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UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

**Telephone versus Face-to-Face Psychological Therapy in an Improving
Access to Psychological Therapies (IAPT) Low-Intensity Service: An
exploration of practitioners' and patients' experiences and its effectiveness**

by

Joshua Turner, BSc (Hons.)

Thesis for the degree of Doctor of Philosophy

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UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF HEALTH SCIENCES

Doctor of Philosophy

**TELEPHONE VERSUS FACE-TO-FACE PSYCHOLOGICAL THERAPY IN AN IMPROVING
ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT) LOW-INTENSITY SERVICE: AN
EXPLORATION OF PRACTITIONERS' AND PATIENTS' EXPERIENCES AND ITS
EFFECTIVENESS**

By Joshua Turner

Over-the-Telephone (OTT) delivered therapies as an alternative method to face-to-face (F2F) therapy are becoming more prevalent in mental healthcare. This mixed methods project explored the differences between OTT and F2F low-intensity therapies within the Improving Access to Psychological Therapies (IAPT) programme. The views and experiences of IAPT service users and practitioners were collected using questionnaires and interviews. Service user psychometric outcome data were also collected.

Established research documents a range of benefits of OTT use in psychotherapies but there are growing concerns over its potential effects on the therapeutic relationship. The results from this project raised five topics for discussion:

- (1) The effectiveness of OTT versus F2F therapy: Symptom score reductions were found across both modalities, but OTT users showed significant improvements which were not evident with F2F users.
- (2) The impact of OTT versus F2F on the therapeutic relationship: The therapeutic relationship is central to recovery in therapy and the absence of visual and non-verbal communication in OTT use contributed to a potential loss of 'humanness' in the experience of therapy.
- (3) Improving access to psychological therapies: OTT use was commended by patients and practitioners for removing barriers to access psychotherapies.
- (4) Patient attitudes to telephone use: Patients were initially sceptical about OTT because of their view that F2F is the 'norm' in psychotherapies.
- (5) Practitioner views on telemedicine use and the IAPT process: Practitioners expressed wariness towards OTT use, particularly in the context of the IAPT services' quantitatively driven goals.

Overall, these results support previous research in telemedicine. However, this project is unique in providing data on the patient and practitioner experiences of OTT and F2F in IAPT and contributes new understanding to an emerging research area. Possibilities for future research are outlined including ideas about how to develop and apply theoretical models which are relevant to the experience of therapy in an IAPT service.

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Academic Thesis: Declaration of Authorship

I, **Joshua Turner**, declare that this thesis titled, '**Telephone versus Face-to-Face Psychological Therapy in an Improving Access to Psychological Therapies (IAPT) Low-Intensity Service: An exploration of practitioners' and patients' experiences and its effectiveness**' and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission.

Signed:

Date:

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Author's Note

Language and Terminology

I would like to highlight that the terminology used in the research identified within literature review (*Chapter 2*) involves the use of medical model-based language, e.g. 'doctor-patient relationships', 'treatment', 'intervention', 'compliance', and 'adherence'.

Historically, mental health was largely associated with the profession of medicine (e.g. Psychiatry) and adopted its biological terms. For example, mental health disorders are 'diseases' of the body, as opposed to subjective illnesses of the mind. However, current approaches have noted the importance on the subjective experiences of the individual rather than objective biological phenomena (Wampold, 2001; Wampold, Ahn and Coleman, 2001; Mulligan, 2012).

Mental healthcare has increasingly made a move away from a paternalistic way of working, in which the therapist prescribes the mechanism in which the 'issue' can be 'treated', to a more collaborative relationship between the service user and the health professional (e.g. Sparks, Duncan and Miller, 2006; House and Loewenthal, 2010). For instance, the Improving Access to Psychological Therapies (IAPT) initiative is based on psychological therapies (primarily those utilising Cognitive-Behavioural Therapy principles) which claim to be collaborative (DoH, 2010; Westbrook, Kennerley and Kirk, 2011) and thus the language which denotes this type of approach was used where appropriate.

When discussing the method of providing therapy (telephone or face-to-face), the term 'treatment delivery modality' or 'modality type' was used to distinguish the use of these modalities during the initial assessment period from their use in the treatment period in IAPT. This is consistent with the language deployed in IAPT. Vocabulary which may be classed as 'medical-model based' (which are subject to some critique) has also been found to be acceptable and is utilised in IAPT (e.g. the term 'patient' is accepted by IAPT service users; Richards and Whyte, 2009) – thus, the terms 'patient' and 'service user' are used interchangeably.

Explanations of technical terms used in this thesis, which are not outlined in-text, are presented in the *Definitions* section.

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List of Abbreviations and Symbols

APA	American Psychological Association
BAI	Beck Anxiety Inventory
BDI / Brief-BDI	Beck Depression Inventory / Brief version of the Beck Depression Inventory
BT	Behaviour Therapy
CAQDAS	Computer-Assisted Analysis of Qualitative Data
CBT	Cognitive-Behavioural Therapy
cCBT	Computerised Cognitive-Behavioural Therapy
CDC	Centers for Disease Control and Prevention
CMD	Common Mental Health Disorder
CORE-OM	Clinical Outcomes in Routine Evaluation Outcome Measure
CT	Cognitive Therapy
DIT	Dynamic Interpersonal Therapy
DoH	Department of Health
DNA	Did Not Attend
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
ECT	Electroconvulsive Therapy
EDD	Eye-Direction Detector
EPDS	Edinburgh Postnatal Depression Scale
EuroQOL	European Quality of Life Questionnaire
F2F	Face-to-Face
GAD	Generalised Anxiety Disorder
GAD-7	7-item Generalised Anxiety Disorder Scale
GHQ-12	12-item General Health Questionnaire
GP	General Practitioner
HADS	Hospital Anxiety and Depression Scale
HI	High-Intensity
HRSD	Hamilton Rating Scale for Depression
HSCIC	Health and Social Care Information Centre
HSCL-20	Hopkins Symptom Checklist-20
IAPT	Improving Access to Psychological Therapies
ICD-10	International Statistical Classification of Diseases and Related Health Problems
ICT	Information Communication Technologies
IPT	Interpersonal Psychotherapy
IPT-T	Interpersonal Psychotherapy delivered over-the-telephone
LI	Low-Intensity
Mdn	Median
NEPHO	North East Public Health Observatory

List of Abbreviations and Symbols

NHS	National Health Service
NICE	National Institute for Clinical Health and Excellence
NPT	Normalisation Process Theory
NVCs	Non-verbal Cues
OCD	Obsessive Compulsive Disorder
ONS	Office for National Statistics
OTT	Over-the-telephone
PHQ-9	9-item Brief Patient Health Questionnaire Mood Scale
PCT	Person-Centred Therapy
PDT	Psychodynamic Therapy
PIS	Participant Information Sheet
PRIME-MD	Primary Care Evaluation of Mental Disorders
PTSD	Post-traumatic Stress Disorder
PWP	Psychological Wellbeing Practitioner
PWQ	Psychological Wellbeing Practitioner Questionnaire (developed for this study)
RCTs	Randomised Controlled Trials
SCL-90	Symptoms Checklist 90
SD	Standard Deviation
SES	Socioeconomic Status
SF-20	20-item Short-Form General Health Survey
SF-36	36-item Short-Form Health Survey
SPSS	IBM Statistical Package for Social Sciences
SSP	Statutory Sick Pay
SU	Service User
SUQ	Service User Questionnaire (developed for this study)
T-CBT or CBT-T	Telephone-delivered Cognitive-Behavioural Therapy
TAM	Technology Acceptance Model
ToM	Theory of Mind
TBP	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
VC	Videoconferencing
W&SAS	Work and Social Adjustment Scale
WAI	Working Alliance Inventory
WHO	World Health Organisation
Y-BOCS	Yale-Brown Obsessive Compulsive Scale
χ^2	Chi-Square test
\bar{x}	Mean

Definitions

Bonferroni correction

A statistical method used to control the familywise error rate. It is calculated by dividing the significance level ($\alpha = .05$) by the number of comparisons carried out (Field, 2013) – see *Familywise Error rate*.

Code

An aspect of *Thematic Analysis*. It is a segment of the data that is of interest to the researcher (Boyatzis, 1998; Braun and Clarke, 2006).

Cognitive-Behavioural Therapy (CBT)

A therapeutic approach which inherits aspects of both the Cognitive and the Behaviourist Movements; it is considered an “*umbrella term*” (p. 955) which encompasses Cognitive Therapy (CT), Behaviour Therapy (BT), as well as therapies which utilise a mixture of these two approaches (Beck, 2005).

Common Mental Health Disorders (CMDs)

The collective term for mood and anxiety disorders such as depression, generalised anxiety disorder (GAD), panic disorder (with or without agoraphobia), obsessive compulsive disorder (OCD), specific phobias, social anxiety and post-traumatic stress disorder (PTSD) (National Institute of Clinical Excellence [NICE], 2011).

Credibility

A qualitative concept of rigour by Guba and Lincoln (Guba, 1981; Lincoln and Guba, 1985; 1986). There is confidence in the findings that one has gained as one has collected as much information as possible to be able to describe the phenomenon that was under study (e.g. by having multiple observations or being provided with multiple descriptions). “*Participants recognise the meaning that they themselves give to a situation or condition and the ‘truth’ of the findings in their own social context*” (Holloway and Wheeler, 2010, p. 303). This is also referred to as *Truth Value*.

Definitions

Confirmability

"Confirmability has taken the place of the term objectivity" (Holloway and Wheeler, 2010, p. 303) in qualitative research. A qualitative concept of about thoroughness and competence (rigour) by Guba and Lincoln (Guba, 1981; Lincoln and Guba, 1985; 1986). This notes the importance that data are found through the basis of the research and not through other motivations (i.e. answers should be interpreted based on the question that was asked or the context it was given in and not interpreted for other purposes). This is also referred to as *Neutrality*.

Construct Validity

A concept related to the *Internal Validity* of a questionnaire tool; it is the extent to which the questions were appropriate for the aims and objectives of the study (Streiner and Norman, 1995; Jenkinson and McGee, 1998).

Counter-Transference

A process within the psychodynamic therapeutic approach, it *"...is the response that is elicited in the recipient (therapist) by the other's (patient's) unconscious transference communications"* (Hughes and Kerr, 2000; p. 62) – this includes feelings and thoughts (Howard, 2008).

Dependability

A qualitative concept of rigour by Guba and Lincoln (Guba, 1981; Lincoln and Guba, 1985; 1986). This is the assurance that descriptions and observations remain consistent if replicated with similar, or the same, individuals. *"Although a study cannot be replicated, in similar circumstances with similar participants, it might be repeated"* (Holloway and Wheeler, 2010, p. 302).

Dummy Coding

A method of re-coding a categorical variable with more than two variables into a series of variables that are dichotomous (e.g. for use in a logistic regression model which requires binary coding) (Field, 2013).

Effect Size

An objective measure that describes the magnitude of an observed effect or the difference between two groups (Field, 2013).

External Validity

The extent in which the findings can be applied (or 'generalised') to a wider audience (Stangor, 2006).

Face Validity

A concept related to the *Internal Validity* of a questionnaire tool; it is the extent to which questions can be understood (Streiner and Norman, 1995; Jenkinson and McGee, 1998).

Familywise Error Rate

A familywise error occurs when multiple comparisons are utilised thereby increasing the likelihood of a *Type I error* occurring (Field, 2013).

Frequency Scoring

A quantitative level of analysis that can be applied to qualitative data. The number of items coded in a theme can be taken into account in the analysis (Boyatzis, 1998; Joffe and Yardley, 2004).

Intensity Scoring

A form of quantitative level of analysis that can be applied to qualitative data – can be used in instances where it is possible to divide the data in terms of affect (e.g. negative or positive attitudes) and using the frequency of these affect statements, intensity could be proposed (Boyatzis, 1998).

Internal Validity

The extent to which one could ensure that the dependent variable was a product of the independent variable (Stangor, 2006).

Interviewer Bias

A type of bias in which the researcher could unintentionally influence the responses of the interviewee – this can be due to their body language or tone of their voice (Stangor, 2007).

Low-Intensity (LI) Therapy

A treatment paradigm where patients have less contact time with a specialist therapist (in Step 2 they are known as Psychological Wellbeing Practitioners [PWP]) or where a cost-effective

Definitions

method is used in therapy, such as shorter sessions, self-help materials, group therapy sessions or using telecommunication services (Bennett-Levy *et al.*, 2010).

Sensitivity

When exploring the validity of a psychometric instrument, it is the proportion of patients who fall within the diagnostic criteria (Lalkhen and McCluskey, 2008).

Social Desirability Bias

A type of bias in which a participant may provide an answer to a question which is 'socially acceptable' but it is a view which they do not hold (Streiner and Norman, 1995).

Specificity

When exploring the validity of a psychometric instrument, it is the proportion of patients who have been correctly identified as meeting its diagnostic cut-off (Lalkhen and McCluskey, 2008).

Statistical Power

The ability of a test to detect an effect of a particular size (Field, 2013).

Telemedicine

An umbrella term for the use of a health service (e.g. consultations, diagnosis, implementing therapy, and monitoring) delivered over a distance through the use of a telecommunication technology (e.g. telephone, computer/internet, mobile device, etc.). This can be carried out in real-time or via delayed response depending on the technology in use (Bashshur, Rearden and Shannon, 2000; Craig and Patterson, 2005). Similar and synonymous terms include: *Telecare*, *Telehealth* and *Telemonitoring*.

Telemental Health

Mental health services delivered over a distance through the use of a telecommunication technology (e.g. telephone, internet, and videoconferencing) – see *Telemedicine*. Similar and synonymous terms include: *Telepsychiatry* and *Telepsychology*.

Thematic Analysis

A qualitative analysis method. It can be described as “...*a way of seeing*” (Boyatzis, 1998; p. 1). Qualitative data are highlighted or ‘coded’ into segments of interest to the research (e.g. it may display emotions about a certain aspect of OTT use). These *codes* form *themes*.

Theme

An aspect of *Thematic Analysis*. Patterns of *codes* identified can be organised into *themes*. These describe and provide understanding to the phenomenon under study (Boyatzis, 1998; Braun and Clarke, 2006).

Transference

A process within the psychodynamic therapeutic approach, it is a “...*phenomenon whereby we unconsciously transfer feelings and attitudes from a person or situation in the past on to a person or situation in the present*” (Hughes and Kerr, 2000; p. 58).

Transferability

A qualitative concept of rigour by Guba and Lincoln (Guba, 1981; Lincoln and Guba, 1985; 1986). The degree to which findings can be applied in other contexts and/or with other groups. This is also referred to as *Applicability*.

Type I Error

When the null hypothesis (H0) is true, but is rejected – a false positive (Field, 2013).

Yea-Saying

A response bias in which participants have a tendency to agree with all the questions, indicate a positive connotation, or select one side of a likert scale for all questions (Streiner and Norman, 1995). Also known as a *Positive Ratings bias* or *Acquiescence bias*.

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Personal Statement and Thesis Overview

The subject of psychology has fascinated me ever since I began to study it at A-Level. This interest grew and I wanted to expand on the knowledge introduced during my time at sixth form. As a result, I went on to read for a BSc (Hons.) in Psychology at Royal Holloway, University of London where I was intrigued about the different approaches in the explanation and treatment of 'Mental Disorders'. After completing my studies, I was unsure whether to pursue a career as a Clinical Psychologist thereby applying my knowledge in a practical application or to contribute knowledge to the field of mental health through research.

My research career began at the University of Southampton, Faculty of Health Sciences in 2010 as a PhD Studentship researcher for a project investigating the use of technologies for support in Post-Natal Depression. Regrettably, this project ended prematurely due to the departure of the grant holder. Fortunately, I was encouraged and supported by my faculty to continue to pursue my passion in mental health research. I developed this research project with the help of my supervisors at the end of 2010, with the intention of exploring the differences between face-to-face contact and use of telecommunication technologies (such as the telephone) in psychological therapies. At the time, my experiences in research were mainly quantitative-led but I was keen on expanding my skillset and wished to include qualitative methodologies to help increase my knowledge and understanding of this research perspective.

I currently apply and am developing my quantitative research skills in a research position at the Office for National Statistics (ONS). In this post, I also hoped to gain a different insight in a research career path situated outside of academia.

This thesis outlines the process and findings of a research project which investigated the differences between the uses of face-to-face or telephone-based psychotherapies within the Improving Access to Psychological Therapies (IAPT) programme. More specifically, it explores practitioner views and experiences, as well as patient satisfaction and therapeutic outcomes. *Chapter 1* sets IAPT in the context of mental healthcare policies in Britain, as well as alluding to topics relating to a wider debate regarding this programme. *Chapter 2* establishes the literature regarding the use and effectiveness of telecommunication technologies in psychotherapies and establishes the justification and research question implemented in this

research project. *Chapter 3* constitutes the methodology, research design, ethical considerations and procedures for data collection and analysis for the four aspects of the project: (1) the Service User Questionnaire, (2) the Psychological Wellbeing Practitioner (PWP) Questionnaire, (3) the IAPT Outcome Database, and (4) the PWP Interviews. *Chapter 4* consists of the results from the data collected. A discussion of the findings of the research using previous literature and theoretical concepts is presented in *Chapter 5*. Finally, *Chapters 6 and 7* concern the recommendations for future work and the project's conclusions.

CHAPTER 1: Background

1.1 Introduction

This background chapter aims to set the Improving Access to Psychological Therapies (IAPT) programme – where this research project was set – in the context of how mental healthcare policies have developed in Britain. It presents the following:

- 1) A brief summary of key historical milestones in the developmental of mental healthcare policy in Britain.
- 2) The impact of common mental health disorders, particularly with regards to their economic implications.
- 3) The aims of the processes of the IAPT programme in the English National Health Service (NHS). It also explores aspects of a debate surrounding the IAPT programme.
- 4) An outline of the Step 2 service in IAPT and a description of the low-intensity therapies where telecommunication technologies are used.
- 5) How telecommunication technologies have been used previously in emotional support.

1.2 Mental Health, Common Mental Health Disorders (CMDs) and the IAPT Programme

1.2.1 Mental Health in the Britain: Contextualising the IAPT Programme

During the Victorian period in Britain, people with mental disorders (often labelled as ‘mad’, ‘insane’ or ‘lunatics’) were incarcerated within asylums. Individuals with this label tended not to act in accordance to social norms or were known to be part of a ‘deviant group’ (this commonly included the poor). Individuals were often ‘locked away’ and kept from public display (Rogers and Pilgrim, 2001). Michel Foucault’s writings on mental health (or ‘madness’) explored the major influences of societal norms, medicine and psychiatric practices and its efforts to ‘control’ these ‘deviants’ (Gordon, 2013). Although restraining individuals was a usual occurrence in asylums, some implemented an approach known as ‘moral treatment’ (developed by William Tuke) which treated patients more humanely. This psycho-social approach noted that a healthier environment (e.g. good food, fresh air and exercise) would help to alleviate the ‘madness’ from the patient (Bewley, 2008). There are differing views

Chapter 1: Background

surrounding the effectiveness of this approach, with many historical summaries suggesting that it was ineffective in helping to 'cure' madness (Carpenter, 2010; 2011).

Since the conclusion of the First and Second World Wars, there was a rise in interest surrounding emotional and mental health as many of the soldiers who had survived the battlefield were experiencing 'shell-shock' (Post-Traumatic Stress Disorder). As there were a substantial number of people affected by the war, health policy began to look at improving standards of care. There was a decision to move away from psychiatric care in asylums and towards treating patients within general hospitals (Rogers and Pilgrim, 2001). Around this period the use of biological-based treatments for mental illnesses, such as Electroconvulsive Therapy (ECT), insulin-induced comas, and (in extreme circumstances) lobotomies were often utilised. The use of these became less frequent by the end of the 1950s (Lawton-Smith and McCulloch, 2013). The 1960s saw the development and increased use of drug therapies for mental health disorders (e.g. tranquilisers, antipsychotics and lithium) (Butcher, Mineka and Hooley, 2010).

Economic factors have been noted as one of the main considerations taken when devising the development of mental health policy. For example, the 'de-institutionalisation' of the mentally ill from asylums during the 1960s period was partly driven by economic pressures and there was a need to close down large establishments that cost a great deal to run (e.g. asylums). Fiscal demands in the 1970s, in part due to the 'Welfare State' culture developed and government spending constraints after the 'Oil Crisis' established a shift from the dominance of hospital-based care to community-based support. Moreover, the privatisation of some public sector facilities expanded large NHS hospitals who offer a wider range of services provided by local authorities, as well as the public and voluntary sectors. There was also a shift towards the increase of service user involvement and empowerment during treatment and care (Coppock and Hopton, 2000; Rogers and Pilgrim, 2001).

By the 1990s, mental health policy became a higher priority for the Department of Health (DoH). The anti-psychiatry movement, which started in the 1960s (not only in the UK), spurred a new wave of thought outside of the medical model so by the 1990s, a wider range of mental health professions rose in prominence within the NHS (including Clinical Psychologists, Community Mental Health Nurses, etc.). In addition, increasing numbers of treatment models outside of medical model-based care were offered; commonly referred to as 'Talking

Treatments'. This include: Behavioural Therapy, Psychotherapy, and Cognitive Therapy (Coppock and Hopton, 2000; Rogers and Pilgrim, 2001).

From the 1990s to the present day, mental healthcare services became more important and embedded at the Primary Care level. There has been a drive to involve General Practitioners (GPs) in what was a predominantly Secondary Care agenda. This view and approach also extends on a more global scale (World Health Organisation [WHO], 2008). In 1999, a 10 year programme was launched by the NHS to help reform mental healthcare (Appleby, 2007; McManus *et al.*, 2009) and in 2001, the DoH begun to strongly recommend the use of psychological interventions as an alternative to psychotropic drugs/pharmacological therapy in the treatment of mental disorders (DoH, 2001).

Critical Perspectives: De-Medicalising Mental Health

The *Author's Note* on the use of language and terminology in this thesis expressed that the practice of mental healthcare once principally aligned itself with the medical profession and adopted its biological approaches (i.e. the medical model) which treats emotional distress as an 'illness' or 'disease'. Such practices specify a set method of treatment which are typically led by the practitioner (Freeth, 2007; Rapeley, Moncrieff and Dillon, 2011; Johnstone, 2014). In this chapter, it was outlined that more recently mental healthcare practice distanced itself from this paternalistic way of working to a more collaborative relationship between service users and the practitioner (e.g. Sparks, Duncan and Miller, 2006; House and Loewenthal, 2010). However, practices such as protocol-led therapies e.g. in Cognitive-Behavioural Therapy (Westbrook *et al.*, 2011) could be considered to be less focussed on the individual and more focussed on the completion of set steps which may not be considered to be 'collaborative working' (Reynolds, 2003; Chadwick 2006) but a rather more prescriptive, medical model-like, approach.

As noted in *section 1.2.1*, the medicalisation of mental health is a contentious topic as highlighted by the anti-psychiatry movement (e.g. Szasz, 1960), which advocated the de-medicalisation and separation of medicine and practices in mental health (e.g. Psychiatry) and challenges medical model notions of mental health as a "disease". In this section, the implications of this medical model approach on the therapeutic relationship, ethical practices in therapy, practitioner reflexivity and the education of mental health practitioners are detailed.

The Therapeutic Relationship

The utilisation of the medical model can have an impact on the ‘therapeutic relationship’¹. The medical model approach is ‘disease-focussed’ which objectifies the problem of the individual but often ignores the background, thereby ignoring the ‘whole picture’ of the patient. This ‘whole picture’ includes the context the individual is situated in: social, political and economic, as well as the experiences of the individual and their relationships (Graham, 2010; Boyle, 2011). The lack of context and patient perspectives in therapy are noted to be barriers in the formation of a therapeutic relationship (Chadwick, 2006). More current therapeutic approaches highlight the importance of the subjective experiences of the individual rather than objective symptoms or biological phenomena (Wampold, 2001; Wampold, Ahn and Coleman, 2001; Mulligan, 2012). For example, *section 1.2.4* discusses humanistic approaches which advocate the importance of the subjective reality of the individual, their experiences, and perceptions (Paul and Haugh, 2008a). Chadwick (2006), a Cognitive-Behavioural Therapist who advocates person-centred approaches, suggested that practitioners should be able to convey their understanding of the unique experiences of an individual.

Although medical model practitioners employ practices which are noted as ‘empirically effective’ (i.e. evidence-base therapies), the therapies aligned to medical model practices are often therapist-led and protocol driven. Humanistic approaches could be considered to be more collaborative as the patient is noted as the expert of themselves and the practitioner does not direct them in therapy (Haugh, 2008). Chadwick (2006) noted that the need to complete set protocol steps is detrimental to the therapeutic relationship especially if the focus on the individual to express their experience and views is lost due to a rigid focus on structure.

There are a vast number of factors which are required to form a positive and successful therapeutic relationship (e.g. Bordin, 1979; Ong et al., 1995; Williams, Weinman and Dale, 1998; Chadwick, 2006; Paul and Haugh, 2008b; Egan, 2010; Brown, 2012)². One aspect is for the practitioner to provide and hold unconditional positive regard for the patient – i.e. a want and desire the help the patient. This requires an ‘authentic’ rapport where the practitioner must convey openness and interest, placing value on the patient in order to build trust and

¹ The therapeutic relationship is an interpersonal bond between the therapist and the patient, it can be defined in many different ways (Paul and Haugh, 2008a); this is explored further in *section 2.2.3*

² See *section 2.2.3* for more information.

honesty, particularly when encouraging confidence in discussing sensitive issues (Thomas, 2008). If there is too much focus on structure to the therapy than on the patient, then the rapport may feel inauthentic, especially if there is less value placed on the experiences of the patient.

In a patient-practitioner relationship that is based on the medical model, there is often a power imbalance. Patients place themselves at the hands of the practitioners – they wish to seek help from the practitioner who is deemed to have the technical knowledge about their mental health. During this, patients place trust on the practitioner that they will use their knowledge ethically (Goffman, 2007).

An alternative approach to mental healthcare moves away from this medical model practice and towards a more ‘human’ approach that takes the service user into account (Grant, 2009). In this approach, there is a collaborative relationship between the patient and the professional in the selection of their own treatment (Westbrook *et al.*, 2011; Haugh, 2008). For instance, there is emphasis placed on patient experience and perceptions (Freeth, 2007; Johnstone, 2014). Graham (2010) suggests that care should explore the features or characteristics of the issues as well as the uniqueness and circumstance of the individual affected (i.e. the context of the individual). There is also a rejection of the imposition of an ‘objective’ and external measure which informs the practitioner that the patient is (or is not) in the ‘correct’ mental state, or within the ‘norms’ (Grant, 2010b).

An approach known as the “Recovery model” (Anthony, 1993) advocates the use of personal stories to provide understanding to the ‘recovery’ process. Recovery is a restoration of wellbeing and, unlike the medical model, there is no ‘end point’ or ‘correct’ state. It aims to empower the individual so they are able to optimise their life with their mental health experience (Grant, 2010b). Similarly, a humanist approach towards mental healthcare known as the “Lifeworld” enforces a close examination of the experiences and perspectives of the patient when receiving their care to improve their understandings of the world around them. It is a phenomenological movement which seeks knowledge and truth through relational experiences but it does not distinguish between an objective and subjective world (Todres, Galvin and Dahlberg, 2007; Dahlberg, Todres and Galvin, 2009).

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The ethical implications on these de-medicalised approaches enable a collaborative approach that balances the power between the practitioner and patient – the sharing of experiences and knowledge. This can help the therapeutic relationship to flourish as patients feel more empowered; they are given a more active role in their recovery which, in turn, can improve trust and establish respect between the patient and practitioner (Todres *et al.*, 2007; Grant, 2009; Dhalberg *et al.*, 2009).

Bracken and Thomas (2011) outlined a ‘Post-psychiatry’ movement which challenges the legitimacy of medicine and psychiatry in ‘treating’ social and human problems. This movement provides a framework which encourages the power of the service user and explores the importance of the individual’s social and cultural context.

Ethical Practices

The mismatch of the concepts of mental health and the medical model mirrors the conflict between the paradigms³ used in the natural observable sciences and the human subjective sciences. The medical model advocates the labelling of a condition through objective observations and using the evidence-base, thus supporting a positivist approach (Rapeley *et al.*, 2011; Thomas and Bracken, 2011). For example, interventions used in IAPT are founded on an evidence-base where Randomised Controlled Trials (RCTs) are considered ‘gold standard’ (e.g. NICE, 2010a) (Layard *et al.*, 2006; Westbrook *et al.*, 2011). However, it is acknowledged that there are arguments which suggest that the RCT approach may not be suitable in the investigation of effectiveness of different psychotherapies (e.g. Bohart and House, 2008; Evans, 2008; Moloney and Kelly, 2008; Proctor, 2008). These reasons include:

- RCTs often exclude individuals with a co-morbid condition
- RCTs ignore individual differences and the subjective experience in therapy (e.g. preferences and preconceptions of treatments before randomisation)
- RCTs do not consider how a therapist may affect therapy
- the therapeutic relationship is not considered as a main factor in RCTs
- the outcomes are often measured quantitatively which can be ambiguous and may not necessarily relate to all aspects of effectiveness (e.g. the experience of the individual)

³ i.e. ‘Positivism’ and ‘Interpretivism’ (e.g. Kuhn, 1962; Sandelowski, 1995; Mackenzie and Knipe, 2006); this paradigm debate is further discussed in *section 3.2.1*

Moreover, it could be suggested the use of terminology related to psychiatric diagnosis (such as 'CMDs') by the IAPT programme shows some alignment to the medical model despite a claim to collaboration.

The purpose of a diagnosis is to help select the 'correct' treatment, predict outcomes (prognosis), and to outline the cause (aetiology) (Goffman, 2007). However, mental health is often un-observable, and mental health diagnoses currently have no definitive aetiology, nor do they provide accurate prognosis (Freeth, 2007; Goffman, 2007; Johnstone, 2014). Nevertheless, the implications of a diagnosis for a patient can be both positive and negative. A positive view notes the ability to offer the patient a method of legitimising their mental health issue by naming it and also providing some more understanding of their experiences with a diagnosis. In addition, it provides a reference point between health practitioners and provides structure to treatment (Freeth, 2007).

However, often diagnoses are influenced by societal factors (Conrad, 1992; Szasz, 1960). There is great value placed on appearances (observables), functioning and the 'norm'. For those who deviate from this norm, the medical model seeks to 'correct' them in order to protect the community at large but this can lead to stigmatisation of those who cannot be 'corrected', and in many cases they were incarcerated in mental asylums to 'protect' the public and the individuals themselves (Goffman, 2007). This approach to mental health was briefly explored in *section 1.2.1* (e.g. Foucault's writings on 'madness' which explored society's use of medical and psychiatric practices to 'control' those who deviated from the norm – Gordon, 2013).

Negative ramifications of this approach are evident throughout history (e.g. the classification of homosexuality in previous editions of the Diagnostic and Statistical Manual of Mental Disorders [DSM]), and its applications in different cultures (e.g. non-western cultures) has been heavily criticised (Johnstone, 2014)). The labelling of emotions as a pathological condition (e.g. unhappiness) may be seen as unconstructive; the Midlands Psychology Group (2007) argued that certain emotions are often not due to psychological issues (e.g. they note that the general health of an individual could be reasons why someone may be 'unhappy'). The recent development of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has been criticised for medicalising behaviours considered 'everyday' (e.g. "temper tantrums" as "Disruptive Mood Dysregulation Disorder") and as a consequence more individuals may be prone to being labelled as 'mentally ill' (Frances, 2012; Watts, 2012).

For the patient, the medical model approach can provide a mixed message with regards to their role in mental healthcare. The labelling of a 'disorder' both alleviates the individual of blame because they cannot control their 'mental health disorder', however individuals retain a responsibility to be 'compliant' with the treatment or care that is typically prescribed to them by the health professional – these actions again highlights the power imbalance (Freeth, 2007; Johnstone, 2014).

This power imbalance is further emphasised with the connotations of the classification of mental health issues used by the medical model:

- a 'disorder' is seen as undesirable;
- it prevents an individual from 'functioning correctly';
- but the patient is 'helpless' and 'vulnerable' to the disorder (they are unable to control it);
- and therefore a treatment is often 'applied to them' by the health professional in order to 'correct' their functionality (Graham, 2010; Grant, 2010a).

Conversely, collaborative and person-centred therapies (or ones which embody the humanistic approach) provide patients with control, they are seen as a source of knowledge about their own experiences and themselves and it is the role of the practitioner to encourage this exchange of information to better inform them of how they can approach the issue and work with the patient (Chadwick, 2006; Haugh, 2008).

Practitioner Reflexivity and the Psychological Practitioner Training

As noted previously, collaborative approaches such as the humanistic practices advocate phenomenology, the exploration of experiences, but this is not just for the patient but it can also be for the practitioner – it is important that practitioners are reflexive; they should consider their own views and thoughts during the therapy (Paul and Haugh, 2008a; Brown, 2012). Practitioner reflexivity can be defined as an active way practitioners can analyse and evaluate their practice using previous learning and experiences to help inform their future practices and actions (Reid, 1993). Reflective practice has been noted to be important in stimulating personal and professional development (Boud and Walker, 1998; Jasper, 2003).

Practitioners should learn to be open to all approaches in mental health and be encouraged not to only take a single approach. For example, some practitioners may only take a positivist view and will only accept empirical approaches (e.g. evidence-based practices) thereby disregarding reflexivity and the value of individual experiences or the social construction of knowledge (Todres *et al.*, 2007; Grant, 2009; Dhalberg *et al.*, 2009). Indeed, it has been suggested that effective practitioners should be self-critical of therapeutic actions and be self-reflective (Green *et al.*, 2014). It is noted that the de-medicalisation or post-psychiatry movement can be an opportunity for the professionals to redefine their roles and approaches and to move beyond coercive interventions (e.g. the promotion of pharmacotherapy) and the consideration of not only the experiences of the patient, but also to think reflectively on their own experiences and perspectives (Thomas and Bracken, 2011).

A positivist approach to mental health will have an impact on the development and training of mental health practitioners (Grant, 2009). *Appendix I* outlines the current training overview for IAPT Psychological Wellbeing Practitioners (PWP) (Richards and Whyte, 2009; 2011). It is noted that a lot of the module objectives utilises de-medicalised language such as “*Recovery*” and “*Reflection*” but it can be argued that other phrases such as “*evidence-based interventions*” and “*diagnostic category systems*” may suggest underpinnings of the medical-model approach. In addition, learning outcomes such as “*understanding and critical awareness of concepts of mental health and mental illness*” suggest potential to explore all viewpoints of mental health; however the remainder of the course focusses on the use of evidence-based therapies. Although there is a module entitled “*Reflection*”, the content of this module does not enable students to critically reflect on their practice; rather it covers practical aspects of their day-to-day working.

There has been a recent review of the PWP training (University College London, 2015) which highlighted a number of changes to the curriculum. For instance, there is now a focus on the experiences of the patient: “*shared understanding of the problem rooted in the person’s own experience*”. This review further described the importance of helping the patient understand their experiences using their own terms, thus suggesting that there is an increased awareness of de-medicalising mental health practices towards a more truly ‘collaborative’ method of working.

1.2.2 The Impact of Common Mental Health Disorders (CMDs)

Common Mental Health Disorders (CMDs) have been ranked as some of the most prevalent mental disorders in Europe (Alonso *et al.*, 2004; WHO, 2004; Andlin-Sobocki and Wittchen, 2005). In the UK, approximately one in six people are diagnosed with depression and/or a chronic anxiety disorder at any one time (Layard *et al.*, 2006; McManus *et al.*, 2009; NICE, 2011).

As outlined in section 1.2.1, economic pressures have often been catalysts in the development of mental health policy (e.g. Coppock and Hopton, 2000). Financially, the cost of mental illness accounted for 2% of NHS expenditure (approximately £77.4 billion) in the 2002/2003 period (The Sainsbury Centre for Mental Health, 2003). This figure rose to £105.2 billion in the 2008/2009 period (The Centre for Mental Health, 2010). In addition, around 40% of people who claim incapacity benefit indicate that their primary reason for claiming is due to CMDs; amounting to a cost of £7 billion (The Sainsbury Centre for Mental Health, 2003; Layard *et al.*, 2006).

The impact of CMDs on employment (e.g. through the loss of work output due to absenteeism, or low work productivity, etc.) amounts to approximately £12 billion per annum with over 100 million working days lost every year (Tennant, 2001; The Sainsbury Centre for Mental Health, 2003; Thomas and Morris, 2003). Furthermore, cycles of events may perpetuate and cause larger problems within the workplace (Gilbody, Bower and Rick, 2012). For example, an individual may experience a level of depression due to work-related stress which leads to absenteeism, and this places more pressure on other colleagues due to the increases in their work-load, which can lead to other individuals experiencing depression, leading to further absenteeism, etc.

1.2.3 Government Aims and Strategy for the IAPT Programme

In 2007, the IAPT initiative was introduced into the NHS mental healthcare system. This move was largely in response to the 2006 Layard Report (British Psychological Society [BPS] News Release, 2007; Cohen, 2008).

The Layard Report (Layard *et al.*, 2006) stated that mental illness not only posed a problem for an individual's health, but also had economic implications (as noted in section 1.2.2). Layard and colleagues proposed that evidence-based psychological therapies should be used to help

individuals with mental health problems and, in turn, alleviate the associated healthcare and economic costs (Westbrook *et al.*, 2011). The IAPT programme therefore offers treatments which embody the Cognitive-Behavioural Therapy (CBT) principles which are in line with the clinical guidelines set by the National Institution of Clinical Excellence (NICE) (NICE, 2010a; 2010b; 2011).

The initial strategy for IAPT invested £173 million between 2008 and 2011 (Cohen, 2008). During this period, funding was aimed at financing the training of 3,600 new therapists, increasing numbers accessing psychological treatments by 900,000, and reducing the number of individual in receipt of sick pay and benefits by 25,000. The current Conservative-Liberal Democrat coalition government provided a further £400 million in funding for 2011 to 2015 (DoH, 2008; 2010; 2011a; 2011b; Clark, 2011).

Evaluative reports of the programme's progress have been positive. IAPT outcome practices were found to be viable (e.g. Glover, Webb and Evison, 2010; Gyani *et al.*, 2011) and in the first three years of the programme's implementation, it was noted that some of the initial strategy targets set in 2010 were achieved (DoH, 2012), including:

- The number of psychological practitioners trained/in training was reported at 4,000 new psychological practitioners
- An increase in return to work and reduction in benefit receipt where 45,000 people were recorded to have moved off sick pay and benefits
- A large volume of people entering the system where approximately 1.34 million were referred and 680,000 were reported to have 'completed'

The recovery rate aim of 50% has yet to be met, with the rate being 45% at the time of the report. Previous reports (e.g. Clark, Layard and Smithies, 2008; Clark *et al.*, 2009) have noted that these aims are still achievable. More recent figures from the Health and Social Care Information Centre (HSCIC) annual reports for the IAPT programme suggested that in 2012/13 and 2013/14 the recovery rate was reported at 43% and 45%, respectively (HSCIC, 2014a; 2014b).

1.2.4 Cognitive-Behavioural Therapies in the IAPT Programme

The Layard Report advocated the use of NICE evidence-based therapies and thus, the IAPT programme largely offers therapies aligned with Cognitive-Behavioural Therapy (CBT)

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principles. In this section, I provide a brief overview of CBT and how its role in IAPT is a topic of contention. Although the thesis did not specifically aim to explore these debates, some of the findings from this research expressed similar viewpoints, and these are discussed further in *Chapter 5*.

A Brief Overview: Key Principles of CBT and Therapeutic Characteristics

The CBT paradigm inherits aspects of both Cognitive and Behaviourist approaches which are used in Cognitive Therapy (CT) and Behaviour Therapy (BT) (Beck, 2005).

The Behaviourist Approach

Behaviourists emphasise that empiricism (testing hypotheses), particularly on observable actions and behaviours, can help to explain psychological phenomena. This was a counter approach to the Psychodynamic movement whose methods were criticised by Behaviourists as untestable and subjective as the ‘unconscious’ could not be directly and objectively tested (Leahey, 2004).

Behaviourism focuses on how behaviours can be learnt – by association (Classical Conditioning), through consequences (Operational Conditioning), or by observing others (vicarious learning, Social Learning Theory). How behaviours could be ‘unlearnt’ (e.g. by extinction, flooding, and systematic desensitisation, etc.) was also of interest. A limitation of this approach was that it discounted internal mental processes; a concept that the Cognitive movement largely focuses on (Butcher *et al.*, 2010).

The aim of BT centres on unlearning ‘maladaptive’ (or harmful) behaviours. During sessions, the therapist aims to help the individual focus on their own behaviours and the role of how these behaviours were learnt to help them understand why they may react in certain ways. Goals for each session, and the long term, are agreed between the therapist and the individual. Individuals are encouraged to carry out tasks outside of the session to help the individual assess and evaluate what they have learnt in their contact time (Butcher *et al.*, 2010; Westbrook *et al.*, 2011).

The Cognitive Approach

The Cognitive Approach places importance on how an individual via internal processes (cognition, emotions, behaviour and physiology) interacts with environmental factors or external events (physical, social, cultural, economic). It is purported that symptoms associated with certain psychological conditions are due to 'systematic distortions' within internal cognitive processing of these external events, e.g. 'dysfunctional beliefs' or 'negative automatic thoughts' (Leahey, 2004; Beck, 2005; Butcher *et al.*, 2010).

The 'Cognitive Triad' or 'Negative Triad' (Beck *et al.*, 1979; Beck, 2005) is a cognitive theory of depression developed by Aaron T. Beck which suggests that individuals hold a negative view of the world or outside environment, themselves and the future; these can be characterised in statements such as: "*the world is unfair*", "*I am worthless*", and "*the future is hopeless*". A Cognitive explanation of anxiety disorders proposes that individuals overestimate threat resulting in a heightened sense or anticipation of worry in certain situations or when exposed to an object (McManus *et al.*, 2008). In CT, the aim is to change these cognitions.

In CT sessions, this is achieved through the examination of how and why an individual processes certain information in a certain way (e.g. what meanings they may associate the event or object with and the reaction or emotion this elicits). This exploration can be undertaken through verbal reports from the individual or by therapist observations of the individual's behaviour. Similar to the psychodynamic approach, past experiences may be used to explain the present phenomena and akin to BT, an experimental approach is also used with the individual encouraged to carry out 'experiments' outside of the session (known as 'homework'). Individuals are encouraged to apply the new ways of thinking and behaving, learnt during sessions, in their practical situations (Leahey, 2004; Butcher *et al.*, 2010).

The Cognitive-Behaviourist Approach

Analogous to Behaviourists, CBT emphasises the need for empiricism; well established theories are paramount and methods are tested with rigour. In therapy, the individual is encouraged to test theories discussed during sessions (experiments) and outside of sessions (homework) (Westbrook *et al.*, 2011).

CBT also primarily focusses on the 'here and now', i.e. on the symptoms which are currently maintaining the condition, and attempts to improve them. Unlike the Behavioural approach

but consistent with the Psychodynamic approaches, previous experiences or developmental processes can be considered or uncovered during therapy sessions. Comparable to the Cognitive approach, CBT places importance on how the individual or their internal processes interact with environmental factors and the resulting psychological phenomena. In anxiety disorders, these could include a focus on avoidance behaviours and ‘irregularities’ in emotional regulation (McManus *et al.*, 2008; Driessen and Hollon, 2010).

Contrary to the medical approach⁴, an important principle within CBT is that it sees mental health on a continuum scale where pronounced or more severe conditions are at one end of the scale with what could be considered as ‘normal functioning’ at the other. Moreover, an individual is not fixed at a certain point but can move across the scale (Westbrook *et al.*, 2011).

Critique of IAPT: The use of CBT – Does One Size Fit All?

As noted in section 1.2.4, CBT is the prevailing therapeutic method of choice by the UK government and healthcare authorities (e.g. in the IAPT initiative) due to its evidence-base (Layard *et al.*, 2006). The effectiveness of CBT has been investigated in treatments for the following psychological conditions: depression, GAD, PTSD, OCD, eating disorders, and schizophrenia (NICE, 2004; 2005; 2006a; 2009; 2010a; 2010b). Despite some positive findings, there is limited support for its application in the treatment of anorexia, schizophrenia and bipolar disorder (Roth and Fonagy, 2006; Butler *et al.*, 2006).

Some authors have been critical of the promotion of CBT as the main treatment method in the mental health services (Loewenthal and House, 2010). For instance, there was a debate on advocating CBT as the therapy paradigm for treatments of nearly all CMDs was discussed in a series of published open letters by Samuels and Veale (2009). Andrew Samuels, a professor of Psychoanalytic Studies at Essex University, commented on the potential limitations of CBT and his fears that CBT was being oversold through IAPT. Conversely, David Veale, the chairman of the ‘British Association for Behavioural and Cognitive Psychotherapies’ (BABCP), countered with the issue that the use of psychotherapy approach would benefit a vast number of people in the community and that its evidence base (e.g. from Randomised Controlled Trials [RCTs] and consultations with Health Professionals) is robust and therefore its use can be trusted and justified.

⁴ The medical approach views mental health conditions dichotomously (i.e. there is the presence or the absence of this ‘disease’) (Westbrook *et al.*, 2011).

In relation to this, there has been some critique which suggests that no single therapeutic approach is better than any other (Paul and Haugh, 2008a). In a study set within NHS primary and secondary care units, Stiles and colleagues (2006) explored the differences in CBT, Person-Centred Therapy (PCT) and Psychodynamic Therapy (PDT). Using the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM), the scores of six groups of patients were analysed: three groups utilised CBT, PCT or PDT, and the remaining experienced one of the three approaches along with an extra form of support (e.g. integrative, supportive or art therapy). Stiles *et al.* (2006) found marked improvement across all therapeutic modalities suggesting non-inferiority among the approaches. These findings were further enforced in a larger sample within NHS primary care services (Stiles *et al.*, 2008). There has been commentary on these findings which identified potential shortcomings of these studies. First, the number of missing cases involved was between 33% and 38% of cases seen by therapists within the primary care setting. Secondly, information regarding therapist training was missing. Finally, there was a lack of randomisation of participants between the different treatments and thus, it was considered that there was a lack of control on other potential sources of recovery (Clark *et al.*, 2008a).

The rise of evidence-based therapies has also caused an increase of concerns regarding mental health services over-reliance on the NICE guidelines (Guy *et al.*, 2012). McPherson, Evans and Richardson (2009) established that the evidence-base and economic aims of IAPT were not compatible as literature within the NICE guidelines are not primarily orientated to economic effectiveness. Moreover, there are critics of 'evidence-based' therapies. For example, Shedler (2013a; 2013b) noted that many 'evidence-based' therapies were not compared with other 'active' psychotherapies and were evaluated against participant groups who experienced no therapy or 'treatment as usual' which often had no psychotherapeutic element. As expressed in the *Author's Note*, it has also been suggested that RCTs may not be suitable for investigating the effects of psychological therapies as they often excludes factors such as co-morbidity, individual differences, therapist effects and subjective experiences in therapy that are considered important factors in therapy (Bohart and House, 2008; Evans, 2008; Moloney and Kelly, 2008; Proctor, 2008).

It was posited that the promotion of CBT may be a product of the modern era, given the rise in popularity of evidence-based practices (Clarke, 2008; Hemmings, 2008; Lees, 2008). Bryceland

and Stam (2008) offered cautionary commentary suggesting that this rise in popularity and the emphasis placed on CBT by the NHS may marginalise the recognition of other therapies available (e.g. counselling). They further noted that this could, in turn, limit patient choices – this is an important message as the concept of mental health has many competing approaches.

For a time, the main position taken in mental health was the medical model approach with its ideas that mental health disorders were a ‘disease’ of the brain (e.g. Wampold, 2001; Wampold *et al.*, 2001). Drawing much criticism for this reductionist view, models of mental health outside of medicine were developed. These included the behaviourist and cognitive approaches, as well as, two further models of psychotherapies including:

- **The Psychodynamic / Psychoanalytic Approaches:**

This approach notes the importance of the unconscious and its interactions with the conscious as well as the outer or social world. Unlike the behaviourist and cognitive approaches, there is no endeavour for an objective truth (Howard, 2008; Butcher *et al.*, 2010). One of the pioneers of this approach was Sigmund Freud. Freud proposed that individuals are in a continual state of conflict as a product of biological desires (e.g. sexual) and from restrictions placed by society (Cave, 1999; Leahey, 2004; Butcher *et al.*, 2010). It is “...*the interplay between love and suffering*” (Howard, 2008, p. 23). The main aim of this approach in therapy is to assist the individual in coping with these conflicts (Paul and Haugh, 2008a). The individual is emboldened by the therapist to talk through their issues and experiences and is often characterised as the ‘talking cure’. The therapist encourages the individual to remember their past (this may include traumatic experiences) which could help increase their understanding of these conflicts. Transference and allowing the individual to express their experiences in sessions is important (Clarkson, 2003; Leahey, 2004; Howard, 2008).

