and Hardy, G. (2001), Process research in understanding and applying psychological therapies. *British Journal of Clinical Psychology*, 40: 1–21.

- Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T. P., Berman, J. S., Levitt, J. T., Seligman, D. A. and Krause, E. D. (2002), The Dodo Bird Verdict Is Alive and Well—Mostly. *Clinical Psychology: Science and Practice*, 9: 2–12
- Lucock, M. Barber, R., Jones, A., & Lovell, J. (2007) Service users' views of self-help strategies and research in the UK. *Journal of Mental Health*, 16 (6), 795 – 805
- Lutz, W., Lambert, M. J., Harmon, S. C., Tschitacz, A., Schurch, E. & Stulz, N. (2006). The probability of treatment success, failure and duration—what can be learned from empirical data to support decision making in clinical practice? *Clinical Psychology & Psychotherapy*, 13, 223-232.
- Lutz, W., Leon, S. C., Martinovich, Z., Lyons, J. S., & Stiles, W. B. (2007). Therapist effects in outpatient psychotherapy: A three-level growth curve approach. *Journal of Counseling Psychology*, 54, 32-39.
- Ma, S. H. & Teasdale, J. D. (2004). Mindfulness-based cognitive therapy for depression: replication and exploration of differential relapse prevention effects. *Journal of Consulting and Clinical Psychology*, 72, 31-40.
- Macran, S., Ross, H., Hardy, G.E., & Shapiro, D.A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health*, 8(4), 29-35.
- Marcus, D.K., O'Connell, D., Norris, A.L., & Sawaqdeh, A. (2014). Is the Dodo bird endangered in the 21<sup>st</sup> century? A meta-analysis of treatment comparison studies. *Clinical Psychology Review*, 34, 519-530.
- Mayou, R., Ehlers, A., & Hobbs, M. (2000). Psychological debriefing for road traffic accident victims: three year follow-up of a randomised controlled trial. *British Journal of Psychiatry*, 176, 589–593.
- McLeod, J. (2001). *Qualitative Research in Counselling and Psychotherapy*, Sage Publications Ltd, London.
- McLeod, J. (2012). *Qualitative Research in Counselling and Psychotherapy, Second Edition*. Sage Publications Ltd, London.
- Mueller, T.I., Leon, A.C., Keller, M.B., Solomon, D.A., Endicott, J., Coryell, W., Warshaw, M. & Maser, J.D. (1999). Recurrence after recovery from major depressive disorder during 15 years of observational follow-up. *American Journal of Psychiatry*, 156(7),1000–1006.

- Miller, S. D., Hubble, M. A., Chow, D. L., & Seidel, J. A. (2013). The outcome of psychotherapy: yesterday, today, and tomorrow. *Psychotherapy (Chic)*, 50(1), 88-97.
- Mollon, P. (2009). The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help. *Psychodynamic Practice*, 15(1), 9-24.
- Murray, G., Suto, M., Hole, R., Hale, S., Amari, E., and Michalak, E.E. (2010). Self-Management Strategies Used by 'High Functioning' Individuals with Bipolar Disorder: From Research to Clinical Practice. *Clinical Psychology and Psychotherapy*, 18(2), 95-109.
- NICE. (2009). *Depression: the Treatment and Management of Depression in Adults (Update)*. Quick Reference Guide. London: NICE.
- NICE (2011) *Generalised Anxiety Disorder and Panic Disorder (With Or Without Agoraphobia) in Adults: Management in Primary, Secondary and Community Care*. Quick Reference Guide. London: NICE.
- NICE. (2012). *Methods for the development of NICE public health guidance (third edition)*. London: NICE.
- Nilsson, T., Svensson, M., Sandell, R. & Clinton, D. (2007). Patients' experiences of change in cognitive-behavioral therapy and psychodynamic therapy: a qualitative comparative study. *Psychotherapy Research*, 17 (5), 553-566.
- Okiishi, J., Lambert, M.J., Nielsan, S.L., & Ogles, B.M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology and Psychotherapy*, 10, 361-373.
- Prochaska, J.O., Norcross, J.C., and DiClemente, C.C. (2013). Applying the stages of change [online]. *Psychotherapy in Australia*, 19 (2), 10-15.
- Ramnero, J., & Ost, L.G. (2007). Panic and avoidance in panic disorder with agoraphobia: clinical relevance of change in different aspects of the disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 38(1), 29-39.
- Rayner, K., Thompson, A.R., Walsh, S. (2011). Clients' experience of the process of change in cognitive analytic therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 299-313.
- Renaud, J., Brent, D.A., Baugher, M., Birmaher, B., Kolko, D.J., & Bridge, J. (1998). Rapid response to psychosocial treatment for adolescent depression: A two-year follow-up.



*Journal of the American Academy of Child and Adolescent Psychiatry*, 37(11), 1184–1191.

