The Experiences of Therapists Working in Improving Access to Psychological Therapies Services

By

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A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology

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Faculty of Science

Declaration

I declare that 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.

Word Count

Literature Review	**7988**
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Lay Summary

Improving Access to Psychological Therapies (IAPT) services were implemented in England to meet the needs of adults experiencing depression and anxiety. IAPT services are under pressure to meet the needs of increasing numbers of individuals who require the service. Practitioners working in these settings also experience additional pressures to meet recovery rate targets with clients. The experience of burnout has been demonstrated amongst individuals working in IAPT settings and the negative impact of service and organisational pressures on IAPT workers has also been investigated. Ultimately, the experiences of IAPT therapists and practitioners, especially if they feel burnt out and stressed, can impact negatively upon their work with clients.

With this in mind, it is imperative that the experiences of individuals working in IAPT are explored to understand more about what it is like to work in this setting. This is important in order to ensure that IAPT services can develop and improve whilst considering the views and experiences of their workers. It is also essential in making sure that therapists and practitioners are offered the support that they need and want within the service.

A meta-synthesis of 15 studies was carried out to understand more about the experiences of IAPT practitioners. The findings from this thematic synthesis identified a number of themes including the concept of the development of the therapeutic relationship, the social and cultural context of clients and the experience of developing and working in an IAPT setting. Participants also expressed their need for support and the impact of IAPT service pressures on therapists and practitioners. The results found that there was overlap across the themes that captured participants' experiences and a

tension between flexibility and adherence within IAPT services was identified. The study limitations, clinical implications and ideas for future research are discussed.

A study exploring the experiences of IAPT therapists was conducted to understand more about what factors IAPT therapists believe impact upon client outcomes. The 12 therapists involved in this study had been involved in a research trial in their IAPT service and the study also aimed to explore their experiences of working as part of this trial. Template analysis was used to analyse the data gathered from semi-structured interviews with 7 CBT therapists and 5 counsellors. Results revealed common themes across both groups of therapists. The therapeutic relationship was considered very important by therapists and that therapist and client factors contribute to its development. Participants also discussed the importance of being supported at work and the impact of service pressures on them. Additionally, participants discussed their own emotional wellbeing. Experiences of working on a trial were also shared amongst participants. Unique themes included the experiences of counsellors working in an IAPT service and the trial being experienced as exciting by CBT therapists and seen as supporting their profession by counsellors. Study limitations are discussed and it was concluded that IAPT services should consider the impact of service pressures on their workers.

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Section One: Literature Review

The Significant Aspects of working in Improving Access to Psychological Therapies Services for Practitioners: A Meta-Synthesis

Abstract

Objectives

This meta-synthesis aimed to understand the experiences of practitioners working in an IAPT setting. Additionally, it sought to critically appraise the quality of the literature exploring this phenomenon.

Design and Methods

A systematic search was carried out using three major databases and a grey literature database. Fifteen studies that met the inclusion criteria were included and data from these studies was analysed using thematic synthesis.

Results

Five analytical themes were identified in the data: *Social and cultural context; Developing a therapeutic relationship; Developing and working in an IAPT setting; Need for support; IAPT service structure and pressures.* Synthesis of the data revealed a tension between flexibility and adherence that was captured within each of the analytical themes.

Conclusions

The therapeutic relationship highlights how highly therapists working in IAPT settings value this in their work. Additionally, the need for staff support and experiences of organisational pressures were also prominent experiences for IAPT therapists. The wider context of clients accessing IAPT was also highlighted by practitioners. The findings suggest that practitioners working in IAPT often experience a tension between being flexible to meet client needs, for example, and adhering to protocols used within an IAPT framework.

Practitioner Points

- IAPT services should review the impact of service pressures on its staff to reduce burnout.
- Additional training for IAPT practitioners could be considered to enable workers to feel more skilled and confident in their roles.

Keywords

IAPT, practitioners, thematic synthesis, qualitative

Introduction

There is considerable evidence to show that healthcare professionals experience burnout (Bridgeman, Bridgeman, & Barone, 2018). Lomas, Medina, Ivtzan, Rupprecht and Eiroa-Orosa (2018) found in their meta-analysis that this is a persistent experience for staff and stress and strain were the most investigated experiences for healthcare staff. There has been an abundance of research regarding mental health professionals' wellbeing and reported high levels of burnout (Dobie, Tucker, Ferrari, & Rogers, 2016; O'Connor, Neff, & Pitman, 2018; Raab, Sogge, Parker, & Flament, 2015; Rocco, Dempsey, & Hartman, 2012).

The Five Year Forward Plan from the independent Mental Health Taskforce to the NHS England (2014) highlights the importance of supporting staff who work in mental health care in the NHS, with specific reference to the wellbeing of professionals working in this context. An important finding highlighted in the Five Year Forward Plan is that 43% of mental health workers reported that work related stress was the primary reason for their absence from work. In light of these findings it is imperative to understand staff experiences in more detail in order to support professionals, given what we know about the increased risk of burnout and stress.

Improving Access to Psychological Therapy (IAPT) services were introduced in the National Health Service (NHS) in England to increase the availability of psychotherapy for those experiencing depression or anxiety (Clark, 2011). NHS England (2017) report that 560,000 individuals enter therapy through IAPT each year (Clark, 2018). IAPT services are often the first experience individuals have of mental health services and the Five Year Forward plan highlights that 9 out of 10 individuals accessing mental health care are supported through IAPT.

Given the role that IAPT practitioners play in the supporting a large number of individuals with emotional difficulties in England, it is important to ensure IAPT staff are supported so that they can deliver therapy effectively and with reduced risk of burnout. One way in which to support IAPT practitioners effectively is to understand their experiences of working within this setting. Research regarding therapists working in IAPT has consistently highlighted that, as a professional group, they experience high levels of burnout. A study involving eight IAPT services found that practitioners commonly showed high levels of emotional exhaustion and burnout was shown to be predicted most strongly by service-related pressures, such as job demands (Steel, Macdonald, Schröder, & Mellor-Clark, 2015). Westwood, Morison, Allt, and Holmes (2017) explain that IAPT therapists are at high risk of experiencing burnout and their study identified that emotional exhaustion was strongly associated with feeling under pressure.

A literature search highlights some studies have investigated the levels of burnout in IAPT therapists, however Mason and Reeves (2018) argue that there is a paucity of published research regarding the overall experiences of those working in an IAPT setting. Therapy success is highly monitored in IAPT services through patient reported outcome measures (PROMS) and IAPT services are focused on generating this outcome data to measure the effectiveness of their interventions (Clark, 2011; Clark et al., 2018). It is likely that this may have an impact on practitioners delivering therapy in such settings and Delgadillo, Saxon, and Barkham (2018) identified that IAPT therapist burnout is contributed to by organizational pressures and that therapist burnout was strongly associated with poorer therapy outcomes. Given the increased monitoring of performance in IAPT services and additional organizational pressures, burnout is likely. Therefore, the experiences of therapists working in a highly monitored service might

provide insight into how having therapist performance monitored through clients' outcome measures impacts upon such therapists' practice.

For IAPT practitioners to be supported effectively and helpfully, information needs to be gathered to understand more about what it is like to work within an IAPT setting. In order to recognize the consequences of burnout, emotional exhaustion and the overall experience of working as a practitioner within an IAPT setting in more depth, the need to gather information and data regarding these experiences is paramount. The overall aim of the current review is therefore to synthesize the qualitative research regarding the experiences of therapists working within an IAPT context.

The aims of this literature review are:

1. To systematically identify the qualitative literature that explores the experiences of therapists working in an Improving Access to Psychological Therapies (IAPT) setting.
2. To critically appraise the research identified that explores therapists' experiences of delivering therapy within an IAPT setting.
3. To synthesize the main themes from the qualitative research identified to provide information about what the significant aspects of working in an IAPT setting are for therapists.

Method

In order to identify appropriate papers to include in this review, a systemic search strategy was developed, inclusion and exclusion criteria were identified and study quality was appraised. Finally, thematic synthesis was used to synthesise the data generated through the search. Guidance from Thomas and Harden (2008) was followed to carry out the thematic synthesis.

Systematic Search

A search in the Cochrane Library and in PROSPERO in March 2019 did not find any literature reviews on this subject that had taken place or that had been planned to take place.

In order to identify the focus of the review, a search strategy tool defined by Cooke, Smith, and Booth (2012) was implemented. The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) tool was used to identify the key elements of the review and these have been summarised in table 1.

Table 1.

Key elements of the review using the SPIDER tool

SPIDER tool component	Key elements
Sample	Therapists working within an IAPT setting
Phenomenon of Interest	Experience of working within an IAPT context
Design	Interviews, case studies, focus groups, qualitative questionnaires
Evaluation	Experiences and attitudes
Research Type	Mixed methods, qualitative

Searches were carried out using three electronic databases; Scopus, PsychINFO and Web of Science. Grey literature was also searched using the electronic database OpenGrey. The SPIDER tool was used to identify search terms and these were used to generate the literature search. Search terms included: "(qualitative) AND (therapist) AND (experience) and (IAPT)". The full list of the search terms employed can be found

in appendix A. Once literature was generated, titles and abstracts of articles were reviewed using the inclusion and exclusion criteria listed in table 2 to identify papers appropriate to be included in the analysis.

Table 2.

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Qualitative in design that generated data either exclusively qualitative or part of a mixed-methods design	If the article is not peer reviewed
Focused fully or partially on therapists working in an IAPT setting and their experiences of this	Published in languages other than English

The full text of articles that were deemed to be appropriate to review further according to the criteria in table 2 were screened using the same criteria. Any duplicate articles were removed and figure 1 shows the process undertaken to identify appropriate papers using a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram (Moher, Liberati, Tetzlaff, Altman, 2009). Fifteen papers were identified that met the inclusion criteria.

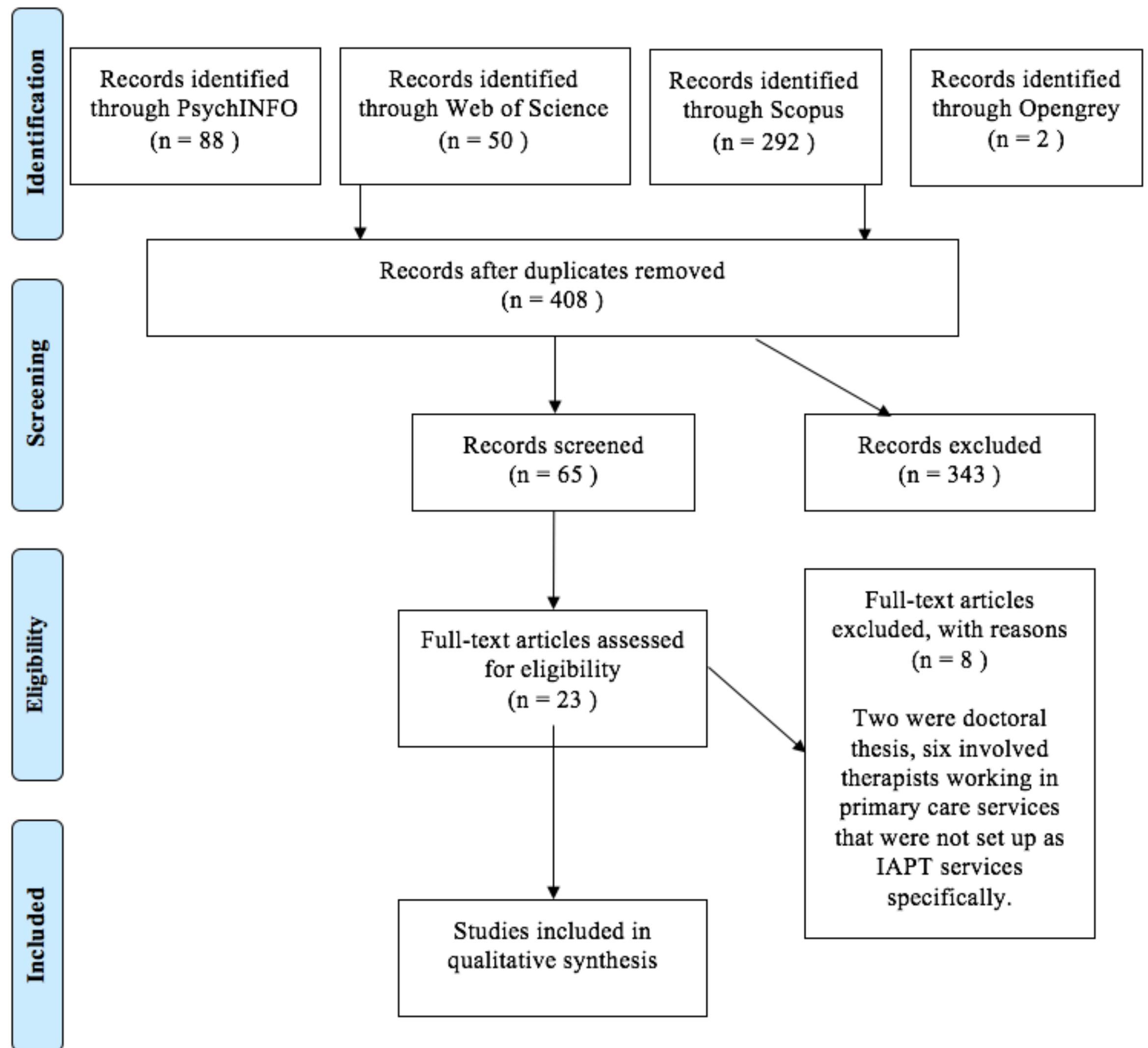

Figure 1. PRISMA diagram outlining search strategy used.

Quality Appraisal

The Critical Appraisal Skills Programme Checklist for Qualitative Research (CASP, 2013) was used to assess the quality of all of the studies identified (appendix B). The CASP tool for qualitative research (2013) suggests that a scoring system is inappropriate and therefore Dixon-Woods et al.'s (2007) categories were adopted to organise and classify the quality level of each paper and these have been included in table 3. A paper was identified as a key paper if the study met the criteria for qualitative research identified by the questions in the CASP tool. Where papers were rated as

satisfactory, the papers did not meet all of the criteria but the majority was met. A table summarising the CASP tool ratings and Dixon –Woods et al.'s (2007) categories for each study can be found in appendix C.

Table 3.

Categories used to illustrate the quality assessment of each study from Dixon-Woods et al. (2007)

Code	Category
KP	Key paper which should be included in the review
SAT	Satisfactory paper to be included in the review
U	Unsure as to whether the paper should be included in the review
FF	Fatally flawed paper which should be excluded

To ensure that the quality appraisal of the studies was not at risk of bias, a second trainee clinical psychologist who was also conducting a meta-synthesis appraised 20% (n = 3) of the papers. Agreement was met through discussing any discrepancies that arose. Table 4 summarises the main details of the studies included in the review and the quality appraisal classifications.

Table 4

Summary of papers and quality appraisal

Code	Study (date)	*N*	Participants	Aim	Design	Method of Analysis	Key themes	Quality Appraisal
1	Bassey and Melluish (2012)	10	CBT therapists working in IAPT services	To understand therapists' views on culture in their clinical work, their experiences of training and their experiences of working with BME clients using CBT	Semi-structured interviews in focus groups	Template analysis	Awareness; knowledge; skills; IAPT training	Unsure
2	Robinson, Kellett, King and Keating (2012)	6	High intensity IAPT therapists who had transitioned from a mental health nurse role.	To investigate the transition to HIT from a mental health nursing profession.	Individual semi-structured interviews	Thematic content analysis	Learning a new repertoire of skills; historical context; high need for support; impact of supervisor approach and style; focus of supervision; forming a new identity.	Key paper
3	Shankland and Dagnan (2015)	55	IAPT therapists	To explore the views of IAPT therapists in relation to working with people with intellectual disabilities.	Online questionnaire with qualitative and quantitative components	Thematic analysis	Equality; therapists' negative expectations; specific problems with using a mainstream setup; positive solutions; engagement; ability to learn new skills; availability of suitable resources; communication; therapists' confidence and skills; positive outcomes for the patient; positive outcomes for the therapist; patient's limitations; limitations of the therapist; limitations of the system or mainstream setup.	Satisfactory