Contemporary psychodynamic assumptions (for instance, what is deployed in Dynamic Interpersonal Therapy [DIT]) examines the importance of interpersonal relationships. It notes that behaviour is determined unconsciously and that feelings and thoughts are affected by both external and internal factors. DIT focusses on the current interpersonal relationships that patient has (including that the therapist) and encourages them to consider the strategies used to build them. One of the aims is to ‘resolve’ transference as it helps the individual recognise and manage their (unconscious) subjective views, emotions,

behaviours and expectations which underpin these strategies. The role of childhood experiences on these strategies are also explored (Hughes and Kerr, 2000; Lemma, Target and Fonagy, 2010; 2011; Lambert, 2013).

- **The Humanistic Approach:**

The humanistic approaches advocate the importance of phenomenology – the subjective reality of the individual, their experiences, and perceptions (Paul and Haugh, 2008a). The individuals are considered as whole (a Gestalt viewpoint) which includes their context (Cave, 1999; Maltby, Day and Macaskill, 2007). It proposed that the main aim for an individual is to achieve purposive meaning or self-actualisation (e.g. Abraham Maslow’s Hierarchy of Needs). This is a motivational force for personal-growth which can be affected by societal pressures (e.g. how we relate to others). In this approach, the patient is the expert of themselves and the practitioner does not direct them in therapy (Haugh, 2008).

It should be noted that these alternative approaches are employed at IAPT, namely at the high-intensity services. These therapies include: DIT, counselling, interpersonal psychotherapy (IPT) and couples therapy (Lemma *et al.*, 2010; 2011; Hovington, 2011; IAPT, 2012). Although there is the promotion of other therapeutic approaches, CBT is still regarded as the main approach used across mental health care and there are many who are still sceptical of its promotion nationwide⁵ (e.g. House and Loewenthal, 2008; 2010; Loewenthal and House, 2010). In addition, groups have formed to explore the improvement of access to and promotion of counselling and psychotherapies (e.g. the New Savoy Partnership⁶).

1.3 The Improving Access to Psychological Therapies (IAPT) Initiative

1.3.1 The IAPT Process

This section provides an overview of the key features of the IAPT programme.

Referral and Assessment

Access and entry to the IAPT service can be made through referral by the GP, community and employment services, or by self-referral. During an initial assessment, individuals complete a

⁵ The Limbus Critical Psychotherapy Conference (<http://www.limbus.org.uk/cbt/>) held in November 2014 aimed to discuss the use of CBT and its evidence-base in psychotherapies.

⁶ The New Savoy Partnership (<http://www.newsavoypartnership.org>) is a group of organisations (professional bodies, mental health charities, researchers and providers) which seek to “...improve access to counselling and psychotherapy on the NHS for all who need it, and to improve the quality of what people who get help then receive”.

series of self-administered psychometric questionnaires to help assess what the problem they may be experiencing, and its severity. Along with GP referral notes, the results of the self-reported questionnaires aid in assessing the 'Provisional Diagnosis' for the individual which are based on tenth edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes (Clark *et al.*, 2008b; DoH, 2008a; 2008b; 2011; IAPT, 2011a; 2011b; 2011c).

The Stepped-care Pathway

IAPT works on a stepped care model, with two levels of treatment: Low-intensity (or Step 2) and High-intensity (or Step 3) (DoH, 2008a; 2008b; 2011). The severity and complexity of the provisional diagnosis dictates which service the individual enters and the NICE recommended therapy that will be suitable. E.g. those with mild-to-moderate depression enter Low-intensity treatment and those with severe depression or complex disorders enter High-intensity treatment (DoH, 2008a; 2008b; 2011). Please see *Figure 1* for an illustration of the stepped care pathway and associated therapies. This project focussed on Step 2 therapies.

Access and progression can be stepped or stratified. The stepped approach involves individuals 'stepping-up' or 'stepping-down' the two services of psychological services. Alternatively, the individual can enter straight into more intensive therapies (Step 3) if symptoms were of high severity. Outcome data taken session-by-session helps to determine the progress of the individual (DoH, 2008a; 2008b; 2011).

Staff/Service	Disorder	Intervention
Step 3: High-intensity service	Depression – mild, moderate and severe	Cognitive-Behavioural Therapy (CBT), Behavioural Activation Interpersonal Psychotherapy (IPT), Counselling, Couples Therapy, Dynamic Interpersonal Therapy (DIT)
	Panic Disorder	CBT
	Generalised Anxiety Disorder (GAD)	CBT
	Social Phobia	CBT
	Post-traumatic Stress Disorder (PTSD)	CBT, Eye Movement Desensitisation and Reprocessing (EMDR)
	Obsessive Compulsive Disorder (OCD)	CBT
Step 2: Low-intensity service	Depression – mild-to-moderate	Computerised-CBT (cCBT), Brief CBT, Guided Self-Help, Behavioural Activation, Exercise
	Panic Disorder – mild-to-moderate	cCBT, Guided Self-Help, Pure Self-Help
	GAD – mild-to-moderate	cCBT, Guided Self-Help, Pure Self-Help, Psychoeducational Groups
	OCD – mild-to-moderate	Guided Self-Help
Step 1: Primary care/IAPT service	Recognition of problem	Assessment/watchful waiting

Notes: Step 2 is highlighted in this diagram, emphasising which service this research project was set.

Figure 1: The IAPT stepped model of care delivery (adapted from DoH, 2008b, p. 23)

IAPT Psychometric Instruments (Patient Reported Outcomes)

IAPT routinely collects patient data session-by-session to assist in following the progress of the patient. The main self-assessment instruments completed by all patients in IAPT include (DoH, 2008a; 2008b; 2011):

- The 9-Item Brief Patient Health Questionnaire Mood Scale (PHQ-9)
- The 7-item Generalised Anxiety Disorder Scale (GAD-7)
- The Work and Social Adjustment Scale (W&SAS)
- The IAPT Phobia Scales

Further data collected during each session includes employment status and whether or not the individual is receiving Statutory Sick Pay (SSP) or benefits. These data are known collectively as the 'Minimum Dataset' (IAPT, 2011a).

Defining "Recovery" in IAPT

In IAPT, a service user who has "*recovered*" can be defined as someone who has ended contact with the service, had at least two sessions of treatment, and whose clinical scores have improved by falling below 'caseness' (i.e. falling below clinical cut-off scores on the outcomes instruments). If all of these conditions are satisfied, IAPT considers this as "*case completed*". There are instances in which service users reach an "*agreed ending*" in treatment where they are still above caseness but symptoms improvements are sufficiently evident that contact is no longer a necessity (DoH, 2010; Cairns, 2014).

Brief Patient Health Questionnaire Mood Scale (PHQ-9)

The PHQ-9 is an assessment instrument that is used to provide diagnoses of depressive or other mental disorders within Primary Care. It is an adapted form of a longer assessment tool known as the Primary Care Evaluation of Mental Disorders (PRIME-MD). It uses nine criteria based on the diagnoses within the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) for Mood and Depressive Disorders (see *Box 1*). This self-report questionnaire asks participants to rate symptoms on a rating scale from 0 (not at all) to 3 (nearly every day) based on the previous two weeks experienced. Cumulative scores can range from 0 to 27 (see *Table 1*). The clinical cut-off score in IAPT is 10 and above (IAPT, 2011a).

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around more than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way

Box 1: Items in the PHQ-9 (Kroenke, Spitzer and Williams, 2001)

PHQ-9 Score	Depression Severity
1 – 4	None
5 – 9	Mild
10 – 14	Moderate
15 – 19	Moderately Severe
20 – 27	Severe

Table 1: PHQ-9 Scores (Kroenke and Spitzer, 2002)

A multiple choice severity measure (“How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?”) is also asked after the nine DSM-IV criteria. The questionnaire is then scanned through a computer which applies diagnostic algorithms (Spitzer *et al.*, 1999; Kroenke, Spitzer and Williams, 2001; Kroenke and Spitzer, 2002).

Practitioners should ensure that physical causes of depression, as well as bereavement and a history of manic episodes are ruled out before a diagnosis can be made (Spitzer *et al.*, 1999; Kroenke *et al.*, 2001; Kroenke and Spitzer, 2002). Patients who are found to be unsuitable due to these criteria or low scores on the symptom scales do not enter the IAPT pathway and

alternative steps are discussed with the patient. If applicable, the original referrer (e.g. the GP) is informed (DoH, 2011b).

There have been a number of studies testing the validity of this symptom scale. More specifically, they have looked at its 'specificity' and its 'sensitivity' (Lalkhen and McCluskey, 2008). For example, Arroll *et al.* (2010) found that the PHQ-9, when accounting for the 'scores of 10 or higher' cut-off, was noted to have a specificity of 91% and a sensitivity of 74%. This suggests that approximately 36% of individuals diagnosed with unipolar depression were false positives.

It has been found to produce comparable sensitivity and specificity with existing diagnostic instruments such as the PRIME-MD (Spitzer *et al.*, 1999; 2000), the Hospital Anxiety and Depression Scale (HADS) and the Beck Depression Inventory (BDI) (Cameron *et al.*, 2008), the Brief version of the Beck Depression Inventory (Brief-BDI) and the 12-item General Health Questionnaire (GHQ-12) (Martin *et al.*, 2006), the Hopkins Symptom Checklist-20 (HSCL-20) (Lee *et al.*, 2007) and the Edinburgh Postnatal Depression Scale (EPDS) (Flynn *et al.*, 2011). Kroenke and colleagues (2001) also found that the PHQ-9 had positive concordance with the 20-item Short-Form General Health Survey (SF-20) whereby as the severity scores on the PHQ-9 increased, the SF-20 scores on functional scores decreased suggesting an inverse relationship where the increases in severity of depression results in a decrease in the ratings of quality of life.

Löwe *et al.* (2008a) also noted that the PHQ-9 was able to distinguish 'persistent', 'partial' or 'full' remission from the changes in pre- and post-treatment scores. Pinto-Meza *et al.* (2005) further noted that telephone-based assessments using the PHQ-9 generated similar diagnoses as face-to-face assessments.

Generalised Anxiety Disorder Scale (GAD-7)

The GAD-7 is an assessment instrument which is used to diagnose GAD. This self-report questionnaire asks participants to rate, on a scale of 0 (not at all) to 3 (nearly every day); seven anxiety related questions (see *Box 2*). These ratings should be based on the previous two weeks that have been experienced. The scores can range from 0 to 15 (see *Table 2*) and the clinical cut-off score in IAPT is eight and above (IAPT, 2011b). Again, it must be ruled out that

these symptoms are not due to physical causes and other confounding factors, such as bereavement (Spitzer *et al.*, 2006).

1. Nervous, anxious, or on edge
2. Easily annoyed or irritable
3. Afraid as if something awful might happen
4. Worried about different things
5. Restless and unable to sit still
6. Unable to stop or control worrying
7. Had trouble relaxing

Box 2: 7-items in the GAD-7 (Spitzer *et al.*, 2006)

GAD-7 Score	Generalised Anxiety Disorder Severity
0 – 4	None
5 – 10	Mild
11 – 15	Moderate
16 – 21	Severe

Table 2: GAD-7 Scores (Spitzer *et al.*, 2006; IAPT, 2011b)

Similar to the PHQ-9, there have been several studies which have investigated validity of the instrument. Spitzer *et al.* (2006) found that the GAD-7 provided accurate diagnoses of GAD and comparative diagnostic rates to mental health practitioner interviews. Additionally, the instrument provided similar diagnostic trends when compared to the diagnostic criteria of GAD in the DSM-IV. A systematic review by Kroneke *et al.* (2010) noted a positive correlation against the Beck Anxiety Inventory (BAI) and the anxiety subscales of the Symptoms Checklist 90 (SCL-90). Löwe *et al.* (2008b) also presented supportive evidence for its reliability and validity when utilised within a face-to-face household survey of over 5,000 participants. It was reported that it can be successfully employed in a study of determining prevalence, impairment and co-morbidity of anxiety disorders in primary care (Kroenke *et al.*, 2007).

Work and Social Adjustment Scale (W&SAS)

The W&SAS is a five-item patient self-report scale which measures the impact of mental health on the ability of the individual to function across a number of areas (Mundt *et al.*, 2002). For example, it measures the level of functional impairment on: work, home management, social and private leisure activities, and personal and family relationships (see *Box 3*). Upon these factors, the individual rates the level at which their mental health problem affects the activities from a scale of 0 (not at all) to 8 (very severely). The level of severity, according to the scores the individual provides, is shown in *Table 3*. Within the IAPT service, it is used to help measure anxiety, depression and phobic disorders (IAPT, 2011b).

1. **WORK** – If you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A (not applicable)
2. **HOME MANAGEMENT** – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills, etc.
3. **SOCIAL LEISURE ACTIVITIES** - With other people, e.g. parties, pubs, outings, entertaining, etc.
4. **PRIVATE LEISURE ACTIVITIES** – Done alone, e.g. reading, gardening, sewing, hobbies, walking, etc.
5. **FAMILY AND RELATIONSHIPS** – Form and maintain close relationships with others including the people that I live with.

Box 3: W&SAS Items (Mundt *et al.*, 2002; IAPT, 2011c)

W&SAS Score	Functional Impairment scores
0 – 10	Subclinical
11 – 20	Significant functional impairment but less severe clinical symptomatology
20 +	Moderate to worse psychopathology

Table 3: W&SAS Scores (Mundt *et al.* 2002)

The validity of the instrument was observed by Mundt and colleagues (2002) who found it correlated positively with the Hamilton Rating Scale for Depression (HRSD) and the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) thus suggesting a good association between the symptom severity of depression, OCD and functional impairment. Additionally, Mataix-Cols *et al.* (2005) found that the scale is also consistent in the measurement of phobic disorders. Cella, Sharpe and Chadler (2011) further noted that the measure was sensitive to changes in symptom levels when pre- and post- treatment scores were compared.

A recent study investigated the W&SAS as an outcome measure in the context of the IAPT programme; it explored whether it helped measure factors not otherwise measured by the PHQ-9 and GAD-7. It was found that the reliability and sensitivity of W&SAS was comparable to the PHQ-9 and GAD-7 – this was previously noted to be a positive trait of these two instruments. In addition, it was noted that it helped measure a ‘social functioning’ factor which the other outcome measure scales did not capture and therefore, the study authors suggested that the W&SAS could be further used as an additional outcome measure (Zahra *et al.*, 2014).

The IAPT Phobia Scales

The IAPT service developed three self-report scale measures (sometimes referred to as ‘questions’) which help to identify the severity of social phobia, agoraphobia and specific phobias (see *Box 4*). This was established in order to assess patients with enduring phobic conditions that often do not meet the clinical cut-off scores of the PHQ-9 and GAD-7. The phobia scales are used to determine the level of avoidance behaviours (behaviours which ‘prevent’ anxious affect) that cannot be measured by the PHQ-9 and GAD-7. Patients rate these phobias according to the question: “How much would you avoid each of the situations or objects?” The situations are rated on a scale between 0 (would not avoid it) and 8 (always avoid it); the cut-off score is four on any of the scales (IAPT, 2011b).

Question/Scale 1 – Social phobia

Social situations due to a fear of being embarrassed or making a fool of myself

Question/Scale 2 – Agoraphobia

Certain situations due to a fear of experiencing a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness)

Question/Scale 3 – Specific phobia

Certain situations due to a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying).

Box 4: IAPT Phobia Scales (IAPT, 2011c; IAPT, 2011c)

Because these are a novel instrument constructed for use in the IAPT programme, there have been no studies exploring the validity or reliability of the scales. However in a review of the first roll-out year of IAPT by the North East Public Health Observatory (NEPHO) (Glover, Webb and Evison, 2010), it was noted that the phobia questions were poor in sensitivity, specificity and predictive power. This could ultimately affect the extent to which the patients can be successfully assessed in terms of their recovery. However, it was acknowledged that revisions could be made for improvement. At the time of writing this thesis, there remains no research into this psychometric instrument.

1.4 The IAPT Low-Intensity / Step 2 Services

This research project was set within the Low-intensity (LI), or Step 2 service, of the IAPT programme. Service users who enter the LI service often experience mild-to-moderate CMDs – please refer to *Figure 1*. Step 2 is often characterised as a ‘low contact-high volume’ service (Clark *et al.*, 2009).

The evidence-based treatments (established on CBT principles) within the IAPT Step 2 service includes the following (DoH, 2008a; 2008b; 2011b):

- Brief face-to-face psychological interventions (or Brief CBT)
- Guided self-help
- Pure self-help

- Behavioural activation therapy
- Prescribed exercise or physical activity
- Psychoeducational group therapy
- Computerised CBT (cCBT)

In a review of the first year of implementing the programme, Glover *et al.* (2010) found that 71% of those who entered the IAPT service had utilised a type of LI therapy. Guided or pure self-help were the most common with over 80% of those who used an LI treatment opting to use it.

LI services can help to increase the speed and access to treatment for psychological services. LI has been noted to be cost-effective in its resources and allows a substantial number of people access to a service at any given point. Furthermore, it enables patient choice as many may not wish or need to use High-intensity (HI) therapies so they may opt for less contact time with the therapist because of scheduling conflicts or the incurring of expensive travel costs (Bennett-Levy *et al.*, 2010).

The Step 2 service often utilises over-the-telephone (OTT) delivery of treatment as well as face-to-face (F2F) (Parry *et al.*, 2011; Hammond *et al.*, 2012). Farrand and Williams (2010) note that both modes of delivery in LI therapy share features, some of which are also associated with the CBT approach, including:

- time-limited therapy (usually 30-40 minutes in duration)
- focusses on the here and now
- pursuit for a collaborative relationship
- taking of clinical measures
- use in supporting, motivating and encouraging

1.5 Existing Telephone Support Helplines

Telephone communication in mental health treatment, particularly in emotional support, is not an entirely new concept. Helplines that can be used by those who wish to discuss certain situations and/or their awareness of particular issues in confidence (e.g. child abuse, domestic violence, suicide ideations, etc.) are in existence. These helpline services differ from formal mental healthcare (e.g. the IAPT service) in a number of different ways as discussed in a literature review by Campos (2009), and summarised in *Table 4*.

Chapter 1: Background

Helplines may be viewed as an informal way of gaining emotional support or advice (in comparison to visiting a GP or health professional) as users are not referred to these services (Featherstone and Evans, 2004). They are usually implemented by charities (e.g. *The Samaritans*, *Rape Crisis*, *ChildLine*, etc.) whom specialise in helping a particular audience or relevant issue; the service reach can range from region-wide to nationwide. Conversely, formal mental healthcare is typically delivered by a local health authority or community service. A monetary fee may be introduced with the use of formal mental healthcare (primarily in private counselling services outside of the NHS); whereas telephone helplines are often a free of charge service.

Individuals who contact helpline services are primarily in control of the 'session' as they can decide when to end it, how much information they wish to divulge, how long they wish to speak for, and so on. On the other hand, those who enter a formal mental healthcare service may be required to follow the suggestions of the health professional or a set therapeutic protocol (e.g. using self-help manuals). A symptom assessment is also often carried out in formal healthcare. One of the other key differences between the two types of services is that people who contact helplines remain anonymous (unless absolutely necessary – e.g. in cases where the person is in danger) while those who enter a mental healthcare service do not remain anonymous to the practitioner.

Most importantly, helplines are generally a 'listening service' where formal treatment is not implemented. However, some services or the charities associated with these helplines (such as *Rape Crisis*) may offer more professional services – for example, counselling by external health services or in-house trained counsellors (Rape Crisis, 2008). Those who implement therapy or support in formal mental healthcare have obtained the relevant mental health qualifications. On the other hand, helplines are often manned by volunteers who may have little-to-none of the relevant qualifications. In most cases, volunteers have been given training regarding common practices when dealing with certain individuals – e.g. what to do in cases of emergency (Harrison, 2000).

Helplines	Formal Telephone Mental Healthcare
<ul style="list-style-type: none"> • Services are often delivered by a charity organisation – regionally or nationally • Users remain anonymous • It is generally a free service for users • Some services are implemented by volunteers who do not necessarily have qualifications relevant to mental health, but training is provided • There is no formal assessment carried out • There is no ‘treatment’ offered and/or action carried out by the service and it is mainly a ‘listening service’ • User can choose conditions (e.g. duration, length, topics covered) • User can choose to end session when they want • User usually contacts through own volition 	<ul style="list-style-type: none"> • Services are often delivered by local health authority or community services • Users not anonymous • There are costs incurred in some cases • Services employ health professionals with relevant qualifications • Symptom assessments may be carried out • ‘Treatment’ for symptom improvement and management is implemented • Treatment conditions may be set (e.g. duration, number of sessions, schedule of therapy) • The end of the programme is usually decided by the health professional^[1] • User often referred to service by GP or other organisation^[2]

Notes:

^[1] However, some patients may drop-out and end treatment before an agreed end-point.

^[2] In the IAPT service, patients are able to self-refer – a unique method of entry in the NHS.

Table 4: Distinction between helplines and formal mental healthcare delivered over-the-telephone (adapted from Campos, 2009)

Overall, helpline use has a positive impact. A recent evaluation studying one helpline service, *The Samaritans*, found that up to 71% of service users surveyed have rated the service as ‘good’ or ‘excellent’. Most reported to have ‘felt better’ after using the helpline and are very appreciative of the service (Stace and Wyllie, 2011). *The Samaritans* provide a confidential listening medium, as well as providing people a “befriending service” at both national and local levels.

Other similar freely accessible telephone-based telecare services, including *ChildLine* and the National Domestic Violence Helpline, have also found to be helpful and vital to those of the target audience. For instance, in the 2008 National Domestic Violence Helpline Impact Study, it was noted that 89% of past users who were surveyed and interviewed stated that the helpline was “essential” or “very important” in changing their situation (Comic Relief, 2008). *ChildLine* users commented that the helpline allowed them to access help when it was difficult to confront their parents, or when there were no resources for them to use in a time of need or crisis (National Society for the Prevention of Cruelty to Children [NSPCC], 2007a; 2007b; 2009a; 2009b).

1.6 Summary of Background

In the last two centuries, mental healthcare within the UK has evolved considerably from the forcible incarceration of the ‘mad’ to the more modern viewpoint of patient-centred care. However, there are ongoing debates with regards to the de-medicalisation of mental health and its implications in mental health practices (e.g. the therapeutic relationship, practitioner reflexivity) and in the education of mental health practitioners.

The most recent English NHS development was the IAPT programme which aimed to increase patient access to psychotherapies and promoted a new entry channel with self-referrals. The programme delivers evidence-based therapies and utilises a stepped model of care to provide therapies dependent on the severity and complexity of the symptoms an individual is experiencing. Progression and the ascertainment of whether an individual has completed and/or ‘recovered’ is based on outcome measures (e.g. PHQ-9, GAD-7, etc.) collected after each session. The use of IAPT is growing with its ever increasing number of referrals reaching just under one million in the 2013/14 period (HSCIC, 2014b).

Despite its growing popularity, there are some who have concerns with IAPT. Many have critiqued its reliance on CBT which could limit patient choice through the exclusion of therapies that utilise alternative approaches (e.g. humanistic, psychodynamic, etc.). The endorsement of CBT is primarily due to its rich evidence-base, although many have argued an evidence-base founded on RCTs may not be entirely applicable when exploring the outcomes of psychological therapies. Although this thesis did not study this debate directly, the exploration of the views and experiences of IAPT practitioners (PWPs) did add some insight which might contribute to this discussion and are explored in *Chapter 5*.

This thesis did explore the differences of using F2F and/or OTT psychological therapies in the IAPT programme within the Step 2 services. Telephone-based contact for emotions support is not a new concept, although its presence in the healthcare setting is increasing. *Chapter 2* examines the literature surrounding the use of telecommunication technologies within mental healthcare.

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CHAPTER 2: Literature Review

2.1 Introduction

2.1.1 Chapter Overview

This thesis investigated the differences of working with telephone and/or face-to-face delivery modalities in psychological therapies. This chapter explores the following:

- 1) It introduces the concept of 'telemedicine' and its use within psychological therapies (such as the IAPT Step 2 services).
- 2) Literature investigating the effectiveness of utilising technology within therapies, specifically focussing on comparing over-the-telephone (OTT) with face-to-face (F2F).
- 3) Factors considered as advantages and disadvantages of the use of telecommunication technologies in mental healthcare, with a focus on its effects on therapeutic relationship.
- 4) How the views and experiences of service users can be used to outline advantages and disadvantages of working with OTT or F2F therapies.
- 5) And similarly, how the views and experiences of practitioners can be used to help outline further advantages and disadvantages.

2.1.2 The Literature Presented

The main aim of the thesis was to explore the use of telecommunication devices (primarily the telephone) in psychological therapies and establish the gap in knowledge. The search strategy began with a wide scope which narrowed in order to develop the research question and objective; overall, there were five main searches carried out (see *Figure 2* for an illustrated depiction). These literature searches were first carried out in January 2011 and were repeated on a regular basis until January 2015 and were carried out in the following databases:

- the Cochrane Library
- CINHAL
- MEDLINE
- PsycINFO
- PsycARTICLES
- EMBASE

- the Web of Knowledge

The search engine Google Scholar was also utilised. In addition, literature was retrieved from reference and bibliographies from works and systematic reviews within the field. A hand search was carried out on research articles within available issues of the *Journal of Telemedicine and Telecare*.

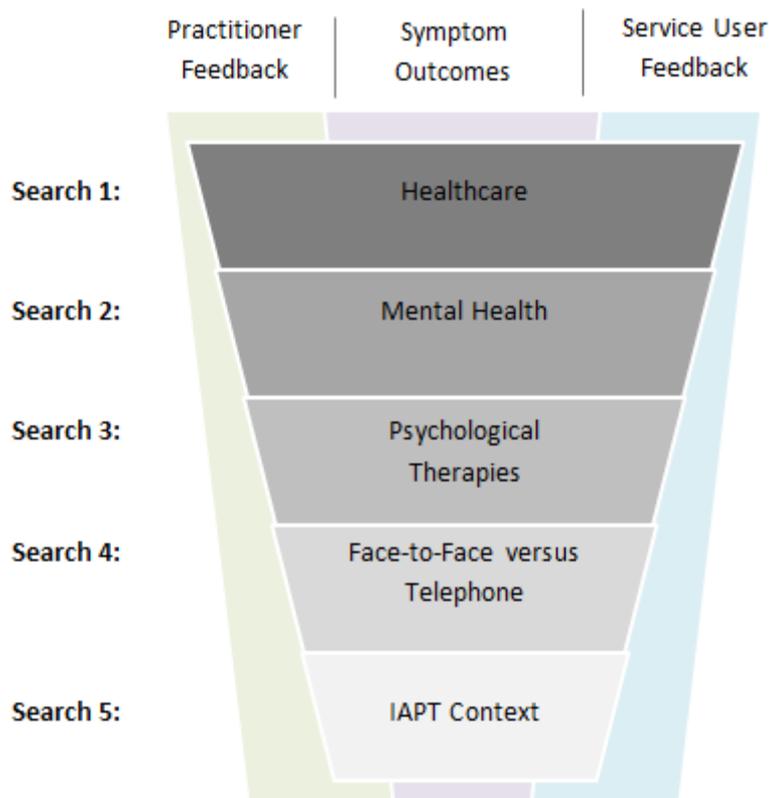


Figure 2: Broad-to-narrow scope of search strategy

Given the context the project is situated in – the relatively new IAPT initiative – the literature covered is current and contemporary. The majority of the literature does not pre-date the previous decade. However, earlier texts were used with regards to well-established concepts (e.g. the Therapeutic Relationship) and where research is sparse (e.g. the experiences of mental health practitioners working with telemedicine). Only English language papers were explored as there were no resources available to translate non-English language texts.

As depicted in *Figure 2*, in order to gain a more summative understanding of the use of these technologies, the initial search strategy was framed to gather information on its use across the

healthcare domain (i.e. with regards to its uses in assessments and diagnoses, treatments and support, and management and monitoring, and in different healthcare professions).

The scope of the search strategy was then reduced to explore the implementation of these technologies in mental healthcare. Searches were then further limited to investigate the use of the telephone in psychological therapy treatments and/or support. They were then narrowed to explore literature in which face-to-face or in-person treatment was a comparator to telephone therapies.

Finally, searches relating to the use of the telephone within the context of the IAPT service were applied. The selected literature was ensured to explore the following main outcomes: (1) symptom outcomes, (2) patient or service user feedback, and (3) practitioner or health professional feedback. *Table 5* outlines these parameters.

Search #	Parameters
All	<ul style="list-style-type: none"> • English language papers • Most papers included do not predate 1990 (for IAPT-related papers, these did not predate the 2000s) • Explored patient/service user feedback and/or practitioner feedback and/or symptom outcomes • Population under study were of all ages (for IAPT-related papers, this was limited to adults only as adolescents and children do not utilise the IAPT programme under study)
1	<ul style="list-style-type: none"> • Papers related to telemedicine or telecare in a general health setting (i.e. all healthcare disciplines) • Papers related to assessment, diagnosis, treatment, support, management and monitoring • Telemedicine or telecare for both physical and mental health conditions
2	<ul style="list-style-type: none"> • Papers related to telemedicine in the context of mental healthcare (telepsychology, telepsychiatry, telemental health) • Papers related to assessment, diagnosis, treatment, support, management and monitoring • Papers exploring mental health conditions
3	<ul style="list-style-type: none"> • Papers related to the use of telemedicine in specific psychological therapies (e.g. Cognitive-Behavioural approaches which IAPT utilises)
4	<ul style="list-style-type: none"> • Paper comparing telephone-based interventions for mental health with a face-to-face/In-person intervention
5	<ul style="list-style-type: none"> • Treatment intervention for CMDs, including CMDs related to physical/non-psychological conditions • Psychological therapy approach utilising a Cognitive-Behavioural approach • Set within a Low-intensity psychological therapies setting (i.e. a brief therapy setting or therapy with minimal therapist support)

Table 5: Literature search parameters

Where possible, Medical Subject Headings (MeSH) terms were utilised – in some cases (as each database had their nuances) the databases’ equivalent ‘Key Words’ were used. *Table 6* outlines the search terms used in the five literature searches.

Keywords from the research question (e.g. *“Patient views/feedback”*, *“Practitioner views/feedback”*) and topics which emerged (e.g. *“Therapeutic Relationship”*) were also employed.

Search #	Search terms
1	Telemedicine, Telecare, Intervention, Assessments, Monitoring, Support, Therapy, Treatment
2	Telepsychiatry, Telepsychology, Telemental Health, Intervention, Assessments, Monitoring, Support, Therapy, Treatment
3	Telepsychiatry, Telepsychology, Telemental Health, Intervention, Support, Therapy, Treatment, Cognitive Therapy, Counselling/Counseling, Psychotherapy, Behaviour/Behavior Therapy, Cognitive-Behavioural/Behavioral Therapy/CBT
4	Search 3 + Telephone, Face-to-Face, In-Person
5	Improving Access to Psychological Therapies/IAPT, Telephone, Face-to-Face, In-Person, Intervention, Support, Therapy, Treatment, Treatment, Cognitive Therapy, Behaviour/Behavior Therapy, Cognitive-Behavioural/Behavioral Therapy/CBT, Depression, Depressive Disorder, Generalised / Generalized Anxiety Disorder, Anxiety, Panic Disorder, Obsessive-Compulsive Disorder, Post-traumatic / Posttraumatic Stress Disorder, Social Anxiety Disorder, Social Phobia, Mood Disorder, Affective Disorder, Common Mental Health Disorder, Brief therapy, Minimal therapist support

Table 6: Search terms utilised

The topic of the utilisation of different communication modalities within mental health is sparse and minimal, thus the literature covered spans a variety of text types which include:

- Published and peer-reviewed journal articles: Systematic reviews, Meta-analyses, Randomised Controlled Trials (RCTs), Case studies, Observational studies, Intervention studies
- Research commissioned and funded by charities and non-governmental organisations
- Published text-books
- Government documentation, reports and literature
- Practitioner and professional periodicals
- Doctoral theses
- News articles

Systematic reviews and meta-analyses were used in sections covering topics with a large expanse of research in order to gain a comprehensive perspective. Pilot studies and smaller scale intervention studies were also considered because of the limited range of published articles available on comparing face-to-face delivered and telephone-based psychotherapies.

2.2 Telecommunication Technologies in Healthcare: Tele- medicine, health, care, *et al.*

The IAPT Step 2 service involves therapeutic approaches which require less therapist contact and use cost-effective methods of delivery. One such method is the use of telecommunication devices (i.e. OTT, internet, text messaging, etc.) referred to as ‘telemedicine’, ‘telecare’, ‘telehealth’ or (when referring specifically to internet-based treatment) ‘eHealth’. This approach has been adopted within the fields of radiology, neurosurgery, dermatology, psychiatry, as well as in general practice where patient health data are stored and communicated between the different care phases (Wootton, 1996; Mair and Whitten, 2000; Yellowlees *et al.*, 2003).

In a general healthcare setting, telemedicine has been effectively utilised within consultations. Patients found OTT consultations acceptable and were highly satisfied with its use (Bunn, Byrne and Kendall, 2009). Other positive aspects of using telehealth technologies include the reduction in workload of health professionals (e.g. a reduction of in-practice contacts and out-of-hours visits) and the ability to improve access to, and speed of, consultations for patients (McKinstry *et al.*, 2002). It was also suggested that symptom evaluations were found to be analogous to evaluations of F2F consultations (Gilmour *et al.*, 1998; Car and Sheikh, 2003); this was similar when using the PHQ-9 OTT (Pinto-Meza *et al.*, 2009).

In the management of health conditions, telecare or ‘telemonitoring’ programmes have also been shown to be effective. For instance, there was an improvement in quality of life scores and reduction in healthcare costs and hospital visits for patients with chronic heart disease who used a telemonitoring programme (Inglis *et al.*, 2010). Furthermore, it was found that the depth and the accuracy of information provided (alcohol consumption, dietary intake, etc.) was unchanged when using a telecommunication device compared to when informative was provided F2F (e.g. Greenfield, Midanik and Rogers, 2000; Brustad *et al.*, 2003).

2.2.1 Telecommunication Technologies in Mental Healthcare: Tele- mental health, psychiatry, and psychology

For this research project, the main focus was to investigate the application of telecommunication technologies in mental health services and its impacts when compared to standard F2F care. This practice has often been referred to as ‘telepsychiatry’, ‘telepsychology’ or ‘telemental health’. Mental healthcare can be delivered a number of ways: telephone, email, videoconferencing (VC), or internet chat services. It should be noted that telepsychiatry is synonymous with psychotherapy delivered by VC technologies (Baer, Elford and Cukor, 1997; Hailey, Roine and Ohinmaa, 2008; American Psychological Association [APA], 2010).

In a systematic review of telehealth in mental health settings, the approach was found to be comparatively effective when contrasted to usual care or waiting lists (Roine, Ohinmaa and Hailey, 2001). There have been a number of studies which have sought to discover the effectiveness of telemental health (utilising either a telephone-based or internet-based service) in the mental health services. Many have reported the effectiveness of psychotherapy or emotional support administered OTT. For instance, a systematic review of studies which investigated telephone-based peer support for individuals with Postnatal Depression (PND) suggested that it helped reduce depressive symptoms (Dale *et al.*, 2008). Meta-analyses further suggested that outcome effects reported after a course of telepsychiatry (or VC) were equivalent when compared to F2F treatment and there were no differences in consultation accuracy and satisfaction rates (Monnier *et al.*, 2003; Hyler, Gangure and Batchelder, 2005).

A recent meta-analysis explored CBT delivered through different modalities within a primary care setting for depression and/or anxiety symptoms (e.g. telephone CBT, cCBT). It was noted that these modes were more effective than treatment-as-usual or no primary care treatment; and it was more effective if these modalities were used adjunct to treatment-as-usual (Tworney, O’Reilly and Byrne, 2014).

Telephone-based Psychological Therapies

The focus of this literature review now centres on the use OTT psychological therapies in previous research – in line with the aims of this research project. This section is divided according to the psychopathology that was being treated by OTT mental health therapies. OTT delivery of psychological services is becoming more prevalent in mental health in the UK (e.g.

in the IAPT Step 2 service) and in the US. Between the period of 2000 and 2008, the use of OTT contact in mental healthcare in the US has increased by 85% (APA, 2010). A systematic review by Leach and Christensen (2006) outlined that OTT mental health interventions can be effective.

Mood Disorders

Telephone-delivered CBT (sometimes referred to as 'T-CBT') has been shown to provide positive outcomes for individuals experiencing depression. After eight sessions of T-CBT, there was a significant reduction of depression scores over three and six months. High satisfaction evaluations were also described by participants (Tutty *et al.*, 2010). Mohr *et al.* (2005) reported significant improvements in depression and positive affect after patients with Multiple Sclerosis took part in a 16-week treatment programme of T-CBT. T-CBT was also demonstrated to have outperformed the positive results of using an OTT-delivered supportive emotion-focussed therapy (Mohr *et al.*, 2005). Significant improvements in depression symptom scores were found in the use of OTT therapy in a rural primary care setting (Mohr, Hart and Marmar, 2006).

OTT therapy has also been investigated as a component in a therapeutic programme for patients experiencing depressive disorders with a psychopharmacological aspect (i.e. drug therapy). Tutty, Simon and Ludman (2000) found that patients who were provided with OTT counselling and support (using Behavioural and Cognitive-Behavioural concepts) showed more positive symptom improvements, as well as an increased likelihood to follow their course of antidepressants, compared to treatment as usual. This was maintained after a three month follow up in which symptoms were significantly lower than patients who were randomly assigned to usual treatment. A comparable effect was also found in a nurse-based care supportive intervention delivered OTT to facilitate the management of pharmacotherapy for depressed patients (Hunkeler *et al.*, 2000). Moreover, Ludman *et al.* (2007) found that when compared an information-only group, patients who had recently begun antidepressant treatment and used T-CBT reported significantly lower depression scores after 18 months. It is acknowledged that some argue that treatment and care of those experiencing mental health disorders should be moving away from medicalised approaches (e.g. the aims set by the Department for Health in 2001). These studies could suggest that T-CBT may be useful in a mixed approach practice.

It was noted in section 1.2.2 that the impact of CMDs can have negative economic implications in the employment domain due to the loss of work output due to absenteeism or low work productivity (Tennant, 2001; Thomas and Morris, 2003). Thus, studies have explored the use of brief T-CBT in a workplace setting. For instance, users of a brief T-CBT programme showed a decrease in depressive symptoms, and improvements in global functioning and in productivity. The OTT service also elicited high satisfaction scores from users (Lam *et al.*, 2011). In support of this, Furukawa *et al.* (2012) found that there was a decrease in depression scores after T-CBT but, when compared to an employment assistance programme (information provided by an external company) which also saw user symptom scores reduce, there was a non-significant difference in their outcomes suggesting comparable effects between the two interventions. Simon, Ludman and Rutter (2009) also found positive effects on depression and anxiety symptoms within a workplace setting after the use of an OTT care management system adjunct to a course of brief F2F CBT for work-related mental health issues. From this, it might be suggested that OTT care could be useful, not only as a therapeutic approach on its own, but also used as part of a F2F talking therapy.

Similar to many OTT interventions delivering the CBT approach, it has been noted that Interpersonal Psychodynamic Therapy OTT (IPT-T) was also helpful by significantly lowering depressive symptoms, and improving social and work functioning ratings (Miller and Weissman, 2002). This finding offers that OTT-delivery may be suitable for a number of psychological treatment approaches and thus in future, LI approaches may not need to be restricted to primarily CBT-based therapies. It should be highlighted however that Miller and Weissman recruited only female participants and so results may not be generalisable to a wider population.

Anxiety Disorders

For anxiety disorders such as OCD, symptom improvements were observed in patients who used T-CBT (Lovell *et al.*, 2000). These sessions were supplemented with F2F sessions at the start and the end of the T-CBT course and thus may confound the findings because two treatment delivery methods were used. It should be noted that Lovell and colleagues (2000) observed marginal improvements in OCD symptoms but this is positive nonetheless. These findings may therefore suggest that a combination of F2F and OTT therapy could provide positive effects on psychological symptoms.

A further study investigating the effect of T-CBT with OCD patients was conducted by Taylor *et al.* (2003); they randomly assigned patients with OCD to a T-CBT treatment plan, a minimal contact intervention, or to be placed on a waitlist group. A reduction in OCD symptoms were found in both 'active treatment' groups (T-CBT and self-help) compared to the waitlist group and these gains were maintained after a 12-week follow up. T-CBT also elicited a lower drop-out rate, similar to the minimal contact group. However, these positive effects were more evident in patients with only OCD; the authors found limited improvements in their patient sample with OCD and depressive symptoms.

Taylor and colleagues' (2003) findings may support the issue that many authors have raised: the NICE Guidelines (and the use of RCT findings) may not be suitable for those experiencing a co-morbid psychopathology. This can be due to the evidence-base prominently featuring studies which often exclude patients with co-morbid or more complex mental disorders (e.g. Ward *et al.*, 2008; McQueen *et al.*, 2010). The findings by Taylor *et al.* may also suggest that whilst T-CBT may provide positive outcomes for patients, it may not be as distinct from other minimal-contact interventions. However, a recent study observed that there were no significant differences in symptom outcomes of patients who experienced co-morbid anxiety disorders when using either FTF or OTT CBT (Stiles-Shields *et al.*, 2014a).

For panic and agoraphobia, a telephone behaviour therapy provided improvements in panic symptoms post-treatment compared to treatment as usual. It was further noted that the waitlist group, when they eventually utilised the OTT therapy, had showed similar reductions in symptoms as the original treatment group. These effects were then maintained after a three to five month follow-up (Swinson *et al.*, 1995). McNamee *et al.* (1989) investigated the use of two OTT-supported guided self-help treatments for participants who were experiencing Panic Disorder with Agoraphobia. These self-help treatments were: self-exposure (in which participants carried out tasks exposing them to stimuli which induced their panic disorder) and relaxation (where relaxation techniques were provided). From the two, it was found that self-exposure improved phobia and social adjustment scores more significantly than relaxation techniques. This study may provide positive evidence for the use of OTT supported guided self-help; a prominent therapeutic option within IAPT (Glover *et al.*, 2010). However, McNamee and colleagues' recruited a small sample and so findings may be limited in their generalisability.

The applicability of OTT therapies has been further explored in relation to the age-group targeted. For example, Turner *et al.* (2003) investigated the use of an OTT intervention for young people (ages 13 to 17) with OCD and found significant decreases in symptom scores. At the other end of the age spectrum, Brenes and colleagues (2012a; 2012b) explored the use of T-CBT with individuals aged 60 years and over who were experiencing an anxiety disorder. They found high satisfaction ratings, as well as low study attrition. When compared to an information-only group, there was a reduction in general anxiety, anxiety sensitivity, and worry post-intervention; although worry scores were the only aspect maintained after six months which could suggest that the effect of T-CBT for late-life anxiety patients is only short-term.

Other Psychological Disorders

The effectiveness of psychological therapies delivered OTT has been explored in more complex disorders. For example, after the use of guided self-help with OTT support, there was a decrease in symptoms (e.g. binge eating episodes) of those experiencing an Eating Disorder. The sample within this study provided positive satisfaction comments which praised the increased accessibility and flexibility of the treatment. Also, they felt an increase in autonomy when using this delivery modality (Wells *et al.*, 1997). An OTT intervention for those with Schizophrenia was reported to have helped reduce the likelihood of re-admission to hospital, and decreased time spent in re-admission. These effects were found in both conditions where patients only received information via the telephone or nursing intervention of reducing stress delivered OTT (Beebe, 2001).

Complex mental health disorders would not normally be presented by service users who enter the Step 2 service in IAPT and those that do would be provided with more intensive therapeutic approaches at Step 3. Nevertheless, it is of interest to find that a less intensive, minimal contact, approach could help in the support and management of more complex psychological cases as a potential method of follow-up and aftercare from therapist-led interventions.

Summary

Current research has suggested that OTT psychological therapies are feasible in practice, and produce positive outcomes for a range of psychological disorders. However, it should be noted that there are methodological flaws present within some of these studies. Primarily, a number of these are pilot studies with small samples sizes and a relatively short follow-up period, thus,

reliability could be put under question. Furthermore, there may be bias in the samples used (e.g. a disproportionate amount of females in the sample) issues could also be raised about the effectiveness of OTT-delivered therapies for people with co-morbid presentations (e.g. Taylor *et al.*, 2003). A number of the studies also utilised different treatment schedules (e.g. some involved F2F support or OTT support was used as part of a minimal contact therapy).

Despite these various issues, the studies are of importance as they present findings relating to psychological interventions delivered OTT. The use of pre-2000 studies to help explore this research area is due to the prominence of online video chat and internet-based interventions in more recent literature – the increase in number of studies exploring these modalities could reflect the major advances in online and video communication technology in the past decades.

Comparisons with conventional methods: OTT versus F2F

The research presented in the previous section explored studies investigating the effects of using an OTT psychological therapy. Swinson *et al.* (1995) and Taylor *et al.* (2003) suggested that the size of effect found from OTT therapy were comparable to those found in the F2F equivalent. These comments were of interest to note, however these studies did not provide their own F2F comparisons which would have improved the validity of these comments. As the main focus of this research project was to investigate and compare the differences between OTT talking therapies with F2F contact, this section outlines research that directly compares the two modalities.

Meta-analyses, which have explored the use of OTT therapies along with other methods of remote communication (e.g. VC and internet-delivered) for depression, suggested positive results of its effectiveness when compared to usual F2F treatment (Bee *et al.*, 2008). User satisfaction rates were also found to be equivalent when compared with F2F delivery (Hyer *et al.*, 2005; Bee *et al.*, 2008). Further to this, it was observed that attrition rates during a course of OTT psychotherapy were lower than a F2F equivalent (Mohr *et al.*, 2008; 2012).

Patients with depression undertaking a course of antidepressant medication and additionally utilised and OTT support intervention exhibited an increase in the likelihood of medication adherence, as well as reductions in lower depressive symptoms when compared with F2F care (Simon *et al.*, 2004). This was similarly observed by Mohr *et al.* (2000) who noted that patients

with Multiple Sclerosis were more likely to follow the recommended psychopharmacological programme of depressive medication when they utilised T-CBT rather than F2F usual care.

To date, few research findings observed that an OTT intervention for depression provides more significant improvements of symptoms when compared to F2F usual care (Datto *et al.*, 2003). Potential superiority in the effects of OTT interventions, when compared to F2F, was further noted in a preliminary pilot study by Lynch, Tamburrino and Rollin (1997). They found that, for patients with mild depression, OTT counselling provided bigger reductions in BDI scores compared to a F2F comparison group. However, this was not replicated in a follow-up study by Lynch *et al.* (2004). They found no significant differences in the reduction of depressive symptoms between an OTT problem-solving treatment package and usual F2F stress management treatment.

Mohr *et al.* (2012) found that patients experiencing major depressive disorder, showed significant improvements after working with T-CBT. These improvements in symptoms were comparable with F2F CBT but were not statistically significant. It was noted that after six months, F2F users reported less depressive symptoms than those who used T-CBT. This statistical non-significance between the two therapies was also found in studies which involved participants with HIV and experiencing depression (Himmelhoch *et al.*, 2013) and Dementia caregivers of African American origin (Glueckauf *et al.*, 2012).

In a more recent study, Fann *et al.* (2014) explored the use of T-CBT with individuals who were experiencing depression after traumatic brain injury. They noted that T-CBT significantly improved symptom ratings using the Hamilton Depression Rating Scale (HAM-D-17) and the Symptom Checklist-20 (SCL-20) after 16 weeks of therapy when compared to the usual care group; however, when compared to F2F CBT, the effects were similar.