- Rogers, A., Oliver, D., Bower, P., Lovell, K., & Richards, D. (2004). Peoples' understandings of a primary care-based mental health self-help clinic. *Patient Education and Counseling*, 53(1), 41-46.
- Rosenzweig, S. (1936). "Some implicit common factors in diverse methods of psychotherapy". *American Journal of Orthopsychiatry* 6 (3): 412–15
- Rudkin, A., Llewelyn, S., Hardy, G., Stiles, W.G., & Barkham, M. (2007). Therapist and client processes affecting assimilation and outcome in brief psychotherapy, *Psychotherapy Research*, 17(5), 613-621.
- Ryle, A., and Kerr, I.B. (2002). *Introducing Cognitive Analytic Therapy: Principles and Practice*. West Sussex: John Wiley & Sons Ltd.
- Safran, J.D., Muran, J.C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy*, 48(1), 80-87.
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, 18, 179–183.
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.
- Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist*, 50, 965–974.
- Shea, M., Elkin, I., Imber, S., Sotsky, S., Watkins, J., Collins, J., Pilkonis, P., Beckham, E., Glass, D., Dolan, R., & Parloff, M. (1992). Course of depressive symptoms over follow-up. *Archives of General Psychiatry*, 49, 782-787.
- Sibiltz, I., Amering, M., Gossler, R., Unger, A., & Katschnig. (2007) Patients' perspectives on what works in psychoeducational groups for schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 42, 909-915.
- Simpson, E. L., & House, A. O. (2002). Involving users in the delivery and evaluation of mental health services: systematic review. *British Medical Journal*, 325(7375), 1265.

- Singh, R. (2014). Evidence-based practice and practice-based evidence: reasons for optimism. *Journal of Family Therapy*, 36(2), 105-106.
- Sofaer, S. (1999). Qualitative Methods: What are they and why use them? *Health Services Research*, 34(5), 1101-1116.
- Southwick, S.M., Vythilingam, M., Charney, D.S. (2005). The psychobiology of depression and resilience to stress: Implications for prevention and treatment. *Annual Review of Clinical Psychology*, 1, 255–91.
- Steinert, C., Hofmann, M., Kruse, J. and, Leichsenring, F. (2014). Relapse rates after psychotherapy for depression – stable long-term effects? A meta-analysis. *Journal of Affective Disorders*, 168C, 107–118.
- Sterling, E., von Esenwein, S., Tucker, S., Fricks, L., & Druss, B. (2010). Integrating wellness, recovery, and self-management for mental health consumers. *Community Mental Health Journal*, 46(2), 130-138.
- Stiles, W.B., Honos-Webb, L., Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice*, 5(4), 439-459.
- Strauss, A.L.. and Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage Publications.
- Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M. & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68, 615-623.
- Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research*, 17, 305-314.
- Todd, N, J., Jones, S.H., and Lobban, F.A. (2012). “Recovery” in bipolar disorder: How can service users be supported through a self-management intervention? A Qualitative focus group study. *Journal of Mental Health*, 21(2), 114-126.
- Trepka, C., Rees, A., Shapiro, D.A., Hardy, G.E. and Barkham, M. (2004). Therapist Competence and Outcome of Cognitive Therapy for Depression. *Cognitive Therapy and Research*, 28(2), 143-157.
- Valkonen, J., Hänninen, V., & Lindfors, O. (2011). Outcomes of psychotherapy from the perspective of the users. *Psychotherapy Research*, 21(2), 227-246.


- Vanaerschot, G., & Lietaer, G. (2007). Therapeutic ingredients in helping session episodes with observer-rated low and high empathic attunement: a content analysis of client and therapist post session perceptions in three cases. *Psychotherapy Research, 17*, 338-352.
- Viklund, E., Holmqvist, R., Zetterqvist Nelson, K. (2010). Client-identified important events in psychotherapy: international structures and practices. *Psychotherapy Research, 20*(2), 151-164.
- Vittengl, J.R., Clark, L.A., Dunn, T.W., Jarrett, R.B. (2007). Reducing relapse and recurrence in unipolar depression: A comparative meta-analysis of cognitive-behavioral therapy's effects. *Journal of Consulting and Clinical Psychology, 73*, 475-488.
- Wallace, L. M., & von Ranson, K. M. (2012). Perceptions and use of empirically-supported psychotherapies among eating disorder professionals. *Behaviour Research Therapy, 50*(3), 215-222.
- Wampold, B. E. (2001). *The great psychotherapy debate: Model, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Wampold, B. E. (2006). What should be validated? The psychotherapist. In J. C. Norcross, L. E. Beutler & R. F. Levant (Eds.), *Evidence-based practices in mental Health: Debate and dialogue on the fundamental questions* (pp. 200-208). Washington, DC: American Psychological Association.
- Wampold, B. E. (2007). Psychotherapy: The Humanistic (and Effective) Treatment. *American Psychologist, 62*, 857-873.
- Wampold, B.E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270-278.
- Wampold, B. E., & Brown, G. S. (2005). Estimating therapist variability: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73*, 914-923.
- Wampold, B. E., Mondin, G.W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). "A meta-analysis of outcome studies comparing bona fide psychotherapies: empirically, 'All must have prizes'", *Psychological Bulletin 122*: 203-15
- Webb, C.A., De Rubeis, R.J., & Barber, J.P. (2010). Therapist Adherence/Competence and Treatment Outcome: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology, 78*(2), 200-211.