4	Altson, Loewenthal, Gaitanidis and Thomas (2014)	5	Non-IAPT therapists working in an IAPT setting	To investigate the perspectives of non-IAPT therapists working in an IAPT setting	Individual semi-structured interviews	Foucauldian discourse analysis	Professional discourse; institutional discourse; scientific approach discourse. Crossing discourses were also identified: non-IAPT discourse vs IAPT discourse; psychological versus medical power.	Key paper
5	Millett et al. (2017)	14	IAPT therapists (women accessing IAPT were also in the study but have not been included here).	To investigate the views of women accessing IAPT for perinatal support and IAPT therapist perspectives.	Two focus groups	Thematic analysis	Barriers to access; flexibility individualisation and choice; constraints of the IAPT framework; lack of perinatal-specific training and resources; a non-baby friendly environment; involving fathers.	Key paper
6	Gellatly et al. (2017)	20	PWPs delivering interventions for those with an OCD diagnosis.	To explore the experiences of PWPs working as part of a large RCT.	Individual semi-structured interviews	Constant comparative method alongside thematic analysis	Flexibility in intervention delivery and fit with patient lifestyle; need to tailor interventions to fit with patient need; integration between new treatment models and existing protocols; limitations in the model used to deliver low intensity interventions; capacity to develop confidence and skills; capacity of low intensity interventions to disenfranchise practitioner role.	Key paper
7	Newbold, Hardy and Byng (2013)	27	Staff members working in different IAPT services (clients accessing IAPT support were involved in the study but have not been included here)	To understand and explore staff perspectives of group-based interventions in an IAPT setting.	Individual semi-structured interviews	Framework analysis	Self-disclosure; normalisation; group cohesion; group support; the benefits of sharing experiences; the role of hope; problems with group interaction; suggested improvements. (only highlighted themes with staff comments included).	Satisfactory
8	Turner, Brown and Carpenter (2017)	9	IAPT practitioners who had worked with	To understand the experiences of IAPT practitioners using over the telephone	Individual semi-structured interviews	Thematic analysis	The therapeutic relationship and embodied presence; the therapeutic relationship and auditory presence; proper	Key paper

			clients face to face and/or over the telephone.	methods to work with clients.			therapy or "life coaching"; widening access: democratizing therapy?; the nuts and bolts: bureaucratising therapy; time for therapy: "that time pressure"; therapy in the 21st century: "production line therapy"	
9	Jones, Bale and Morera (2013)	9	IAPT therapists (psychological wellbeing practioners and high-intensity therapists).	To explore the views of practitioners towards using telephone assessments.	Semi-structured questionnaires	Thematic analysis	Worried anticipation vs. actual experience; timely efficiency; the "riskiness' of risk; positive rapport; patient perspectives; environmental impact.	Satisfactory
10	Rizq (2011)	5	Counsellors working in an IAPT service.	To explore the experiences of counsellors in IAPT working with clients with a diagnosis of borderline personality disorder	Semi-structured interviews	Interpretive Phenomenological Analysis	Recognition and implications; managing feelings of inadequacy; managing dilemmas in the primary care context.	Satisfactory
11	Mason and Reeves (2018)	1	The first author who worked in an IAPT service	To explore how working as a counsellor in an IAPT service affected the first author both professionally and personally.	Three documents written previously by the author regarding personal and professional development.	Analytical auto-ethnography	The loss of a counsellor's validity after the implementation of IAPT; the uncertainty of counsellor's being "out group" in IAPT; the gain that comes with acculturalisation into the IAPT programme; the certainty that comes with being "in group" within IAPT.	Key Paper
12	Watson, Carty and Becker (2017)	16	Therapists in an IAPT setting who have worked with a female client over 45 years of age.	To explore the experiences of practitioners when working with mid-life and older women and intimate partner violence in an IAPT setting.	Face to face interview.	Grounded theory	"Helpless helper" framework developed with underlying themes: hidden referrals; presentation severity; practitioner experience; perceived incompetence; emotional state; helplessness; assuming; avoiding; treating the symptoms; referring to others; rescuing; breaking the	Key paper

							rules; facilitator: supervision; facilitator: hope for a happy ending; block: time limits; block: conflict; burnout and vicarious traumatisation.	
13	Drewitt, Pybis, Murphy and Barkham (2017)	6	Counsellors using CfD in an IAPT setting.	To explore the views of CfD practitioners regarding their training and working in an IAPT service.	Semi-structured telephone interviews	Thematic analysis	Challenging experiences of CfD training; positive experiences of CfD training; CfD course supervision; managerial supervision experience; clinical supervision experience; impact of CfD on practice; experience of implementing CfD in a service setting.	Satisfactory
14	Tutani, Eldred and Sykes (2017)	13	CBT therapists and PWPs working in an IAPT setting	The experiences of IAPT therapists working with interpreters.	Semi-structured interviews	Thematic analysis	Negotiating a three-way interaction; challenges in communicating empathy; establishing a shared understanding; creative collaboration with interpreters.	Satisfactory
15	Hakim, Thompson and Coleman-Oluwabusola (2019)	4	PWPs in an IAPT service	To describe the experience of PWPs transition from BME community mental health workers.	Semi-structured interviews	Thematic content analysis	Training experience in two different roles; wider context; differences encountered; post-training adaptations for BME patients; undervalued cultural and language expertise; ideas for the future.	Satisfactory

Note:

CBT = Cognitive Behavioural Therapy
IAPT = Improving Access to Psychological Therapies
BME = Black and Minority Ethnic
HIT = High Intensity Therapist
PWP = Psychological Wellbeing Practitioner
OCD = Obsessive Compulsive Disorder
RCT= Randomised Controlled Trial
CfD = Counselling for Depression

Synthesis of Studies

Thematic synthesis is the process of coding data systematically to produce themes that are both or either descriptive or analytical (Nicholson, Murphy, Larkin, Normand, & Guerin, 2016). Thomas and Harden (2008) propose a method for thematically synthesizing qualitative data as part of a meta-synthesis. Thematic synthesis is made up of three stages which are included in table 5.

Table 5.

The Stages of Thematic Synthesis from Thomas and Harden (2008)

Stage	Description
Coding the text	Line-by-line coding of text from the findings of each study
Development of 'descriptive themes'	Group codes into a hierarchical tree structure to summarise the findings of the studies into descriptive themes
Generation of 'analytical themes'	The descriptive themes are used to identify and generate new themes whilst considering the research question

Coding the text.

The results section of each study was coded line-by-line using QSR International's NVivo 12 qualitative analysis software. As suggested by Thomas and Harden (2008), the review focus was put to one side to ensure richer codes were generated. Each line of text was then coded according to meaning and content and new codes were created where appropriate. Each sentence had a code applied and some sentences were coded several times using different codes.

Development of 'descriptive themes'.

When developing the descriptive themes, differences and similarities were looked for across the initial codes generated. A hierarchical tree structure was generated to illustrate the relationships between the descriptive themes and this has been included within the results section.

Generation of 'analytical themes'.

The focus of the review was held in mind throughout the process of generating the analytical themes. This process involved using the descriptive themes in order to understand more about the experiences of practitioners working in an IAPT setting. The experiences of the IAPT therapists were inferred from their views captured by the descriptive themes to generate analytical themes that were sufficiently abstract enough to describe and explain the original descriptive themes.

Reflexivity

Reflexivity is important in qualitative research to ensure the research process is transparent and to highlight the researcher's own stance in relation to the research which may influence the process itself (Berger, 2015). Throughout the thematic synthesis process, the researcher reflected on what they were drawn to in the data and how this may have shaped the findings. Although a formal reflexive log was not kept, the researcher was aware of their focus on wider cultural and social issues present in the data. Additionally, the researcher noticed their own critique of IAPT focus on outcome measures and so attempted to address this throughout the research process by reflecting on the feelings and thoughts that discussions centered around recovery rates raised for them.

Results

Thematic synthesis was adopted to draw together themes from each of the papers included in this literature review. The papers were published between 2012 and 2018 and were interested in IAPT practitioners' experiences of working in this setting and with a range of foci. The practitioners involved in the studies were working in a variety of jobs roles: psychological wellbeing practitioners (PWPs), counsellors, cognitive behaviour therapy (CBT) therapists and clinical psychologists.

The foci of the studies included the experiences of the following in an IAPT setting:, the impact of culture, the transition from a nursing background to CBT therapist, working with individuals with a learning disability, working as a non-IAPT therapist, working with women requiring perinatal support, working with those with an obsessive compulsive disorder (OCD) diagnosis as part of a randomised control trial (RCT), delivering a group based intervention, delivering IAPT interventions using the telephone, over the phone assessments, working with individuals with a borderline personality disorder (BPD) diagnosis, personal and professional development as a counsellor, working with mid-life and older women experiencing intimate personal violence, counsellors using counselling for depression (CfD), using interpreters and the transition from working as Black, Asian and other non-white minority ethnic (BAME) community mental health workers.

A range of analysis methods were employed in each paper to identify themes within the data. These included thematic analysis, interpretative phenomenological analysis (IPA), template analysis, thematic content analysis, Foucauldian discourse analysis, framework analysis, analytical auto-ethnography and grounded theory.

Using the data from each paper, 46 initial codes were identified. These initial codes were then grouped in terms of their similarities and differences and 10 descriptive

themes were identified. In order to generate analytical themes, the interest of the review was held in mind, i.e. the experiences of therapists working in an IAPT setting. An example of the process of data coding and analysis has been illustrated in figure 2.

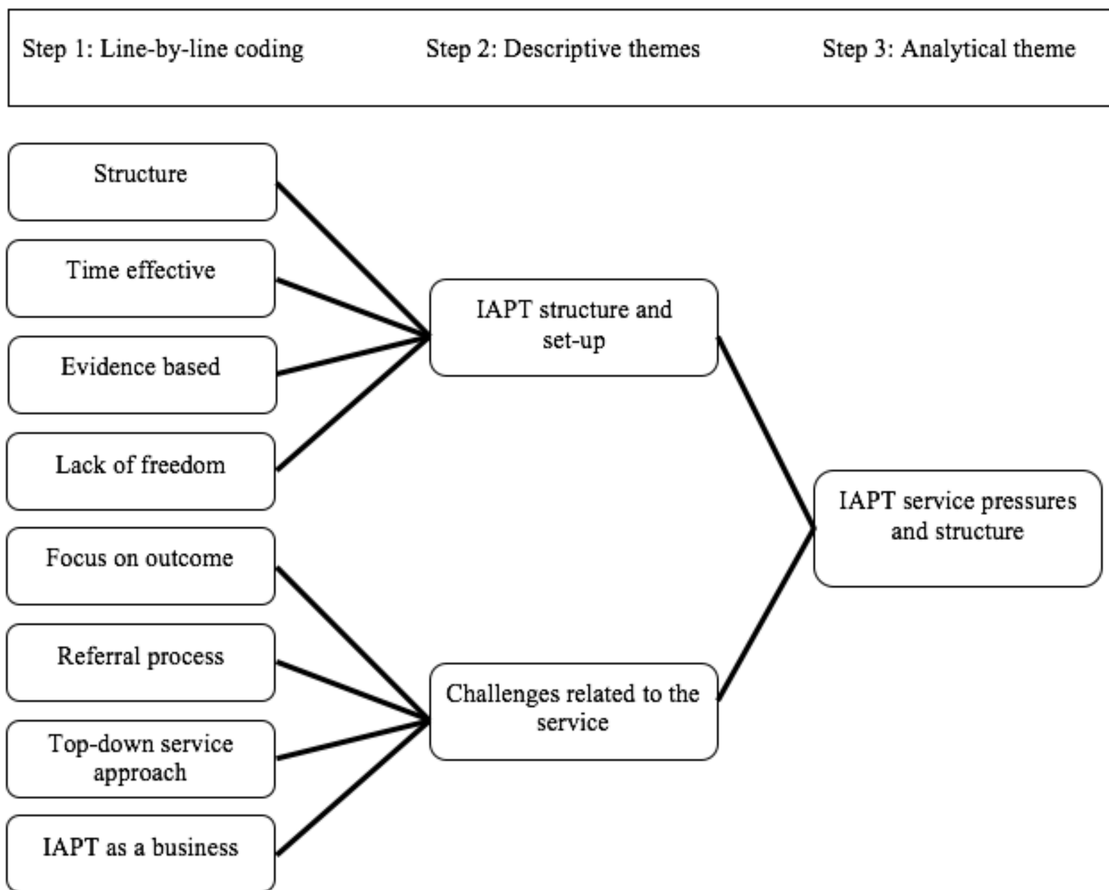

Figure 2. Example of data coding, the development of descriptive themes and the generation of analytical themes.

A total of 5 analytical themes were generated through this process and these were “social and cultural context”, “developing a therapeutic relationship”, “developing and working in an IAPT setting”, “need for support” and “IAPT service structure and pressures”. The 10 descriptive themes were then grouped together within the analytical themes (table 6). The analytical themes have been discussed below using quotes with study and page numbers to illustrate.

Table 6.

Themes identified within each study

		Social and cultural context		Developing a therapeutic relationship		Developing and working in an IAPT setting		Need for support		IAPT service structure and pressures	
Code	Author (year)	Culture and context	Engaging in IAPT	Therapeutic relationship	Adapting to client need	Professional development	Availability of resources and training	Challenges of client group	Support structures	IAPT structure	Challenges of service
1	Bassey and Melluish (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
2	Robinson, Kellett, King and Keating (2012)			Yes	Yes	Yes	Yes	Yes	Yes		Yes
3	Shankland and Dagnan (2015)	Yes	Yes	Yes	Yes	Yes	Yes		Yes		Yes
4	Altson, Loewenthal, Gaitanidis and Thomas (2014)	Yes	Yes	Yes	Yes	Yes			Yes	Yes	Yes
5	Millett et al. (2017)	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes

6	Gellatly et al. (2017)	Yes	Yes	Yes	Yes	Yes	Yes			Yes	Yes
7	Newbould, Hardy and Byng (2013)	Yes	Yes	Yes	Yes			Yes	Yes		Yes
8	Turner, Brown and Carpenter (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
9	Jones, Bale and Morera (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10	Rizq (2011)	Yes		Yes	Yes	Yes		Yes	Yes		Yes
11	Mason and Reeves (2018)	Yes			Yes	Yes	Yes		Yes	Yes	Yes
12	Watson, Carty and Becker (2017)	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
13	Drewitt, Pybis, Murphy and Barkham (2017)					Yes				Yes	Yes
14	Tutani, Eldred and Sykes (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15	Hakim, Thompson and Coleman-Oluwabusola (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Analytical Themes

Social and cultural context.

Different cultures and the use of interpreters was a specific focus of two of the papers included in this review, however the cultural and social context of clients more generally was considered in the other papers. Specifically, the cultural context of the individuals accessing IAPT services was considered to be important to hold in mind when working with individuals from a Black and Minority Ethnic (BME) background.

> *"Many participants made statements that reflected sensitivity to the dynamics of difference that could exist between therapist and client with some paying attention to a client's feelings/beliefs associated with the cultural dynamic in the dyad, and explored these openly with the client." (1, p. 226)*

The impact of the individual's social context was also considered as important, especially when related to the accessibility of IAPT. For example, offering online or telephone therapy was seen as helpful in some cases to improve the likelihood of clients being able to use the IAPT service. Specifically, when individuals worked and were not able to attend sessions in person at an IAPT or GP base, offering over-the-phone appointments meant that they could still access help.

> *"Especially for people who may be working in the day, or need to be able to access something at a time convenient for them … I guess with accessing an online programme and opting for telephone calls it's slightly more anonymous." (6, p. 5)*

Other studies, however, identified that the social context of a client may impact upon the likelihood of therapy being helpful and useful and that these social contexts must be considered when working with such clients. For example, IAPT therapists

identified that certain social contexts may not so easily be accounted for in the delivery of IAPT services due to the western influence on the IAPT service structure.

> *"Participants recognised how social forces may be relevant to the client's presentation and were conscious of the impact that interventions can have on a BME client's social functioning in their environment, due to values and attitudes implicit in Western therapies." (1, p. 226)*

Findings from some studies illustrated that IAPT therapists have had experiences where the IAPT service has not been able to meet client need due to the social and cultural context of a client. For example, some BAME communities are less likely to access services for help and support for mental health difficulties and that without the consideration of the social and cultural context of BAME individuals, IAPT services may limit the likelihood of these individuals accessing support.

> *"Participants shared that they thought that the information requirements of IAPT services represented a barrier for BAME patients to access services. As such, requests were often met with suspicion generally due to higher levels of stigmatization associated with feared repercussions should other people know that they had difficulties." (15, p 8)*

Developing a therapeutic relationship.

A consistent discussion amongst the studies in this review related to the therapeutic relationship. IAPT practitioners spoke about the importance of developing this relationship and the different aspects of it, including how being face-to-face (F2F) with a client, rather than speaking on the phone, can help with the relationship connection.

"Ros described a therapeutic relationship as one in which she could implicitly say "I'm 100% with you" and the majority of practitioners suggested that F2F allows for a deeper connection between them and the patient" (8, p. 289)

The different aspects of a therapeutic relationship were also discussed in different studies including empathy, listening and trust. Empathy was discussed in relation to working with those from a BAME background illustrating the importance of relationship building and sense-making with clients from a different culture.

"Well, I think my stance is when I see somebody from a BME background I try and, I suppose its empathy. I'm trying to put myself in their shoes and I guess I, I don't say it this way but I kind of plead ignorance and say you know I'm not sure er, perhaps you can tell me, inform me what the problem is from your perspective, from you know, not just your perspective, your family, your culture." (1, p. 228)

Although this was also perceived in other studies as a challenge when working with interpreters to ensure that the empathy is "translated" appropriately.

"Participants identified that working with an interpreter presented additional challenges to communicating understanding, and empathy, which are considered crucial aspects of developing the therapeutic alliance. The limitation of direct translation within interpreter facilitated triad was highlighted." (14, p. 9)

Curiosity on the part of the therapist and developing a shared understanding with the client was also a common theme across the studies.

"Many participants stated that a therapeutic alliance could be fostered and maintained by curiously exploring what was important to the client; thereby

allowing any culturally relevant issues to emerge during this process." (1, p. 228)

There was also reference to developing the relationship being tiring and sometimes difficult, especially if the needs of the client were more complex. This ties in with another analytical theme, 'need for support'.

"Participants all described feeling overwhelmed by the extent of what their clients wanted from the therapeutic relationship, using images of being sucked dry, emotionally swamped, or psychologically sapped by the perceived level of demand." (10, p. 40)

Another important aspect of developing the therapeutic relationship was that therapists need to be flexible in their approach in order to meet the needs of the client. Again, this analytical theme crosses over somewhat with the 'social and cultural context' theme as being flexible with therapy within IAPT to develop therapeutic relationships may be necessary because of the cultural background of the client.

"Some participants advocated a personal exploration of the potential differences in worldview and philosophical orientation that may exist between cultures and recognised how alternative worldviews may not fit with the CBT model, therefore necessitating flexible application of the therapeutic approach to clients." (1, p. 227)

There was also some indication that working flexibly within IAPT was not viewed in a positive light by management for example, but the IAPT practitioners felt it was essential for developing the relationship with their client so that therapy could be effective.

"Breaking the rules included working on days off or adding on extra sessions. Therapists assumed these were practices not viewed favourably in the wider

organisational context of IAPT. However, the benefit of getting a positive outcome with patients was worthy of the cost of being disciplined." (12, p. 228)

Developing and working in an IAPT setting.

IAPT therapists consistently spoke about working within an IAPT service and the potential challenges of working in this setting. IAPT training was a focus in a range of studies where participants indicated that their training was not sufficient for the specific groups of patients the IAPT therapists were working with.

"It was woefully, woefully inadequate I think as a, you know. I mean I know they've tried to squeeze everything into the IAPT into a very short time to save money but I think that part of it was, was really skipped over...." (1, p. 229)

"Some participants spoke about a need for more specialist training and advice in working with this group of clients, feeling they lacked sufficient knowledge and theoretical background. (10, p. 42)

These experiences often led IAPT therapists to feel de-skilled and unsure about their role and how to help some client groups.

"The participants described feeling unable to act in the right way and ask the correct questions due to having no prior training or concrete experiences to draw on, further supporting the core condition of helplessness." (12, p. 226)

The consequences for therapists working with a client group with whom they did not feel trained, included feeling worried about the usefulness of their skills as a therapist.