For patients with OCD who were randomly allocated to a telephone-guided course of Exposure Therapy, Lovell *et al.* (2006) found similar clinical outcomes when compared to a F2F treatment course. This telephone-guided treatment produced high satisfaction ratings from users. Correspondingly, Day and Schneider (2002) also found that the use of a two-way audio communication (simulating OTT-delivery) provided similar small, but positive, psychological effects when compared to F2F and VC. Patients with weight concerns, problems with their

Chapter 2: Literature Review

body image, low self-esteem, or issues within relationships (e.g. family), utilised these interventions.

A recent study by Turner and colleagues (2014) explored the use of T-CBT for OCD for adolescents. They found that the effects of T-CBT when compared with F2F CBT (with measurements using the Children's Yale-Brown Obsessive-Compulsive Scale [CY-BOCS]) were non-inferior at three and six months but at twelve months, the effects were comparable; the users also rated satisfaction highly. Turner *et al.* (2014) concluded that improvements to OCD using T-CBT were effective at a mid-term range (i.e. up to twelve months).

Telephone-delivered therapies have been shown to provide benefits similar to that of F2F interventions in contexts outside of healthcare. For instance, a workplace programme of brief T-CBT offered a decrease in work-related stress and depressive symptoms. It also provided an improvement in global functioning and increase in productivity. The improvements were largely similar to usual care which involved F2F support sessions. The T-CBT service also elicited high satisfaction scores (Bee *et al.*, 2010a).

Overall, these studies have noted that OTT-delivery provides equivalent therapeutic outcome effects when compared to F2F. The meta-analysis by Bee *et al.* (2008) enforces this as it found that the effect size of symptom change for OTT-delivered therapies was similar those found in courses of F2F delivered treatment.

The findings by Lynch *et al.* (1997) did observe that OTT therapy may be more effective than F2F therapy but there has been little evidence to support this. Although when looking at mental health literature outside of mood and anxiety disorders, certain studies have noted potential advantages of OTT therapies when compared to F2F support. For example, McKay *et al.* (2004) investigated the effects of OTT counselling and monitoring on patients with a substance abuse issue relating to cocaine or alcohol. Abstinence rates for cocaine substance abuse patients did not differ between OTT-delivered support and treatment as usual (a F2F relapse prevention group). However, alcohol patients who used the OTT modality reported better abstinence rates when compared to treatment as usual. A course of CBT delivered OTT provided equivalent reported improvements in sleep quality (e.g. via a clinical questionnaire and sleep diary) for patients with Insomnia when compared to individual or group session based F2F CBT (Bastien *et al.*, 2004).

In the previous section it was noted that OTT therapy and support could be utilised in more complex and severe disorders (e.g. eating disorders and schizophrenia [Wells *et al.*, 1997; Beebe, 2000]) but when compared to F2F care its impact may not be as effective. For example, Palmer *et al.* (2002) randomly allocated patients with Bulimia to an OTT-delivered support, F2F support, self-help with minimal guidance, or a waitlist control. They observed that F2F and OTT-delivered support produced similar reductions in symptom severity (such as a decrease in bingeing episodes and self-induced vomiting). However, F2F delivery was also found to be more superior in its symptom improvements when compared to self-help with minimal guidance. Findings from Hugo *et al.* (1999) also noted similar reductions in Eating Disorder symptom measures (such as binge eating, vomiting and laxative abuse) when comparing counselling delivered OTT or F2F. From these studies, the more intensive F2F method had been observed to be more suitable for eating disorders this may potentially be due to the briefer courses of therapy are normally associated with telephone-based care, which might not be suitable for more severe and complex mental health disorders. However, it should be noted that OTT care still provides positive improvements to symptoms.

Summary

Overall, the research presented within this section notes that OTT therapies for CMDs provide comparative positive treatment outcomes when contrasted to F2F therapies. Some research may suggest that it could provide better outcomes, yet these findings have yet to be replicated. Moreover, some studies suggest that OTT is not as effective for complex mental disorders in comparison to F2F delivered interventions.

An Author's Note: Systematic Review

I began a systematic review in order to explore the effectiveness of OTT psychological therapies in comparison to F2F psychological therapies (in relation to symptom changes). However, despite a reasonable number of studies exploring the use of the OTT in psychological therapies, only three papers could be included in a review. A number of the papers found in the initial search were missing key details, such as a lack of description about the comparison group or there were some methodological aspects which would not have been suitable for the review. For example, in some studies therapy involved a mixture of F2F and OTT treatment or there was an adjunct pharmacological therapy provided. The review was therefore discontinued due to a limited number of papers which met the inclusion criteria.

2.2.2 The Benefits of Telemental Health: Overcoming Treatment Barriers

The literature explored in section 2.2.1 has shown that outcome effects of OTT-delivery are comparable to conventional F2F methods for mild-to-moderate CMDs. However, one of the main advantages of utilising telecommunication technologies to deliver healthcare in comparison to F2F is its potential to help alleviate a number of treatment barriers. These barriers are perceived by patients and can prevent them from seeking help or they could make them more reserved in therapy sessions (Galinsky, Schopler and Abell, 1997; Miller and Weissman, 2002).

Telemedicine could be financially cost-effective

Reviews of literature have noted that telemental health is considered to be financially cost-effective (Bashshur *et al.*, 2000; Whitten *et al.*, 2002; Mohr *et al.*, 2006; Marks and Cavanagh, 2009). This is due to a reduced demand on the time of the health professional and thus, they are able to contact more patients in a shorter space of time. Furthermore, therapies can utilise telecommunication equipment which the majority of patients may already have access to (e.g. telephone, internet access, etc.). Simpson *et al.* (2001a) noted that, by using telepsychiatry (videoconferencing) a patient could save approximately \$210 through no longer requiring childcare, travel, and time off work to attend sessions. A recent study within the IAPT setting compared OTT use with F2F found that OTT was more cost-effective than F2F (Hammond *et al.*, 2012).

Telemedicine could overcome mobility and geographical location issues

Telemedicine can also be applied to treat problems in areas where qualified therapists are scarce (King, Spooner and Reid, 2003; McLaren, 2003; Newman *et al.*, 2003; 2011). Regardless of geographical location or distance, patients are able to seek help from health professionals without mobility costs or other concerns (Bashshur *et al.*, 2000). Telemental health studies situated within rural locations also highlighted the positive aspect of telemedicine (Hilty *et al.*, 2007; Swinton, Robinson and Bischoff, 2009). A recent study by Cavanagh (2014) explored the distribution of CBT therapists in England and Wales and found that numbers have increased from the previous decade since the introduction of CBT-based programmes (e.g. IAPT) but an inequity is still apparent in some areas.

Telemedicine could overcome timing constraints

It is suggested that as telemedicine uses a more flexible approach, it could remove the scheduling or timing constraints that patients often cite as a help-seeking barrier (Lovell *et al.*, 2000). A review of help-seeking barriers by Mohr *et al.* (2006) suggests that these scheduling constraints include: responsibilities of childcare, looking after loved ones, employment, among others. Doze *et al.* (1999) obtained the perspectives of health practitioners on the use of telepsychiatry in their clinic and many commented that they were able to use their clinical time more productively and also cut waiting times so they were able to respond to patients quicker before their symptoms become more severe.

Telemedicine could help alleviate the feeling of stigma when help-seeking

Beliefs, attitudes, and knowledge about health services are also considered as major influences on the ability of an individual to seek help. One of the main affecting factors on the beliefs and attitudes of an individual towards help-seeking, and is often cited as a treatment barrier, is the issue of stigma (Corrigan, 2004; Eisenberg, Golberstein and Gollust, 2007). There are two types of stigma: 'self-stigma' and 'public-stigma'. Self-stigma relates to the reactions of the individual and their self-esteem (e.g. being embarrassed or labelling oneself as 'abnormal' or 'crazy'). Public-stigma stems from the reactions or attitudes of others; for example, negative perceptions of a medical or psychological condition (Vogel, Wade and Haake, 2006; Vogel, Wade and Hackler, 2007; Wood *et al.*, 2014).

Barney *et al.* (2006) found that a common societal attitude is that mental health issues are considered socially unacceptable. Thus, there is often the belief that if an individual seeks professional help, it will elicit negative reactions from others (including the health professional) and this ultimately leads to shame and embarrassment felt by the individual. As a consequence, this leads to the avoidance of help-seeking for mental health help in order to avoid this negative stereotyping (Vogel *et al.*, 2006). In treatment, public-stigma factors may inhibit the ability for an individual to fully express themselves. In one-to-one settings, patients noted that disclosing private and personal topics and the perception that they will be received negatively may make them more hesitant and uncomfortable in sessions (Mohr *et al.*, 2006).

The feelings of stigma and anxiety associated with mental health treatment-seeking could be reduced by the use of health technologies. Often individuals are physically detached from others (e.g. the professional OTT) and in some instances anonymity can be maintained

(Rosenblum, 1969; Miller, 1973; Yellowlees *et al.*, 2003). For instance, those who utilised Telepsychiatry commented that they were able to talk more freely which resulted in satisfying their needs for the treatment (Hilty *et al.*, 2007).

Miller (2003) stated that there were some issues surrounding the protection of privacy when utilising certain modes of delivery in healthcare practice (e.g. over the internet). The National Society for the Prevention of Cruelty to Children or NSPCC (2007a; 2007b; 2009a; 2009b) noted that confidentiality and anonymity during telephone calls were some of the major reasons why children preferred this medium when discussing serious issues such as sexual abuse, depression, suicide and mental health. Furthermore, users of *The Samaritans* commended the anonymity available to them which provided more confidence in the service (Stace and Wyllie, 2011).

Telemedicine could potentially tackle other individual factors which prevent help-seeking

As well as practical concerns, it should be noted that individual factors may also be considered as treatment barriers (e.g. sociodemographic characteristic, social and cultural differences). A student survey regarding barriers to help-seeking in mental health found that females were most likely to seek mental health help. In addition, those less likely to seek help tend to include: those of an older age, Asian or minority groups, bi-sexual or gay/lesbian individuals (Eisenberg *et al.*, 2007). It was also found in other questionnaire studies that older aged individuals were less inclined to seek mental health help or talking therapies, particularly from a mental health service. However, it was suggested that older adults may be more likely to discuss this problem with their GP (MacKenzie *et al.*, 2006; Anderson and Brownlie, 2011). It had been noted in a literature review that men are more reluctant to seek help for health-related conditions. Moreover, this was evidenced across ages, nationalities, ethnicities and racial backgrounds (Addis and Mahalik, 2003).

Issues relating to the psychological condition (or other medical conditions) of the individual may also reduce the likelihood of seeking help. For instance, McManus *et al.* (2009) reported that a smaller proportion of individuals with an anxiety disorder were less likely to search for help. Moreover, the severity of the condition was noted to affect the decision of individual to seek treatment. In major depression, if the individual felt that they could handle the episode or considers it as 'non-serious' they are less likely to seek treatment. An individual may be more

likely to seek help if severity levels were higher (e.g. interpersonal and/or individual functioning was severely affected), or if the depressive episode lasted longer than anticipated (Blumenthal and Endicott, 1996/1997; Mojtabai, Olfson and Mechanic, 2002).

Telemedicine could help improve general health practice

Another advantage of using telemedicine or OTT services are that it can help to deliver a structured system which results in better monitoring, feedback and support, organisation of care, as well as record keeping (King *et al.*, 2003; McLaren, 2003; Newman, 2004). These findings have been offered by authors after reviewing the literature available. Comments from service providers located in a rural district where telepsychiatry was implemented stated that the main advantage of this service was that it helps to increase service provision to patients (Doze *et al.*, 1999). These were also mirrored from the perspectives of patients in a rural district after receiving telemental health support (Swinton *et al.*, 2009).

Summary

Overall, it has been suggested that telehealth technologies can help to reduce or remove treatment barriers often associated with mental health help-seeking; it has been demonstrated with regards to both practical factors and the concerns of an individual (see **Table 7** for a summary of these issues).

Practical Concerns	Individual Differences Issues
<ul style="list-style-type: none"> • Scarce resources • Financial costs • Geographical location or distance • Scheduling or time constraints • Mobility issues 	<ul style="list-style-type: none"> • Beliefs and attitudes of services (including awareness and knowledge) • Stigma towards mental health help-seeking • Psychopathological factors • Sociodemographic characteristics, social and cultural differences

Table 7: Treatment barriers associated with mental health services

Despite these positive findings, there are still many who have reservations regarding its use. For example, Miller (2003) explained that there may be issues around privacy when utilising certain modes of delivery (e.g. over the internet). Furthermore, they suggested that these modes of delivery could affect the therapeutic relationship (e.g. Wootton, 1996).

2.2.3 Potential Issues of Using Telemental Health: The Therapeutic Relationship

This section aims to cover the issues that many researchers regard as disadvantages of using alternative forms of therapeutic delivery in psychotherapies.

Whilst the aims and methods in therapy do not drastically differ when using F2F or OTT (Richards and Whyte, 2009; 2013), one of the main disadvantages is that OTT use could alter or be a threat to the formation of the therapeutic relationship (Wootton, 1996; Miller, 2003; Farrand and Williams, 2010).

What is the Therapeutic Relationship and why is it important?

Defining the Therapeutic Relationship

The Therapeutic Relationship is the interpersonal connection between the therapist and patient. Within psychotherapies, it can be defined in many different ways (Paul and Haugh, 2008a).

Reynolds (2003) notes that the aim of this interpersonal relationship is for the therapist to support and to provide understanding, allowing the patient to be empowered and learn to

cope in order to help reduce or resolve the problem which the patient sought for practitioner help and guidance. Reynolds outlined three phases in the building of a therapeutic relationship:

- 1) **Orientation:** where the two individuals in the dyad begin to get to know one another, assessing boundaries, working through the aims of the relationship, beginning to accept each other and build trust.
- 2) **Working Phase:** this step is where the therapeutic models are applied.
- 3) **Resolution:** a mutually agreed end to the therapeutic process – the patient should be more autonomous and have a greater understanding of their problem and there should be a resolution or a reduction in their problem.

Factors or the ‘ingredients’ in forming a positive and successful therapeutic relationship have been discussed by many authors (e.g. Bordin, 1979; Ong *et al.*, 1995; Williams *et al.*, 1998; Chadwick, 2006; Paul and Haugh, 2008b; Egan, 2010; Brown, 2012). These ingredients⁷ can be organised into three aspects which include:

- **Unconditional positive regard:**

Practitioners should convey commitment and a desire to help the patient. It is also important to build an authentic, positive and friendly interpersonal bond using warmth and empathy, good manners and courteous behaviour. Trust and honesty should be created which can encourage openness. Practitioners should also ensure that respect of the patient is expressed by being non-judgemental.

- **Verbal and non-verbal competencies:**

Non-verbal cues such as eye contact and facial expressions have been noted to be important. In addition, verbal communication competencies such as mirroring, guided questioning, the positive use of tone and volume of voice, and providing times of silence when needed can contribute to a positive therapeutic relationship. Moreover, the use of humour (e.g. making appropriate jokes, laughing where suitable) was also noted to be facilitative.

- **Practical approaches in therapy:**

The need for the practitioner to make their presence felt with the patient and attentive listening has been found to be important strategies in building a positive therapeutic

⁷ It should be noted that there are many ‘ingredients’ and the factors expressed is not a definitive list.

relationship. Providing encouragement when needed and keeping to the designated time has also been suggested to be a beneficial factor. Practitioners should also use clear vocabulary, with little jargon, to ensure understanding.

As well as these aspects, most authors would agree that the schools of psychological therapy approach the therapeutic relationship in different ways (Paul and Hauge, 2008a).

As briefly outlined in section 1.2.4, the psychoanalytic approach aims to help individuals to cope with conflicts of their unconscious desires and subjective views on the conscious and external or social world (Cave, 1999; Howard, 2008; Butcher *et al.*, 2010). The role of the psychodynamic therapist is to encourage the patient to speak about these conflicts and past experiences in order for the patient to gain an increased understanding of the underlying reasons for these conflicts. There is importance placed on 'transference' where the patient expresses their unconscious desires and views within the therapeutic space. It is important for the therapist to ensure that there is a space established to enable this expression. 'Counter-transference' has been regarded by some in having a negative impact on the therapeutic relationship. Thus, boundaries and caution to self-disclosure have been noted to be important. Contractual agreements between the patient and the therapist can help to maintain these boundaries. However, some analysts suggested that the active participation of the therapist within the narrative of the patient may be helpful and thus some are not as dogmatic about the possibility of counter-transference (Hughes and Kerr, 2000; Howard, 2008).

In CBT, the goal of therapy is "*...to modify thinking patterns*" (Thomas, 2008, p. 92) and, in turn, behaviours (Cave, 1999). The ability to build a therapeutic relationship is a key skill and a competency for CBT therapists in order to establish a safe environment in which therapy can occur (Gilbert and Leahy, 2007; Hardy, Cahill and Barkham, 2007). Patients place a level of trust and confidence on the therapist due to the sensitive nature of what they are disclosing about their mental health experiences, which are sometimes difficult and distressing. There is importance placed on building an 'authentic' rapport, conveying openness and interest, and placing value on the patient (Thomas, 2008).

In the IAPT Step 2 service, the role of a Psychological Wellbeing Practitioner (PWP) is that of educator, supporter, motivator and self-help coach (IAPT, 2010). In their training, PWPs are taught to utilise 'common factor skills'. These are recognised as helping establish and build a

therapeutic alliance and include: providing a positive and non-judgemental attitude, the use of non-verbal (e.g. eye contact, posture) and verbal competencies (paraphrasing, reflection, empathy and summarising) (Richards and Whyte, 2009; 2013). These CBT therapy skills help to promote joint understanding and show the patient that the therapist recognises their feelings they are experiencing (Gilbert and Leahy, 2007). PWPs are also encouraged to be reflective (Richards and Whyte, 2009; 2013). Reflexivity (whereby the practitioner considers their own thoughts during the process, e.g. their ideas of how therapy should happen) is also important (Brown, 2012).

Within CBT, collaboration is a key component in the patient-therapist relationship (Westbrook *et al.*, 2010). Collaboration has been shown to have a positive association with the quality of a therapeutic alliance, with an agreement of goals also being a positive indicator of a strong relationship (Bordin, 1979; Hatcher, 1999; Martin, Garske and Davis, 2000). In a recent meta-analysis review of collaborative care in European countries, Sighinolfi *et al.* (2014) noted that when collaborative care is provided, it was more beneficial in improving depression treatment outcomes when compared to a non-collaborative, health professional-led treatment.

The humanistic approach focusses on the importance of the individual and their experiences, and the drive of personal development in order to achieve their ultimate goals. Unlike, psychodynamic and traditional CBT approaches, a person-centred approach (e.g. the person-centred CBT approach by Chadwick [2006]) promotes the patient taking the lead in therapy as the expert of themselves and so the therapist has a non-directive role (Cave, 1999; Haugh, 2008; Paul and Haugh, 2008a). One of the roles of a CBT therapist is to monitor the relationship and promote their knowledge in the therapeutic approach and tools (Thomas, 2008). A common factor skill for PWPs is to establish their relevant expertise with the patient (Richards and Whyte, 2009; 2011). Although collaboration is an important aspect of CBT therapy, it could be argued that the therapist should still be the one to take the lead in sessions. Chadwick (2006) suggests that therapists should aim to understand the unique perspective and experiences of the individual through active listening and supportive discovery, rather than following protocols that he criticises as a barrier to the formation of a therapeutic relationship.

The use of manuals in therapy has been suggested to reduce the variability in therapeutic outcomes across different therapists although there has been little evidence to suggest any

increased benefits (Fonagy, 1999; Beutler *et al.*, 2004). PWP's follow a set way of working (e.g. the use of an interview schedules for first and subsequent contacts) (Richards and Whyte, 2009). Chadwick (2006) emphasises that practitioners should be committed to working with the patient and aiming for understanding rather than 'a cure' or completing particular steps. An example of this could be the utility of 'empathy dots' which are used to remind PWP's to use empathy statements at regular times during contact with the patients (Richards and Whyte, 2009; 2013). This could be argued as means of tick-boxing rather than an authentic consideration of the person which a person-centred approach advocates (Reynolds, 2003; Chadwick 2006). However, the CBT approach and the use of protocol-led therapies have been noted to be successful in their therapeutic outcomes with good levels of patient satisfaction (Thomas, 2008).

It has been suggested that the therapeutic relationship is more important than the therapeutic approach utilised (Paul and Haugh, 2008b). As outlined in section 1.2.4, some authors have noted little difference in effectiveness across therapeutic approaches (Paul and Haugh, 2008a; Stiles *et al.*, 2006; 2008). Lambert (2013, p. 8) detailed that current approaches to psychotherapy should be more "*eclectic*" and that therapists should take an "*integrative position*" using aspects of different schools of thought to suit the distinctive needs of the patient. It has been suggested that CBT approaches could be utilised alongside the psychoanalytic and humanistic approaches (Howard, 2008).

Seminal work by Clarkson (from the late 20th Century to the present day) proposes, what could be suggested, as being a more integrative approach. Clarkson (2003) outlined five 'modalities' or 'types' that could describe the therapeutic relationship. Each of these types embodies a combination of the approaches to mental health. There is no sequence to the use of these types and is dependent on the context of the therapy. The patient, the stage of the therapy and the amount of time spent may affect which strategies to utilise. Clarkson suggests that these types can be used together and can occur at any point in the therapeutic process and these strategies should be used to help support the unique situations of the patient (Clarkson, 2003; Antoniou and Blom, 2003). The five therapeutic relationship modalities include:

1) *The Working Alliance*

This explores the need for the patient and therapist to form a co-operative relationship. It is noted to be the “*sine qua non*” (Clarkson, 2003, p. 36) – the essential action, condition, or ingredient – in psychotherapy that enables the patient and therapist to work together even when there is no desire to do so. It works on similar principles to those outlined by Bordin (1979) who suggested that the working alliance is based on shared goals, bonds and agreed tasks.

2) *The Transferential/Counter-Transferential Relationship*

This type of relationship builds on work from the psychoanalytic school of thought. Specifically the idea is that there is a need to consider what each individual brings to the relationship and the process of ‘transference’ as ‘unconscious’ fears and desires of both parties could either facilitate or disrupt the therapeutic process.

3) *Reparative and Developmentally-Needed Relationship*

This therapeutic relationship builds on a developmental view which suggests the role of the therapist is supportive and helps to ‘repair’ deficiencies in original parenting (e.g. if the parent was negative, absent, overprotective, etc.). Therefore, it provides a ‘corrective’ therapeutic experience.

4) *The Person-to-Person Relationship*

This modality takes a humanistic view. There is great emphasis placed on the relationship being ‘authentic’ and ‘real’ and to have a human-feeling. There should be emotional involvement within the dyad.

5) *The Transpersonal Relationship*

This form of therapeutic relationship refers to a spiritual view in which the relationship can provide some curative or healing purpose (Brown, 2012). This modality is noted to be impossible to describe.

The work of Clarkson (2003) was used to explore and understand the findings of this research project within the discussion chapter (*Chapter 5*).

The Therapeutic Relationship and Therapeutic Outcomes

There are many ways of assessing and measuring the therapeutic relationship. For example, there is the Working Alliance Inventory (WAI) (Horvath and Greeberg, 1989; Tracey and Kokotovi, 1989) which is based on the three features which Bordin (1979) proposed in his appraisal of the working alliance (goals, bonds and tasks). An alternative alliance scale called the California Psychotherapy Alliance Scale (CALPAS) (Gaston, 1991) also explores these elements but additionally measures factors related to patients (e.g. whether they have a strong commitment to change, and how much they are willing to self-disclose) and therapists (e.g. their capacity to intervene tactfully, showing their commitment to patients, and capacity to understand). Tichenor and Hill (1989) found that other alliance scales (Penn Helping Alliance Rating Scale and the Vanderbilt Therapeutic Alliance Scale) also emphasised collaboration and support.

Previous literature has shown that the therapeutic relationship has a strong and significant relationship to the quality of therapeutic results (Woolley *et al.*, 1978; Krupnick *et al.*, 1996). A meta-analysis of research has suggested that the working alliance was positively correlated with clinical therapy outcomes and an early formation of alliance was also found to have a good predictive factor of success (Martin *et al.*, 2000). Lemma *et al.* (2011) noted that the successful building of a therapeutic relationship was associated with positive outcomes which were found across the different therapeutic models (cognitive-behavioural, psychodynamic, and humanistic). A survey study within the NHS showed that the quality of the working alliance, when rated by the patient, was predictive of therapeutic outcomes (Trepka *et al.*, 2004). This predictive factor has been to be present regardless of the type of therapy used and the treatment length (Horvath and Symonds, 1991). It should be noted that the therapeutic relationship is not exclusive to mental health. Amongst other health professionals (e.g. nurses, doctors, etc.); the relationship between patient and health professional has significant clinical implications (Reynolds, 2003).

In addition, the therapeutic relationship has been shown to be related to patient satisfaction (Waitzkin, 1984; Williams *et al.*, 1998). Ong *et al.* (1995) suggested that a good therapeutic relationship was important for optimal care (e.g. for successful co-operation in medical decision making, patient satisfaction with care, recall and understanding of health related information, etc.). It has also been noted that a strong therapeutic relationship can increase patient engagement and commitment. However Chadwick (2006) noted that the main focus of building the therapeutic relationship should not be in order to 'get a patient to commit or

engage' but to build a positive relationship which should, in turn, encourage patients to engage.

How could Telemedicine affect the Therapeutic Relationship?

The literature surrounding the potential reasons how telemedicine could affect the therapeutic relationship often offers two common aspects: the absence of non-verbal communication and physical distance.

Absence of Non-Verbal Communication

It has been observed that the disruption to non-verbal aspects of communication in telemental health may hinder the formation or development of a therapeutic relationship. For instance, in OTT-delivery, there is a notable absence of the visual medium.

For the therapist, non-verbal cues (NVCs) are an important indicator of the emotional state of the patient (e.g. discomfort, anger, mistrust and satisfaction). These NVCs are stated to be important in preventing 'ruptures' in the therapeutic working alliance (Stewart, McWhinney and Buck, 1979; Westbrook *et al.*, 2011). Along with the disrupted visual NVCs, it can also be difficult for the therapist to detect any vocal changes of the patient (e.g. in tone or volume) (McLaren *et al.*, 1996; King *et al.*, 2003).

It has been suggested that only 5% of affective behaviour can be expressed verbally, whilst 55% can be conveyed through visual or NVCs (Bensing, 1991). Egan (2010) suggested that providing eye contact and non-verbal signs convey openness and relaxation which could elicit a more positive relationship. Furthermore, Wootton, Whitten and Kingsley (2003) notes that eye contact, facial expressions and body positioning, as well as tone and audible hesitations, are important in assessing emotion. In addition, these NVCs were suggested to be indicative of patient satisfaction and level of understanding (Waitzkin, 1984). For instance, Bensing (1991) also found that patient satisfaction was positively related to non-verbal factors.

It has also been observed by Wright and Davis (1994) that the perceptions the patient has of therapist characteristics can predict the therapeutic outcome of the treatment (e.g. if the patient perceives the therapist positively, it is more likely that they may better engage with the treatment). As a result, with certain senses absent in the telemental health process, these perceptions may become based on a reduced amount of information normally found in F2F interaction.

Moreover, Friedman (1979) noted that patients are very perceptive of the NVCs of their health professional (e.g. tone of voice, eye contact, facial expressions, etc.) and the subtle hints they provide surrounding their mental health. This is important as it is acknowledged that a patient often feels uncertainty about their condition when seeing a health professional. Clues about their health, therefore, would be of significance to them. Spiro and Devenis (1991) discussed in their case study of OTT psychotherapy that emotion transference and counter-transference – an important component in psychotherapy – was affected by the lack of visual information. The patients felt as though they had to use their imaginations to complete the missing visual information.

Physical Distance

Another key element noted in literature reviews around the use of telephone or other telemedicine devices affecting the therapeutic relationship is the effect of the physical distance between the patient and the therapist. It was suggested that there may be a reduction of the intimacy usually found in F2F communication (Cukor and Baer, 1994).

In Primary Care, Larsen and Smith (1981) observed that the degree of closeness between the patient and the health professional was related to the level of satisfaction of interaction. More specifically, it was established that NVCs were rated high in importance for a successful interpersonal relationship. Egan (2010) noted that the actions and position of a therapist in the session could help provide a more comfortable environment (e.g. sitting at a comfortable distance from the individual, leaning forward, conveying signs of interest and listening). Smith, Polis and Hadac (1981) found that there was a positive correlational relationship between physical closeness and the amount of understanding the service user reported. *ChildLine* counsellors suggested that they felt uncomfortable or helpless when dealing in situations OTT where a physical intervention may be needed at times of crises, e.g. during a conversation about suicide (NSPCC, 2007a). Similarly, King *et al.* (2003) suggests that one disadvantage to telemedicine included the inability for crisis intervention as the therapist is not physically with the patient to prevent harmful behaviours.

Summary

In summary, the literature suggests two potential reasons why telemedicine might be detrimental to the formation of a therapeutic relationship:

1. The loss of non-verbal communication cues
2. The physical distance between the therapist and the patient

The next section explores research which supports the idea that telemedicine might not affect the formation of the therapeutic relationship.

Does Telemedicine Research Suggest Otherwise?

Some studies of OTT-delivered psychotherapies have reported high satisfaction ratings and a lower attrition level when compared to a F2F equivalent (e.g. Bee *et al.*, 2008; Mohr *et al.*, 2008). These could suggest that the formation of the therapeutic alliance may not be as altered as others may suggest. Further telemedicine research provides evidence that the working alliance can be rated highly and that there may be no difference in quality when compared to a F2F counterpart.

Absence of Non-Verbal Communication

In a small scale research project and a larger follow-up study, the therapeutic relationship was rated by patients consistently between F2F, videoconferencing methods, and a two-way audio system simulating OTT-delivery (Day, 1999; Day and Schneider, 2002). It has also been observed that counselling patients who communicated with a counsellor OTT or F2F had given equivalent ratings of the 'counselling relationship'. Patients also provided good satisfaction scores (Reese, Conoley and Brossart, 2002). Ratings of therapeutic alliance (using the WAI) suggested a positive alliance was formed when utilising an OTT support service. Moreover, the similar levels of therapeutic alliance were found in previous studies regarding F2F support (Lingley-Pottie and McGrath, 2006).

Furthermore, an internet-based text-only treatment for PTSD was noted as providing a good therapeutic relationship. This was indicated by a high working alliance rating and a low-dropout rate. The authors suggest that this could provide evidence for success and stability of the therapeutic relationship in a text-based intervention (Knaevelsrund and Maercker, 2006). In support of this, Cook and Doyle's (2002) pilot study which utilised an online text-based only medium of counselling was compared with a F2F equivalent. The text-based therapy was

primarily in real-time using an instant messaging programme (although email was sometimes used outside of sessions). When the researchers accounted for the therapeutic approach, the presenting mental health symptoms of the user, and therapist factors, the ratings from the WAI were found to be non-significant between delivery types.

Physical Distance

Spiro and Devenis (1991), using a case study as an illustration, noted that the use of the OTT in psychotherapy may help patients to feel more equal in the relationship which made them more responsive in sessions. This could indicate that the delivery method might have increased the intimacy between the patient and analyst. These factors may be perceived as important in building a therapeutic relationship. Moreover, Miller (1973) proposes that OTT use can be regarded as more 'intimate' than some may suggest due to the closeness of the voice emitted from the device into the ear of the caller. Findings from studies of Pure Self-Help treatments suggest that minimal contact from the therapists provided similar improvements in symptom alleviation in patients with anxiety and depression when compared to regular contact with a therapist (Bilich *et al.*, 2008; Houghton, 2008).

Summary

The argument regarding the problem of forming a successful therapeutic relationship in psychotherapy using telemedicine has been examined by many. However, studies of telephone- and online text-based only interventions, as well as intervention studies which investigated minimal contact therapies suggest that this may not be entirely true and that a therapeutic relationship may be formed successfully without the need for non-verbal communication and close physical distance.

In the Step 2 service of IAPT, PWPs are trained to “...*compensate for the lack of non-verbal communication*” (Richards and Whyte, 2011, p. 20) when undertaking OTT work. Importance is placed on their verbal skills (e.g. summarising, paraphrasing, being emphatic, pausing to give patients time to respond and provide information) in order to build a positive therapeutic relationship (Richards and Whyte, 2011). In addition, it has been noted that the therapeutic relationship can be conveyed both verbally and non-verbally, and could take place in a number of settings (Paul and Haugh, 2008a).

It is acknowledged that these studies explored findings using self-report scales which sought to quantitatively measure the quality of the therapeutic relationship and it could be argued that this might be reductive as the therapeutic relationship has been noted to have several facets that may be difficult to measure (e.g. the 'Transpersonal Relationship' from Clarkson, 2003). Moreover, caution should also be taken when interpreting these studies as the majority are small scale and some are only case studies. In addition, some studies did not use a F2F comparison group.

Other potential problematic issues using Telemental Health

In a review of the telemedicine approach, King *et al.* (2003) suggested that technical limitations and technical failures in the devices could inhibit the usefulness of telemedicine. For example, a survey by Rohland *et al.* (2000) found that factors of concern when using telemedicine (such as telepsychiatry) included: hearing and visual problems, as well as the lack of knowledge about the technology used in therapy. These factors could be mainly related to computer-based and VC methods but with the advances in current technologies (e.g. high definition video cameras), and the wider reach of internet and phone connectivity (e.g. broadband capabilities and mobile phones), these issues may be a product of the time when this research was undertaken. Although in saying this, these limitations could still be present through lack of access to these new technologies (e.g. due to financial cost and product availability in the marketplace).

The issue of privacy was raised by Miller (2003) with regards to the use of newer health technologies (e.g. internet-based communication) in healthcare. Wright and Davis (1994) noted that patients utilising psychotherapies (such as CBT) place high importance in the therapeutic setting a therapist should provide; particularly one which is physically safe, private and confidential. It was found by Haas, Benedict and Kobos (1996) that users of an OTT therapy service, although commented on the ability to disclose more information, stated that there was an element of risk in privacy during OTT sessions (e.g. a danger of others listening, unauthorised access to information, etc.).

Technological advances (e.g. increased anti-virus and security programmes) may help to alleviate these issues. It could be proposed that during the time of these reports, security methods may have been less sophisticated and thus the danger of unauthorised data access much higher. However, the act of 'hacking' and harvesting data without permission is still

present and becoming more prominent, despite the current advances in technological 'defences' to these acts.

Summary

Telemedicine research proposes a number of issues that could arise when using telecommunication technologies within psychological therapies.

First is the issue of whether telemedicine may negatively impact on a therapeutic relationship. The therapeutic relationship can be defined in many ways and is approached differently across the therapeutic modes (psychoanalysis, behaviour, cognitive and humanistic). What can be agreed upon is that the therapeutic relationship is central and instrumental in therapy. The relationship between the patient and practitioner could also be considered as more important than the theoretical concept that underpins the therapy itself with much of the literature noting its importance and association with the quality of the therapeutic outcome (e.g. symptom improvements and satisfaction rates). In telemedicine, the loss of non-verbal cues in communication and the physical distance between the patient and the therapist were presented as factors which could inhibit a good working alliance.

Other potential factors in telemental health also include worries from users regarding technical issues (e.g. lack of knowledge, errors from technology or poor technical specification) and potential privacy issues when transferring sensitive information across newer communication technologies. Nevertheless, some research and the advances in technology may suggest that telemedicine is not as detrimental to mental healthcare as previous authors have proposed.

2.2.4 Patient Views of Telemedicine

By gaining views of service users, further issues regarding telemental health have been outlined and explored. In a systematic review of telemedicine within a general healthcare setting (including psychiatry, dermatology, oncology, home nursing, etc.), Mair and Whitten (2000) described that patients reported good levels of satisfaction towards the technology. However, many of the studies synthesised in the review were noted by the authors as having certain methodological deficiencies (e.g. no control groups) which limited their ability to generalise their overall findings.

As telemental health can be delivered in a number of ways (e.g. OTT, by VC, and by internet), this section is divided by delivery type. The final part of this section investigates potential patient factors which may affect their views and the likelihood of selecting telemental healthcare.

Patient views of using OTT therapy

One of the main objectives of this project was to explore the views service users have on the use of OTT psychological therapies. User satisfaction rates for OTT use have been found to be similar with F2F delivery (Hyer *et al.*, 2005; Bee *et al.*, 2008).

A study which compared an OTT-delivered and F2F counselling service found that patients provided similar ratings in therapeutic alliance and satisfaction; users also commented at the helpfulness of OTT-delivery. It was further suggested that the telephone modality may prevent successful therapeutic alliances being formed (Reese *et al.*, 2002).

The use of the telephone in support sessions for patients with Eating Disorders was rated high in satisfaction. The service users noted that they felt more autonomous due to the flexibility and ease of access the delivery modality provided them (Wells *et al.*, 1997). A similar OTT programme by Hugo *et al.* (1999) also found that users praised the convenience of accessing support services when using the telephone. The user also noted that the status of anonymity helped them in session and they offered no concerns about confidentiality. Tutty, Ludman and Simon (2005) found that participants who utilised T-CBT for depression treatment provided positive ratings and satisfaction, and the users were also more likely to maintain contact with the therapist which suggests that a positive rapport may have been built.

A pilot study by Lam *et al.* (2011) in a workplace setting elicited favourable responses from the users of a brief T-CBT programme. It should be noted that there was no systematic satisfaction rating used, and these positive views were noted by the authors from anecdotal comments given (e.g. a user commented that they felt “*empowered*” after using the programme). Although, there was no aim in their study to explore patient views, the study is of particular interest as it uses similar outcome measures as IAPT (the PHQ-9 scale and work absence records) and thus its findings could potentially simulate those found in IAPT.

It should be noted that many of these studies described were pilot projects and they utilised simple satisfaction rating scales; however, there are relatively fewer studies which have explored patient views of OTT use in great qualitative detail.

A case report by McLaren (1992) highlighted that one patient felt that others in the practice may be listening during their sessions and thus had privacy concerns, as telephone calls may not always be held in private. Conversely, its convenience was highlighted as an advantage. A recent qualitative study by Bee *et al.* (2010b) noted mixed viewpoints from 30 patients who utilised a T-CBT programme. Those who adapted to the telephone programme commended its ease of use and it was suggested that its improvement on access and availability to services were also an advantage. However, patients who showed more resistance to OTT care highlighted the lack of visual information as a disadvantage and there was also a level of scepticism because F2F was seen as the norm.

Patient views of using Videoconferencing-based and Online/Computer-based services

Videoconferencing

When compared to those who used F2F treatment, those who were randomised to utilising VC rated satisfaction similarly (Bishop *et al.*, 2002). Interviews with users of VC revealed that they were comfortable and felt less self-conscious and thus were able to raise more personal issues (McLaren *et al.*, 1996). Users also suggested that they felt more support and encouragement in sessions when using VC that they did in F2F sessions (Urness *et al.*, 2006).

Positive effects on treatment barriers (e.g. time and monetary cost) were also noted by VC users and provided good satisfaction scores (Doze *et al.*, 1999; Simpson *et al.*, 2001a). In addition, Doze *et al.* (1999) found that patients did not consider any confidentiality and privacy issues when using VC and they praised the potential for increased treatment choices and ability to access therapies. However, technical issues with the equipment were often noted as a drawback (Browne, Reilly and Bradley, 2006).

As explored in section 2.2.3, there is concern that telemedicine could adversely alter certain factors of a talking therapy (e.g. preventing a therapeutic alliance from being formed [Wootton, 1996]). It was found that VC patients offered more critical comments suggesting that VC felt impersonal (Doze *et al.*, 1999). Swinton *et al.* (2009) also found that patients were concerned with how a relationship may be formed by use of a telecommunication device (e.g.

due to the inability to look into someone else's eyes and their body language or to truly know who the other person was). On the other hand, Bose *et al.* (2001) observed that 75% of the VC users were happy with their standard of care, and they did not believe their treatment experience was distorted.

Online

Users of an online cCBT self-help package indicated good satisfaction ratings. They suggested that it was helpful, easy to use and its effects would be enduring (de Graaf *et al.*, 2009). Furthermore, users rated it better than their previous treatment and would recommend it to others (Cavanagh *et al.*, 2009).

Convenience of use and access from home, as well as patient anonymity were regarded as highly advantageous for this delivery modality (Beattie *et al.*, 2009); however, some patients suggested that the impersonal contact may inhibit information disclosure (Richards and Timulak, 2013). When compared to therapist-led CBT, cCBT was noted by users to lead to more misunderstandings and doubts due to lack of clarification. Users also suggested that the absence of personalisation lacked affect. Conversely, the researchers noted that disclosure was facilitated by the anonymity and privacy created by the use of a computer (Gega, Smith and Reynolds, 2013).

Summary

It should be noted that this project did not investigate videoconferencing and internet-delivered/computer-based therapies because at the time this study was carried out, the IAPT service did not utilise these modalities. However, collating research which gained user feedback from these delivery types may be important as it presents similar potential disadvantages to OTT-delivery. In particular, with regards to the loss of NVCs and/or the increase of physical distance that may alter the therapeutic relationship.

Patient likelihood of selecting Telemedicine

The research presented so far within this section has shown generally positive feedback from users of telemedicine in psychotherapies. One study of interest explored the uptake likelihood OTT-delivered, internet-based, or F2F healthcare intervention.

Mohr *et al.* (2010) found that of the 74.8% of 658 participants, who were ‘interested’ in receiving some behavioural and/or psychological treatment, a greater majority indicated that they would ‘definitely use’ or were ‘willing to consider’ using F2F delivered therapies compared to OTT and internet. Furthermore, more participants were ‘not interested’ in the use of OTT delivery. See *Table 8* for a summary.

Modality	“Definitely use” response	“Willing to consider” response	“Not be interested” response
Face-to-face	43.4	48.2	6.7
Telephone	18.7	43.7	36.6

Table 8: A summary of telephone vs. face-to-face findings from Mohr et al. (2010) - values represent percentages

One factor which could explain the reluctance of the participants was, at the time of the study, these delivery mediums were not widely available in the US and so healthcare insurance providers were less likely to cover these modalities (Mohr *et al.*, 2010). This factor would not be applicable to the UK healthcare system via the NHS. Barriers to treatment (e.g. cost, time constraints and the inability to travel due to physical symptoms) were also noted to have the biggest relationship to patient interest in receiving telephone- or internet-based care.

One of the reasons why this piece of research was of great interest was that the samples surveyed were not actively seeking treatment and thus could reflect attitudes better than from those who require treatment as the desire to receive treatment may influence views. For example, Richards and colleagues (2006) sought to explore the views of patients (as well as practitioners) on a collaborative care model of treatment for depression that utilised telephone contact. They also found that patients had fewer reservations on OTT use (i.e. in its effect on therapy sessions) as they placed getting access to mental health services as of greater concern for them.

In addition, intervention studies (e.g. RCTs) have noted that patient preferences and preconceived attitudes to treatments could affect research outcomes (King *et al.*, 2005;

Howard and Thornicroft, 2006). For instance, Doze *et al.* (1999) noted that a strong preference to try new things may affect the outcomes. Parry *et al.* (2011) observed that patients in an IAPT setting, who rated the use of the telephone modality more negatively confessed a dislike for using the telephone.

Patient factors which affect likelihood of Telemental health uptake and satisfaction?

Hardiker and Grant (2009), in a literature review, explored a number of demographic factors which could affect patient engagement in eHealth services (online-based telemedicine). These included: age, ethnicity, socioeconomic status, and educational attainment. These aspects may be of interest due to their potential to affect the views of using telemedicine (e.g. factors that may prevent access to treatment and thus telemedicine could help increase access).

For example, Hardiker and Grant (2009) found that older individuals compared to younger ages found eHealth services to be less helpful. This may be linked to previous literature which suggests that the older population may be less inclined in seeking help from mental health services (e.g. Mackenzie *et al.*, 2006; Anderson and Brownlie, 2011). In addition, gender may also be a factor – Burgess *et al.* (2008) investigated demographic characteristics of a telephone counselling service and found that females were more likely to access these services.

Psychopathology may also play a role in affecting likelihood of uptake of telemental health. Bouchard *et al.* (2000) noted that a telepsychiatry treatment service for panic disorder which allowed patients with severe agoraphobia to access treatment may have played a role in the high satisfaction rates. Geographical location of the user may also affect their views – again the need for treatment may influence their perceptions. Bishop *et al.* (2002) suggest that the convenience and the timeliness in which the treatment could be carried out influenced its success with patients who lived in a more rural location. However, users within an inner-city sample (e.g. McLaren *et al.*, 1996; Bose *et al.*, 2001) also provided high satisfaction ratings.

Summary

In summary, the literature presented noted that patients who have utilised telemedicine in mental healthcare provided a generally positive view on its use. They provide good satisfaction ratings, are willing to recommend to others, and some have rated it better than previous psychological treatment. Please see *Table 9* for a summary of the advantages for using

telemedicine provided by patients. The table is divided into two overarching factors: Emotional and Experiential factors, and Practical factors.

Practical factors feature highly when exploring the literature and this could be due to the main aim of telemedicine (and by extension IAPT) which is to improve access to health services to those who may be limited by a number of aspects. Many practical issues are based on financial benefits and it could be suggested that a majority of these advantages may be culture specific (e.g. western cultures emphasis on economic factors which can influence social issues [Owusu-Bempah and Howitt, 2000]).

Emotional/Experiential	Practical
<ul style="list-style-type: none"> • Felt comfortable • Felt less self-conscious • Felt less inhibited • Felt safer • Felt less stress between appointments • Felt treatment was unaffected by use of the telephone – it felt similar to face-to-face 	<ul style="list-style-type: none"> • Easy to use • Less delay in access • Reduced need for absences from work to attend sessions • Less monetary costs (e.g. costs of travel, childcare, etc.) • No privacy issues (e.g. someone listening in on their conversation)

Table 9: A summary of patient views of Telemedicine: Advantages

Critical views of telemedicine from users of it discuss its potential in disrupting the therapeutic alliance (e.g. due to the detached and impersonal nature of the OTT contact). However there were mixed reactions to this issue as although some pointed out similar concerns, they regarded these as being facilitative in making them feel less self-conscious or inhibited to provide information in therapy. *Table 10* provides a summary of the disadvantages outlined by those who have used the telemedicine approach; these are again split into the two overarching factors.

Emotional/Experiential	Practical
<ul style="list-style-type: none"> • Felt less connected with the practitioner • Felt they could hold more information back • Did not like the impersonal nature of contact 	<ul style="list-style-type: none"> • Technical difficulties (e.g. errors on the system, poor specifications) • Difficult to understand how to use • Difficulty in finding a place a suitable place to take a telephone-therapy call • Worries about confidentiality

Table 10: A summary of patient views of Telemedicine: Disadvantages

Findings regarding patient choice, prior to undergoing treatment (or without the need for it), noted that F2F was the popular option than telephone- or internet-delivered therapies. However, it was noted that help-seeking barriers were strongly related to preferences of the telephone modality (e.g. increased access and less monetary cost); this is similar to the practical advantages provided in other investigations from patients who have utilised the telemedicine approach.

Demographic Factors	Individual Differences
<ul style="list-style-type: none"> • Age • Ethnicity • Gender • Socioeconomic status • Location • Level of education attainment 	<ul style="list-style-type: none"> • Attitudes and preferences (e.g. wanting to try new things, not liking communicating via the telephone) • The desire access to treatment

Table 11: A summary of patient factors which could influence views on Telemedicine

Patient characteristics (e.g. demographic factors) are also of interest as it could be possible that certain characteristics may influence whether a person is willing to access telemental health. These preferences and attitudes in alternative methods may also play a role in their views and thus could provide confounds when analysing patient satisfaction rates and comments. For instance, the desire to access treatment could be considered as an important factor because their need could override their views about the delivery method as it meets their initial goals of accessing the therapy and thus the individual provides a more positive

Chapter 2: Literature Review

view due to this. *Table 11* summarises these factors stated and divided into two overarching factors: Demographic Factors and Individual Differences.

2.2.5 Health Professional Views of Telemedicine

As well as viewpoints of service users, the opinions practitioners have of telemedicine could also provide further insight into the advantages and disadvantages of this method of therapeutic delivery method.

In case report by McLaren (1992), the psychotherapist stated that OTT-use without visual feedback posed a difficulty in ascertaining the impact of the intervention, as well as causing ambiguity in the situation. Due to this ambiguity, they noted that the patient was more sensitive to any form of feedback (e.g. the tone of their voice). However, once their style of communication was changed, a therapeutic relationship was successfully built.

