Exploring Experiences and Processes within Psychological Interventions for People with Bipolar Disorders

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Declaration

This thesis has been submitted for the award of Doctorate in Clinical Psychology at the University of Sheffield. It has not been submitted for any other qualification or to any other academic institution.

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Acknowledgements

Firstly, I would like to express my sincere gratitude to my research supervisors Professor Gillian Hardy, Dr Warren Mansell and Dr Sara Tai for their invaluable encouragement, guidance, support and immense knowledge over the past couple of years. I have enjoyed being part of the TEAMS research team, and I have learnt a great deal about bipolar disorders from being involved within this process. I would also like to thank Anamarie Churchman, Rosa Hardy and Sabrina Tan for volunteering to transcribe some of the session recordings for me.

I would like to thank my family for their positive words of encouragement and patience over the past few months whilst I completed this work. They have always supported me and been optimistic in my abilities to achieve my goals.

I owe a massive thank you to my husband Chris for his endless support and belief in me, especially during the times when I needed it the most. He has been my biggest strength throughout this rollercoaster journey, and I could not have done this without him. I think this thesis has come at a timely point that it can be an appropriate paper gift for our anniversary!!

Finally, I would like to dedicate this thesis to my late Grandad. It is through his wisdom, guidance and love that I am in this position today, and I know he has supported me in spirit throughout this doctorate.

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Word Count

Literature Review	
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Abstract

This thesis consists of a literature review and a research study exploring the experiences and processes within psychological interventions for people with bipolar disorders.

A thematic synthesis was conducted to explore individual experiences of psychological-based interventions for bipolar disorder. A critical appraisal tool was used to assess the quality of the identified studies. The themes identified from the synthesis were compared with existing literature around individual experiences of bipolar disorder. The review highlighted methodological limitations of the studies and suggested areas for future research and clinical implications.

The empirical study was based on an existing dataset from the feasibility trial of Think Effectively About Mood Swings (TEAMS), which is a novel cognitive-behavioural approach for people with bipolar disorders. The overall aim of this mixed-methods study was to investigate patterns of change and in-session client-therapist behaviours, in order to improve TEAMS delivery for the next phase of development.

Study 1 aimed to examine patterns of change, and in particular, whether sudden gains were present in TEAMS. Study 2 explored potential factors influencing therapeutic change, such as client involvement and therapist responsiveness, through an in-depth analysis of recorded therapy sessions. Template analysis was used to explore session transcripts of clients who had improved following TEAMS, compared to those who made no change.

The findings from Study 1 showed there were minimal sudden gains found within the TEAMS therapy. Study 2 found that client involvement was a key factor in the differences between the two groups. Further research into the experiences and processes of psychological interventions for people with bipolar disorders is needed.

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Part One: Literature Review

Individual Experiences of Psychological-Based Interventions for Bipolar Disorder: A Systematic Review and Thematic Synthesis

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Abstract

Objectives. To conduct a thematic synthesis to evaluate qualitative studies exploring individuals' experiences of psychological-based interventions for bipolar disorder (BD).

Method. A systematic search of relevant databases (Web of Science, PsycINFO, MEDLINE, CINAHL) was conducted using predefined search terms related to 'Bipolar' 'Qualitative method', 'Psychological-based interventions' and 'Adults'. Studies meeting the inclusion criteria were selected and were then evaluated using established quality appraisal criteria. A thematic synthesis was used to synthesise the findings.

Results. From the thematic synthesis, nine analytical themes were derived from the ten identified research studies. These were helpful and unhelpful aspects of the intervention, increased knowledge of BD, mood recognition, control of moods, change of perspective, mood stability, empowerment, improved relationships, and lifestyle changes.

Conclusion. Findings from the review suggest there were characteristics of psychological-based interventions that individuals with BD valued, and some which created barriers. There were elements from interventions that helped facilitate areas of positive change. The review highlights methodological issues within the identified studies. Future qualitative research is needed to explore individual experiences within a range of psychological interventions, in order to understand therapeutic processes which may facilitate recovery.

Practitioner Points

- Psychological-based interventions for BD need to consider facilitating and measuring empowerment in individuals, rather than focusing just on mood stability.
- Clinicians with expertise and knowledge in BD should provide timely information to individuals and their families to help increase their understanding of the diagnosis.

Limitations of Study

- Results are based on a small number of qualitative studies exploring individual experiences of psychological-based interventions for BD; many of which were low in quality rating.
- The majority of included papers were based within the United Kingdom and focused on psychoeducation-based interventions for BD, which limit the generalisability of the findings.

Introduction

Bipolar disorder (BD) is defined as a severe, chronic and disabling mental health disorder characterised by recurrent episodes of depression and mania or hypomania (Royal College of Psychiatrists, 2015). In addition to mood instability, BD is associated with significant psychosocial functional impairments, reduced quality of life and higher incidences of suicide (American Psychiatric Association, 2013; Novick et al., 2010; Rosa et al., 2010). The primary treatment for BD still remains the use of mood-stabilising or antipsychotic medication (Geddes & Miklowitz, 2013; Nivoli et al., 2013). However, pharmacological treatments do not always lead to absence or prevention of relapse and do not benefit the residual depression that many people experience out of the episode (Vieta et al., 2013).

There have been a number of studies that have either developed or adapted psychological interventions for use within the BD population, to be used in conjunction with pharmacological treatment. These include psychoeducation (Colom et al., 2009; Depp et al., 2015; Proudfoot et al., 2012), cognitive behavioural therapy (CBT: Castle et al., 2010; Costa et al., 2012; Jones et al., 2015), interpersonal and social rhythm therapy (ISRT: Inder et al., 2015; Swartz et al., 2012), dialectal behavioural therapy (DBT: Goldstein et al., 2014; Van Dijk et al., 2013), mindfulness-based cognitive therapy (MBCT: Perich et al., 2013; Williams et al., 2008), and family-focused therapy (Miklowitz et al., 2008, 2013, 2014).

A number of recent reviews have been conducted investigating the effectiveness of different psychological interventions on psychosocial outcomes in BD (Oud et al., 2016; Reinares, Sanchez-Moreno & Fountoulakis, 2014; Salcedo et al., 2016). Most reviews concluded that specific adjunctive psychotherapies have been shown to improve outcomes (Geddes & Miklowitz, 2013); however, outcomes varied between studies and not all randomised controlled trials (RCTs) of psychological interventions

have shown positive outcomes (Gomes et al., 2011; Scott et al., 2006). All the reviews concluded that psychological interventions were effective in conjunction with pharmacological treatment for BD, but these effect sizes were small (Oud et al., 2016).

The variability in quantitative research findings on the effectiveness of psychological interventions is reflected within the National Institute for Health and Care Excellence (NICE, 2015) guidelines for treatment and management of BD, as a specific psychological intervention is not recommended. Instead, it recommends the use of any structured manualised psychological intervention – individual, group or family, which has at least one RCT published. This is only for depression in BD, and there are no recommendations for the psychological treatment of mania in BD. The NICE recommendations are based on a large number of meta-analyses, which contained a small number of RCT studies (Jauhar, McKenna and Laws (2016). In addition, a majority of the included studies were of low quality, had methodological concerns and statistical issues. Little is known about how people with BD experience psychological interventions and thus there is a need to understand this more.

Qualitative evaluation of the experience of interventions is encouraged by the 'Framework for Developing and Evaluating Complex Interventions' (Medical Research Council, 2008), and can provide a deeper understanding of individuals' experiences of treatment. Evaluating interventions qualitatively is important to fully understand its feasibility, acceptability and effectiveness (Harper & Thompson, 2012). The synthesis of qualitative studies is based on an established procedure of reviewing and collating findings from existing qualitative research (Timulak, 2009). There are a number of synthesis methods for qualitative studies, including meta-ethnography, narrative synthesis, thematic synthesis and meta-study (Dixon-Woods et al., 2005; Noblit & Hare, 1988). Thorne, Jensen, Kearney, Noblit and Sandelowski (2004) state "meta-syntheses are integrations that are more than the sum of parts, in that they offer novel

interpretations of findings. These interpretations will not be found in any one research report, but, rather, are inferences derived from taking all of the reports in a sample as a whole" (p. 1358).

A synthesis of qualitative studies could provide insight and clarification about individuals' views and experiences of psychological-based interventions to understand what is helpful or unhelpful, and clarify what is perceived as meaningful change or what might contribute to individual recovery. This may identify whether any changes are needed to improve the effectiveness of psychological treatments. To the author's knowledge, there have been no published reviews that synthesise the findings from qualitative studies to provide insights into the individual experiences of psychological-based interventions. The review aims to address this gap within the research.

Aims of Review

The aim of this synthesis was to:

i) Systematically identify for qualitative studies exploring individual experiences of psychological-based interventions (individual, group or internet-based) for BD.

ii) Assess the quality of the research.

iii) Integrate the findings using a thematic synthesis approach to explore what individuals perceive to be the benefits and difficulties of psychological-based interventions, and the processes that might facilitate positive change.

Method

In order to improve the conduct and reporting of this qualitative synthesis, the Enhancing Transparency in Reporting the Synthesis of Qualitative Research guidelines (ENTREQ: Tong et al., 2012) were used. ENTREQ is a 21-item framework which outlines the synthesis processes involved, such as searching and selecting research,

quality appraisal, and synthesis of findings.

Search Strategy

The CHIP tool (Shaw, 2010) was used to break down the key components of the search question into Context, How study was conducted, Issues examined, and People involved. Search terms were developed through consideration of terms used in previous literature reviews and guidelines for searching qualitative studies (Shaw, 2012; Toye et al., 2014). See Table 1 for search terms. A number of key databases were used to ensure a comprehensive search of all the relevant literature was conducted. The following databases were searched: Web of Science (Core Collection), PsycINFO, MEDLINE, CINAHL and Google Scholar. References were searched from the period of their inception up until January 2017. The references of all relevant studies were checked, and Google Scholar was used to examine citations of articles meeting the inclusion criteria.

Authors of the identified papers, as well as authors of RCTs for psychological interventions for BD (published since 2010), were contacted to identify whether they published or were aware of further qualitative studies exploring individual experiences of interventions.

Inclusion Criteria

i) Qualitative or mixed-method studies (e.g. qualitative data which can be extracted from within RCTs), and also studies using structured questionnaires if these allowed for participants to relate to experience in an open-ended way.
ii) Published peer reviewed articles.
iii) English language articles.
iv) Studies that offer a substantial focus on the aim to explore and report on participant experiences following a psychological-based intervention for bipolar disorder.

v) Interventions must have a psychological focus/element.

vi) Adult participants (age 18 years or older) with a diagnosis of bipolar disorder.

Exclusion Criteria

i) Book chapters, commentaries, supplements and grey research.

ii) Studies that did not present qualitative data of participant experiences in the results or appendices, or were unavailable to obtain from the author(s).

iii) Studies which included and combined perceptions of other people as well as participants (e.g. carers/ family members or professionals), which had no clear separation of responses or themes presented within the results section.

Table 1

Parameters of Review Questions and Search Terms Employed

CHIP Components	Search Terms
Context: Bipolar disorder	bipolar disorder/ manic-depression/ bipolar spectrum/ bipolar depression
	AND
How: Qualitative methods	qualitative/ theme*/ thematic analysis/ IPA/ grounded theory/ narrative*/ focus group*/ ethnology/ experience*/ perspective*/ attitude*/ feedback/ view*/ perception*/ reaction*/ satisfaction/ opinion*
	AND
Issue: Psychological-based interventions	therap*/ psychotherap*/ psychosocial/ cognitive behavio*/ CBT/ psychoeducation/ intervention*
	AND
Population: Adults	client*/ participant*/ service user*/ individual*/ patient*

Note. * = search terms were broadened to include variations of those specific words

Appraisal of Study Quality

Upon completion of the search process, relevant information from the identified papers was imported into an Excel spreadsheet in order to allow the study characteristics to be summarised and to prepare for the quality analysis.

Quality assessment was used within this synthesis in order to assess and consider the impact and value of the primary studies quality on the review findings and to avoid drawing unreliable conclusions (Dixon-Woods et al., 2004). The quality appraisal was not used to exclude papers, but was used to provide a 'quality context' within which the outcome of the synthesis can be placed. The Critical Appraisal Skills Programme for qualitative research (CASP, 2010; Appendix A) was used to assess the quality of the identified studies. It has been widely used in a number of qualitative syntheses (Coleman et al., 2017; Devereux-Fitzgerald et al., 2016; Katsakou & Pistrang, 2017). The tool assesses 10 key areas, including suitability and appropriateness of qualitative method, recruitment strategy, consideration of ethical issues and data analysis methods. An overall quality rating was assigned to each paper: 'satisfactory', 'unable to evaluate' due to insufficient information, or 'fatally flawed' and must therefore be treated with caution (Dixon-Woods et al., 2007).

A peer researcher, blind to the author's ratings, appraised a third of the papers chosen at random. The results from the appraisal were discussed and any areas of uncertainty or discrepancy were resolved through discussion.

Synthesis Process

A thematic synthesis based on the method described by Thomas and Harden (2008) was used to analyse the data from the primary studies and address the review questions. Thematic synthesis was developed and applied to systematic reviews that consider individuals' perspectives and experiences in order to address specific review questions about need, appropriateness, acceptability and effectiveness of interventions

(Barnett-Page & Thomas, 2009). Therefore, this methodology was chosen as it was well suited to meeting the aims of this review.

Studies were read and re-read to fully immerse in the data. In accordance with Thomas and Harden's (2008) recommendations, all text within the 'Results' or 'Findings' of the primary studies were extracted and entered verbatim into NVivo software. Both participant quotes and author interpretations were treated equally as primary data.

The following three stages were carried out:

1. Line by line coding to generate descriptive codes. Each line had at least one code applied, although most were classified using several codes.
2. Development of descriptive themes by comparing and grouping codes based on similarities and differences across papers. Data from each study was also extracted and grouped together in Excel to further identify themes.
3. Analytical themes were generated by looking at the studies as a whole in relation to the review questions. Themes emerged through an iterative process of reflection and interpretation of all of the descriptive themes within and across studies.

The preliminary coding framework, descriptive and analytical themes were discussed and refined with research supervisors in regular meetings, as part of a 'triangulation' process. A summary of the theme development is presented in Appendix B.

Results

The search identified 1069 studies. Following the removal of duplicates, 750 titles were screened for relevance. After excluding titles that were irrelevant, 84 abstracts were screened for relevance based on the inclusion/exclusion criteria.

Following this, 41 full-text papers were checked based on the inclusion/exclusion criteria. A total of ten studies were identified for the review and were assessed for their methodological quality. Two authors (Morris et al., 2016; Straughan & Buckenham, 2006) were contacted for qualitative information that was contained within the appendices of the papers.

No additional papers were identified through alternative sources. Several authors from RCT studies who were contactable shared that they either did not seek qualitative feedback from their participants, or if they did, they were in the process of analysing the data, or the results had not yet been published. The process of identification and inclusion of relevant studies in the review is also shown in Figure 1 using the 'preferred reporting items for systematic reviews and meta-analyses' (PRISMA; Moher, Liberati, Tetzlaff, Altman & The PRISMA Group, 2010).

Quality Assessment

A detailed breakdown of the quality appraisal of the identified papers is presented in Appendix C. Following the evaluation of studies with the CASP, there were no studies that were assessed as 'fatally flawed'; however, five papers (Evans et al., 2016; Menezes & Conceicao, 2012; Morris et al., 2016; O'Connor et al., 2008; Poole, Simpson & Smith, 2012) were reported in insufficient detail to allow for a clear rating. Therefore caution must be taken when interpreting the findings of these papers. The majority of the papers failed to report author reflexivity (i.e. relationship between researcher and participants).

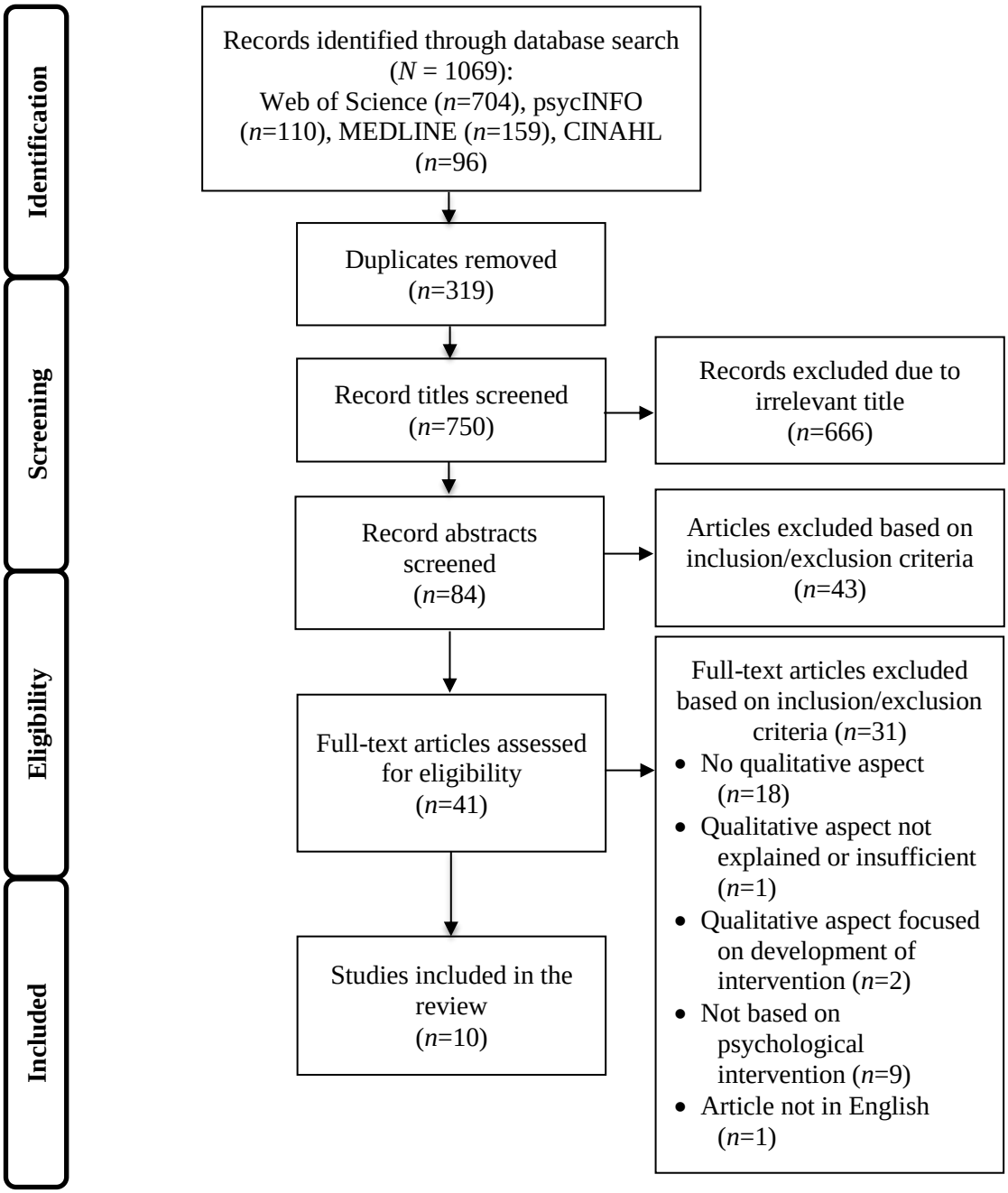

Figure 1. PRISMA flow diagram

Description of Studies

A summary of key characteristics of the ten primary studies and quality ratings is provided in Table 2. In total across the ten papers there were 155 participants, with ages ranging from 20 to 76 years. Of the 155 participants in the studies, 90 were female. Menezes and Conceicao (2012) focused exclusively on all female accounts. Participant

ethnicity and diagnosis clarification were often not presented within papers.

Six studies were group-based interventions, three were individual interventions and one study was internet-based (Poole, Simpson & Smith, 2012). Seven studies focused on psychoeducation and relapse prevention interventions. The content of these interventions included evaluating the causes of BD, understanding early warning signs and triggers, focusing on lifestyle factors, medication and non-pharmacological treatments and developing coping strategies.

Other psychological interventions included cognitive analytic therapy (CAT: Evans et al., 2016), MBCT (Chadwick et al., 2011) and a novel CBT approach (Joyce et al., 2016). Interventions ranged from 6 - 24 sessions, with sessions ranging from 50-minutes to 3-hours. Two studies (Chadwick et al., 2011; Evans et al., 2016) included follow-up sessions. Mental health professionals, including clinical psychologists, mental health nurses, psychiatrists and care coordinators facilitated the majority of interventions. Both the Menezes and Conceicao (2012) and Morriss et al. (2016) studies had mixed input from mental health professionals and service users. The Straughan and Buckenham (2006) study evaluated a service-user led intervention.

Nine studies used semi-structured or open-ended interviews and thematic analysis as the qualitative methodology. Evans et al. (2016) collected their qualitative data from participant feedback on post-session Helpful Aspects of Therapy forms. O'Connor et al. (2008) used interpretative phenomenological analysis (IPA) for their qualitative methodology. All but one study (Straughan & Buckenham, 2006) were published during the last decade. Nine of the studies were conducted in the United Kingdom and one study (Menezes & Conceicao, 2012) was conducted in Brazil.