"These strategies, whilst serving on the one hand to alleviate guilt and boost participants' sense of efficacy, also raised participants' anxieties about their therapeutic skills and motivation on the other." (10, p. 43)

In addition to feeling de-skilled, a perceived lack of knowledge in certain

areas was also cited as being problematic for IAPT practitioners.

"[…] What it is that makes me feel incompetent? lack of knowledge […]." (12, p. 226)

However, there was also a shared reflection within some of the studies to indicate that working in IAPT had been helpful in developing skills and knowledge as a therapist, specifically as a consequence of their training and through supervision.

"Participants shared how the IAPT training helped them with their personal development, such as self-confidence and gave them a sense of achievement. This experience led them to value training." (15, p. 6)

"Seeing the benefits in supervision of keeping it very structured and kind of applying that to my own clinical sessions." (2, p. 361)

Another key experience of therapists working in IAPT related to feeling valued, or not valued, as an IAPT practitioner. There was a relationship identified here between the structure of IAPT services and the impact this had on the recognition that IAPT practitioners felt they received.

"…we are really cramped into do all the work . . . and in additional another language, but we are not actually being recognised" (15, p. 12)

"As far as the organisation is concerned we're all doing the same thing' and that 'even though I have done the CfD training, it hasn't really made any difference'." (13, p. 10)

Furthermore, the analytical theme of 'developing and working within an IAPT setting' was also characterized by the resources that the practitioners had access to. The apparent lack of resources in some cases meant that working with specific groups was more challenging and could impact upon the helpfulness or effectiveness of the service.

"In the IAPT position in particular, the work requires an ability to work with reading/writing materials on some level. Particularly at the low intensity level, we don't have the time/resources to accommodate patients who need additional support" (3, p. 211)

Other IAPT therapists explained that adaptations to the IAPT model, such as the implementation of telephone sessions instead of face-to face sessions, meant that resources could be more easily distributed.

"Saving time led to several participants feeling that they were providing a more efficient service for all." (9, p. 6)

However, for others it seemed that working within an IAPT service in ways to manage resources more effectively, such as using telephone assessments and triage, meant that the individuals accessing IAPT were not able to get the most out of the service. In some cases, the IAPT practitioners felt it impacted the commitment of individuals to engage with the service.

"One disadvantage was trying to get hold of people to commit to a time to do the triage undisturbed. It seems not seen as important by them." (9, p. 10)

Need for support.

Supervision was spoken about in a range of the studies and was an important factor in the experiences of IAPT practitioners. There were different reported experiences of why supervision helped, but there was a general consensus that it was an imperative aspect of working in IAPT.

"Half of the participants recognized the priority given to supervision. Regularity, commitment, emphasis and organizational support meant that supervision was highly regarded and viewed as central to developing effective CB practice." (2, p. 360)

It was also acknowledged that supervision was not always helpful, particularly if the focus was on measuring how well therapy was going and on therapy outcome, rather than processes occurring in the therapy room between therapist and client.

"I also got a sense it's used to measure my performance [] they're measuring me and [voice goes up to a higher pitch] this can feel a bit /intrusive/…." (4, p. 387)

It was also clear that when IAPT therapists were working with complex needs of individuals, supervision might be less helpful if the supervisor did not have a good understanding of that area.

"Good supervision was seen as important, but was not always easy to obtain: 'It's not that my supervisor isn't good but she's not, her area isn't perinatal'." (5, p. 431)

The data extracted from the studies also demonstrated that supervision was not the only identified support structure for IAPT therapist. It was clear that IAPT practitioners also valued peer support as a way to manage difficult experiences with clients and to seek out advice.

"Participants discussed how they tried to manage the demand by sharing the translated material and giving colleagues in their team, advice. They also gave advice to other health professionals and gave examples, showing how important culture understanding and sensitivity is." (15, p. 12)

However, due to the set-up of IAPT services, this more informal but necessary peer support was often not accessible due to lone and agile working. Support systems in general were seen as less accessible within an IAPT context.

"However, many counsellors felt there was a lack of coherent support systems available and some described only limited or sporadic contact with local GPs and secondary care services." (10, p. 44)

"I also work in secondary care you see and when you work in secondary care, it's easier to manage people with personality disorder because there's somebody if they do feel suicidal or make a suicide attempt, there's some structure in place. Whereas in primary care you're kind of left on your own with somebody, and you don't have a team to consult, you don't have the support." (10, p. 44)

This last quotation highlights the complexity of the clients that access IAPT services and IAPT therapists also spoke about experiences of burnout and feelings of personal responsibility, hence the need for support. Participants across the studies identified with a sense of feeling overwhelmed and burnt out in relation to the clients they were seeing within IAPT and the demands they felt were put on them as therapists.

"Not surprisingly, participants spoke repeatedly about the need to maintain a psychological distance from clients in order to prevent themselves from becoming overwhelmed or burned out." (10, p. 39)

In addition to feelings of burnout, IAPT therapists also spoke about a sense of personal responsibility for clients they were working with and this speaks to the idea that support and supervision is imperative for ensuring therapists are able to manage their caseloads effectively.

"Rescuing resulted in therapists assuming sole responsibility for their patients' wellbeing in an attempt to restore their own self-belief. As a result, therapists described feeling like they were placed in positions that they would not have

normally allowed. This was often beyond the remit of their therapeutic practice." (12, p. 228)

These experiences of holding personal responsibility for their clients may impact on IAPT therapist's ability to hold boundaries and work in a way that was good for their own wellbeing.

"I used to go home and be in tears worried that people were at risk and I should do more and I used to go out of my way, I'd be going in on my days off." (12, p. 228)

"Therapists would try to "rescue" patients by going above and beyond their normal role both during and out of sessions. This ranged from calling patients from withheld numbers to limit suspicion from perpetrators to working on days off." (12, p. 228)

Whilst boundaries were talked about in terms of being difficult to maintain, there was also the sense of how important it was to be clear about the boundaries in a therapeutic relationship.

"But it's like you're the person; you're not just a therapist that's carrying out a therapy; you're the be all and end all that'll sort out all their problems and sometimes it will get you involved with different, they want you to get involved with doing other things, then that boundary actually needs to be very clear you know." (1, p. 228)

IAPT service structure and pressures.

IAPT therapists in the studies consistently commented on the IAPT service itself and the impact of this on them and their clients. There was specific reference to the short-term goals of IAPT services and the tension with this and the needs of some clients.

"Look, although I'm not doing my job properly here — I'm seeing people for longer, I'm, you know, they're dropping in, topping them up every so often when they need it — so on the one hand I see that as a failing in me, but I think it's also a response to the needs of this type of client. So it's not just coincidence, or inexperience in this field, in this type of work with personality disorder'." (10, p. 43)

There was an overlap between the structure of the IAPT service and the focus on therapy outcome monitoring and how some IAPT therapists noticed that this was not always in the client's best interests.

"Because of the limited number of sessions we are just getting going with people then they have to leave so we are not meeting the recovery targets that they are hoping to so there is always that feeling of knowing this model could work for people but we just haven't got enough time." (13, p. 10)

The impact and prevalence of the focus on outcome monitoring in IAPT service was identified by IAPT therapists in a range of situations, such as in supervision. There was consensus that focusing too heavily on therapy outcomes was not helpful and meant that the "symptoms" of emotional distress were focused on, rather than underlying causes of client's difficulties, and so therapy may therefore be less effective.

"Unfortunately there are constraints, whether it be kind of structural in terms of the buildings that we work in, or the … rather relentless IAPT targets and the model." (5, p. 431)

"You work at this at a sort of symptom level, if you want to create change you have to go to another level but be prepared for a longer term piece of work." (12, p. 228)

The quality of the therapy delivered by practitioners in IAPT was seen as affected by this focus on therapy outcomes and the “numbers”. There was a common experience of pressure on IAPT therapists regarding the measuring of how many people were seen each day and whether clients were reaching “recovery” as defined by the outcome measures.

“Production line therapy; it’s a bit – it’s a very fast pace, I think the quality of treatment we are able to offer is limited …they seem very geared up towards the stats, more or less it is benchmark… if we follow the stats, and cram in 9 people a day or whatever, there’s none of that quality.” (8, p. 291)

There were also reflections made about how the time-limited nature of IAPT could be helpful for some clients. However, given the increasing complexity of clients accessing IAPT services, the time-restraints may impact negatively on meaningful therapeutic change for some clients.

“In six sessions some useful work may be done to benefit the client; however a more flexible time restraint would allow for time to absorb therapeutic change” (3, p. 210)

“Only one of the 14 onward referrals I made following telephone assessment was rejected. Some stayed within our service but were allocated to a different colleague; some were referred to a different service. Months later, it was clear from correspondence I received that 13/14 had been accurately diagnosed and sent to an appropriate team. This assured me that I was not missing important information or cues when on the phone.” (9, p. 7)

The hierarchical structure of IAPT was also discussed in the studies and this links to the idea of IAPT therapists feeling monitored by supervisors and managers and the impact of this on their confidence and sense of autonomy.

"IAPT is constructed as being able to monitor or measure her 'performance' through her clients' CORE questionnaires and there was a change in pitch to her voice when she described this sense of being measured as 'intrusive'." (4, p. 387)

This illustrates the sense of helplessness experienced by some IAPT therapists, given the focus on how their clients are progressing through therapy. This is despite the influence of other contextual factors as discussed previously and highlights the relationship and possible tension between the client context and what is expected from the IAPT service in regards to the therapist's skills.

Synthesis of Analytical Themes

There is cross-over, tension and interactions between different elements of the themes generated in the analytic synthesis. This led to a more in-depth synthesis of the findings from the studies in this review. The overarching concept linking these dynamic and complex relationships is "tension between adherence and flexibility". This can be seen in the tension between service delivery requirements and adapting services for different client groups identified in the "social and cultural context' theme where therapists aim to adhere to the structure of the overall IAPT service but are met with challenges to be flexible for the client group they work with to meet their needs. Additionally, there is a tension between therapists delivering protocol treatments and working with complex clients which was illustrated in the "therapeutic relationship" theme. Within this theme, therapists identified attempts at working with a structured protocol but needing to be flexible and "go above and beyond" for more complex clients in order to develop a meaningful therapeutic alliance. Additionally, the tension between therapist's need for support and tension with the use of supervision time being used to monitor the service requirements for measuring client outcomes was illustrated in the

“IAPT setting” theme and demonstrates the need for flexibility when assessing therapist performance through client outcomes.

Through the discussions of the experiences of practitioners working in an IAPT context, there is a tension between the client’s social context and the service demands and structures. Sometimes this was met by flexibility in the IAPT service and sometimes not; in the latter case this resulted in problems for individuals accessing IAPT services. For example, over the telephone sessions and assessments make service access easier for people who work. However, IAPT practitioners had also described that being flexible within the IAPT model was more difficult when working with clients who were also experiencing difficulties in their wider social context or when the client’s cultural context was different to the western context of IAPT. For example, where a client’s understandings of emotional wellbeing were different to those proposed by the models of mental health in IAPT, tension between adherence to the model and flexibility for the client’s needs was highlighted.

The interaction between the therapeutic relationship and the perceived complexity of the client has also been identified as a tension through the thematic synthesis. For example, working with more complex individuals appeared to require more input from the therapist which appeared to contribute to the need for additional support to maintain the therapeutic relationship. The maintenance of the therapeutic relationship with complex clients was also identified as being demanding as therapists appear to work harder to develop such a relationship, for example by working on days off. Developing a therapeutic relationship with complex clients within IAPT settings contributed to increased burnout leading to increased need for support leading to increased efforts to maintain a therapeutic relationship which then contributes to further burnout.

The thematic synthesis identified a complex relationship between being flexible to the client needs and the limits of flexibility within IAPT services due to the organisational structure and set-up. This was suggested by participants speaking of "breaking rules" by offering additional sessions, for example. There is a pull between being flexible in response to what the client needs and the structured set-up of IAPT. IAPT practitioners appear to be in the center of this tension and their experiences illustrate the tension between adhering to the IAPT model and being flexible to support the client. Another tension identified was the one between support and supervision for therapists and the measuring of outcomes within the IAPT service. Although the usefulness of outcome measuring was commented on, the infiltration of outcome measuring into clinical supervision impacted on its helpfulness. Outcome scores were used in supervision to measure therapist performance and IAPT practitioners also had the experience of supervision not being focused enough on process issues occurring in the therapeutic relationship between client and therapist. The focus on outcome monitoring contributed to feelings of intrusiveness for IAPT practitioners. This illustrates the tension between clinical support and supervision with regards to the specific focus on outcomes for therapists working in IAPT.

Discussion

This thematic synthesis enabled the development of a clearer and more comprehensive understanding of the experiences of practitioners working in IAPT services. A total of 15 papers using qualitative methodologies were reviewed, meaning that the views and experiences of 177 IAPT therapists could be considered. Understanding the experiences of practitioners in IAPT is vital to ensure that they are trained well and supported so that ultimately IAPT services can be helpful and effective

for those accessing it. The themes generated in this review have highlighted common experiences amongst IAPT therapists which should be considered during service developments.

Findings from this thematic synthesis highlighted the role of culture when IAPT therapists are working with a client. This reflects the diverse communities that IAPT services are based in and highlights the need for additional training and support for IAPT therapists in regards to understanding other cultures and working cross-culturally. The wider social and cultural context of clients accessing IAPT was a further point of tension for IAPT practitioners who wanted to make a difference for their clients. Therapists acknowledged the diverse backgrounds of their clients and that some clients had difficult personal and social circumstances outside of therapy. Research regarding cultural competence and training within mental health services has been found to be limited (Clegg, Heywood-Everett, & Siddiqi, 2016). This is clearly problematic across all mental health services and as IAPT therapists in the studies in this review highlighted, it continues to be a problem for IAPT practitioners who often feel de-skilled in regards to working cross-culturally. Training regarding culture and diversity for practitioners working in a range of mental health services has been discussed as something that would benefit the individuals accessing the service (Dogra, Vostanis, & Frake, 2007; Hilton, 2015).

Burnout amongst therapists was also discussed regularly within the studies included in the review, with specific reference to the clients accessing IAPT services being more complex and thus requiring more input and support. “Burnout and vicarious traumatisation” was identified as a specific theme in one study looking at the experiences of therapists working with women experiencing intimate partner violence. Indeed, the analysis from all studies highlighted burnout in relation to a greater need for

supervision and support. It was clear from the thematic synthesis carried out that burnout and emotional exhaustion were significant experiences of IAPT therapists and this was linked to a range of other factors. For example, the experience of having supervision focused on outcome measures and less access to support from peers, due to lone working in GP practices for example, meant that IAPT therapists felt personally responsible when working with clients with complex needs. Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler (2012) proposed that not attending to the emotional needs and potential burnout of mental health staff can have an impact on not only the workers themselves but the wider organisation and indeed the people using the service. With regards to clinical implications, addressing this within an IAPT service is therefore imperative. Whilst there is some evidence for individualised programmes related to improving mental health staff wellbeing (Ewers, Bradshaw, McGovern, & Ewers, 2002), authors of a recent meta-analysis proposed that interventions should be both organisationally and individually focused (Dreison, et al., 2018). Therefore, within an IAPT setting it would be appropriate to discuss what the needs of their staff are with the workers themselves to develop a strategy that addresses both organisational and individual needs, such as additional training and peer support groups.

A tension within IAPT services that was experienced by the IAPT practitioners in these studies related to the structure of IAPT services sometimes being at odds with the need for flexibility for clients accessing the service. A great deal of evidence from the meta-synthesis also highlighted the impact of IAPT service set-up on IAPT practitioners. There was also a pressure for therapists in IAPT to see a certain number of clients and meet particular targets regarding recovery rates. These pressures and the implications of IAPT service structures indeed contributed to the emotional demands of working within IAPT which added to an overall sense of therapists not being able to

deliver their best in therapy. IAPT is a time-limited service and although this was highlighted as helpful for some clients, the experience that increasing numbers of clients with additional complex needs are accessing IAPT services was also reported. Thus, time-limited services such as IAPT may not be meeting the needs of everyone using the services; a genuine concern for IAPT therapists. Implications for clinical practice in relation to service pressures could be considerable, where IAPT services are re-designed, however the feasibility of this is low. Supporting therapists in light of these pressures, however, would be more feasible and acknowledging this tension within supervision and clinical management sessions may enable therapists to feel heard and valued in their roles. Caring leadership has been shown to improve the retention of staff and workers valued being treated as a whole person (Baggett et al., 2016).

Quality of the literature

The quality appraisal of the studies included in the review identified one paper as "unsure" in regards to whether or not to include the paper in the review due to some aspects of the CASP tool for qualitative research (2013) not being met. Bassey and Melluish's (2012) study did not discuss their recruitment strategy in sufficient detail and ethical approval was not discussed within the paper. The relationship between participants and researcher was also not described and this is an important, yet significantly under-reported, element of qualitative research (Yu, 2011). However, given that the study met the other CASP tool for qualitative research (2013) criteria and gave detailed content regarding themes and a good amount of quotes to illustrate the themes that were generated. In light of this, the study was included in the review but it's limitations must be held in mind when interpreting the analysis.

A total of 5 papers were identified as key papers for the review given that they met all of the CASP tool for qualitative research (2013) criteria. These papers also

demonstrated particular significance in relation to their findings and the aims of this review. For example, Turner, Brown, and Carpenter (2017) were very clear in their description of thematic analysis to understand IAPT practitioners' experiences. The remaining 9 papers were identified as satisfactory, therefore the overall quality of the papers included in the review were deemed acceptable for this meta-synthesis. Further research in this area should, however, aim to meet quality criteria as outlined in the CASP tool for qualitative research (2013) to ensure the reliability of further literature reviews of the experiences of IAPT therapists.

Limitations

The current review should be considered in light of the following limitations. The CASP tool for qualitative research (2013) is open to risk from subjectivity and although this was addressed by a second person also quality assessing the papers, a different quality tool such as the Joanna Briggs-Qualitative Assessment and Review Instrument (JBI QARI; Briggs, 2010) could have been implemented. Given that the additional rater rated the papers in their sample in the same way as the researcher, the reliability of the use of the CASP tool for qualitative research (2013) for this review was demonstrated.

Further, the studies included in the review were mostly interested in specific experiences of niche groups of therapists, for example, mental health nurses that had transitioned into an IAPT therapist role (Robinson, Kellett, King, & Keating, 2012). Therefore, through the synthesis of these experiences, the rich experiences of specific groups of IAPT therapists may not have been captured. Further research should investigate the overall experiences of IAPT practitioners so that further meta-synthesis can be more confident in identifying shared experiences across therapists working in an IAPT setting.