In VC, McLaren *et al.* (1996) found that practitioners conveyed less than favourable ratings when compared to patients. Practitioners felt difficulty in detecting crying or other emotions when using telemedicine. This may be in part due to the technical limitations of the equipment where they commented on the poor picture quality – these findings could be a product of the time as there have been improvements to video communication in recent years. Practitioners also suggested the disadvantages to using Telepsychiatry that have been previously described, e.g. altering the therapeutic relationship (McLaren *et al.*, 1996). On a similar note, comments by practitioners in a rural clinic which piloted OTT-delivered psychotherapy raised the issue of whether the therapeutic relationship may be difficult to maintain due to the distance from the patient (Swinton *et al.*, 2009).

In contrast, interviews with practitioners from another pilot clinic project utilising telepsychiatry showed a more positive outlook. They commented on the improvement to service provision which telepsychiatry offered by improving access to therapies for patients. The practitioners also reported that their therapeutic time was more productively used; for example, they could contact patients quicker after the initial referral appointment (Doze *et al.*, 1999).

Conclusions from a pilot study by Simpson *et al.* (2001b) reported that health professionals commended the use of telepsychiatry as it facilitated referral, reporting and follow-ups. It also allowed them to schedule sessions more easily. Further to this, they stated that, in their experience, VC was easy for the patient use and provided a sense of comfort for practitioners. However, they did comment that the 'sense of presence' could be lost during OTT sessions.

Clinician views surrounding the use of computer-based psychological treatments were also explored. Stallard, Richardson and Velleman (2010) observed that there was a positive consensus amongst some clinicians they surveyed. However, they also found that clinicians raised potential problems. For instance, there were concerns over the lack of a therapeutic relationship and professional support in using a new piece of technology. Clinicians did discuss a further positive about the use of cCBT and this was that it could be used by the patient at home. This would result in increasing convenience for the patient and could hold potential for increasing their willingness to participate in treatment (Stallard *et al.*, 2010). It must be noted that their views were on the use of cCBT on adolescents and children only, however these issues may still be relevant and prevalent in the use of cCBT in adults.

A survey outside of mental health practice by Harrison, Clayton and Wallace (1996) described that, when using a teleconferencing method in treatment, health professionals (GPs and Specialists) rated the modality very highly in terms of the level and quality of information received. They also found that health professionals felt that the rapport between them and their patients was good and stated that they were satisfied with how their patients received the treatment. In addition, they commented that appointments were easier to arrange when using the modality.

A recent study conducted by Gordon (2014) interviewed mental health practitioners about their views on the therapeutic relationship and the use of mobile telephones. Gordon reported a number of advantageous aspects to its use, such as: increasing access, ease of use and convenience. However, the practitioners who expressed that there were elements missing that were important for a therapeutic relationship to build fully (e.g. the lack of non-verbal cues), they also raised an issue regarding privacy. Overall, participants noted that it could be a useful tool if used alongside F2F therapy. This study was conducted in the US and may not be comparable to UK practices. For example, practitioners within the Gordon (2014) study had given their private contact details to patients (e.g. social media profile). In the UK, the provision of contact details would be through official channels (e.g. work-based telephone numbers) and the General Medical Council advocates that professional boundaries between practitioners and patients should be maintained for ethical purposes (General Medical Council, 2013).

A qualitative study explored the views of stakeholders of mental healthcare (GPs, mental health practitioners and patients) on a model of collaborative care for depression in the UK primary care system which utilised telephone contact (Richards *et al.*, 2006). Richards and colleagues found that mental health workers expressed many reservations on the use of the telephone and were concerned with its effect on their judgements and in the context of the therapeutic alliance.

Summary

Overall, health professional views were relatively mixed. The majority of the advantages proposed related to practical concerns (e.g. improving convenience and access) that were similar to those provided by patients. Issues which related to its effect on the therapeutic relationship and interaction with patients were also raised. It should be noted that a number of these findings were taken from pilot studies which used a small sample, but due to the limited pool of studies available, these findings still hold some merit. *Table 12* outlines the main positives and concerns suggested by practitioners.

Positives	Concerns
<ul style="list-style-type: none"> • Increasing access to psychological therapies • Attend to patients quicker • Easier to schedule sessions • Comfortable to use • Provided a good rapport and can build a therapeutic relationship • Patient disclosed more information • OTT can focus and provide structure of therapy • Risk can be reduced if not directly interacting to 'high risk' patients • Telemedicine in home setting could be beneficial (e.g. could increase willingness to participate in therapy) 	<ul style="list-style-type: none"> • Technical difficulties and technology limitations • Issues in learning to use a new technology • It may affect the therapeutic relationship • Issues with the physical distance from the patient (e.g. lack of crisis intervention) • No non-verbal communication or visual feedback • No "sense of presence"

Table 12: A summary of Practitioner comments regarding telemedicine

The scope of this research area is limited. There were very few studies found which explored practitioner views regarding the use of telemedicine, more specifically about the use of the telephone, in both a mental health and general healthcare setting. The views from health professionals who have used videoconferencing and computerised modalities in therapies are still applicable due to the nature of therapy being conducted at a distance and not F2F with the patient. Thus, one aim of this thesis is to add knowledge within this field. It explored the views and experience of practitioners working at Step 2 in IAPT, and more specifically regarding their views on how telecommunication modalities could affect the therapeutic relationship – again a topic which has not been fully investigated in previous literature.

2.3 Research within IAPT

The aim of this research was to explore the differences between OTT and F2F delivery modalities via three aspects: patient views, therapist/practitioner views, and patient symptom outcomes within the context of the IAPT Step 2 service. Since this project began in 2010, three studies have been published which covered similar aspects to these aims proposed.

2.3.1 Hammond *et al.* (2012)

The first is an observational study by Hammond *et al.* (2012); they studied the effectiveness of F2F and OTT-delivered methods within IAPT services in the East of England. Using propensity scoring matching, the outcome data of 4,106 patients were statistically analysed. These participants were grouped according to their use of computerised CBT sessions either supported by the therapist F2F or OTT. The aim of the observational study was to explore the clinical and cost-effectiveness of F2F and OTT LI therapies.

Akin to previous literature assessing F2F and OTT psychotherapies, Hammond and colleagues (2012) found that OTT-delivery provided equivalent effects compared to F2F. Their research utilised outcome data scores from the PHQ-9, GAD-7 and W&SAS scales at baseline and post-treatment. They found in cases of patients with severe symptoms, the use of F2F therapy was more effective than OTT-delivery.

Hammond and colleagues (2012) also reported that individuals using OTT services were more likely to use cCBT and those using F2F were more likely to select psychoeducational groups as a treatment type. F2F delivered therapies were also found to last longer in terms of duration.

Although, when taking these factors into account the findings further showed that there was no significant difference in effectiveness between the two modalities of delivery.

The telephone modality is primarily used in minimal therapist contact interventions. It could be reasoned that patients with more severe symptoms do not respond as well to OTT therapy, when compared to those with mild-to-moderate symptoms, because they tend to require more time with a therapist. Shapiro *et al.* (1994) found that patients with severe depression symptoms improved more when they had more CBT sessions (16 sessions) compared with a briefer version (8 sessions).

As IAPT works on a stepped-care model, patients are differentiated on the basis of initial symptom severity and complexities. Individuals experiencing more severe symptoms are more likely to enter Step 3 (high-intensity) services which do not offer OTT-delivery as an option (DoH, 2008a; 2011a; 2011b). However, when looking at the findings relating to the outcome scores of patients with symptom severity levels that are targeted by Step 2 services (mild-to-moderate), the effects of both delivery modalities on outcome scores are positive and comparable (e.g. Hammond *et al.*, 2011).

This could be supported by Bower *et al.* (2013) who explored the literature regarding the effects of depression severity on outcomes after using LI treatments (e.g. those with minimal contact – including OTT-delivered treatments). The meta-analysis, with the limited literature available, found that symptom improvements between those with moderately severe depression and those with mild depression were comparable. Moreover, patients with slightly more severe presentations showed a greater symptom improvement.

Whilst this current project also aimed to explore the differences between F2F and OTT modalities by analysing service user outcome data, it additionally did the following:

- 1) Collected data on service user views of F2F versus OTT therapy.
- 2) Collected data on patient factors (e.g. demographics, psychopathology, etc.) in order to explore any potential influences on patient opinions of either OTT or F2F delivery.
- 3) Collected data on the views of IAPT health practitioners of the therapeutic delivery methods.

2.3.2 Parry *et al.* (2011)

The second study which covered similar aspects as this current project was by Parry *et al.* (2011). Their report was commissioned by the National Institute for Health Research (NIHR) and explored the views of service users from the Doncaster and Newham IAPT demonstration sites. This was initially explored through the use of a Client Satisfaction Questionnaire (CSQ) – an 8-item questionnaire assessing global satisfaction on a 1 to 4 scale. 435 patients took part, as part of a cohort study ran by Parry and colleagues.

In addition to this, interviews were carried out with 77 purposively selected patients who had been discharged from the demonstration sites. The questions asked related to the experiences of the patient within their care pathway at the IAPT demonstration sites. More specifically, Parry and colleagues explored the views of those who had a good and those who had a poor experiences, those who had ‘stepped up’, and those who had not completed treatment. Within these interviews service users were also asked about their opinions on how therapy and support were delivered. Patients who utilised the Step 2/LI service provided mixed views to the use of health technologies (e.g. telephone and computer-based treatments). One of the main advantages reported by service users was that OTT work was more convenient for patients to utilise, with others commenting of increased feelings of safety when OTT (Parry *et al.*, 2011).

On the other hand, some users responded that they found using the telephone and cCBT problematic. For instance, in OTT work, service users commented on feeling less connected with their PWP. It was also observed that service users felt it was easier to avoid talking about their problems and thus were unable to communicate their true feelings to their PWP due to the indirect nature of the communication. They also noted logistical difficulties (e.g. finding a place to have a private phone call) when undertaking OTT work and felt distracted when they could hear the background noise occurring the PWP’s side of the line (Parry *et al.*, 2011).

Some service users also felt that they were not benefitting from their OTT sessions; with a number feeling they could improve quicker F2F with their practitioner. Parry and colleagues noted that a few service users disliked their OTT sessions, further stating that they were not comfortable with using this mode of communication in general. These pre-conceived attitudes may provide a major influence in some of the feedback provided and thus, these views could be considered as biased (Parry *et al.*, 2011).

To date, this is the only report found which has interviewed and gained viewpoints from patients who have utilised the IAPT service (including patients' views on treatment delivery type). The current project also aimed to investigate service user views on treatment delivery type within an IAPT service however, unlike Parry and colleagues; it also carried out the following:

- 1) Used likert-type questions and free-text qualitative sections focussing solely on the use of OTT and/or F2F delivered therapies in an LI setting.
- 2) The questions asked engaged in key issues specifically related to the use of telecommunication devices in psychological therapies (e.g. the effect on the therapeutic relationship, etc.).
- 3) Collected patient factors (e.g. demographics, psychopathology, etc.) in order to explore any potential influences on views.
- 4) Collected outcome data from service users and analysed to explore the differences in OTT versus F2F users.

In addition, the current project further aimed to provide a more recent update on service user views within an established IAPT service.

2.3.3 Jones, Bale and Morera (2013)

The third and most recent study which explored similar topics to the current project was by Jones, Bale and Morera (2013). Their study explored the views of practitioners on the use of OTT assessments within an IAPT service. The qualitative study explored the views of health practitioners before and after a trial period of completing health assessments OTT using a semi-structure questionnaire. To date, this is one of the first papers which have explored the views and experiences of IAPT practitioners.

Overall, Jones and colleagues found that many of the participants shared a cautious view prior to using the telephone (e.g. there would be a lack of visual cues, the alteration of the therapeutic alliance, etc.); although after the pilot trial, many were fairly positive. Some participants suggested that the use of the telephone could help focus their time more efficiently and that it was easier to structure the assessment session. In addition, the telephone could allow them to assess a 'risky' individual without placing themselves within an

environment whether they may face a risk themselves. Practitioners noted a positive rapport with many of the patients. They also commended the role of the telephone in improving patient access to the service. However, practitioners noted some worries about confidentiality and disclosure and practical issues of using the telephone (e.g. not reaching the person or getting the wrong number) (Jones *et al.*, 2013).

Although this paper strikes similar components to the current research project (particularly in the objectives relating to the practitioner views – PWP Questionnaire), there are a number of differences:

- 1) Jones *et al.* (2013) did not focus on a comparison between OTT use and F2F working for practitioners – thus the current research project helps to fill a gap in this field.
- 2) The participants in the Jones *et al.* (2013) paper were asked on their views and experiences of a pilot trial of OTT assessments with IAPT, whilst the current research project explores the therapeutic treatment phase within IAPT Step 2.
- 3) The current project carried out interviews to gain more in depth views from practitioners, primarily on the subject of the therapeutic relationship, which Jones *et al.* (2013) did not explore.

2.4 Summary of Literature Review

The utilisation of Telemedicine (or the use of telecommunication devices) is becoming an important tool used in both General and Mental Healthcare. Much of the literature regarding telemedicine (specifically OTT-delivered psychological treatments) have been positive and reported equivalent symptom improvement outcomes when compared to F2F therapies for mild-to-moderate CMDs. Previous findings have found good satisfaction ratings from its users; however, feedback from health professionals has been mixed.

As well as these positive outcome effects, one of the main advantages to telemedicine practice is its ability to remove treatment barriers which will help to improve access to psychological therapies for a larger portion of the population (e.g. reducing financial cost, time constraints, increasing access to those in a certain geographical location, and reducing help-seeking stigma). However, there is one issue that many researchers cite regarding telemedicine in psychological practice and this is its potential negative impacts on the therapeutic relationship

between the patient and practitioner. This is particularly important as the therapeutic relationship has been shown to be linked to treatment outcomes.

The views of patients on telemedicine are, in general, positive after using these modalities. But when presented with options prior to treatment, some are more reluctant to opt for alternatives to F2F delivery. A number of factors have been discussed to provide potential explanations for these views (e.g. patient preferences and attitudes during the selection of a delivery modality).

Health professionals offered relatively mixed views on telemedicine. Some err on the side of caution with possible threats to the therapeutic relationship especially the increase in physical distance from the patient. On the other hand, others see that it aids patients with certain practical issues in accessing psychological help, and further commend it on its positive patient feedback. Within an IAPT context, the views are also mixed, with many practitioners experiencing initial worry about OTT use which often changes after use.

Overall, the use of telemedicine in mental healthcare has been shown to be feasible as an alternative to F2F care, but it still faces much critique before there is a unilateral embrace of it in psychological practice.

2.5 Research Question and Objectives

From the literature review, key issues have emerged about the use of telecommunication technologies in psychotherapies, particularly with regards to the use of OTT versus F2F contact. The current research project investigated these issues in several ways:

- First, IAPT service views were explored and differences in therapy outcomes (i.e. symptom changes) were collected. This helped to update previous literature findings regarding the effectiveness of OTT compared to F2F therapies and expand on service users' views on issues specifically related to the OTT and/or F2F use in IAPT.
- Secondly, the views and experiences of using OTT or F2F from practitioners were gathered. This helped to add knowledge in the sparse research field of practitioner views, especially as there were few exploring the comparison of OTT and F2F use. Additionally, in-depth interviews were carried out to explore a salient topic which was highlighted in the literature and preliminary findings of this project regarding the

effect of OTT use on the therapeutic relationship and the research project added new insight in this understudied issue.

The current research project therefore addressed the following research question:

Does the modality in which an intervention is delivered (telephone versus face-to-face), within the IAPT low-intensity service, affect practitioners' views of its effectiveness, as well as patients' satisfaction and therapeutic outcomes?

The following objectives and their subsidiary questions were used to explore the research question:

Objective 1: Service User Questionnaire

To analyse the views of service users of treatment modalities in a low-intensity IAPT service

- (a) What are patients' satisfaction ratings and attitudes on face to face versus telephone therapy?
- (b) Do factors other than modality type affect patients' satisfaction ratings?
- (c) What are patients' views on face-to-face and telephone therapy in their own words?

Objective 2: Psychological Wellbeing Practitioners Questionnaire and Interview

To analyse the views and experiences of Psychological Wellbeing Practitioners of different delivery types

- (a) What are practitioners' views on the treatment modality (or modalities) they work with?
- (b) Which treatment delivery modality is most preferred by the practitioners?
- (c) How do practitioners explain their views and preferences about F2F versus OTT work?

Objective 3: IAPT Outcome Database

To analyse service user outcomes using data from the IAPT outcome database

- (a) Does F2F or OTT work offer more beneficial outcomes when compared to the other, or are they comparable?
- (b) Do factors other than treatment modality affect treatment outcomes (e.g. demographic factors, etc.)?

CHAPTER 3: Methodology, Research Design and Procedures

3.1 Introduction

This chapter outlines the methods, research design, and paradigm that were selected for this project. The importance of ethical practice in health research was addressed and other methodological considerations for good ethical research practice were also covered.

3.2 Research Paradigms and Design

3.2.1 The Paradigm Debate: A Brief Overview

Methodological paradigms help to guide how research is conducted. They are philosophical (or ideological) views which vary with regards to their stances on epistemology (the nature of knowledge), ontology (the understanding of reality) and methodology (the mode of which the research is undertaken) (Guba, 1990; Sandelowski, 1995). There has been an on-going “paradigm war” between quantitative and qualitative methods from the opposing view of Positivism and Interpretivism (or Social Constructivism). Purist researchers are those who practice one of these approaches and view that that research can only be carried out with a single view (Bryman, 2001). However, some authors argue that utilising only one views provides an incomplete picture of the phenomena under study (Sale, Lohfeld and Brazil, 2002; Doyle *et al.*, 2009).

Positivism was one of the main approaches in studying the natural world and in the ‘physical’ sciences (i.e. biology, chemistry, physics). Interpretivists argue that this approach cannot be applied the study of humans and the ‘social’ world (Holloway and Wheeler, 2002). Positivists view a single, concrete and observable reality in which knowledge can be gained through the senses. They claim that objectivity is possible and they can remain detached and value-free from what is under study to prevent biases; control of external causes is important. In this approach, Positivists implement quantitative methods to analyse data from observations and experimentation in order to test theories and hypotheses (a deductive approach) and to determine cause and effect (Kuhn, 1962; MacKenzie and Knipe, 2006; Creswell, 2009).

With regards to investigating humans, Interpretivists suggest that the Positivist view is a narrow approach and only valid for “...individuals who exist in a vacuum” (Holloway and Wheeler, 2002, pp. 7). Interpretivists argue that humans possess free will and therefore cannot be controlled. Multiple realities are contended as the research is viewed within its context and social interactions and subjective views (e.g. thoughts and perception of others) are considered – Positivists would ignore these factors as they are not measurable or observable. Neutrality is claimed impossible to achieve because Interpretivists note that the values and backgrounds of researchers and participants can play a role in research. This approach utilises qualitative methods to gain descriptive data allowing the researcher to understand rather than determine. These could also help to build a theory (an inductive approach) (Holloway and Wheeler, 2002; Creswell, 2009). *Table 13* outlines the key elements of the two main research paradigms and the methods associated with them.

This research project considered the topic pragmatically and agreed that both approaches were useful to explore the research question but did not wish to participate in a “...forced choice dichotomy between post-positivism and constructivism” (Creswell and Plano Clark, 2007, p. 27). Instead, the position adopted for this research was Critical Realism.

Critical realism helps to describe an interaction between the ‘natural’ or ‘physical’ world view (which Positivists hold) and a ‘social’ world view (which Interpretivists hold). It notes that there are different perspectives on ‘reality’: there is a reality which exists independently of our views and theories and one that takes into account that our understanding of this reality can be constructed from our own subjective views and perspectives. It does, however, reject the notion that there are multiple realities and claims that these different views on reality co-exist in the same world but under different ‘strata’ or ‘layers’ in order for us to obtain knowledge (Archer *et al.*, 1998; Maxwell, 2012; Gorski, 2013).

In the context of this research project, a methodology embodying the principles of both quantitative and qualitative methods was applied. A triangulation design was selected and quantitative and qualitative data were collected. The aims of Mixed Methods research is to help provide a more enriched view using different perspectives. There is a focus on practical aspects of research and in selecting the most appropriate tools to answer the research question (Broom and Willis, 2007; Creswell, 2009; Feilzer, 2010). The exploratory nature of the research question is similar to an inductive approach characteristic of qualitative research.

However, the methods used to explore the topic are influenced by previous literature (e.g. the questions posed in the questionnaires) – a strategy similar to the deductive approach in quantitative research.

	Positivism/Postpositivism	Interpretivism/Constructivism
Ontology	Single reality; concrete	Multiple realities; can be affected by context
Epistemology	Knowledge is objective; unbiased ^[1]	Knowledge is subjective; socially constructed
Methodology	Quantitative data collection	Qualitative data collection
	Deductive approach; theory testing	Inductive approach; theory generating
	Deterministic; seeks cause and effect	Seeks to understand
	Narrow and reductionist view of phenomenon (due to numerical data)	More complex view of phenomenon under study (due to words, pictures, etc.)
	Observation of outcomes in manipulated event	Observation of outcomes in a more natural setting

Note:

^[1] Value-free research is recognised by Positivism; however, the Postpositivist paradigm acknowledges that biases may be present, although methods are used in quantitative research to control for potential biases (Kuhn, 1962; Mackenzie and Knipe, 2006).

Table 13: Summary of the Positivist/Postpositivist and Constructivist/Interpretivist paradigms

3.2.2 Research Design

There were two phases to the project:

- **Phase I:** Service User Questionnaire (SUQ), Psychological Wellbeing Practitioner Questionnaire (PWQ), and IAPT Outcome Database
- **Phase II:** Psychological Wellbeing Practitioner (PWP) Interviews

A survey method, analysis of outcome data, and semi-structured interviews were carried out.

The following sections describe aspects of the research design implemented in this project.

Quantitative aspect: Statistical Analysis

The quantitative component of the research was derived from the methods utilised in Phase I of the project. It was based on the use of closed-question and likert scale responses from the SUQ and PWQ. These helped to explore the ratings participants gave certain aspects of their experience when using over-the-telephone (OTT) and/or face-to-face (F2F). In addition, within the SUQ, categorical data were used to explore whether demographic factors could affect participant ratings.

Likert scales are a common assessment scale that measures the attitudes of participants. The degree, or intensity, of the response by the participant to the question is inferred from value chosen on the scale – these responses can range from negative, neutral or positive (Likert, 1973; Clason and Dormody, 1994). Likert scales were chosen as it has been used in previous studies which received service user and practitioner feedback regarding telemedicine (e.g. McLaren *et al.*, 1996; Mohr *et al.*, 2010; Stallard *et al.*, 2010). Quantitative data were also captured from the IAPT Outcome Database. This data helped to investigate the effectiveness of the two modality types by analysing clinical outcome data.

Results from diagnostic questionnaires routinely completed by service users were attained; these included the first and last entries from PHQ-9, the GAD-7, the W&SAS, and the IAPT Phobia Scales. Furthermore, other data from the IAPT Outcome Database were collected (e.g. demographic data, number of sessions, etc.) which helped explore whether other factors contributed to any potential effects of the delivery modality on the clinical outcomes.

Qualitative aspect: Thematic Analysis

The qualitative data component of the research was derived from both Phase I and Phase II of the project:

1) *The open-ended question responses within the Service User and PWP Questionnaires*

From the open-ended and free-text sections of the questionnaires, a more in-depth view allowed for further understanding of participant views and experiences of utilising either OTT or F2F delivered psychological therapies.

2) *Interviews with PWPs*

A one-to-one semi-structured interview method was used (Singleton and Straits, 2012). An advantage of utilising a one-to-one interview is that there is opportunity to explore the perspective of each individual (Firth and Gleeson, 2012). This second phase

of the project was used to attain richer qualitative data, as well as to help further expand on the data collected from the PWP Questionnaires. Interviews allowed for an opportunity for clarification and/or to expand discussion on concepts of interest raised by participants (Stangor, 2007; Firth and Gleeson, 2012).

For both aspects of the project, Thematic Analysis was employed to analyse this data.

Thematic analysis can be described as “...a way of seeing” (Boyatzis, 1998; p. 1). It is a method of analysis in which qualitative data are highlighted or ‘coded’ into segments of interest to the research (e.g. it may display emotions about a certain aspect of OTT use). As the data are coded, patterns can be identified and codes then organised into ‘themes’. Themes can help describe and provide understanding to the phenomenon under study (Boyatzis, 1998; Braun and Clarke, 2006).

There are no ‘standardised’ themes or codes as so the judgement of the researcher is used to determine the recognition of a theme. Researchers should be open and can be flexible in their approach (Joffe and Yardley, 2004; Braun and Clarke, 2006). Coding can be inductive or deductive and can also be derived from the explicit statements (the ‘Manifest content’) or from implicit meanings in the text (the ‘Latent content’) – e.g. on a semantic level (Miles and Huberman, 1994; Boyatzis, 1998; Braun and Clarke, 2006). It is important that codes do not overlap to provide more distinctive understandings (Boyatzis, 1998; Crabtree and Miller, 1999; Joffe and Yardley, 2004; Braun and Clarke, 2006)).

Inductive coding (or ‘Data-driven’ coding) draws themes from the raw data during analysis. Deductive coding (or ‘Prior-research-driven’ coding) generates questions prior to data analysis using existing literature, research or theory that helps to initially guide the coding of the data (Boyatzis, 1998; Crabtree and Miller, 1999; Braun and Clark, 2006) – in this project, they were referred to as ‘Deductive questions’ which are outlined in sections 3.3.1, 3.3.3 and 3.3.4. This research utilised both coding approaches.

A coding frame was developed during analysis to help organise and present the themes/codes recognised in the data. Coding frames were structured with a name or label, a definition or description of the code, and examples of it from the text (Boyatzis, 1998; Crabtree and Miller, 1999; Joffe and Yardley, 2004). Please see *Figure 3* for an example of the theme frame which

was utilised in the analysis. *Appendices F, G and H* present a sample of the coding frames used for the Service User Questionnaire, PWP Questionnaire and PWP Interviews, respectively⁸.

Theme Name	Description	Examples (Quotes)		
		Quotes relating to Face-to-Face	Quotes relating to Telephone	Quotes relating to non-specific topic
Embarrassment & Fear; Mental health stigma	Text which relates to participants suggesting that they feel ashamed and embarrassed about their mental health problems	<i>"I fear someone will find out... and it will be embarrassing"</i>	<i>"...I feel anonymous and they can't judge me"</i>	<i>"My mental health should be between me and the therapist"</i>

Figure 3: Example Theme Frame

Although thematic analysis is considered a qualitative approach in data analysis, a quantitative aspect can also be applied as part of the process (Boyatzis, 1998). Similar to ‘Content Analysis’, the number of items coded in a theme can be taken into account – this is known as ‘Frequency Scoring’ (Boyatzis, 1998; Joffe and Yardley, 2004).

Another method suggested by Boyatzis (1998) is ‘Intensity Scoring’ which can be used in instances where it is possible to divide the data in terms of affect (i.e. negative attitudes or positive attitudes towards the theme) and intensity is derived from the frequency of these. A quantitative level of thematic analysis was used to explore the characteristics of the service users and the trends in their comments.

Mixing Methods

The SUQ collected both quantitative and qualitative data and the IAPT Outcome Database collected only quantitative. Therefore, the quantitative component was considered as the main dataset for the exploration of outcomes regarding IAPT service users’ views and clinical outcomes. It should be noted that the qualitative data collected from the questionnaire also provided important insight into the views and experiences of service users.

⁸ Note: only selected quotes were included in each coding frame due to the sheer volume of data collected.

When exploring the experiences and views of the delivery modality in relation to PWP (via the PWP Questionnaire and the PWP Interviews), the qualitative component was the main dataset. Whilst quantitative data were also collected from the PWP Questionnaire, a small sample was anticipated to complete this part of the project and thus the quantitative results were unable to reach sufficient statistical power – nevertheless, quantitative data from the questionnaire were of interest for the project. The qualitative also component allowed for deeper exploration of themes raised by the PWPs in the quantitative section of the survey.

As this project progressed, the balance between quantitative and qualitative aspects changed. Initially, the quantitative aspect of the project was the main dataset but due to a smaller than anticipated sample taking part in all parts of the project, there was a shift to increase the prominence of the qualitative dataset – particularly with the development of Phase II and the PWP Interviews.

For the Triangulation component of this research design, the project utilised a Convergence Model in which the quantitative and qualitative data collected were analysed separately and then brought together during discussion to provide further insight (Creswell and Plano Clark, 2007).

There are a number of advantages to the use of this mixed methods strategy. Both data types are collected at the same time, leading to efficiency. The research can also draw on the advantages of both approaches whilst minimising the disadvantages (Bryman, 2006; Johnson and Onwuegbuzie, 2011). For example, by using quantitative closed-questions, social desirability is likely to be present; however, qualitative open-ended questions do not offer direction in a response and thus could reduce this likelihood (Stangor, 2007).

In quantitative research, the aim is to reduce ‘biases’ that may affect the data collected (Stangor, 2007). It is acknowledged by some that a degree of ‘bias’ may exist within qualitative research. For example, within in-depth interviews the information gathered can be considered as a product of not only the views of the participant but also factors relating to the researcher and the relationship that has been built (Finlay, 2003). It is noted that quantitative research terms such as ‘bias’ may not be applicable in qualitative research and this will be explored in the following section.

Rigour

To ensure rigour in the analysis of the data collected, a number of strategies were implemented.

For quantitative rigour, the concepts of 'Internal Validity' and 'External Validity' were observed for the questionnaire and IAPT database aspects of the project – particularly as these were quantitatively driven:

First, internal validity was explored through a questionnaire pilot study (see *sections 3.3.2 and 3.3.5*). To ensure that the views and opinions of the individuals were based on their experiences of using a particular delivery modality, the pilot study also helped to test two further concepts: 'Face Validity' and 'Construct Validity'.

Another aspect of internal validity was considered by exploring validity of the outcome measures utilised in the analysis of the IAPT Outcome Database. As noted from section *1.3.1*, previous research has investigated the outcome measures (PHQ-9, GAD-7, W&SAS) specificity and sensitivity. It was acknowledged that one of the outcome measures, the IAPT Phobia Scales, may not be an appropriate measure as it has had little research which explored its validity and reliability, and Glover *et al.* (2010) noted it scoring poorly in sensitivity, specificity and predictive power. Glover and colleagues did state that these scales can be revised in the future.

'External Validity' was also considered when calculating the required sample size for adequate power. Unfortunately, the sample sizes were not achieved and so could not meet sufficient statistical power to be fully generalisable to a wider audience. Therefore caution was applied to some of the analysis results from the study.

It is noted that these quantitative concepts of rigour (e.g. external validity and internal validity) were not applicable when considering rigour for qualitative methods, such as the semi-structured interview phase (Krefting, 1991). It was therefore useful to discuss rigour by using different terms such as the ones proposed by Guba and Lincoln to ensure trust was built in the qualitative data captured by the interviews (Guba, 1981; Lincoln and Guba, 1985; 1986).

For example, the concept of 'transferability', it could be considered to be related to 'generalisability' (external validity) but it differs from it as qualitative research does not seek to validate a particular theory or hypothesis. Instead, qualitative research seeks to explore and attain descriptions, views and experiences which may not necessarily translate to the general population but can be transferable within the scope of the research. For instance, some views of PWPs were shared by other PWPs, but may not be shared by other health professionals. The answers captured from the interviews were interpreted within the context of PWPs and the IAPT service.

A semi-structured interview with an interview schedule was implemented to ensure 'dependability' so that the same questions and topics were explored with all participants. However, unlike a more quantitative approach, in which closed questions are posed in a particular order (Firth and Gleeson, 2012), the PWP interviews utilised open-ended questions relating to key topics. A series of prompts were used to help encourage participants to elaborate or clarify the information they provided (Singleton and Straits, 2012)

In regards to the concept of 'confirmability' or 'neutrality', the potential issue of interviewer bias was a factor noted to potentially arise from the interview method which may have led to participants provide socially desirable answers (Streiner and Norman, 1995). Qualitative researchers with an Interpretivist viewpoint may reject the idea of 'bias' as it would imply that objectivity, a view Positivists/Postpositivists consider, is possible (Guba, 1990; Sandelowski, 1995). Hollway and Wheeler (2010) point out those researchers can demonstrate that their work is trustworthy by offering a clear decision trail and by being reflexive about their own preconceptions and role in the research.

For thematic analysis, consistency and reliability of theme establishment is important to ensure a robust understanding. Methods to ensure a good level of dependability include the use of 'Double Coding' in which two different people can analyse and code the data and then ensure there is consistency in the formed codes. Another method to increase the consistency of coding is for the researcher to code the data at two different times (e.g. the data can be re-coded two-weeks after initial coding); this is known as a test-retest approach (Boyatzis, 1998; Joffe and Yardley, 2004). The project aimed to provide consistent and reliable theme construction but due to limited resources and timing constraints, it was not possible to double code using another individual and thus, a test-retest approach was implemented.

A Reflexive Approach

As noted, data captured from in-depth interviews may hold a degree of bias as there is a “...co-construction of knowledge” (Finlay, 2002, p. 209) between the participant, the researcher and their relationship within the interview. The role of the researcher is critical as they create the situation and define the topic of conversation through the questions and themes (Kvale, 2002).

The research relationship can be affected by demographic differences (e.g. age, gender), how language is interpreted, or the context in which the interview has arisen – e.g. the aims of the researcher, how the participant was recruited, etc. In addition, the researcher may have their own subjective view on the subject of study and ‘subconsciously’ influence the interview (Finlay, 2002; Gough, 2003).

‘Reflexivity’, in which “...researchers turn a critical gaze towards themselves” (Finlay, 2003, p. 3), can be utilised in order to ensure that these factors of ‘influence’ are acknowledged. The researcher can address factors which may or may not have affected the data or how the data were collected (Gough, 2003). In this project, I noted my thoughts and experiences after each interview in order to describe how the interviews went and to reflect on whether I felt that there were any factors which could have affected the answers provided or how the interview was carried out.

In supervision, I was also encouraged to critically reflect on the terms I was using to ‘justify’ my research and on my training in psychology. My supervisors and I also had broader discussions about the politics of IAPT and the hierarchy of knowledge in which RCTs are privileged.

3.3 Methods and Procedures

This section is divided into four to describe each part of the research project:

3.3.2	The Service User Questionnaire (SUQ)	<i>p. 95</i>
3.3.3	The IAPT Outcome Database	<i>p. 109</i>
3.3.4	The Psychological Wellbeing Practitioner Questionnaire (PWQ)	<i>p. 115</i>
3.3.5	The Psychological Wellbeing Practitioner Interviews	<i>p. 121</i>

The first two parts of the project helped capture data from service users, whilst the remaining two capture data from the PWPs.

Each section presents the inclusion and exclusion criteria used for participants, as well as the sample sizes that were required for each group. Materials used in the project (the SUQ, PWQ, and PWP Interview Questions) and the data items required from the IAPT Outcome Database are described. A description of how each part was carried out and the procedures used for quantitative statistical and qualitative thematic analysis are also outlined.

For the SUQ, PWQ and PWP Interviews, a summary of the pilot studies carried out are presented. Their aims were to (1) test the readability and comprehensibility of each questionnaire, and (2) ensure the interview questions could be understood by the participant.

3.3.1 IAPT Sites

Five Psychological services who adopted the IAPT programme in the South of England took part in this research project, with each site participating in all four stages from April 2013 to June 2014.

3.3.2 The Service User Questionnaire (SUQ)

Participants

Using G*Power 3.1 (Faul *et al.*, 2007), a priori power analyses were carried out to calculate an appropriate sample size required for the SUQ. The sample size required for a two-tailed Mann-Whitney test generated the largest value with a statistical power of 0.95, 'medium' effect size of $d = 0.5$, and a significance level of $p = 0.05$ (Cohen, 1988).

Therefore, for the SUQ, a purposive sample of 250 participants was required, ideally 125 who have used the OTT modality and 125 who have used the F2F modality; however, service users who have used both modalities were able to participate. *Table 14* provides the inclusion and exclusion criteria for the participants of the SUQ.

Literature on service user feedback using postal questionnaires report that the return rate is typically below 35% (Larsen *et al.*, 1979; Nguyen, Attkisson and Stegner, 1983). Therefore, approximately 750 questionnaires were planned to be distributed.

Inclusion Criteria	Exclusion Criteria
<ol style="list-style-type: none"> 1. Step 2-exclusive Service users 2. Service users who have experienced telephone and/or face-to-face delivered psychological therapy^[1] 3. Service users who have had 2 or more treatment sessions^[2] (not including initial assessment)^[3] 4. Service users with single and mixed psychopathologies may participate providing that their primary psychopathology is depression and/or anxiety^[4] 5. Speakers, readers, and writers of English 	<ol style="list-style-type: none"> 1. Service users whom PWP's believe are unfit to take part^[5] 2. Service users who are not exclusive to Step 2 services (e.g. those who have been 'stepped up' or have 'stepped down' from Step 3 services)^[6] 3. Service users who have experienced other types of treatment delivery other than telephone and/or face-to-face (e.g. internet)^[7] 4. Service users who have had less than 2 treatment sessions (not including initial assessment) 5. Service users with mixed psychopathologies where primary psychopathology is not depression and/or anxiety 6. Those that need questionnaires to be translated to other languages^[8]

Notes:

- [1] It was acknowledged that service users may have utilised both modalities and it was still of interest to gain their experiences of using each modality. The SUQ layout accommodated for this (please see *Appendix B1*).
- [2] The decision to use the amount of treatment sessions as a criterion was taken from the earlier studies by Clark *et al.* (2008b; 2009) and Gyani *et al.* (2011).
- [3] The focus of the project was to investigate the effects and experience of delivery modalities (telephone or face-to-face) in treatment, and thus it is important to distinguish between the assessment and treatment phases of service user contact with the IAPT service.
- [4] It was acknowledged that service users who utilised Step 2 services may present more complex psychopathologies; the reason that for such criteria being used was that service users who took part within this project should primarily present depression and/or anxiety symptoms as previous research within IAPT utilised similar sample criteria (Clark *et al.*, 2008b; 2009; Gyani *et al.*, 2011; Hammond *et al.*, 2012). Furthermore, it aligns itself to the initial aims of Step 2 IAPT in which its primary users are individuals with mild-to-moderate depression and/or anxiety (DoH, 2008a; 2008b).
- [5] PWP acted as Gate Keepers (see section 3.4.1 Ethical Practices).
- [6] It is important that the service users were exclusive to Step 2 during their use of the IAPT service as the main aim was to explore experiences of the delivery modalities available in low-intensity treatment.
- [7] This criteria applies to the use of alternative delivery modalities within the IAPT service; it was stipulated that service users who used an alternative type of delivery modality in previous treatments (outside of IAPT) could take part.
- [8] Due to limited resources and funding, the research was unable to provide translations for the questionnaires or assistance to complete them.

Table 14: Inclusion and exclusion criteria for Service User Questionnaire

Materials

The SUQ is divided into three sections and contains 56 questions – please see *Appendix B1* for the full questionnaire. The questionnaire aimed to explore salient topics which emerged from previous telemedicine research. The questions were devised with reference to the extensive literature review detailed in *Chapter 2*. The full rationale for each question is located in *Appendix A1*.

Section A contained 43 questions which examined patient ratings of satisfaction and attitudes concerning the use of telemental health (Objective 1(a)). Service users were asked to rate aspects of their experiences in treatment with regards to the delivery modality they used. The topics investigated include:

- views on the effects of the delivery modality on the information exchanged (e.g. the amount of information disclosed, the level of information understood, and how information was conveyed)

- views on the effects of the modality on the therapeutic relationship (e.g. ratings of rapport with the practitioner, and the perception of practitioners listening to them)
- ratings of comfort in session
- perception of privacy in session
- views on the presence or absence of visual/non-verbal information in session
- views and ratings of satisfaction (e.g. on helpfulness, likelihood to recommend to others and repeated use in future, as well as a comparison to previous treatments)

Section B contained six open-ended questions which explored patient views on the use of OTT and F2F in psychotherapy in their own words (Objective 1(c)). *Section C* consisted of seven multiple choice and short answer questions which helped to investigate whether factors, excluding modality type, (e.g. demographic features) that could affect patient views and satisfaction ratings (Objective 1(b)).

There has been one study which has investigated the views of service users within an IAPT service: Parry *et al.* (2011) – please see section 2.3.2 for more information. This questionnaire allowed the exploration of opinions and attitudes on issues focussed solely on the use of OTT and/or F2F delivery LI therapies in an IAPT setting.

Piloting the Questionnaires (SUQ and PWQ)

Successful questionnaires should have good Face Validity and Construct Validity (Streiner and Norman, 1995; Jenkinson and McGee, 1998). Therefore a small scale pilot study was carried out with the aim of gaining feedback on the SUQ and PWQ materials. Moreover, it helped to test the face and construct validity of the questionnaires.

Participants

Twenty-four lay participants, who have not had experience with undertaking any mental healthcare treatment, and two PWPs were chosen through opportunistic sampling.

Method

Twenty-four lay participants were provided with the following materials:

- Service User Questionnaire (SUQ) (*Appendix B1*)
- Service User Information Sheet (PIS) (*Appendix B2*)

- IAPT Database Consent Form (*Appendix B3*)

The two PWP's were provided with the following materials:

- PWP Questionnaire (*Appendix C1*)
- Practitioner Information Sheet (PIS) (*Appendix C2*)

They were asked to read through the Participant Information Sheet (PIS) and other materials, as well as answer the questionnaire. Participants were then asked to comment on a number of issues.

For the PIS and IAPT Database Consent Form. Spelling, grammar and typographical errors were asked to be identified and the following feedback questions were also asked:

- Could you understand the language used?
- Could you understand what was expected if you were to participate?
- Could you understand their rights as a participant?
- Could you understand why the research is being carried out?
- Could you understand what you needed to do on the Consent Form?

For the SUQ and the PWQ, participants were also asked to identify Spelling, grammar and typographical errors and asked to feedback on the following:

- How long did you take to complete each section?
- Did you understand each question?
- Was the questionnaire appropriately described in the PIS?
- Did the questions match what is trying to be achieved in the title of the project and objectives?
- Were the questions phrased appropriately?
- Where there any question topics that were repeated in other questions?
- Were the instructions on the questionnaire clear?
- Do you have any other comments about the questionnaire?

For the SUQ, the twenty-four lay participants were randomly assigned to groups relating to 'modality type' to assist in measuring the time it would take participants to complete the questionnaire. The mean completion time for those who had answered as someone who has used only one modality (only F2F or only OTT) was used as the lower; this was because these

participants would have needed to answer only 24 of the 43 questions in Section A. The upper range for the completion time was calculated from the time it took a participant who answered as if they had used 'both' modalities – they were required to answer 37 of the 43 questions in Section A. For the PWQ, both PWPs completed the questionnaire as they wished to answer it and the average time calculated.

Results, Conclusions and Subsequent Actions

The time to complete the SUQ ranged between 15 and 25 minutes. The average time taken to complete the PWQ was 30 minutes.

The feedback from the pilot study assisted in correcting the materials of spelling, grammatical and typographical errors, as well as the phrasing of some questions. For example, in the PWQ, it was commented that using the singular term 'patient' as opposed to the plural may cause a form of bias in answering – PWPs may answer the question on the basis of an experience with one patient instead of basing their answers on their general experience.

In addition, the layout of the likert scales was altered for the SUQ. The likert scales were coded with value '1' being the most negative statement and value '5' being the most positive. In some questions these scales were reversed (1 = negative, 5 = positive). This was to prevent 'yea-saying' (Streiner and Norman, 1995). However, feedback indicated that most of the participants did not like this method with some commenting that it was "*annoying*" and it caused many to make mistakes in their answers. This method was therefore removed. On the other hand, this method was found useful when used in the PWQ. Practitioner participants noted that PWPs may have time constraints with their schedule and this was raised as a potential factor that could cause them not to read the questions accurately and therefore mark their answers incorrectly.

Procedure

The recruitment phase for the SUQ lasted over six months. PWPs acted as Gatekeepers and used the inclusion and exclusion criteria, along with their judgement informed by their mental health training, to decide whether a patient could or could not participate in the study. Initially, 750 Service User Questionnaire Packs were prepared and printed; they included the following:

- Service User Participant Information Sheet (PIS) (see Appendix B2)
- A Service User Questionnaire (see Appendix B1)
- IAPT Database Consent Form (see Appendix B3)
- Pre-paid IAPT Database Consent Form Return envelope
- Freepost Questionnaire Return envelope

The 750 questionnaire packs were divided over the five clinical sites. The numbers of questionnaire packs were allocated based on negotiations with each site. Each received a number that they believed they could distribute within the recruitment period.

PWPs were instructed to introduce the project to service users who had completed at least two sessions. Introducing the questionnaire as early as possible helped to avoid potential biases in the findings (for example, a positive ratings bias). It is often observed that during long-running programmes, those who have left or dropped out could hold more dissatisfied opinions than those who complete (Nguyen *et al.*, 1983). Additionally, it was used to ensure that potential participants received two or more sessions which was an inclusion criterion.

The modality of the session (OTT or F2F) affected how the PWP introduced the project. During a F2F session, PWPs could direct service users to a copy of the 'Service User Information Pack' that was available on site. Conversely, if the session was OTT, the PWPs were required to gain verbal consent from the service user to confirm that they would like to receive the information pack by post. If the service user agreed, PWPs sent the pack from the site.

The PIS enclosed in the information pack contained information regarding both the SUQ and the IAPT Outcome Database parts of the project. Potential participants were informed on the PIS that it was not mandatory to take part in both parts of the project. If the service user wished to participate in the IAPT Outcome Database part of the project, they were instructed to complete the 'IAPT Database Consent Form'.

Participants were advised to complete and return the questionnaire within two weeks of completing their treatment with the IAPT service. As demonstrated by the Pilot Study, the questionnaire was described to participants as taking between 15 and 25 minutes to complete in one sitting. Freepost return envelopes addressed to the researcher were provided in the questionnaire pack.

Choosing a postal questionnaire method for users of OTT delivery helped to avoid any further sampling biases as more people are able to receive physical mail. A sampling bias could have occurred if the questionnaire was distributed by electronic means only (e.g. using email or an internet survey) as these services are inaccessible to some.

Each questionnaire was given a unique participant code (code structure is presented in *Table 27*). It was noted that return rates rise to over 42.5% when questionnaires were made anonymous. The inclusion of a postage paid return envelope in the information pack was discovered to also increase the likelihood of a response (Linksy, 1975; Edwards *et al.*, 2002).

Unfortunately, only approximately 250 of the 750 questionnaires were successfully distributed over the course of the six-month recruitment period. The participating sites suggested that it would have been beneficial for the distribution period to have been longer in duration as there were a high proportion of service users who had made contact with the service during this period and either refused to participate or were considered unsuitable to participate by the PWP Gatekeepers.

Data Analysis

Statistical Analysis

Quantitative analysis was carried out using the *IBM Statistical Package for Social Sciences (SPSS) – Version 19* software. Descriptive statistics were used to summarise the data. The following statistical tests were discussed with the faculty Statistician.

To fulfil the aims of Objective 1(a) some planned tests were implemented. The SUQ produced mainly ordinal and categorical/nominal data types, e.g. from the likert scales (see *Table 15*) and thus non-parametric data tests were selected (Norman, 2010; Field, 2013). As each test was carried out multiple times, a Bonferroni correction was calculated by dividing the significance level ($\alpha = .05$) by the number of comparisons carried out (Field, 2013).

In order to analyse whether there were significant differences present in the likert scores from service users, Mann-Whitney tests were implemented. Separate Mann-Whitney tests were carried out for each of the treatment factors measured (see *Table 15*). For these, a Bonferroni correction of $\alpha = .003$ was used. In cases where the service user experienced both OTT and F2F during their treatment, the Wilcoxon Signed-Ranks test was used to compare the likert scale

ratings for the treatment factors assessed in each treatment modality. Similarly, for these, a Bonferroni correction of $\alpha=.003$ was calculated.

In addition, Chi-Square (χ^2) tests were used to analyse whether there were any associations between the categorical/nominal data provided in questions 14/33 and 16/35 and the use of either a F2F or OTT modality. For the Chi-Square tests, a Bonferroni correction of $\alpha=.025$ was applied.