Table 2

Study Characteristics and Quality Ratings

Authors, year & country	Participants (gender)	Intervention	Data collection	Data analysis	Quality rating
1. Straughan & Buckenham (2006) England	N=13 (6 male) Age = 24–76 years	*PE:* 12-week service-user led lifestyle development group training, 3 hour sessions. Manual based on researcher experience of BD and professional delivered therapies. Lifestyle component included linking thoughts, feelings and behaviour, sleep, diet and exercise, and medication adherence. Skills training included relaxation, counteracting negative thoughts and problem solving. Tools included life event charts, personal mood signature and self-monitoring diaries.	Interviews.	Thematic analysis	S
2. O'Connor, Gordon, Graham, Kelly & O'Grady-Walshe (2008) Ireland	N=11 (4 male) Age = 34–53 years	*PE:* 8-week psychoeducation groups lasting 90 minutes. Content was informed by BD information pack on the Centre for Clinical Interventions website, including overview of BD, relapse prevention, cognitive and behavioural strategies for managing depression and mania, and coping with psychosocial stressors.	Face-to-face semi-structured interviews.	IPA	U
3. Pontin, Peters, Lobban, Rogers & Morris (2009) England	N=21 (8 male) Age = 24–63 years	*PE:* Enhanced relapse prevention psychoeducation manual for care coordinators. Six 60-minute sessions focusing on previous mood episodes, identifying triggers and early warning signs, and enhancing coping strategies.	Semi-structured interviews, conducted until data saturation achieved.	Thematic analysis	S

Table 2
(Continued)

Authors, year & country	Participants (gender)	Intervention	Data collection	Data analysis	Quality rating
4. Chadwick, Kaur, Swelam, Ross & Ellett (2011) England	N=12 (7 male) Age = 24–58 years	*MBCT:* 8-week mindfulness group plus 6-week booster session. 90 minute sessions, which included formal mindfulness practices, followed by reflections. Practices included body scan, mindful eating and walking, mindfulness of sounds and feelings, and 3-minute breathing space. Home practice included CD exercises, breathing space and everyday mindful activity.	Semi-structured interviews.	Thematic analysis	S
5. Menezes & Conceicao (2012) Brazil	N=12 (All female) Age = 35–73 years Attendance = 6–17 times (50% attended >10)	*PE:* 1-hr monthly psychoeducation group, focusing on themes such as characteristics of BD, causal and triggering factors, medical and non-medical interventions, early recognition of mood episodes, and stress management techniques.	Semi-structured interviews.	Thematic analysis	U
6. Poole, Simpson & Smith (2012) England	N=20 (13 male) Age = 20-65 years 14 high users (completed 6-8 modules) 6 low users (completed 1-4 modules)	*PE:* Online psychoeducation called Beating Bipolar. Initial face-to-face delivery followed by internet-based interactive delivery and use of web forum. 8 modules delivered every 2 weeks. Key areas included diagnosis and causes of BD, medication, lifestyle changes, relapse prevention and early intervention and psychological approaches.	Semi-structured telephone interviews.	Thematic analysis	U

Table 2
(Continued)

Authors, year & country	Participants (gender)	Intervention	Data collection	Data analysis	Quality rating
7. Poole, Smith & Simpson (2015) Wales	N=13 (3 male) Mean age = 42.7 years	*PE:* 10 weekly manualised psychoeducation group, 2 hour sessions. Topics included definition and causes of BD, medication, psychological approaches, lifestyle, monitoring moods and identifying triggers and early warning signs.	Telephone interviews 3 months' post-intervention.	Thematic analysis	S
8. Evans, Kellett, Heyland, Hall & Majid (2016) England	N=9 (2 male) Mean age = 48.3	*CAT:* 24 individual sessions followed by 4 follow up sessions (1, 2, and 6 months' post therapy). Therapy focused on reformulation (sessions 0-6), recognition (sessions 6-12) and revision (sessions 12-24).	Qualitative descriptions on the Helpful Aspects of Therapy forms.	Thematic analysis	U
9. Joyce, Tai, Gebbia & Mansell (2016) England	N=14 (3 male) Age = 23–61 years	*CBT:* Thinking Effectively About Mood Swings: 16 sessions of a CBT-based individual therapy. Client led and focused on the present-moment, addressing current symptoms.	Face-to-face semi-structured interviews.	Thematic analysis	S
10. Morriss et al. (2016) England	PE group (*n*=18) Peer group (*n*=19) (19 male) Age = 26 - 69	*PE:* Structured psychoeducation group vs. unstructured peer support group. 21 weekly sessions for 2 hours. Peer support group set own agenda and programme content. Psychoeducation group focused on life charting, early warning signs, and coping strategies.	Semi-structured interviews. Interviews were done until themes were saturated.	Thematic analysis	U

Note. PE = psychoeducation; BD = bipolar disorder; IPA = interpretative phenomenological analysis; MBCT = mindfulness-based cognitive therapy; CAT = cognitive analytic therapy; CBT = cognitive behavioural therapy. Key: S = satisfactory, U = unable to evaluate.

Thematic Synthesis Findings

The findings from the ten primary studies were synthesised into nine analytical themes. Table 3 presents the themes from the included studies, along with quotations from participants' and authors' interpretations. The first theme 'Helpful and unhelpful aspects' addresses the review question of what individuals find beneficial or difficult from the interventions. The remaining eight themes are grouped together to understand the processes of positive changes (Figure 2).

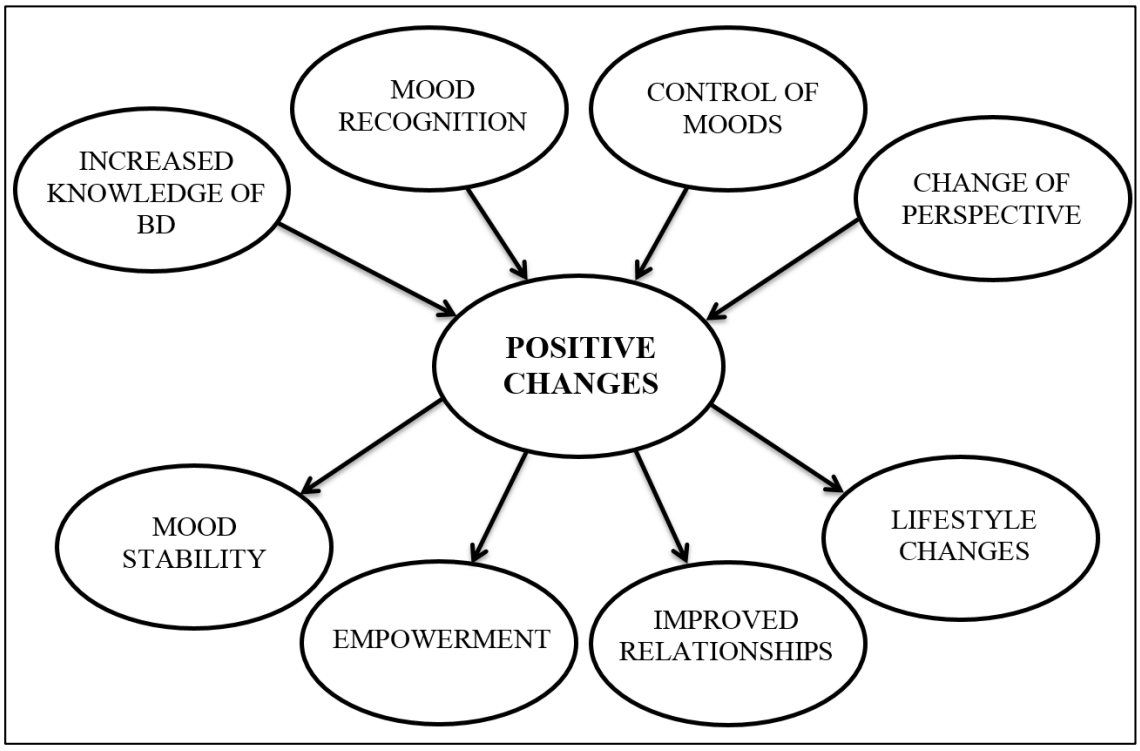

Figure 2. Process of positive changes following interventions.

Table 3

Themes and Quotes from Participants' and Authors' Across Studies

Analytic & descriptive themes	Papers evidencing theme	Quotes from papers
Helpful and unhelpful aspects	2, 5, 6, 7, 9	**5.** [Ppts] also indicate that getting this information from specialized professionals on the theme makes them feel more confident. (A)
- *Professional expertise*		
- *Similar experiences*	1, 2, 3, 5, 6, 7, 10	**5.** '(...) I saw that 'Hell, I'm not alone!' there are so many people with the same problem as I!
- *Learning from others' experiences*	1, 5, 6, 7, 10	**1.** I think the group helped get things into perspective… people learn from other people's experiences, 'cos we all have highs, we all have lows. It was a common core of experience there... People can learn what other people do, and that's good.' **10.** 'We learnt probably the same if not more of what they were just teaching just from our experiences from the other people with their experience of the mental health sector…'
- *Intervention structure*	6, 7, 9, 10	**6.** Ppts liked being able to access programme in own time, at own pace and the option of revisiting modules. (A) **9.** 'He spaced it out and that's where a lot more of the benefit, I I found a lot more of the benefit because I, no no I'm not seeing [therapist] this week, well I'll just try that again'
- *Therapist style*	1, 3, 7, 8, 9	**7.** Facilitators were keen to listen to [ppts] and learn from them. Ppts appreciated the personal touch facilitators demonstrated in that they expressed an interest in them, were caring and looked after them. (A)
- *Therapy techniques*	2, 3, 4, 6, 7, 8, 9, 10	**3.** An element of intervention that was particularly valued was creating a timeline, charting past manic and depressive episode. (A) **6.** 'I can remember a timeline […] that did kerfuffle me a bit, remembering back all the bad stuff, wasn't good. […]'
- *Opportunity to talk*	3, 5, 6, 7, 8, 9, 10	**8.** 'Just talking, with no holding back and in confidence, about things I would never speak about'
- *Impact of mood*	4, 6, 7, 8	**4. '**When I am getting depressed my motivation goes and my ability to be disciplined'

Table 3 *(Continued)*

Analytic & descriptive themes	Papers evidencing theme	Quotes from papers
Increased knowledge of BD	1, 3, 5, 6, 7, 10	**10.** Ppts described having gained greater understanding about BD the different forms it could take and ways of managing it, both in general, but also how it applied to themselves. (A)
Mood recognition	1, 2, 3, 4, 5, 6, 7, 8, 9, 10	**3.** Ppts described how increased awareness of triggers, early warning signs and coping strategies… rather than relying on care coordinators they were able to do it themselves (A)
Control of moods	1, 2, 3, 4, 5, 6, 7, 9, 10	**4.** 'It has certainly helped me manage mood changes I think…just reducing the amount of anxiety and worry in my life is one of the key benefits'
Change of perspective		
- *Attitude towards medication*	3, 5, 6, 7	**7.** Ppts were less resistant to taking medication for BD as acknowledged that it enabled them to feel well and accepted that they would be taking medication for the rest of their lives. (A)
- *Taking responsibility*	1, 3, 5, 7, 9	**1. '**… something where I could see that just by taking responsibility for actions, you can actually change your behaviour to help yourself'
- *Acceptance*	2, 3, 4, 5, 6, 7, 9	**5. '**Gives you this awareness, right, that you are capable of having a healthy life, work, live normally! […] So you're the one who has to accept it, the disease is yours'
- *Thinking differently*	1, 2, 4, 9	**2. '**I've learned to think more positively, I practice everyday, often I think paranoid thoughts, and I try to revert to the positive. Instead of sitting around, I try to go out and do something. I feel more in control.'
Mood stability	1, 3, 4, 5, 7	**4.** Ppts attributed mindfulness to narrowing and stabilising in the range of mood change experienced. (A)
Empowerment	1, 2, 3, 5, 7, 9	**9.** Ppts reported feeling empowered and thus able to be more assertive and express their needs in social situations. (A)
Improved Relationships	1, 3, 6, 7	**3.** Improved relationships between ppts and care coordinators… because of increased time together, there was more time to get to know one another better. (A)
Lifestyle changes	1, 5, 6, 7, 9	**6.** Some ppts adapted their health behaviour, lifestyle or routine as result of the programme. (A)

Note. 1 = Straughan & Buckenham (2006); 2 = O'Connor et al. (2008); 3 = Pontin et al. (2009); 4 = Chadwick et al. (2011); 5 = Menezes & Conceicao (2012); 6 = Poole, Simpson & Smith (2012); 7 = Poole, Smith & Simpson (2015); 8 = Evans et al. (2016); 9 = Joyce et al. (2016); 10 = Morriss et al. (2016); Ppts = participants; (A) = Author quotes from studies.

Helpful and Unhelpful Aspects

Professional expertise. Five of the ten papers reported that individuals valued and appreciated having expert knowledge from professionals. Individuals felt that they had more confidence in information about BD because they trusted professional knowledge (Joyce et al., 2016; Menezes & Conceicao, 2012; O'Connor et al., 2008; Poole et al., 2012, 2015).

Similar experiences. Participants who attended the group interventions found that sharing their experiences with other individuals with BD was helpful and important (O'Connor et al., 2008; Menezes & Conceicao, 2012; Morriss et al., 2016; Pontin et al., 2009; Straughan & Buckenham, 2006). For some individuals it was their first time meeting other people experiencing BD (Poole et al., 2015). In Morriss et al.'s study, individuals shared that one of the reasons they participated in the RCT was to meet others with similar experiences. Many individuals found it satisfying to meet others and reported that they realised they were not alone with their experiences of BD. Individuals reported increased support and some made friendships from the interventions (Morriss et al., 2016; Poole et al. 2015; Straughan & Buckenham, 2006).

Some individuals reported that meeting others with BD was also helpful as they were able to make comparisons with others in the group in relation to the extent of their illness (Menezes & Conceicao, 2012; O'Connor et al., 2008; Poole et al., 2015). Individuals reported a sense of relief when they met others who had worse experiences than their own (Menezes & Conceicao, 2012).

The exception to this was reported in Poole et al.'s (2012) study as some individuals perceived that engaging with other people with BD would be a negative experience. Individuals stated that it would be unappealing because they did not want to identify themselves with mental illness or be reminded of the experience of being

unwell. Some people also worried that this might lead to a deterioration in their own mental health.

Learning from others' experiences. Individuals reported that they had learnt from other people's experiences of BD, benefitting from their knowledge and understanding (Menezes & Conceicao, 2012; Morriss et al., 2016; Poole et al., 2015; Straughan & Buckenham, 2006). In particular, individuals stated that they learnt from others insights and coping methods, which subsequently motivated and inspired them to make changes. Learning was not regarded as a one-way process, and individuals described how sharing their own knowledge with others was also valuable (Menezes & Conceicao, 2012; Poole et al., 2015). Individuals highlighted that learning from others' experiences would be helpful for those who were newly diagnosed (Morriss et al., 2016).

In the Poole et al. (2012) study, individuals reported that they would have preferred naturalistic videos within the online modules, which should include people with BD talking about their experiences. Similarly, participants reported preferring learning with and from other people's experiences.

Intervention structure. Some individuals considered the timing, spacing, number and context of sessions to be important. Participants acknowledged spacing between sessions allowed them time to engage with content and their goals (Joyce et al., 2016; Poole et al., 2012). Individuals within the internet-based study found that accessing the modules in their own time in a private environment provided safety (Poole et al., 2012). Likewise, a group in the community setting in Poole et al.'s (2015) study was seen as a helpful aspect as it provided a neutral, social setting, compared to if the group was set within a hospital environment. The timing of the group was considered by some individuals, such as time of the day (e.g. impact on work) and time of the year (e.g. cold winter evenings) (Poole et al., 2015).

Participants within group interventions (Morriss et al., 2016; Poole et al., 2015) reported one unhelpful element was that group discussions were dominated by other people and this was not facilitated well. This led to participants dropping out of the Morriss et al.'s study.

Therapist style. Three studies reported positive experiences of the therapist within interventions (Evans et al., 2016; Joyce et al., 2016; Poole et al., 2015). Individuals felt that the therapists were responsive and facilitated engagement. Therapists were seen as kind, calming and good listeners, who provided a relaxed and comfortable space for individuals. People felt the therapist adapted their style according to the individual needs, rather than adhering to a rigid structure. This helped build therapeutic alliances and facilitated communication (Joyce et al., 2016). In the Straughan and Buckenham (2006) study, individuals found the service user led style helpful.

However, not all participants in the Poole et al. study found the facilitators helpful. Some reported that the facilitators had poor group management skills, with a disengaged approach. The facilitators were focused on the PowerPoint slides and individuals felt they could have been more flexible to the needs of the group. Similarly, individuals in the Pontin et al. (2009) study found their care coordinators to be more structured and focused within the intervention, which was seen as unhelpful.

Therapy techniques. Most studies focused on helpful or unhelpful techniques used within the different interventions.

For the psychoeducation and relapse prevention interventions (Morriss et al., 2016; Pontin et al., 2009; Poole et al., 2012, 2015), there were mixed views from participants regarding the use of the life chart exercise. Some individuals valued creating a life timeline, as it gave them the opportunity to clarify and understand their diagnosis. It helped increase their understanding of previous mood episodes and provide

a link to triggers. Individuals reported that it facilitated reflection on how the diagnosis had affected them personally and enabled them to think about more helpful ways to manage their moods in the future (Morriss et al., 2016; Pontin et al., 2009; Poole et al., 2015).

However, some individuals reported feeling uncomfortable about recalling past episodes, triggers, and warning signs (Pontin et al., 2009; Poole et al., 2012, 2015). Participants in Poole et al.'s (2012) study found the online life chart exercise difficult to complete and recall mood episodes. For some, remembering past events led them to feeling upset, whilst others were reluctant to think about it as they were worried it would trigger a depressive episode. Individuals recommended that they be prepared and supported to complete the exercise, or have the option of opting out if they did not feel prepared or want to do it (Poole et al., 2015). Furthermore, a few studies (Joyce et al., 2016; Poole et al., 2015; Pontin et al., 2009) reported that individuals found creating individualised safety action plans helpful.

Additional effective techniques were unique to the type of intervention. For example, the use of mindfulness techniques and focusing on the present moment was seen as a useful way of broadening individual awareness on difficult thoughts and feelings (Chadwick et al., 2011). In the Evans et al. (2016) study, individuals found the reformulation letter and the process of finding 'exits' helpful. In the novel CBT study, participants found that identifying the advantages and disadvantages of mood and 'finding a middle ground' helpful to try and conceptualise an ideal self-state. Reappraisal techniques to consider alternatives and using metaphors to facilitate positive perspectives were also seen as helpful techniques. However, two individuals reported unwillingness to learn therapeutic techniques, requiring only emotional support (Joyce et al., 2016).

Opportunity to talk. Being given the opportunity to talk was described as a helpful experience (Evans et al., 2016; Joyce et al., 2016; Morriss et al., 2016). It was seen as a comforting and necessary process, as individuals reported not having the opportunity to share their thoughts, emotions and experiences around BD or talk about important personal topics in their day-to-day lives. Feeling safe within the interventions was highlighted as an important element to facilitate communication (Menezes & Conceicao, 2012; Poole et al., 2015). However, in the Pontin et al. (2009) study, some individuals stated that talking about their experiences was 'emotionally tiring and upsetting' and for some this induced feelings of anxiety.

Individuals within the Poole et al. (2012) study highlighted that an unhelpful element to the online intervention was the lack of opportunity to engage with others.

Impact of mood. A few studies reported that individuals' moods affected engagement within interventions (Evans et al., 2016; Poole et al., 2012;). Low mood seemed to impact on the concentration and motivation levels required to engage with interventions, and some individuals felt less sociable (Chadwick et al., 2011; Poole et al., 2015). The experience of high moods led to some individuals feeling angry, upset and restless (Poole et al., 2015). The impact of mood led to some individuals missing sessions or dropping out of interventions completely (Poole et al., 2012, 2015).

Increased Knowledge of BD

Several studies (Pontin et al., 2009; Poole et al., 2015; Straughan & Buckenham, 2006) highlighted the importance that individuals attributed to increased knowledge around BD. This enhanced their insight and understanding of the diagnosis, the different forms it can take, the causes, and treatment options. Some participants had experienced symptoms for years without receiving any information or an understanding of their diagnosis (Menezes & Conceicao, 2012), and one of the main reasons for being involved in the research was to access this knowledge (Morriss et al., 2016). In the

Poole et al. (2012) study, individuals had experienced BD for a significant number of years, and although they reported learning little new information, the information reinforced and consolidated their existing knowledge. The participants suggested that the online intervention would be helpful for those who were newly diagnosed, as they also reported having difficulty accessing sufficient information at the time of their diagnosis.

Mood Recognition

All ten studies highlighted that following the interventions individuals reported an increased self-awareness of early warning signs of mood changes, as well as recognising triggers to mood and noticing mood changes better. Due to the increase in self-awareness and monitoring of moods, individuals were able to deal with symptoms better.