With regards to the synthesis process, although the findings were reviewed with the research supervisor, a more in-depth review of the quality of the synthesis would have been beneficial. The researcher did use the CASP tool for systematic reviews (2018) to review this piece of work however, to ensure that the criteria for systematic reviews were met. To further ensure the quality of the review, an in-depth reflective log would have ensured that any biases held by the researcher were highlighted throughout the process and the influence of this on the analysis of the data could have been discussed.

Conclusions

The experiences of therapists working in an IAPT setting are varied, however there are some significant themes identified across the studies. The social and cultural context of the clients accessing IAPT services was considered by therapists across the studies and the focus on the development of the therapeutic relationship was also a prominent theme across the papers. The process of working in an IAPT setting and the professional development within this context was also discussed amongst the papers. The need for support for practitioners working in an IAPT setting was also identified as a theme across the studies. The structure and pressure of the IAPT service on therapists was also highlighted as a key theme and IAPT therapists are under rising pressures related to organisational structures and the focus on recovery outcomes for clients accessing IAPT services. Practitioners working in IAPT services are also working increasingly more with complex clients and are thus experiencing burnout as a result of higher demands on them as a therapist but within a time-limited framework. Further synthesis of the themes generated in this review highlighted the tension between adhering to structures within IAPT and the need for flexibility to provide a meaningful and effective service that responds to the needs of the workers and the clients. IAPT

therapists in the studies included in this review identified that good supervision and peer support were important aspects of working within an IAPT setting and this review has highlighted the importance of therapist care, supervision and training to support IAPT practitioners in their roles.

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Appendices

Appendix A: Literature Review Search Terms

(Qualitative AND ("grounded theory" OR "discourse analysis" OR "interpretative phenomenological analysis" OR "interview*" OR "focus group*" OR “case stud*” OR “mixed method*” OR "thematic analysis" OR ethnograph* OR “narrative analysis” OR phenomenolog* OR psychological OR psychosocial OR “content analysis”))

AND

(Therapist* OR clinician* OR counsellor* OR practitioner*)

AND

(Experience*)

AND

(IAPT OR Improving Access to Psychological Therap*)

Appendix B: CASP tool

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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CASP
Critical Appraisal
Skills Programme

Paper for appraisal and reference: ....

Section A: Are the results valid?

Question			Hint
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

Comments:

Question			Hint
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

Comments:

Is it worth continuing?

Question			Hint
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)

Comments:

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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)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐ Can't Tell ☐ No ☐

HINT: Consider
- If the setting for the 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 are 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

Comments:

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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

Comments:

Section B: What are the results?

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

Comments:

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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

Comments:

9. Is there a clear statement of findings?

Yes ☐ Can't Tell ☐ No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's 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

Comments:

CASP
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Section C: Will the results help locally?

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

Comments:

Appendix C: Table Summarising Quality Appraisal

	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Were the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?	QUALITY
Bassey and Melluish (2012)	✔	✔ to understand whether IAPT practice is sensitive to cultural differences	✔ template analysis as literature already exists to guide the analysis	Not defensible	✔focus groups and semi-structured interviews	Not defensible	Not defensible	✔Themes in template used in analysis summarised in appendix	✔	✔discussion of implications for practice, further research	Unsure
Robinson, Kellett, King and Keating (2012)	✔	✔to understand the lived experience of therapists transitioning between roles	✔ good detail regarding thematic content analysis	✔ high intensity therapists recruited from a high intensity CBT course	✔ semi-structured interviews used to gather data	Unsure – researcher bias is commented on brielfy	Unsure - information regarding ethics committee but no other detail	✔ good amount of raw data included	✔	✔good discussion of how the findings can be transferred to other groups	Satisfactory

Shankland and Dagnan (2015)	✔	✔to describe the views of IAPT therapists working with people with intellectual disabilities	✔ thematic analysis used	✔ online survey with qualitative responses	Unsure – amount of qualitative data limited	Not defensible	Unsure – only very briefly in relation to ethics committee	✔ analysis process outlined	✔	✔ discussion regarding implications for training and providing equal care	Satisfactory
Altson, Loewenthal, Gaitanidis and Thomas (2014)	✔	✔ to investigate the experiences of non-IAPT therapists	✔specific discussion around why foucauldian discourse analysis was used	✔discussion regarding external recruitment	✔ semi-structured interviews	✔ considered in detail influenced by foucauldian discourse analysis	✔good level of detail	✔process discussed in detail	✔	✔further research suggestions made	Key paper
Millett et al. (2017)	✔	✔aim to understand therapists experience of perinatal mental healthcare in IAPT	✔ thematic analysis	✔ good detail of recruitment	✔ focus groups	✔ however considered in more detail for other group (clients)	✔	✔ good amount of raw data included	✔	✔ implications for services discussed	Key paper
Gellatly et al. (2017)	✔	✔to hear the voices of the practitioners in the study	✔ thematic analysis	✔very detailed	✔semi-structured interviews with good descriptive detail	✔ discussed in limitations	Unsure – only in reference to ethics committee	✔ good detail of thematic analysis process	✔	✔ implications for services, clients and practitioners discussed	Satisfactory

Newbold, Hardy and Byng (2013)	✔	✔ to explore the experiences of staff delivering group-based therapy	✔framework analysis	✔ heterogeneity was a priority in terms of sample base	✔ semi-structured interviews and interview guides developed with clients and staff	Unsure – only briefly discussed	Unsure – only mentioned in regards to ethics committee	✔step by step description provided and good level of raw data included,	✔	✔ discussion regarding the understanding of the processes of group-based interventions	Satisfactory
Turner, Brown and Carpenter (2017)	✔	✔ to explore the experiences of practitioners in IAPT working with clients over the telephone	✔ thematic analysis	✔ participants invited to interview following completing questionnaires	✔semi-structured interviews	✔ good detail on reflexivity	✔ more detail than simply ethics committee approval	✔ process detailed	✔	✔good detail regarding the implications for practice	Key paper
Jones, Bale and Morera (2013)	✔	✔experience of over the telephone assessments	✔good level of detail regarding thematic analysis	Unsure – not detailed	✔ pragmatic choice of questionnaires instead of interviews	✔ good detail when discussing stages of analysis	Not defensible	✔good detail of process of analysis	✔	✔ implications discussed and future research proposed	Satisfactory
Rizq (2011)	✔	✔ to explore IAPT therapist experiences working with a complex population	✔ detailed discussion regarding use of IPA	✔IAPT service identified where therapists are working with this population	✔good detail about semi-structured interviews	✔Background of researcher considered	Unsure – detail not provided	✔high level of detail provided regarding analysis	✔	✔ implications for understanding therapist experience of complex clients in IAPT services	Satisfactory

Mason and Reeves (2018)	✔	✔specific to one individual's experiences	✔analytical auto ethnographic approach to understand experiences of primary author	✔	✔data extracted from a journal and doctoral assignment	✔	Unsure – not talked about explicitly given participant was also researcher	✔detailed explanation of analysis approach chosen	✔	✔ appears to be an honest and open interpretation of the authors experience	Key Paper
Watson, Carty and Becker (2017)	✔	✔to address a gap in the literature	✔ grounded theory to identify a framework	✔ purposive sampling employed	✔ clear description of data collection and interview process	✔reflexive accounts from researchers	✔ good detail of ethical considerations	✔clear description of the generation of the framework	✔	✔a theoretical framework was generated	Key paper
Drewitt, Pybis, Murphy and Barkham (2017)	✔	✔	✔qualitative methods important to understand therapist experience of delivering CfD	✔purposive sampling of eligible participants in the British Association for Counselling and Psychotherap y	✔	Not defensible	✔very detailed description of ethical considerations and informed consent	✔ detailed description of thematic analysis	✔	✔ helpful understanding s of CfD counsellors working in IAPT	Satisfactory
Tutani, Eldred and Sykes (2017)	✔	✔	✔rationale for richer understandings of working with interpreters in IAPT	✔ensure participants had spent a significant amount of time working with interpreters	✔semi-structured interviews	✔ adopted a critical realist approach	Unsure – only discussed very briefly	✔thorough account of analysis	✔	✔ experience of working with interpreters is important to understand	Satisfactory

Hakim, Thompson and Coleman-Oluwabusola (2019)	✔	✔aim to explore experience of transition of role	✔clear rationale for qualitative method to identify participant experiences	✔sampling method specific to target population	✔ clear information about generation of questions	Unsure - One researcher's background only mentioned briefly.	Unsure – ethical approval granted but not discussed in detail.	✔ Good amount of detail of how thematic content analysis took place	✔	✔ implications for BAME communities accessing IAPT and the experiences of IAPT workers transitioning roles and what their needs are	Satisfactory

Section Two: Research Report

Therapist effects: A qualitative exploration of therapist perceptions.

Abstract

Objectives

A number of factors that impact upon the effectiveness of psychotherapy have been identified in research, including therapist effects. The study aimed to explore the experiences of therapists working in an Improving Access to Psychological Therapies (IAPT) and on a research trial. The study was also interested in what factors therapists understand impact upon the delivery of therapy in an IAPT setting.

Design and Methods

The study employed a qualitative design, using template analysis. Semi-structured interviews were carried out with 5 counsellors and 7 CBT therapists working in an IAPT service.

Results

Five common themes across the two groups of therapists were identified: *The therapeutic relationship; Support structures for therapists; Therapist emotional wellbeing; Service-level impact; Experience of working in a trial.* Two unique themes also emerged: *Counsellor role in IAPT; The meaning of being part of a trial.*

Conclusions

Findings highlight that therapists believe that their own empathy and levels of resilience, can impact upon the therapeutic relationship. Additionally, therapist support is a key component to working in IAPT however the focus on recovery rates can contribute to additional stress and pressure for therapists. Working on a trial meant that therapists could develop their therapy skills through listening to session recordings however they feel they should be consulted in future research trials in the service. Counsellors highlighted their unique experiences working in an IAPT setting, for

example, feeling undervalued. Counsellors felt they were supporting their profession within the trial and CBT therapists felt excited about being part of research.

Practitioner Points

- The development of the therapeutic relationship is understood by therapists to be influenced by therapist and client factors.
- IAPT services should ensure therapists feel heard within their organisations so that appropriate support structures can be put in place.
- Service and organisation pressures in IAPT services should be addressed in consultation with therapist to reduce burnout.
- Therapists working in IAPT settings should be consulted in the development of research trials within services to ensure their experiences can be considered.

Keywords

IAPT, therapist effects, template analysis, qualitative

Introduction

Psychotherapy has been shown to be effective for different emotional difficulties across a range of studies (Lemmens et al., 2015; Calati, & Courtet, 2016; Cuijpers, Ebert, Acarturk, Andersson, & Cristea, 2016). However, not everyone benefits from therapy; for example, Cahill et al. (2003) found that 28.6% of clients who completed Cognitive Therapy (CT) did not demonstrate improvement. A recent meta-analysis also identified that not all therapies are effective and factors associated with this lack of improvement and dropout from therapy included client levels of distress (Reich & Berman, 2018). Given the influence of such factors on therapy outcomes, it is reasonable to consider further potential explanations for why psychotherapy is not always effective.

Wider social contexts also contribute to therapy outcomes and Epstein (2018) argues that social problems, such as poverty and lack of access to education and safe communities cannot be influenced or remedied through individualized psychological therapy. In addition to social contexts, further potential explanations for differing therapy outcomes include differences in therapeutic alliance (Cameron, Rodger, & Dagnan, 2018), therapist adherence to and flexibility within the therapy model (Katz et al., 2019) and client characteristics (Lorenzo-Luaces, DeRubeis, & Webb, 2014). The contribution of therapist effects on outcome has been consistently found (Okiishi, Lambert, Nielsen, & Ogles, 2003; Baldwin, & Imel, 2013, Zuroff et al., 2017), however the level of contribution does differ. Zimmerman, Rubel, Page, and Lutz (2017) found that client characteristics were not the only predictors of client engagement and 5.7% of the variance in client outcome could be assigned to therapist effects however, Kim, Wampold and Bolt (2006) found therapist effects contributed to around 8% of outcome variance using multi-level modelling. Likewise, therapist effects have also been shown

to account for 12.6% of dropout variance and in fact 10.1% of client deterioration variance (Saxon, Barkham, Foster, & Parry, 2017).

Given the research proposing that therapist effects may be partially responsible for therapy outcomes and client drop-out rates, a number of studies have investigated the therapist characteristics linked to variance in client outcomes. Green, Barkham, Kellett, and Saxon (2014) found that therapist confidence contributed to better client outcomes. Other therapist variables associated with client outcomes include resilience and the ability to build a therapeutic alliance (Green, Barkham, Kellett, & Saxon, 2014; Horvath & Symonds, 1991; Norcross & Lambert, 2011; Pereira, Barkham, Kellett, & Saxon, 2016). A substantial evidence base demonstrates that there is a range of therapist effects contributing to therapy outcomes including therapists practicing their therapy skills, therapist personality, therapists' level of resilience and therapist wellbeing.

For example, therapist competence has been identified as a contributing factor to therapy outcome and O'Malley et al. (1988) found that therapist skill accounted for 23% of the variance in patient-rated change in Interpersonal Psychotherapy (IPT) for depression. Kellett, Bennett, Ryle, and Thake (2013) concluded that therapist competence in delivering the therapy model, was a significant factor in the effectiveness of therapies. Clients working with more competent therapists also have better outcomes (Branson, Shafran, & Myles, 2015) and an association between working alliance, therapist competence and positive therapy outcomes has also been found (Haug et al., 2016).

A key process that therapists can engage in to increase their therapy skills is deliberate practice. Deliberate practice is the act of purposefully engaging in the repetitive practice of a skill in order to improve ability in that specific skill (Ericsson,

Krampe, & Tesch-Römer, 1993). This component has been found to be instrumental in the development and improvement of skills (Ericsson, 2006). Chow et al. (2015) found that those therapists that achieved better outcomes spent nearly triple the amount of time in a week using deliberate practice than therapists with poorer outcomes. Chow et al. (2015) argue that deliberate practice of therapy skills increases therapist competence and expertise in therapy, thus increasing the likelihood of highly effective therapists.

The personality of the therapist has also been identified as having an impact on therapy processes and outcomes. One theory of personality coined the “Big Five” (Digman, 1990) or the “five-factor model” proposes that there are five general factors within the domain of personality; extraversion, openness, neuroticism, agreeableness, and conscientiousness. Engvik (1999) investigated the most desirable therapist personality characteristics for clients. The study identified that agreeableness, conscientiousness and stability (used in this study as the opposite of neuroticism) were highly correlated with therapist popularity, proposing that these are desired therapist personality traits. The therapeutic alliance has been demonstrated to be an important aspect of therapy and a meta-analysis involving 79 studies found a moderate effect size (r = .22) indicating the effect of alliance on therapy outcomes. Given the established link between therapeutic alliance and outcome of therapy and Taber, Leibert, and Agaskar’s (2011) study identifying the influence of therapist personality on bond making between client and therapist, it is appropriate to understand more deeply the role of therapist personality in therapy.

Stress related factors have also been shown to impact on a therapist’s performance (Linley & Joseph, 2007). Due to the impact of stress and poor mental wellbeing on the ability to make decisions (Starcke & Brand, 2012) and to attend effectively to one’s

environment (Skosnik, Chatterton, Swisher, & Park, 2000), such factors could negatively impact therapist effectiveness, as found by Lambert and Barley (2001). Delgadillo, Saxon, and Barkham (2018) found that therapist burnout significantly predicted poorer patient outcomes regarding depression and anxiety and burnout was also associated strongly with lower job satisfaction. The study highlighted the importance of considering therapists becoming burnt out as a result of vicarious trauma, which has been demonstrated amongst mental health nurses (Sabin-Farrell & Turpin, 2003), and wider service and organization pressures which has been demonstrated in mental health professionals (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000).

Considerable evidence highlights the impact of working in Improving Access to Psychological Therapy (IAPT) services on therapists. Westwood, Morison, and Holmes (2017) found a 50.0% (95% CI 39.6-60.4%) prevalence of burnout amongst high intensity therapists in IAPT services. High levels of emotional exhaustion have been found amongst IAPT therapists and this has been attributed to service-level pressures (Steel, Macdonald, Schröder, & Mellor-Clark, 2015). Given the prevalence of burnout and stress amongst mental health professionals, specifically those working in an IAPT setting, and indeed, the association it has with therapy outcomes, therapist wellbeing is an important therapist factor to consider.

Much of the previous research regarding therapist effects has analysed large data sets using quantitative methods which means there are limits to the development of new knowledge, given the specific focus of quantitative methods. ,Thus, the specific and unique experiences of therapists have not been captured. Additionally, therapists' understandings of their own strengths and weaknesses that could contribute to therapy effectiveness have not been investigated. Such research would provide rich information about what qualities therapists recognise in themselves and how they understand these

to affect their work. In light of the existing quantitative literature on therapist effects, it is important to contribute to these findings from the perspective of the therapist using a qualitative approach to explore therapists' experiences and understandings of therapist qualities in an IAPT setting. Trial studies aim to reduce bias, including therapist differences by using competent therapists who deliver protocol treatments. Even in such trials therapist differences are sometimes reported (Bedics, Atkins, Comtois, & Linehan, 2012; Tyrer et al., 2015), providing further evidence that therapist effects are a stable phenomenon. It also provides an important context for understanding why differences between therapists occur, as in such cases the setting, client group and adherence to treatment protocols are held constant. Therefore, this study will also look at therapists' understandings in relation to the experience of taking part in a trial and the consequences of this on therapists' practice.

This study therefore proposes to investigate how therapists experience delivering therapy as part of a trial, what therapist factors they consider impacts on therapy success and whether such experiences are influenced by factors such as levels of stress, resilience, their personality characteristics and deliberate practice.

The aims of this study are to:

1. Explore the experiences of therapists delivering therapy working both in a primary care mental health service and as part of a psychotherapy trial.
2. Add to the literature on therapist effects using qualitative methods to explore therapists' understandings of the possible impact of their own qualities and characteristics on therapy outcomes.