Section A: Question Number		Treatment Factor Measured	Question Type
Face-to-face	Telephone		
6	25	The amount of information willing to be given by service user rating	Likert scale
7	26	Health professional listening to service user rating	Likert scale
8	27	Service user ability to clearly explain information to health professional	Likert scale
9	28	Health professional's level of understanding of the information given by the service user rating	Likert scale
10	29	Service user's level of understanding of the information provided by the health professional rating	Likert scale
11	30	Likelihood of service user asking for clarity rating	Likert scale
12	31	Level of comfort rating	Likert scale
13	32	Rating of Therapeutic Relationship	Likert scale
14	33	Concern for privacy	Yes/No
15	34	<i>(If 'Yes' on Q14/33)</i> Privacy: perceived level of effect rating	Likert scale
16	35	Concern for presence/absence of visual/non-verbal information	Yes/No
17	36	<i>(If 'Yes' on Q16/35)</i> Visual/non-verbal information: perceived level of effect rating	Likert scale
18	37	Rating of Helpfulness	Likert scale
19	38	Likelihood of recommendation to others rating	Likert scale
20	39	Likelihood of repeat use rating	Likert scale
21	40	Overall Satisfaction rating	Likert scale
24	43	Comparison of previous treatment modality (if different from current modality) rating	Likert scale

Table 15: Service User Questionnaire: Treatment Factors measured

If significant differences in ratings for the treatment factors ‘Overall Satisfaction Level’ and/or ‘Rating of Therapeutic Relationship’ were noted between the delivery modalities, Logistic Regressions were to be implemented. These tests explored whether certain factors measured within the questionnaire (e.g. age, gender, number of interventions, ethnicity, etc. – see *Table 16*) could predict these treatment aspects. These features were selected as they have been of interest for much of the literature presented in *Chapter 2*. A Bonferroni correction of $\alpha=.025$ was calculated for the regression analyses⁹. Categorical variables with more than two categories (e.g. ethnicity and employment status) were dummy coded before entered into the regression model (Field, 2013). Ratings of these treatment factors were transformed into binary coding to compute within the logistic regression model^{10 11}.

Section A: Question Number(s)	Factor Measured
4	Modality type
2	Recovery programme used
3 & 5	Number of treatment sessions
Section C: Question Number	Factor Measured
1	Age
2	Gender
3	Ethnicity
4	Dependent children?
5	Employment status
6	Educational attainment
7	Distance from IAPT site

Table 16: Service User Questionnaire: Other Factors measured

⁹ A Bonferroni correction can be option in this statistical scenario as it was noted that according to statistics literature (e.g. Rice, 1989; Cabin and Mitchell, 2000), the use of a Bonferroni correction does not need to be applied to tests of main effects (e.g. in ANOVA, regression) but can be applied when using post hoc testing if main effects return a significant value.

¹⁰ For Logisitic regression analysis, likert scores for ‘Overall Satisfaction Level’ were coded as follows: 1 & 2 = “Very Unsatisfied/Unsatisfied” and 3, 4 & 5 = “Neutral to Very Satisfied”.

¹¹ For Logisitic regression analysis, likert scores for ‘Rating of Therapeutic Relationship’ were coded as follows: 1 & 2 = “Very Bad One/Bad One” and 3, 4 & 5 = “Neutral to Very Good One”.

Thematic Analysis

The qualitative data from the free-text sections (*Section B*) of the SUQ was explored by Thematic analysis to help meet Objectives 1(c). Themes help to capture key aspects of the data; they are rich descriptions with latent or numerous semantic meanings (Braun and Clarke, 2006). In this study, the themes helped to highlight important topics in the views and opinions around the treatment modality the service user used.

The current project employed both inductive (data-driven) and deductive (prior-research-drive) coding (Miles and Huberman, 1994; Boyatzis, 1998; Crabtree and Miller, 1999; Braun and Clarke, 2006). Deductive coding was driven by questions to guide the initial coding and these ‘Deductive questions’ were informed by previous research which also explored Telemedicine views of service users (e.g. Galinsky *et al.*, 1997; Miller and Weissman, 2002; Yellowlees *et al.* 2003; Stallard *et al.*, 2010). The deductive questions used for the SUQ are presented in *Table 17*.

Topic deduced from literature	Explanation of topic	Deductive Question
Therapeutic Relationship	Text which relates to the ‘Therapeutic Relationship’ (e.g. quality of communication, level of description, ease of communication and disclosing private information).	<i>Does telephone versus face-to-face affect the therapeutic relationship?</i>
Treatment Barriers	Text which relates to the delivery modality’s ability to either remove or cause an issue that may or may not prevent the service user seeking treatment e.g. stigma beliefs, travelling barriers, work/childcare commitments, etc.).	<i>Can a treatment modality remove or pose barriers to treatment & help-seeking?</i>
Demographic Factors	Text which relates to any issues surrounding age, gender, ethnicity, etc., which may alter their response and treatment uptake.	<i>Are there certain demographic factors which affect service user views on a delivery modality?</i>

Table 17: Deductive Questions (from literature review) for the Service User Questionnaire

Due to limited resources, a test-retest approach was used where the data was coded at two separate instances by the researcher. On the first instance, the data were coded manually, and

on the second instance, a computer-assisted analysis of qualitative data (CAQDAS) programme was implemented – this was *QSR NVivo 10*.

The advantages of using a CAQDAS include the speed of processing a large volume of data, and assisting in quantitative levels of analysis (e.g. word frequency counts) (Seale, 2000). It also helped to provide a different perspective during analysis due to how the data was displayed and organised by the researcher (e.g. using NVivo, tree diagrams can be generated and help assist the researcher describe the data). A quantitative level of analysis was also used during analysis of the questionnaires in the form of intensity and frequency scoring (Boyatzis, 1998; Joffe and Yardley, 2004).

3.3.3 The IAPT Outcome Database

Participants

Service user datasets from the IAPT Outcome database or *IAPTus*®¹² were analysed separately from the Service User questionnaire data. Therefore, a sample size for this portion of the project was also calculated.

Utilising G*Power 3.1 (Faul *et al.*, 2007), a priori power analyses were undertaken to calculate an appropriate dataset sample size. The sample size required for a two-tailed Mann-Whitney test generated the largest value with a statistical power of 0.95, ‘medium’ effect size of $d = 0.5$, and a significance level of $p = 0.05$ (Cohen, 1988). Thus, 250 service user datasets were required for the IAPT Outcome Database data sample – 125 who have used the OTT modality and 125 who have used the face-to-face modality. The table below (*Table 18*) describes the dataset inclusion and exclusion criteria. These were similar to those set out for the SUQ.

The dataset pool consisted of IAPT Outcome Datasets from participants who were taking part in the SUQ part of the research and have consented to the use of their outcome data. The participants were informed through the PIS and the IAPT database consent form (see *Appendices B2 and B3*).

¹² IAPTus® is a Psychological Therapy Patient Management System (Mayden Health, 2010) that many IAPT services use. However, some IAPT services utilised a personalised data storage system. Therefore, in this project, the term “IAPT Outcome Database” was used.

Inclusion Criteria	Exclusion Criteria
<ol style="list-style-type: none"> 1. Datasets of service users who have experienced only one treatment delivery type (i.e. telephone or face-to-face)^[1] 2. Datasets of service users who are exclusive to Step 2 services 3. Datasets of service users who have had fewer than two treatment sessions (not including initial assessment) 4. Datasets of service users who have depression and/or anxiety as their primary psychopathology 5. Datasets of service users where data from the PHQ-9, GAD-7, W&SAS and IAPT Phobia scales were complete for all sessions 	<ol style="list-style-type: none"> 1. Datasets of service users who have experienced mixed treatment delivery types (i.e. both telephone and face-to-face)^[1] 2. Datasets of service users who are not exclusive to Step 2 services, i.e. those who have 'stepped up' to or 'stepped down' from Step 3 3. Datasets of service users who have had less than 2 treatment sessions (not including initial assessment) 4. Datasets of service users who do not have depression and/or anxiety as their primary psychopathology 5. Datasets of service users where data from the PHQ-9, GAD-7, W&SAS and IAPT Phobia scales were partial or incomplete

Note:

^[1] The use of datasets from service users who had experienced both treatment delivery types in the IAPT service would have been difficult to analyse statistically and are therefore excluded from this part of the project.

Table 18: Inclusion and exclusion criteria for IAPT Database

Materials

Table 19 outlines the data items that were extracted from the IAPT outcome database and the factor of interest it relates to, as well as the associated research objective.

Item No.	IAPT Outcome Data Item	Factor of interest	Related Objective
1	Appointment medium	Modality Type	N/A
2	Intervention given	Intervention type used (e.g. cCBT, Guided Self-Help, etc.)	3(b)
3	Reason for end of IAPT care pathway	Attrition and 'Drop-out' rates	3(a)
4	Contact duration	Duration of intervention / Number of sessions	3(b)
5	Provisional diagnosis	Psychopathology	3(b)
6	Date of Birth	Age	3(b)
7	Gender	Gender	3(b)
8	Ethnic category	Ethnicity	3(b)
9	Employment status	Return to Work rate	3(a)
10	Receiving Statutory sick pay (SSP)	Receipt of Statutory Sick Pay rate	3(a)
11	PHQ-9 Score	Symptom changes	3(a)
12	GAD-7 Score	Symptom changes	3(a)
13	W&SAS Score	Symptom changes	3(a)
14	Agoraphobia score	Symptom changes	3(a)
15	Social phobia score	Symptom changes	3(a)
16	Specific phobia score	Symptom changes	3(a)

Note: As each IAPT site utilised a different database system, the names of the data items presented above may differ.

Table 19: IAPT Outcome Database Items and the factors of interest (adapted from IAPT, 2011a)

Procedure

Participants who wished to take part in the IAPT Outcome Database part of the project were instructed to complete the 'IAPT Database Consent Form' (see *Appendix B3*) enclosed in the Service User Information Pack. Completed IAPT Database Consent Forms were to be returned used the pre-paid envelope provided marked "IAPT Database Consent Form". These forms were sent to the IAPT service site which helped maintain their questionnaire anonymity. No information from the questionnaire was present on the consent form (e.g. questionnaire codes and answers). Once a sufficient number of completed forms were obtained, the member of the IAPT service administrator used them to select the appropriate datasets to extract from the database. The researcher had no involvement in the data extraction process.

The datasets were entered into either a *Microsoft Word*® or a *Microsoft Excel*® document and identifiers removed (e.g. name, NHS number, etc.) before being delivered to the researcher. The researcher checked the delivered data based on the inclusion and exclusion criteria (see *Table 18*). Dataset participant codes (IAPT Outcome Database Dataset code) were then randomly assigned for anonymity purposes (see *Table 27*).

Data Analysis

Statistical Analysis

Similar to the SUQ data analysis, *SPSS – Version 19* was used. Wilcoxon Signed-Ranks tests were employed to find differences between the two modality groups of the changes in treatment outcomes from start- to end-of-treatment measures (see *Table 20*). A Bonferroni correction was applied; for the Wilcoxon tests this was: $\alpha = .004$.

A χ^2 test was also implemented to find any differences in the number of patients that did not complete their treatment programme (i.e. the number of people who 'dropped out' or 'did not attend') between the two modalities (see *Table 19*).

Data item	Time points analysed
PHQ-9 Score	Start and end of treatment
GAD-7 Score	Start and end of treatment
W&SAS Score	Start and end of treatment
Agoraphobia score	Start and end of treatment
Social phobia score	Start and end of treatment
Specific phobia score	Start and end of treatment
Reason for end of IAPT care pathway	End of treatment

Table 20: IAPT Outcome Database: Treatment Outcomes measured

In addition, to explore Objective 3(b), Logistic Regression was used. This investigated different factors (e.g. age, gender, ethnicity, provisional diagnosis, etc. – see *Table 21*) and whether there were any significant relationships with the symptom changes from those who have used either the OTT or F2F delivery modalities. Categorical variables (e.g. provisional diagnoses and ethnic category) required dummy coding before applied in the regression model. Similar to the SUQ analysis, data were transformed into binary coding to compute within the logistic regression model^{13 14}. A Bonferroni correction of the significant level was also calculated at $\alpha = .008$ ¹⁵.

¹³ In this project, an ‘improvement’ in symptoms was defined as a reduction of psychometric scores from the first to the last recorded. For logistic regression analysis, changes were coded in binary. These were as follows: 1 = “Yes, a reduction in score” and 0 = “No reduction in score”.

¹⁴ For “recovery” to be noted, psychometric scores should be under the clinical cut-off point (DoH, 2010; Cairns, 2014) - clinical cut-off criteria are outlined in *Box 5*. For logistic regression analysis, changes were coded in binary. These were as follows as 1 = “Below clinical cut-off score” and 0 = “Not below clinical cut-off score”.

¹⁵ See *footnote 9* in *section 3.3.2* with regards to the Bonferroni correction.

Data item	Data type
Appointment medium	Categorical/Nominal
Intervention given	Categorical/Nominal
Contact duration	Ratio
Provisional diagnosis	Categorical/Nominal
Date of Birth/Age ^[1]	Ratio
Gender	Categorical/Nominal
Ethnic category	Categorical/Nominal

Notes:

^[1] Using the Date of Birth variable, age was derived as of the 30th June 2014 (when data collection ended at all sites).

Table 21: IAPT Outcome Database: Other Factors measured

3.3.4 The Psychological Wellbeing Practitioner Questionnaire (PWQ)

Participants

For the completion of the PWP questionnaires, a purposive sample was taken from the Step 2 Practitioner workforce from each of the participating IAPT sites. It was noted that a small sample size for the questionnaire was expected due to the limited numbers in each workforce. As a consequence, the sample size was not sufficient enough to provide statistically robust results. However, as there had been little research investigating practitioner opinions, particularly on views comparing OTT and F2F therapies, the findings were of great interest. *Table 22* outlines the participant inclusion and exclusion criteria used for the questionnaire.

For qualitative data analysis, a minimum number to achieve ‘meaningful interpretations’ was not required (Sandelowski, 1995). However, ‘data saturation’ is necessary to ensure rich and meaningful interpretations can be collected. For thematic analysis, saturation has been suggested to be met when the emergence of new themes becomes less frequent (Guest, Bunce and Johnson, 2006).

Inclusion Criteria	Exclusion Criteria
1. Any PWPs/Psychological Practitioners working within the IAPT services where the study was implemented	1. Trainee PWPs/Psychological Practitioners ^[1]

Note:

^[1] Trainees were excluded as their position and responsibilities may still be relatively new and thus they may not have formed their own views and opinions on the treatment modalities yet.

Table 22: Inclusion and exclusion criteria for Psychological Wellbeing Practitioner Questionnaire

Materials

The PWQ is divided into two sections – please see *Appendix C1* for the full questionnaire. The questions utilised examined topics which were highlighted within previous telemedicine research. Similar to the SUQ, the questions were devised with reference to the extensive literature review presented in *Chapter 2*. The full rationale for each question is located in *Appendix A2*.

Section A comprised of 41 questions which explored the views of PWPs on the delivery modality they utilise in practice (Objective 2(a)). It also asked practitioners to state their preferred modality which helped achieve Objective 2(b). The topics investigated include:

- views on patient engagement in session and in tasks
- views on the progress of patients when using a particular modality type
- perceptions on the effect of the modality type on the information exchanged in sessions (e.g. their ability to explain information clearly, the amount of information disclosed by patients, and the level of information understood)
- ratings of comfort in session
- views on the effect of the delivery modality on aspects of the therapeutic relationship (e.g. rapport rating, and the level of empathy conveyed)
- perceptions on the effect of modality on clinical practice (e.g. treatment scheduling)
- ratings of satisfaction

Section B is an open-ended question section which asked participants to justify, in their own words, their views and reasons for their given ratings in the *Section A*. This helped to achieve Objective 2(c) which investigated how practitioners explained their views and treatment modality preference.

Only one study, at the time of writing this thesis, had investigated the perspectives of therapists who have used the telephone modality within the IAPT service: Jones, Bale and Morera (2013) – please see section 2.3.3 for more information. Previous research has mainly explored patient views (via surveys and interviews) on the use of the OTT in psychological therapy (e.g. Bee *et al.*, 2010a) and of LI therapies within IAPT (e.g. Parry *et al.*, 2011). However, due to their different ‘expertise’ and experiences, therapist views may differ from patients’ and can provide an alternative insight.

Piloting the PWQ

Alongside the SUQ materials, the PWQ materials were piloted to gain feedback on the readability and comprehensibility of the materials used (please see *section 3.3.2* for more information).

Procedure

The recruitment phase for the PWQ lasted six months and ran in parallel with the SUQ recruitment. Service/Clinical leads introduced the project, including the inclusion and exclusion criteria, to the PWPs during a staff meeting. Approximately 40 ‘PWP Information Packs’ were printed and divided between the five clinical sites; these packs contained:

- Practitioner Participant Information Sheet (PIS) (see *Appendix C2*)
- A PWP Questionnaire (see *Appendix C1*)
- Pre-paid Questionnaire Return envelope.

PWPs who were interested in participating could collect a pack at their IAPT site. The PIS requested the PWP participants to complete the questionnaire outside of working hours. Before completing the questionnaire, participants were required to be satisfied and to have understood the information provided to them in the PIS. Using the pilot study results, the PWQ was described to take approximately 30 minutes to complete.

These completed questionnaires were returned directly to the researcher using the return envelope enclosed in the pack. A return date was stipulated within the PIS; this date was one month after the initial introduction of the project at each site. Each PWQ was also randomly assigned a questionnaire code for anonymity purposes (please see *Table 27*). The return rate for the PWQs was 75% with a total of 30 completed and returned.

Data Analysis

Statistical Analysis

Akin to the data analysis methods that were chosen for the SUQ, in order to help explore Objective 2(a), separate Mann-Whitney tests were applied to each treatment factor measured (see *Table 23*). These tests were used to find out whether there were any significant differences of likert ratings between PWP who experienced either OTT-based or only F2F treatment delivery. Moreover, Wilcoxon Signed Ranks tests were used when comparing the ratings of PWP who had experience implementing both delivery types.

For questions 14/33, 19/28, 20/39, 40 and 41, Chi-Square (χ^2) tests were used to analyse whether there were any associations between the categorical/nominal data and the use of either a F2F or OTT modality.

Similar to the SUQ analysis, Bonferroni corrections were used. For the Mann-Whitney tests and Wilcoxon tests, a Bonferroni correction of $\alpha=.003$ was employed. For the Chi-Square tests, a Bonferroni correction of $\alpha=.012$ was used.

Treatment Factor Measured	PWP – Section A Question Number		Question Type
	Telephone	Face-to-Face	
Rating of belief that SU is engaged in the treatment	2	21	Likert scale
Rating of belief that SU completes therapeutic tasks	3	22	Likert scale
Satisfaction of SU progress rating	4	23	Likert scale

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Likelihood of relapse rating	5	24	Likert scale
Amount of information provided by SU rating	6	25	Likert scale
Level of understanding SU information rating	7	26	Likert scale
Amount of information given to SU rating	8	27	Likert scale
Ability to explain information to SU rating	9	28	Likert scale
SU understanding of information given rating	10	29	Likert scale
Likelihood of information clarification by SU rating	11	30	Likert scale
Comfort rating	12	31	Likert scale
Level of empathy given to SU rating	13	32	Likert scale
Concern for presence/absence of visual/Non-verbal information	14	33	Yes/No
<i>(If 'Yes' on Q14/33)</i>			
Visual/Non-verbal: perceived level of effect rating	15	34	Likert scale
Rating of rapport with SU	16	35	Likert scale
Effect of scheduling treatment sessions rating	17	36	Likert scale
Modality satisfaction rating	18	37	Likert scale
The preferred treatment modality?	19	38	Yes/No
<i>(If 'No' on Q19/38)</i>			
Which is the preferred treatment modality?	20	39	Categorical
Treatment Factor Measured	PWP – Section A Question Number		Question Type
The preferred treatment modality (if 'Both')?	40		Categorical
Perceived treatment modality preferred by SU?	41		Categorical

Note:

'SU' = 'Service User'

Table 23: Psychological Wellbeing Practitioner Questionnaire: Treatment Factor

Thematic Analysis

Similar to the SUQ, Thematic analysis explored the data captured in the free-text section of the PWQ to help meet Objectives 2(a) and 2(c).

Deductive coding also helped guide initial coding for the PWQ thematic analysis. *Table 24* outlined these ‘deductive questions’ derived from the literature review. A test-retest approach was also implemented (using hand and CAQDAS programme, *NVivo 10*, coding).

Topic deduced from literature	Explanation of topic	Deductive Question
Therapeutic Relationship	Text which relates to the therapeutic relationship (e.g. quality and ease of communication, acceptance and uptake of the treatment, etc.).	<i>Can a delivery modality (OTT vs. F2F) affect the therapeutic relationship?</i>
Treatment Barriers	Text which relates to PWP/Psychological Practitioner belief or thoughts that a modality may help to alleviate or cause treatment barriers service users may face.	<i>Does a treatment modality remove or present barriers for treatment access?</i>
Clinical practice/working approach	Text which relates to PWP/Psychological Practitioner thoughts on whether the delivery modality may alter the way they work – e.g. making it easier or more difficult.	<i>Can a delivery modality alter routine clinical practices?</i>

Table 24: Deductive Questions (from literature review) for the Psychological Wellbeing Practitioner Questionnaire

3.3.5 The Psychological Wellbeing Practitioner Interviews

Participants

For the one-to-one PWP interviews, a purposive sample of nine was required from Step 2 Practitioner workforces of the participating IAPT sites – *Table 25* presents the participant inclusion and exclusion criteria used for the interview phase.

There are many conflicting views regarding the number of interviews needed for data saturation and it is difficult to reach a consensus as there is not an operational definition of “saturation”. A range of two to twenty-five interviews have been suggested by different authors (Creswell, 1998; Thomas and Pollio, 2002; Boyd, 2001). Guest, Bunce and Johnson (2006) found that the infrequency of novel theme emergence was noted between six to twelve interviews.

Inclusion Criteria	Exclusion Criteria
<ol style="list-style-type: none"> 1. Any PWPs/Psychological Practitioners working within the IAPT services where the study is implemented^[1] 2. PWPs/Psychological Practitioners who have worked with both telephone and face-to-face delivered psychological therapies^[3] 	<ol style="list-style-type: none"> 1. Trainee PWPs/Psychological Practitioners^[2] 2. PWPs/Psychological Practitioners who have worked with only 1 delivery modality: telephone or face-to-face^[3]

Note:

- ^[1] PWP interview participants need not have completed the PWP questionnaire in order to participate, nor were they excluded due to the small workforce size at the participating IAPT sites.
- ^[2] Trainees were unable to participate as their position and responsibilities would have been relatively new and thus they may not have formed their own views on the treatment modalities yet.
- ^[3] This was to gain perspectives for both delivery modalities.

Table 25: Inclusion and exclusion criteria for Psychological Wellbeing Practitioner Interviews

Materials

The interview schedule explored eight topics using 12 questions; these helped investigate the views and experiences practitioners had of working with each delivery modality (Objective 2(c)), as well as exploring whether the delivery type has any effect on the formation of a therapeutic relationship. This phase of the project helped to add knowledge in the limited research on therapist views on the use of OTT delivery in psychotherapies, as well as expand on key themes and topics which emerged from the PWQ and SUQ preliminary findings, particularly on aspects related to the therapeutic relationship.

It has been noted that it is important to gain practitioner views as their views of a therapeutic alliance could affect how they deliver therapy (Hatcher, 1999). The alteration of the therapeutic relationship by telemedicine has been a key topic arising from the literature (e.g. Farrand and Williams, 2010). Therefore, one of the main aims of the interviews was to explore the perspectives and experiences of practitioners on the therapeutic alliance within OTT therapies compared to F2F – this has not been encountered within the literature.

The interview schedule used is presented in *Appendix D4*. Prompts were used after the lead questions to encourage elaboration, guide the participant back on topic, or to clarify the aim of the lead question asked. Prompts in bold font, marked key topics the researcher wished to cover if the participant has not explored it within their initial answer. Please note that the term ‘patient’ was used for this stage (instead of ‘service user’) as it has been noted from the PWQ that the practitioner participants refer to ‘service users’ as ‘patients’ or ‘clients’.

The final question helped to provide more general views on different treatment modalities. From the sparse literature exploring the views of health professionals on telemedicine, general mixed opinions arose. For example, some found that telemedicine benefitted them for practical reasons (e.g. aiding them in follow-up and scheduling sessions easier), or it benefitted patients practically (e.g. Simpson *et al.*, 2001). However, others have not been so favourable, primarily due to the potential change in the strength of the therapeutic relationship or its lack of formation in telemedicine (e.g. McLaren *et al.*, 1996).

Interview Pilot

In order to ensure questions asked in the PWP interview were easily understood, a pilot interview was carried out. This helped to refine questions, reducing ambiguity and ensuring that they were appropriate and reflected the aims of the interview (Wang and Yan, 2012). It also helped to improve the interview techniques of the researcher. These interviews hoped to increase trustworthiness in the qualitative method used, particularly to help improve credibility and consistency (Guba, 1981; Lincoln and Guba, 1985).

One PWP volunteered to take part in the pilot interview.

Prior to the interview, the volunteer was presented with information about the aims of the project and interview. The pilot interview was not recorded and the answers provided were

not used in the research findings. The researcher's supervisors observed the pilot interview and provided feedback on the interview technique. No feedback was given regarding the volunteer participant or their responses.

After the interview, the volunteer participant was asked to provide feedback on a number on two main aspects:

- How the interview was conducted (e.g. the pacing, the interview style, etc.)
- The questions asked (e.g. were they relevant? Were they easy to understand?)

Procedure

The recruitment phase for the PWP Interviews involved the introduction of the interview phase the PWPs by the researcher at the IAPT sites. Those who were eligible to participate were provided with the PIS to read. Participants who wished to take part signed a Consent Form that was available to collect on-site. After signing, the participant could contact the researcher by email to arrange the most suitable time and date for the interview to take place. The interviews took place in a private room at the workplace of the PWP (at the IAPT site) and lasted approximately 45 minutes to one hour.

Participants were provided with the following:

- Participant Information Sheet (PIS) (see *Appendix D1*)
- Consent Form (see *Appendix D2*)

For the interview, the researcher utilised the following:

- Interview Schedule (see *Appendix D4*)
- Note paper
- Tape recorder

On the day of interview, the participant was given the opportunity to ask the researcher any further questions regarding the interview. The researcher also reiterated the key information (found on the Interview PIS) about the interview. If the participant was still happy to continue, the researcher then countersigned the Consent Form and then informed the participant that the audio recording would begin shortly.

During the interview, the researcher prompted the participant for further information to clarify any misunderstandings. The researcher also used prompts so the participant could

elaborate on information stated during the interview. It should be noted that the participant could control the amount or level of depth of information disclosed in the interview.

At the end of the interview the researcher thanked the participant, debriefed and informed them that audio recording would shortly stop.

Data Analysis

Thematic Analysis

Thematic analysis was also used for the interview data analysis. Deductive questions were used to guide the coding; these were underpinned by previous literature, as well as key themes which emerged from the findings of the PWQ and SUQ – the parenthesis included within the ‘Topic of Interest’ column of *Table 26* denotes the source of the topic.

Verbatim transcription was carried out; non-verbal changes (e.g. change of tone in voice, laughter, volume) were noted alongside hesitations and repetitions as these were potentially useful in analysis as it has been suggested that this aspect of communication can help convey more affective information in communication (Bensing, 1991; Miller, 2002). A test-retest approach for coding was also applied using hand and CAQDAS coding, similar to the PWQ and SUQ analysis.

Topic deduced from literature or other source (stated in parenthesis)	Deductive Questions
Experiences of working with telephone and face-to-face therapy delivery (from the Literature)	<i>What are PWPs’ experiences of working with therapy face-to-face?</i>
	<i>What are PWPs’ experiences of working with therapy over-the-telephone?</i>
The Therapeutic Relationship (from the Literature, PWQ, & SUQ Themes)	<i>What are PWPs’ views and experiences of the therapeutic relationship?</i>
	<i>Are there factors in working face-to-face or over-the-telephone which could affect the therapeutic relationship?</i>
Therapeutic modality and delivery modality (from the Literature & PWQ Themes)	<i>What are the views of PWPs’ regarding the use of the CBT-model in over-the-telephone therapy?</i>

<p>PWP experiences of patient expectations, perceptions and characteristics (from the Literature, PWQ, & SUQ Themes)</p>	<p><i>Are there certain patient characteristics which affect how they may perceive therapy through a certain delivery modality (face-to-face vs. telephone)?</i></p>
	<p><i>What are PWPs' experiences of patients' perceptions of them as a practitioner through a certain delivery modality (face-to-face vs. telephone)?</i></p>
	<p><i>What are PWPs' experiences of patients' expectations of therapy through a certain delivery modality (face-to-face vs. telephone)?</i></p>
<p>Therapy Effects on outcome (from the Literature)</p>	<p><i>Are there any factors involved with delivery type (face-to-face vs. telephone) which therapists view as helpful in therapeutic outcomes (e.g. symptom improvements)?</i></p>
<p>Views on other delivery modalities (from the Literature)</p>	<p><i>What are PWPs views on advantages and disadvantages of the use of other delivery modalities in therapy (e.g. computerised/internet and videoconferencing)?</i></p>
	<p><i>What are PWPs' views on the effects of using other delivery modalities (e.g. computerised/internet and videoconferencing) on the therapeutic relationship?</i></p>

Table 26: Deductive Questions (from literature review) for the PWP Interviews

3.4 Ethical Considerations

3.4.1 Ethical Practices and Procedural Ethics

Ethics can be considered as a “...*science of morality*” (Hofman, 1991, p. 1). Morality can be described as a set of norms depicting ‘right and wrong’ or ‘good and evil’ shared by everyone as a “...*stable social agreement*” (Beauchamp and Childress, 2009, p. 2); it can relate to behaviours or character traits. For example, fundamental moral rules include: one should not kill others, one should rescue those who are in danger, one should be trustworthy, etc.

Research ethics concerns the application of these principles in practice: to help protect and safeguard the welfare of the research participants involved (Williams, 2008). This research project was carried out in accordance with notes and guidance provided by The Central Office for Research Ethics Committees (COREC, 2009a; 2009b), and The BPS Code of Ethics and Conduct, and Good Practice Guidelines (BPS, 2009; Cooper *et al.*, 2005).

Gatekeepers

The PWP acted as Gatekeepers during recruitment of the SUQ. Their trained judgement was used to decide whether a service user could take part in the project and thus specified in the inclusion/exclusion criteria set. There were no Gatekeepers required for the PWQ or the Interview phase.

Consent

During the initial recruitment phase of the SUQ and IAPT Outcome Database, PWPs asked service users whether they would like to receive more information about the project. Service users who used a F2F modality in sessions were able to collect a pack on site. However, those who engaged in OTT sessions were asked whether they could be sent information by post. This verbal consent permitted the PWPs to distribute the Service User Information Pack to them by post. It should be noted that this verbal consent did not refer to their participation in the study and their mailing details were not used for purposes outside of the research project.

One reason that verbal consent, and not written consent, was gained from OTT users was the difficulty of presenting a physical version of a PIS and Consent Form to them. Other methods

were considered such as utilising email to send information to OTT users, but this could have introduced a sampling bias as some may not have access to these services.

Information regarding the project (for both service users and PWPs) was provided in their respective PIS (*Appendices B2, C2 and D1*). Implied consent to take part was attained from the return of completed questionnaires. Service users were able to consent to the use of their outcome data by completing the IAPT Database Consent Form (*Appendix B3*) and PWPs consented to taking part in the interview and confirmed they were aware that the interview would be audio recorded by completing the PWP Interview Consent Form (*Appendix D2*).

The PISs and the Consent Forms were written using the '*Information Sheets and Consent Forms: Guidance for Researchers & Reviewers*' provided by the National Patient Safety Agency (NHS, 2011). Each information sheet was tailored to the specific IAPT service the service user/PWP is associated with.

The IAPT administrative team were the only personnel who had access to completed IAPT Database consent forms in order to extract the correct datasets; the researcher was unable to see this information to ensure participant anonymity.

Participant Withdrawal

To ensure that all data from the returned questionnaires and the consented IAPT Outcome Database datasets remained anonymous to the researcher, participants were unable to withdraw their data. This was explicitly stated within the PIS (*Appendices B2 and C2*) and Consent Form (*Appendix B3*).

Conversely, interview participants were informed that after consenting to take part, they could withdraw at any time. If a participant decided to withdraw from the project, it was noted that the data collected from the interviews (audio recordings, notes, transcripts, etc.) would not be used and destroyed.

Health and Safety

As a questionnaire method was chosen for this research project, no health and safety issues were considered to arise because the questionnaire could be carried out at a location selected by the participant.

On the agreement with the IAPT Site Lead and Clinical Lead, the interviews were located at the IAPT site where the participants work – thus there were no issues in providing travel to and from the venue. If it was necessary, the health and safety procedures (e.g. fire safety) of the IAPT site would have been followed. The room where the interviews were held contained only a table and chairs. Objects which posed as tripping hazards (e.g. bags) were stored on one side of the room. Tape recording equipment was ensured to be in working order prior to the interview and was not placed near any liquids.

The interview lasted approximately one hour; participants were informed that if they felt uncomfortable after a long period of sitting down or if they required a bathroom break, they could stop the interview and recording would be paused until they were ready to resume.

Minimising Distress and Offence

One of the main ethical issues a questionnaire method could pose is the participants, particularly the service users, recounting unpleasant memories when answering questions about aspects of their treatment. In order to minimise this potential distress, questions were phrased in a manner that reduced this likelihood. The questionnaire was piloted to gain feedback on question phrasing and no issues arose from this. In the free-text section, it explicitly stated that service users could include as much detail as they wished. Service users were instructed in Section 3 of the SUQ that they could choose to refrain from completing some of the demographic questions. Furthermore, questions only asked about their treatment experience, and not their mental health experience.

The researcher utilised feedback from the pilot interview to help improve their interview technique and ensure that the procedure and schedule were feasible. Participants were asked, using open-ended questions, to discuss their experiences in practice and how different delivery types may affect how they work with patients. Clarifications were sought to ensure that what was recounted by the participant was interpreted as intended. There were no questions regarding personal information (e.g. names, age, gender, etc.).

An issue that could arise from the PWQ and the PWP Interviews is their potential to be a critical tool, questioning aspects of the role of a PWP. Despite this, the researcher understood that PWPs have completed a university education and their clinical training requires them to

continually question and reflect on their practice and role (including the modality they use to communicate with service users). The PWQ questions were constructed in a neutral tone and were not phrased in a way that challenged their role as PWPs.

Participation Time

The total time that a participant was involved with the project (from initial recruitment, distribution of information packs, completion and return of questionnaires) was estimated to take between two and three months. This approximation was due to the return date for the PWQ being assigned to a date one month after distribution. In addition, service users were requested to return their questionnaires within two weeks of completing their time with the IAPT service or sooner. Step 2 treatments are recommended to last up to seven sessions (NICE, 2010a; DoH, 2008a); if the sessions were given weekly (noting that the project would be introduced after session 2), approximately five or six weeks would pass between the end of the set sessions and when the service user was introduced to the project by the PWPs.

The issue of clinical time being consumed when healthcare professionals participate was eliminated as they were not required to complete the questionnaire during working hours. Furthermore, service users were asked to complete the questionnaires outside of sessions.

The interviews each lasted approximately 45 minutes to one hour. Upon agreement from the site and/or clinical lead (or line managers), PWP interviews occurred during working hours. To minimise the amount of practitioner time taken up at each of the sites, the interviews were scheduled to take place during a day that suited the PWPs and the service and were carried out consecutively to minimise scheduling conflicts.

Researcher and Participant Contact

There was little contact between the researcher and participants unless a participant requested more information from and/or contacted the researcher regarding the project. The researcher's contact information (telephone, email and postal address) was provided on all PISs. Participants were instructed to contact only the researcher involved; the IAPT services were not mentioned as a point of contact regarding project information. The only form of participant contact the IAPT sites had was through the direct receipt of the IAPT Database Consent Forms to prevent the loss of questionnaire anonymity and to assist the service in selecting the appropriate data sets.

For the purpose of the interview, one-to-one face-to-face contact between the participant and the researcher occurred. Participants were informed of this in the PIS and the consent form.

Confidentiality and Anonymity

Strict data collection and handling practices were carried out to assist with confidentiality and fulfil the need for anonymity. Participants were not required to complete any personal details (e.g. name, address) as part of the questionnaire or interview. Identifiable information from data retrieved from the IAPT database (e.g. NHS number) was removed by a member of IAPT staff before the researcher was given this data. The IAPT Database and the SUQs were analysed separately and thus, there were no issues of linked anonymity. Also, interview data cannot be linked to any PWQ data.

The IAPT sites did not have access to questionnaire answers or interview data (recordings, transcripts, notes); only the researcher involved in the project has access to this data.

Participant Codes

Each questionnaire and dataset was randomly allocated a unique code to help identify the data entered into the data analysis programmes (e.g. in Microsoft Excel, NVivo and SPSS). The code structure is presented in the table below (*Table 27*). The participant numbers 0000 to 9999 were randomly assigned to all data. To distinguish each study part, these numbers were prefixed with 'SU', 'PW', 'IA' or 'IN'.

Item	Code
Type	SU: Service User Questionnaire PW: Psychological Wellbeing Practitioner Questionnaire IA: IAPT Outcome Database Dataset IN: Psychological Wellbeing Practitioner Interview
Participant Number	0000 – 9999

Table 27: Participant codes

Data Storage, Handling and Management

The project ensures that all data processed and entered was handled in accordance to the *Data Protection Act 1998*. All consented questionnaire and database data were viewed and analysed strictly and solely for the purpose of this research project and only by the researcher associated with this project.

All paper copies of the completed questionnaires were filed in lockable filing cabinets at the University of Southampton which only the researcher has access to. Any data stored on computers or external memory storage devices (for data back-up purposes) was also kept at the University of Southampton and were password protected to provide complete security and guarantee sole access by the researcher. Any transfer and copying of data concerning this project, was completed exclusively by the researcher.

Monitoring and auditing of research conduct was carried out in accordance to University of Southampton Research Governance policies. According to University of Southampton's 'Research Integrity and Academic Conduct' policy, all data and documents used for this project are stored and "*...kept for 10 years after collection or subsequent publication, whichever is later*" (University of Southampton, 2010).

Write Up and Data Analysis

During the write up and analysis of raw data, it was ensured that interpretations and findings were stated in a way which would not cause any distress or offence. No identifiers were used during write up. Due to the small cohort attained for the PWQ and PWP Interviews, care and attention was paid to quotations from participants in case of potential identification by colleagues. Any personal information was not included. For thematic analysis, participants were given a pseudonym when quoting from their responses (see *Tables 32, 39 and 40*).

Whilst demographic data were collected in the questionnaires and the IAPT Outcome Database, they were statistically analysed and therefore an overall result was presented. In qualitative analysis, the overall view is generated by thematic analysis – thus only themes, not individuals, were discussed.

Project Costs

The IAPT staff member who helps to extract data from the IAPT Outcome Database was reimbursed, by the hour, from the researcher's University of Southampton Bursary/Studentship. All materials used (e.g. envelopes and cost of postage, etc.) were supplied by the researcher and also paid by the Research Bursary/Studentship. For the interview phase, no reimbursement was available. No rewards were offered to participants as an incentive

Ethical Approval from R&D and RECs

The project was reviewed by the Faculty of Health Sciences (University of Southampton) Peer Review system, as well as regular checks from project supervisors. A Favourable Opinion was provided by an NHS Ethics Committee and approvals to implement the project was provided by the relevant NHS Trust R&D, as well as the executive panel of the mental health charity that provides the service for one of the IAPT Step 2 sites. In addition, the IAPT site Service Leads and Step 2 Clinical Leads provided their approval and indicated support for the project. The University of Southampton sponsored the project and provided insurance protection.

The PWP Interview phase was an additional stage in the data collection process and thus an Amendment to the Protocol was submitted to the NHS Ethics Committee and received a Favourable Opinion; the relevant NHS Trusts R&D, as well as the Clinical and Service Leads also approved of this stage. For all R&D and REC documents please see *Appendix E*.

3.4.2 Relational Ethics

Relational ethics concerns the responsibilities of the researcher on how knowledge is gained through an interpersonal bond which is often formed between the researcher and the participant and its implications of this on the relationship (Ellis, 2005):

“Relational ethics recognizes and values mutual respect, dignity, and connectedness between researcher and researched, and between researcher and the communities in which they live and work” (Ellis, 2005, p. 4).

The quote from Ellis (2005) can be organised into four commitments, which a number of authors have noted (e.g. Pauly and James, 2005; Macdonald, 2007; Kunyk and Austin, 2011), these include:

- **Mutual Respect:**

This relates to the need to being open to and respecting all values and ideas of others in order to develop understanding of one another.

In a 'research relationship' the researcher is often seen as the more dominant participant as the research context is usually initiated, and discussions led by them. This power imbalance may also exacerbate vulnerabilities that participants hold (e.g. if researcher designs a discussion to focus on a sensitive topic experienced by the individual that they may not willingly disclose due to stigma). Mutual respect aims to reduce these power imbalances, allowing the participant to communicate their views without judgement.

- **Engagement:**

A strong connection between the researcher and the participant is important. It is essential that trust is built. When exploring sensitive topics or discussing information that could potentially reveal identities, it is important that participants have the confidence that anything they disclose is not utilised outside of what is agreed with the researcher.

- **Embodied Knowledge:**

When "*engaging the 'lived life'*" (Macdonald, 2007, p. 123) it is important that objective thinking (or scientific knowledge) and subjective feelings (or human emotion) are considered equally as these two aspects shape the cognition and reasoning of individuals, or how individuals interpret and experience situations.

- **Recognition of Interdependent Environment:**

It is important to consider the complexities of the wider context and the environment in which the 'research relationship' is situated – this may include understanding the situations of the participants that could affect or reflect what or how a topic is explored and discussed.

This project had an overall exploratory aim that engaged with multiple views relating to the use of telecommunication technologies within the low-intensity step of the IAPT programme. The exploratory nature of the project is reflected in the questions selected for the interviews and the questionnaires, and how they were phrased in order to capture all views – both

positive and negative. The ethical practices presented in *section 3.4.1* (e.g. the use of informed consent, preserving the anonymity of all participants with the use of participant codes and pseudonyms, etc.) established the research project and my research relationship with the participants on a foundation of trust and agreement. During the interview stage, I ensured that my interviewing style and approach helped to build a positive bond and rapport, which encouraged the participants to engage with, and discuss, the topics outlined within the interview schedule as well as ensure they felt comfortable to express their views.

The context of the research relationship was situated within mental health practice and as a researcher, it was important that I upheld these ethical practices (see *section 3.4.1*), particularly as I was exploring sensitive issues and topics relating to mental health experiences. I considered this topic pragmatically and opted for a mixed methods approach that allowed me to explore the lived experiences of the participants (using qualitative methods) alongside findings and trends from the more 'objective' quantitative outcome measures (e.g. likert scale scores); in *chapter one* and *section 3.2* it was discussed that quantitative and objective measures does not consider all aspect, particularly when mental health cannot be objectively observed and is unobservable (Freeth, 2007; Goffman, 2007; Johnstone, 2014). Thus, to help gain a better understanding, a qualitative approached helped gather more subjective information.

I attempted to position myself as, what I perceived to be, a 'neutral' individual – although it is noted that my background of Psychology and other experiences will have no doubt 'influenced' my position and thus was not truly 'neutral'. Nevertheless, this position was held to preserve mutual respect for all the participants, to encourage all views to be captured in the process and attain a broad perspective from all aspects of the IAPT debate – as noted previously, this was an exploratory project and the research question was not directed at satiating a specific side of this debate. In IAPT, I was an outsider and I had no preconceptions of the experiences of the participant groups. I was a non-practitioner and an individual that has not experienced mental health issues that led me to seek help from a health professional. Additionally, I was mindful that some individuals may view that an 'outsider' from the group cannot 'properly' represent the experience of the group that is under study (Bridges, 2001) and this further encouraged me to exercise this approach. My autoethnography (*Chapter seven*) further explores my decisions to present my work in this manner.

Despite this approach, in the case of the practitioner interviews, there were a number of topics and themes¹⁶ which were disclosed by participants that could be considered ethically challenging¹⁷, for instance:

- The effect of the telephone on the therapeutic relationship in which practitioners felt a lack of 'presence', or the advantages of multi-tasking when working over-the-telephone which could disrupt their empathic engagement with the service user
- Comments which related to the need to complete the therapy protocol in a short space of time and due to this lack of time were unable to discuss the narratives of the patient and fully explore their experiences.

As a researcher, it was important that I viewed these topics and themes within the context of the IAPT programme rather than discussing individual competence, as a number of these themes and practices stem from, and are, products of the 'low contact-high volume approach'¹⁸ which the low-intensity step applies – e.g. a short amount of time allowed in low-intensity therapy sessions, the use of telecommunication technologies that removes the visual senses, protocol-led therapies which do not advocate the use of patient narratives (e.g. Chadwick, 2009; Moorey, 2014).

The debates surrounding the IAPT programme are outlined and discussed in *sections 1.2.4* and *5.6.2*. These critical discussions surround the premise of the IAPT programme with its main driver being economic aims, also its over-reliance of the CBT paradigm (e.g. House and Loewenthal, 2010; Griffiths and Steen, 2013; Griffiths, Steen and Pietroni, 2013). This posed an ethical dilemma surrounding the incompatibility of the aims of care with economic drivers (e.g. McPherson *et al.*, 2009). As well as these critical debates, the findings were also presented within the background and current understanding of telecommunication devices in healthcare (e.g. the rise in telemedicine due to improvements in technologies and their potential for use in different domains).

The literature in *chapter two* presented that the telephone modality could provide similarly positive effects when compared to face-to-face work. Indeed, both service users and practitioners also commented on its advantages (e.g. the practice aspects) (Galinsky *et al.*,

¹⁶ Please see *chapters four* and *five* for the results and discussion topics.

¹⁷ It could be suggested that some answers (e.g. the perceived advantage of being able to multi-task when using the telephone) may be considered as 'bad practice'.

¹⁸ A phrase coined by Clark *et al.* (2009)

1997; Bee *et al.*, 2008). It is important to note that participants from the questionnaires and the interviews presented both positive and critical aspects of their IAPT experience (e.g. some reported that, in their experience, a good relationship or rapport was built or could be built using either face-to-face and telephone modalities). It is therefore important that, as researcher, I highlighted both these viewpoints that add to the current knowledge and debates. It was recognised that these critical viewpoints with regards to the IAPT programme (e.g. one participant terms it as a 'production line') will have implications on all individuals involved (i.e. the patients and practitioners) and in the wider respect of the public. This is especially true of the highlighted ethically challenging practices which could undermine the trust and confidence in health practitioners who have a fundamental commitment to healthcare and hold high regard for safe, competent and ethical care. This could then lead to dissatisfaction from all parties.

Outside of healthcare, the public will most likely be aware of the economic pressures faced by the healthcare system and will acknowledge the economic need for these delivery modalities. Some will note the benefits of these modalities (e.g. removing treatment barriers which enable increased access, particularly to a growing demand for access to mental health). Some will also note that, as highlighted in the discussion of the debates surrounding the IAPT programme, these benefits do not work for everyone (e.g. Roth and Fonagy, 2006).

When accounting for the background contexts, both patients and the public have been shown to have a preconception of 'what therapy is'. In some cases, it was commented that patients often had preconceived ideas that face-to-face was the primary modality of communication rather than telephone; this led to some initial dissatisfaction. It was also acknowledged that for some patients the goal of attaining a 'cure' to their experiences of mental health issues outweighed their concern surrounding the method used to achieve this. It is therefore important to ensure that the promotion of the IAPT service, particularly at low-intensity, should be explicit and clear with respect to the types and mode of therapy delivery available.

For practitioners, it was noted that each previously held a variety of backgrounds (e.g. some who were trained at university as PWP's, others were previously counsellors, or social workers) and these previous experiences will have shaped their views. It should be noted that it was not possible to explore this in more depth as it would compromise participant anonymity due to the small sample sizes. The recognition of these previous experiences may be an important

aspect for the professional training and education of IAPT practitioners, particularly if it is advocating an adaptation to a new way of working (Grant, 2009) – e.g. one participant noted that other factors of the patient are often ignored (e.g. hygiene and self-care) in favour of completing protocol for the session¹⁹.