Control of Moods

All but one study (Evans et al., 2016) reported that due to the increased mood recognition, individuals consequently described responding differently to their mood changes. Some participants had developed coping strategies, such as distraction techniques, to prevent or manage mood escalations, as well as regulate their behaviour (Joyce et al., 2016; Menezes & Conceicao, 2012; Morriss et al., 2016; Poole et al., 2012, 2015). In the Chadwick et al. (2011) study, individuals adapted their mindfulness practice according to the mood state they were in to help control changes. However, some individuals within the Pontin et al. (2009) study felt that when their mood changes occurred too quickly, their strategies were ineffective.

Some studies identified that individuals had become aware of how to control their moods in order to maintain their wellbeing (Poole et al., 2015; Pontin et al., 2009; Straughan & Buckenham, 2006). Individuals reported feeling less overwhelmed by moods, and experienced an increased tolerance to mood swings (Chadwick et al. 2011;

Joyce et al., 2016). In Joyce et al.'s study, some participants reported no impact of the therapy on their mood management.

Change of Perspective

Attitude towards medication. Following a number of psychoeducation interventions, some individuals described a change in their attitude towards medication, and acknowledged its role in relapse prevention (O'Connor, 2008; Poole et al., 2015; Pontin et al., 2009). Some participants also reported feeling more confident and willing to try medication (Poole et al., 2012).

Taking responsibility. Half of the papers described how individuals were feeling more determined to take personal responsibility in managing their BD (Joyce et al., 2016; Pontin et al., 2009; Poole et al., 2015). Individuals reported awareness in the need to engage in active in the treatment process and in taking responsibility for their actions in order to change behaviour (Menezes & Conceicao, 2012; Straughan & Buckenham, 2006).

Acceptance. Following interventions there was a reported increase in acceptance of the mood changes, diagnosis and the self (Chadwick et al., 2011; O'Connor et al., 2008; Poole et al., 2012, 2015; Pontin et al., 2009). For some individuals this meant coming to terms with the disorder, and learning to live a 'normal' and 'happy' life despite the BD (Menezes & Conceicao, 2012). The process of normalising and understanding that everyone can experience mood changes helped with the acceptance of moods (Joyce et al., 2016).

Thinking differently. Three papers reported that individuals responded differently to their thoughts and had changed their way of thinking (Chadwick et al., 2011; Joyce et al., 2016; Straughan & Buckenham, 2006). From the interventions, individuals learnt to reappraise situations to consider alternatives and respond to negative thoughts differently, such as challenging thoughts and beliefs or letting go of

the thoughts. This led to individuals feeling less overwhelmed by their thoughts and changed their patterns of behaviour. Participants described an increase in meta-cognitive awareness into their thoughts (Chadwick et al., 2011; Joyce et al., 2016). However, three individuals in the Joyce et al. study reported no changes in their thinking.

Mood Stability

Five papers highlighted individual experiences of mood stability following interventions (Chadwick et al., 2011; Pontin et al., 2009; Poole et al., 2015). Individuals reported a reduction in negative affect and increased mood stability. Individuals felt they were maintaining their wellness for longer periods (Straughan & Buckenham, 2006) and had experienced a reduction in the number of hospitalisations (Menezes & Conceicao, 2012).

Empowerment

Individuals reported a sense of empowerment, as well as increased confidence and self-esteem following interventions (O'Connor et al., 2008; Menezes & Conceicao, 2012; Pontin et al., 2009; Straughan & Buckenham, 2006). Some individuals described an increase in assertiveness, enabling them to cope better in situations they originally found challenging (Joyce et al., 2016; Poole et al., 2015).

Improved Relationships

Individuals reported improved relationships with partners, family and mental health professionals due to an increase in their understanding and support (Pontin et al., 2009; Straughan & Buckenham, 2006). Family and partners were more accepting of an individual's diagnosis and supported their involvement within interventions (Poole et al., 2015). Giving or sharing of information with others helped to facilitate this process, in particular information on diagnosis and aetiology (Poole et al., 2012). Individuals in Poole et al.'s (2015) study gave information to family members so that they could also

identify and be aware of mood changes. Due to their increased knowledge and understanding about their diagnosis, individuals were able to communicate their experiences of BD to others in a concise way that helped reduce experience of stigma.

For some, the intervention did not impact on individuals' personal relationships (Poole et al., 2015). For example, some family and friends were not interested or considerate to the individual's mental health needs, and individuals reported cutting out these particular people from their lives.

Lifestyle Changes

Individuals made healthier lifestyle changes as a consequence of the interventions, and also experienced increased levels of functioning and quality of life (Poole et al., 2012, 2015). Participants shared that they had adopted healthier behaviours; such as reducing alcohol intake, adjusting their sleep patterns, eating more healthily and exercising, as well as creating and maintaining a structure to daily life. Individuals reported engaging with their life goals and managing their daily work and personal responsibilities better (Joyce et al., 2016; Menezes & Conceicao, 2012; Straughan & Buckenham, 2006).

Discussion

The thematic synthesis of ten primary qualitative studies provides valuable insight into what individuals with BD find helpful and unhelpful within psychological interventions, as well as summarising the processes within the interventions that facilitate positive changes. Despite there being a relatively sparse body of research exploring individual experiences of psychological-based interventions, this review highlights some common themes across studies.

The hypothetical model of processes which might facilitate positive change (Figure 2) suggests increasing individuals' knowledge and understanding of BD,

especially early on in diagnosis, can help individuals recognise their early warning signs and triggers. This meant individuals could cope better with mood fluctuations - using strategies learnt in interventions, such as reappraisal of thoughts and moods and mindfulness techniques. These enabled individuals to feel less overwhelmed by their mood changes and helped with mood stability. Overall, this led to individuals feeling more in control and empowered in their lives. The effect of feeling empowered, along with increased skills and knowledge meant that individuals dealt with situations, relationships and lifestyle choices better.

The findings of this review mirror some qualitative studies exploring experiences of individuals with BD in general. Mansell et al. (2010) investigated qualitative accounts of the process of recovery in individuals with BD. Similar helpful approaches were found, including understanding and acceptance of BD. These were important processes for personal growth, which also helped change individual thought processes about behaviours, and take more responsibility. Individuals found information on BD a helpful resource, as they gained insight into their thoughts, feelings and behaviours, and learnt how to manage these. Similarly, lifestyle factors and social support were also seen as important in increasing mood stability.

The themes ‘Control of moods’ and ‘Change of perspective’ seem consistent with the integrative cognitive model (Mansell et al., 2007). This model proposes that individuals with BD have conflicting beliefs about their internal mood states and how to control them. Re-appraisal techniques may help individuals disconfirm these beliefs, which are linked to control, and therefore enhance mood states.

Another study by Barker (2002) identified coping techniques commonly used by members of Mood Swings Network. Seventy-five percent of individuals reported using non-medical strategies such as support from family and friends, positive thinking, healthy lifestyle management, understanding the diagnosis and talking to others.

Finally, the themes in the review are also supported by Billsborough et al.'s (2014) findings about what individuals with BD want from support. These included being listened to, empowerment through self-coping strategies, and an understanding of early warning signs in order to respond quicker and maintain wellbeing.

Limitations and Future Research

This review used a systematic and rigorous method to ensure a broad range of all relevant studies were included. However, the inclusion of only peer-reviewed English papers may have narrowed the results and be subject to bias. Excluding 'grey' area research may have distorted the findings, as theses, service evaluations, or case reports may have added value. All but one study was conducted in the UK, and the findings from the review may not be generalisable to other countries or cultures, which may have alternative views.

The majority of the included papers focused on psychoeducation interventions. Only one of these studies was based on a service user led intervention. This limited the findings of the review to those specific types of interventions. However, it is important to highlight that the majority of themes were represented across all interventions. There is a need for further qualitative studies obtaining the perspectives of individuals diagnosed with BD on CBT, CAT, and mindfulness, but also on other interventions such as DBT and family therapy, which might expand further on understanding of intervention processes. Future qualitative research across psychological interventions other than CBT and psychoeducation, looking at facilitators and barriers may add to the inconsistent quantitative research on effectiveness of psychological interventions for BD. There are authors who are due to publish separate qualitative aspects embedded within the RCTs in due course (Evans et al., 2016; Morriss et al., 2016). Future RCTs should consider the use of qualitative methods in order to address the gap in individual perspectives on interventions and strengthen the evaluative research.

Similarly, there is an absence within the review findings about the importance of addressing anxiety and past trauma within psychological-based interventions, despite the reported high levels of comorbidity within BD and individual accounts of trauma histories (Maniglio, 2013; McIntyre et al., 2006; Palmier-Claus, Berry, Bucci, Mansell & Varese, 2016). Future qualitative research should explore whether this is something individuals would like to address within psychological-based interventions.

The findings of the thematic synthesis were limited due to the quality and depth of some of the included studies. Some studies provided a 'thin' description of participant experiences, which contributed less to the final analysis when compared to studies that were more detailed in their Results/ Findings. The insufficient detail presented in some papers may be due word limit issues within journal publications, which are more appropriate for quantitative studies. These studies were included in the review due to the small number of studies available investigating qualitative experiences of psychological interventions for BD.

In addition, the majority of studies did not highlight the impact of researcher and participant relationship in their methodological information. Future qualitative research needs to remain attentive to conducting rigorous analyses, including researcher reflexivity, and provide rich descriptions of individual experiences of psychological-based interventions.

Implications for Clinical Practice

The present review brings together helpful and unhelpful aspects of psychological interventions for people with BD and highlights intervention characteristics which might facilitate positive change. This links to areas for future development of research and clinical practice of existing treatment approaches for BD.

Jauhar, McKenna and Laws (2016) reported that the majority of intervention studies focus measure outcomes relating to mood stability across time and social

functioning. This review highlights that these are important measures of positive change; however, there is also a need for interventions to use outcomes of empowerment and improved relationships to measure positive change. Furthermore, it seems there is a need for psychological interventions to facilitate these active processes more directly. If individuals with BD feel empowered, they may experience more engagement in, and control over, their lives.

As a helpful starting point to empower individuals, clinicians should consider providing a choice of options within interventions. For example, providing the option for either individual, group, online, or a combination of these approaches. In addition, negotiating the timing, number of sessions, and the involvement of significant others may be useful. Clinicians should be flexible and adapt approaches where necessary, and create a safe and supportive environment to provide an opportunity for the individual to talk about what is most important to them. Clinicians need to be highly attuned in order to work with individuals across the diverse mood states and interpersonal styles. The interventions and information provided to individuals should be delivered by those with knowledge and expertise, and that this should be provided as early as possible to, increase individuals understanding and knowledge of BD. The role of peer support within interventions should also be considered to reduce feelings of isolation.

Given the effects of psychological-based interventions for BD are modest, it is important that researchers and clinicians discover what clients would want from therapy, rather than only focussing on what clients felt worked in those therapies, in order to improve the effectiveness of treatment.

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Appendix A
Critical appraisal screening tool (CASP)

Screening Questions

1. Was there a clear statement of the aims of the research? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

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2. Is a qualitative methodology appropriate? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

Is it worth continuing?

Detailed questions

3. Was the research design appropriate to address the aims of the research? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the researcher has justified the research design (E.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

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5. Was the data collected in a way that addressed the research issue? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the setting for data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
- If methods were modified during the study. If so, has the researcher explained how and why?
- If the form of data is clear (e.g. tape recordings, video material, notes etc)
- If the researcher has discussed saturation of data

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6. Has the relationship between researcher and participants been adequately considered? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during
  (a) Formulation of the research questions
  (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

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8. Was the data analysis sufficiently rigorous? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings?

❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

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10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Appendix B

Table A1

Summary of Theme Development

Analytical theme	Descriptive theme	Example of descriptive codes
Helpful and unhelpful aspects	Professional expertise	Valued expert knowledge
		Confidence in information from professionals
		Trust in professional expertise
		Appreciation of facilitator knowledge
	Similar experiences	Meeting others with bipolar important
		Satisfaction of meeting others with bipolar
		Feeling not alone in experiences
		Being with others with similar experiences
		Appreciation of others experiences
		Comparing self to others with bipolar - extent of illness
		Did not want to associate with others – negative experience
	Learning from others' experiences	Valued others knowledge and experiences
		Learning from others experiences and making changes
		Sharing knowledge with others
		Feeling inspired by others experiences
		Preference over learning with and from others with bipolar
	Intervention structure	Spacing and number of sessions important
		Access to programme in own time
		Accessing in private environment important
		Community vs. hospital setting
		Group unstructured – domination of group

Table A1 *(continued)*

Analytical theme	Descriptive theme	Example of descriptive codes
Helpful and unhelpful aspects	Therapist style	Therapist responsive
		Trust in therapist
		Therapist listened
		Too structured and focused style
		Poor facilitator style - disengaged
	Therapy techniques	Reflecting on past events helpful
		Mindfulness techniques – being in present
		Identifying exits helpful
		Map of thoughts helpful
		Reformulation helpful
		Metaphors useful
		Reappraisal techniques helpful
		Use of action plan helpful
		Valued life chart
		Life chart difficult
		Fear of triggering memories in life chart
		Mood mapping helpful
	Opportunity to talk	Talk about what was important to person
		Talking about things not discussed before
		Wanting opportunity to talk to others
		Emotionally tiring to talk
	Impact of mood	Mood impacted on engagement

Table A1 *(continued)*

Analytical theme	Descriptive theme	Example of descriptive codes
Increased knowledge in bipolar disorder	Understanding bipolar	Education of bipolar
		Greater understanding of bipolar
		Importance of gaining knowledge
		Gaining new information
		Reinforced or consolidated knowledge
		Information suitable for newly diagnosed
Mood recognition	Awareness of early mood changes	Recognising early warning signs
		Noticing mood changes more quickly
		Increased awareness of early mood changes
	Awareness of mood triggers	Awareness of triggers
Control of moods	Responding differently to mood changes	Doing something different to manage moods
		Manage with mood changes
		Responding to mood changes quicker
		Avoiding mood escalation
		Learning to control moods
		Use of techniques to manage moods
Change of perspective	Attitude towards medication	Increased treatment adherence
		Acceptance of medication
		Change in attitude to medication

Table A1 *(continued)*

Analytical theme	Descriptive theme	Example of descriptive codes
Change of perspective	Taking responsibility	Individual active in treatment process
		Taking responsibility over bipolar and treatment
	Acceptance	Accepting bipolar as part of self
		Increased acceptance of diagnosis
		Accepting mood changes
	Thinking differently	Increased meta-cognitive awareness
		Responding differently to thoughts
		Thinking differently
		Recognising thought processes
		Feeling less overwhelmed by thoughts
Mood stability		Increased mood stability
		Reduced negative affect
		Finding a 'middle' ground, more balanced
		No impact on moods
Empowerment		Improved confidence
		Increased self-esteem
		Feeling empowered
Improved relationships		Sharing knowledge with family increased understanding
		Improved relationships with family
		Improved relationships with professionals
Lifestyle changes		Improved functioning and management of situations
		Lifestyle changes
		Returning to everyday activities

Appendix C

Table A2

Quality Appraisal Ratings for Primary Papers

	Straughan & Buckenham (2006)	O'Connor, Gordon, Graham, Kelly & O'Grady-Walshe (2008)	Pontin, Peters, Lobban, Rogers & Morris (2009)	Chadwick, Kaur, Swelam, Ross & Ellett (2011)	Menezes & Conceicao (2012)	Poole, Simpson & Smith (2012)	Poole, Smith & Simpson (2015)	Evans, Kellett, Heyland, Hall & Majid (2016)	Joyce, Tai, Gebbia & Mansell (2016)	Morriss et al. (2016)
1. Clear aims	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Qualitative method	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Design	✓	✓	✓	✓	**?**	✓	✓	**?**	✓	✓
4. Recruitment strategy	✓	**?**	✓	✓	**?**	✓	✓	**?**	✓	**?**
5. Data collection	**?**	**?**	**?**	✓	✓	**?**	**?**	**?**	✓	✓
6. Reflexivity	✗	✗	✓	✓	✗	**?**	**?**	✗	✓	✗
7. Ethical issues	✓	✗	✓	✓	✓ (partial)	**?**	✓	✓	✓	✓
8. Rigorous data analysis	**?**	**?**	**?**	✓	✗	**?**	**?**	✓	✓	**?**
9. Clarity of findings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗
10. Value of research	✓	✓	✓	✓	✓	✓	✓	**?**	✓	**?**
Overall quality rating	Satisfactory	Unclear	Satisfactory	Satisfactory	Unclear	Unclear	Satisfactory	Unclear	Satisfactory	Unclear

Part Two: Research Report

Investigating Patterns and Processes of Change in a Novel Cognitive-Behaviour Therapy for People with Bipolar Disorders

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Abstract

Objectives. The aim of the study was to explore patterns of change and client-therapist in-session behaviours within Thinking Effectively About Mood Swings (TEAMS) therapy.

Design. A mixed-method design was used.

Method. Quantitative: Session data from 33 participants who completed the therapy were analysed based on the sudden gains criterion. Qualitative: Template analysis was used to analyse 24 therapy sessions representing sessions one and twelve of the 'Recovered' group (n = 8) and 'No Change' group (n = 4).

Results. Only three participants experienced a sudden gain. There were no differences on treatment outcomes compared to those who did not experience a gain.

Four main overarching themes were developed. Some of these differences between the two groups were in relation to: 'Therapy structure', 'Risk and safety', and 'Therapist behaviour'. The main differences between the groups were related to 'Client Behaviour', such as openness and willing to talk about moods, thought processes and emotions, psychological mindedness and expectations of the therapy process.

Conclusion. Compared to previous literature on sudden gains, there were minimal sudden gains found within the TEAMS therapy. Further research is needed to establish whether the phenomenon of sudden gains can be identified within interventions for bipolar disorder.

The findings from the template analysis emphasise the importance of client involvement. There was less variability in therapist responsiveness between the 'Recovered' and 'No Change' groups. Methodological limitations of the study are discussed and clinical implications for TEAMS and future process research are outlined.

Practitioner points

- TEAMS therapists need to consider factors which may influence client involvement within therapy, such as client expectations of therapy and motivation and willingness to make changes.
- When completing therapy as part of a research trial, therapists need to consider getting clients to complete session measures outside of the therapy session. In particular during the initial therapy sessions, as this may impact on the level of engagement.

Limitations

- The study was based on a small number of participants. Future research in this area need to utilise large sample sizes to detect any significant effects.
- The study only examined two sessions within TEAMS therapy. Further research is needed to understand the patterns and processes of change across different time points of TEAMS therapy, as well as within other psychological interventions for bipolar disorder.

Introduction

Bipolar disorder (BD) is a potentially recurrent condition characterised by episodes of mania or hypomania and episodes of depressed mood (NICE, 2015). Depressive symptoms are the biggest factor in causing impaired functioning for people with BD (Gitlin, 1995; Morris et al., 2007). Even during periods of relative 'remission', many people continue to experience symptoms of depression. At present, antidepressant treatment does not always assure the absence of relapse (Vieta et al., 2013), and evidence for the effectiveness of existing cognitive behavioural therapy (CBT) for BD is mixed (Reinares, Sanchez-Moreno & Fountoulakis, 2014).

Thinking Effectively About Mood Swings (TEAMS) (Mansell et al., 2007; Searson, Mansell, Lowens & Tai, 2012) is based on a cognitive model of BD, which is different to previous CBT interventions that typically focus on relapse prevention or use models of unipolar depression. The model proposes that individuals with BD have multiple, contradictory interpretations of their internal mood states, which have a reciprocal impact on behaviour, physiology and the environment, and are the core mechanisms which maintain and escalate symptoms. The aim of TEAMS therapy is therefore to help people with BD identify, explore and monitor their internal states on a continuum, and identify the associated cognitive appraisals which are usually in conflict. The goal is to facilitate broadening the 'bandwidth' of internal states that can be tolerated and accepted by the individual. By doing so, individuals are less likely to engage in extreme 'descent' and 'ascent' behaviours in order to try and manage internal states. A key aspect is forming a sense of a 'healthy self', which is about achieving individual goals that are less dependent on internal states. The therapist helps the client develop an awareness of core personal goals and values and how to strive for these in a way that does not necessarily require extreme attempts to control or change their moods. Contrary to traditional CBT, TEAMS does not aim to directly challenge extreme

appraisals, which could confirm an opposing belief. The emphasis is on developing awareness and choice to help people to regain control over their lives. Specific strategies often employed in TEAMS therapy include naming and exploring different mood states and exploring links with conflicting beliefs and behaviours; in particular using imagery and metaphors, and using curious questioning to encourage processing experiences 'online' as they occur in order to facilitate the development of alternative perspectives. TEAMS therapy aims to ensure that therapy is based on an individualised formulation.

When working therapeutically with individuals, certain steps need to be made within TEAMS, which are approached in a hierarchical manner described as the Pyramid of Principles (see Figure 1; Mansell, Harvey, Watkins & Shafran, 2009). It would be necessary for the therapist and client to reach a basic level of safety and engagement before the client is willing and able to talk about their experiences, and then move on to reflecting on a collaborative formulation of these experiences. However, it is likely that over the course of the TEAMS, clients will move up and down these stages, as both gains and ruptures occur in the therapy (Mansell et al., 2009).