Method

Design

A qualitative methodology was implemented in order to generate rich and detailed data. Questionnaires and semi-structured interviews were used to collect the data. Template analysis (TA) was used to analyse the interview data because of its flexibility as a qualitative approach in psychological research (Brooks, McCluskey, Turley, & King, 2015).

Participants

IAPT services offer a range of therapies at step 3 the primary ones include CBT and counselling. Participants were therefore included from both these types of therapy. The participants were therapists recruited from the PRaCTICED trial that was carried out within the local IAPT service. This is a pragmatic randomised controlled trial assessing the non-inferiority of person centered experiential therapy (PCET) versus cognitive-behaviour therapy (CBT) for patients in primary care meeting a diagnosis of moderate or severe depression (PRaCTICED; Saxon et al., 2017). Therapists in the PRaCTICED trial offered either PCET or CBT at step 3 in an IAPT service. These therapists were included in this study due their roles in IAPT services and their experiences of working as part of a research trial. This meant that both their experiences of primary care mental health services and research in such a setting could be captured which is important in understanding more deeply the experiences of IAPT workers and the interface between research and clinical services.

Forty-six therapists from the PRaCTICED trial (Saxon et al., 2017) were invited to take part in the current study. There were 31 CBT therapists (25 females, 6 males) and

15 PCEP therapists (14 females, 1 male). Therapists were contacted by the trial research assistant via email, invited to take part in this study (appendix A) and provided with the study information sheet (appendix B). Participants were asked to complete the study questionnaires online using Qualtrics or using paper copies. Participants were asked to leave their email address if they wished to be contacted regarding the interview.

Twelve therapists consented to taking part in an interview (appendix C) and their demographics information has been included in table 1. This participant number is in-line with other template analysis studies that have taken place (King, Carroll, Newton & Dornan, 2002; Bassey & Melluish; 2012; Brooks, McCluskey, King, & Burton, 2012). Seven participants were CBT therapists (one male) and five were counsellors (one male). This was important as it meant that differences between therapists trained in different modalities could be explored and similarities between the two groups could also be investigated. All therapists had worked in the service for over five years. All except one therapist identified as white British and the mean age of the participants was 48.7 years. Most therapists identified as having a great deal of practitioner experience.

Table 1.

Participant demographics

Participant characteristics	*n*
Ethnicity	
White British (English/Welsh/Scottish/Northern Irish/British)	11
Asian (Asian British, Indian, Pakistani, Bangladeshi, Chinese, Japanese)	1
Age (years)	
30 - 39	4

40 - 49	2
50 - 59	4
60 - 69	2
Number of years in the role	
1 - 2	0
2 - 3	0
3 - 4	0
4 - 5	0
5 +	12
Amount of practitioner work-related experience	
A little	1
A moderate amount	0
A lot	1
A great deal	10
Number of therapy sessions in a typical work-week	
1 – 5	2
6 – 10	3
11 – 15	4
16 – 20	1

Measures of therapist characteristics included overall wellbeing, personality characteristics and deliberate practice and were used to provide additional demographic information about the participants. These measures are: The Big Five Inventory-2 Extra Short Form (BFI-2-XS; Soto & John, 2017; appendix D), the Warwick-Edinburgh Mental Well-being Scale (WEMWBS; Stewart- Brown & Janmohamed, 2008; appendix

E), the Connor-Davidson Resilience scale (CD-RISC, Connor & Davidson, 2003; appendix F) and a shorter adapted version of the RAPIDPractice measure (Chow et al., 2015; appendix G).

Measures.

BFI-2-XS.

The BFI-2-XS (Soto & John, 2017) is a 15 item measure of personality based on the Big Five personality traits. Questions are scored from 1 (disagree strongly) to 5 (agree strongly). Sub-scales within the BFI-2-XS relate to the Big Five personality traits. Potential total scores on the BFI-2-XS range from 15 to 75. The BFI-2-XS has good reliability and validity and has been shown to be useful for assessing personality in research (Soto & John, 2017).

WEMWBS.

The WEMWBS (Stewart-Brown & Janmohamed, 2008) has 14 questions scored from 1 (none of the time) to 5 (all of the time). Therefore, the potential total scores on the WEMWBS range from 14 to 70. The WEMWBS demonstrated good consistency in the general population (Cronbach's $\alpha = 0.91$) and also showed high correlations with currently used well-being scales and low correlations with measures of general health, evidencing the WEMWBS as a reliable measure of well-being (Tennant et al., 2007). Normative data from a population sample of 1749 participants found a mean score of 51 with an inter-quartile range of 45 – 56 (Tennant et al., 2007).

CD-RISC.

The CD-RISC (Connor & Davidson, 2003) has 25 questions which are scored from 0 (not true at all) to 4 (true nearly all the time). The total potential scores on the CD-RISC range from 0 to 100. The CD-RISC has been found to have good psychometric properties. Connor and Davidson (2003) found that the measure had good internal consistency (Cronbach's $\alpha = 0.89$) and validity as it correlated positively (Pearson $r = 0.83$, $P<.0001$) with the Kobasa hardiness measure (Kobasa, 1979). Connor and Davidson (2003) found an average score of 82 in a general US population ($n = 577$) and that a score of 55 would indicate an individual is within the lowest 25% of the general population in relation to their resilience levels and a score of 89 would place them in the 50 – 75% percentile.

RAPIDPractice.

Chow et al. (2015) describes RAPIDPractice as a survey instrument that can be used to identify how much time a therapist is spending in improving their therapeutic performance. The adapted RAPIDPractice measure for this study included the domain related activities section, concerned with different activities carried out by therapists. Participants rated activities in relation to (1) time in hours spent carrying out that activity in the last month, (2) confidence in relation to the accuracy of their time estimate (0 = not at all confident in my time estimate, 10 = highly confident in my time estimate), (3) the relevance of the activity in relation to improving client outcomes (0 = not at all relevant, 10 = highly relevant) and (4) the mental effort exerted when carrying out that activity (0 = no effort exerted at all, 10 = highest possible effort exerted).

Measure Data.

The measure data was collected in order to provide further contextual information about the sample and their personality characteristics, levels of wellbeing, resilience, and deliberate practice. The BFI-2-XS showed that the agreeableness was scored most highly across the sample. The levels of wellbeing in the group of participants on the WEMWBS was comparable to normative data however the resilience average score of the sample was lower than the normative data for the CD-RISC. There is no normative data for the RAPIDPractice measure but the results provide descriptive information regarding this sample in relation to the therapy activities they engaged in over the past month. On average, therapists spent the most time in the previous month "mentally running through and reflecting on the past sessions in your mind" and the least amount of time of 0.1 hours was spent in the past month on 'live supervision provided during sessions (e.g., supervisor as co-therapist, one-way mirror/reflecting team, etc.)'. Details of the outcomes from the measures can be found in appendix H.

Data Collection

Interviews.

The semi-structured interview schedule (figure 1) was developed focusing on 1) therapists' understanding of what it is that contributes to therapy outcomes, 2) understandings of resilience, 3) what they think they do that affects therapy, 4) the practicing of their therapy skills, 5) overall wellbeing and 6) their experiences of being part of the PRaCTICED trial. Semi-structured interviews were conducted face-to-face except with one participant where the interview was conducted over the telephone. The interviews lasted from 36 minutes to 58 minutes (mean = 49.2 minutes).

1. As a therapist, what do you think you do that contributes to positive therapy outcomes?

2. As a therapist, is there anything you think might contribute to poor therapy outcomes?

3. Could you tell me about an experience you have had in therapy where you feel the client had a successful outcome?

4. Could you tell me about an experience you have had in therapy where you feel the client did not have a successful outcome?

5. What do you think your strengths are as a therapist?

6. What do you think you do as a therapist that is perhaps less helpful?

7. How important to do you think resilience is as a therapist?

8. How do you manage feeling "stressed" as a therapist?

9. How important would you describe therapist wellbeing is?

10. What is your experience of practicing your therapy skills?

11. Please could you describe what your experience as a therapist as part of the PRaCTICED trial has been like?

12. What was the process of seeing a client and having to remain in a specific model like?

13. What was your experience of being recorded for the trial?

Figure 1. Interview Schedule.

Procedure.

The audio data was recorded on an encrypted device and once the audio files were uploaded, they were stored in a secure folder on the researcher's university account.

Files were transferred securely for any transcribing and transcripts were also sent back to the researcher securely and transcribers signed a confidentiality agreement (appendix I).

Analysis

The interview transcripts were analysed using TA (King, 2004). TA is a form of thematic analysis and allows for the development of descriptive or interpretive codes and then organizing these codes into hierarchical themes through the development of a template. This method of qualitative analysis is flexible as initial codes (*a priori* codes) are identified by the researcher that are then changed and adapted so new codes and themes develop as transcripts are analyzed (Brooks, McCluskey, Turley, & King, 2015). TA is also suitable for analyzing larger data sets whilst allowing participant voices to be acknowledged. The stages of analysis outlined by King (2012) have been included in table 3.

Table 3.

Stages of analysis in template analysis.

Stage of Analysis	Description
Become familiar with data set	Read through all of the data set to familiarise self with the accounts.
Preliminary coding of the data	Use *a priori* themes (appendix J) that have been identified in advance, however hold these tentatively and remove or re-define where necessary. Code the text from each

	interview transcript and generate new codes where needed.
Organise emerging themes	Once themes have been identified, organise them into clusters that reflect how the themes relate to each other. Hierarchical and lateral relationships may be identified to illustrate the links between themes.
Create initial coding template	A coding template will be generated using a subset of the data that captures an appropriate cross-section of the data that reflects experiences discussed in the overall data set.
Apply initial coding template to more data	The initial coding template will then be used to look at whether the themes in the initial template reflect the experiences in the remaining interview transcripts.
Finalise template and apply to full set of data	Apply the "final" template to the full data set and ensure that the template enables the coding of the data set. If there is a considerable amount of data relevant to the research question is unable to be coded to it, then revision of the template must take place.

Once the initial codes were generated, they were grouped by the researcher using post-it notes. A process of moving the notes then entailed until themes began to emerge that described groups of codes. This involved the generation of over-arching themes and sub-themes that captured each of the original codes within them.

Ethics

The research project had ethical approval from the Health Research Authority (HRA). The reference number for the project is 19/HRA/0525 (appendix K). This study was also linked to the PRaCTICED trial study who had also gained ethical approval (reference 14/YH/0001).

Reflexivity

TA is a specific type of thematic analysis. Braun and Clarke (2006) propose that in thematic analysis, researchers should be upfront about their own epistemological influences. This piece of research in particular used TA from a "subtle realist" viewpoint as described by Hammersley (1992) which acknowledges that the researcher may provide their own interpretations regarding a topic, however there are also phenomena found in the data that are independent of the researcher and their perspectives.

The researcher had no experience of working in an IAPT setting and had no preference for CBT or PCET. However, as a mental health professional, the researcher is influenced by the theoretical models they draw on in their clinical work which could influence the questions they ask and the aspects of the data that they are drawn to. Berger (2015) highlights the importance of reflexivity in qualitative research to ensure the quality and rigour. To ensure that the researcher's own thoughts, beliefs and judgements were attended to throughout the research process, a reflective log was kept (excerpts in appendix L). The researcher's expectations regarding the experiences of the different therapists were made aware of so that their impact on the data analysis was limited. Whilst generating the final coding template, an audit trail aimed to reduce subjectivity from the researcher.

Quality Checks

To ensure the rigour of this study, a number of quality checks were undertaken. The questions developed for the semi-scheduled interview were developed between researcher and the research supervisor to ensure they reflected all areas that the study was interested in. The transcripts from each interview were reviewed and the researcher listened to the interviews to ensure transcript accuracy. One participant checked their transcript and agreed accuracy.

The development of the coding template was audited with the researcher's research supervisor to review how the codes were grouped and the final template decided upon. One PCET therapist and one CBT therapist also reviewed the themes generated in the TA and offered reflections on the coding templates. The PCET therapist offered feedback on the wording of sub-theme 4.3 on the PCET therapist coding template. Originally this was "taking care of oneself as a counsellor out of the work context" but we agreed "taking care of oneself as a person" was more appropriate. Discussions with the CBT therapist centered around whether the CBT coding template reflected frustrations with working as part of the PRaCTICED trial. We agreed this would be captured within sub-themes of theme C5 "experience of working in a trial". The template was also reviewed with another trainee clinical psychologist conducting their own qualitative study to ensure that the template accurately captured the experiences in the data.

The researcher's reflective log enabled awareness of possible biases throughout the research process. For example, the researcher had an interest in some areas of mental health, for example, the social context of individual's accessing mental health services. Where particular participants spoke about the wider context of the client, the researcher was aware of continuing such conversations rather than focusing on the

interview schedule. Therefore, the reflective log was used to monitor these biases and ensured that the researcher continued to reflect on the process. The reflective log was also used during the TA process to ensure that the researcher's interest in cultural contexts did not impact heavily on the development of themes.

Results

Analysis of the CBT therapists' interview transcripts produced 6 main themes: *"therapist support", "client factors", "adherence to the model", "the therapeutic relationship", "therapist wellbeing"* and *"working as part of a trial".* Each main theme also contained lower level themes in the coding template (figure 2).

A1. Therapist Support
- 1.1 Peer Support
- 1.2 Internal supervisor
- 1.3 Supervision
- 1.4 Managerial Support
- 1.5 Service-Level

A2. Client Factors
- 2.1 Client's readiness for therapy
- 2.2 Wider context of client

A3. Adherence to the model
- 3.1 Flexibility
- 3.2 Evidence based

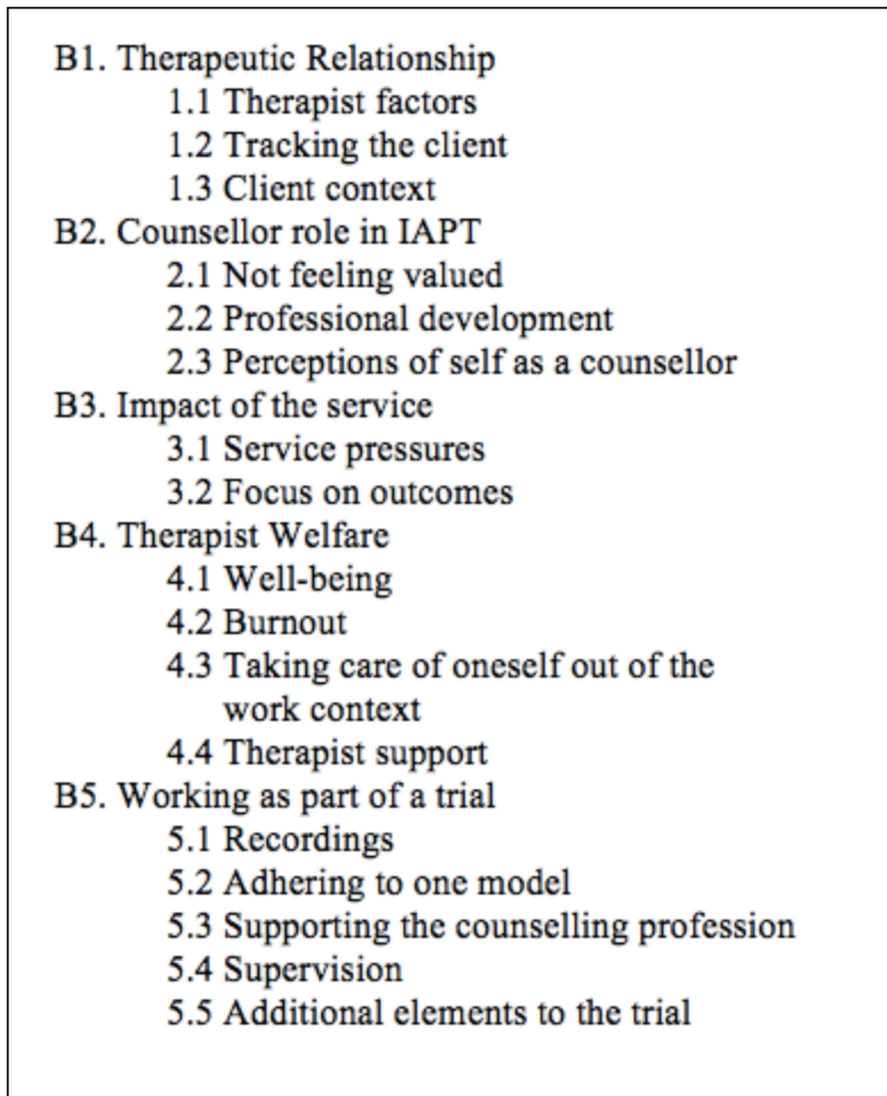
A4. Therapeutic Relationship
- 4.1 Honesty
- 4.3 Therapist factors
- 4.4 Team work between client and therapist
- 4.5 Understanding the problem

A5. Therapist Wellbeing
- 5.1 Resilience
- 5.2 Therapist wellbeing
- 5.3 Self-care
- 5.4 Emotional impact of work

A6. Working as part of a trial
- 6.1 Prescriptiveness of the trial
- 6.2 Supervision
- 6.3 Exciting to be part of a trial
- 6.4 Additional pressure
- 6.5 Recording sessions

Figure 2. Coding template for CBT therapists.

Analysis of the PCET counsellors interview transcripts found 5 main themes *"the therapeutic relationship", "counsellor role in IAPT", "impact of the service", "therapist welfare"* and *"working as part of a trial"*. Lower level themes were identified within each main theme (figure 3).