Returning to the four commitments of relational ethics, *Table 28* summarises the actions of the project in relation to the commitments:

Relational Ethics commitment	Actions
<p>(1) <i>Mutual Respect</i> (2) <i>Engagement</i></p>	<ul style="list-style-type: none"> • The aim of the project was exploratory and did not have a set agenda; this aim was retained throughout • Questions in the questionnaires and interviews were asked/written in ways which helped to capture all views and not one aspect • The research relationship was set on a foundation of agreement and trust by following procedural ethics (e.g. informed consent, etc.) which included the use of participation codes and pseudonyms • Results were interpreted by taking into account both the advantages and disadvantages of the use of telephone and/or face-to-face methods of delivery of psychological therapies and respective views by presenting all views

¹⁹ The implications of a manual-led therapy are explored in *sections 1.2.1* and *2.2.3* with regards to its effect on the therapeutic relationship.

<i>(3) Embodied knowledge</i>	<ul style="list-style-type: none"> • Utilisation of a mixed methods approach to explore both subjective experiences and objective symptom score measurements as a way of understanding the use of these delivery modalities, as well as explore the topic of mental health which is noted to not be directly observable
<i>(4) Recognition of Interdependent Environment</i>	<ul style="list-style-type: none"> • The results and findings were presented and discussed within the context of the IAPT debates which explored both favourable and critical views • It was recognised that answers provided by participants were discussed with respect to the context outside of the IAPT programme (i.e. within the current economic climate) • These contexts were noted and thus ethically challenging answers were not discussed in a manner that inferred the abilities of a practitioner to carry out their job but rather it was acknowledged that some aspects were implications of the IAPT programme as whole

Table 28. Relational ethics commitments summary of actions

Overall, I ensured that the results were presented in a manner whereby the critical debates surrounding IAPT have been outlined and presented with its implications on the findings discussed (see *chapter five*). This was in order to uphold the initial agreement between the researcher and the participants which was outlined in the main aim of the research project: to explore their views and the effectiveness of these delivery modalities.

Ethically challenging practices were not highlighted because it was not the intention of the project but they were discussed in relation to the background context of the IAPT service and economic pressures on healthcare practices – it was clear to see that such forces enabled these themes to emerge (e.g. themes related to the reduced clinical time available for sessions) and is thus in no way a method of inferring the ability of the practitioner. The themes were raised and discussed within the context of critical debates surrounding IAPT, the use of CBT, and previous literature regarding the therapeutic relationship. What is clear is that the findings presented add to the growing body of knowledge and the debates that surround it to inform not only future research, but also practices surrounding practitioner training and promotion of mental health services to the public and patients.

CHAPTER 4: Results

4.1 Introduction

This chapter presents the results from the data collected in the research project. First, results from the data collected from Service Users are presented which covers the data analysis from the SUQ and the IAPT Outcome Database. Following that, the analyses of the data captured from PWPs, via the PWQ and the PWP Interviews, are then outlined.

4.2 Service User Questionnaire (SUQ) Results

4.2.1 SUQ Participants

Data from 45 returned SUQs were analysed and are presented. Unfortunately, the sample size did not meet the required number for sufficient statistical power (as presented in section 3.3.2), thus statistical analysis results may not be generalisable. The service user participants were aged between 18 and 70 years ($\bar{x} = 44.4$, $SD = 15.9$), 73% were female, and 91% were White British. Over half of the participants (57.8%) were in employment when they took part, with over half of the participants (58.1%) living within 5 miles from the IAPT site where they received their questionnaire pack. For a more detailed description of the participants, please see *Table 29*.

	Frequency (%)	Mean (s.d.)	Range (Min. - Max.)
Age			
18-30	11 (24.3)		
31-40	6 (13.2)		
41-50	10 (22.1)	44.4 (15.9)	52 (18 - 70)
51-60	9 (19.8)		
61+	9 (19.9)		
Gender			
Male	12 (26.7)		
Female	33 (73.3)		
Ethnicity^(a)			
White (British)	41 (91.1)		
White (Other)	2 (4.4)		
Mixed (White & Asian)	1 (2.2)		
Dependent Children?			
Yes	12 (26.7)		
Employment Status			
Employed	22 (48.9)		
Self-Employed	4 (8.9)		
Unemployed (<1 year)	2 (4.4)		
Homemaker	3 (6.7)		
Student	5 (11.1)		
Retired	7 (15.6)		
Unable to Work	2 (4.4)		
Level of Education^(a)			
No qualifications	1 (2.2)		
Secondary School	9 (20.0)		
Sixth Form	13 (28.9)		
Undergraduate	6 (13.3)		
Postgraduate	5 (11.1)		
Specialist qualification	10 (22.2)		
Distance from IAPT Site (miles)^(a)			
< 1	5 (11.6)		
1 – 5	20 (46.5)		
6 – 10	10 (23.3)		
11 – 15	4 (9.3)		
16 – 20	2 (4.7)		
20 >	1 (2.3)		

Notes:

^(a) 1 Service User did not respond to these questions (n=44)

Table 29: Service User Participant Demographic Information (N=45)

Of the 45 participants, 62% had experienced OTT-delivered therapy, 33% utilised F2F contact and 4% of participants used a mixture of delivery modalities during therapy. Approximately half of the service users in this study utilised a Brief CBT intervention. Telephone-based sessions lasted between 2 and 13 sessions ($\bar{x} = 5.9$, $SD = 2.3$), whilst F2F sessions lasted between 2 and 7 sessions ($\bar{x} = 4.7$, $SD = 1.4$). For a more detailed description of the treatment information, please see *Table 30* below.

	Frequency (%)	Mean (s.d.)	Range (Min – Max)
Treatment Modality			
<i>Face-to-Face</i>	15 (33.3)		
<i>Telephone</i>	28 (62.2)		
<i>Both</i>	2 (4.4)		
Number of Treatment Sessions^(a)			
<i>Face-to-Face</i>		4.7 (1.4)	5 (2 - 7)
<i>Telephone</i>		5.9 (2.3)	11 (2 - 13)
Assessment Modality			
<i>Face-to-Face</i>	15 (33.3)		
<i>Telephone</i>	30 (66.7)		
Intervention Type^(b)			
<i>Brief CBT</i>	21 (47.7)		
<i>Guided Self-Help</i>	12 (27.3)		
<i>Pure Self-Help</i>	1 (2.3)		
<i>Behavioural Activation</i>	1 (2.3)		
<i>Psychoeducational</i>	2 (4.5)		
<i>Group</i>			
<i>Not Sure</i>	7 (15.9)		

Notes:

^(a) 2 Service Users did not respond to this question ($n=43$)

^(b) 1 Service User did not respond to this question ($n=44$)

Table 30: Service User Participant Treatment Information (N=45)

4.2.2 SUQ: Statistical Analysis

A series of Mann-Whitney tests and Chi-Square procedures were implemented on likert and binary measure questions from participants who utilised one delivery modality in treatment ($n=43$). Most of the treatment factors questioned within the Service User Questionnaire, as presented in *Table 16* resulted in no significant differences between the groups ($p > .003$ for Mann-Whitney tests; and $p > .025$; for Chi-Square tests).

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Question/Topic	Face-to-Face (n=15)			Telephone (n=28)		
	Median	Mode	Range (Min – Max)	Median	Mode	Range (Min – Max)
<i>Amount of information SU thought they could disclose rating</i>	5.0	5	2 (3-5)	5.0	5	2 (3-5)
<i>Rating of PWP listening to SU</i>	5.0	5	2 (3-5)	5.0	5	2 (3-5)
<i>Rating of how well information was communicated</i>	5.0	5	2 (3-5)	4.5	5	4 (1-5)
<i>PWP comprehension of SU problems rating</i>	5.0	5	2 (3-5)	5.0	5	2 (3-5)
<i>Patient comprehension of information given rating</i>	5.0	5	2 (3-5)	5.0	5	3 (2-5)
<i>Likelihood of clarification needed rating</i>	2.0	2	4 (1-5)	4.0	4	4 (1-5)
<i>Comfort rating</i>	5.0	5	1 (4-5)	5.0	5	3 (2-5)
<i>Relationship rating</i>	5.0	5	1 (4-5)	5.0	5	2 (3-5)
<i>Helpfulness rating</i>	5.0	5	2 (3-5)	4.5	5	3 (2-5)
<i>Likelihood to recommend to others rating</i>	5.0	5	1 (4-5)	5.0	5	4 (1-5)
<i>Likelihood of repeat use rating</i>	5.0	5	3 (2-5)	5.0	5	4 (1-5)
<i>Satisfaction rating</i>	4.5	4	1 (4-5)	5.0	5	3 (2-5)
<i>Rating of the amount of effect privacy has in sessions^{(a)(b)}</i>	n/a	3	n/a	4.0	4	2 (3-5)
<i>Rating of the amount of effect Visual/Non-verbal aspects of communication have in session^{(c)(d)}</i>	1.0	1	4 (1-5)	3.0	2	3 (2-5)
<i>Rating / Comparison to previous experiences in therapy^{(e)(f)}</i>	n/a	1	n/a	4.0	4	4 (1-5)

Notes:

‘SU’ = Service User

Not all service users opted to answer the last three questions in *Table 16*.

- Privacy: ^(a) Face-to-face users (n=1), ^(b) Telephone uses (n=4)
- Non-Verbal Communication: ^(c) Face-to-face users (n=13), ^(d) Telephone uses (n=7)
- Comparison to previous therapy: ^(e) Face-to-face users (n=1), ^(f) Telephone uses (n=5)

Table 31: Service User Participant Treatment Information (n=43)

Using the descriptive statistics, it was overall found that the service users rated all treatment aspects asked within the questionnaire positively in both delivery types. It was also observed that satisfaction ratings from participants were generally high for both delivery modalities, but there was no significant difference between them (F2F: *Mdn* = 4.5; OTT: *Mdn* = 5.0). Similarly, participants rated the relationship with the PWP positively and these ratings did not statistically differ between the treatment modalities (F2F: *Mdn* = 5.0; OTT: *Mdn* = 5.0).

Logistic regression analyses were planned to be implemented to explore whether demographic (e.g. age, gender) and/or treatment factors (e.g. session length) influenced satisfaction or relationship ratings, however this was not possible due to the absence of statistically significant differences in the ratings of satisfaction and relationship. Furthermore, the range of scores for satisfaction was 1 and for relationship was 3, suggesting a relatively homogenous spread of scores.

A large proportion of the participants (88.4%) did not have a concern for privacy when using their modality. On the other hand, approximately half of the service users (48.8%) indicated a concern for the presence or absence of visual and non-verbal cues (NVCs) in communication with their practitioner. *Figure 4* represents the distribution of 'Yes/No' responses from participants between the modalities regarding these two potential concerns.

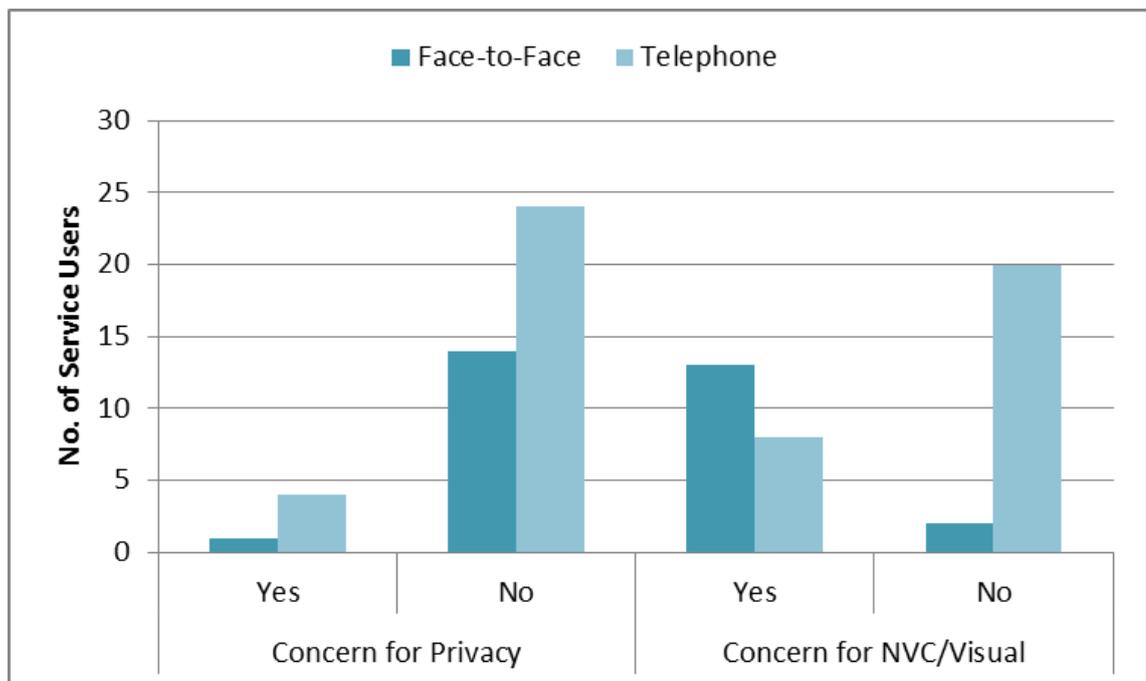


Figure 4: 'Yes/No' response distribution between delivery modalities ($n=43$)

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A significant difference was found in participant ratings for the perceived level of effect visual cues (or NVCs) had in sessions; these were from participants who indicated an initial concern for this communication aspect ($n=21$). F2F users rated that visual and NVCs had very large impact on their treatment experience in session ($Mdn = 1.0$) and this significantly differed from OTT users who rated its impact less ($Mdn = 3.0$), $U = 93.50$, $p < .003$, $r = .70$. Due to the small sample involved, the exact significance value (p) was used. From Pearson's correlation coefficient (r), a large effect size for this ratings difference was noted.

Both modalities provided similar ratings on the likelihood that participants would recommend the modality they used to others (F2F: $Mdn = 5.0$; OTT: $Mdn = 5.0$), however the range in answers (as presented in *Figure 5*) was more extensive for users of OTT in comparison to F2F who noted more favourable ratings, although this spread of scores was non-significant ($p > .003$).

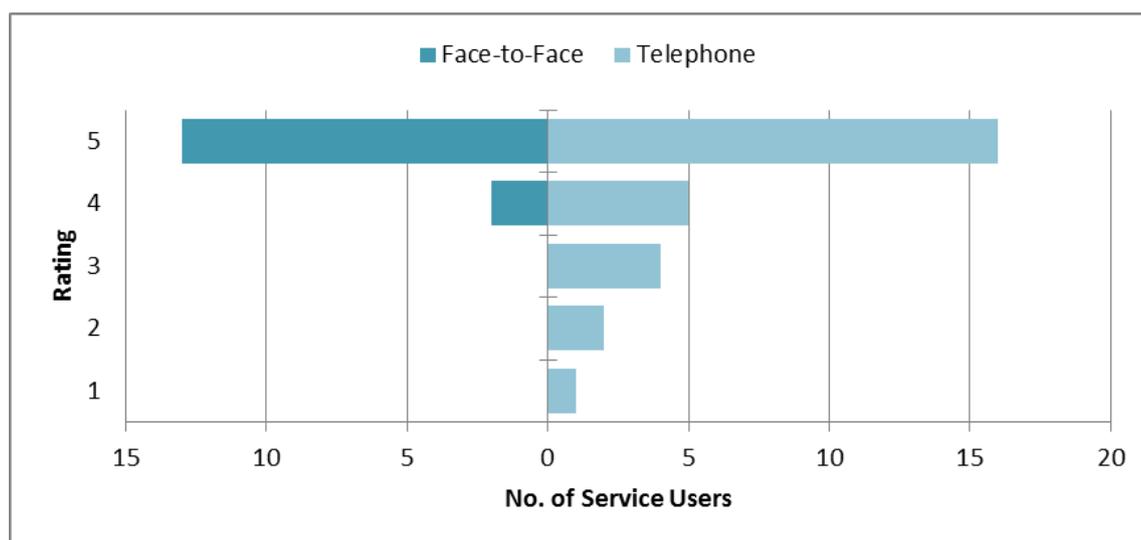


Figure 5: 'Likelihood to recommend to others' ratings ($n=43$)

As only two participants completed their treatment using a mixture of both OTT and F2F delivery, there was not enough data to compute a Wilcoxon rank analysis.

Frequency and Intensity Scoring from Qualitative Data

For purely exploratory purposes, frequency and intensity scoring was carried out on the service user qualitative data and as a result, quantitative data were produced. The rationale behind this was to provide further information regarding the spread of qualitative data in

terms of positive and negative comments regarding the delivery modalities of interest. Qualitative data whereby the service user participants were neutral or mixed were not included. It should also be noted that these quantitative data were not statistically analysed to explore significant differences between the groups.

Firstly, a manual count was carried out regarding the number of advantages and disadvantages service users provided regarding each delivery modality (see *Figure 6*). From this figure, it can be observed that there were a larger proportion of positive comments compared to more negative or disadvantages relating to OTT use. F2F delivery posed similar counts of comments regarding advantages and disadvantages.

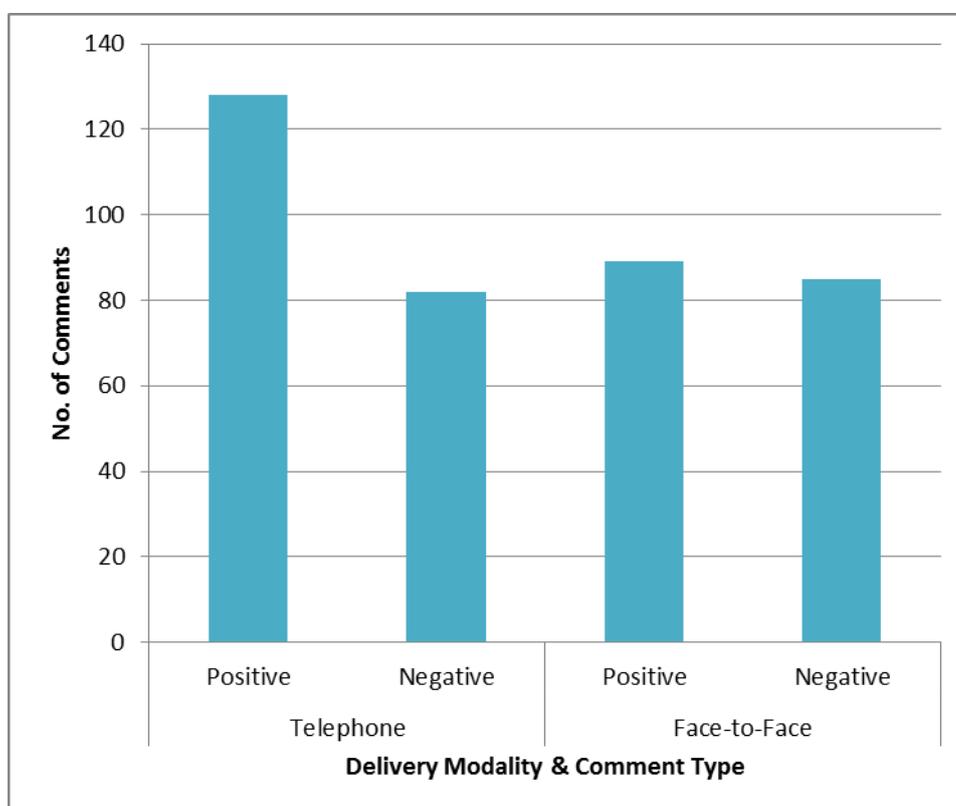


Figure 6: Service User Comments – Overall: Positives and Negatives

It was interesting to observe that a large proportion of comments from older participants (aged 61 years and over) produced more positive comments regarding the OTT modality (44%) when compared to positive comments relating to F2F (14%). Also of interest is that the same age group provided more negative comments regarding the F2F (30%) than positive comments (14%). The reverse trend can be seen amongst the younger age groups – for example, 22% of

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the comments from age group 18 to 30 were negative comments for F2F and 26% of positive comments (please see *Figure 7*).

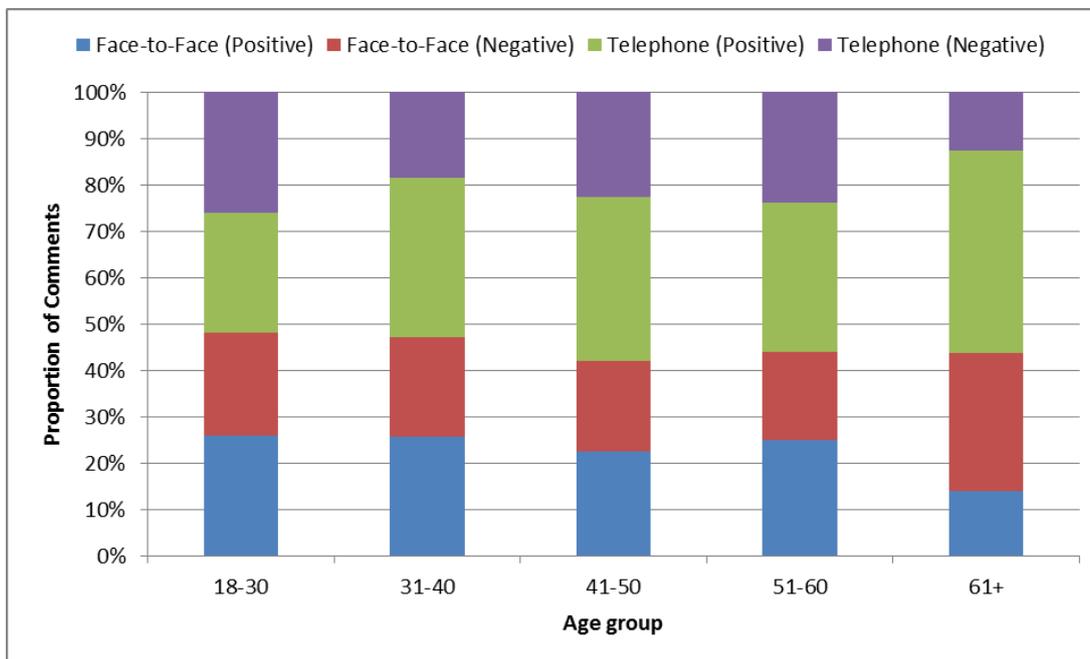


Figure 7: Service User Comments – Organised by: Age Group

When intensity scoring was queried in terms of gender (see *Figure 8*), it can be seen that there was a similar trend for both males and females with regards to the higher proportion of positive comments relating to OTT use when compared to the negative OTT comments. When discussing F2F, both males and females provided almost the same proportion of positive and negative comments.

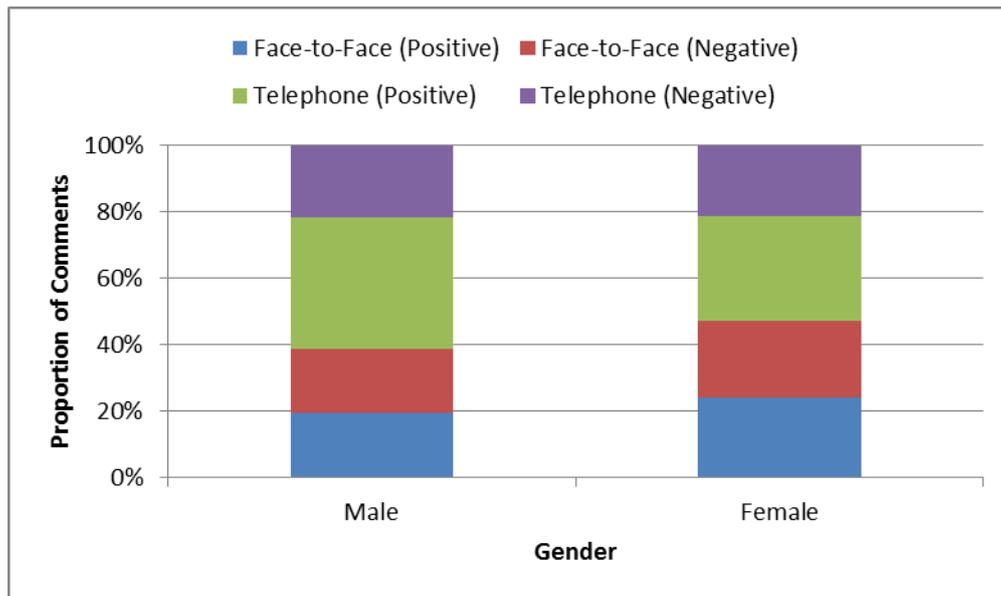


Figure 8: Service User Comments – Organised by: Gender

Figure 9 outlines the proportion of positive and negative comments relating to each delivery type with respect to how far the participant lived from the IAPT site. It was interesting to note that those who lived 20 miles away or further did not provide any positive comments for the F2F modality and over a third of their comments relating to F2F modality being negative.

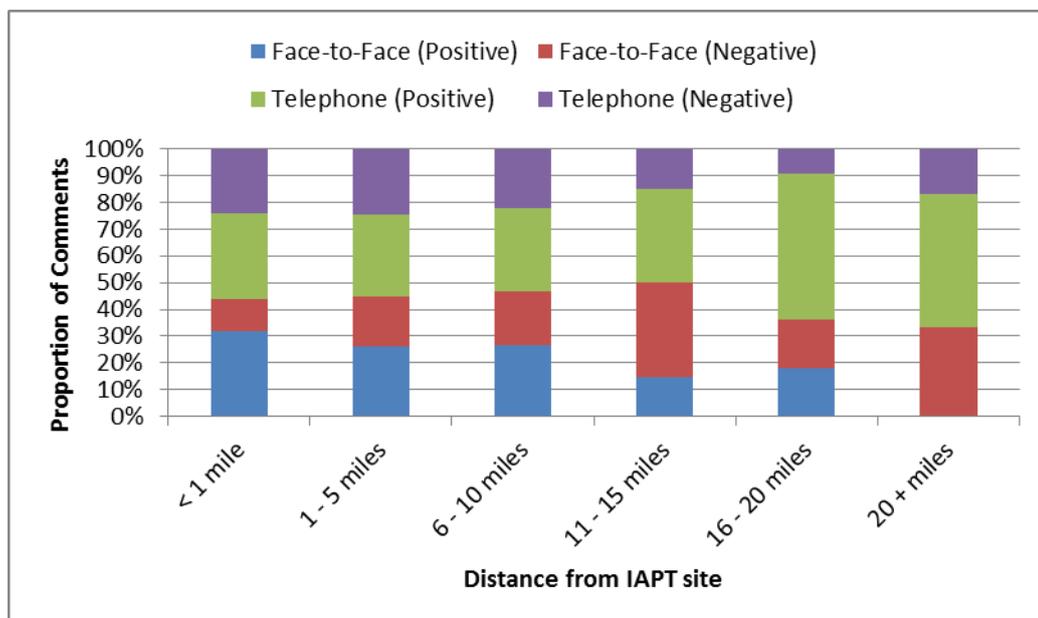


Figure 9: Service User Comments – Organised by: Distance from IAPT site

4.2.3 SUQ: Thematic Analysis

Section B of the SUQ helped to capture qualitative data from service users: their views on the advantages and disadvantages of F2F and OTT use in psychotherapies. All 45 service user participants completed some or all of this section.

Analysis began by coding the data, this initial coding of the data was helped by Deductive Questions (see *Table 17*) which explored particular topics highlighted in the literature, including:

- 1) *The Therapeutic Relationship*
- 2) *Treatment Barriers*
- 3) *Demographic Factors*

From the coded data, patterns were explored and identified to form ‘themes’; these themes helped to highlight important topics using rich descriptions (Braun and Clarke, 2008). In this project, the themes helped to capture the main issues that could arise from using OTT or F2F delivery. 11 main themes became evident during the analysis – one theme which emerged was particularly emotive.

In this section, the themes are presented under the heading of topic deduced from the literature. The examples used to illustrate each theme are quoted as it was written by the participant (*sic erat scriptum*). Each participant was given a pseudonym (see *Table 32*) for a summary of the participants:

'Name'	Age	Delivery Modality
Aaron	50	Telephone
Alison	41	Telephone
Anne	69	Face-to-Face
Anthea	62	Both
Billy	67	Telephone
Carol	43	Face-to-Face
Craig	69	Telephone
Cynthia	53	Telephone
David	69	Telephone
Doug	27	Face-to-Face
Elizabeth	61	Telephone
Emma	38	Telephone
Erin	54	Face-to-Face
Felicity	42	Telephone
Felix	18	Telephone
Gavin	22	Telephone
Geoff	60	Face-to-Face
Gregory	18	Telephone
Harrison	53	Face-to-Face
Helen	43	Telephone
Jack	23	Face-to-Face
Jason	25	Face-to-Face
Jennifer	33	Telephone
Judy	51	Telephone
Kate	27	Telephone
Kimberley	19	Face-to-Face
Larry	46	Telephone
Margaret	66	Telephone
Melissa	23	Telephone
Michael	38	Telephone
Natalie	23	Face-to-Face
Noah	35	Telephone
Olive	70	Telephone
Peter	49	Face-to-Face
Rachel	37	Face-to-Face
Roger	50	Telephone
Rosemary	61	Face-to-Face
Samantha	41	Both
Selena	45	Telephone
Susan	43	Telephone
Tommy	25	Face-to-Face
Vernon	55	Face-to-Face
Victoria	58	Telephone
William	40	Telephone
Yolanda	56	Telephone

Table 32: Service Users who took part in Section B of the SUQ

Therapeutic Relationship

(I) Building a ‘Connection’

In this first theme, service users discussed the potential effect of the delivery modality on their relationship with the practitioner. As highlighted by one of the participants, it was important for a successful and amiable relationship to be formed as it could affect their satisfaction and overall therapeutic experience:

“Not getting on with your counsellor affects good experience”

Cynthia, 53, Telephone

Some of the responses suggested that rapport and trust can only be established in-person and would be absent OTT:

“I think you do need to have some face to face contact to establish rapport & trust

Telephone only would not do this”

Angela, 62, Both modalities

However, one of the participants did note that *“Verbal signs can build up trust”* (Cynthia, 53, Telephone) suggesting that they believed a relationship could be developed by telephone using verbal signals. Conversely, many participants noted that NVCs help to build a relationship; this was further explored in the ‘See who you are talking to’ theme (III):

“Build up trust and rapport – can look in their eyes”

Anthea, 62, Both

In addition, one of the participants posited that in F2F, mutual trust could be formed quicker:

“Perhaps more trust or building trust more quickly”

Susan, 43, Face-to-face

In contrast, for OTT use, service users suggested that you must put trust into the voice you are hearing without knowing who this person was:

"You just have to trust they are who they say they are."

Kate, 27, Telephone

It was noted that despite patients largely praised OTT-support for the ability to stay anonymous with the absence of the visual aspect of communication (see *The 'Mental health taboo' theme VIII*), anonymity was seen as a potential disadvantage when discussing it with regards to building a good rapport with the PWP:

"Although you have a person's name it all feels very anonymous"

Cynthia, 53, Telephone

"I think it is hard to build a relationship with someone you've never met (professional/patient relationship!!)"

Margaret, 66, Telephone

Service users suggested emotional factors and support differed between the two modalities. With F2F, it was suggested that it could be *"more personal"* (*Cynthia, 53, Telephone*) for some individuals or that a stronger connection could be built:

"I feel more connected to the person and get the feeling they are more connected to me"

Rachel, 37, Face-to-face

"I feel when you are face to face you can express your feelings better and build up a bond or relationship with someone"

Harrison, 53, Face-to-Face

In terms of providing emotional support, some service users noted that during F2F, it could be given whenever possible:

"Can be reassured when needed"

Cynthia, 53, Telephone

Conversely, it could be suggested that service users noted the restriction to verbal cues may limit the ability to provide emotional support in OTT use:

“Health professionals can only use words for consoling someone who is upset”

Judy, 51, Telephone

It could therefore come across as *“Impersonal [sic], cold, detached”* (Erin, 54, Face-to-Face) OTT. Moreover, this could lead to some participants feeling lonely in the process:

“It felt distanced and detached... feeling that I was on my own through this really.”

Peter, 49, Face-to-Face

It was further suggested that individuals who were already feeling isolated would benefit from F2F contact:

“Maybe some people might feel even more isolated with their worries and need to be able to actually be face-to-face to have eye contact.”

Craig, 69, Telephone

On the other hand, it was suggested that the therapeutic situation F2F may be *“too personal”* for some (Rachel, 37, Face-to-face).

(II) ‘Understanding and Disclosing’; the exchange of information

This next theme captures service user comments on how the delivery type affects the exchange of information between patient and practitioner; this includes the level of understanding and the amount of information service users wish to disclose.

Service users commented that F2F interaction allowed for better understanding of information communicated during treatment suggesting that *“... a much better understanding between patient & practitioner”* (Victoria, 58, Telephone) could be established. In addition, some participants suggested that they felt more confident that the message they were trying to convey was interpreted correctly by the practitioner:

“...you get a better understanding of whether or not you are conveying your thoughts well.”

Tommy, 25, Face-to-Face

In contrast, some individuals “... found it difficult to clearly explain [my] problems” (Selena, 45, Telephone) when speaking to the practitioner OTT.

One of the service users suggested that a benefit of F2F therapy was that it may allocate “...more time to go through and understand your situation” (Michael, 38, Telephone); session length may differ depending on the intervention used. In addition, the therapeutic time was noted by some service user participants to be a factor related to the comprehension of information.

In terms of information disclosed, service users provided a mixture of advantages and disadvantages, mainly with regards to OTT use. For example, some suggested that using the telephone would allow them to disclose more information:

“I know I can talk freely and he won’t judge me”

Elizabeth, 61, Telephone

“Felt able to talk more easily about personal matters”

David, 69, Telephone

It could be suggested that this increased disclosure in OTT therapy may be due to the reduction of anxieties regarding mental health stigma. This reduction may be due to the increase in anonymity OTT due to the absence of the visual information:

“Some people may find it easier to talk about how they’re feeling over the phone as they cannot see the person.”

Natalie, 23, Face-to-Face

“...might be inclined to tell them more because you can’t see their face”

Zachary, 36, Face-to-Face

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However, one participant noted the anonymity increased reluctance to disclosure as they would *"...find it difficult to talk to someone if I can't see their face, especially about personal information"* (Tommy, 25, Face-to-Face).

In contrast, other service users have noted that they may be less willing or unable to disclose as much information by *"not being able to express yourself properly"* (Carol, 43, Face-to-face) and attributed the restriction of expression to the lack of visual cues in OTT therapy:

"Body language and eye contact missing may have disclosed a little more info face-to-face"

Felicity, 42, Telephone

Indeed, when service users discussed F2F therapy, more positive comments were made suggesting that users are *"...able to express yourself and open up"* (Carol, 43, Face-to-face).

The quote above suggests that individuals can *"open up"* in F2F, which may contradict what other participants may have noted about the modality. However, this may be due to the ability to withhold information. Telephone users suggested that it may be easier to conceal information from the PWP OTT and *"not to be as honest as often as required"* (David, 69, Telephone) which again could be attributed to the absence of visual cues. One participant noted that in F2F, one may not be able to conceal these feelings as easily:

"You can't hide. You might put on a "front" to mask your condition."

Yolanda, 56, Telephone

One participant noted that although it may be distressing to disclose personal information, it is necessary to do so in order to achieve the goals in therapy; thus, in F2F, the decreased chance of this withholding information is beneficial:

"Although it may be sometimes painful it is much more difficult to put up a wall of defence against some of the issues that may be causing or adding to your state of mind"

Victoria, 58, Telephone

Yet one participant commented that with F2F interaction, one may feel less inclined to provide information:

“The person may be overwhelmed and therefore not comfortable to say what they want” Craig, 69, Telephone

(III) ‘See who you are talking to’; the visual aspects of communication

As noted in the previous themes, one key aspect of communication many participants commented on was the visual medium.

Being F2F and in the same room with the PWP was noted by some to be advantageous. This was because you were able to “see who you are talking to” (Rosemary, 61, Face-to-face) and therefore, communication felt more “direct” (Rachel, 37, Face-to-face). One participant speculated:

“You feel like you have seen someone who is going to help you rather than a voice on the end of the phone.”
Kate, 27, Telephone

However, it was suggested that one advantage of the absence of the visual medium in OTT interaction was that “you don’t have to put too much effort in your look” (Rachel, 37, Face-to-face) or it was easier to express their feelings without feeling conscious about how they were expressing themselves physically:

“May find it easier to answer/explain when not being concerned with how you are presenting physically”
Vernon, 55, Face-to-Face

The non-verbal aspect of communication was one of the most prominent issues participants stated regarding the visual medium. The absence of NVCs was suggested as one of the main reasons why OTT use is disadvantageous when compared to F2F; some suggested that this may be important for health professionals:

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“I feel it is important to see patient mannerisms when assessing their needs as this can tell a great deal about their condition”

Victoria, 58, Telephone

“As a high percentage of communication is via Body Language, the healthcare professional “may” lose some of the communication/messages being (attempted) to be given”

Judy, 51, Telephone

“I can see if a person understands me and my facial expression show if I understand him/her”

Rachel, 37, Face-to-face

Service users suggested that non-verbal aspects (e.g. body language and eye contact) help to supplement the information provided verbally and without this the PWP might not be able to fully assess the condition of the service user or to accurately know if the information provided was understood.

However, it was also noted that eye contact may be *“embarrassing”* (David, 69, Telephone) for some and thus this absence of NVCs may be advantageous; this could further link across to theme related to mental health stigma (theme VIII).

Potentially, some service users view the empathy cues from practitioners negatively. Some suggested that it was patronising and thus commended the lack of visual contact OTT:

“Don’t have to worry about patronizing speeches or sympathetic gaze”

Gregory, 18, Telephone

Service users noted that the visual medium had a number of important uses for them. For instance, it was useful for them to aid familiarisation with the practitioner and form a judgement which could affect the likelihood of disclosing information to them:

“...more possibility that you as a patient form an opinion of the therapist because you see them and if for any reason are not happy from the first contact may make you less likely to be honest about how you feel”

Roger, 50, Telephone

They also utilised it to check whether the PWP was responsive and listening intently during their sessions:

“You know that you are getting 100% of your practitioners [sic] attention”

Natalie, 23, Face-to-Face

In OTT, service users found it difficult to judge without the visual medium and some suggested that they were unsure whether the PWP was distracted – potentially impacting on the quality of the therapeutic relationship:

“I had no idea if they were using a computer checking emails or such like whilst listening to me or how interested they really were in my problems”

Helen, 43, Telephone

Another key use for the visual medium was to help service users gauge the reaction of the PWP to the information they disclosed. Some service users noted the importance of this visual feedback, and the lack of it as a disadvantage:

“You can see the therapist’s body language/reactions to what you say”

Helen, 43, Telephone

“Cannot see how what you are saying is being received”

Cynthia, 53, Telephone

On the other hand, some participants felt the absence of visual feedback allowed them to disclose more information; again potentially linked to the ‘*The Mental Health taboo*’ theme (VIII):

"I know I can talk freely"

Elizabeth, 61, Telephone

"You can't see their facial expressions so you don't feel ashamed or worried about what you say."

Melissa, 23, Telephone

The use of the visual medium was also important to some service users who wanted to communicate with physical gestures or through visual cues (e.g. drawings). This was useful in instances when they did not know the correct words required to express their feelings, or simply if they did not wish to speak:

"Can write or signal or draw if feel cannot talk"

Cynthia, 53, Telephone

"I prefer speak/talk face-to-face, because I can explain myself with "hands" as well"

Rachel, 37, face-to-face

"Paperwork can be directly shown and discussed and questions/feedback given"

Judy, 51, Telephone

(IV) 'Verbal Signs' in communication

Service users highlighted the importance of verbal communication due to the absence of the visual medium OTT. For example, in terms of the therapeutic relationship, one participant notes that *"Verbal signs can build up trust"* (Cynthia, 53, Telephone). Moreover, *"...a sympathetic voice encourages communication"* (Margaret, 66, Telephone).

However, verbal cues may prove to be problematic for some users particularly if English is not their first language:

"My English is not as good and I pronounce wrong sometimes [sic]"

Rachel, 37, Face-to-face

Or in terms of conversational turn-taking, it was difficult to identify if it was “...*your turn to speak or if you should stop speaking*” (Cynthia, 53, Telephone); contrastingly, this was not seen as a problem when F2F:

“Not likely to get cut off mid-sentence”

Rosemary, 61, Face-to-face

Participants have also commented on the issue that verbal cues may not be entirely useful during emotional support and perhaps some physical presence is required:

“Health professionals can only use words for consoling someone who is upset – can’t hand over a tissue!”

Judy, 51, Telephone

Treatment Barriers and Demographic Factors

(V) ‘I would not be able to attend’; barriers to treatment

Several practical factors were named as barriers that could prevent service users attending sessions or seeking help. A strong viewpoint from the service users was that OTT-delivery would help to alleviate these barriers.

The first barrier recognised was monetary cost: Telephone use could help eliminate or reduce the financial cost of attending sessions (e.g. travel costs):

“Convenient, no travel costs or time use”

Anthea, 62, Both

On the other hand, one service user noted that OTT therapy could lead to increased costs in phone charges – although it should be noted that the IAPT practice would make contact with service users, therefore this would be the participant speculating:

“A large phone bill!”

Carol, 43, Face-to-face

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In addition, it was suggested that the reliability of the OTT service (or potentially the telephone/mobile device itself) could affect the usefulness of OTT delivery due to *“Technological interference”* (Gavin, 22, Telephone).

The physical health of a service user was also commented as a potential barrier. For instance one of the participants (Victoria, 58, Telephone) stated that ‘she’ had a *“severe spinal problem”* and thus, it was difficult to attend a F2F session (which was their preferred method) and because of this, she was able to see some merit in the use of OTT delivery.

On the other hand, another participant simply stated that due to their medical condition, F2F care was their primary choice and that they were in need of it:

“I have a brain injury. I need face to face”

Geoff, 60, Face-to-face

In addition to physical, a range of psychological, emotional or mental health factors were also cited by service users which lead to a positive or negative outlook for a certain delivery modality use. For example, some suggested that the psychopathology or symptoms which they or others may experience could be aggravated when attending F2F sessions:

“Patients that have deep depression may find it difficult to make the effort to attend an appointment at a set given time”

Victoria, 58, Telephone

“...suffering panic attacks would have been stressed by finding office, parking space, waiting, etc.”

Susan, 43, Face-to-face

“Patient with severe confidence/anxiety issues may avoid service”

Jack, 23, Face-to-Face

One service user noted that F2F sessions could increase the likelihood of non-attendance due to those who may feel uncomfortable discussing their issues in front of another individual:

“If you are nervous of seeing new people or have a phobia of being somewhere new this may cause problems resulting in missed appointments, causing waste of time for professionals.”

Doug, 27, Face-to-Face

Some service users have suggested that it may be easier for them to feel more “relaxed” (Gavin, 22, Telephone) in session or to not experience the initial anxiety or ‘shyness’ upon meeting the PWP for the first time when using the telephone:

“You don’t have initial shyness on 1st meeting”

Cynthia, 53, Telephone

“If you’re shy and don’t feel comfortable speaking face to face it’s a good way of getting across your problems without feeling uncomfortable.”

Kate, 27, Telephone

One participant suggested OTT sessions may be easier to forget when compared to F2F sessions:

“I would not be able to... or remember”

Geoff, 60, Face-to-face

Other factors which may be seen as barriers to treatment were also noted by the service users and was explored in the following themes (VI to IX).

(VI) Location: ‘My comfort zone’

One of the main advantages of OTT-delivered therapy was that service users were not always restricted to a certain location for sessions:

“Don’t have to go to a specific place to meet and be there at a particular time if on mobile”

Cynthia, 53, Telephone

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Some participants also discussed that their distance from the psychological services (e.g. their home location or work travel commitments) or travel difficulties may have impacted their session attendance but OTT delivery allowed them to overcome this barrier:

"I would choose phone because of distance"

Rachel, 37, Face-to-face

"I travel for work but was still able to have the session (once whilst in a quick corner of an airport)"

Susan, 43, Face-to-face

"Very convenient, especially ... without ... a car to travel to appointments"

Jennifer, 33, Telephone

In addition, being in their own chosen location in OTT therapy was suggested to have positive effects on mood in-session, as they were able to feel more comfortable and relaxed. It could be suggested that these positive feelings can be due to the privacy of the location:

"...you can relax in your own home and not worry about the surroundings."

Billy, 67, Telephone

"More relaxed and therefore more receptive when in comfort zone of my own home"

David, 69, Telephone

"Can be somewhere comfortable i.e. home to take call, or somewhere private at work or out and about if necessary"

Cynthia, 53, Telephone

One participant noted that travelling and seeing the practitioner in person outside of their home or chosen location may produce negative emotions:

"Patient may feel hostile in an unfamiliar environment"

Erin, 54, Face-to-Face

“Not having to travel somewhere & getting stressed out with traffic & parking etc.”

Billy, 67, Telephone

On the other hand, service users did suggested that they may be calling in an environment where they are more likely to get distracted:

“On the phone you can do other things while you speak and be distracted”

Rachel, 37, Face-to-face

Conversely, when F2F with the PWP, it was noted that there is little chance of this occurring:

“No distractions which can occur on telephone”

Rosemary, 61, Face-to-face

Nevertheless, it was further commented that being in the same room as the PWP whilst they recorded notes may be off-putting and consequently, a distraction:

“Probably useful not to see them writing notes as you speak”

Felicity, 42, Telephone

Some service users introduced the idea that a close physical proximity with the practitioner could elicit more positive feelings and therefore an increased likelihood of disclosing information:

“I feel more relaxed in the presence of another person than I do alone”

Jason, 25, Face-to-Face

One individual noted an advantage of F2F contact is that it could help provide a division from their ‘issues’ and routine day-to-day activities:

“Somewhere to go where you can safely release you emotions and feeling with someone who is there to help you and remain totally separate from your life”

Harrison, 53, Face-to-Face

(VII) Time: 'It's Convenient'

In this theme, many services users commented on the advantages of OTT-delivered treatments regarding saving time due to its flexibility and convenience in scheduling (or shorter session time frames). Participants noted that using the telephone allowed them to schedule sessions at times best for them without many restrictions on work commitments, childcare commitments, or room availability within the psychological service site:

"It fits in with my busy day"

Elizabeth, 61, Telephone

"Problems of having to arrange time out from work to get appointments..."

Helen, 43, Telephone

"Limited to times when room + counsellor at surgery are available"

Cynthia, 53, Telephone

"Very convenient, especially ... without childcare..."

Jennifer, 33, Telephone

Along with these examples, the terms *"easy to fit in"* (Felicity, 42, Telephone), *"convenient"* (Jennifer, 33, Telephone) and *"flexibility"* (Susan, 43, Telephone) – including stemmed words and similar phrases – were popular amongst the participants when discussing the advantages of OTT use. Conversely, when discussing F2F treatments, *"more time required"* (Judy, 51, Telephone) or similar issues were suggested by the participants as disadvantages.

One service user commented that flexibility and convenience would have a positive impact on the speed of access to OTT-delivered care:

"Telephone delivery enables therapist to start treatment much quicker."