Westen, D., Novotny, C.M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies. *APA Psychological Bulletin*, 130(4), 63.

Willig, C. (2008). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Maidenhead: McGraw Hill Open University Press.

APPENDICES

Appendix 1: CORE-OM 34 questionnaire



**Site ID**

letters only   numbers only

**Client ID**

Therapist ID     numbers only (1)   numbers only (2)

**Sub codes**

D D M M Y Y Y Y

/   /

**Date form given**

**Male**

**Age**   **Female**

**Stage Completed**

S Screening  **Stage**

R Referral

A Assessment

F First Therapy Session

P Pre-therapy (unspecified)

D During Therapy

L Last Therapy Session

X Follow up 1

Y Follow up 2

**Episode**

**IMPORTANT - PLEASE READ THIS FIRST**

This form has 34 statements about how you have been OVER THE LAST WEEK.  
Please read each statement and think how often you felt that way last week.  
Then tick the box which is closest to this.  
*Please use a dark pen (not pencil) and tick clearly within the boxes.*

<b>Over the last week</b>	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1 I have felt terribly alone and isolated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
2 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
3 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
4 I have felt OK about myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
5 I have felt totally lacking in energy and enthusiasm	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
6 I have been physically violent to others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
7 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
8 I have been troubled by aches, pains or other physical problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
9 I have thought of hurting myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
10 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
11 Tension and anxiety have prevented me doing important things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
12 I have been happy with the things I have done	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
13 I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
14 I have felt like crying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W

**Please turn over**

Over the last week							OFFICE USE ONLY
		Not at all	Only Occasionally	Sometimes	Often	Most or all the time	
15	I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
16	I made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
17	I have felt overwhelmed by my problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W
18	I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
19	I have felt warmth or affection for someone	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
20	My problems have been impossible to put to one side	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
21	I have been able to do most things I needed to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
22	I have threatened or intimidated another person	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
23	I have felt despairing or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
24	I have thought it would be better if I were dead	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
25	I have felt criticised by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
26	I have thought I have no friends	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
27	I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
28	Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
29	I have been irritable when with other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
30	I have thought I am to blame for my problems and difficulties	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
31	I have felt optimistic about my future	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
32	I have achieved the things I wanted to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
33	I have felt humiliated or shamed by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
34	I have hurt myself physically or taken dangerous risks with my health	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R

**THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE**

<b>Total Scores</b>	<input style="width: 50px; height: 25px;" type="text"/>	<input style="width: 50px; height: 25px;" type="text"/>	<input style="width: 50px; height: 25px;" type="text"/>	<input style="width: 50px; height: 25px;" type="text"/>	<input style="width: 50px; height: 25px;" type="text"/>	<input style="width: 50px; height: 25px;" type="text"/>
	↓	↓	↓	↓	↓	↓
<b>Mean Scores</b> <small>(Total score for each dimension divided by number of items completed in that dimension)</small>	<input style="width: 50px; height: 25px;" type="text"/>	<input style="width: 50px; height: 25px;" type="text"/>	<input style="width: 50px; height: 25px;" type="text"/>	<input style="width: 50px; height: 25px;" type="text"/>	<input style="width: 50px; height: 25px;" type="text"/>	<input style="width: 50px; height: 25px;" type="text"/>
	(W)	(P)	(F)	(R)	All items	All minus R

## Appendix 2: NHS Ethical Approval

### NRES Committees - North of Scotland

Summerfield House  
2 Eday Road  
Aberdeen  
AB15 8RE

Telephone: 01224 558458  
Facsimile: 01224 558609  
Email: nosres@nhs.net



23 September 2015

Mrs Claire Howarth  
The University of Leeds  
Leeds Institute of Health Sciences  
Doctorate in Clinical Psychology  
Charles Thackrah Building, Room G.04  
101 Clarendon Road  
LEEDS  
LS2 9LJ

Dear Mrs Howarth

**Study title:** Understanding how patients recently discharged from psychological therapy manage their mental health problems  
**REC reference:** 15/NS/0097  
**IRAS project ID:** 171400

Thank you for e-submitting the revised documents. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 9 September 2015.

#### Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Letters of invitation to participant: Opt in letter	2	22 September 2015
Participant Information Sheet (PIS)	2	9 September 2015

#### Approved documents

The final list of approved documentation for the study is therefore as follows:


<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)	1	17 September 2014
Interview schedules or topic guides for participants	1	20 July 2015
IRAS Checklist XML: Checklist 22092015		22 September 2015
Letter from Sponsor	1	3 August 2015

<i>Document</i>	<i>Version</i>	<i>Date</i>
Letters of invitation to participant: Opt in letter	2	22 September 2015
Appendix 1 - Research Panel Constitution	1	13 July 2015
Appendix 3 - Information Letter about the Trainee Clinical Psychology Research	1	1 August 2015
Participant Consent Form	1	13 July 2015
Participant Information Sheet (PIS)	2	9 September 2015
REC Application Form: REC Form 01092015	171400839 5121725	1 September 2015
Referee's report or other scientific critique report: Joint Report of the Transfer Assessment Panel	1	8 July 2015
Research protocol or project proposal	1	1 September 2015
Summary CV for Chief Investigator (CI): Claire Howarth	1	20 July 2015
Summary CV for Supervisor (student research): Gary Latchford	1	1 August 2015

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

<b>15/NS/0097</b>	<b>Please quote this number on all correspondence</b>
-------------------	---

Yours sincerely



**Carol Irvine**  
**Senior Ethics Co-ordinator**


Copy to: Faculty Research Ethics and Governance Administrator  
Lubena Mirza, South West Yorkshire Partnership NHS Foundation Trust



## Appendix 3: R&D approval



With all of us in mind

South West Yorkshire Partnership   
NHS Foundation Trust

2<sup>nd</sup> October 2015

Mrs Claire Howarth  
The University of Leeds  
Leeds Institute of Health Sciences  
Doctorate in Clinical Psychology  
Charles Thackray Building  
Room G.04  
101 Clarendon Road  
Leeds  
LS2 9LJ

Research Department  
Ward 2  
Castleford & Normanton District Hospital  
Lumley Street  
Castleford  
WF10 5LT

Tel: 01977 605285

Fax: 01977 605298

Ref: Approval Letter

Email address: [research@swyt.nhs.uk](mailto:research@swyt.nhs.uk)

Dear Mrs Howarth

**Re: Understanding how patients recently discharged from psychological therapy manage their mental health problems**

**Rec reference: 15/NS/0097**

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within South West Yorkshire Partnership NHS Foundation Trust.

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Evidence of Insurance – valid to 28/09/2016		17 <sup>th</sup> September 2015
Letters of Invitation to Participant: Opt In Letter	2	2 <sup>nd</sup> September 2015
Participant Consent Form	1	13 <sup>th</sup> July 2015
Participant Information Sheet	2	9 <sup>th</sup> September 2015
Research Protocol	1	1 <sup>st</sup> September 2015
Summary CVs: Researcher and Academic Supervisor		
Interview Schedules/Topic Guides for Participants	1	20 <sup>th</sup> July 2015

This approval is granted subject to the following conditions:

- You must comply with the terms of your approval. Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform us immediately.

Chair: Ian Black Chief Executive: Steven Michael OBE



© Copyright Barnsley LGBT Forum 2006



The Government Standard

- You must comply with the procedures on project monitoring and audit.
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care<sup>1</sup>(RGF). Failure to do this could lead to permission to carry out this research being withdrawn
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.

Research projects will be added to any formal Department of Health research register.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator<sup>2</sup>**.

They should **also** be reported to:

- The R&D Department
- the Research Ethics Committee that gave approval for the study (if applicable)
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

**Changes to the agreed documents MUST be approved in line with guidance from the Integrated Research Applications System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.**

Projects sponsored by organisations other than the Trusts are reminded of those organisations obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

---

<sup>1</sup> Details from: <https://www.gov.uk/government/publications/research-governance-framework-for-health-and-social-care-second-edition>

<sup>2</sup> SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

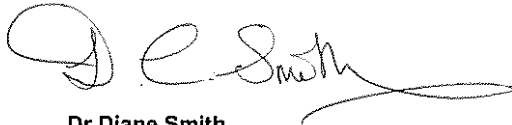
Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time.

May I take this opportunity to wish you well with the project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Diane Smith', with a long horizontal flourish extending to the right.

**Dr Diane Smith**  
**Director of Health Intelligence & Innovation**

cc: Professor Mike Lucock, Local Collaborator, SWYPFT

### Appendix 4: Dataset of referrals to respective services

Table showing distribution of clients who have had referrals to respective service: Total clients within the area = 1008

	136 Place of safety	SPA / Crisis	Physio Service	CMHT	OT	Psychiat ric Liaison Team	Day services	APTS	PLATT	Dietetic s	Early intervent ion service	Treatme nt Teams	ADHD	AOT	Dual diagnosi s	ECT	emergen cy medic teams	<b>no contact</b>
<b>Total Ref</b>	<b>61</b>	<b>396</b>	<b>71</b>	<b>418</b>	<b>88</b>	<b>53</b>	<b>272</b>	<b>841</b>	<b>175</b>	<b>33</b>	<b>31</b>	<b>18</b>	<b>11</b>	<b>6</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>135</b>
<b>%</b>	<b>6%</b>	<b>39%</b>	<b>7%</b>	<b>41%</b>	<b>9%</b>	<b>5%</b>	<b>27%</b>	<b>83%</b>	<b>17%</b>	<b>3%</b>	<b>3%</b>	<b>2%</b>	<b>2%</b>	<b>&lt;1%</b>	<b>&lt;1%</b>	<b>&lt;1%</b>	<b>&lt;1%</b>	<b>13%</b>

**Appendix 5: Opt in letter**

Adult Psychological Therapy Services

Dear *participant name*,

I am writing to invite you to take part in a research study that is taking place within the service.