B1. Therapeutic Relationship
- 1.1 Therapist factors
- 1.2 Tracking the client
- 1.3 Client context

B2. Counsellor role in IAPT
- 2.1 Not feeling valued
- 2.2 Professional development
- 2.3 Perceptions of self as a counsellor

B3. Impact of the service
- 3.1 Service pressures
- 3.2 Focus on outcomes

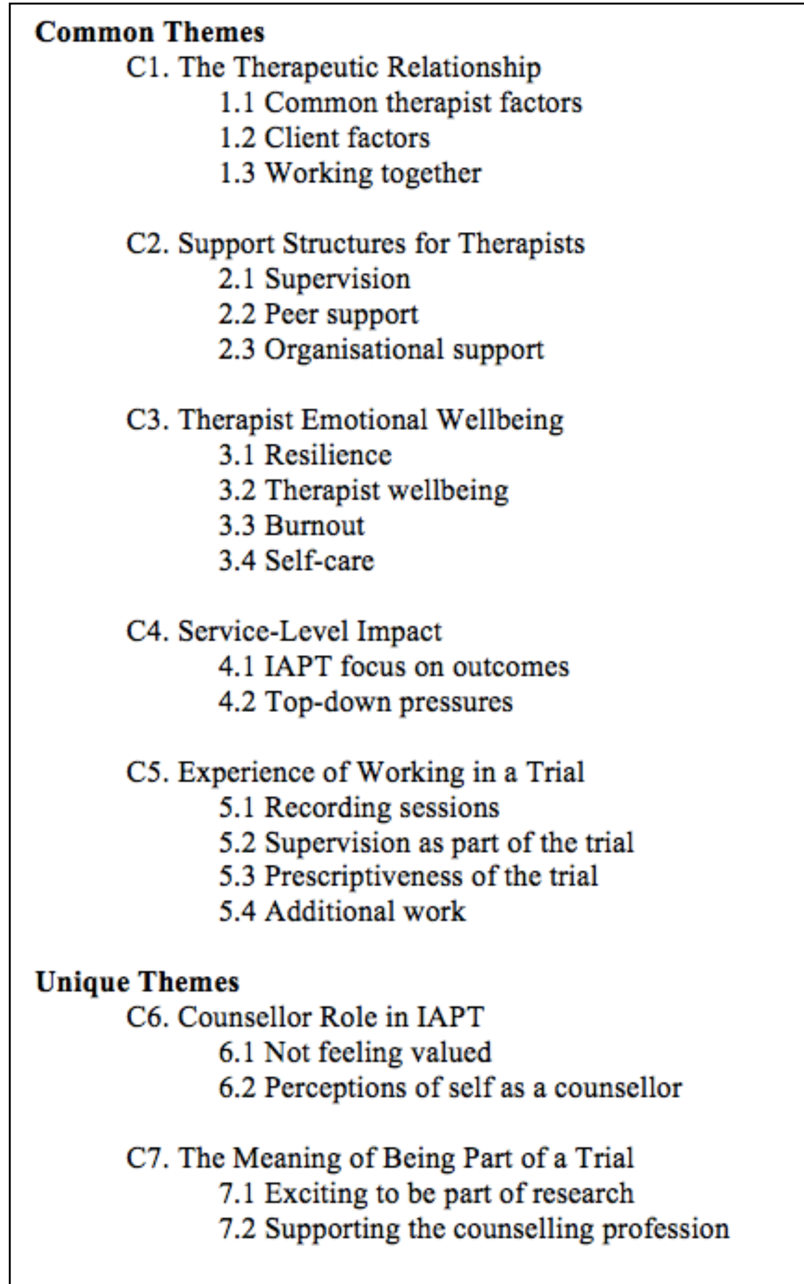
B4. Therapist Welfare
- 4.1 Well-being
- 4.2 Burnout
- 4.3 Taking care of oneself out of the work context
- 4.4 Therapist support

B5. Working as part of a trial
- 5.1 Recordings
- 5.2 Adhering to one model
- 5.3 Supporting the counselling profession
- 5.4 Supervision
- 5.5 Additional elements to the trial

Figure 3. Coding template for PCET therapists.

There were a number of similarities and differences across the themes generated in the interviews with each group of therapists and a final coding template was generated (figure 4). See appendix M for conceptual map. The main themes identified were *"the therapeutic relationship", "support structures for therapists", "therapist*

emotional health" "service-level impact" and *"experience of working in a trial"*. Unique themes identified in the final coding template were *"counsellor role in IAPT"* and *"the meaning of being part of a trial'*.



Common Themes

C1. The Therapeutic Relationship
- 1.1 Common therapist factors
- 1.2 Client factors
- 1.3 Working together

C2. Support Structures for Therapists
- 2.1 Supervision
- 2.2 Peer support
- 2.3 Organisational support

C3. Therapist Emotional Wellbeing
- 3.1 Resilience
- 3.2 Therapist wellbeing
- 3.3 Burnout
- 3.4 Self-care

C4. Service-Level Impact
- 4.1 IAPT focus on outcomes
- 4.2 Top-down pressures

C5. Experience of Working in a Trial
- 5.1 Recording sessions
- 5.2 Supervision as part of the trial
- 5.3 Prescriptiveness of the trial
- 5.4 Additional work

Unique Themes

C6. Counsellor Role in IAPT
- 6.1 Not feeling valued
- 6.2 Perceptions of self as a counsellor

C7. The Meaning of Being Part of a Trial
- 7.1 Exciting to be part of research
- 7.2 Supporting the counselling profession

Figure 4. Final coding template with common and unique themes across CBT and PCET therapists.

These main common and unique themes also contain lower level themes. An example of how sub-themes and main themes fit with data has been included in

appendix N. Each theme identified is illustrated with an example from the transcripts. Further examples from the transcripts to illustrate each theme can be found in appendix O. The presence of themes in each participant's transcript has also been depicted in appendix P.

Common Themes

C1. The therapeutic relationship.

The positive impact of the therapeutic relationship on client outcomes was commonly referred to by the therapists. The therapeutic relationship was often referred to initially when therapists were asked to think about what contributes to clients achieving good outcomes in therapy.

1.1 Common therapist factors.

Both groups of therapists highlighted the importance of therapists having particular characteristics to develop a meaningful therapeutic relationship. For example, empathy and listening to your client were recognised as valuable factors that the therapist should have. Therapists identified their ability to build relationships as being a strength.

"I think I can form quite good relationships with people and I think that, I think I'm quite a gentle person." Participant 1 (PCET)

The definition of what makes a "good therapist" was linked to the therapist's ability to develop an alliance.

"I think the rapport between yourself and the patient, obviously I'm a CBT therapist so that really shapes my view of what I think makes a good therapist." Participant 3 (CBT)

1.2 Client factors.

Additionally, participants spoke about the influence of client factors on therapy.

Limited client motivation and psychological mindedness were seen as barriers to the building of a therapeutic relationship. The wider social context of the client was also acknowledged as something that could affect the development of meaningful therapeutic relationships.

"Sometimes if a community or individual is chaotic, they need to sort their benefits out or they need to have childcare or social services, you know we need to settle, help them settle those things down so its head space for them to engage with our work" Participant 7 (CBT)

1.3 Working together.

The concept of teamwork was also emphasized by the participants, specifically how being collaborative with clients can improve the therapeutic alliance. The experiences of therapists that are captured within this sub-theme also relate to the idea of power within a therapeutic relationship and how it is important to recognise this with clients.

"…so we are experts in all that but we don't exercise expert over the client, we erm, we use our expertise to help the clients become confident in the expert of themselves." Participant 12 (PCET)

C2. Support structures for therapists.

The participants highlighted that the support for their needs was paramount for them being able to work effectively delivering psychological therapy in an IAPT setting. A number of avenues for support were identified in regards to being essential. Some support structures were also seen as needing to be improved to be more effective.

2.1 Supervision.

Supervision was highly valued amongst the participants for learning

and reflecting. There was also a common experience amongst the participants that supervision could be used effectively when you are overwhelmed with the client work.

"I do find that they're always helpful in that they, you have to choose something to reflect on and in the supervision then you can also reflect and make some learning points, erm some of them you come away with more than others I suppose at times." Participant 2 (CBT)

2.2 Peer support.

Participants highlighted that peer support is an important aspect of their job in order to debrief and gain advice, especially if they had had a difficult session.

"…if a client is talking to you about injustice, it can be really grating, it's really difficult, but you can't go home and talk about it, so supervision and colleagues." Participant 9 (PCET)

Many participants also discussed the impact of working in different sites to their peers, making accessing this support less likely.

"If I've had a difficult session with a patient might try and catch them and just have a little bit of a peer debrief but I don't get the opportunity to do that very often." Participant 3 (CBT)

2.3 Organisational support.

Another source of support identified by the therapists was from line managers and although a general sense of feeling supported was discussed, there were also experiences of feeling let-down and micro-managed.

"I reckon the person who's using the micro-managing style would say you need to develop your resilience whereas the other Manager would acknowledge there's a lack of resource." (Participant 7 (CBT)

Therapists also indicated that the wider organisational pressures impacted on how well therapists felt they were supported. Participants highlighted a major focus on outcomes within IAPT and that they even felt pressure from commissioners to meet targets, leaving them feeling unsupported, which may then impact negatively on clients.

> *"I suppose it's quite a current thing, it's just probably harder for managers and people organising services to put meaningful things in place, where there's – where resources are increasingly tight."* *Participant 10 (CBT)*

C3. Therapist emotional wellbeing.

The wellbeing of therapists was regarded as highly important and there were a number of factors related to this that were discussed.

3.1 Resilience.

There was an acknowledgement that resilience is essential for working with clients in order to keep the therapist and the client safe. There were also a number of things that were identified as impacting upon a therapist's resilience levels, such as service pressures and out-of-work problems. Participants also commented on the impact of hearing traumatic stories.

> *"I think it's tough, kind of, it's interesting isn't it, I think it's a privilege to be with people, I think, I think we absorb such a lot of trauma from our clients" Participant 12 (PCET).*

3.2 Therapist wellbeing.

Participants also commented on therapist wellbeing in relation to their personal lives and how having a lot going on outside of work could impact upon one's ability to be effective as a therapist. There was also reference to the impact of the work itself on

the wellbeing of therapists and the additional stress of service pressures and increasingly complex clients.

"For instance if they're not really looking after themselves and noting they're going through this divorce stuff and really angry and all the rest of it and they're not taking it somewhere then that's stuffs gonna get, there's a potential for it being caught up with their work really." Participant 6 (PCET)

3.3 Burnout.

Additionally, experiences of burnout were common with therapists making reference to increasing client loads and pressures to meet targets.

"I was seeing more people and just getting tired you know so yeah that's important, important not to get burnt out, important to not get kind of exhausted." Participant 6 (PCET)

3.4 Self-care.

In order to lessen the impact of burnout and improve emotional wellbeing, self-care strategies were discussed by the participants. Activities out of the work context were highlighted, such as exercise and spending time with friends. Participants also highlighted the impact of separating work and home life as a way to manage feeling of stress to allow them to look after themselves.

"*I try not take work home, I'm quite lucky at the moment because I can walk to and from work and find that walking really can help to clear your head and hopefully by the time I've got home I've left it" Participant 4 (CBT)*

C4. Service-level impact.

The effects of service-pressures were discussed by participants with particular focus on the negative impact of this on therapists and subsequently, clients.

4.1 IAPT focus on outcomes.

Participants often made reference to outcome targets where therapists are expected to demonstrate a 50% recovery rate is met with their clients. This left some therapists feeling that they needed to work harder and that they were under continuous scrutiny to meet national targets.

"So sometimes it's stressful working with therapy challenging cases or, and figuring, feeling that you have pressure to get everybody better." Participant 2 (CBT)

Amongst the participants, there was also a sense that the outcome measures used to monitor recovery rates are not suitable and that sometimes clients report positive changes that are not necessarily reflected in the data.

"It's just an ongoing source of frustration that, yeah, that the service and the – wants to measure different things from what the therapy that we offer is offering really." Participant 8 (PCET)

4.2 Top-down pressures.

Therapists also said that the pressures and expectations from the service did not match their values.

"So it feels like a constant battle, in many ways, um, to kind of match what I believe in professionally with working within the organisation." Participant 9 (PCET)

C5. Experience of working in a trial.

The therapists also had some common experiences whilst working on the PRaCTICED trial. These experiences ranged from helpful to unhelpful within different aspects of the trial.

5.1 Recording sessions.

There was a common experience of finding the recordings anxiety provoking

initially but eventually very helpful for their practice. The continued use of recording therapy sessions for reflecting on in supervision after the trial was also commonly discussed amongst the therapists.

"I thought it was really helpful sometimes doing the audio recordings, it forced us to kind of do a bit more reflective observation." Participant 2 (CBT)

5.2 Supervision as part of the trial.

The experience of supervision within the trial was also identified as helpful. However, it was also acknowledged that because usual clinical supervision was used for the trial, therapists sometimes felt they were not able to discuss elements of the trial due to other clinical needs to be discussed.

"…some big crisis or some very risky situation happening, that would, might be your priority for supervision for that week." Participant 2 (CBT)

5.3 Prescriptiveness of the trial.

Therapists also noticed an improvement in confidence when using the model that they were in trained in for the PRaCTICED trial.

"I thought it was good because working in that model meant that I was improving in it, or believed that I was improving in it, becoming more and more familiar with it." Participant 12 (PCET)

However, participants also identified that adhering to a different way of working was sometimes difficult and that it did not always meet client needs, and so flexibility was key.

"…when I first started seeing trial patients and then I think probably after a while I thought this is, you know you can't do this you've got to go with people a bit more, go with patients and if it takes longer, you're not doing that in session 2 then it really doesn't matter." Participant 4 (CBT)

5.4 Additional work.

The therapists also spoke about extra work required as part of the trial being a hassle, for example, needing to upload recordings and send these to a representative for the research. It was also acknowledged that some of the difficulties in the beginning of the trial were ironed out and that it did improve. The therapists spoke about not being involved in the consultations leading up to the trial, which may have been helpful in making the trial go more smoothly.

"I think with a lot of the practical aspects of the trial it kept changing over time. Um, so it got better, but then there was a bit of a level of confusion about what we should and shouldn't be doing…" Participant 10 (CBT)

Unique themes

C6. Counsellor role in IAPT.

Specifically, the PCET therapists spoke about their role within the wider IAPT service and this was not a theme identified within the CBT therapist interviews.

6.1 Not feeling valued.

The PCET counsellors identified that IAPT was based on CBT and therefore felt that their profession was not as valued within this setting. Additionally, recovery rates are measured using outcome measures that counsellors feel are specific to CBT and not necessarily for counselling.

"We didn't actually take any measures at all, so when IAPT did come along, it felt so CBT orientated that we – you know, I think we all as counsellors felt very, very uncomfortable." (Participant 9)

6.2 Perceptions of self as a counsellor

The PCET therapist shared some personal experiences of working with people

and how they recognise themselves as counsellors. The counsellors often spoke about how they enjoy their work.

"…more to do with being a counsellor is that I enjoy sharing that with other people." Participant 12 (PCET)

C7. The Meaning of Being Part of a Trial.

Within this main theme, two sub-themes were identified separately within the two groups of therapists and although both groups showed interest in being part of the PRaCTICED trial, the meaning of the trial for CBT therapists and PCET counsellors was different.

7.1 Exciting to be part of research

CBT therapists spoke more specifically about being keen to be involved in research and how the PRaCTICED trial was an exciting project to be involved in.

"I'm quite excited about like research and evidence base is being developed and stuff like that, so I thought oh brilliant this is exciting." Participant 3 (CBT)

7.2 Supporting the counselling profession

Interestingly, the counselling participants spoke about being keen to take part in the PRaCTICED trial but rather than this being solely about being involved in research, they discussed in more detail the importance of it for the counselling profession to demonstrate their value as counsellors.

"So if this trial didn't happen it wouldn't survive in the NHS and probably wouldn't survive across world really but that's my feeling, belief." Participant 6 (PCET)

Discussion

This study aimed to explore the experiences of therapists working in a primary care mental health service, specifically IAPT, and on a psychotherapy research trial.

The impact of therapist characteristics on their experiences and client outcomes was also explored. Interview transcripts from twelve therapists working in an IAPT setting were analysed using TA. There were two distinct groups of therapists; CBT therapists and counsellors. Five themes common across the two groups were identified. Firstly, the role of therapist factors in therapy was highlighted within *"the therapeutic relationship"* theme, as was the impact of client related factors such as client motivation and working together. Therapists highlighted needing support in *"support structures for therapists"* and this was further evidenced given the emotional impact of working in IAPT in the theme of *"therapist emotional health"*. The *"service-level impact"* theme captured experiences of organisational and service pressures. The experiences of working on the PRaCTICED trial in relation to supervision and recordings were revealed in the theme *"impact of working in a trial"*. Two unique themes highlighted the particular experiences of being a non-CBT therapist in an IAPT setting; captured in the *"counsellor role in IAPT"* theme. Feeling invalidated and undervalued in the work context was captured for counsellors and highlights the lack of support they feel they have in an IAPT setting. The theme *"the meaning of being part of a trial"* revealed distinctive experiences of what the trial meant for CBT and counselling therapists.

The therapists' perceptions of therapist effects and the perceived impact of these on the outcome of therapy was identified, such as the use of warmth and empathy to develop genuine therapeutic relationships. Positive relationships between therapist empathy and therapy outcome have been well documented in the literature (Elliott, Bohart, Watson, & Greenberg, 2011). Furthermore, participants' discussed how their emotional wellbeing and levels of resilience influence client outcome. Therapists experiencing burnout may be less likely to achieve successful outcomes with clients (Delgadillo, Saxon and Barkham, 2018), therefore the experiences of therapists in this

study reflect wider literature on therapist emotional health and stress-levels of therapy outcomes.

The levels of therapist resilience as measured by the CD-RISC (Connor & Davidson, 2003) appear to be lower than normative data from Connor and Davidosn (2003) however therapist wellbeing as measured by the WEMWBS (Stewart-Brown & Janmohamed, 2008) appear to be within a normative range (Tennant et al., 2007). The BFI-2-XS (Soto & John, 2017) revealed that this group of therapists were particularly agreeable and conscientious. Some research that suggests conscientiousness and agreeableness are correlated positively with professional efficacy (Hurt, Grist, Malesky, & McCord, 2013), although there is very limited work about therapist personality and client outcomes.

The data from the adapted RAPIDPractice questionnaire highlighted that "mentally running through and reflecting on the past sessions in your mind" was used most frequently by the therapists in this study to develop their therapy skills whereas 'live supervision provided during sessions'' was used the least. This is indicative of service pressures and lack of resources in IAPT whereby time to reflect on one's therapy work is limited to lone-reflection. Therapists did not discuss their experiences of deliberately practicing in detail within the interviews. However, experiences of recording sessions and discussing this in supervision within the PRaCTICED trial were seen as helpful and suggests that therapists value the opportunity to develop their skills through reviewing their practice. The difficulty in doing so appears to be related to service pressures and a focus on seeing a high volume of clients.