The TEAMS research programme has just finished its fourth phase of development and testing - a pilot feasibility randomised controlled trial (RCT) providing an estimate of the effect size for TEAMS when compared to usual care (Mansell et al., 2014). The results did not provide evidence of a clinically significant benefit of TEAMS compared to treatment as usual, and no overall effects on depression were found at either 6-, 12- or 18-month follow-ups (Mansell et al., 2017). Joyce, Tai, Gebbia and Mansell (2016) explored participants' experiences of the TEAMS trial to understand useful changes following therapy and recommendations for improvement.

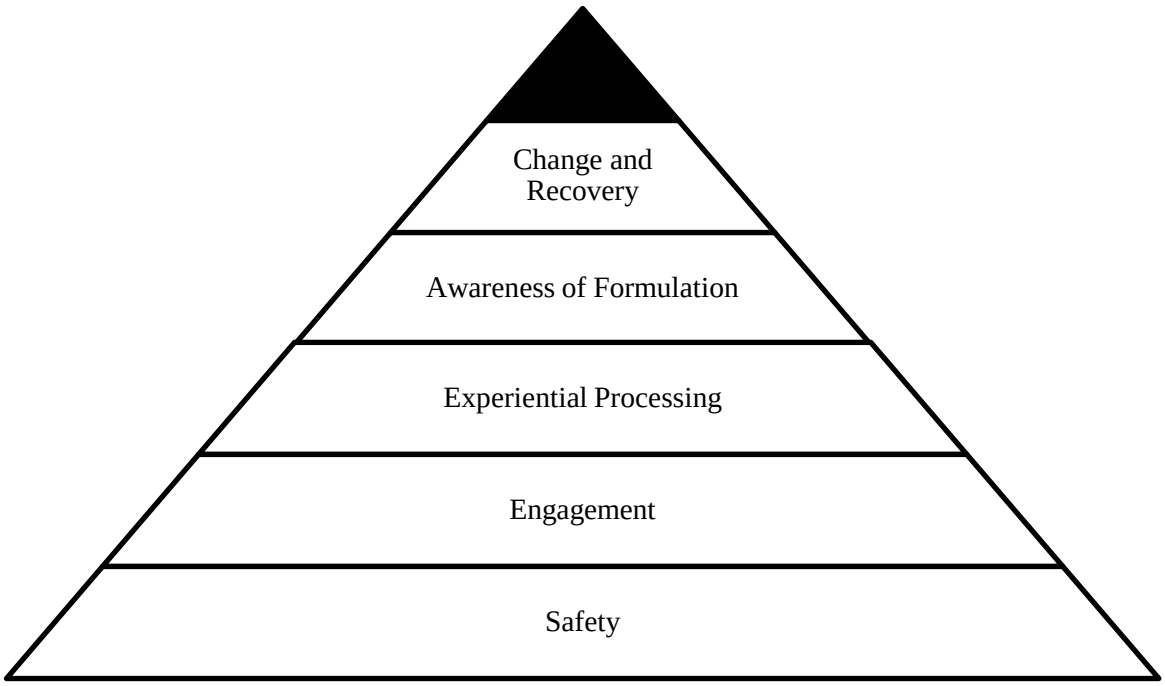

Figure 1. The Pyramid of Principles (Mansell et al., 2009).

Further research is needed to investigate participants who did and did not experience therapeutic change following the TEAMS therapy. This would provide potential reasons for why there were differences between clients, which could indicate where changes to the therapy might be required before conducting the next RCT of TEAMS. It is important to understand how and why the intervention achieved its effects and the therapeutic processes that were responsible for producing change (DeRubeis & Feeley, 1990).

There have been no studies regarding the role of therapy processes in treatment outcomes with individuals diagnosed with BD. Previous research does not address the session-to-session decision-making that is expected of the therapist within either a structured or individualised treatment. Further evaluation of the efficacy of TEAMS for individuals with BD is needed, and an important step in effective treatment development is to identify the change processes in relation to therapy outcomes (Greenberg, 1986).

Process Research

An important goal of psychotherapy research is to understand the relationship between therapeutic process variables and outcome. Ablon and Marci (2004) state that studies that neglect in-session treatment processes risk generating results that will not advance the understanding of interventions and what makes them effective. Elliott (2010) suggests that process change research is a necessary complement to RCTs and can include patterns of improvement over therapy and micro-analytic process research of client-therapist in-session behaviours.

Patterns of change. Within the literature of depression, sudden gains (Tang & DeRubeis, 1999) are defined as rapid, large decreases in symptoms that occur in one between-session interval. In psychotherapy for depression, sudden gains are common, with 30–50% of patients experiencing sudden improvements (a reduction in depressive symptoms), and these sudden gains predict better treatment outcome (Aderka et al., 2012; Tang, DeRubeis, Beberman, & Pham, 2005). The existence of sudden gains has also been replicated in other studies looking at CBT in individuals experiencing depression (Hardy et al., 2005; Kelly et al., 2005), and for other disorders such as generalised anxiety disorder (GAD; Stiles et al., 2003), post-traumatic stress disorder (König, Karl, Rosner, & Butollo, 2014) and eating disorders (Cavallini & Spangler, 2013).

Sessions that occur just before the sudden gain are considered noteworthy since these sessions are assumed to influence long lasting symptom improvement. Determining what triggers sudden gains in these sessions may contribute significantly to the mechanisms of change. The factors determining sudden gains remain largely unexplored. From possible predictors of sudden gains, like therapist adherence and therapeutic alliance, Tang and DeRubeis (1999) found that client cognitive change was the only significant predictor. Other factors have also been investigated, such as

achieving insight in the pre-gain sessions which had been associated with sudden gains (Goodridge & Hardy, 2009), as opposed to client characteristics, which were found not to be associated (Hardy et al., 2005).

The presence of sudden gains is clinically meaningful in several ways. Exploring the potential existence of sudden gains in individuals with BD may produce valuable knowledge that could impact current treatment methods. Tracking a client's symptom trajectory during treatment may allow therapists to assess clients' progress and make adjustments accordingly (Lambert, 2013). The experience of sudden gains may also increase clients' confidence in treatment, leading to improved therapeutic alliance and subsequently further gains (Tang & DeRubeis, 1999). In addition, understanding the characteristics of critical therapy sessions could identify aspects of treatments that therapists may focus on to improve client recovery.

Given the research findings related to sudden gains in CBT for depression and other disorders, sudden gains may also be operative in CBT for individuals with BD. At present, there are no published studies looking at sudden gains within BD treatment. Sudden gains may be particularly relevant to the TEAMS data due to the therapy's focus on client cognitive appraisals as a change method. It might also be important to try and consider whether there are specific factors involved in facilitating this change.

Client-therapist in-session behaviours. There have been numerous qualitative process studies investigating micro-analytic in-session behaviours (for example, Bischoff & McBride, 1996; Gallegos, 2005; Hardy et al., 1999; Rennie, 1992). This research has identified four categories that contribute to effective psychotherapy: 1) Client factors, 2) Therapeutic relationship factors, 3) Therapy techniques, and 4) Model factors. Some researchers have proposed that clinical change arises from common, non-specific factors related to the client, therapist and their interaction and relationship (Hill, 2005; Lambert, 2013). Therefore, it is

suggested that process research should investigate client and therapist behaviour and their contributions within therapy (Ablon & Marci, 2004).

The contribution of client factors in the psychotherapeutic process has often been overlooked. Ablon and Marci (2004) suggest that the study of change processes must also focus on client contributions alongside those of the therapist. Krupnick et al. (1996) found that client contribution appeared more important to the process of psychotherapy. Client involvement is an essential contributing factor to therapy outcome (Drieschner, Lammers & van der Staak, 2004; Lambert, 2013). Morris, Fitzpatrick and Renaud (2014) highlight that client involvement is the degree to which clients behaviourally engage in therapy tasks, which includes both homework and participation of skills in the therapy session. It also involves the extent to which the client is willing to initiate topics, explore and report on thought processes, and consider alternatives to their thought patterns and interactions. Additionally, whether the clients allow themselves to examine, experience and label emotions is important.

The behaviour of the therapist is also likely to have an effect on outcomes. Even in manualised therapies, skilled therapists may be responsive to individual's style of presentation within session, adapting their intervention in an effort to maximise effectiveness for each individual (Stiles & Shapiro, 1994). Therapist responsiveness is the degree to which the therapist is attentive to the individual, for example, whether the therapist acknowledges and attempts to understand the client's concerns, and shows interest in and responds to the client's communication, in terms of content and feelings (Elkin et al., 2014). The concept of therapist responsiveness permits a distinction between two meanings of importance: clinically valuable versus statistically predictive of desirable outcomes. Appropriate responsiveness is doing what is required to produce a desired outcome, such as reduction in symptoms or improvement in life functioning. Levitt, Butler and Hill (2006) highlight that research on therapist responsiveness must

examine “moment-to-moment process within the psychotherapy session” (p. 314).

Aims & Hypotheses

The overall aim of this research was to explore patterns of change and client-therapist in-session behaviours within TEAMS in order to improve its delivery for the next phase of its development. In order to meet the overall aim of the research, two studies were carried out.

The aim of Study 1 was to examine whether participants receiving the TEAMS intervention experienced sudden gains and, if so, whether sudden gains were associated with better outcomes at the end of therapy. In line with previous research, it was hypothesised that some participants will experience at least one sudden gain during TEAMS therapy. It was also hypothesised that participants who experienced a sudden gain would have greater symptom improvement in depression at the end of treatment than those who did not experience a sudden gain, and that this would be maintained at 18-month follow-up.

The aim of Study 2 was to investigate in greater detail in-session therapist and client behaviours. Initially it was planned to compare clients who experienced sudden gains and those who did not. However, following completion of Study 1 this was not possible due to the minimal number of sudden gains found. Therefore, sessions of clients who improved following TEAMS therapy were compared to those who made no change. The aim of this discovery-orientated study was to explore whether process of change and outcome in clients who did and did not improve were affected by differences in therapist responsiveness or by client involvement factors, or both. If such differences in factors could be identified, this could then be considered by the TEAMS researchers on how to further improve the quality of their therapy.

Method

Design

The study used both quantitative and qualitative methodologies. It utilised a secondary analysis of an existing dataset from the TEAMS feasibility RCT, which included session-by-session measures of bipolar symptomatology and cognitions, as well as analysing recorded therapy session data.

Ethics

The TEAMS study was approved by the London Queens-Square Research Ethics Committee (REC reference: 11/LO/1326, see Appendix A). Participants consented to completing brief session assessment measures, consisting of self-report measures prior to each treatment session. Participants also consented to having their assessment and therapy sessions audio recorded, and for this data to be subject to further analyses outside of the aims specific to the RCT.

TEAMS Therapy

The TEAMS approach involves an individualised treatment plan of CBT based on the integrative cognitive model of BD (Mansell et al., 2007). Specific treatment strategies and therapy techniques are determined by an individual formulation using the model. There are several published descriptions of the interventions, as well as a therapy manual in development (Mansell, 2007; Searson et al., 2012; Mansell & Hodson, 2009). TEAMS therapists were three male therapists and two female therapists. Two of these therapists were the developers of the TEAMS model. The other therapists were either Clinical Psychologists or CBT therapists employed by the NHS who were trained in using the TEAMS model.

Study 1: Patterns of Change in TEAMS Therapy

Method

Participants

A total of 41 participants were randomised to the TEAMS therapy intervention. Participants were aged 16 years or over and met Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV; American Psychiatric Association, 2013) criteria for a diagnosis of BD. Participants met all of the study criteria: DSM-IV criteria for bipolar I or II disorder, or bipolar not-otherwise-specified, characterised by a past major depressive episode and DSM-IV hypomania of two days or more; and had a baseline score of at least 15 on the Beck Depression Inventory-II (BDI-II; Beck, Steer & Brown, 1996). Participants were recruited through clinicians, key workers and care co-ordinators within a number of NHS Trusts in and around the North West of England.

The majority of participants (n = 28) attended 16 planned (upper limit) TEAMS therapy sessions on a one-to-one basis. Eleven participants did not complete the full 16 sessions and two participants had four booster sessions, in order to address a specific need (e.g. risk). Five participants had less than five sessions with measure data and three participants had no 12- or 18-month outcome data and were therefore excluded from the analysis. Therefore, there was sufficient session-by-session data from 33 participants to investigate sudden gains (see Table 1 for baseline demographics).

Measures

The BDI-II (Beck et al., 1996) was used as the main outcome measure for the TEAMS trial at pre- and post-treatment, and at 12- and 18-month follow-ups. Beck et al. found Cronbach's alpha ranged from 0.81 to 0.86.

Prior to each session, clients completed the Internal State Scale (ISS; Bauer et al., 1991). The ISS is a 16-item self-report scale which assesses a range of bipolar

symptoms, with each item rated from 0 to 100 along a visual analogue scale. It has four subscales; Activation, Depression, Conflict, and Well-Being. Bauer et al. found Cronbach's alpha ranged from 0.81 to 0.92 on the four factors.

Table 1

Baseline Demographical Characteristics (N=33)

		Total (%)
Age (in years)		Mean = 45.1
Gender	Male	8 (24.2)
	Female	25 (75.8)
Ethnicity	White	31 (94.0)
	Non-White	2 (6.0)
Marital status	Not stated	1 (3.0)
	Single	7 (21.2)
	Married/ Civil partnership	11 (33.3)
	Cohabiting	2 (6.1)
	Separated/ Divorced	11 (33.3)
	Widowed	1 (3.0)
Employment status	Not stated	1 (3.0)
	Unemployed	12 (36.3)
	Full-time employment	6 (18.2)
	Part-time employment	4 (12.1)
	Self-employed	1 (3.0)
	Voluntary	2 (6.1)
	Student	3 (9.1)
	Retired	4 (12.1)
Diagnosis	Bipolar 1	15 (45.5)
	Bipolar 2	18 (54.5)
Number of past episodes	Not stated	3 (9.1)
	1-7 episodes	5 (15.2)
	8-19 episodes	5 (15.2)
	20+ episodes	20 (60.6)
Past hospitalisations	Not stated	1 (3.0)
	Yes	22 (66.7)
	No	10 (30.3)
Participants with comorbid diagnoses		27 (81.8)

Procedure

Terminology. Consistent with the terminology used by Tang and DeRubeis (1999), the therapy session immediately preceding a sudden gain is known as the pre-gain or critical session. The therapy session immediately after the gain is known as the post-gain session. The session before the pre-gain session is called the pre pre-gain session. The temporal sequence of sessions is as follows: pre pre-gain (N-1) → pre-gain (N) → sudden gain → post-gain (N+1).

Criteria for sudden gains. The current study assessed sudden gains in TEAMS therapy by using the Depression subscale of the ISS session-by-session measure. This is in line with previous literature that has investigated sudden gains in depression and CBT (Tang & DeRubeis, 1999; Busch et al., 2006; Kelly et al., 2005). Also, as mentioned in the Introduction section, depressive symptoms are the main cause of impairment in functioning in individuals with BD. The primary outcome within the TEAMS RCT trial was depressive symptoms (as demonstrated on the BDI-II) and therefore, it was helpful to identify sudden gains using a session-by-session measure in line with this. The Depression subscale of the ISS has been validated alongside an established clinical measure of depression - the Hamilton Depression Rating Scale (Hamilton, 1960), r = 0.84 (Bauer et al., 1991).

The study followed the three criteria as described by Tang and DeRubeis (1999), which include 1) large absolute magnitude of change, 2) relative magnitude of change, and 3) stability of the change in symptomatology relative to symptom fluctuation. Sudden gains occurred when all three of these conditions were met.

In the original sudden gains study, Tang and De Rubeis (1999) identified a reduction of at least 7 points on the BDI indicated absolute magnitude of change. Stiles et al. (2003) were the first to reframe Tang and DeRubeis's absolute magnitude of change criteria using the concepts of clinical significance and statistical reliability. In

their study, they examined the presence of sudden gains in the treatment of GAD, and therefore needed to use a measure other than the BDI to measure therapeutic gains. Stiles et al. noted that the gain in the BDI was similar to the BDI reliable change index (RCI). When using a measure of anxiety, Stiles et al. used the RCI formulas (Jacobson & Truax, 1991) to determine the change in absolute magnitude requisite for considering whether a sudden gain had occurred. Hardy et al. (2005) found this definition advantageous as it links sudden gains with the widely used concept of reliable change and it can be applied to a variety of measures.

For the third criterion, Tang and DeRubeis (1999) measured the mean difference between the scores of the three sessions before the gain and the three sessions after the gain. Even though the stability criterion has been shown to be important in defining sudden gains, there have been several criticisms of this criterion; namely, it impossible to evaluate changes occurring between the first and second sessions. Tang et al. (2005) modified the original third criterion to require that the mean difference between the pre-gain and post-gain scores exceeds 2.78 times the pooled standard deviation of these two groups of sessions' scores.

Therefore, in the current study the sudden gains criteria were operationalized as follows:

Criterion one. A change is required that is not due to the standard error of measurement (SEM). For this, the RCI for the Depression subscale of the ISS will need to be calculated using the formula by Jacobson and Truax (1991, p.14). Other sudden gains studies which have not used the BDI as a session-by-session measure have substituted Cronbach's alpha in the calculation for re-test reliability (König et al., 2014; Krüger et al., 2014). As the ISS RCI has not been previously calculated, this was done using the standard deviation (SD) and the retest reliability of the ISS Depression subscale (SEM = SD$\sqrt{}$re-test reliability). The standard error of difference (SED) was

calculated using the following: $\sqrt{2}$ (SEM^2). The RCI for the Depression subscale was calculated using a 95% confidence interval. The RCI for the Depression subscale was a reduction score of at least 110.

Criterion two. The gain must be relative to the previous score and represent at least 25% reduction in ISS scores from one week to the next, e.g. post-gain session score (*N+1)* – pre-gain score (*N)* ≥0.25 * score (*N).*

Criterion three. The difference between the mean ISS Depression subscale of the three sessions before the gain (n-2, n-1, and n) and the three sessions after the gain (n+1, n+2, and n+3) is at least 2.5 times greater than the pooled standard deviations of these two groups of sessions' ISS Depression subscale scores. The differences in the sets of means must exceed $t(4) \geq 2.50$, $p < .05$ (Hardy et al., 2005). In order to identify very early sudden gains, the study adopted the criterion of Gaynor et al. (2003), which states that for first session sudden gains, 50% of the gains must have been maintained for two sessions, as data from both n-2 and n-1 sessions do not exist.

Data Analysis

A post-hoc power analysis was conducted in order to determine whether the current sample size is large enough to prevent type II errors. With an effect size of 0.5, probability of 0.05 and sample size of 33, this yielded a power of 0.41 (one-tailed) and 0.29 (two-tailed). This suggests that with current sample size, the study is underpowered. In addition, if sudden gains were identified and the initial sample size was divided (possibly decreasing the sample size by an expected 50%), the likelihood of making an incorrect no-difference conclusion increases. However, since this is the first study looking at sudden gains within a new bipolar therapy, it was important to identify the feasibility of sudden gains. Missing data on each measure was handled by using mean substitution. All data was analysed using Excel and SPSS.

Results

Out of the 501 between-session intervals of the 33 included participants, the criteria found three sudden gains experienced by three different participants. There were 13 participants who experienced a 'partial gain', where they met criterion one and two only. Of the three participants with sudden gains, only one participant had improved from baseline to 12- and 18-month follow ups on BDI-II outcome, with a 13 score improvement. One participant showed only slight improvement on BDI-II outcome (reduction of 2 scores), whereas the other participant showed some deterioration (-2.67 score difference). The mean BDI-II outcomes for the sudden gain participants from baseline, 12-months and 18-months were 20.0 (*SD*=1), 18.0 (*SD*=14) and 18.3 (*SD*=13.7) respectively.

From further analysis of the data looking at participants who experienced partial gains and participants with no gains on overall outcomes (e.g. BDI-II scores at 12- & 18-month follow-up), a 2 x 3 mixed-design ANOVA showed no significant group effects, $F(2,56) = 2.123$, $p = .13$ and no significant interactions, $F(2,56) = .020$, $p = .98$. See Table 2 for group descriptive statistics on outcomes.

Table 2

Descriptive Statistics of BDI-II Outcomes

	Partial gain (*n*=13) Mean *(SD)*	No gain (*n*=17) Mean *(SD)*
Baseline	22.6 *(13.6)*	25.4 *(12.2)*
12-months	17.6 *(14.2)*	20.1 *(15.8)*
18-months	20.0 *(14.7)*	21.8 *(14.6)*

Discussion

This was the first study to examine sudden gains in CBT for individuals with BD. The results showed that there were sudden gains found in the TEAMS therapy; however the proportion of participants experiencing sudden gains was much lower in this study (9%) compared to previous research on sudden gains, which has shown between 17% and 50% of clients experiencing sudden gains (Gaynor et al., 2003; Hardy et al., 2005; Stiles et al., 2003; Tang et al., 2005; Vittengl et al., 2005). There were no differences in outcome between individuals with and without sudden gains on BDI-II measure at post-treatment and follow-up. This finding is in line with some studies (Tang et al., 2002; Vittengl et al., 2005), but again is inconsistent with much of the previous literature on sudden gains. Aderka, Nickerson, Bøe and Hoffman (2012) conducted a meta-analysis on the sudden gains literature in psychological treatments for anxiety and depression, and found that the existence of sudden gains had a positive impact on both short- and long-term treatment outcome.