At present we know very little about how people manage their mental health problems once they have been discharged from therapy. In our research project, we would like to gather information on the experiences of people who feel they have benefitted from therapy and how they manage their mental health on a daily basis. We hope the findings will lead to recommendations on how to improve the experience of therapy, and offer some insight into the things that are useful after therapy sessions have ended.

You have been contacted as you have recently been discharged from therapy, and you completed a clinical outcomes in routine evaluation (CORE) questionnaire when you began therapy. The questionnaire consists of 34 items and asked how you had been feeling over the last week.

We are looking for people who have recently been discharged from the Adult Psychological Therapy Service and feel they benefitted from the therapy they received i.e. the therapy has helped the person to manage their mental health after therapy sessions have ended. **If you feel you have benefitted, we would very much like to hear from you.**

Participation in the study would involve an interview about your experiences and filling in a questionnaire. This may last between an hour and an hour and a half. Please find enclosed an information sheet and consent form which gives further information about the study.

If you would like to take part in the study or would like further information, please email [umclro@leeds.ac.uk](mailto:umclro@leeds.ac.uk), call \*\*\* or return the slip at the bottom in the stamped addressed envelope. By responding to this letter you are not committing to take part in the study, this is simply an initial registration of interest and consent to a telephone call for further information. If you wish to take part in the study, all information will be anonymised and kept confidential, apart from exceptional circumstances which will be fully discussed with you. The therapist you worked with and other clinicians in the service will not know if you participate in the study.

Yours sincerely,

Professor Mike Lucock

**Opt in response form**

I confirm that I feel I have benefitted from psychological therapy and I would like to discuss the option of taking part in the research further. I give consent for Claire Howarth (chief investigator) to get in contact with me to discuss this.

Print name.....

Signature.....

Date.....

Please list below a telephone number that we will be able to contact you on.

.....

## Appendix 6: Information Sheet



### Doctor of Clinical Psychology Training Programme *Participant information sheet*

***Title of research project: Understanding how patients recently discharged from psychological therapy manage their mental health problems***

I am writing to you to invite you to take part in a research project which aims to gain an understanding of how people who feel they benefitted from therapy manage their mental health after therapy sessions have ended. The researcher is myself, Claire Howarth and I am completing the research as part of the qualification of the Doctorate in Clinical Psychology. Please find below information explaining the project and what it would involve for you, so you can make a decision as to whether you would like to take part. If you have any questions or queries or if anything is unclear; please do not hesitate to ask me for further clarification.

***What is the purpose of the study?***

At present, there is little research on how people who have been discharged from adult psychological therapy services manage their mental health once therapy sessions have ended. We would like to gather information on the experiences of people who feel they have benefitted from therapy, and how they manage their mental health on a daily basis. We hope the findings will inform recommendations to improve the experience of therapy and offer insight into strategies that are useful after therapy sessions have ended.

***Why have I been invited?***

You have been invited to take part in the study if you have recently been discharged from adult psychological therapy services, found therapy to be of benefit and completed a clinical outcomes in routine evaluation (CORE) questionnaire when you began therapy. The questionnaire consists of 34 items and asked how you had been feeling over the last week.

***Do I have to take part?***

No, it is entirely up to you to decide whether to take part or not. If you decide to participate you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you can withdraw without giving a reason, up until four weeks after your interview. After this time, it will not be possible to withdraw as the results will be being analysed. A decision to withdraw will not have any impact upon any future care you may receive.

***What will happen if I decide to take part?***

If you decide to take part in the study you will be asked to read and sign a consent form. You will then be asked to attend an interview at a time which is convenient for you, which will last for around an hour to an hour and a half. The interview can take place in your home or at the hospital where you received therapy sessions. Interviews will be held in a private and quiet room where you will be asked questions regarding your experience of psychological therapy and how you manage your mental health on a daily basis since therapy sessions ended. Following the interview you will be asked to fill in a CORE questionnaire which will take approximately 5-10 minutes. With your permission, the interview will be audio-recorded and later transcribed so it can be analysed.

***Are there any possible advantages of taking part?***

You will be helping the service develop an understanding of the management of mental health once therapy sessions have ended. It is hoped this understanding will then inform the service on how to incorporate these strategies to make therapy more effective and be of benefit to others. Though taking part may not be of direct benefit towards yourself, it may help in contributing towards improvements in therapy and treatment for future clients.