Victoria, 58, Telephone

"Possibly quicker response than waiting for an appointment with a practitioner"

Peter, 49, Face-to-Face

It was also remarked by service users that F2F delivery may offer them more time to discuss their concerns and issues with practitioners, particularly in one-to-one sessions – this may be due to the allocated therapeutic times differing between each intervention type (e.g. guided self-help, Brief CBT, etc.):

“Have time to work through problems or concerns”

Cynthia, 53, Telephone

“...have more time to go through and understand your situation”

Michael, 38, Telephone

It should also be noted that despite a potential advantage in therapeutic time in F2F care, certain limitations may present themselves as barriers (e.g. scheduling issues):

“Limited times when room + counsellor at surgery are available”

Cynthia, 53, Telephone

One service user suggested that telephone use was best used for shorter sessions rather than full sessions:

“...useful for quick catch up sessions... Not good for a normal session”

Zachary, 36, Face-to-Face

(VIII) The ‘Mental health taboo’

Many of the service user participants had noted that the use of OTT services would help reduce their anxieties and the stigma of attending mental healthcare. One individual acknowledged stigma as a key issue:

“Mental health is such an important issue that often carries a taboo”

Jennifer, 33, Telephone

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Many described this in a more discrete manner, with one feeling OTT sessions were “*less embarrassing*” (Rosemary, 61, Face-to-face) than F2F treatment. Moreover, a ‘fear’ or ‘anxiety’ of an acquaintance knowing that they attend mental health support was also often raised. It was commented that this fear would manifest in F2F interventions:

“Fear of being recognised by other persons while in premises”

David, 69, Telephone

Some service users suggested that OTT use helped to alleviate this:

“Reduced my anxiety about being seen at mental health care”

Felicity, 42, Telephone

When seeking or attending mental healthcare OTT, participants attributed a reduction of anxiety or the reduced chance of being “*...embarrassed to see someone you know in the waiting room*” (Kimberley, 19, Face-to-Face) that they could face in F2F sessions due to the maintenance of anonymity from the PWP or other individuals within the community:

“Total privacy especially if live in a small community or work in the NHS where know a lot of people & could be known where you are attending”

Angela, 62, Both

Furthermore, a home location when using the OTT modality was noted to increase the feeling of safety for some service users and confidence that their personal information would remain private:

“Safe in one’s home from prying eyes and away from people who may be inclined to gossip”

David, 69, Telephone

When this theme was discussed in reference to F2F treatment, many participants suggested a negative impact, primarily on the “*loss of anonymity*” (Judy, 51, Telephone) and a reduction in privacy:

“Some people would not be able to have the privacy they would need to get the most out of the service”

Angela, 62, Both

(IX) Feeling ‘Palmed Off’; legitimising face-to-face

Some service users viewed F2F treatment with higher regard compared to OTT treatment. Participants suggested that F2F may be a more legitimate way of delivering psychological therapies:

“It feels more professional to speak face-to-face”

Rachel, 37, Face-to-face

Moreover, some service users suggested that, seeing the practitioner in person made the experience feel “...like you’re talking to a therapist not a friend” (Gregory, 18, Telephone).

This has resulted in one of the participants reacting negatively when allocated to a OTT-delivered service as they felt it would be detrimental to their treatment – particularly feeling that their issues may not have been taken seriously:

“Initially I felt a bit ‘palmed off’ + that the NHS must be making cut backs + why didn’t I merit a face to face appointment... May feel like your concerns/problems are being taken more seriously if you are given a face to face appointment”

Jennifer, 33, Telephone

Indeed, some service users suggested that OTT contact was not appropriate for their issues:

“I did call the service during an anxiety ‘episode’ (to see if I could have an appointment asap) and the telephone was a totally inadequate way to deal with my anxiety at the time.”

Peter, 49, Face-to-Face

After using the OTT modality, one participant noted a feeling that the service, as a whole, may be driven by statistics:

"Feels more like a conveyor belt service, which is good for getting through numbers i.e.: quantity preferable to quality"

Aaron, 50, Telephone

One service user stated that F2F contact felt more "human" (Geoff, 60, Face-to-face) and another noted that they preferred a F2F modality as they were more of a "... 'person' person" (Susan, 43, Face-to-face). A strong comment from one participant suggested that OTT services cannot compare to F2F contact:

"No, always face to face, the telephone service just doesn't do the job for me. I needed to see and relate to another human face"

Peter, 49, Face-to-Face

However, it was acknowledged that not everyone enjoyed such close contact and it actually "...might be too personal" for some people (Rachel, 37, Face-to-face):

"For those who might feel uncomfortable talking face to face with someone, a phone conversation would put that person at ease"

Carol, 43, Face-to-face

Many participants suggested that their initial attitudes and expectations changed once they had begun using the delivery modality:

"I had thought of myself as a 'person' person so was surprised how well telephone delivery worked for me"

Susan, 43, Face-to-face

(X) 'The assessor can...'; Practical factors for practitioners

Practical factors such as improving access (seeing more patients) and the potential safety risks for PWPs during sessions were also remarked by service user participants:

"The healthcare professionals able to have better output or "see more patients""

Judy, 51, Telephone

“Possibly a risk factor for assessor as they do not know the mood of the patients”

Michael, 38, Telephone

It was also considered that in OTT, the PWP was unable to see how the service user was reacting to the information provided and thus would affect their ability to help support or assess the service user:

“They can’t see how you are reacting or if it causes any concern of distress”

Cynthia, 53, Telephone

“The assessor cannot see your face for your expression and mood”

Michael, 38, Telephone

One participant noted that this lack of visual feedback could allow the practitioner to conceal their judgement from the service user which could be of benefit as it has been highlighted that this could elicit more patient disclosure:

“Maybe if the health worker is shocked/annoyed/disappointed in what you have to say it is easier for them to hide their true emotions, compared to face-to-face”

Jennifer, 33, Telephone

Some service users suggested that the use of the telephone would be beneficial for practitioners and their working role with regards to time: *“I guess it saves time and makes assessment quicker” (Samantha, 41, Both)*

(XI) ‘Making the effort’; Part of the treatment process

As previously noted, some participants suggested that the use of the telephone was convenient and helpful for individuals whose psychological condition may prevent them from accessing treatment. For example: *“Patients that have deep depression may find it difficult to make the effort to attend an appointment at a set given time” (Victoria, 58, Telephone).*

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However, it could be noted that OTT contact might maintain the problem, particularly in cases where the psychological condition of the individual relates to a phobia or anxiety of interaction with other individuals in person or an environment external to their own home. Indeed some suggest that it is *“...too easy to stay shut in at home”* (Zachary, 36, Face-to-Face).

On the other hand, some participants suggested that F2F sessions helped them to leave their home:

“Gets me out of the house”

Zachary, 36, Face-to-Face

Furthermore, it allowed them to realise that they are not alone in their situation; as noted in the first theme (*Building a ‘Connection’*) some participants suggested they could feel *“distanced and detached”* (Peter, 49, Face-to-Face) when using the telephone:

“Going to the appointment and seeing others there gives makes you realise you are not the only one in this situation”

Vernon, 55, Face-to-Face

This further reinforces the idea that F2F contact would help alleviate the feeling of isolation:

“Maybe some people might feel even more isolated with their worries and need to be able to actually be face-to-face to have eye contact.”

Craig, 69, Telephone

As previously outlined, some have noted that it may be too distressing to disclose personal information F2F but that this may be necessary for progress:

“...face to face breaks down the barriers easier, you cannot hide your true feelings with face to face contact.”

Aaron, 50, Telephone

4.3 IAPT Outcome Database Results

4.3.1 IAPT Outcome Database Participants

Data from 27 service users who consented to the use of their outcome data were analysed and are presented. Similar to the SUQ, the required sample size was not met and thus statistical results are not sufficiently powered. The participants were aged between 18 and 70 years (\bar{x} = 46.0, SD = 16.0), 70% were females, and all were White British. No service users were on employment support and 18.5% were in receipt of Statutory Sick Pay. Over 59% were given a provisional diagnosis of experiencing Depression, whilst 7% were noted as experiencing a Specific Phobia. See *Table 33* for a more detailed description.

	Frequency (%)	Mean (s.d.)	Range (Min. - Max.)
Age (derived from Date of birth as of 30 June 2014)			
		46.0 (16.0) ^(a)	52 (18 - 70)
Gender			
<i>Male</i>	8 (30)		
<i>Female</i>	19 (70)		
Ethnic Category			
<i>White British</i>	28 (100)		
<i>Other</i>	0		
Provisional diagnosis (using ICD-10 codes)			
<i>Depression</i>	16 (59.3)		
<i>GAD</i>	6 (22.2)		
<i>Panic Disorder</i>	3 (11.1)		
<i>Specific Phobia</i>	2 (7.4)		
Employment support indicated			
<i>Yes</i>	0		
<i>No</i>	27 (100)		
Receiving Statutory sick pay (SSP)			
<i>Yes</i>	5 (18.5)		
<i>No</i>	22 (81.5)		

Note

^(a) 1 service user did not provide a date of birth and thus age could not be derived ($N=26$)

Table 33: Service User Demographic Information ($N=27$)

Of the 27 participants, a larger proportion (67%) utilised the OTT modality. Approximately 93% of participants were noted as ‘completers’ at the end of their IAPT contact, whilst the remainder ‘declined’ to continue – it should be noted that the ‘completers’ group could not be

distinguished with regards to ‘case complete’ or ‘agreed ending’ (see section 1.3.1). Guided Self-Help was the most popular intervention technique (63%), whilst Brief CBT had the least number of participants (7%). *Table 34* below presents the treatment characteristics.

Overall, across all participants, the mean session length was 6.4 ($SD = 2.1$). Between the individual delivery modalities, the mean number of sessions for F2F users averaged at a mean of 6 sessions ($SD = 3.0$), whilst OTT users averaged at a mean of 6.4 ($SD = 1.8$).

	Frequency (%)	Mean (s.d.)	Range (Min. - Max.)
Modality			
<i>Face-to-Face</i>	9 (33.3)		
<i>Telephone</i>	18 (66.7)		
Intervention			
<i>Guided Self-Help</i>	17 (63.0)		
<i>Psychoeducational Group</i>	4 (14.8)		
<i>Behavioural Activation</i>	4 (14.8)		
<i>Brief CBT</i>	2 (7.4)		
Reason for end of IAPT care pathway			
<i>Completed</i>	25 (92.6)		
<i>Declined</i>	2 (7.4)		
Number of Sessions			
		6.4 (2.1)	10 (3 - 13)

Table 34: Treatment Characteristics (N=27)

4.3.2 IAPT Outcome Database: Statistical Analysis

A series of Wilcoxon tests was implemented on the psychometric instruments data collected from the IAPT outcome database. A Bonferroni correction was applied to the significance level due to the number of Wilcoxon tests carried out ($\alpha=.004$).

Regarding the PHQ-9, there was a reduction in symptoms of participants using the F2F modality from when they started at IAPT ($Mdn = 17.0$) to when they finished ($Mdn = 4.0$), however this was non-significant ($T = 1.5$, $p=.013$). In contrast, there was a statistically significant difference in the PHQ-9 scores from users who utilised the telephone, from $Mdn = 14.5$ to $Mdn = 3.5$, $T = .000$, $p<.004$, $r = -.88$. From the calculated Pearson’s correlation coefficient (r), there was a large effect size for this difference observed.

A similar pattern emerged from the GAD-7 scores whereby there was a non-significant reduction in scores of F2F users from $Mdn = 13.0$ to $Mdn = 4.0$ ($T = .000$, $p = .011$) whilst there was a significant reduction in scores from the first score noted ($Mdn = 12.5$) to the last score ($Mdn = 3.0$), $T = .000$, $p < .004$, $r = -.85$; from this there was also a large effect size observed.

In addition, from the Social Phobia Scale data, there was an overall reduction in scores across both modalities, although for OTT users there was a statistically significant reduction in scores from their first ($Mdn = 2.0$) to their last ($Mdn = 0$), $T = .000$, $p < .004$, $r = -.73$ and a large effect size was calculated for this difference. It should be noted that these statistically significant differences are from a small sample size and should be interpreted with caution.

For the remaining instruments (the W&SAS, Agoraphobia scale, and Specific Phobia scale), participants in both modalities saw a reduction in their scores. These reductions were statistically not significant ($p > .004$).

Logistic regressions were run to explore whether a reduction in scores was related to factors such as the number of sessions, age and gender – they returned a non-significant result ($p > .05$), this may be due to not having enough data points because of the number of participants recruited dropping below the number required for sufficient statistical power.

Table 35 presents the mean scores for each psychometric instrument explored in this part of the analysis. Across both modalities, there was a reduction in scores from first to last for all instruments.

Psychometric Instrument	Face-to-Face (<i>n</i> =9)			Telephone (<i>n</i> =18)		
	Mean First Score (s.d.)	Mean Last Score (s.d.)	Mean Difference (s.d.)	Mean First Score (s.d.)	Mean Last Score (s.d.)	Mean Difference (s.d.)
<i>PHQ-9 score</i>	13.3(7.9)	4.1(2.4)	-9.2 (6.4)	14.5 (6.4)	4.6 (4.1)	-9.9 (4.9)
<i>GAD-7 score</i>	10.7(5)	4.4(2.6)	-6.2 (3.5)	11 (5.2)	2.7 (2.1)	-8.3 (4.8)
<i>W&SAS score</i> ^(a)	16.9(9.5)	6.8(4.7)	-10.1 (9.2)	16 (10.8)	7.3 (8.7)	-10.4 (10.3)
<i>Agoraphobia score</i>	2.9(2.5)	1(1.0)	-1.9 (2.6)	2.3 (2.2)	1.2 (1.3)	-1.2 (2.2)
<i>Social Phobia score</i>	2(2.0)	1(1.0)	-1.0 (1.8)	2.5 (2.2)	0.8 (1.2)	-1.7 (1.8)
<i>Specific Phobia score</i>	1.1(1.4)	0.7(1.1)	-0.4 (0.7)	2.6 (2.4)	0.9 (1.5)	-1.7 (2.3)

Note

^(a) 2 Telephone users did not complete their first W&SAS score (*n*=16)

Table 35: Mean values for first and last score, and the difference between these scores

A high proportion of F2F participants saw a reduction in their scores from the PHQ-9, GAD-7 and W&SAS instruments (at approximately 89%). In contrast a higher proportion of OTT users saw a reduction in PHQ-9 scores (100%) and GAD-7 (94%), but a similar rate in W&SAS scores (81%). The proportion of users who have experienced a reduction in IAPT Phobia Scale scores (Agoraphobia, Social Phobia and Specific Phobia) were largely similar across both modalities ranging from 55% to 66%. *Figures 10 and 11* illustrate these trends.

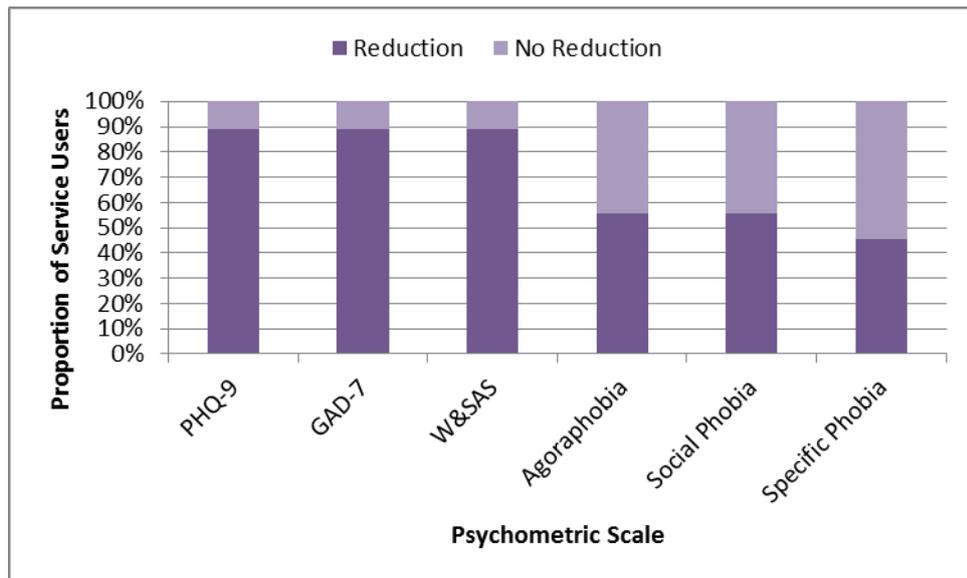
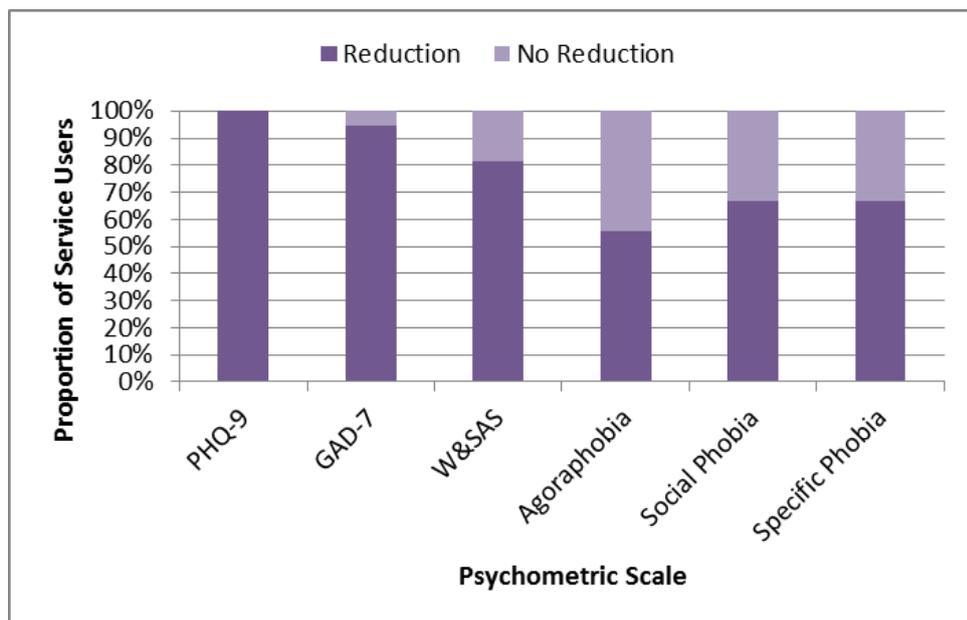


Figure 10: Proportion of Face-to-face users with a reduction in score at last measurement from first measurement ($n=9$)



Note

(a) 2 Telephone users did not complete their first W&SAS score ($n=16$)

Figure 11: Proportion of Telephone users with a reduction in score at last measurement from first measurement ($n=18$)^(a)

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Exploring these score reductions further, *Figures 12 and 13* illustrate the proportion of participants whose score had reduced since their first measurement and that the last measurement is below 'clinical caseness' (i.e. below the cut-off points of the psychometric instruments – see *Box 5* for the criteria used for analysis).

PHQ-9 – scores of 10 and above
GAD-7 – scores of 8 and above
W&SAS – scores of 11 and above^(a)
IAPT Phobia Scales – scores of 4 and over

Note:

^(a) IAPT does not have a clinical cut-off point for the W&SAS, although scores 11 and over are noted to be of 'significant functional impairment', whilst scores of 0 to 10 are 'subclinical' (Mundt *et al.*, 2002, p. 465).

Box 5: Clinical cut-offs for caseness – used for this analysis (see section 1.3.1)

All F2F users who had a reduction of scores on the PHQ-9 fell below caseness; in comparison only 89% of OTT users whose PHQ-9 scores improved fell below caseness. A higher proportion of OTT users with a reduction in GAD-7 and W&SAS scores fell below caseness (94% and 85%, respectively) when compared to F2F users (86% and 75%). A high proportion of users from both modalities who had a reduction in IAPT phobia scales scores fell below caseness (between 91% and 100%).

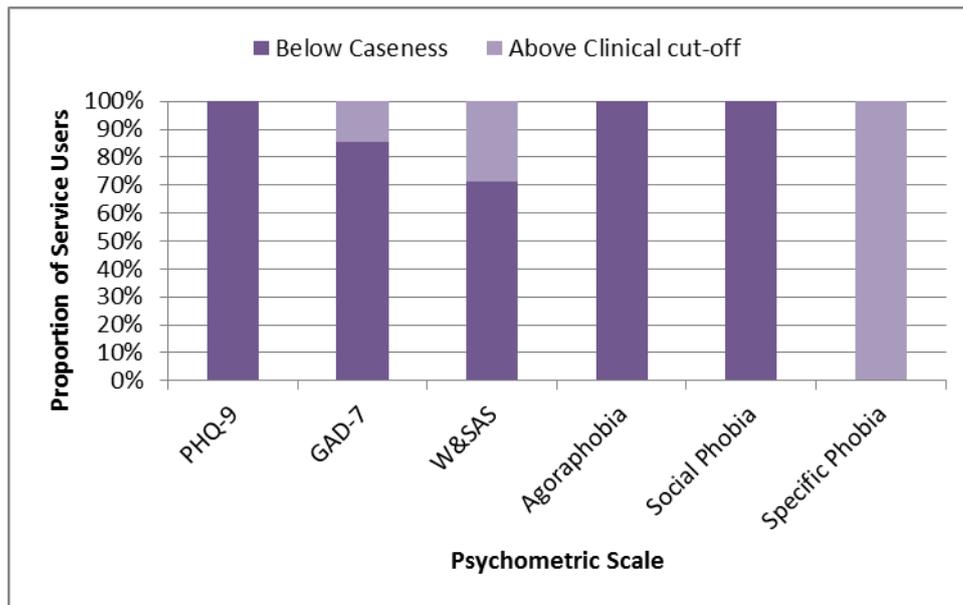
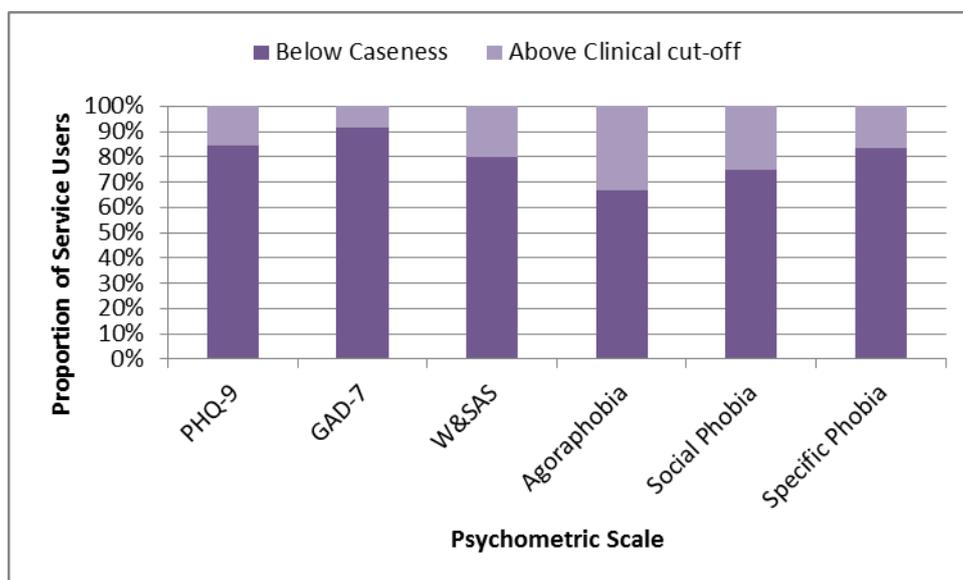


Figure 12: Proportion of Face-to-face users with a reduction in score at last measurement from first measurement and are below 'clinical caseness' (n=9)



Note

(a) 2 Telephone users did not complete their first W&SAS score (n=16)

Figure 13: Proportion of Telephone users with a reduction in score at last measurement from first measurement and are below 'clinical caseness' (n=18) (a)

4.4 Psychological Wellbeing Practitioner Questionnaire (PWQ) Results

4.4.1 PWQ Participants

Data from 30 returned PWQ were analysed and are presented in this section. 13 of the PWP participants worked with OTT and F2F delivery modalities, 12 with only OTT and five with only F2F.

Modality	Frequency (%)		
	Modality Worked With ^(a)	Modality Preference ^(b)	Patient Modality Preference ^(c)
<i>Face-to-Face</i>	5 (16.7)	14 (56.0)	23 (82.1)
<i>Telephone</i>	12 (40.0)	11 (44.0)	4 (14.3)
<i>Both</i>	13 (43.3)	-	-
<i>Other</i>	-	-	1 (3.6) ^(d)

Notes:

- (a) All PWP participants completed this question ($N=30$)
- (b) 5 PWP participants left this question incomplete ($n=25$)
- (c) 2 PWP participants left this question incomplete ($n=28$)
- (d) *Other* modality was indicated as 'Internet delivery'

Table 36: Overall PWP Participant Modality Preferences

Table 36 presents the overall PWP responses when asked, between OTT and F2F, which delivery modality was preferred. It can be seen that a higher proportion of PWP participants indicated a preference for the F2F modality (56.0%). This was similarly observed when PWPs were asked which delivery modality patients are most likely select (82.1%). One participant noted that patients may prefer the use of internet delivered therapy.

4.4.2 PWQ: Statistical Analysis

All PWP Participants

In this first part, all PWP responses presented in Table 23 regarding treatment modality preference, and most popular modality likely to be selected by patients were analysed using the Chi-Square method. There were no significant differences between the groups and their selections ($p > .015$).

Figure 14 illustrates that, of practitioners who answered this question, there was a 50% split in preference for F2F and OTT between PWP with both modalities. There was a higher proportion of OTT users who selected telephone as their preferred modality. In contrast, there were no F2F users who selected telephone as a preferred modality.

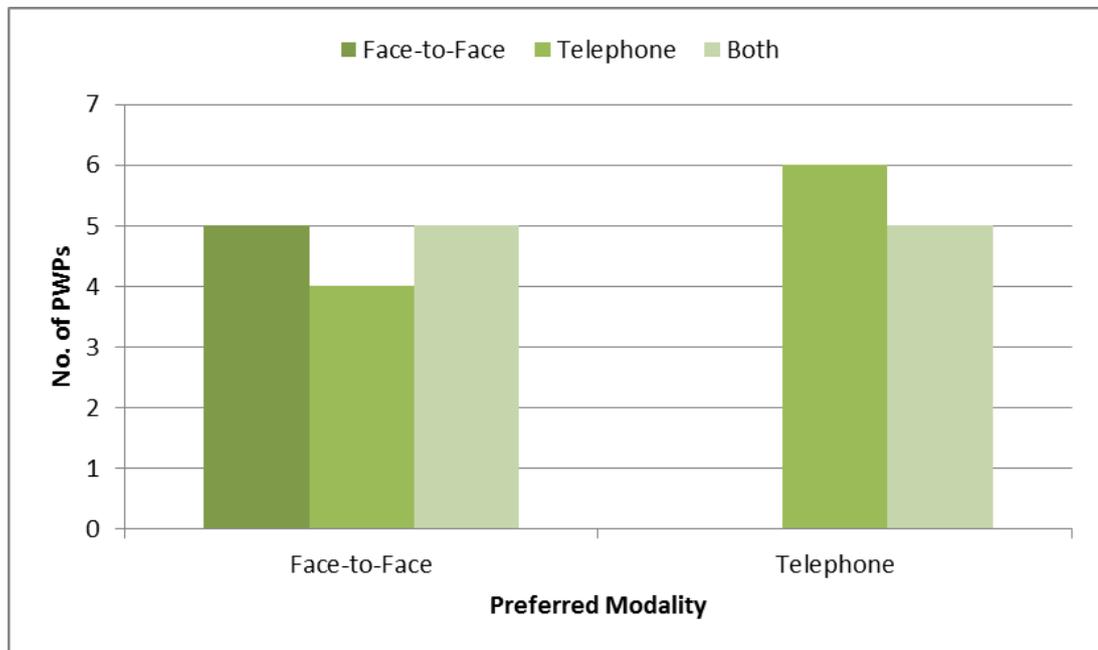


Figure 14: PWP Modality Preference ($n=25$)

Figure 15 illustrates that, of those who completed the question relating to PWP perception of patient modality preference, none of the F2F users selected the telephone. Meanwhile, a larger number of OTT chose F2F. Similarly, practitioners who have worked with both modalities also selected F2F as their most preferred medium.

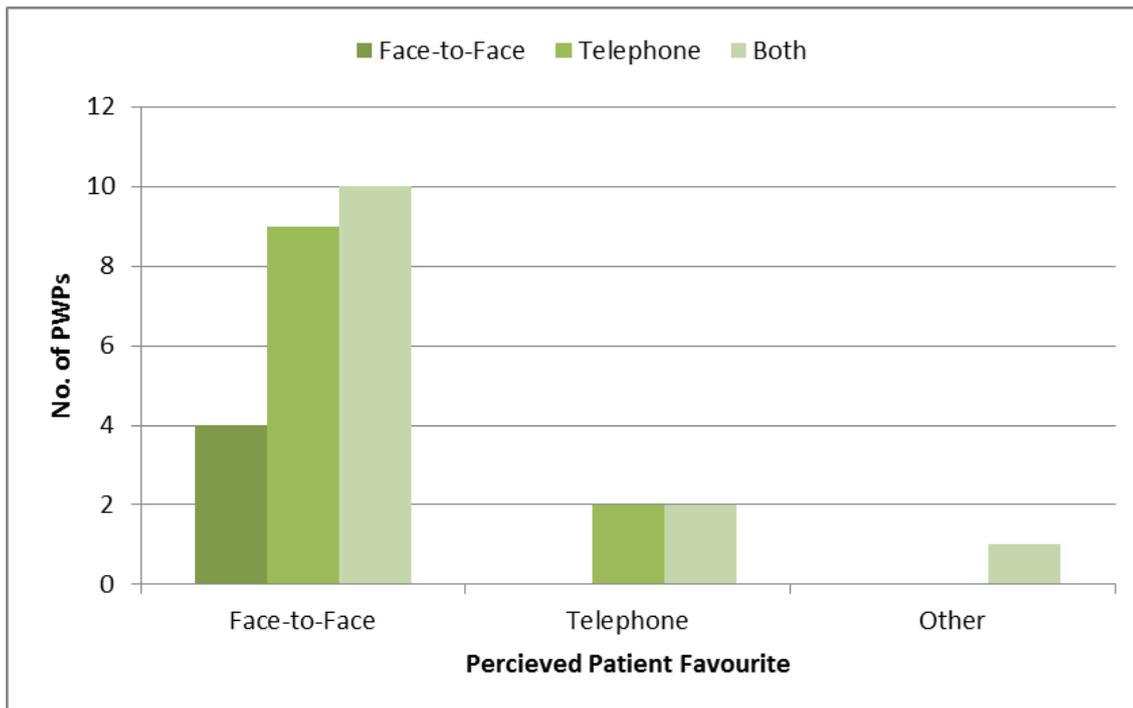


Figure 15: PWP thoughts on patient modality preference (n=28)

PWPs working with One Delivery Modality

In these analyses, likert scores from PWP participants who worked with one delivery modality (n=17) were analysed. Mann-Whitney tests were carried out. Similar to the SUQ, most of the treatment factors measured within the PWQ (see Table 23) resulted in no significant difference in ratings between the groups ($p > .003$).

Question/Topic	Face-to-Face (n=5)			Telephone (n=12)		
	Median	Mode	Range (Min – Max)	Median	Mode	Range (Min – Max)
<i>Patient Engagement in sessions rating</i>	4.0	2	3 (2-5)	4.0	4	2 (3-5)
<i>Patient Adherence in sessions rating</i>	3.0	4	3 (1-4)	2.5	2	3 (1-4)
<i>Satisfaction of Patient Progress rating</i>	4.0	2	3 (2-5)	4.0	4	1 (4-5)
<i>Likelihood of relapse rating</i>	3.0	3	1 (3-4)	4.0	4	3 (2-5)
<i>Patient information disclosure rating</i>	5.0	5	3 (2-5)	5.0	5	1 (4-5)
<i>Ease of PWP comprehension rating</i>	5.0	5	3 (2-5)	5.0	5	3 (2-5)
<i>Amount of PWP information given rating</i>	4.0	5	4 (1-5)	5.0	5	1 (4-5)
<i>Ease of explaining information rating</i>	4.0	5	4 (1-5)	4.0	4	4 (1-5)
<i>Patient comprehension of information provided rating</i>	4.0	4	3 (2-5)	4.0	4	1 (4-5)
<i>Likelihood of patient requiring more explanation rating</i>	3.0	3	2 (1-3)	3.0	3	3 (2-5)
<i>Comfort rating</i>	2.0	1	4 (1-5)	5.0	5	1 (4-5)
<i>Level of empathy conveyed rating</i>	4.0	4	4 (1-5)	4.0	4	3 (2-5)
<i>Rapport rating</i>	4.0	4	4 (1-5)	5.0	5	3 (2-5)
<i>Treatment scheduling rating</i>	5.0	5	4 (1-5)	5.0	5	1 (4-5)
<i>Modality satisfaction rating</i>	4.0	1	4 (1-5)	4.5	5	4 (1-5)
<i>Level of visual/non-verbal effect in sessions^(a) rating</i>	4.0	2	3 (2-5)	2.5	2	2 (2-4)

Note:

^(a) Not all 'Telephone' users selected that they were concerned with the absence/presence of visual/non-verbal cues during communication with the patient (n=8)

Table 37: Median, Mode and Range values of ratings from PWP participants working with 1 delivery modality (n=17)

From *Table 37* it can be observed that both PWP groups rated aspects of the treatment process similarly. For example, both groups gave high ratings for overall satisfaction when working with one of the delivery modalities (F2F: *Mdn* = 4.0; OTT: *Mdn* = 4.5), as well as their rapport quality with patients (F2F: *Mdn* = 4.0; OTT: *Mdn* = 5.0). However, similar mid-to-low ratings were given by PWPs in terms of the likelihood that patients require more explanation (F2F: *Mdn* = 3.0; OTT: *Mdn* = 3.0) and patient adherence (F2F: *Mdn* = 3.0; OTT: *Mdn* = 2.5).

Face-to-face users rated comfort lower ($Mdn = 2.0$) than PWP who worked OTT ($Mdn = 5.0$). However, there was a non-significant difference; $U = 7.00, p = 0.14$.

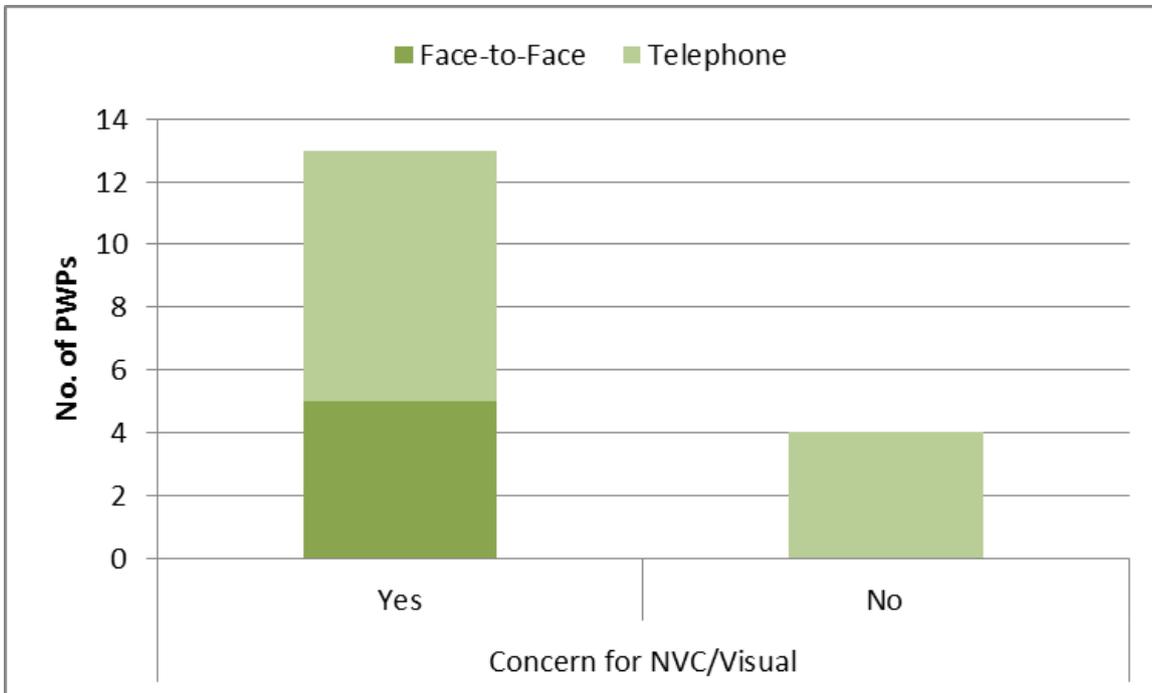


Figure 16: PWP participants working with 1 delivery modality - Concern for Visual / NVC ($n=17$)

From Figure 16, it is represented that there was a high proportion of PWP who work with one delivery type that indicated some concern or importance to visual and NVCs in communication. A Chi-Square test produced no significant differences between the two groups ($p > .015$).

PWPs working with Both Delivery Modalities

For this part of the statistical analysis, the likert scores from PWP participants who worked with both delivery modalities ($n=13$) were analysed by a series of Wilcoxon procedures. There were no significant differences in ratings between the two modality types ($p > .003$).

Overall, ratings were largely similar across the topics addressed in the questionnaire (see Table 38). For example, satisfaction was rated highly in both modalities (F2F: $Mdn = 4.0$; OTT: $Mdn = 4.0$); this was also found when PWP had rated rapport (F2F: $Mdn = 5.0$; OTT: $Mdn = 4.0$) and

the level of empathy they believed they could convey to the patient (F2F: *Mdn* = 5.0; OTT: *Mdn* = 5.0).

Question/Topic	Face-to-Face			Telephone		
	Median	Mode	Range (Min – Max)	Median	Mode	Range (Min – Max)
<i>Patient Engagement in sessions rating</i>	4.0	4	2 (2-4)	4.0	4	3 (2-5)
<i>Patient Adherence in sessions rating</i>	4.0	4	2 (2-4)	3.0	4	2 (2-4)
<i>Satisfaction of Patient Progress rating</i>	4.0	4	2 (2-4)	4.0	4	2 (3-5)
<i>Likelihood of relapse rating</i>	3.0	3	2 (2-4)	3.0	3	3 (2-5)
<i>Patient information disclosure rating</i>	4.0	4	1 (4-5)	5.0	5	3 (2-5)
<i>Ease of PWP comprehension rating</i>	5.0	5	2 (3-5)	4.0	4	3 (2-5)
<i>Amount of PWP information given rating</i>	5.0	5	1 (4-5)	4.0	4	3 (2-5)
<i>Ease of explaining information rating</i>	5.0	5	1 (4-5)	4.0	4	4 (1-5)
<i>Patient comprehension of information provided rating</i>	4.0	4	3 (2-5)	4.0	4	3 (2-5)
<i>Likelihood of patient requiring more explanation rating</i>	2.0	2	3 (1-4)	3.0	4	4 (1-5)
<i>Comfort rating</i>	4.0	4	4 (1-5)	5.0	5	3 (2-5)
<i>Level of empathy conveyed rating</i>	5.0	5	1 (4-5)	5.0	5	2 (3-5)
<i>Rapport rating</i>	5.0	5	1 (4-5)	4.0	5	3 (2-5)
<i>Treatment scheduling rating</i>	3.0	2	4 (1-5)	5.0	5	3 (2-5)
<i>Modality satisfaction rating</i>	4.0	5	4 (1-5)	4.0	5	3 (2-5)
<i>Level of visual/non-verbal effect in sessions^(a) rating</i>	4.0	4	2 (3-5)	3.0	3	1 (2-3)

Notes:

^(a) Not all 'Both' participants selected that they were concerned with the absence/presence of visual/non-verbal cues during communication with the patient (*n*=11)

Table 38: Median, Mode and Range values of ratings from PWP participants working with both delivery modalities (*n*=13)

PWPs valued that it was easier to explain information to patients F2F (*Mdn* = 5.0) when compared to OTT (*Mdn* = 4.0). Moreover, PWPs who worked with both modalities also rated that the amount of information disclosed by the patient was marginally higher F2F (*Mdn* = 5.0) than OTT (*Mdn* = 4.0).

In terms of the ease of scheduling treatments, PWPs working with both modalities rated that it was easier OTT (*Mdn* = 5.0) and higher than their scores in F2F work (*Mdn* = 3.0), however there was also a non-significant difference; $T = 9.00, p > .003$.

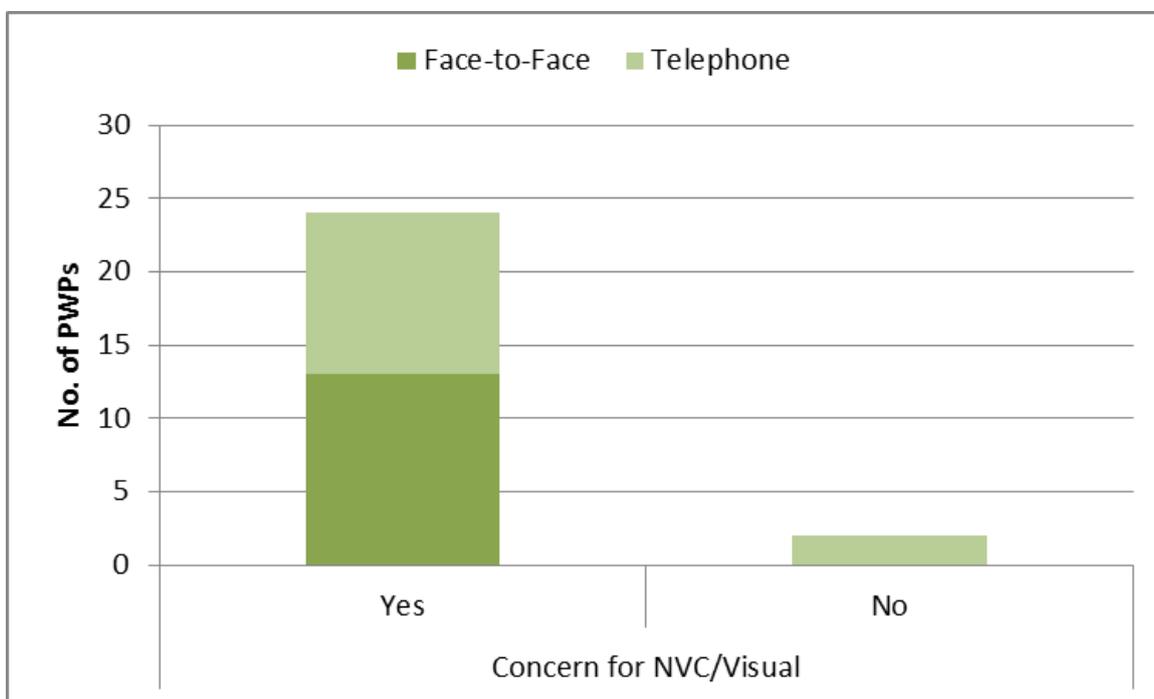


Figure 17: PWP participants working with both delivery modalities - Concern for Visual / NVC (n=13)

Figure 17 illustrates whether PWPs indicated some concern with the absence/presence of visual cues and NVC when delivering psychological therapies via OTT or F2F. In addition, the Chi-Square test produced no significant differences between the two modalities ($p > .015$).

From the PWPs who expressed a concern regarding visual and NVC cues (n=11), it was rated that OTT, visual cues (or in this case, a lack of these cues) had a more negative impact on communication in sessions (*Mdn* = 3.0) when compared to their more positive rating of it in

F2F (Mdn = 4.0). The differences in ratings were shown to be non-significant, $T = 45.00$, $p > .003$.

4.4.3 PWQ: Thematic Analysis

Out of the 30 PWP participants, 27 completed the free text question in Section B.

Similar to the SUQ, initial coding of the PWP qualitative data was also guided by topics which were deduced from the literature (see *Table 24*) which included:

- 1) *The Therapeutic Relationship*
- 2) *Treatment Barriers*
- 3) *Clinical practice/working approach*

Ten main themes and four sub-themes were constructed from the analysis to help describe the main topics highlighted by PWPs with regards to the benefits and difficulties of working F2F or OTT. Randomly allocated pseudonyms were given to each participant as demographic information was not collected from this participant group (see *Table 39* for a list of participant pseudonyms used). It should also be noted that within the analysis, the terms 'patient' and 'client' are used interchangeably with 'service user' as these terms were used by the PWP participants.

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'Name'	Delivery Modality
Alex	Both
Ashley	Telephone
Bailey	Both
Billie	Telephone
Cameron	Face-to-Face
Chris	Both
Danny	Both
Drew	Telephone
Dylan	Face-to-Face
Elliot	Telephone
Frankie	Telephone
Gerry	Telephone
Hayden	Telephone
Jamie	Face-to-Face

'Name'	Delivery Modality
Jesse	Both
Joey	Both
Jordan	Both
Kim	Both
Lee	Both
Max	Both
Nic	Both
Pat	Telephone
Reese	Telephone
Robin	Telephone
Sam	Face-to-Face
Terry	Both
Vic	Telephone

Table 39: PWPs who took part in Section B of the PWQ

The Therapeutic Relationship

(I) 'Forming and maintaining rapport'

The first theme from the PWP data regards the formation and maintenance of the therapeutic relationship.

A mixed view of whether rapport can be affected by the delivery modality used has been noted from the PWP responses. Some have suggested that a bond can be formed quicker in-person and that this alliance can be more robust and easier to sustain:

"Benefits to face to face – rapport is easier to form & maintain"

Robin, Telephone

"...is easier to develop a stronger therapeutic alliance"

Pat, Telephone

"I imagine people will feel more of a connection"

Jamie, Face-to-face

However, many have found no difference in the development of a patient-PWP relationship when using the OTT:

"I feel rapport is easily developed in the same way as F2F"

Hayden, Telephone

"I find it easy to build a rapport with patients on the phone"

Robin, Telephone

Whilst participants suggested that they can convey empathy through both modalities; some commented that it was more difficult to communicate and sense empathy OTT when compared to F2F – this may be attributed to the lack of the visual aspects of communication:

"I also feel more empathy F2F"

Sam, Face-to-face

“...the work is less ‘emotionally draining’ over the phone”

Pat, Telephone

In one instance, the reduction in affect felt by the PWP has been attributed to their working environment which suggests that distractions in the environment may affect this aspect of emotional communication:

“It is also easier to feel less involved/affected by a person’s distress when delivering telephone sessions, especially when working in a busy office”

Jordan, Both

(II) ‘Visually see the patient’; visual aspects of communication

The loss of visual cues in OTT use and its effects on communication was also highlighted by many of the PWP participants. Firstly, some PWPs have emphasised the importance of visual cues:

“In my experience I feel the visual cues are very important when engaging with a patient”

Jesse, Both

PWP participants noted that the lack of NVCs may prevent them from being able to assess emotions and the mood of the patient effectively:

“Telephone harder to pick up on body language, emotions [sic]”

Alex, Both

On the other hand, PWPs commented that NVCs in F2F delivery may help accurately evaluate patient symptoms:

“As non verbal cues and facial expressions can be helpful and being able to see someone face to face enables practitioners to assess severity of depression”

Elliott, Telephone

“...because you are able to pick up on non-verbal cues that assist in your understanding of the client”

Pat, Telephone

In contrast, the absence of NVCs have been commented as beneficial for the patients who may be distracted or feel less inclined to be open if they can see the reactions of the PWP – this is linked to the perceived stigma associated with accessing mental health treatments which are outlined in the ‘Talking to a stranger’ theme (VIII):

“Clients often feel more comfortable offering more information about themselves over the phone, without noticing non-verbal reactions from the practitioner”

Danny, Both

One interesting aspect captured from the PWP data regarded the view that without the visual medium, they felt less judgement by the patient based on their appearance – particularly when related to their level of experience or age:

“We do not get to visually see what our pts [patients] look like and they don’t see us either. I think this has a really positive effect on both PWPs + pts making judgements about each other. It is very easy to make negative judgements about others because of their appearance”

Nic, Both

“...often get comments made about my age or level of experience when meeting patients face to face”

Robin, Telephone

One issue which PWPs have noted during OTT use is that they are unable to use visual cues or resources to help explain information to patients which seem largely beneficial in F2F, particularly for individuals who require extra attention – this is linked to the ‘Understanding and Following Tasks’ theme (IV(a)) as the explanation of information could be limited with only verbal cues:

“Face to face easier to explain/show self-help materials”

Alex, Both

“It is often easier to explain using diagrams and other visual aids (for those with learning difficulties or where English is not their first language)”

Danny, Both

“Explaining info is much easier to use written materials or a white board”

Joey, Face-to-face

The use of visual prompts and resources is linked to the ‘resources to hand’ theme as PWP have expressed that these visual resources can be sent to OTT users. However there may be limitations in terms of the timing of receipt of these resources (see theme X).