The results showed that there were more participants who experienced a partial gain, as gains were not maintained for the two further sessions (criterion three). This initially appeared to be an interesting finding; however, there is research showing that this is a common phenomenon within the sudden gains literature (Stiles et al., 2003). Further exploration of pattern of change within the TEAMS therapy and BD is needed.

Study 2: Processes of Change in TEAMS Therapy

Method

Identification of 'Recovered' and 'No Change' Groups

Clinical significance of changes in scores on the BDI-II were used to identify groups of participants who had 'recovered' at the end of TEAMS therapy and those who

did not. According to Jacobson et al. (1984), to be clinically significant the data need to satisfy a two-fold criterion: the participant's score at post-treatment must be within the range of a 'functional' group (defined as the mean ± 2 SD in the direction of functionality) and it must demonstrate statistically reliable change.

Cut-Off Points: For the first part of the criteria, it was necessary to calculate a cut-off point for the BDI-II. Where normative data is available from clinical and non-clinical populations, it is recommended that cut-off *c* is used (Jacobson et al., 1984). To calculate *c* for the BDI-II, the baseline mean scores and standard deviations from the TEAMS sample were used. The normative data from the non-clinical sample were used (mean = 12.6 and *SD* = 9.9; Beck et al., 1996). The cut-off for the current sample on the BDI-II was calculated as 16.

Reliable Change Index (RCI): The RCI was calculated using the following formulae by Jacobson & Truax (1991). The value used for reliability for the BDI-II was based on test-retest reliability, which was 0.93 (Beck et al., 1996). It was calculated that a 10-point change on the BDI-II was required to demonstrate reliable change.

Participants

To be 'recovered', participants needed to have crossed the cut-off point and made reliable change in the direction of functionality on the BDI-II, i.e. a cut-off score of 16 and a 10-point reduction on the BDI-II, between baseline and 12-month follow up. The 12-month follow up data was used, as this was a time point by which all participants had fully completed the TEAMS therapy. For participants to show 'No Change', their scores from baseline up to the 12-month follow-up must not have exceeded a 4-point change in either direction on the BDI-II.

Out of the 33 participants with full session-by-session data, eight individuals met the criteria for the recovered group, and four individuals met the criteria for the No Change group. The remainder of the participants fell under the following categories:

met cut off score, but not change score (*n*=7); met change score, not cut off score (*n*=4); significantly deteriorated (*n*=2); improved or deteriorated more than 5-points but did not meet other criteria (*n*=9). The significantly deteriorated group were initially considered to be included within the analysis; however, both participants attended less than 10 sessions.

Table 3 highlights the client characteristics for recovered and No Change groups. Please note that for the remainder of this report, the term 'client' rather than 'participant' will be used.

Table 3

Client Characteristics

Client*	Age	Gender	Years since BD onset	Relationship status	Employment Status	Number of sessions completed	Therapist Number (Gender)
Recovered group							
Sally	48	F	6	Married	Unemployed	16	2 (M)
Jodie	40	F	27	Married	Employed	15	2 (M)
Emma	45	F	11	Divorced, In relationship	Employed	16	5 (F)
Louise	56	F	23	Married	Employed	16	1 (M)
Helen	46	F	15	Married	Unemployed	16	2 (M)
Mel	49	F	41	Married	Employed	14	2 (M)
Alice	32	F	21	Single	Employed	16	2 (M)
Tracey	27	F	12	Single	Unemployed	12	4 (F)
No Change group							
John	47	M	6	Single	Unemployed	15	2 (M)
Amanda	38	F	19	Cohabiting	Unemployed	16	1 (M)
Jacob	36	M	23	Cohabiting	Employed	16	4 (F)
George	43	M	31	Single	Unemployed	15	2 (M)

Note. * = pseudonyms are used for confidentiality purposes

Measures

Along with the other measures previously mentioned, the Questionnaire about the Process of Recovery (QPR; Neil et al., 2009), which measures client recovery, was

also completed at pre- and post-treatment, and at 6 and 12-month follow-ups to measure client recovery. Law, Neil, Dunn and Morrison (2014) found Cronbach's alpha of 0.93.

Prior to each session, clients completed a personalised 10 to 15-item Client version of the Hypomanic Attitudes and Positive Predictions Inventory (Client-HAPPI; Searson et al., 2012). The Client-HAPPI shorter version of the HAPPI (Mansell, 2006) is a self-report measure, which assesses relevant cognitions related to mood swings and cognitive change. Internal consistency was Cronbach's alpha 0.97 for the overall scale.

At the end of each session, clients completed the Therapist Rating Scale (TRS) which was a satisfaction item, which ranged from 0 = *not at all* to 10 = *extremely* (Mansell et al., 2014). Therapist adherence to the TEAMS model was completed by the therapists using the TEAMS-Treatment Adherence Checklist (T-TAC) measure. This measure was developed specifically for the trial (Mansell et al., 2014), which generated a score of 0-16 based on eight items that addressed key components of the model.

Data Analysis

Research examining processes of change within psychotherapy has largely relied on quantitative methods; however qualitative methods may provide another avenue for capturing the complexity of the psychotherapeutic research process. Williams (2001) suggested that qualitative research is necessary to identify mechanisms of change. There is emerging evidence in process research and for the use of qualitative methods (Elliott, 2002; Hodgetts & Wright, 2007; McLeod, 2001).

Quantitative questions seek information and aim to identify patterns or relationships between variables, whereas qualitative questions require methods that seek to "map and explore the meaning of an area of human experience" (McLeod, 2001, p. viii). The current study investigated change processes using both quantitative and qualitative methodologies.

Quantitative. Descriptive information of treatment measures of clients who

'Recovered' and clients in the 'No Change group' will be presented visually, similar to case series data.

Firstly, treatment outcomes means (e.g. BDI-II & QPR) are presented to identify differences between the two groups. To examine the patterns of change within clients, session-by-session mean group scores of the ISS and Client-HAPPI are presented. The ISS composite score using the Depression, Activation and Conflict subscale totals were used.

Presumably, successful responsiveness is reflected in a positive alliance, which in turn is predictive of positive outcome (Horvath & Symonds, 1991). Stiles et al. (1998) report that the alliance and outcome are predictable from appropriate therapist responsiveness to the individual's needs. Therefore, the group mean TRS scores are presented to understand whether there were differences across groups in therapeutic alliance.

Finally, the group mean T-TAC scores are also presented to see if there were differences across groups in therapist adherence to the TEAMS model.

Qualitative. Audio recordings of session 1 and session 12 for each client in the 'Recovered' and 'No Change' groups were used as part of the analysis - a total of 24 sessions. These sessions were chosen as they represent early and late stages of therapy, and allow for a comparison of change between the two groups. Session 12 was selected, as not all clients attended sessions 15 and 16, and it was felt that session 13 and 14 would be focused on termination processes of therapy. The audio recordings were transcribed verbatim by the author (n=2 sessions), volunteer researchers (n=8 sessions) and experienced transcribers (n=14 sessions). All signed a confidentiality agreement (Appendix B).

Rationale for the choice of qualitative analysis. Transcripts were analysed using Template Analysis (TA; King, 1998, 2004). TA is a form of thematic analysis

(Braun & Clarke, 2006) and is a practical method of generating either descriptive or interpretative codes from qualitative data and organising them into hierarchically-ordered themes through a structure of a template. The principle advantage of TA for this study analysis was its flexibility in structuring the analysis according to initial areas identified by the researcher (*a priori* codes) to guide the outline of the template, whilst allowing for the development of emergent themes through full immersion of the data (Brooks & King, 2012). TA offers a good balance between providing an adequate qualitative analysis to large datasets within a manageable time frame, whilst acknowledging the voices of the research clients. TA was also selected due to its suitability to novice qualitative researchers (King, 2012).

Epistemology. King (2012) argued that TA can be used at any point along the continuum of epistemological positions – from realism to contextual constructivism. The author adopted a critical realist perspective (Cook & Campbell 1979) within the study. Critical realism sits between an independent, real and knowable world; however the knowledge and understanding of this is constructed and interpreted through subjective, cultural and social processes that the researcher can access (Sayer, 2000). It is a position which assumes there are multiple ways of interpreting the data (Madill et al., 2000).

Template analysis procedure. Transcript analysis of therapy sessions of 'Recovered' and 'No Change' groups followed the procedures developed by King (2004).

The complete analysis process of organising, connecting and corroborating themes involved creating a coding scheme, hand coding the text and sorting segments to get all similar text in one place. An initial coding scheme was developed based from items on the Client Involvement items (Morris et al., 2016) and the Responsiveness Rating Scale (Elkin et al., 2014) to help explore both client involvement and therapist

responsiveness behaviours within sessions. This formed the basis of higher order themes. Initially session 1 transcripts of both the 'Recovered' and 'No Change' groups were read thoroughly. Each section of text that seemed to identify something of relevance (e.g. therapist change in response to client, client contributions or client-therapist interaction) were marked with either pre-defined or preliminary codes in the margin, describing what is of interest. An initial template was then created by clustering the codes together to form hierarchal themes. This was a very fluid, exploratory and continuous cycle, in which new codes and themes were created, deleted or merged under more appropriate headings. Many different ways of organising the themes were attempted. The initial template was then applied to session 12 transcripts for both 'Recovered' and 'No Change' groups. For this process, the author remained open to new themes, and the initial template was modified and adapted as necessary. The author then independently re-applied the final coding template to the entire data set. Appendix C contains an example extract from one transcript to demonstrate the coding process and extracts from several transcripts for one subtheme from the final template.

Quality control. In accordance with recommendations by King (2004), quality control procedures were followed. Transcripts were systematically checked for accuracy against audio recordings. During the coding process, equal attention was paid to both the transcripts and recordings. To add to the credibility of the analysis, a quality check of the coding results was ensured by a peer review process. Four researchers external from the TEAMS trial independently coded and applied the final template to a total of sixteen transcripts. Each reviewer had session 1 and 12 from one 'Recovered' and one 'No Change' participant. Similarities and differences were discussed and the template was revised as appropriate, and a final set of themes were agreed upon. Appendix D contains examples of previous versions of the template.

Reflexivity. King (2004) stated that 'the reflexivity of the researcher, the

attempt to approach the topic from different perspectives and the richness of description produced are all important requirements'. In order to keep a reflection of the role of the researcher on the analysis process, the author kept a reflective diary as an audit trail recording the steps and decisions made throughout the coding process towards the development of the template. These included acknowledging the author's role as a trainee therapist, as well as recording any assumptions and emotional reactions in response to client and therapist interactions. The author's reflections were also used during discussions with the peer researchers as part of the quality control process (see Appendix E for the outline of quality control and reflexive process).

Results

Quantitative

BDI-II. The BDI-II scores from baseline to 12- and 18-month follow-ups across both groups are presented in Table 4.

The BDI-II scores at 18-month follow-up showed that four individuals from the 'Recovered' group had deteriorated according to their BDI-II scores. For two of these, BDI-II scores were higher than their baseline scores. The other four clients within the 'Recovered' group had maintained their low levels of depression at follow-up. Three clients from 'No Change' group made no changes on their BDI-II scores at 18-months. However, one client (Jacob) demonstrated reliable and clinically significant improvement on BDI-II scores at 18-month follow-up.

Table 4

Client BDI-II Scores Across TEAMS and Experience of Sudden Gains

Client	Baseline	12-Months	18-Months	Progress maintained	Sudden gains
Recovered group					
Sally	25	6	46	N	PG
Jodie	38	11	25	N	-
Emma	19	8	6	Y	SG
Louise	26	1	1	Y	-
Helen	20	3	24	N	-
Mel	45	14	26	N	PG
Alice	22	7	5	Y	-
Tracey	12	2	4	Y	-
No Change group					
John	34	34	29	NC	-
Amanda	30	29	38	NC	PG
Jacob	26	22	4	I	PG
George	29	28	25	NC	PG

Note. BDI-II = beck depression inventory; N = no; Y = yes; NC = no change; I = improved; PG = partial gain; SG = sudden gain

QPR. The QPR scores from baseline to 12- and 18-month follow-ups across both groups are presented in Table 5. Clients in the 'Recovered' group showed greater levels of recovery at baseline compared to the 'No Change' group. There were increases across both groups in recovery at 12-month follow-up.

ISS. The composite scores of the ISS for both groups across the TEAMS therapy are presented in Figure 2.

Even though the 'No Change' group had higher ISS composite scores, the pattern of change showed a similar decrease in ISS scores over the course of therapy for each group.

Table 5

QPR Mean Scores of Recovered and No Change Groups Across TEAMS

Client	Baseline	12-months	18-months
Recovered group			
Sally	79	105	43
Jodie	64	87	64
Emma	71	85	82
Louise	93	104	108
Helen	82	84	79
Mel	64	96	91
Alice	78	123	87
Tracey	87	85	85
Overall mean (SD)	*77.3 (10.4)*	*96.1 (13.8)*	*79.9 (19.3)*
No Change group			
John	59	58	-
Amanda	46	82	-
Jacob	71	72	86
George	65	64	63
Overall mean (SD)	*60.3 (10.7)*	*69 (10.4)*	*74.5 (16.3)*

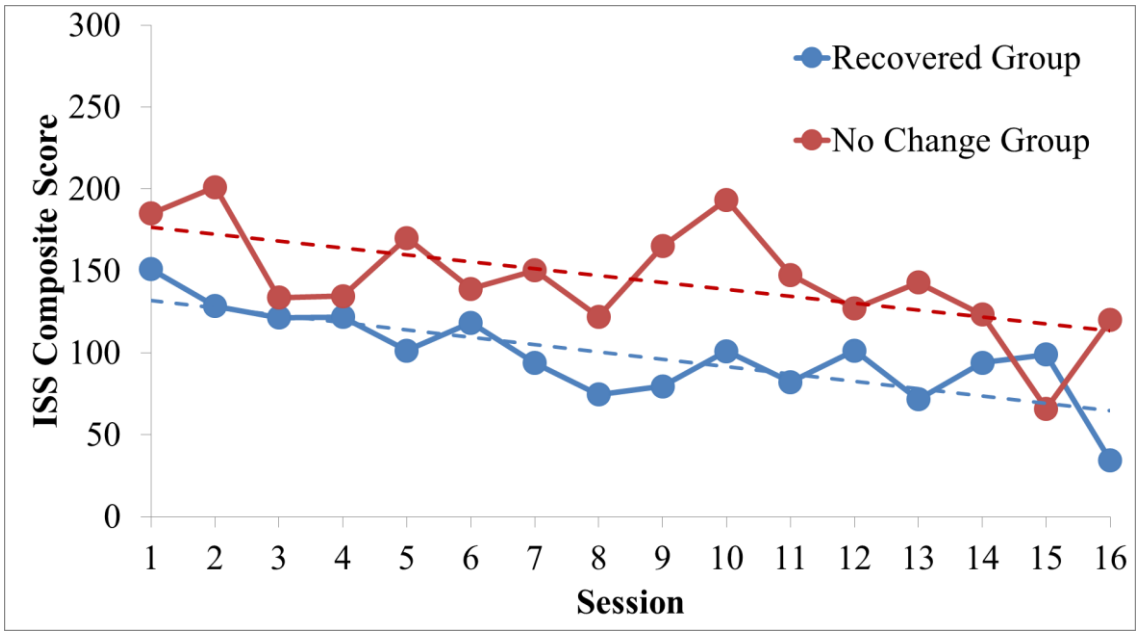

Figure 2. ISS composite scores across TEAMS therapy for Recovered and No Change groups.

Client-HAPPI, TRS and T-TAC. Mean scores and standard deviations of the session-by-session Client-HAPPI, TRS and T-TAC for both groups are presented in Table 6. On the T-TAC measure, three clients had missing data and therefore their scores were not included.

Mean totals of the Client-HAPPI scores across therapy show that the 'Recovered' group reported lower dysfunctional beliefs compared to the 'No Change' group. Both client satisfaction and therapy adherence ratings across groups were similar.

Individual session-by-session graphs for the 'Recovered' and 'No Change' groups on the Client-HAPPI, TRS and T-TAC are presented in Appendix F.

Table 6

Mean and Standard Deviation (SD) of Session-by-Session Measures of Client-HAPPI, Therapy Rating Scale (TRS) and TEAMS-Therapist Adherence Checklist (T-TAC)

Client	Client-HAPPI Mean *(SD)*	TRS Mean *(SD)*	T-TAC Mean *(SD)*
Recovered group			
Sally	56.1 *(13.9)*	8.1 *(0.7)*	11.6 *(2.5)*
Jodie	57.7 *(7.2)*	8.5 *(0.6)*	-
Emma	49.3 *(17.1)*	8.7 *(0.6)*	13.4 *(2.4)*
Louise	14.3 *(6.7)*	10.0 *(0)*	13.9 *(1.5)*
Helen	38.1 *(12.2)*	8.4 *(1.2)*	12.6 *(2.4)*
Mel	57.2 *(8.6)*	8.7 *(0.5)*	12.1 *(2.0)*
Alice	45.5 *(10.7)*	9.9 *(0.3)*	11.4 *(3.2)*
Tracey	57.2 *(10.9)*	9.2 *(0.5)*	-
Overall	*42.6 (19.0)*	*9.0 (0.9)*	*12.6 (2.4)*
No Change group			
John	51.6 *(14.0)*	9.7 *(0.6)*	10.7 *(5.8)*
Amanda	74.7 *(10.7)*	9.8 *(0.5)*	12.7 *(2.7)*
Jacob	69.3 *(7.1)*	8.8 *(0.4)*	-
George	65.1 *(10.8)*	7.1 *(0.6)*	9.8 *(2.5)*
Overall	*65.2 (9.9)*	*9.2 (1.2)*	*11.6 (3.7)*

Template Analysis

The following analysis examined 24 transcripts of eight clients from the recovered group and four clients in the No Change group, in order to explore whether there were differences between client and therapist behaviours in session 1 and 12 of the TEAMS therapy.

Four top-level themes were developed in order to understand the therapy processes: ‘therapy structure’ with 11 subthemes, ‘risk and safety’, ‘therapist behaviour’ with 8 subthemes, and ‘client behaviour’ with 27 subthemes. There were similarities and differences found across groups. Due to the word limitations within this thesis, it is beyond the focus to deal with all four main themes and subthemes in equal depth due to the volume of textual data. Therefore, the author has chosen to concentrate the findings relating to the key themes which highlight differences between the groups, in order to provide a rich and detailed account of the findings, in order to address the aims of the research question. Table 7 provides an overview of the themes taken from the final template which are presented in order as discussed within the findings. The findings are presented in a way which provides a narrative of the therapy process from session 1 to session 12, with illustrative examples from the transcripts. The final template is presented in Appendix G.

Table 7

Final Template Themes Highlighting Differences across 'Recovered' and 'No Change' Groups

Top-Level Theme	Second-Level Theme	Third-Level Theme
Therapy Structure	Goals for therapy	
Client Behaviour	Levels of hope and expectation of therapy	
Client Behaviour	Psychological mindedness	*Attitudes towards medication*
Therapy Structure	Completion of measures	
Risk and Safety		
Therapist Behaviour	Curious and open to client direction	
Client Behaviour	Bringing therapeutically relevant material	
	Emotional openness	*Discusses topics freely*
Therapist Behaviour	Use of minimal encouragers	
Client Behaviour	Bringing therapeutically relevant material	*- Awareness and understanding of bipolar disorder* *- Talks about previous relapse experience* *- Spontaneously relates to childhood experiences* *- Discusses current relational problems*
	Emotional openness	*Exploring and talking about emotions*
	Bringing therapeutically relevant material	*Talking about physiological symptoms*
	Psychological mindedness	*- Self-reflective* *- Use of psychological strategies*
	Active participation	
	Making changes in and out of therapy	*- New patterns of behaviour and interactions* *- Taking responsibility* *- Changes in thinking*
	Acceptance and normalising	

Therapy structure.

Goals for therapy. For the majority of the 'Recovered' group, clients shared that their main goal for TEAMS was to develop and strengthen on strategies in order to manage with their moods and external situations betters.

> Therapist: *Yeah like out of today, and also in general like you know towards the end what's your, hopes or?*
>
> Jodie: *Um to be able- well, my goal is to have actual tools, techniques, I want a toolkit [T: right] in order to be able to, assess where I am and manage what I'm doing*

In the 'No Change' group, both John and Jacob wanted to change their experiences of extreme mood swings. Amanda and George had highlighted that the opportunity to talk and feel listened to were their main reasons for taking part in TEAMS. By session 12, it appeared that Amanda and the therapist had worked together to on developing a goal of being more assertive within situations; whereas George was still developing clear goals with his therapist, although he did highlight that he would like to work on being more flexible within situations.