The impact of wider system effects on therapists and their work was highlighted in the results. For example, the effect of wider organisational pressures focused on outcome measures may reduce the availability of supervision that is focused on

supporting therapist wellbeing and developing their resilience. The findings indicated that the focus on outcomes within an IAPT setting has a negative impact on therapists and their confidence due to the pressure of making sure they meet the targets that are set. Additionally, if a therapist feels under pressure to meet targets, then clients may be impacted by the stress that a therapist is under. Furthermore, valuable change for the client is not recognised in the specific outcome measures used by the IAPT service and therapists felt they were unable to record client improvements in a meaningful way and may even feel chastised for the outcome measures not reflecting such changes.

This study also provides valuable insight into the experiences of working on a research trial as an NHS employee in an IAPT service. Therapists felt they should have been consulted in the development of the PRaCTICED trial in order to highlight service needs to the researchers. Both groups of therapists found that taking the sessions recordings to supervision was important to develop their practice however due to supervision being somewhat limited, clinical risk meant that there was often a backlog of recordings that needed listening to in supervision. Both groups alluded to additional elements of the trial, such as organising the recordings, being burdensome and not being consulted in the initial stages. Some themes were not shared across the two groups. There was a stronger theme in the PCEP group of supporting the counselling profession through researcher whereas comparatively, the theme related to research in the CBT group was more generally focused on excitement at being involved in a research project.

Limitations and Future Directions

There are potential limitations of the current study. Firstly, the group of participants was highly self-selecting as they chose to take part in the research and therefore may not be representative of the potential participants approached for this

study. Also, the numbers of PCET and CBT therapists in the sample were not equal and there were only 5 PCET therapists who took part in an interview. Although this number reflects the differing proportion of therapists in the service, there is a possibility that the analyses reflected more strongly the views of CBT therapists. To counter this the interviews were analysed separately for each group of therapists.

Furthermore, not all participants completed all of the measures in the study and feedback via email from therapists indicated that the length of the measures in total was laborious. Future research should attempt to reduce the labour-intensity of measures in acknowledgement of the busy schedules of therapists working in an IAPT setting. Additionally, the use of a focus group with therapists working in the service could be considered in future research to identify areas of concern such as this and also to develop the interview schedule so that it appropriately captures the therapist's experiences.

Typically, questionnaires are not included in template analytic studies and as the questionnaires were used to guide the interview schedule, the data generated in the interviews may have been influenced by them. Future research may seek to develop a less specific interview schedule to identify even broader experiences of IAPT therapists in relation to their strengths and weaknesses.

Moreover, the homogenous sample of participants is a potential limitation and future studies should aim to recruit more participants from different ethnic backgrounds, more participants who are male and more participants who have worked in the service for less time.

Clinical Implications

The findings from this study highlight a number of factors that should be considered in the future. Firstly, therapists were clear about impact of service pressures

in this IAPT service on them, and ultimately on clients. This is a challenge for IAPT services who have to balance client demand against pressure on therapists. Consulting with therapists more regularly about the impact of service pressures and dedicating time in supervision and line management sessions to think about it openly would be beneficial. Additionally, the focus on recovery rates and outcome measures appears to cause therapists' stress and so more open conversations about their use and functionality from the perspective of managers and even commissioners would be helpful.

There was also the concern that IAPT services are not set-up to support clients with wider social and cultural needs, despite the diverse range of clients accessing this IAPT service. IAPT services should allow more flexibility in regards to clients with wider social needs, such as those with problems with their benefits, differences in language and indeed differences in understandings regarding emotional wellbeing. Services could make contact with the communities that IAPT serve to enable IAPT to know more about these communities and the services open to them to make sign-posting and support more accessible. Therapists could then be offered specialist in-house training regarding these services and other cultures and make contact with these services to offer them training about the workings of IAPT.

Finally, it appears the relationship between counsellors and the IAPT service could be improved so that they feel that they are valued and supported at work. In order to achieve this, counsellors could be represented at a management level in IAPT services and counsellors could be involved more generally in the development of services.

In terms of implications for future research trials involving services such as this one, there is a recommendation that therapists should be included in the consultation stages to provide their insights and share any concerns. It should also be noted that the

recording sessions and supervision element of the trial were seen as helpful. However, additional supervision provision in the future would mean that clinical practice was not impacted and that the needs of the research trial could still be met.

Conclusions

The current study highlighted common themes amongst therapists working in an IAPT setting, including them valuing the role of the therapeutic relationship when working with clients. The influence of therapist factors, such as therapist resilience and characteristics such as empathy are important for developing this relationship and increasing the likelihood of a positive therapy outcome. The importance of therapists feeling supported in an IAPT setting was also revealed, including the use of supervision and therapists wellbeing is important when working in an IAPT service and this should be supported too. The impact of wider pressures on therapists was acknowledged, with specific reference to the focus on recovery rates in an IAPT context. Unique themes were also identified between CBT therapists and counsellors. Counsellors specifically spoke about their role within an IAPT service and feelings of being undervalued at work. In light of these findings, the pressures placed on therapists should be acknowledged and meaningful changes should be made in consultation with therapists to improve this experience in IAPT settings. The experiences of therapists working on a research trial were also highlighted and although therapists found additional training and listening to recordings helpful, there was a consensus that therapists should be consulted in the design of such trials within services.

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Appendices

Appendix A. Invitation

Invitation to take part in the research project;

"Therapist effects: A qualitative exploration of therapist perceptions."

Dear therapist,

As part of my Doctorate of Clinical Psychology at the University of Sheffield, I am carrying out the above piece of research. The study is interested in finding out about therapist's experiences of delivering therapy are. This study is particularly interested in therapists who are currently working on the PRaCTICED trial in the Sheffield IAPT service.

Therefore, you are invited to complete three questionnaires regarding your wellbeing, self-reported level of resilience and levels of deliberate practice. You may then be invited to take part in an interview lasting around 45 minutes. As a therapist in the PRaCTICED trial you are in an ideal position to give valuable information regarding your experiences of delivering therapy.

Your responses on the questionnaires and in the interviews will be kept confidential. The interviews will be assigned codes to ensure personal information is not revealed during the analysis of the responses.

There is no compensation for participating in this study. However, your participation will contribute valuable information regarding your experiences as a therapist in the IAPT service and on the PRaCTICED trial.

If you are willing to participate please complete the attached consent form and send your contact information to the email address below. If you have any questions, please do not hesitate to ask.

Thank you,

Aisling McFadden

Amcfadden1@sheffield.ac.uk

Appendix B. Participant Information Sheet

Participant Information Sheet

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme Clinical supervision training and NHS research training & consultancy.

Aisling McFadden, trainee clinical psychologist
Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

Email: amcfadden1@sheffield.ac.uk

PARTICPANT INFORMATION SHEET FOR STUDY:
Therapist effects: A qualitative exploration of therapist perceptions.

What is the purpose of the study?

The study aims to investigate therapist's beliefs about their strengths and weaknesses in relation to delivering a therapy. Another purpose of the study is to find out about their experience of delivering a therapy within a randomised controlled trial.

Why have I been invited?

There is a lot of research that suggests therapist effects contribute to the outcome of therapy however there is no research that investigates how the therapist themselves experience the delivery of therapy and what they believe their strengths and weaknesses to be. IAPT services play a large role in the delivery of psychotherapy in England. Therefore, it is appropriate to ask IAPT therapists about their experiences. As a therapist in the IAPT service, you have been invited to take part in this study to provide useful information in relation to your experience as an IAPT therapist and also your experience on the PRaCTICED trial.

Do I have to take part?

Your participation in this study is voluntary. You also have the right to withdraw at any time during the study.

What will happen if I take part?

You will be asked to complete some questionnaires focused on self-reported resilience, wellbeing and deliberate practice. You may then be invited to take part in an interview. If you agree to complete the questionnaire, you do not have to take part in the interview if you do not wish. If you agree to be interviewed, the interview will be recorded so the researcher can listen to it after the interview and transcribe for further analysis. The interview will consist of a number of questions that will be focused on your experience as an IAPT therapist and also your experience of being a therapist in the PRaCTICED trial.

What are the benefits of taking part?

Being part of the study will hopefully give you insight into a research project and how these types of projects are carried out. The information that you provide will contribute to a written thesis regarding therapists' experiences of delivering therapy within an IAPT service. This may then be used to consider future implications to improve the delivery of therapies and to provide good support for the therapists themselves.

What if there is a problem?

If there is a problem, at any time, please speak with the researcher or contact the Research Support Officer (details below) and ask the researcher to contact you.

Will all the information be kept confidential?

Any information provided by you will remain confidential to the researcher. The interview recordings will be stored on an encrypted device and placed into an encrypted file on a secure computer at the University of Sheffield. As soon as is possible, the interview recordings will be coded to remove any identifiable information. The questionnaire information will also be coded and the information will remain confidential.

General Data Protection Regulation and Data Protection Act 2018

The University of Sheffield is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Sheffield will keep identifiable information about you for a maximum of 3 months.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information dataprotection@sheffield.ac.uk.

Will I receive any reimbursement of expenses for taking part in this research?

There will be no reimbursement for you taking part in this study.

What will happen to the results of the study?

The results of the study will be written up for submission to the University of Sheffield as a Doctorate of Clinical Psychology thesis.

What if I wish to complain about the way the study has been carried out?

Gillian Hardy & or Andrew Thompson, Director of Research Training.

If you feel that your complaint has not been handled to your satisfaction following this, you can contact the University's Registrar and Secretary Dr Andrew West, Email: registrar@sheffield.ac.uk and Tel *0114 222 1051*

Can I withdraw at any time?

You are able to withdraw at any time through the study. Once the results have been written up, however, it will not be possible to remove your data.

Contact Information

This research is being conducted by Aisling McFadden, Trainee Clinical Psychologist. This research will be used to write a thesis which fulfils part of their doctoral training. If you have any questions about the research, you can leave a telephone message with the Research Support Officer on: 0114 222 6650 and he will ask Aisling to contact you.

Appendix C. Participant Consent Form

Consent form

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme Clinical supervision training and NHS research training & consultancy.

Aisling McFadden (trainee clinical psychologist)
Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

Email: amcfadden1@sheffield.ac.uk

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
I understand that the data I provide as part of this study will remain confidential and will be anonymised when appropriate.	
I agree to take part in completing the questionnaire as part of the above study.	
I agree to being interviewed as part of the above study. My email address for the researcher to contact me to arrange the interview is: …………………………………………………………………………………	

Date　　　　　　Signature

Appendix D. BFI-2-XS

The Big Five Inventory–2 Extra-Short Form (BFI-2-XS)

Here are a number of characteristics that may or may not apply to you. For example, do you agree that you are someone who *likes to spend time with others?* Please write a number next to each statement to indicate the extent to which you agree or disagree with that statement.

1 Disagree strongly	2 Disagree a little	3 Neutral; no opinion	4 Agree a little	5 Agree strongly

I am someone who...

1. __ Tends to be quiet.
2. __ Is compassionate, has a soft heart.
3. __ Tends to be disorganized.
4. __ Worries a lot.
5. __ Is fascinated by art, music, or literature.
6. __ Is dominant, acts as a leader.
7. __ Is sometimes rude to others.
8. __ Has difficulty getting started on tasks.
9. __ Tends to feel depressed, blue.
10. __ Has little interest in abstract ideas.
11. __ Is full of energy.
12. __ Assumes the best about people.
13. __ Is reliable, can always be counted on.
14. __ Is emotionally stable, not easily upset.
15. __ Is original, comes up with new ideas.

Please check: Did you write a number in front of each statement?

BFI-2 items copyright 2015 by Oliver P. John and Christopher J. Soto.

Appendix E. WEMWBS

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)
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Appendix F. CD-RISC

(Measure removed due to copyright)

Appendix G. Adapted RAPIDPractice Questionnaire

(Measure removed due to copyright)

Appendix H. Outcome from Measures

BFI-2-XS

The mean score on the extraversion domain was 3.33 (SD = 1.41) and similar mean scores of 3.7 (SD = 1.33) and of 3.81 (SD = 1.2) were found on the conscientiousness and open-mindedness domains respectively. The agreeableness domain mean score was 4.16 (SD = 0.93) which was the highest scoring domain across the sample.

WEMWBS

The average overall score for participants on the WEMWBS was 51.75 (*SD* = 3.74). Potential scores on the WEMWBS range from 14 to 70. The normative mean score of 51 across a large population size provided by Tennant et al. (2007) is similar to the mean score of 51.75 for participants in this study.

CD-RISC

The results from the CD-RISC indicate an overall mean score of 69.7 (*SD* = 10.21) (Possible range 0-100, with higher scores reflecting greater levels of resilience). Using the normative data from Connor and Davidson (2003), a mean score of 69.7 is lower than the average score of 82 in the general population.

Mean data from Deliberate Practice measure

Activities	Time in hours (SD)	Confidence Ratings (SD)	Relevance (SD)	Cognitive Effort (SD)
General clinical supervision as a supervisee (without review of audio/visual recordings of sessions).	3.1 (1.3)	9.3 (0.9)	8.7 (1)	8 (0.7)
Clinical supervision as a supervisee (with review of audio/visual recordings sessions).	0.2 (0.5)	8 (3.8)	7.2 (3.7)	7 (3.4)
Clinical supervision as a supervisee (review of difficult/challenging cases and/or cases with nil improvement).	1.2 (1.1)	8.7 (1.2)	9.1 (1)	7.7 (2.5)
Live supervision provided during sessions (e.g., supervisor as co-therapist, one-way mirror/reflecting team, etc.).	0.1 (0.3)	8 (4)	5.4 (4.2)	6.9 (3.7)
Reading of journals pertaining to psychotherapy and counselling.	3.4 (5.7)	7.4 (2.4)	5.9 (2.1)	6.3 (1.4)
Reading/re-reading of core counselling and therapeutic skills in psychotherapy.	1.5 (2.8)	6.9 (2.8)	6.5 (2.5)	7.3 (1.5)
Focused learning in specific model(s) of psychotherapy.	2.7 (4)	7.8 (2.4)	7.9 (2.4)	8.1 (1.5)
Reviewing therapy recordings alone.	1.2 (2.8)	9.5 (0.7)	7.3 (3.1)	7.5 (2.5)
Reviewing of therapy recordings with peers.	0.4 (0.7)	9.3 (1.1)	6 (3.5)	6.6 (3.5)
Reviewing difficult/challenging cases alone.	3.3 (3.7)	6.4 (2.8)	7.5 (2.7)	7.3 (2.5)

Attending training workshops for specific models of therapy.	2 (4.4)	9.2 (1.6)	7.6 (2.4)	6.2 (3.5)
Case discussion/ conceptualisation/ formulation with a mentor/clinical supervisor	2 (1.8)	8 (1.9)	7.4 (3.4)	6.4 (3.2)
Mentally running through and reflecting on the past sessions in your mind.	8.5 (9.6)	5.2 (2.2)	6.8 (2)	7.8 (1.5)
Mentally running through and reflecting on what to do in future sessions.	5.1 (5)	5.2 (2.2)	6.8 (2.2)	6.7 (2.6)
Writing down your reflections of previous sessions.	3.7 (6)	7.4 (2.3)	7 (2.2)	7 (2.8)
Writing down your plans for future sessions.	2.1 (2.9)	6.6 (2.7)	5.7 (2.5)	5.8 (2.2)
Case discussion/ conceptualisation/ formulation with peers.	1.7 (1.9)	7.1 (2.7)	6.9 (2)	6.6 (2.1)
Viewing master therapist videos, with the aims of developing specific therapeutic skills as a therapist.	0.2 (0.3)	9.6 (0.1)	7.8 (2.2)	5.5 (3.3)
Reading case examples (e.g., narratives, transcripts, case studies).	0.8 (1.2)	8.7 (1.8)	7.5 (1.6)	7.2 (1.4)
Discussion of psychotherapy related subjects with contemporaries/ peers/ mentors	3.9 (3)	5.8 (1.2)	6.7 (2)	6 (1.5)
Tending to self-care activities and emotional needs (e.g. attending personal therapy, group work, quiet time, meditation, spiritual/religious practices, etc.) with the aim of being a better helper in the therapeutic relationship	3.6 (2.1)	6.6 (2.9)	7.4 (1.6)	5.8 (2.2)
Socialising	16.4 (11.9)	5.4 (3.2)	6.7 (2.3)	5.5 (2.7)
Exercising	14.8 (17.1)	5.8 (3)	6.8 (1.9)	4.4 (2.8)

Rest (e.g., naps in the day, going for a walk, engaging in non-therapeutic activity that is enjoyable).	8.2 (5.2)	4.7 (2.6)	6.6 (2)	4.5 (2.8)
Other (e.g. mental health outreach work, none, childcare, singing, walking, cooking meals)	49.25 (111)	3.7 (3.9)	3 (3.5)	3.9 (3.8)

Appendix I – Transcriber Confidentiality Agreement

Doctorate in Clinical Psychology, University of Sheffield

Transcribing Confidentiality Form & Guidance Notes

Type of project: Research thesis

Project title **Therapist effects: A qualitative exploration of therapist perceptions.**

Researcher's name Aisling McFadden

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 J. *a priori* Themes

Main Themes
Therapist Resilience
Therapist Wellbeing
Deliberate Practice
Therapist Personality

Appendix K. Ethical Approval

Miss Aisling McFadden
Trainee Clinical psychologist
Sheffield Health and Social Care
Fulwood House
Sheffield
S10 3TH

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

11 December 2018

Dear Miss McFadden

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Therapist effects: A qualitative exploration of therapist perceptions.**
IRAS project ID:	**249217**
Protocol number:	**155766**
REC reference:	**19/HRA/0525**
Sponsor	**University of Sheffield**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation immediately following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

IRAS project ID	249217

If not already done so, you should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. After entering your IRAS ID you will be able to access a password protected document (password: **Redhouse1**). The password is updated on a monthly basis so please obtain the relevant contact information as soon as possible; please do not hesitate to contact me should you encounter any issues.

Commencing research activities at any NHS organisation before providing them with the full local information pack and allowing them the agreed duration to opt-out, or to request additional time (unless you have received from their R&D department notification that you may commence), is a breach of the terms of HRA and HCRW Approval. Further information is provided in the "*summary of assessment*" section towards the end of this document.

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

IRAS project ID	249217

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Amrit Sinha

a.sinha@sheffield.ac.uk

0114 2226650

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **249217**. Please quote this on all correspondence.