Although it is not the intention of the research to cause distress, it is possible that taking part in the study and discussing your experiences may bring up difficult issues for you. If this is the case and you become upset during the interview, we can pause until you feel able to continue. The researcher will direct you to the most appropriate forms of support and services should you feel distressed and would like information regarding further input. If you wish to discontinue the interview at any time, you are free to do so without having to provide a reason.

***What will happen if I don't want to carry on with the study?***

If you decide you no longer wish to take part in the study, please contact me. You are able to withdraw up until four weeks after the interview date; where any interview data or questionnaires will then be destroyed and will not be included in the final study. It will not be possible to withdraw four weeks after the interview date due to the research being analysed.

***Will my taking part in this study remain confidential?***

All data will be anonymised and any identifying information will be taken out. Transcribers of the data will be required to sign a confidentiality agreement and storage of the data will be kept on a password protected server at the University. The only circumstance in which confidentiality would be broken is if the researcher feels you may be at risk of causing harm to yourself or others, or be concerned for your safety, in which case the researcher would be bound to take action. If confidentiality was to be



broken and the researcher had to discuss your safety with the appropriate services, the details of the actions the researcher would take would be fully discussed with you.

***What will happen to the results of the study?***

The results will be written up as part of the Doctorate in Clinical Psychology Training Programme and will be held by the University of Leeds Library. The results may also be written up for submission to a journal and may be presented at a conference to peers in the future. You will be offered a summary of the results of the study.

If you would like this or any other information about the project then please contact me at the address below.

Claire Howarth  
 Psychologist in Clinical Training  
 The University of Leeds  
 Leeds Institute of Health Sciences  
 Doctorate in Clinical Psychology  
 Charles Thackrah Building, Room G.04  
 101 Clarendon Road, Leeds, LS2 9LJ

0113 343 2732

[umclro@leeds.ac.uk](mailto:umclro@leeds.ac.uk)

Supervised by;

Dr Gary Latchford  
 The University of Leeds  
 Leeds Institute of Health Sciences  
 Hospital  
 Doctorate in Clinical Psychology  
 Charles Thackrah Building, Room G.04  
 101 Clarendon Road, Leeds, LS2 9LJ

Professor Mike Lucock  
 Adult Psychological Therapy Services  
 Castleford, Normanton and District  
 Lumley Street  
 Castleford  
 WF10 5LT

The research is sponsored by the University of Leeds. The research has been reviewed and approved by NRES Committees – North of Scotland (1) and South West Yorkshire Partnership NHS Foundation Trust Research and Development Department.

***What if there is a problem?***

If you have any concerns about any aspect of the study, please speak to the researcher who will be happy to address your questions. If you would like to make a complaint about the research, details about the process can be obtained from;

Claire Skinner  
Faculty Head of Research Support,  
Faculty of Medicine and Health Research Office,  
Room 10.110, Level 10,  
Worsley Building, University of Leeds,  
Clarendon Road, Leeds,  
LS2 9NL

Alternatively, you may wish to speak to someone at the Trust, if so, please contact the Trusts' Customer Services department via;

Telephone – XXX

Email – XXX

Post – XXX

Fax – XXX

Thank-you for taking the time to read this information. If you wish to take part in the study, your travel expenses to the interview location will be reimbursed.

## Appendix 7: Consent Form



### Doctor of Clinical Psychology Training Programme

**Title of project:** *Understanding how patients recently discharged from psychological therapy manage their mental health problems*

**Name of researcher:** *Claire Howarth*

**Participant Consent Form**

Once you have read the participant information sheet (version X and date) and are happy to participate in the research, please read the items listed below. Please initial each item you agree with and sign and date at the bottom before handing back to the researcher.

If you agree, please initial box

- I have read and understood the participant information sheet for the above study.
- I have had the opportunity to consider the information sheet and to discuss and ask questions about the project. I have had any questions about the study answered satisfactorily.
- I understand that if I have any problems regarding the research I can discuss this with the researcher who will plan a course of action with me.
- I understand that taking part in the study is voluntary and I am free to withdraw from the project up until four weeks after interview without giving a reason.
- I understand that taking part in this project will not have any effect upon the healthcare I receive.
- I understand that some direct quotes may be used in the final report, however these will be anonymised and any identifiable information will be removed.
- I understand that my responses will be kept confidential unless the researcher feels there is a significant risk to myself or others, which has been discussed with me prior to conducting the interview.
- I agree to the interview being audio-recorded.
- I agree to take part in the research project.
- I would like to receive a summary of the research.

Name of participant:

Signature:

Date:

Name of researcher:

Signature:

Date:

## Appendix 8: Topic Guide

### Outline

- Check information sheet and consent form has been received, that they have read and understood them. Give the opportunity to ask any questions they may have
- Go over confidentiality – everything will remain confidential unless some information is shared that I feel places the participant or others at risk, this information will then be shared with the necessary organisations in discussion with the participant.
- Go through and sign the consent form
- Explain they are able to take a break if anything we discuss makes them feel uncomfortable
- Confirm they are able to withdraw from the research without giving any reason until four weeks after the interview date
- Explain the outline of the interview – asking questions about their experiences which will take around 60-90 minutes, then filling in a questionnaire which will take around 5-10 minutes.