> Therapist: *You know, think about that, goals, what is important in your life over the week.*
>
> George: *Is like priorities important, similar, yes?*
>
> Therapist: *And maybe list the things, list the things that are your priorities, what are the things that are most important in your life?*
>
> George: *Yes…Oh, just, um, I think rigidity and just you know, being more flexible and less time conscious and also I need to lose some weight as well, just.*

This theme slightly overlaps with the ***'Client behaviour - Levels of hope and expectations of therapy'*** subtheme, as there was a clear difference between the two groups on what they hoped and expected from the therapy process. Within the 'Recovered' group, some clients talked about having a hope for recovery and wellness from the therapy process (Jodie, Louise and Helen). Jodie, Helen and Alice shared that they were pleased they were chosen to be within the therapy arm of the trial *('I'm so honestly I'm so excited about it I'm so glad that I was chosen'* Jodie S1*)* and there was a particular interest in attending the sessions and learning about CBT. There was a recognition that the therapy process was going to be difficult, but important in order to learn and gain something positive from the therapy. There was a sense that there was an expectation of the therapist and client working together in order to achieve the client goals.

> Louise (S1): *I think it's, I think it's going to be difficult and I think I'm probably going to do a lot more crying but I think it's something that I do need to address really in order to properly move forward and kill all this stuff once and for all really.*
>
> *....I realise that, you know, sometimes you can evoke resistance by persisting with, you know, and I also know from all the recovery stuff that (LAUGH) you can't make someone recover either, you know it does have to come from internally.*

Conversely in the 'No Change' group, there were mixed senses of hope and expectation for TEAMS. Jacob highlighted that he was unclear how the therapy would work.

> Jacob: *So if I'm getting that real bad, I'll have to have a tranquiliser, because I can't, you know, I know you want to help me with verbal stuff*

and talking, but I just – I'm not clear how that could work, because I do have to sometimes rely on the medication.

Amanda shared that she was worried that she would never recover and 'end as a failure'. George was attending TEAMS therapy as a way of accessing support, but acknowledged that even though he finds the therapy useful for the practical support, this only provides a 'short-term' fix. John, on the other hand, talks about previous experiences of therapy not working and puts all his hopes and expectations on to the therapist to 'fix' and take control of his difficulties and change his life. John highlighted that he would assess at the end of therapy if his thinking had changed.

John: *Yeh, which is, which is awful to say, because it puts a big weight on your shoulders. If you know what I mean, but if you want me to be honest that is what it is*

Therapist: *That's absolutely fine, and that's why it's important that we have this nicely contained place –*

John: *Because obviously for me I'm like 'shit, I'm giving this gentleman all this pressure on his shoulders, that in 16 1-hour sessions he's going to change the last 47 years of my life. And then to the next 47. (laughs)*

Therapist: *So again, is that what you hope or expect then, that I'll be able to change-*

John: *I hope, but I don't expect it, because it's never worked out in the past.*

Therapist: *Well, what if it didn't this time.*

John: *I don't know, I can analyse it at the end of the 16 – because at the end of the 16 sessions, my way of thinking might be different.*

Similarly, this overlaps with the ***'Client behaviour - Attitudes towards medication'*** subtheme. Clients within the 'Recovered' group spoke about the negative side-effects of medication, but recognised its importance in keeping them well. Even though they acknowledged its use, they also highlighted the importance of psychological processes in coping, such as changes in thoughts and behaviour.

In the 'No change' group, both Amanda and Jacob highlight the need to use medication to control mood, and do not highlight any of the psychological aspects of staying well. Jacob, in particular, throughout both sessions indicated that medication is the only main help in controlling moods due to the biological nature of the illness, and talks about increasing his medication when he notices subtle changes in his moods.

> Jacob: *Yes, my mood hasn't been too bad but three weeks ago as well, about three or four weeks ago, I decided to increase my quetiapine a bit – no, not quetiapine, lithium.*
>
> Therapist: *What made you decide that?*
>
> Jacob: *Just because I was sick of just the change of moods and just, you know, I thought, well, I could be up to 800, I could even be on more than this, and I'm at 600 at the moment, so I thought if I kind of meet the psychiatrist in the middle, sort of give it a bit of scope and after I took, increased it, after a good few days it did sort of stabilise the mood a bit, so.*

Completion of measures. In session 1 for the 'Recovered' group, all clients complete the TEAMS therapy measures either before the start of the session recording or at the end of the session; with some clients taking the measures home with them to complete for the following session.

However, in the 'No Change' group, with the exception of Jacob, all clients

completed the measures in the middle of the session. John highlights the impact of completing the measures on the therapy time.

> Therapist: *So filling in various bits and pieces, which are going to help, which we keep a track of, we can notice how they change over time, but also help with the individual um, sort of therapy sessions as well. One of them, well, both of them you've done before, this one, I don't know if, you could fill that in now actually, because we have to do that for each session, would that be alright?*
>
> John: *But do we do that in the session or after the session?*
>
> Therapist: *Normally before the session, normally before the session, so –*
>
> John: *No, what I'm thinking is, obviously that's impeding on my 50 minutes (laughs).*

In session 12, only the clients in the 'Recovered' group went through the measures with the therapist, and highlighted their changes across the therapy. This links with the *'Client behaviour - Making changes in and out of therapy'* subtheme (see below).

Risk and safety. The difference in this theme across groups was the level of current risk presented in the session. For clients within the 'Recovered' group, there were no immediate risks identified within sessions. Louise, Mel and Helen all shared that they have had previous suicidal thoughts, but there were no current risks and therapists did not go into much detail around the risk. Therapists asked about risk to others within Louise and Alice sessions, as both highlighted recent difficulties with their family members.

In the 'No Change' group, in session 1, John talks about recent suicidal feelings and an attempt to overdose, which he had communicated with the therapist before the

first session. The therapist spends a proportion of the session going through a safety plan with John to ensure his level of risk is managed.

Therapist behaviour. There was limited variability among therapists across groups and sessions. Therapists demonstrated appropriate levels of therapist responsiveness in that they were all collaborative, verbally responded to the client's feelings and behaviour, and made links to patterns of content within the session and across sessions. All therapists used clarification questions to increase their understanding of client difficulties, and presented clients with summaries and used client words throughout sessions. The amount to which the therapists were able to do these behaviours all depended on the level of client involvement across groups (discussed later).

Even though all therapists were **'*Curious and open to the client direction*'**, there were a few times within the 'No Change' group when the therapist took more of a lead within the session. For example, in session 1, John starts talking about relevant material such as extreme moods and patterns, but there were a few times when the therapist suggests talking about it later in therapy, and moves the conversation to the therapist's agenda.

> John: *Yes. Yes. Critical development, because I think I look at things now in two different ways; either in an adult way and a logical way or a childhood way, and I don't think there's any middle ground, there's no –*
>
> Therapist: *That's what, coming back to that overarching goal, was maybe finding that middle ground?*
>
> John: *Maybe.*
>
> Therapist: *Finding, you know, maybe bringing those two together, so it's not necessarily one or the other.*
>
> John: *Yes. Well, that's what I was saying about uniting the two, to make*

one.

Therapist: *Ok, and we'll certainly go into that in more detail. Just coming back and thinking about what we're going to do here – what we're also going to do, on a weekly basis, we also have to do some measures.*

Client behaviour.

Bringing therapeutically relevant material. The content and level of detail that clients in the 'Recovered' group brought to the sessions was significantly richer than the 'No Change' group, in particular within session 1. Within the 'Recovered' group, clients showed more occasions of ***'Discuss[ing] topics freely'***, providing information and detail of their experiences, without much guidance or direction from the therapist. This links to the subtheme ***'Therapist behaviour – use of minimal encouragers'***, as therapists in the 'Recovered' group used more minimal encouragers compared to those in the 'No Change' group.

Jodie (S1): *But I just didn't know that's [T: alright] what it was. The the the depressions have been, they've been but they've been the characteristic [T: mm] element and earlier in my life I would the the the depressions would be for longer periods [T: right] so I would have them for, you know days weeks sort of thing but… it's also been peppered with quite um um an erratic job history and, short contracts and then being out of work and so then it's always, you could always see a life reason for it so that in some ways the illness was hidden [T: mm] in circumstances, if you know what I mean. So [T: yeah] now that I, the job I now have I've had for four years so that's [T: right] given me a you know [T: mm] a baseline a sort of a work baseline [T: yeah] so I can*

track the chaos that goes on around it, if you see what I mean.

Awareness and understanding of bipolar. Clients from the 'Recovered' group in session 1 talked more about their diagnosis of BD and wanting to understand it further and the impact it has had on their lives.

'Recovered' group clients also spoke about ***'Previous relapse experiences'*** and acknowledged the impact this had on others.

Spontaneously relate to childhood experiences. Clients in the 'Recovered' group spontaneously talked about and linked to their past experiences, particularly relating to their childhood and upbringing; whereas those in the 'No Change' group brought up minimal information about past experiences, or were reluctant to talk about it.

> George (S12): *Just one final thing, as a clinical psychologist, in reference, like you always see in a film, like Hollywood movies, the psychologists usually say um, key question when you see somebody, like a new patient, you haven't said it yet, but I don't want to say it, but they always say um 'tell me about your childhood,' you haven't said that but it's good you haven't, but I mean, no thanks, too traumatic and horrific but it's like the classic catchphrase psychologists use.*

Discusses current relational problems. In the 'Recovered' group, clients brought up topics around current relational difficulties they were having, and spoke about their emotional reactions towards these situations. Clients in the 'Recovered' group demonstrated a level of empathy and could relate to others' experiences.

Emotional Openness: Exploring and talking about emotions. Even though both client groups talked about emotions with the therapist, the level of detail in

exploring, expressing and talking emotions differed. Clients in the 'Recovered' group were more open in their discussions and expression of their emotions, whereas clients in the 'No Change' group acknowledged that they try to block or cover up their emotions.

This links with ***'Talking about physiological symptoms'*** subtheme, in which the majority of the 'Recovered' group also related to and spoke about the physiological experiences they were having, whereas the 'No Change' group did not talk this within either session.

> Sally (S12): *I obviously must react physically to these things so that's when I start to feel the physical symptoms of: can't get my breath, and then feel tense and realise I'm not breathing properly and my neck will start hurting, maybe headachy, and then agitated and irritable and then start to feel tired because I've expended all my energy in this sort of fight and flight I guess, where I'm stood on the spot.*

Psychological mindedness. From session 1, most of the 'Recovered' clients demonstrated some level of psychological awareness and thinking about themselves and their experiences. There was a sense that the 'Recovered' group had some insight into what was causing their difficulties from an internal perspective, for example with thought processes. This was opposite to the 'No Change' group, who linked their difficulties to more external factors, such as lack of support.

> Therapist: *It's pretty loose going? How does that sound to you? What's your? What were you imagining?*
> Sally: *Well, it's… this is the thing. I never know what, that you can talk about that that helps with this*
> Therapist: *yeah*
> Sally: *I know it's my thinking that it's wrong*
> Therapist: *right*
> Sally: *And I'm recognising more and more how much my problems are*

to do with my thinking and mainly with my thoughts being negative

The 'Recovered' group were more ***'Self-reflective'*** in their discussions with therapists, and spoke about the link between thoughts, moods and behaviours during particular experiences in a self-reflective manner.

Use of psychological strategies. Similarly, clients in 'Recovered' group talked more about using psychological strategies in session 1 - in particular trying to use positive thinking, rationalising thoughts and remaining in the here and now.

Mel (S1): *I've done it myself, I've yes, yeah it does and from that like your little trigger points and, and I usually do my little arrow, well what if I change that and go over there, that'll happen.*

Active participation. There was a clear difference between the groups on their levels of participation within sessions (with the exception of John in the 'No Change' group). The 'Recovered' group demonstrated more active engagement within both sessions, picking up on what the therapist was saying and elaborating further, resulting in more information. In session 12, there is also evidence of the clients using information from what the therapist had said in previous sessions.

Clients within the 'Recovered' group demonstrated completing work set within sessions such as diaries and workbooks; whereas those in the 'No Change' group had forgotten or not fully completed tasks set within sessions. In both sessions, Amanda shows some lack of engagement with the therapy process, as she chooses to have a phone call in the middle of the session.

Making changes in and out of therapy. In session 12, there was a difference in progress the clients in both groups were making. There was a sense that those within the 'No Change' group were at the formulation stage and making sense of their moods during session 12; whereas the 'Recovered' group were talking about ***'New patterns of***

behaviour, feeling and interactions'. The exception to this was John, who was able to reflect on controlling his 'high' levels of mood during a recent experience.

The 'Recovered' group discussed how they had noticed changes in their behaviour and interactions with others, as well as other people noticing the changes. In addition, clients in the 'Recovered' group were ***'Taking responsibility'*** for their own behaviour, whereas those in the 'No Change' group showed no recognition of self-responsibility to making changes.

Changes in thinking. Similarly in session 12, clients in the 'recovered' group spoke about noticing changes to their thinking. Some clients reported being able to find alternatives to their thoughts, not paying attention to unhelpful thoughts, and thinking differently about their moods.

Similarly, this links to the subtheme ***'Acceptance and normalising'***. Clients within 'Recovered' group during session 12 spoke about starting to accept the diagnosis and mood changes, despite the impact BD had on their lives. They were also able to normalise their own mood experiences.

> Mel (S12): *Yes I know I'm gonna have bad days but I can accept the bad days now, I don't have to, I know I'm gonna go up and down so knowing that I'm going to go up and down makes it a little bit easier cos I can't, I can try and control them but I can't stop them, the agony, it's inevitable that I am gonna do cos everybody does, it's just how far down you go. See I wouldn't have admitted that how many weeks ago.*

Discussion

This study explored patterns and processes of change within the TEAMS therapy, comparing individuals who improved following the intervention with those who made no change.

Quantitative analysis looking at the means of both groups showed that the 'Recovered' group reported lower levels of dysfunctional beliefs across therapy and higher levels of recovery compared to the 'No Change' group. Both groups had similar reported levels of therapeutic alliance and therapist adherence to the TEAMS model across sessions. It is interesting to note that from the 'Recovered' group, only four clients maintained their reduced levels of depressive symptoms at 18-month follow-up. In addition, one client from the 'No Change' group showed reliable and clinically significant improvements in their depressive symptoms at 18-month follow-up.

Template analysis of sessions 1 and 12 from the 'Recovered' and 'No Change' groups found both similarities and differences. However, this study focused on the key themes of differences across groups. In session 1, the main differences were within the individual goals set, expectations of therapy, completing therapy measures within session, and the level of information provided by the client. In relation to the Pyramid of Principles (Mansell et al., 2009), it was clear that in session 1, clients in the 'Recovered' group were already within the engagement and experiential processing stages. They were willing to talk about their BD experiences. 'Recovered' clients demonstrated active involvement as they openly talked about their internal states, mood and cognitions and demonstrated more emotional expression, in comparison to the 'No Change' group. In session 12, the clients in the 'Recovered' group appeared to be within the change and recovery stage in the Pyramid of Principles, as they were referring to changes made within therapy and reported that they were thinking differently about their moods, and coping with situations better. They appeared to have developed an 'internal therapist' (Knox, Goldberg, Woodhouse & Hill, 1999), whereas the 'No Change' group still appeared within the experiential processing and formulation stages. Clients in the 'Recovered' group took responsibility for their extreme and contradictory beliefs and behaviours, which is in line with TEAMS aims (Mansell et al,

2007).

The therapists within TEAMS were shown to be appropriately responsive to clients, and there was little variability in therapist behaviours and adherence to the TEAMS model across both groups and sessions. The only difference across groups in relation to the therapist was linked to the therapy structure and completion of the trial measures mainly within the 'No Change' group. Overall, the study's findings relate to Lambert (1992), who highlighted that 40% of variance in client involvement was due to client variables and extratherapeutic factors, such as knowledge, strengths and abilities, and readiness to change. Other factors related to therapeutic relationship (30%), expectancy (15%) and therapist effects (15%).

The findings from the template analysis highlighted that client involvement, i.e. how clients participate and contribute to the therapy process, was an important factor within the TEAMS. This is in line with previous research, which has demonstrated client behaviours commonly contribute to change in psychotherapy outcomes (Bohart & Tallman, 1999, 2010; Dreischner et al., 2004; Hill, 2005; Morris et al., 2014). The results mirror Bohart's (2006) finding that clients who were actively involved within the therapy process had better outcomes when compared to those who were less involved. Likewise, it seems that client expectations also play a role, as there needs to be some expectations from the client about what therapy involves (Barick, 2002). The findings also relate to Friedlander, Escudero and Heatherington's (2006) study, in which positive client behaviour involved introducing problems to discuss, and negative client behaviours were focused on questioning the value of therapy.

The differences across groups found within this study also link with Joyce et al.'s (2016) study on what individuals found to be helpful within TEAMS. It was reported that there were mixed views on what individuals found to be of benefit within TEAMS. Some individuals found specific techniques within the therapy and the

opportunity to talk as useful elements; whereas some did not find the therapy helpful and were only interested in the research element of the process. This might have had an impact on client involvement and active participation within the therapy process.

Overall Limitations

When considering the results of the study, a few limitations should be noted. Firstly, the sample sizes in Study 1 (n=33) and Study 2 (n=12) were too small to detect any significant differences and patterns. There were no statistical analyses conducted within Study 2, and so caution must be taken when making comparisons between the groups on the quantitative measures. In addition, this small sample size might not accurately represent the population of people diagnosed with BD. Future research within this area requires larger sample sizes in order to examine sudden gains and processes of change in psychological interventions for individuals with BD.

There have been few studies analysing therapy transcripts, and this study has added to the small but growing body of process research. However, the choice of qualitative analysis and the number of sessions analysed may have limited the extent of the findings. A more detailed analysis of transcripts at a conversational level may have highlighted the micro-processes of complex exchanges and interactions between the therapist and client. Nevertheless, the template analysis approach still provided unique insights into in-session client-therapist behaviours.

Furthermore, therapy processes were analysed at two time points in the TEAMS therapy, preventing the examination of trajectory of change process across the intervention. Hill (2005) suggested that therapist behaviours, client involvement and therapeutic relationship are intertwined during the therapy process, and evolve over four stages of therapy. It is worth highlighting that from the ‘No Change’ group, three clients experienced a partial gain. Another approach could have been to select and analyse sessions in which these notable changes were observed, to further understand what

might be contributing to effective change processes in individuals with BD and the effect on treatment outcome (Aspland, Llewelyn, Hardy, Barkham & Stiles, 2008; Greenberg, 2007).

Additionally, there may have been characteristics (such as personality, external factors or other underlying factors) of clients in both groups that might have impacted on outcomes which are not identified in this study.

As it has been recognised that therapeutic alliance is an important factor within the therapy process (Hill, 2005), the study could have utilised an observer rating of alliance between therapist and client across the sessions, such as the Working Alliance Inventory – observer version (WAI; Horvath & Greenberg, 1989) to identify whether there were differences in alliance across the groups, rather than relying on a self-reported measure of alliance.

As with most qualitative research, this study is steeped in interpretations. The knowledge and experience of the author on therapy processes may have influenced the interpretations made, and many other interpretations are possible. Therefore, the results should be taken tentatively.

Research and Clinical Implications

This study has provided some understanding of therapeutic processes of clinical change within the TEAMS therapy, but has also provided an addition to previous literature on change processes within psychotherapy. Most of the previous literature has focused on what therapists can do to facilitate engagement (Norcross & Wampold, 2011); however, this study shows that client behaviours are also important, which might require therapists to respond in different ways than the current model of therapy or alliance suggests.

From the findings, clinicians can only infer what underlies poor client involvement within TEAMS. There could be a number of factors involved, such as

motivation to participate in therapy (Drieschner et al., 2004), emotional disengagement (Whelton, 2004), fear of change (Arkowitz, 2002; Newman, 1994) or dependency on the medical model. There is evidence to suggest that individuals with BD have high rates of cognitive difficulties (Green, 2006; Martínez-Arán et al., 2007), which may impact on the client's ability to fully engage within therapy. TEAMS therapists need to identify and be responsive to these potential barriers to involvement.

In addition, it may be that certain clients are not ready to engage in the therapy process or be willing to learn skills to enable recovery. It is important that clinicians try to assess and acknowledge client ambivalence or resistance early on in the therapy process and support clients to address factors which might be getting in the way of engagement. Client pre-therapy preparation could be helpful in improving client involvement and outcomes (Gomes-Schwartz, 1978), by understanding client expectations and establishing clear, realistic goals before therapy and to assess whether the client is flexible and wiling to develop new skills and make changes. During therapy, some clients may need more encouragement and direction from the therapist to take responsibility for individual progress and participation (Manthei, 2007).

Furthermore, future development of TEAMS therapy should consider the impact of the research process within the therapy, and provide individuals with electronic or paper versions of measures to complete outside of the therapy session. This may allow more time within the therapeutic space to engage with clients and consider some of the client involvement factors highlighted above.

The impact of client involvement may not only be specific to TEAMS therapy and outcome. Meta-analyses of psychological interventions for BD (Miziou et al., 2015; NICE, 2015; Oud et al., 2016) have shown that only specific psychological treatments reduced relapse rates within a select subgroup of participants, and only a small effect was found in reducing overall depressive symptoms. Future RCT studies investigating

outcomes of psychological interventions for BD should consider exploring the impact of client involvement on outcomes by using process research methodology as a necessary complementary method (Elliott, 2010; Greenberg, 1986) or by using validated measures of client participation (Eugster & Wampold, 1996). This will add to the understanding of the different processes that facilitate change within psychological interventions for people with BD, which can then be used to enhance the delivery of such interventions.