Yours sincerely

Alex Thorpe

Senior Assessor

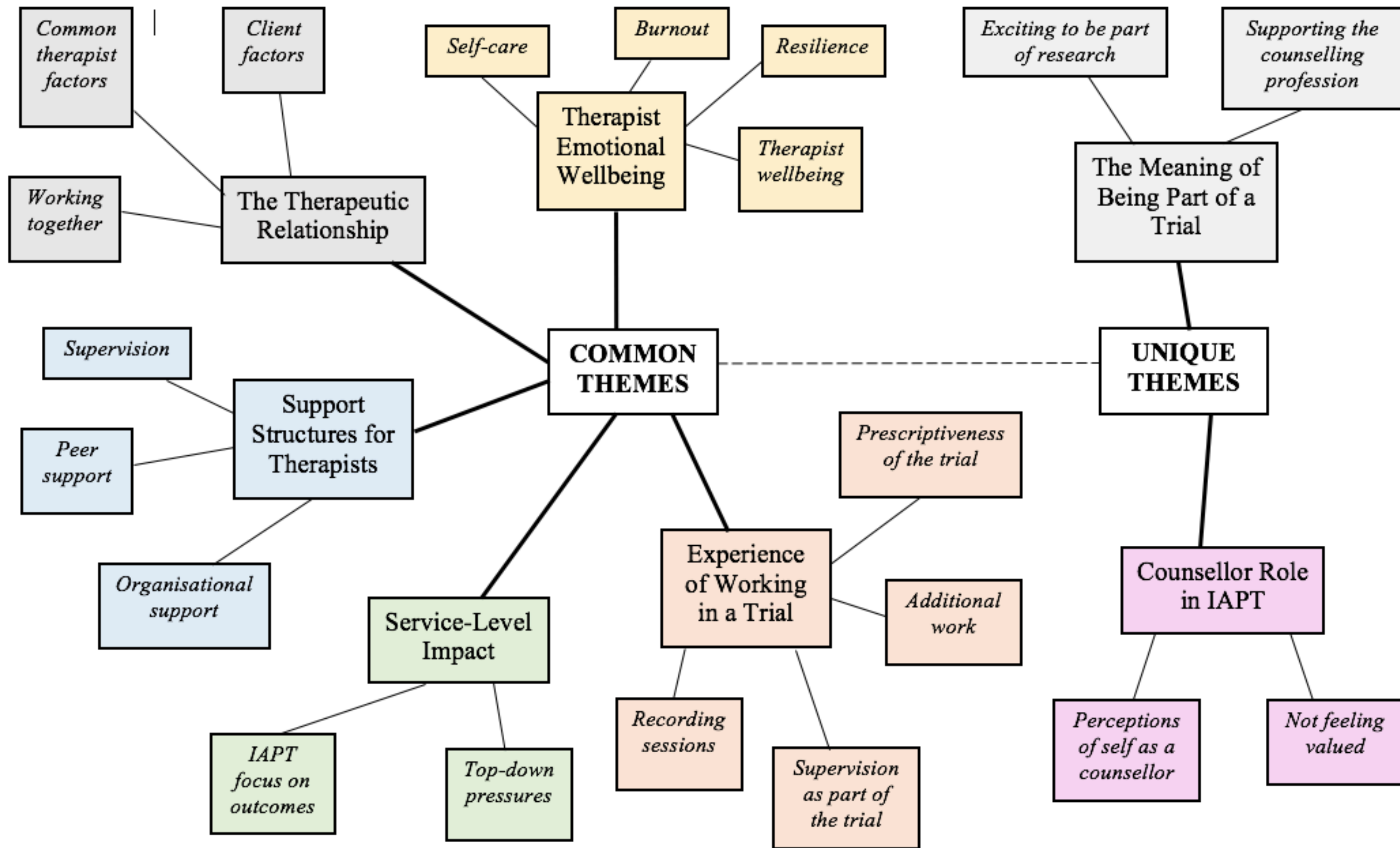
Email: hra.approval@nhs.net

Copy to: *Mr Amrit Sinha, Sponsor's Representative*
Mr Nick Bell, Sheffield Health and Social Care NHS Foundation Trust, Lead R&D Contact

Appendix L. Excerpts from Reflective Log

Stage of Research Process	**Excerpt from Reflective Log**
Interviewing participant	Felt strongly about use of words such as "patient" and allegiance with medical model. Was aware of this throughout the conversation and instead focused on content of their responses. Also struggled at times to follow the point they were making because they discussed a number of points. I was aware of bringing myself back to ensure I was focused on what they were saying and asked follow-up questions to clarify.
Coding participant transcript	Experienced sense of loyalty when talking about social issues of clients and working with clients from diverse backgrounds. Felt aware that I was focused on those ideas, rather than the specific interview schedule and so ensured I brought it back to the research question focus.

Appendix M. Conceptual Map of Final Coding Template



Appendix N. Example of Transcript Coding Process

Participant (Therapy model)	**Section of Transcript**	**Main Theme**	**Sub-theme**
Participant 10 (CBT)	R No, that's ok, so whatever it is you think contributes to therapy outcomes. P Ok, yeah, I think the therapist is fit for their training, so that's often called adherence, so stick to the evidence based models, rather than drifting from that. Um, what else.. um, do you – are you looking at any patient factors or just thinking about like – R Yeah, anything that you think contributes. P Yeah, therapy being a shared responsibility, so patient regularly attending, engaging during the sessions, engaging in the between-session work. Um, yeah, the techniques or the treatment methods provided.. um, probably the main things I would say, off the top of my head. R Ok, and when you - because you said about the therapeutic relationship, um, what does that look like to you? What do you think the important things are, in relation to that? P I think it's about – in the simplest way, teamwork, so that collaboration between the therapist and the patient, they're both contributing to conversations, to ideas, it's honest conversation, so if the patient's struggling, hopefully that person can let the therapist know and the therapist can help address that. That the therapist – certainly if I, as a therapist, don't quite understand what a patient is saying, or any difficulties they're having, I'll let them know that in a gentle way and try and explore that. Um, I think having that trusting relationship with another person it can enable a patient to try things out, to experiment, to try – try the techniques suggested, in a safe place, the therapy room, but also in life, to report back. Um.. yeah.. I guess that's what I mean.	The Therapeutic Relationship	Common therapist factors Client factors Working together

Participant 8 (PCET)	P So as a therapist, um.. yeah, I think I'm lucky – I feel resilient, and I've always thought that one of the strengths I have is that um.. and I don't't' know if this does make a difference in the counselling room, but I seem to be able to leave it behind and go home and not worry about people. Obviously there are days when it's hard, but mostly you, yeah, I can leave it at work. Um, I guess life circumstances affect counsellors as much as they affect clients so I, um, I'm able to not have too many massive anxieties or whatever, so far, it's going to happen, but I think having that, um, you know, having a sort of um, safe, secure private life is probably really helpful. Obviously supervision, that sort of is restorative, um, it's funny, this does feel a bit like a supervision session, ha. R Oh, really? P Yeah, no, it's therapeutic, it's great. Yeah, in that way, that it's like 'blah'; R Let it out. P Yeah, let it out, exactly. So all those things I think are helpful. R Yeah, and what is it about supervision that you feel is particularly restorative? P Um, yeah, just getting it off your chest, being able to get things off your chest. Um, getting unstuck, with your supervisor, if you're feeling stuck with a client, between you and the supervisor, hopefully feeling a bit less stuck or getting unstuck. Just knowing – and it's funny, because you can leave a supervision session thinking 'ok, I know where I'm going to go next' and actually ¾ of the time it doesn't go that way, but it gets unstuck somehow anyway, in some sort of different way, I don't know, it's magic. Um.. yeah, just spending time with colleagues I think is just helpful.	Therapist Emotional Wellbeing Support Structures for Therapists	Resilience Therapist Wellbeing Supervision Peer support

Appendix O. Additional Examples of Themes and Sub-Themes

	Main Theme	Sub-theme	Quotes
Common Themes	The Therapeutic Relationship	Common therapist factors	Participant 3 (CBT) "I think it's things like making sure that your structured and you've got a good understanding between you and your patient about what it is that you working on my experience is where I have good outcomes with patients as well we've been quite clear about what the patient wants to get so having a clear goal and a clear idea about what the patient wants to get from treatment." Participant 12 (PCET) "…by not judging the person. but yeah been accepting, and listening, listening actively not just nodding your head."
		Client factors	Participant 8 (PCET) "Or maybe they need to come back round the loop, so the thing about being ready, clients, maybe sometimes just – you know, had to be the right time in their lives." Participant 11 (CBT) "I must say one person that comes to mind you know as the fact that they were just real, really, really keen, really sort of like quite actively engaged."
		Working together	Participant 6 (CBT) "I guess when it feels like you're working together so you're both kind of trying to work things out, trying to understand one another." Participant 9 (PCET) "To be mindful of the limits that they might want to work in, so very much – this is for my style therapy anyway, to try and follow that client's agenda and not push and not bring in my own thoughts about where we ought to be leading." Participant 11 (CBT) "Rather it being like a passive thing, you know something that, that I guess the very opposite of collaborative, of, of therapy being delivered and just done."

	Support Structures for Therapists	Supervision	Participant 6 (PCET) "it comes back to having a really good relationship with your supervisors where you can do that so you trust her to tell her about stuff, you know you wouldn't, you wouldn't tell your boss, you know you wouldn't, you wouldn't tell people, you certainly wouldn't tell people over a coffee at work or something you know, erm so it's like yeah so that, that reduces the valve to reduce some of the pressure really." Participant 11 (CBT) "so the extra tools are sort of like just talking more, making sure you get supervision, making sure you get erm sort of erm yeah you've got your support both at work and at home and you get out, have a life."
		Peer support	Participant 10 (CBT) "It's very demanding to do that and to still have a life, ha, and be able to talk to your colleagues as well, have a bit of a chat." Participant 9 (PCET) "And what do I do? I have a rant about it, perhaps, with colleagues who are feeling similarly, um, have my say when I can, and then just have to try and set it aside."
		Organisational support	Participant 12 (PCET) "I'd got that to deal with as well as my hand still needing to heal while at work, adjustments needing to be made, and then my manager sort of like questioning why I had taken these clients on." Participant 3 (CBT) "if it's a service thing again I leave the wait for my line management and raise it there or send an email to my manager to clarify it there and then."
	Therapist Emotional Wellbeing	Resilience	Participant 11 (CBT) "you could call it as a sort of like trait in a way that some people are more resilient than others, there's fairly stable, erm and but erm, but I think it does vary a little bit but I think there should be a certain, erm the people that are more resilient I think are gonna be on the whole better Therapists than others are gonna be." Participant 8 (PCET) "I feel resilient, and I've always thought that one of the strengths I have is that um.. and I don't' know if this does make a difference in the counselling room, but I seem to be able to leave it behind and go home and not worry about people." Participant 5 (CBT) "It is a buzz word at the moment in our company, in our organisation because they want people to weather this storm really don't they?"

		Therapist wellbeing	Participant 8 (PCET)" I guess life circumstances affect counsellors as much as they affect clients so I, um, I'm able to not have too many massive anxieties or whatever, so far, it's going to happen, but I think having that, um, you know, having a sort of um, safe, secure private life is probably really helpful." Participant 4 (CBT) "I mean we all have our own stuff and issues and lots of Therapists have depression and anxiety and have therapy themselves erm and I think that's okay as well as your looking after yourself." Participant 2 (CBT) "Organisations try to look after staff, providing supervision support, erm and making sure that they look after the wellbeing of the staff because it wouldn't be, yeah wouldn't be sensible for us all to get stressed and unwell and then go off work and then you know, so there is that emphasis but there's also pressures to meet targets, to use the resources, er see a certain number of patients."
		Burn-out	Participant 7 (CBT) "They'll burn out, they'll, they'll get anxious, they'll try and work harder to get the same level of outcomes expected of them when they're not being supported." Participant 6 (PCET) "I guess if someone tells you something horrible you know and, and you genuinely, you know being in this situation with them because you've been empathising, you've been tracking them really well erm actually you don't feel so great and it is exhausting and you know if you've seen five people on a Friday, you know Friday afternoon you're pretty knackered"
		Self-care	Participant 9 (PCET) "So I think just feeling kind of physically good just helps anyway, and most nights at 9 o'clock I go and watch TV and watch whatever brutal, often, drama is on, at 9o'clock, with my cat." Participant 3 (CBT) "I think for me personally I've got a good idea of what a good model of self-care should look like and I think that I use that well."

	Service-Level Impact	IAPT focus on outcomes	Participant 5 (CBT) "I don't have to be really harsh about it but it is important to be harsh sometimes because if somebody's is just not in the place of therapy and they're ambivalent and they're not coming and you keep that open and open and open you're not seeing somebody else that could benefit so (A) its unethical and (B) it will affect your recovery rate cos the longer you spend twiddling your thumbs while somebody DNA's the less time you have to get someone in who might recover." Participant 9 (PCET) "And personally, I'm more bothered about that than the numbers that come from the questionnaire, the outcome measures. But we have to keep our eyes on that because we have to keep our targets in mind."
		Top-down pressures	Participant 9 (PCET) "But you know, to be able to work effectively, you've got to have some way of letting it go. So, I would say I don't often get stressed actually by working with people; it's more organisational things that cause me stress." Participant 7 (CBT) "it is being able to manage pressures the of working in IAPT and the outcomes versus what's good for the err service user."
	Experience of Working in a Trial	Recording sessions	Participant 4 (CBT) "I think it might have impacted on me at first as well that I felt like I was being recorded I've got to do this well, do it properly so that might have impacted on the way I was and the sort of therapeutic relationship as well but I did get used to it as you do." Participant 6 (PCET) "I knew that it was very important to record therapy sessions because my other studying erm and I would periodically record things and take them to supervision and listen to them anyway so, so that was no problem, that was absolutely no problem, the, the, the scary thing of course is, is being judged on it and not in supervision where its, you know either pass or fail."
		Supervision as part of the trial	Participant 6 (PCET) "You could actually say look I've got four session 6's or something and she would then sample them so you know erm so it meant that in proper supervision,

			I mean that was supervision because you could, you know she, it wasn't just about scoring whether she thought you had passed or failed according to criteria." Participant 10 (CBT) "So we had to always bring trial cases to group supervision, so that was good because you had input from a lot of other people, peers, as well as the supervisor for the group, and it was very close supervision so we listened to recordings or clips from recordings, we had this rating scale about adherence. I think that side of it was good because that was a very rich learning experience for everybody, whether you were in the group listening to somebody else, whether it was your own patient, I thought that was good."
		Prescriptiveness of the trial	Participant 10 (CBT) "The other thing was how prescriptive it was, when you had patients who were in the trial, that you had to use Beckian cognitive therapy, and we had lots of workshops and training refreshers on how to do that." Participant 9 (PCET) "When it came to the PRACTICED trial and that that was the style of counselling that was to be used, if you like, in the comparison, that suited me fine."
		Additional work	Participant 6 (PCET) "It did put an extra burden because there's all these recordings to get listened to, erm and erm it was extra work in that way." Participant 2 (CBT) "Some of the things that I found were more tricky was that it did then create an extra burden of work because there was extra audio recordings needed. and even just a small thing about putting them on encrypted devices and then transferring them to another representative, it's just extra time and effort involved in doing some practical extra bits that are part of the trial that take up your energy and time."
	Counsellor Role in IAPT	Not feeling valued	Participant 12 (PCEP) "So it's helped us find a voice, if you like, a confident Voice not, because I think managers have always thought we're whinging and whining but I think with the language of the PCET model, it has helped us to actually go out to other parts of the service and talk about this is what counselling is, this is what we do and this is how

			it;s different and this is why, this is how we get outcomes and this is the sort of client that we work with."
Unique Themes		Perceptions of self as a counsellor	Participant 9 (PCEP) "So I will talk about clients, not about patients, I will not talk about treating someone, I will talk about working with someone; the language is all – that's a constant frustration and also, if I talk like that with other people, I'm wondering what they're thinking of me doing this? Are they receiving me as being uppity and not wanting to fit in with how other people speak or what? So, there's a bit of a tension there."
	The Meaning of Being Part of a Trial	Exciting to be part of research	Participant 11 (CBT) "You know for me personally and other people in service I know are so interested in, in the use of practice based research that, that erm that that's got to be a you know a good thing and in the service we don't actually get enough time to be involved in, in research unless you know they're in a you know a Masters or a PhD or, or for whatever."
		Supporting the counselling profession	Participant 2 (PCET) "I can't help wondering what the experience was like for the CBT therapists, because for counsellors, it feels really important, it feels really special to be involved in something where you know that counsellors around the country are waiting for the results."

Appendix P. Theme Distribution Across Participants

	Main Theme	Sub-theme	P1 PCET	P2 CBT	P3 CBT	P4 CBT	P5 CBT	P6 PCET	P7 CBT	P8 PCET	P9 PCET	P10 CBT	P11 CBT	P12 PCET
Common Themes	The Therapeutic Relationship	Common therapist factors	X	X	X	X	X	X	X	X	X	X	X	X
		Client factors	X	X	X	X	X		X	X	X	X	X	X
		Working together	X	X	X	X	X	X	X	X	X	X	X	X
	Support Structures for Therapists	Supervision	X	X	X	X	X	X	X	X	X	X	X	X
		Peer support			X	X			X	X	X	X		
		Organisational support			X	X			X	X	X	X	X	X
	Therapist Emotional Wellbeing	Resilience	X		X	X	X		X	X	X	X	X	X
		Therapist wellbeing	X	X		X	X	X	X	X	X	X	X	X
		Burn-out	X		X	X	X	X	X	X	X			X
		Self-care	X	X	X	X	X	X		X	X	X		X
	Service-Level Impact	IAPT focus on outcomes	X	X		X	X	X	X	X	X	X		X
		Top-down pressures	X	X		X	X	X	X	X	X	X		X
	Experience of Working in a Trial	Recording sessions	X	X	X	X	X	X	X	X	X	X	X	X
		Supervision as part of the trial		X	X	X	X	X	X	X	X	X	X	X
		Prescriptiveness of the trial	X	X	X	X	X	X	X	X	X	X		X
		Additional work	X	X	X	X	X	X	X		X	X	X	X
Unique Themes	Counsellor Role in IAPT	Not feeling valued	X								X			X
		Perceptions of self as a counsellor	X					X		X	X			X
	The Meaning of Being Part of a Trial	Exciting to be part of research		X	X		X					X	X	
		Supporting the counselling profession	X					X		X	X			X