### Topic guide

---

#### *Helpful aspects of therapy outline*

---

#### ***Most recent experience of therapy***

- *Can you tell me about your most recent experience of psychological therapy?*
  - *Do you feel you benefitted from your last experience of therapy? If so, how/why?*
  - *Is there anything in particular from the last time you had therapy that stays in your mind? What has stayed with you from therapy?*
  - *Are you still using anything from therapy on a day to day basis? Can you think of an example where that has worked for you?*
  - *In your current life situation, has therapy been helpful? If so, what were the most helpful things about therapy that you use in your life now?*
  - *Was the therapy important to you? If so, why?*
  - *Were you given any relapse prevention or recovery plan information? If so, did you find it to be helpful?*
  - *Is there anything you found to be unhelpful from your most recent experience of therapy?*
  - *If there is anything you could go back and say to yourself at the end of therapy, what would it be?*
-

---

***Previous experiences of psychological therapy***

- *Can you tell me about your previous involvement with psychological therapy services? Have you had therapy previous to the last episode in this service? What were your initial thoughts and feelings about attending therapy? Do you feel you had benefitted from therapy in the past? If first experience of therapy, how did you find it?*
- *What can you remember from the last time you had therapy?*

***Managing mental health***

- *Are there other things you do that help you to manage your mental health on a day to day basis?*

***Further information***

- *Is there anything else you'd like to tell me that you feel we haven't covered?*

***Research aspects***

- *How has it been for you to take part in this interview/research project?*

---

***After interview***

- *Thank them for taking part – acknowledge it can be difficult to talk about past issues, provide contact details of services who can offer support should they feel they would like to talk to someone in the future*
- *Follow up any risk issues should they arise*
- *See if there are any further questions before ending*
- *Pay travel expenses*

## Appendix 9: Examples of NVivo analysis

Look for: <input type="text"/> Search In <input type="text" value="Internals"/> Find Now Clear Advanced Find					
Internals					
Name	Nodes	References	Created On	Created By	
Interview 1	19	163	18-Jan-16 2:11 PM	CLH	
Interview 2	16	172	18-Jan-16 1:58 PM	CLH	
Interview 3	15	128	21-Jan-16 11:13 AM	CLH	
Interview 4	15	131	06-Feb-16 2:07 PM	CLH	
Interview 5	19	136	23-Mar-16 11:20 AM	CLH	
Interview 6	14	100	26-Mar-16 1:03 PM	CLH	
Interview 7	13	60	07-Apr-16 12:20 PM	CLH	
Interview 8	16	85	11-Apr-16 9:00 AM	CLH	

Thesis.nvp - NVivo

File Home Create External Data Analyze Query Explore Layout View

Navigation View Find Quick Coding Dock All Undock All Close All Docked Bookmarks Close Window List View Coding Stripes Highlight Annotations See Also Links Relationships Node Node Matrix Report Previous Next Color Scheme Visualization

Look for: Search In: Nodes Find Now Clear Advanced Find

**Nodes**

Name	Sources	References	Created On	Created By	Modified On	Modified By
Life changing	7	55	23-Apr-16 10:54 AM	CLH	04-Jun-16 10:05 AM	CLH
How therapy could be improved	6	59	14-Apr-16 9:40 AM	CLH	21-Apr-16 11:03 AM	CLH
How therapy is helping me now	0	0	14-Apr-16 9:23 AM	CLH	21-Apr-16 10:35 AM	CLH
Acceptance	0	0	14-Apr-16 9:31 AM	CLH	15-Apr-16 2:55 PM	CLH
Yourself and your mental health	8	48	14-Apr-16 9:32 AM	CLH	21-Apr-16 11:01 AM	CLH
Of previous experiences	6	38	14-Apr-16 9:32 AM	CLH	21-Apr-16 11:01 AM	CLH
Current situation	7	28	15-Apr-16 12:06 PM	CLH	21-Apr-16 11:01 AM	CLH
Continued effort - Distress in life	8	94	14-Apr-16 9:32 AM	CLH	21-Apr-16 11:01 AM	CLH
Practical strategies	0	0	15-Apr-16 2:54 PM	CLH	15-Apr-16 2:55 PM	CLH
Relaxation and mindfulness	6	38	15-Apr-16 11:14 AM	CLH	21-Apr-16 11:02 AM	CLH
Keeping busy - Routine	3	25	15-Apr-16 2:10 PM	CLH	21-Apr-16 11:02 AM	CLH
Cognitive techniques	7	64	15-Apr-16 11:14 AM	CLH	21-Apr-16 11:02 AM	CLH
Responsibility	0	0	14-Apr-16 9:25 AM	CLH	14-Apr-16 9:25 AM	CLH
Value yourself (you're a priority)	8	136	14-Apr-16 9:26 AM	CLH	21-Apr-16 10:37 AM	CLH
Stop putting others first-Taking on too much responsibility	7	50	14-Apr-16 9:26 AM	CLH	21-Apr-16 10:37 AM	CLH
Interpersonal relationships	0	0	14-Apr-16 9:23 AM	CLH	14-Apr-16 9:23 AM	CLH
Impact upon others	4	14	14-Apr-16 9:24 AM	CLH	21-Apr-16 11:02 AM	CLH
How you are with others	8	64	14-Apr-16 9:23 AM	CLH	21-Apr-16 10:33 AM	CLH
Things that helped therapy to be successful	0	0	14-Apr-16 9:33 AM	CLH	21-Apr-16 10:35 AM	CLH
Commitment to change	6	41	14-Apr-16 9:34 AM	CLH	21-Apr-16 11:02 AM	CLH
Relationship with therapist	6	59	14-Apr-16 9:37 AM	CLH	21-Apr-16 11:03 AM	CLH
Approach of therapy	6	57	14-Apr-16 9:38 AM	CLH	21-Apr-16 11:02 AM	CLH