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Appendix A

Ethical Approval

NHS
National Research Ethics Service
NRES Committee London - Queen Square
Room 4W/12, 4th Floor West
Charing Cross Hospital
Fulham Palace Road
London
W6 8RF

Telephone: 020 331 17287
Facsimile: 020 331 17280

21 September 2011

Dr Sara Tai
Senior Lecturer in Clinical Psychology & Hon. Consultant Clinical Psychologist
The University of Manchester
SPS, Coupland I Building,
The University of Manchester
Oxford Road
M13 9PL

Dear Dr Tai

Study title: **A Pilot Randomised Controlled Trial of Cognitive Behaviour Therapy (CBT) for People with Bipolar Disorders and Current Symptoms: Think Effectively About Mood Swings (TEAMS)**

REC reference: **11/LO/1326**

Thank you for your letter of 02 September 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered by a sub-committee of the REC at a meeting held on 15 September. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Mental Capacity Act 2005

The committee did not approve this research project for the purposes of the Mental Capacity Act 2005. The research may not be carried out on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as one Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at non-NHS sites.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

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

Document	*Version*	*Date*
Advertisement	1	19 June 2011
Covering Letter		27 August 2011
Evidence of insurance or indemnity	University of Manchester	13 July 2011
GP/Consultant Information Sheets	1	19 June 2011
Interview Schedules/Topic Guides	Appendices 6,8,10,11 & 13	19 June 2011
Investigator CV		
Letter from Sponsor	University of Manchester	13 July 2011
Other: Therapy manual - in preparation	1	19 June 2011
Other: Therapists Adherence Checklist	1	19 June 2011
Other: CVs of other key participants		
Participant Consent Form	2	02 September 2011
Participant Information Sheet	2	02 September 2011
Protocol	1	19 June 2011
Questionnaire	Appendices 7 & 9	19 June 2011
Questionnaire: Appendix 12 - Satisfaction Scale	1	19 June 2011

REC application	81745/235912/1/875	27 July 2011
Response to Request for Further Information		02 September 2011
Summary/Synopsis		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/LO/1326	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Simon Eaton
Acting Chair

Email: adriana.fanigliulo@imperial.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
"After ethical review – guidance for researchers"

Copy to: *Ms Lynne Macrae,* Faculty Research Practice Co-ordinator FMHS Research Office, 3.53 Simon Building, University of Manchester M15 6FH
Ms Kathryn Harney, Greater Manchester West Mental Health NHS Foundation Trust, NHS Foundation Trust, Harrop House, Bury New Road, Prestwich Manchester M25 3BL

Appendix B
Transcriber Confidentiality Agreement

Doctorate in Clinical Psychology, University of Sheffield

Transcribing Confidentiality Form & Guidance Notes

Type of project: Clinical Skills Assessment / Research thesis

Project title _____

Researcher's name _____

The recording you are transcribing has been collected as part of a research project. Recordings may contain information of a very personal nature, which should be kept confidential and not disclosed to others. Maintaining this confidentiality is of utmost importance to the University.

We would like you to agree:

1. Not to disclose any information you may hear on the recording to others,

2. If transcribing digital recordings – only to accept files provided on an encrypted memory stick

3. To keep the tapes and/or encrypted memory stick in a secure locked place when not in use,

4. When transcribing a recording ensure it cannot be heard by other people,

5. To adhere to the Guidelines for Transcribers (appended to this document) in relation to the use of computers and encrypted digital recorders, and

6. To show your transcription only to the relevant individual who is involved in the research project.

7. If you find that anyone speaking on a recording is known to you, we would like you to stop transcription work on that recording immediately and inform the person who has commissioned the work.

Declaration

I have read the above information, as well as the Guidelines for Transcribers, and I understand that:

1. I will discuss the content of the recording only with the individual involved in the research project

2. If transcribing digital recordings – I will only accept files provided on an encrypted memory stick

3. I will keep the tapes and/or encrypted memory stick in a secure place when not in use

4. When transcribing a recording I will ensure it cannot be heard by others

5. I will treat the transcription of the recording as confidential information

6. I will adhere to the requirements detailed in the Guidelines for transcribers in relation to transcribing recordings onto a computer and transcribing digital audio files

7. If the person being interviewed on the recordings is known to me I will undertake no further transcription work on the recording

I agree to act according to the above constraints

Your name _____

Signature _____

Date _____

Occasionally, the conversations on recordings can be distressing to hear. If you should find it upsetting, please stop the transcription and raise this with the researcher as soon as possible.

Appendix C

Analysis Examples

I: session 12 today, so we've got another 5 left including today, yeah, because it's up to [18] 16 yeah, so we have another 4 [ok] so we'll still have time with you	T: Session structure, remaining sessions
P: oh yeah we've got plenty of time haven't we?	
I: yeah so I'm here until sort of mid-November is my last week	
P: well that explains why I've thought I've felt a bit of a difference then doesn't it? Because you know especially those cycles you wrote out for me	C: Noticing difference in self, linking to cycles T wrote
I: yeah I've typed up actually today [oh, nice one] just to make them a little bit clearer so	T: Typed up cycles to make clearer
P: yeah because when I showed my partner he couldn't read it	
I: no my writing is not brilliant is it [laughter] so	
P: I have no trouble	
I: I've just done that now actually	
P: it's a shame we haven't gone into those cycles in more detail, you know	C: Wanting to go through cycles in detail
I: yeah, we can do	
P: we can do what I bring to the table	*(Interaction – person-centred)*
I: I guess yeah, it's whatever you want	
P: my memories, you know when my friends started getting high I should have written down my thoughts that week because I had a lot of self-realisations that week about how I actually am when I get high [ok] but then it just disappeared into the ether	C: Noticing thought patterns, past week self-realisations
I: right, so I mean bearing in mind that we've got, we're on 12 today, we've got 5 left, I did type these up actually so if we could put these out but are there things that would be really helpful to come back to today?	T: Reminding of session structure, remaining sessions Asking c what helpful to focus on
P: let's see what we did last week because it was quite a good session last week	C: Wanting to focus on positive session last week
I: yeah, so shall we do a bit of a recap and then decide what we want to do	
P: where we want to go forward from it	
I: ok, when I was looking back I think we were talking mostly about the lows last week, I think you weren't feeling that great, you'd rated yourself as quite low [yeah I was quite low] on the scale	T: Recaps last session
P: and I noticed it today when I was marking I thought oh did I put it down here when actually it was not at all really and I meant I'm more depressed now because I was last week. I'm quite a bit better than that, I'd say I originally marked myself lower than normal but just slightly lower [it's it ok just to] and then somebody said I seemed completely normal so I ticked that but I thought -	C: Highlighted that when completed measures, noticed changes in scores
I: right, what do you feel you were?	
P: I put it as a...	
I: right	
P: just a bit next to it	

Top-Level Theme	Second-Level Theme	Notes/ Reflections	Evidence
Client Behaviour	Active participation – Picking up on what therapist says, links to other sessions, talks about processes to engage in therapy	*Client has gone away from session and thought about what therapist has said*	Sally (S12): I think, I think it's the, it's when I've gone away and I've been thinking about what you said about: is it actually a pattern that you go down in September because of the time of year? Or is more to do with what you're doing? Well, that makes more sense to me now
		Talks about doing exercises set from other sessions	I sort of tried to do that on Sunday as well but (laughing). I closed my eyes and started breathing,
		Using therapist language in other situations	Louise (S12): and I have to pick out what words you'd use for her
		Listening to what the therapist says	Well it's interesting that you should say that
		Picks up on what therapist said last week	Mel (S12): Yeah I think I quite like thingying. I've actually had loads of discussions with my husband which is really unusual because like you said last week I'm automatically negative with everything, that's, I'm finding that a little bit difficult getting over the initial negative but it's working.
		During interaction with therapist, client seems to get distracted and checks phone.	Amanda (S12): T So, let's just write these things down. Stress, hearth condition – A Let me just check my phone.. T Do the other stuff in a minute, but stress, heart condition, asthma, um, diabetes, um – A Can I just quickly ring my girl? T Yes… A (On phone) Are you still at home?

Appendix D

Initial Template Examples

Initial Template: First sessions

Change group:	No change group:
Sally, Jodie and Emma	John and Amanda
Louise, Helen, Mel, Tracey and Alice	Jacob and George

1. **Setting up therapy structure (e.g. number of sessions, duration of sessions, outline of therapy)**

   In all sessions, the therapist somewhere towards the beginning of the sessions outlines the number, length and duration of the TEAMS sessions; talks about confidentiality and sharing of information.

   i) **Goals for therapy**
      (1) Management & tools/ strategies to take away to cope with feelings (change group) vs. wanting support and list of changes to have 'normal' moods (no change)
   ii) **Agenda setting**
      (1) Difference in groups: Set by therapist or client
   iii) **Completion of measures within the session:** (no change group completed in middle of session, with only Jacob filling in at beginning before recording) (change group varied when completed measures, but never in middle of session)

2. **Therapist behaviour**
   i) **Curious and open to client's direction**
   ii) **Collaborative: seeking input and feedback from client**
   iii) **Verbally responds to client's expressed feelings**
   iv) **Responds to patterns of content/ feeling**
      (1) Linking thoughts, feelings, behaviours
   v) **Compatible level of disclosure**
      (1) Personal self-disclosure of therapist
      (2) Use of clients own words and summarising what client says
   vi) **Boundary setting: Time management**

3. **Client involvement**
   i) **Bringing material which therapist can start to detect patterns**
      (1) Awareness and understanding of bipolar
         (a) Spontaneously relating relevant childhood experiences to present day
         (b) Recognition of moods and thinking patterns
            (i) Extreme patterns of thinking
            (ii) Self-monitoring & self-awareness
            (iii) Linking to current life stress/ triggers
      (2) Current issues/ problems in life
         (a) Discusses current relational problems

ii) Hopefulness
(1) Expectations of therapy

iii) Emotional openness
(1) Feeling safe/ connection/ trust with therapist
(2) Exploring and talking about their emotions (anger)
(3) Discusses topics freely and candidly

iv) Acceptance of self/ problem

v) Spontaneously add new information to comment made by therapist

vi) Discuss psychological strategies (Psychological mindedness)
(1) Use of metaphors to describe experiences
(2) Self-reflective

4. Risk and safety

- In the no change group, there are discussions between therapist and client around current risk and safety, e.g. suicidal thoughts (John) and risk in home (Amanda).
- Change group (Mel) talks about previous risk of suicide and ending life, but no specific questions asked by therapist about current risk and thoughts.

Template 4

Change group:
Sally, Jodie and Emma
Louise, Helen, Mel, Alice and Tracey

No change group:
John and Amanda
Jacob and George

Themes	Description
1. Setting up therapy structure (e.g. number of sessions, duration of sessions, outline of therapy)	***Session 1:*** In all sessions, the therapist somewhere towards the beginning of the sessions outlines the number, length and duration of the TEAMS sessions; talks about confidentiality and sharing of information. ***Session 12:*** Majority recap on session 12 and highlight how many sessions are remaining. Outline of therapy and states.
i) Goals for therapy	***Session 1:*** Management & tools/ strategies to take away to cope with feelings (change group) Brought a list of changes, to have 'normal' moods (no change)
i) Agenda setting	Whether this is set by therapist or client and who takes lead in setting agenda and following it
ii) Measures within the session	***Session 1:*** No change group completed in middle of session, with only Dave filling in at beginning before recording Change group varied when completed measures, but never in middle of session ***Session 12:*** Discussion of measures within session – recovered group
2. Therapist behaviour	
i) Curious and open to client's direction	Taking client lead within session, showing interest in client discussion - Sometimes therapist might push client topic to discuss later
ii) Collaborative approach	Asking what client thinks, working together to understand thoughts, feelings and behaviour
iii) Verbally responds to client's expressed feelings	Picks up on what client says in terms of feelings and elaborates
iv) Responds to patterns of content/ feeling *(1) Linking thoughts, feelings, behaviours*	Noticing content of client discussion and drawing links to patterns – in relation to either thoughts, feelings, behaviour
v) Compatible level of disclosure *(1) Personal self-disclosure of therapist* *(2) Use of clients own words*	Therapist provides some personal information about themselves in relation to discussion/ content Therapist uses client words and provides

and summarising what client says	summaries
vi) Normalising, validating mood and experience	
vii) Boundary setting: Time management	Therapist making note of time and boundary setting of session
3. Client involvement	
i) Bringing material which therapist can start to detect patterns *(1) Awareness and understanding of bipolar* (a) Spontaneously relating relevant childhood experiences to present day (b) Recognition of moods and thinking patterns (i) Extreme patterns of thinking (ii) Self-monitoring & self-awareness (iii) Linking to current life stress/ triggers *(2) Current issues/ problems in life* (a) Discusses current relational problems (b) New way of being in relationship	 Recognising extreme patterns, talking about finding middle ground Monitoring thoughts, moods and have some self-awareness of impact of these Talks about relationships
ii) Hopefulness *(1) Expectations of therapy*	
iii) Emotional openness *(1) Feeling safe/ connection/ trust with therapist* *(2) Exploring and talking about their emotions* *(3) Discusses topics freely and openly* *(4) Talk about physiological symptoms in relation to mood/ thinking*	

iv) Acceptance of self/ problem	
v) Psychological strategies (Psychological mindedness) *(1) Use of metaphors to describe experiences* *(2) Self-reflective in discussion*	
vi) Changes in therapy (1) Discusses new patterns of behaviour/ feelings (2) Discuss changes in thinking and behaviour, strategies using to change behaviour – used outside of therapy session **(3)** Taking responsibility	
vii) Active participation	
4. Risk and safety	In the no change group, there are discussions between therapist and client around current risk and safety, e.g. suicidal thoughts (John) and risk in home (Amanda). Change group (Mel) talks about previous risk of suicide and ending life, but no specific questions asked by therapist about current risk and thoughts.

Appendix E

Quality Control and Reflexive Process

AIMS: To audit the data analysis process i.e. check themes are warranted and grounded in the raw data. To also consider reflexivity, i.e. the influence of the researcher on the analysis process.

Aims of research: Comparison of session one and session twelve from change and no change group following TEAMS therapy – see whether or not there are differences between two groups of clients – exploratory research process. Is it therapist factor, client factor, therapeutic alliance?

The peer auditor will be provided with the following, in advance of the peer supervision session:

- Non-annotated transcripts: session one and twelve of change client and session one and twelve of no change client
- Annotated transcripts
- Final template of themes

Each peer auditor will follow the steps below:

1) Read the non-annotated transcripts to familiarise themselves with the data.
Note down initial thoughts of themes, anything that stood out - what therapist or client says.

2) Read the annotated transcripts and template analysis. Be observant of any sections completely missed (i.e. no emergent themes noted).

3) Work through the transcript length and code using the template

- Has the theme come from the data, yes or no?
- Note themes difficult to employ to the text
- Aspects of the text not covered by template
- Is the account coherent & plausible? Could anything be clearer?
- Other issues identified in the process

4) Discuss thoughts from the process with the researcher especially any additional ideas on anything of interest/importance, which may have been missed.

5. Discuss the reflexivity processes for the clients presented. Consider as a minimum the emotional impact of transcripts, previous theoretical understandings, and personal characteristics of the researcher that may have impacted on the analysis process.

References

Harper, D., & Thompson, A. (2012), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners*. UK: Wiley-Blackwell.

King, N. (2004). Using templates in the thematic analysis of texts. In G. Symon, & C. Cassell, (Eds.) *Essential guide to qualitative methods in organizational research.* (pp.256-270). London, UK: Sage Publications Ltd.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215-228.

Appendix F

Individual Session-by-Session Graphs

Client-HAPPI, Therapy Rating Scores and Teams-Treatment Adherence Checklist (T-TAC)

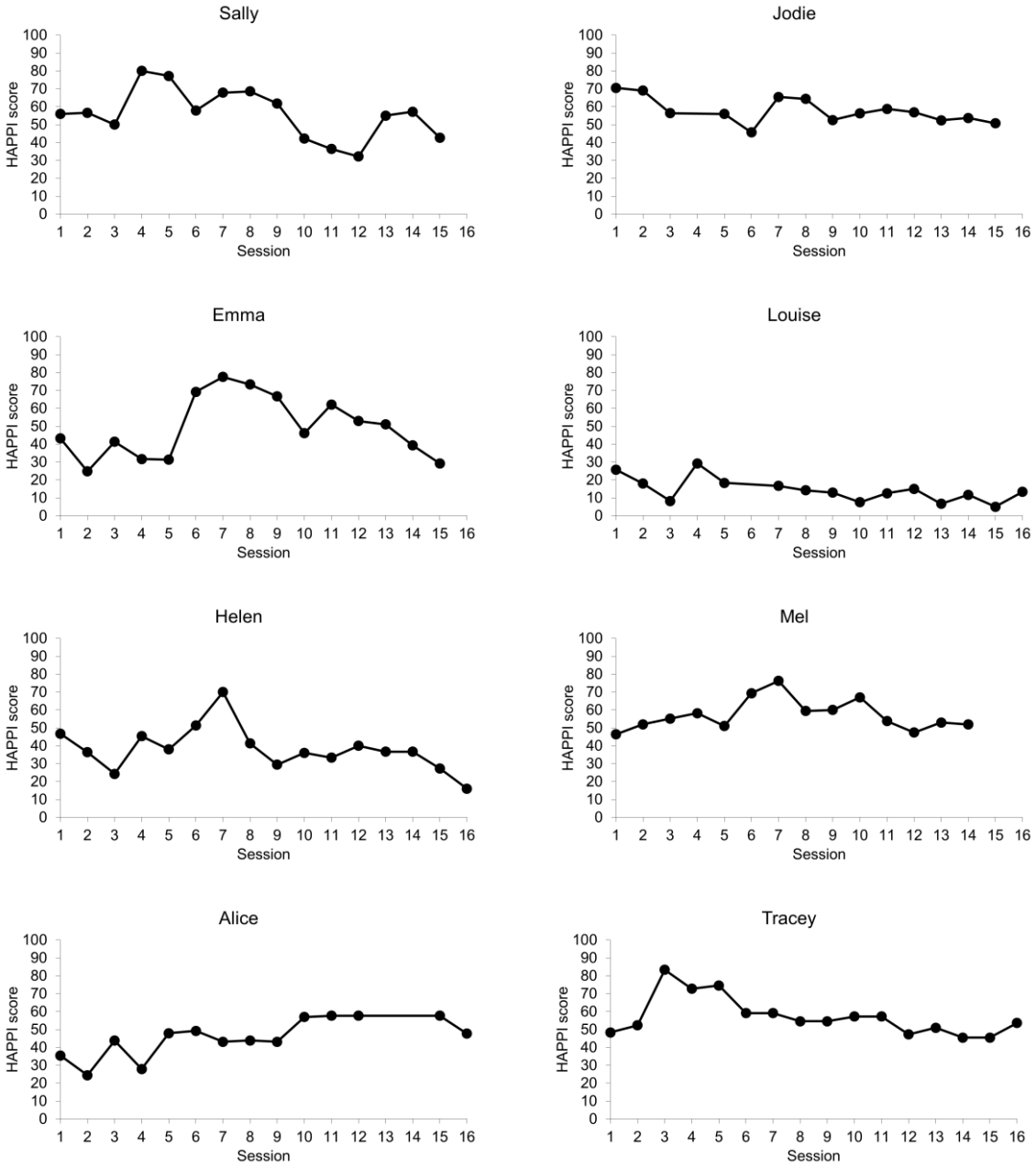


Figure A1. Recovered group session-by-session Client-HAPPI scores

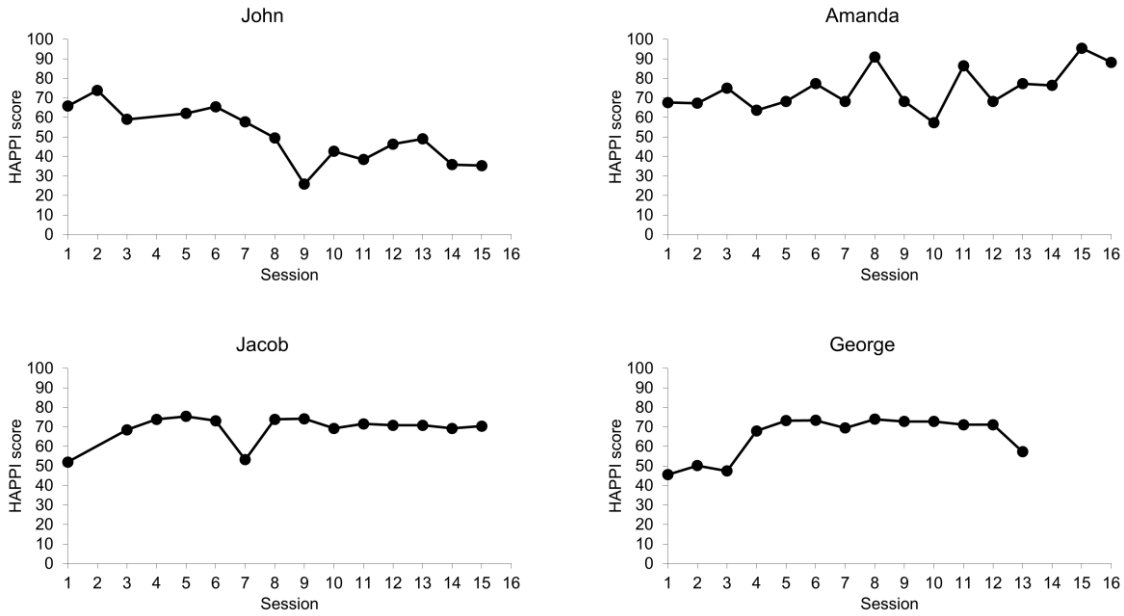
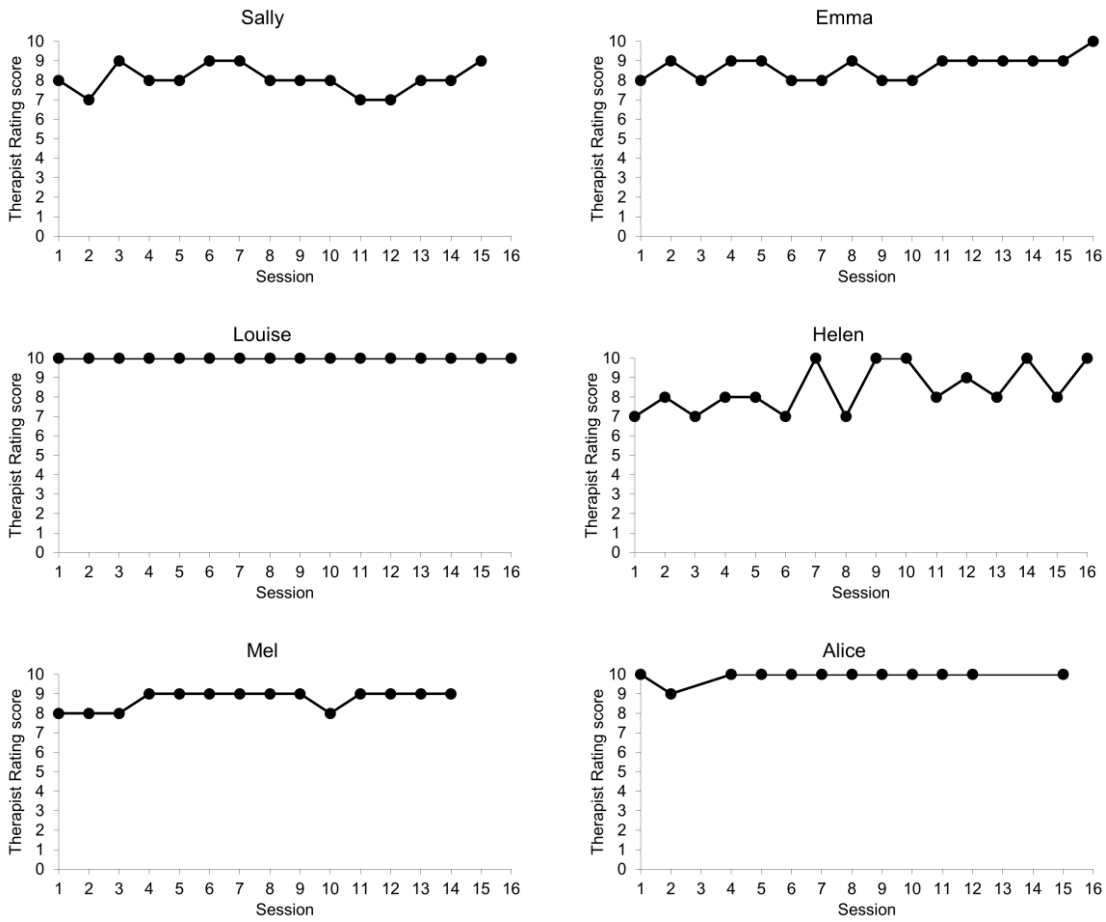


Figure A2. No change group session-by-session Client-HAPPI scores



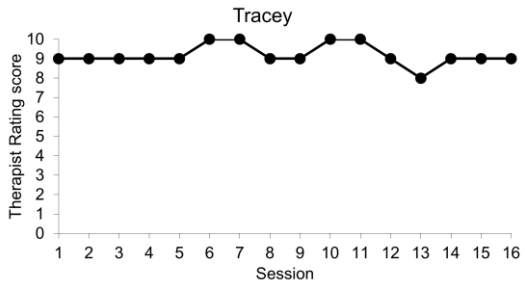


Figure A3. Recovered group session-by-session Therapist Rating scores

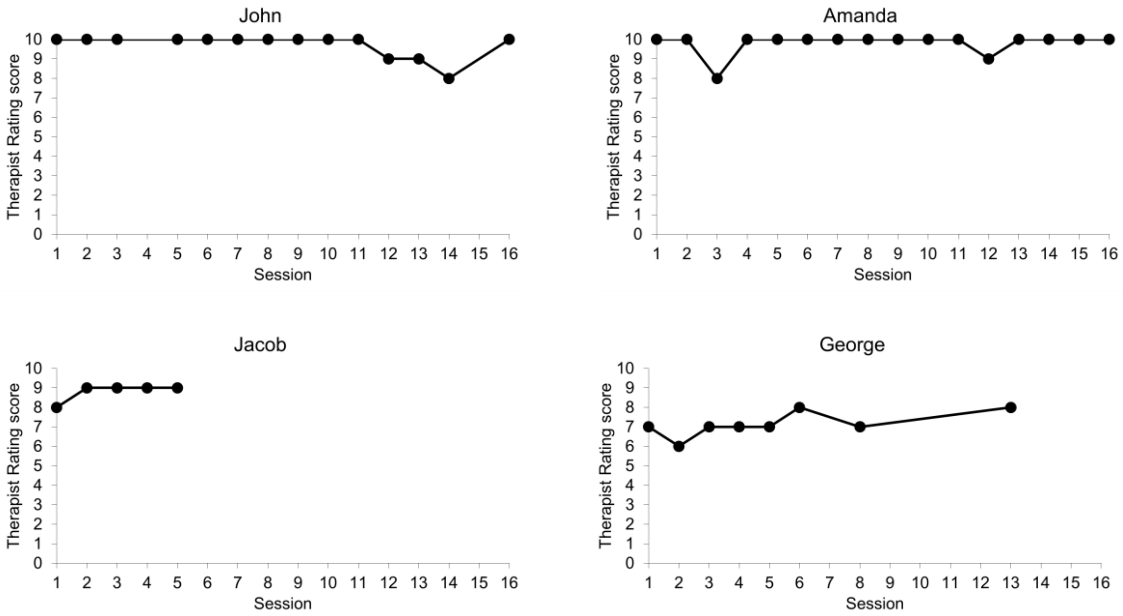
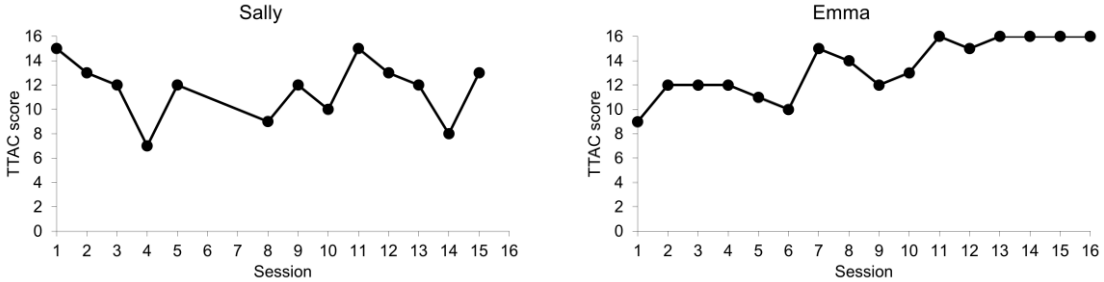


Figure A4. No change group session-by-session Therapist Rating scores



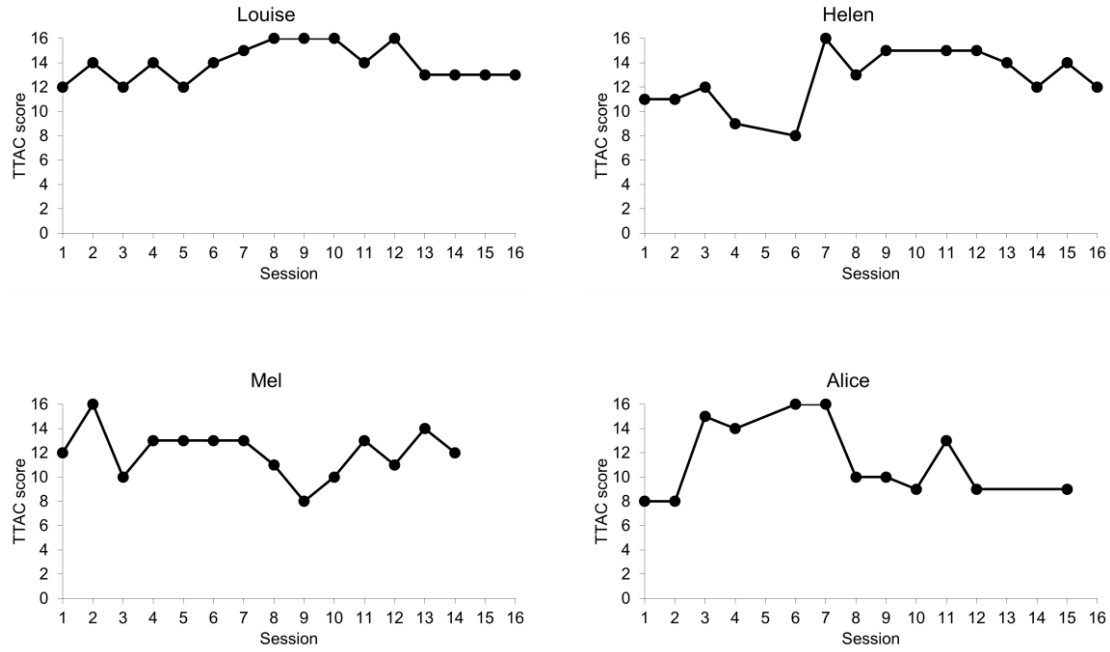


Figure A5. Recovered group session-by-session T-TAC scores

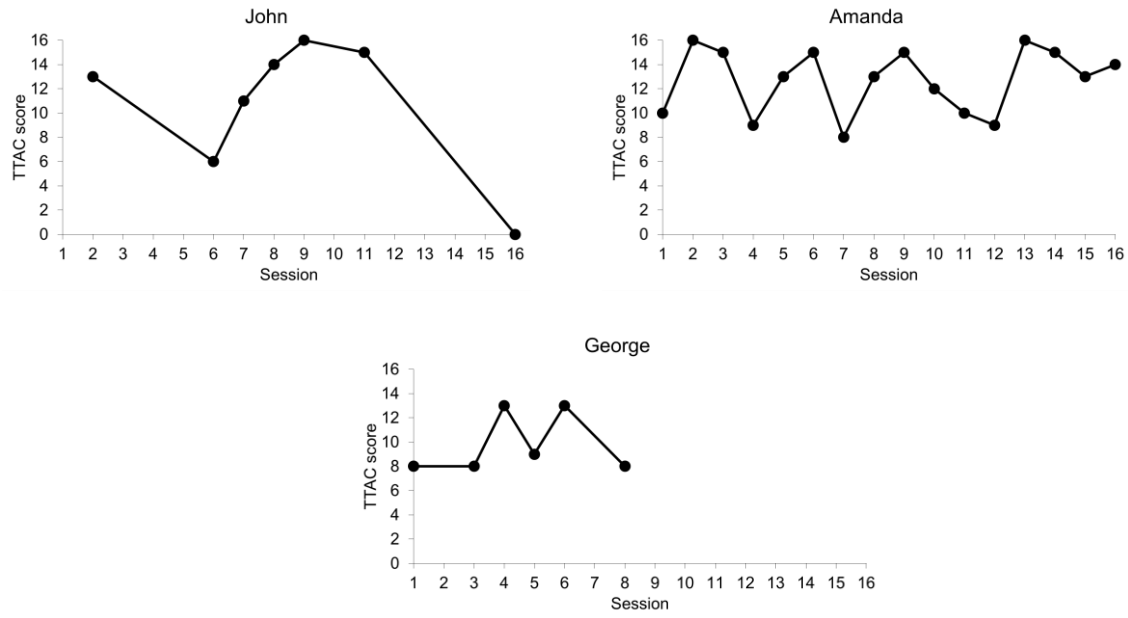


Figure A6. No change group session-by-session T-TAC scores

Appendix G

Final Template

(p) = priori themes	**Description**	**Similarities/ Differences**
1. Therapy structure		
1.1. Setting up sessions	*Session numbers, duration, confidentiality and sharing of information*	Same: For both groups in session 1 and 12
1.2. Goals for therapy (P)	*Individual goals for therapy and whether these are revisited*	**Differences** between goals set in change and no change group (Session 1) No change group – session 12
1.3. Agenda setting	*Therapist or client led: Therapist or client adding to agenda*	Same: For both groups in session 1 and 12Agenda jointly set by therapist and client
1.4. Completion of measures	*Completion of trial measures and satisfaction measures at end of session*	**Difference:** Session 1: Change group - All complete measures at beginning or end of session to take away and bring back (no mention of measures for Louise) Session 12: Change group – track changes and go through measures Session 1: All but Jacob complete measures in middle of therapy session.
1.5. TEAMS model		
1.5.1. Outline model	*Explaining TEAMS model, person-centred approach - focus on what client wants to focus on*	Same: Therapist explains model to both groups in session 1
1.5.2. Naming individual states	*Client or therapist talks about naming internal self-states*	Same: Naming of self-states in both groups in session 12
1.5.3. Use of scaling questions	*Scaling questions (1-10) relating to mood and thought experiences, asking what each would look like on different points on scale*	Same: For both groups in session 1 and 12
1.5.4. Use of diagrams in session	*Therapist writes/draws out links between mood, thoughts and feelings and shares with client*	Same: For both groups in session 1 and 12

1.5.5. Brings focus on here & now	*Therapists asks how client is feeling/ thinking in session - brings client to here and now focus on body sensations and feelings*	Same: For both groups in session 1 and 12
1.6. Time management	*Therapist reminds client how much time is left within the session*	Same: For both groups in session 1 and 12
2. Risk and safety	*Issues of risk and safety raised in session*	**Difference:** Change group: Louise, session 12 - Therapist asks about risk to daughter; Mel, session 1 - talks about previous risk of suicide and trying to end life and impact on family, but no current risk highlighted; Alice, session 12 - risk of son No change group: John, session 1 - feeling suicidal, therapist focuses on developing safety risk plan; Amanda, session 1 – current safety within home, fire risk
3. Therapist behaviour		
3.1. Curious and open to client direction	*Follows direction of client, includes checking in/ maintaining focus if this was agreed, picking up on C words to initiate further discussion*	Same: For both groups in session 1 and 12 **Difference:** John, session 1 - therapist follows own agenda; acknowledges John's topics, but states to discuss later); George, session 12 - follows own agenda but links in with what George says; Therapist takes more direction, states to discuss later.
3.2. Collaborative (P)	*Working together to understand patterns in thinking, mood and behaviour*	Same: For both groups in session 1 and 12
3.3. Verbally responds to client's feelings & behaviour (P)	*Picking up client in-session emotion and behaviour*	Same: For both groups in session 1 and 12
3.4. Responds to patterns of content (P)	*Picks up client content and makes patters. Includes linking content to previous sessions (session 12)*	Same: For both groups in session 1 and 12
3.5. Use of self	*Therapist provides some personal information about themselves in relation to the discussion*	Same: For both groups with Therapist 2

3.6. Clarification, summarising and using client words (P)	*Therapist uses clarification questions to increase understanding of client difficulty, offer summaries of client descriptions and use of client language, e.g. metaphors and imagery*	Same: For both groups in session 1 and 12
3.7. Use of minimal encouragers	*Therapist uses minimal encouragers, used when client talking freely*	**Difference:** Change group: Mainly in session 1 as client bringing more content No change: Therapist asking more questions, discussion
3.8. Normalising and validating client experience		Same: For both groups in session 1 and 12
4. Client behaviour		
4.1. Bringing therapeutically relevant material (P)	*Client brings useful material to session for therapist to make links, understanding*	**Difference:** Change group: Session 1 and 12, bringing useful therapeutic material to session for discussion No change group: Less content brought to session
4.1.1. Awareness and understanding of bipolar	*Understanding self vs. disorder*	**Difference:** Change group: Session 1 and 12 link more to experience and understanding of bipolar disorder
4.1.1.1. Spontaneously relate to childhood experiences (P)	*Client brings in relevant information about past/ childhood experiences to relate to current discussion, makes links with past information*	**Difference:** Change group: session 1 and 12 make more links to past and childhood experiences No change group: Less links to past experiences and reluctance to talk about childhood, or don't bring to session
4.1.1.2. Recognition of moods and thinking patterns	*Talking about different extreme moods and thought processes and its impact*	Same: For both groups in session 1 and 12
4.1.1.3. Talking about physiological symptoms (P)	*Client talks about how they feel physically, either relating to past experiences or in the room*	**Difference:** Change group: Session 1 and 12
4.1.1.4. Making links to life stress and triggers	*Client makes links to stress and triggers*	Same: For both groups in session 1 and 12
4.1.1.5. Talks about previous relapse experiences	*Talking about experience of previous relapse and impact on others and self*	**Difference:** Change group: Session 1 and 12

4.1.1.6. Being in control	*Client talks about being in/ out of control*	Same: For both groups in session 1 and 12
4.1.1.7. Finding mood stability	*Finding a good place, middle ground for mood*	Same: For both groups in session 1 and 12
4.1.2. Discusses current relational problems (P)	*Client talks about current relational difficulties they have been having*	**Difference:** Change group: session 1 and 12: relate more to current relational difficulties and display level of empathy and understanding
4.2. Levels of hope and expectations of therapy (P)	*Talks about levels of hope from the therapy and what hope to gain from therapy. Also includes prior expectations of therapy or therapist*	**Difference:** Change group: Levels of hope and expectations of therapy and therapist different to No change group (both session 1 and 12)
4.3. Acceptance and normalising	*Client talks about accepting their bipolar symptoms, see as positive aspect and living life despite BD, normalising their experience*	**Difference:** Change group: Session 1 and 12 talk about acceptance and normalising experience
4.4. Emotional openness		
4.4.1. Exploring, talking about and expressing emotions (P)	*Client openly talks about their emotions*	**Difference:** Change group: session 1 and 12, openly talk about emotions such as anger, guilt, blame. Awareness of emotions and willing to tolerate emotional distress No change group: Hard to deal with emotions, block emotions, not able to feel emotions, not understanding emotions
4.4.2. Discusses topics freely (P)	*Client talks freely about a topic, spontaneously adding in new information or experiences*	**Difference:** Change group: Discuss topics more feely in both session 1 and 12
4.4.3. Feeling safe and connected with therapist (P)	*Verbally acknowledges they feel safe or connected with therapist*	Same: For both groups in session 1 and 12
4.5. Use of humour (P)	*Client brings in humour, light-heartedness to session*	Same: For both groups in session 1 and 12

4.6. Active participation (P)	*Whether client is actively engaged and participating in session. E.g. picking up on what T says and elaborates, or is just agreeing with what T says, but no follow up*	**Difference:** In levels of active participation across session 1 and 12
4.7. Psychological mindedness		
4.7.1. Use of metaphors	*Clients use metaphors and imagery to describe experiences*	Same: For both groups in session 1 and 12
4.7.2. Use of psychological strategies (P)	*Talk about using psychological strategies - helpful/ unhelpful, recognising*	**Difference:** Change group: Session 1 and 12, talk more about using different psychological strategies: positive thinking, ACT, mindfulness, CBT principles
4.7.3. Self-reflective (P)	*Client talks about topics in a self-reflective manner, i.e. notices how feels, thinks and responds in situations*	**Difference:** Change group: Session 1 and 12 talk about experiences in a more self-reflective way
4.7.4. Attitudes towards medication	*Biopsychosocial model, accepting of medication but in conjunction with psychology*	**Difference:** Change group: Talk about negative side effects, but use of medication in combination with thoughts and psychology No change group: (Jacob) importance of medication and biological understanding of problems
4.8. Making changes in and out of therapy (P)	***Mainly session 12***	
4.8.1. New patterns of behaviour and interactions (P)	*Client talks about noticing or consciously changing behaviour*	**Difference:** Change group: Noticing and making changes in behaviour and relationships, others noticing
4.8.2 Changes in thinking	*Client notices changes in their thinking and perception*	**Difference:** Change group: Thinking differently about moods
4.8.3. Taking responsibility (P)	*Clients talk about taking responsibility for behaviour*	**Difference:** Change group: Taking on individual responsibility to manage bipolar No change: Wanting others support