Thesis.nvp - NVivo

File Home Create External Data Analyze Query Explore Layout View

Navigation View Find Quick Coding Dock All Undock All Close All Docked Bookmarks Close Window List View Coding Stripes Highlight Annotations See Also Links Relationships Node Node Matrix Report Previous Next Color Scheme Visualization

Look for: Search In Nodes Find Now Clear Advanced Find

**Nodes**

Name	Sources	References	Created On	Created By	Modified On	Modified By
Responsibility	0	0	14-Apr-16 9:25 AM	CLH	14-Apr-16 9:25 AM	CLH
Value yourself (you're a priority)	8	136	14-Apr-16 9:26 AM	CLH	21-Apr-16 10:37 AM	CLH
Stop putting others first-Taking on too much responsibility	7	50	14-Apr-16 9:26 AM	CLH	21-Apr-16 10:37 AM	CLH
Interpersonal relationships	0	0	14-Apr-16 9:23 AM	CLH	14-Apr-16 9:23 AM	CLH
Impact upon others	4	14	14-Apr-16 9:24 AM	CLH	21-Apr-16 11:02 AM	CLH
How you are with others	8	64	14-Apr-16 9:23 AM	CLH	21-Apr-16 10:33 AM	CLH
Things that helped therapy to be successful	0	0	14-Apr-16 9:33 AM	CLH	21-Apr-16 10:35 AM	CLH
Commitment to change	6	41	14-Apr-16 9:34 AM	CLH	21-Apr-16 11:02 AM	CLH
Relationship with therapist	6	59	14-Apr-16 9:37 AM	CLH	21-Apr-16 11:03 AM	CLH
Approach of therapy	6	57	14-Apr-16 9:38 AM	CLH	21-Apr-16 11:02 AM	CLH
Things outside therapy that are helping me now	0	0	14-Apr-16 9:42 AM	CLH	21-Apr-16 10:35 AM	CLH
Employment	5	24	14-Apr-16 3:49 PM	CLH	21-Apr-16 11:03 AM	CLH
Healthy Living	6	32	14-Apr-16 3:49 PM	CLH	21-Apr-16 11:03 AM	CLH
Routine	7	16	14-Apr-16 3:52 PM	CLH	21-Apr-16 11:03 AM	CLH
Relationships	6	33	15-Apr-16 11:11 AM	CLH	21-Apr-16 11:03 AM	CLH

Sources Nodes Classifications Collections Queries Reports Models Folders



**Nodes**

Name	Sources	References	Cr
------	---------	------------	----

Life changing x

Reference 11 - 0.21% Coverage

Otherwise, I don't think I would be here, to be honest, in fact I know I wouldn't have been. And I've not thought once, since I've finished with [L], not thought once about suicide.

Reference 12 - 0.04% Coverage

End of the day- it saved my life.

[<Internals\Interview 3>](#) - § 13 references coded [4.71% Coverage]

Reference 1 - 0.24% Coverage

C: If it wasn't for [F] and for Fieldhead, I know I'd be buried now, I'd be six feet under, I know that for a fact

Nodes			
Name	Sources	References	C
Value yourself (you're a priority			

Reference 3 - 0.40% Coverage

C: [Clears throat] Umm, I think to focus on what I'm doing and not focus on who else is there and what they're doing or if they're eyeing me up- just changing my focus I think.

Reference 4 - 0.44% Coverage

C – so I could channel all that stuff again, but um [pause] uh, I've had to realise that I've got to do this for myself and I might never have any grandkids so I've got to carry on working out me-

Reference 5 - 0.13% Coverage

C: Um [pause] not everybody's right all the time [laughs]

---