(III) ‘Verbal Competencies’ in communication

With the absence of visual cues, some PWPs highlighted that they were aware that verbal cues and communication would need to be improved and focussed on when using the OTT modality to ensure that good rapport is established and they are able to convey empathy without visual cues:

“You have to be aware of verbal empathy much more on telephone”

Frankie, Telephone

“Rapport is great – again, it is down to the verbal competencies, being empathetic and showing understanding”

Reese, Telephone

(IV) ‘Clients engage well with both modalities’

This theme related to PWP comments on patient engagement in therapy and whether the delivery modality can affect this. Most PWPs suggest that engagement is not affected by the modality:

“I find that clients engage well with both modalities”

Danny, Both

“I don’t think patients are any less likely to engage over-the-telephone than they are face to face, and most people do engage”

Reese, Telephone

However, there were some disadvantages noted by PWP’s surrounding OTT delivery and engagement:

“Some patients don’t treat sessions as appointments (more DNAs [Did not attend])”

Bailey, Both

“I found that people DNA more frequently by phone”

Sam, Face-to-face

This reduced engagement may be due to *“Distractions in environment during the call”* (Bailey, Both). However, most of the PWP’s reported a positive view of patient engagement in OTT work:

“I have done telephone treatment successfully and found the patients just as committed to learning to manage their difficulties”

Cameron, Face-to-face

“Over the phone is often easier to keep patients in track and focusses on the session - which I have found more difficult face to face”

Robin, Telephone

It was suggested by one PWP that the level of engagement may be higher F2F due to the level of commitment required from the patient as there is more ‘cost’ to the patient in doing so (e.g. travel costs and financial impact, time off work, etc.) – the *‘Improves Access’* theme (VI) explored this further:

“Face to face does potentially involve more commitment from the patient e.g. time off work, clinical care, cost to get there and this can also impact on the commitment to treatment.”

Cameron, Face-to-face

(a) Understanding and Following Tasks

In this sub-theme, PWPs noted that the likelihood of task completion – an aspect of therapeutic engagement in the IAPT context – differed between the modalities. Some have suggested that OTT work suits the use of self-help and patients could complete this type of therapy with assistance OTT:

“People follow guided self help more closely using this modality”

Alex, Both

However, PWPs have noted that patients may be less likely to complete all tasks involved (e.g. homework tasks):

“I think there is a slight difference in engagement – i.e. clients not completing work as readily”

Chris, Both

Furthermore, one PWP suggests this may be because they are unable to visually check that tasks have been completed compared to when seeing patients F2F:

“It is also easier to check whether patients have done their homework!”

Drew, Telephone

OTT, PWPs suggested that it was more difficult for them to establish whether or not the service user has understood the information they provided – this was primarily connected to the lack of visual cues:

“Facial expressions very useful in identifying if people understand and are happy to do the work”

Sam, Face-to-face

“Communication is more difficult – it is difficult to know if the patient has understood the session”

Bailey, Both

(b) Disclosure and Honesty

The disclosure of information in therapy can be another indication of therapeutic engagement. One PWP suggested that the F2F approaches often result in a higher level of disclosure from the patient:

“Benefit from disclosing more face-to-face.”

Jamie, Face-to-face

However, a larger proportion of the PWPs noted the benefits of OTT in allowing disclosure of more information – this may be due to the reduction of patient feelings of mental health stigma. On the other hand, some do question whether the patient is completely honest and this uncertainty is due to the lack of visual cues:

“I find they tend to disclose more”

Chris, Both

“...or may not be being completely honest”

Vic, Telephone

(V) ‘Decreased Practitioner Dependence’

Some PWPs commented that the use of the OTT modality may aid recovery by increasing the internal attributions of a patient or improving their self-management. The detachment from the PWP (e.g. through the lack of visual cues or physical distance) would therefore decrease

external attributions (towards the PWP) of their recovery and thus attribute all improvements and recovery to themselves:

“When a patient improves they are more likely to attribute the improvement to themselves rather than to the practitioner”

Pat, Telephone

“The barriers posed by not being in the same room enables the patient to do more on their own, decrease dependence by still feel supported”

Kim, Both

Treatment Barriers

(VI) ‘Improves access’; patient barriers to treatment

PWPs merited the use of OTT delivery in improving access for service users:

“Benefits to telephone = improves access (especially if transport, mobility or childcare is a concern)...”

Bailey, Both

This theme was further divided into the following two sub-themes:

(a) ‘Individual Circumstance’

In this sub-theme, PWPs noted that individual differences and situations may influence the uptake of treatment and support:

“Face to face is probably much preferable for certain groups: e.g. the deaf, older adults”

Jamie, Face-to-face

“I think the modality does effect the sessions and this can be both in a positive and negative way, depending on individual circumstance”

Vic, Telephone

Many PWP's have cited working adults and childcare commitments as important factors that may influence the use of a particular modality type. F2F treatment may provide more of a hindrance for individuals with these commitments, whilst OTT has a smaller impact:

"Clients can take calls at home looking after children or at work"

Danny, Both

"Telephone working is a lot more practical for those who work"

Nic, Both

"...those who are working and can't/are scared to take time off"

Joey, Both

Similar to service users, PWP participants also noted that physical health (primarily mobility) issues would benefit from the use of OTT work to help improve access:

"However, I have found that telephone can be useful intervention for these people with mobility issues... I have found that I can be useful to do a combination of face to face + telephone sessions ... this is particularly the case on the patients with complex needs and/or issues regarding accessibility"

Lee, Both

In addition, PWP participants suggested that the psychopathology of the patient may prevent them from attending F2F sessions and thus the use of the OTT modality may provide an alternative means of access:

"Telephone appointments can be more suitable for patients experiencing anxiety symptoms as they can find it difficult to get to talk on the phone let alone attend face to face appointments"

Joey, Both

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There were mixed views regarding the suitability of OTT therapy working for individuals with learning difficulties:

“Face-to-face work can work well for some patients, for example, those with learning difficulties/language difficulties...”

Joey, Both

“Concern is minimal for telephone working with people who have some form of complication – e.g. learning difficulty, English as second language, etc.”

Max, Both

Some PWPs have suggested that the F2F experience may form an important part of their recovery as it plays a role in providing a ‘treatment experience’:

“...for some patients attending face to face is part of their recovery, attending appts [appointments] without being anxious, driving to appts, sitting in waiting rooms without being anxious”

Cameron, Face-to-face

(b) ‘Location, the Economic Climate and Availability’

Practical reasons why the OTT modality may be more appealing to patients when compared to conventional F2F were often cited by PWPs. Reasons addressed were shared with the service user participants of the SUQ. For instance, telephone does not restrict patients to a single location which may be difficult for them to travel to:

“Telephone can be flexible for the time of appointment and the location”

Danny, Both

“Ability for patients to be in home surroundings”

Kim, Both

In addition, OTT sessions can be more flexible in terms of scheduling and booking; thus, providing more convenience for the patient particularly those with commitments related to employment and childcare:

“It is also much easier to fit in appointments in around busy schedules”

Pat, Telephone

“It often fits in better with their availability”

Billie, Telephone

Some participants suggested that F2F may increase the rate of DNAs due to costs in travel costs or unpaid time off work:

“For some I think it can increase non attendance especially in a restricted economic climate”

Joey, Both

(VII) ‘Clients tend to choose or prefer...’

PWPs expressed that patient opinions and attitudes to particular delivery modalities may impact on whether they are more likely to actively select or engage with alternatives to traditional F2F work:

“Patient choice is the most likely important aspect as they will engage in what they choose”

Cameron, Face-to-face

PWPs often highlighted that patients were more likely to favour the F2F modality and actively choose it:

“Most of my work was face to face individual. I think that clients preferred this choice”

Chris, Both

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“When I have offered the choice between telephone and face to face appointments, patients have preferred face to face”

Bailey, Both

Some PWP's offered suggestions as to why F2F may be selected over OTT – due to its novelty or the expectancy and stereotype that F2F is the ‘norm’ of psychological therapy:

“I think if given the choices pts [patients] would choose F2F, but that is cos telephone working is quite new”

Nic, Both

“Clients tend to choose face to face if offered because they believe this is how ‘therapy’ is provided”

Danny, Both

However, many commented that in their experience, patients changed their attitudes once they had begun to use OTT-delivery:

“...some people initially prefer the idea of F2F support but after engaging with telephone support are very happy with this”

Hayden, Telephone

“The service users I spoke with were initially hesitant about telephone-delivered therapy. But once tried, they were quite comfortable with it and some said they were surprised at how helpful it was”

Drew, Telephone

“Often patients can be sceptical of telephone working... After a few sessions the sceptism [sic] tends to disappear.”

Gerry, Telephone

Similar aspect to some patient attitudes, one PWP noted that the views of other healthcare professionals may affect the likelihood of the delivery type the patient selects or the service itself may offer:

“The current service tends to use face to face more as GP’s prefer it”

Cameron, Face-to-face

(VIII) ‘Talking to a stranger’; Anonymity and Judgement

PWPs also noted that the use of the OTT modality helps to promote anonymity which some service users may find appealing when discussing mental health or personal information. In addition, it may also be favourable for PWPs:

“Anonymity (some patients have preferred this)”

Bailey, Both

“I think it is good as I can speak to someone and see them in the street the next day without even knowing who they are”

Frankie, Telephone

Anonymity can be linked to the issue of stigma associated with mental health, as some PWPs suggest that the state of anonymity could allow service users to discuss mental health without feeling judged. Also, it may help to reduce anxieties and increase willingness of patients to engage with mental healthcare:

“Often people find the anonymity a helpful thing – so they can open up more without fear of judgement”

Robin, Telephone

“More open on the phone as little judgement”

Frankie, Telephone

However, it was additionally noted that some service users may hold some reserve when speaking to someone whom they did not know:

“Some patients feel uncomfortable speaking to a stranger over the phone”

Bailey, Both

Clinical Practice/Working Approach

(IX) Scheduling and delivering treatment

This theme covers aspects that PWPs highlighted regarding the effects of a delivery modality on the way they work. For example, OTT work has been commented as being positive in terms of the ease of scheduling sessions:

“I find it easier to schedule telephone appointments as don’t have to find a clinic room”

Alex, Both

“On the telephone I have my diary screen in front of me. In my face to face clinic I don’t have that so it is much harder”

Reese, Telephone

This ease of scheduling may allow PWPs to respond quicker to the needs of patients who might require more support:

“Telephone also allows the ease of adding additional appointments if a client is struggling or requires additional support”

Danny, Both

An interesting comment made by one of the PWPs was that the working environment of a OTT-based service was enhanced due to being able to interact with other PWPs, compared to a F2F only service which can be more isolating as the environment features them working individually in their office:

“Working on the telephone also allows good team working and peer support which is really important given the pressures of our job, face to face working is far more isolated.”

Reese, Telephone

PWPs also noted that OTT work can be useful when working under strict time scales – this may differ across the different interventions:

“...the main benefits in doing telephone work is that it lends itself more to the short time frames (20 minutes) that we work in for individual treatments”

Chris, Both

Furthermore, some PWPs suggest that OTT use may allow them to efficiently use this limited time:

“I have found it easier to deliver treatments over the phone and that these are a more effective use of time”

Cameron, Face-to-face

“I prefer telephone working as I can complete majority of my admin and multitask whilst on the telephone.”

Gerry, Telephone

As highlighted in the theme ‘Clients tend to choose or prefer...’ (VII), PWPs commented that patients may view F2F as the ‘norm’ for therapy. PWPs noted that individuals who work with F2F have often viewed sessions as a form of counselling rather than the task and goal orientated approach which CBT utilises. They suggested that this can affect the focus of the sessions and could limit progression:

“Face to face I find people are more likely to give me more story & focus less on the diagnostic problems”

Alex, Both

“Face to face appointments are often approached by patients as a counselling session & they resist working through techniques by continuously focussing on their reflections as opposed to next steps”

Kim, Both

In contrast, OTT PWPs suggested that it is easier to carry out the tasks and goals which they implement in CBT and thus OTT suitable for the therapeutic approach the service utilises:

"I find over telephone it is easier to focus on diagnostic symptoms & their treatment"

Alex, Both

"Fits CBT structure as easier to boundary and plan session"

Frankie, Telephone

"...the intervention is guided self-help this is easily provided over the phone in treatment sessions"

Ashley, Telephone

(X) Explaining information: Having 'resources to hand'

In this theme, issues specifically related to the ability of a PWP to explain information to patients has been prominent topic found in the data.

As highlighted in theme II: *'Visually see the patient'*, explanation of information was hindered by the absence of visual cues in OTT use, thus some services provide patients with resources by post:

"Visual materials can still be used in telephone work by sending things in advance"

Terry, Both

Some PWPs noted that the postal service can be unreliable and, despite the patient receiving the resources on time, the completion of them OTT is time consuming – this is difficult for some when confined by a set length of time:

"The main limitation is that we depend on the post to deliver them & the patient to have them to hand next time."

Kim, Both

"Also, it is difficult to organise and plan for sessions as post is often slow to arrive – as a consequence, patients often need to complete a questionnaire over the phone which eats into session time."

Bailey, Both

However, some OTT users noted that it was useful for them to be able to interact with the patient whilst they had resources they required in front of them or within easy reach:

“Telephone support is also easier on the practitioner who can have all resources to hand”

Kim, Both

Furthermore, some PWPs noted that they were able to fill in assessment resources or take notes without disturbing the patient or worrying about their NVCs:

“I feel I can structure my assessments better over the phone: I’m focused more on info-gathering rather than other things + I can take notes rather than worrying about eye-contact.”

Jamie, Face-to-face

In terms of how the modality can affect the comprehensibility of the delivery of information by a PWP to patients, there was a mixed range of comments. Some have discussed the difficulty in explaining information OTT:

“I’ve felt frustrated trying to explain interventions”

Joey, Face-to-face

Some have suggested that the lack of visual cues can hinder explanations information whilst others have said the contrary:

“It is more difficult at times over the phone to explain things particularly when patients do not have the resources in front of them”

Jordan, Both

“The same information is conveyed over-the-telephone which would normally be given face to face”

Elliott, Telephone

A number of PWP's proposed that it is the responsibility of the PWP to be able to adjust their approach and style to suit the modality when providing information:

"PWPs need to adapt their treatment and approach in order to maximise the usefulness of either intervention for their client"

Lee, Both

4.5 Psychological Wellbeing Practitioner Interviews Results

In this section, data from nine interviews with PWP's are presented. All quotes used to illustrate each theme are presented verbatim. Interview participants were randomly allocated pseudonyms (please refer to *Table 39*).

Similar to the SUQ and the PWQ, topics deduced from the literature helped to initially guide the thematic coding. In addition, further topics highlighted from the thematic analysis of the SUQ and PWQ were used; particularly those which highlighted importance of the therapeutic relationship (see *Table 26*).

From these, a total of 15 themes emerged from the data. For this analysis, the themes have been organised into four parts:

- 1) *Abstract ideas about the Therapeutic Relationship*
- 2) *Concrete experiences of the Therapeutic Relationship*
- 3) *Service Structures and the Therapeutic Relationship*
- 4) *Practitioners Perspectives of Delivery Modalities*

It should be noted that some themes interrelate with other themes and are not necessarily confined to their sections.

The focus of the interviews on the therapeutic relationship was influenced by previous literature outlining concerns that the use of telecommunication devices could affect the development of such a relationship. This issue was also stated by participants in the free-text sections of the SUQ and PWQ. To conclude this section, 'Researcher's reflexivity' helps to describe the views of the researcher on the interview stage to help further understand the data.

Participant Pseudonyms	
Ollie	Izzie
Kelly	Glenn
Lin	Georgie
Ros	Leo
Jay	

Table 40: PWP's who took part in the PWP Interviews

PART 1: Abstract ideas about the Therapeutic Relationship

(I) Essential ingredients: “The Therapeutic relationship to me is...”

This theme emerged when PWP's were asked ‘what a therapeutic relationship means to them’; it encompasses what they believe to be the main components of this bond.

Some of the practitioners highlighted the importance of the therapeutic relationship, and that it was the “...most essential part of the job” (Kelly) and it is central when they interact with patients:

“...the heart of the relationship the foundation is the therapeutic alliance with somebody”

Ros

Many of the PWP's also noted that the collaborative nature of the relationship and that patient engagement was a key factor:

“...to engage with you, able to share the information and feel that they're getting something out of the treatment”

Izzie

It was suggested that the collaborative relationship could help patients to feel that they are contributing to the therapy (“they feel that they're taking part in their therapy”, Lin). In

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addition, the balance in the relationship was suggested to be more equal. Practitioners noted less direction from them:

"...nobody is telling you what the treatment is going to be..."

Ros

And that there was more influence from the patient ("*...they feel they've got choice...*", *Lin*), and often citing that they tell patients that "*You're an expert of yourself*" (*Ros*).

However, it was suggested by one of the practitioners that, despite providing a more 'equal' relationship, they still retain a little more influence in order to help guide the patient:

"if you're pulling a rope, having a bit more grip, all those inter-personal things, I have a bit more grip to, to use for therapeutic relationships to help the patient a little bit more"

Ollie

Practitioners emphasised the importance of empathy: "*empathy is the main one there*" (*Jay*), "*I guess empathy is key*" (*Georgie*). In addition, appropriate provision of compassion was helpful:

"...empathise with the patient, not just for the sake of doing it"

Lin

There was a clear distinction between understanding, rather than sharing, the emotions conveyed by patients:

"Empathy, you know, not sympathy"

Ros

"...being able to not just understand what somebody is going through, but not to kind of wholeheartedly feel it with them"

Jay

“Cos it’s not about sharing my problems”

Glenn

As well as this distinction, some practitioners noted that importance of the nature of their relationship with patients (*“...relationship that has boundaries”, Ollie*):

“it’s a professional relationship which is to do with, um, helping a person, to put it simply, and, um, it’s not about being friends...”

Ollie

“...And also kind of keeping a boundary in a way, so not getting, um - not being eeerm, not sort of too friend”

Glenn

Trust is also an important aspect: *“Therapeutic relationship to me is about trust”* (Georgie) cites one therapist. Moreover, this aspect surrounds the idea that practitioners can increase the confidence patients have that sensitive information they disclosed is kept confidential:

“I could trust them in terms of, you know, confidentiality, um, that er, um, the things that I say they’re not going to talk about me, in, you know, in a negative way”

Leo

As a link to the importance of trust, practitioners noted providing a relationship which establishes their neutrality is important (*“very importantly being non-judgemental”, Ros; “being sort of non-judgemental”, Glenn*). In order to provide this, being *“open and honest as well”* (Georgie) is also essential:

“...making sure you’re giving all the information, you are not beating around the bush, you are not fobbing them off with something”

Lin

A positive connection was also suggested to be another important component in a good therapeutic relationship:

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"...first aim is to form a positive relationship with them"

Kelly

This may include aspects such as providing friendly interaction (*"a nice little bit of banter going"*, Lin) and approaching the matter optimistically:

"...positive attitude. So um, being motivating and, and kind of engaging and showing obviously an interest"

Glenn

It was also noted that providing awareness to patients that they are engaged and present in therapy was of importance (*"...being present with that person"*, Leo):

"...the basic things like being able to listen"

Jay

"...person experiences the fact that I'm listening to them, not just me thinking I'm listening to them"

Ros

Furthermore, one practitioner explained that the therapeutic relations needs to have *"humanness there really, that human element"* (Jay).

The following themes (primarily in *'Part 2: Concrete experiences of the Therapeutic Relationship'*) that are presented help to further investigate the 'essential ingredients' noted in this theme by utilising experiences of practitioners in practice.

PART 2: Concrete experiences of the Therapeutic Relationship

(II) Emotional Presence: “I’m 100% with you” / “I don’t feel I can be 100%”

“...Being present...” (Leo) was noted to be an important aspect of the therapeutic relationship. Practitioners suggested that providing patients with the knowledge that their complete attention is focussed on them was imperative:

“I want them to know that they’ve got my undivided attention”

Ros

In this theme, the views of practitioners about how the delivery modality could affect this concept are explored, particularly with regards to the strength of the relationship. A number of the practitioners suggested that F2F allows for a higher quality connection between themselves and the patient:

“I think you can deliver the whole package and being in the room with somebody, I don’t think anything is going to beat that”

Ros

“I love face-to-face, because it really is a connection”

Lin

Some practitioners suggest this connection is not as robust OTT:

“With the telephone work it, it’s, it just seems that the relationship isn’t quite as strong”

Ollie

“When it’s on a telephone, you get none of that. There’s no other -.”

Georgie

This could be primarily due to the presence of visual cues:

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"...you can see that I'm, I'm listening, I'm, you know, 100% with you, my focus is never else but on what you are telling me about"

Ros

In addition, some further noted that they could not fully engage with patients OTT:

"I don't feel that I can be 100% listening to that person... it's not the same as being in, in the room with somebody, you know, there is that barrier"

Ros

The absence of the visual medium has been noted to be a negative aspect of using the telephone (e.g. *"the things that aren't there with the telephone"*, Georgie) – this aspect is further investigated in the next theme.

On the other hand, a number of practitioners noted that the effects of using different delivery modalities do not necessarily affect the therapeutic outcomes:

"I probably don't feel that I've formed quite a strong relationship when I'm on the phone, which I don't think prevents the treatment from being effective"

Kelly

(III) Embodied Presence: *"There's something about seeing the person"*

One of the richest themes to emerge from the interviews as main disadvantage of utilising the telephone: the lack of the visual component, and as other sensory elements. This is particularly disadvantageous as many of the practitioners noted the importance of body language:

"...they can't see your facial expressions, and obviously we are an extremely emotional eer, being aren't we?"

Lin

"...face to face interaction with somebody being able to see what's not being said, the body language, and obviously you can't capture that over-the-telephone"

Ros

In addition, another aspect felt amongst the practitioners was the inability to get the 'full picture' about the patient:

"The non-verbal stuff I know is important, but just, you know, they can see that you, you're listening, they can see that you're kind of try and take in what they are saying"
Kelly

"...actually you do gain a lot from someone by em, their kind of body language, and, and things... I found that it might be harder to pick up on, on things over the phone"
Jay

This included information which may be attained through other senses such as olfactory senses:

"You, you know the smell of a patient (sniffs) you know, if, if there's a sort of – you get a strong smell of tobacco or a, or a, sort of a bedsit smell of stale cooking sometimes, or, or (sniffs) you know, bodily odour, or, or alcohol"
Ollie

And tactile senses:

"And I quite often think that they might, you know, offer you a handshake or something when the session finishes. And for me that's a really strong sign that they found it helpful"
Kelly

In addition, during therapy, it may be difficult to assess how the individual may be reacting to some of the techniques, whether they understand it, are engaging or are willing to take part:

"...you can pick up on the, the, subtle, a subtle sense of distress"
Ollie

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From a more practical viewpoint, the cognitive-behavioural therapies used in Step 2 utilises a number of worksheets and visual stimuli, and these are problematic trying to when convey these OTT:

“...another advantage of face to face, um, I think it’s just when we are going through the materials there in treatment as well, you can then point out, you know, you can draw a diagram and actually point”

Glenn

“And also using material; it’s a nightmare over-the-telephone, you know, “Can you go to page such and such”, “Er which page?”...”

Georgie

“...what I would say, the difficulty can be, huh, a lot of the cognitive-behavioural therapy work involves written exercises.”

Ros

There is a possibility that it could have a negative impact on patients and the practitioner would be unaware:

“...if they get frustrated with it, again you just rely on the voice, you don’t know they’re frowning over the on phone.”

Georgie

“A lot of that is to do with being able to read engagements, so, um, so people sort of give you a bit of a blank face, you know, you can gauge, you know, er, what is it about this that you’re concerned about, or don’t, don’t get; what’s going on here – that sort of thing”

Leo

In some cases, practitioners could reflect on their practice more negatively if patients did not understand their instructions clearly due to the lack of other sensory cues:

"Sometimes it can feel quite frustrating for you as a practitioner because I think initially I started to think 'Well maybe I didn't explain that well.'"

Jay

Furthermore, this aspect may hinder how the practitioner can interact with the patient without interrupting them, which may result in an awkward feeling or a belief that they could be interpreted by the patients as rude:

"...you can see someone face-to-face you know when they are about to speak, so you can make sure you are not going to ask something else."

"...few times where I was going to speak and the patient then speaks on the phone, and sometimes that can be a little bit awkward"

Jay

Providing a positive, *"safe environment, um, being non-judgemental"* (Georgie) is essential to some of the practitioners in forming a good alliance, and promotes comfort that could lead to more disclosure:

"Feel comfortable, and, and to be open and honest as well"

Georgie

As the purpose of the interaction between the patient and practitioner is one where sensitive information is disclosed, one participant noted that patients may be more likely to engage when they are able to get to know the person they are confiding in and, without certain senses being present OTT, this may be more difficult:

"I think, mental health stigma, um, that they really need to see the person they're talking to to suss out whether they feel confident to actually disclose that"

Izzie

For instance some practitioners noted that when delivering F2F, they like to establish a positive setting for the therapy which may not be easy to convey OTT:

"...making sure that you, you've arranged, set up the room in a way that's um, like friendly to the patient, not being really intimidating the way you're sitting"

Izzie

"I put myself outside the door, be smiling, be welcoming, eye contact, um, and I would want to be able to, kind of, let that person know this is how this is going to go"

Leo

"There's also a kind of a preamble. When, when you are on the telephone, you, you don't get the preamble, but that's more of a physical preamble."

Ollie

Moreover, OTT it is not possible to ensure the patient is in a suitable situation or location which can be problematic:

"When you phone a patient, eeerm, one of the factors is you, you don't always know where they are, and what they're doing... they sometimes ... don't put themselves in a situation that, that's suitable for assessment"

Ollie

(IV) Vocal Presence: "You can have a telephone voice"

It was suggested by some participants that *"we don't need body language to convey the empathy"* (Ros):

"Over-the-telephone where it's more the tone of your voice that, that will carry your feelings through"

Ollie

Practitioners outlined various verbal competencies used in OTT therapy in order to accommodate for the absence of certain sensory cues. These included (e.g., summarising information that was given by them back to the patient, asking the right questions) and these techniques allowed the practitioner to assure patients that their attention is on them and they are able to understand what has been disclosed:

“...reflecting, paraphrasing, the person over the phone knows that you are actually listening and you are getting it... it’s very important to check in to make sure that you are with the patient and have got it right”

Ros

“Feedback more, so you use more sort of empathic phrases, and um, um, sort of reflecting more”

Glenn

As well as what could be said or conveyed vocally, the importance of ‘what was not being said’ was suggested (*“being aware of silence”, Jay*):

“And pauses. Listen. You know, those gaps are so important, and then let the patient speak.”

Georgie

The change of tone was also highlighted as one of the main techniques used when interacting OTT:

“...making sure the tone of your voice is right, ensuring that you’re, you know, giving empathy at a particular time”

Lin

“...change of the tone of voice, so I would use a sort of softer tone of voice”

Jay

“Just a general tone I think, yeah. “What do you want?” “How can I help?”... you know, so it’s with an enquiring sort of tone.”

Georgie

However, this change of tone in voice was suggested to be negatively interpreted:

"It's like this sort of sing song voice you get, and, and, I, I, I think that's a little, maybe a little patronising"

Ollie

As noted by an earlier quote ("*empathise with the patient, not just for the sake of doing it*", *Lin*); a change of tone OTT that is perhaps prolonged or perceived to be patronising could suggest to the patient that the therapist is not taking them seriously or that they are being judged. Indeed, one participant recalled that it was perceived negatively by one patient:

"...so rather than it being silent when I was saying, sort of, OK, or I understand, she actually got really angry and was saying things like, "Don't say that, you're patronising me""

Izzie

This could be perhaps due to patient expectations in which patients expect to be listened to without interruption, as one practitioner notes:

"They are used to being able to, to give their monologue, give their dialogue, sorry give their monologue, their, their, their, their story, uninterrupted"

Ollie

(V) Faceless Voice: "*It's just a voice at the end of the day*"

As previously noted a "*human element*" (*Jay*) was important in building therapeutic relationship. However, when practitioners are delivering therapy and support OTT some remarked that "*you are a disembodied voice*" (*Ollie*):

"It's like when I don't see you talking, it's just a voice at the end of the day.... it's as blunt as it might sound, it's a voice and it's words"

Georgie

The presence of visual cues could help practitioners potentially feel closer to the patient:

“It feels more personal to me, so you know, I’ve seen their face, they’ve seen my face”

Kelly

Indeed, one practitioner notes that the telephone depersonalises them:

“...you know it’s to a person, but there’s, there’s that slightly depersonalised aspect of telephone work”

Ollie

However, some practitioners have noted that OTT delivery can provide similar connections to that which can be conveyed F2F:

“I would say it’s personal over the phone”

Lin

Moreover some practitioners noted that there were benefits to being anonymous, particularly for the patient (*“...on the telephone, you are more anonymous”*, Kelly):

“...they have a sense of that anonymity as well with the telephone, that, that, who you are; you are talking about your situation”

Ollie

This anonymity may aid therapy as some practitioners have found that patients may provide more information OTT:

“...people feeling more anonymous they might be more open with certain things ...most people would just be quite open on the phone. “

Izzie

Conversely, some have noted that the telephone may be a barrier for a patient to be able to fully disclose due to the lack of information from whom they are interacting with:

"I think, mental health stigma, um, that they really need to see the person they're talking to to suss out whether they feel confident to actually disclose that."

Izzie

This lack of information was noted to be an advantage as whereby there would be less focus on them and more on the patient:

"...you are probably a little bit more open to their judgement when they can see you... whereas over the phone I think there's a little bit more anonymous, and it's more about them"

Jay

The removal of practitioner scrutiny has an important effect on practitioners which are explored further in the next theme.

(VI) Professional Demeanours: *"You need to look like a therapist"*

Although many of the practitioners suggested that the presence of visual cues was important in therapy and building a relationship, it was noted by many to be a disadvantage as patient's judgements on them as practitioners have affected their practice.

Some stated that they believe patients seek a certain type of individual: *"You need to look like a therapist"* (Leo) and *"you put on that professional front"* (Jay) and, more importantly, the age of the practitioner could impact the way they are being perceived by the patient:

"I think they want someone who is going to be able to listen, um. I think they like to think that the person they are seeking is knowledgeable. I think age can come into things."

"...would be thinking what experience have they got? How can they help me when they're 20 years younger than me"

Georgie

"...the age of the practitioner maybe brings a barrier..."

Izzie

This judgement and scrutiny of this aspect has been suggested to have a negative impact:

"I had a comment made before that they felt that I was too young, or they felt I would be inexperienced to hear about their difficulties, which is quite difficult really"

Izzie

"I think probably my own, em (tuts) kind of worry is that I would be judged for being young; that would then make the patient feel like, you know, I am not as skilled or something."

Jay

Although, one practitioner noted that *"people can make an assumption about you when they can only hear your voice"* (Leo), the general feeling amongst some of the practitioners was that they felt more positive about the use of the telephone in which there are few cues for them to be judged upon:

"I feel more confident over the phone that I am not being judged"

Jay

"I think because all of that's removed, it's almost like I don't have to justify myself; I know they're just hearing my voice and they don't have any of those other cues... it eliminates all those kind of social cues where they might make a judgement, and actually just having that friendly voice on the end of the phone means that it doesn't matter what age, race, accent, you know, whatever it is, it doesn't matter when you're on the phone"

Izzie

Some practitioners also stated that they felt less pressure on how they should present themselves to patients when using the telephone:

"...like using the phone in a way as well, so it's kind of like a really nice way, 'cos um, it also takes a bit of pressure off you then on the other hand as well when you have got like ... but sometimes with face to face you always have to kind of um, really be aware of your posture as well, and eye contact"

Glenn

"When I'm on the phone, I like to think I'm still doing the same job, but I know I might have my feet on the, on the chair, I might be, you know, doodling a little bit in the background, just because I don't have to be showing to be quite as engaging."

Kelly

Practitioners did note that they hoped that it would not affect how they were perceived by the patient OTT.

(VII) Patient Expectations: *"They assume that we are counselling"*

This theme discusses the experiences practitioners have of working with perceptions and expectations of patients in therapy.

One aspect of interest was how patients viewed the nature of their relationship with the practitioner. Practitioners suggested that they are perceived to provide the all answers and it was noted that most patients wanted to *"get a quick fix"* (Georgie):

"A magic wand, they ought to be better!"

Ros

It could be suggested that there are a number of patients who expected a 'medical' approach to treatment, similar to psychiatrists; one practitioner recounted that they have had to inform some patients that they *"don't have a magic wand, there is no magic pill"* (Leo):

"So sometimes patients see this word "Counsellor" there and they have that expectation of you in Doctor's surgeries"

Ollie

"...they're talking to therapists who don't prescribe (sniffs), I say that it's CBT so we use self-help"

Ollie

Many of the practitioners suggested most patients are unaware of what the cognitive-behavioural approach involves:

"Em, some people do have an idea of what CBT is; quite often people don't."

Ros

This can perhaps be due to preconceived ideas about psychological therapy, primarily the perception that it is similar to counselling:

"...people traditionally assume for counselling or psychological help"

Jay

"...they assume that we are counselling. There's a – there's still that counselling thing attached"

Georgie

"...they say um, counselling as well, rather than sort of CBT, so they think that it's counselling"

Glenn

"I would say a good percentage think it's counselling."

Lin

Although counselling may not primarily involve a directive practitioner, PWP's stated that some patients may expect a level of instruction from them which could re-emphasise patient views of a 'medical' approach to treatment:

"...they're coming to you for the answers, and that's quite important that you try and break that a bit I think"

Izzie

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In contrast, a common view amongst the practitioners was that their main role is to support and provide guidance; that they have more of a teaching role:

"...you're guiding them through it"

Izzie

"...we encourage them to make changes in their life... it's also about educating patients"

Ollie

"...work that we do is a lot about us presenting and teaching techniques when it comes to treatments"

Jay

It was highlighted that it was important to help patients feel *"empowered to make those changes"* (Izzie) – this is an important aspect of the collaborative nature of a relationship which many of the practitioners described in the first theme outlined:

"...they need some education; they need some understanding, they need to learn some tools, and it's a very effective way for people, in passing that knowledge"

Leo

One could suggest that these expectations may be due to the patient's background or age:

"...a lot of older people prefer that personal interaction, because that's how it used to be done"

Lin

"I think older people, eerh, have a few different kind of background and understanding of, em, sort of psychological support"

Jay

“...they were telling me that in Poland you go and see a psychologist to be told what to do, or how to make things better”

Izzie

With regards to the delivery modalities, most practitioners noted that F2F delivery was perceived to be more ‘traditional’ and in some instances the more ‘effective’ form of therapy offered:

“...face-to-face ... I don't know, sort of like people view it as more like proper therapy... some patients have an expectation that the telephone work isn't the proper therapy”

Izzie

Although, this may be due to unfamiliarity with using technologies to deliver therapy:

“...cos it's quite a new way of working for a lot of people, and they will say “Oh I'm not sure about using the phone””

Glenn

(VIII) Patient Commitment: “There's a big onus on them to turn things around”

In the previous theme, it was suggested that the practitioners should help encourage patients to feel “*empowered to make those changes*” (Izzie) and in relation to this, the importance of a patient's motivation and commitment to engage in therapy was stated by many practitioners:

“...there's a big onus on them to, to turn things round, and obviously that's what cognitive-behavioural therapy is”

Ros

In this theme, it is investigated whether this motivation could be affected by the use of certain treatment modalities. For instance, the telephone may be noted as an ‘easy’ option due to its convenience:

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"...over-the-telephone, there's a lot less effort involved..."

Leo

"... I think it depends on the individual, 'cos some patients love telephone work, they haven't even got to leave their house"

Lin

Some practitioners therefore noted that, there may be a higher incidence of patients not following through on sessions and treatment:

"I'm more likely to get drop outs from the phone treatments, yeah."

Georgie

The ease of using the telephone could promote this:

"...but if the telephone is ringing and, and you're thinking I don't really want to speak to them today, and just let the telephone ring"

Ollie

In contrast, it was suggested that as F2F treatment requires more effort, there may be perception that there is a greater chance that patients will engage in therapy:

"...if somebody is attending face-to-face treatment, they have to do quite a lot of the out of bed and actually get to that appointment"

Leo

PART 3: Service structures and the Therapeutic Relationship

(IX) Improving Access: Democratising Therapy

In this theme, participants noted that the advantage of utilising the OTT modality was that it promoted accessibility to the service:

“But, from a telephone point of view, er, from a service perspective, we are being able to support so many more people for this time”

Lin

OTT therapy allows patients to access treatment irrespective of their schedule; for example, those who cannot access treatment due to employment commitments:

“...it’s really helpful, because, er, patients, er are working and they can speak to you in their lunch hour”

Ollie

“Advantages, I’d say people find it really convenient; it fits in with their lifestyle, particular an evening appointment and things like that”

Izzie

In addition, it was noted that OTT working can be flexible enough to accommodate for other lifestyle factors such as child care:

“very, very helpful for people, you know, they can do sessions in their lunch break, they can do sessions in their bedroom upstairs while the kids are doing homework, you know; it’s much more ... I don’t think it’s necessarily goes as far as it should do”

Leo

It was further noted that the use of OTT helped those who had health problems (e.g. *“physical disabilities, so for hearing, um, difficulties”, Jay*) or transport difficulties that would otherwise limit their ability to access the service:

“But a couple of people that may have a disability, they may have transport problems, they may live in the middle of nowhere, em ... they may not be a -, you know, not feel able to um, get out of the house because of their conditions”

Ros

“Physical health issues that a lot of people, for example, have trouble holding a phone”

Glenn

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As well as physical conditions, the use of OTT could help individuals with specific psychological conditions to receive contact with a mental health practitioner:

“Sometimes you would be working with somebody who has got agoraphobia, and they eeerm, will miss lots of face-to-face input appointments, but actually if you speak to them on the telephone, they are fine about it”

Ollie

However, one practitioner posited that OTT could encourage and maintain the psychological problem – for example, by allowing an individual with agoraphobia to stay at home for therapy, it may promote their need to stay at home:

“You could say people who are agoraphobic can do telephone work, and you are helping maintain the problem to some degree, because they, they, you know, it’s an easy option”

Ollie

Some practitioners offered that the OTT modality may be better suited to individuals with less severe symptoms or conditions:

“...telephone, I think its people that engage, um, it’s as effective, and I think generally that is because it’s about lower complexities”

Leo

When practitioners discussed the promotion of access to more people, some noted potential demographic characteristics and how they interacted with OTT or F2F work. For example, when age was considered:

“I found that older people generally have preferred face-to-face appointments”

Kelly

“...older people prefer that personal interaction, because that’s how it used to be done”

Lin

"...older people would - er, on the whole, I would say perhaps are better suited to face-to-face"

Jay

On the other hand, with younger age groups:

"...it might encourage more people to engage, um, particularly younger people perhaps who have come from you know, more of that technological background"

Jay

One practitioner noted that men prefer the use of the telephone because *"a) because it's quicker access, b) because they don't have to actually have to face somebody and share an emotional link with the person sat opposite them"* (Lin).

Outside of the delivery types, practitioners had noted that how a patient accesses the service could impact on how well they engage with the therapy; particularly when the individual feels like *"...they go there under duress, and they won't necessarily point it out"* (Ollie) or they *"...didn't want treatment, um, and... felt ... was forced to come through by her family for treatment"* (Lin). In addition, some may be motivated by other means that are not related to the alleviation of symptoms:

"...they hope to get better, or they hope to please the doctor (sniffs), or, or, or their partner by doing, do what they have been asked to do"

Ollie

Another factor could be that they have *"...been to a lot of agencies and feel that they haven't had any help"* (Ros) and this could have a negative impact on engagement:

"...just their kind of facing general helping services, I think they come to the session with a little bit of mistrust there initially"

Jay

(X) The Nuts and Bolts: Bureaucratising Therapy

This theme explores how delivery modalities may affect the more practical elements of clinical work.

In relation to OTT, in some cases it was noted that basic information such as the telephone number “...is completely wrong” (Ollie), that the patients may not be contactable or that the practitioner is preoccupied with a previous caller outside of their designated session time:

“It’s difficult to get hold of people obviously but that’s not the working over the phone, that’s just a fact that you are on the phone constantly, so people can’t get hold of you, you can’t get hold of people.”

Lin

For one practitioner, F2F contact may consume a lot of their working time, specifically if they must travel to the patient:

“...if you are spending an hour travelling somewhere, that’s a hell of a lot of time”

Lin

They felt this time was wasted if the patient were to cancel the appointment whilst they were in transit, thus they noted the usefulness of OTT working:

“You know, to have then had it wasted, whereas if you were at a desk and they DNA, it doesn’t matter, you can get on with a load of admin”

Lin

On a similar note, one practitioner stated that they use telephone as a means of contact when a patient was unable to attend or has cancelled their appointment:

“...try and be flexible and if a patient can’t make it, we can do a telephone one”

Ollie

Similar to the comments from the PWQ, practitioners have noted that the practice of posting materials to OTT users can be unreliable as some may not receive it in time for the session or

materials that might have been relevant at the time of the session could not be provided immediately:

"...we have to post stuff out to people, or we have to signpost materials to try ... the lack of immediacy when it comes to, to that side of things"

Ollie

"...when you are working with them over the phone, they haven't got the things that you need them to have at the other end, so it can feel a little bit disjointed"

Kelly

Although, from the point of view of the practitioner it may be easier for them to be able to gather more resources that may be useful for the patient:

"I do find that if you're on the telephone you know, you can fiddle around, you can kind of think, 'Ah yeah!' And you can grab things; you can grab prompts and things like that"

Leo

"You can definitely be more creative, um, rather than when you are on the phone."

Glenn

It was also suggested that the use of the telephone may feel isolating for the patient:

"...you could feel that you were working alone ... whereas with the therapist in the room, you're actually getting off to a good start, you are making sure you understand it"

Ros

Some practitioners wanted to note that, regardless of the delivery modality, one of the main aspects that could aid the relationship and interaction is to adapt their practitioner style to suit the patient:

"Sometimes people just er, respond differently to different styles; we all are very different. Everybody is an individual, we all have been taught the same skills in our work, in our professions, but we all bring our own characters, angles to it."

Ros

"...more adapting to the person"

Jay

(XI) Time for Therapy: "That time pressure"

"I would say modality is irrelevant, time is the relevant factor..."

Lin

In this theme, practitioners explored one of the main reasons why OTT delivery may be perceived as a mode of therapy that is considered less effective as F2F-to-face. This is due to the length of time over which telephone therapies are delivered:

"...the 20/25 minutes is very short"

Lin

"...telephone work is very hurried because it's half an hour"

Leo

One of the biggest advantages to the use of the telephone is that practitioners get more time with the patient:

"...on face-to-face you can have more time"

Lin

"...when it comes to being able to work with someone face-to-face, is that we get a little bit longer"

Jay

This can be difficult, and places pressure on the therapists, potentially affecting the therapeutic relationship:

"...one of the biggest pressures on an alliance can be that time pressure"

Jay

"...you're juggling time frames and that kind of thing, that's quite challenging"

Leo

One practitioner described the fast paced nature of their role:

"But I think certainly the PWP role is kind of cramped up really; it's a really fast paced."

Georgie

This could have a negative impact on how they feel when trying to deliver therapy to so many people, as they have little time to remember with whom they are interacting:

"I feel like I am not giving the next person maybe sort of the quality eerm, of, of the support as well"

Glenn

"I think that creates a difficulty in that um, then you've got more people you've got to try and remember, and quite often you can be finishing one call, and going straight, straight into then talking to the next person"

Jay

On the other hand, some practitioners noted that, as information is limited OTT, and due to the sheer number of individuals they are contacting, it prevents potential 'information overload':

"...less cues to remember someone with the telephone working"

Jay

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"I think with the IAPT role, isn't necessarily always a bad thing, because sometimes you only want a limited amount of information as well"

Ollie

In the first theme it was discussed by some of the participants that the therapeutic relationship should have boundaries; the OTT modality and time restrictions allow the practitioner to maintain the structure:

"I do find it easier to keep to the structure a little bit more and be less likely to drift away from it"

Kelly

"...they'd go off on a bit more of a tangent, and they're talking about what they'd done at the weekend... they are kind of more focused I guess, and they, er, they are a bit more direct"

Lin

Some note that a drawback of the F2F modality is that patients may digress from the therapy aims:

"...sometimes they might sort of try and use the session as a sort of general chat, really, and it loses the focus of the therapy"

Glenn

However, they also note that the telephone can restrict how they may want to deliver the session and the time limit does not allow for further exploration of other issues that are not necessarily covered by the therapy schedule:

"You can definitely be more creative, um, rather than when you are on the phone. Um, that sort of restricts you sometimes"

Glenn

"I do tend to let things drift a little bit more... I might spend an extra five minutes just talking about that just to find out, you know, is that relevant, does that contribute to the problem"

Kelly

(XII) Therapy in the 21st Century: "Production line therapy"

One theme which emerged from the interviews that was not specifically discussed within the interview schedule or through the topics that underpinned the questions, was the views of the therapists on the IAPT service as a whole. For instance, some noted restrictions within their roles:

"...there's a very set practice that you have to follow with this role. very structured, um, and there are specific limitations on what you can and can't do"

Lin

"...we have to follow NICE guidelines, there is a very strict kind of you know"

Leo

Although some have suggested that it is not a disadvantage to have these rigid structures:

"I enjoy the role that I have, because there's a certain structure to it"

Ollie

One practitioner noted that *"I don't buy the idea that one size fits all"* (Ollie) and that there is degree to which the service may *"try and fit the patient into the PWP boxes a little bit"* (Kelly).

One individual noted that:

"...you are giving them a choice, but you are giving them a choice that isn't necessarily what they elected they wanted to have"

Leo

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Some practitioners also suggested that the clinic may limit them on whether or not they are able to provide as much choice:

“...we are limited in whether we offer face-to-face”

Jay

One of the practitioners suggested that with the nature of the service and their focus in the attainment of certain goals and benchmarks, the quality of the therapy may be affected:

“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”

Georgie

“And in an office environment, they might take things from that, like you know, oh she’s got loads of people around... so this is a production line”

Jay

The nature of the IAPT service has been noted to assess and interact with as many patients as possible; therefore it further promotes the previous themes of time pressure and the restrictions on the role of the PWP.

PART 4: Practitioner perspectives of delivery modalities

(XIII) Practitioner Preference: Telephone versus Face-to-Face

In this theme, practitioners provided their opinion about whether they had a preference, between OTT or F2F delivery. A majority of practitioners highlighted their dislike of using the telephone, namely in treatment and its effectiveness:

““I – personally I don’t like it. Um, that’s my personal feeling...”

Georgie

"I feel that we are doing the, doing the intervention, but not with quite as much power as it would have behind it"

Kelly

A number of the practitioners noted their preference for the use of F2F, when compared to the OTT:

"...if I have to choose between the two, I would rather see people face-to-face"

Kelly

"I prefer to see somebody face-to-face"

Ros

Some suggested that there are better outcome results when using the F2F modality:

"...Face-to-face, definitely, yeah. People are more likely to recover"

Georgie

"...in terms of bringing people below caseness I would say I was probably more successful doing face-to-face."

Leo

"My hunch is patients engage a bit better when they're um, when they're doing face-to-face work in the surgery"

Ollie

However, it should be noted that not all PWPs believed the use of the telephone was a huge disadvantage, some noted their initial reservations (*"little bit sceptical when I first started"*, Jay) and after use in practice, these views changed:

"I must admit I did have my own reservations about telephone work to begin with... But actually I've been hugely surprised by the success of it"

Izzie

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Other practitioners felt that within the Step 2 treatments, the use of OTT was comparable to the use of the F2F modality and that using both together would be of greater appeal than using just one modality:

“To be honest I don’t really feel there is a difference”

Izzie

“Having flexibility to use both I think is helpful”

Ollie

“So there are pros and cons for each. From a therapist point of view, I like both. I love face-to-face, because it really is a connection. But, from a telephone point of view, er, from a service perspective, we are being able to support so many more people for this time.”

Lin

Some practitioners suggested that the delivery modality had no effect on the quality of the therapeutic relationship:

“But actually I have still found myself ... doing the same things, and forming a similar relationship that I would have done face-to-face”

Kelly

“I think once you’ve built it, there isn’t any difference”

Lin

Although some practitioners suggested that the use of OTT may be better suited to the assessment stage of the Step 2 process rather than for treatments:

“...a straight assessment having telephone triage so we could filter out patients who, who were more appropriate for our service”

Ollie

"I think assessing somebody over the phone, that's ok because you are not actually doing a treatment"

Ros

(XIV) Practitioner Preference: Other Delivery Modalities

In this theme, the viewpoints of practitioners around the use of alternative ways of delivering treatment are explored. These technologies included Skype©, text messaging, instant messaging, computerised therapies and email.

Some noted the practical factors that could inhibit the usefulness of newer technologies, (e.g. technical problems, and user knowledge):

"...technical problems due to static or, or people with telephones cutting out."

Ollie

"...there may be people who you know, might struggle just using the technology or using the Skype, and those kind of things."

Kelly

"...instant messaging texting, I think that could probably work quite well, eeerm, but I think that would depend on the speed of typing for em, you know, for the patient and also for the practitioner"

Jay

In addition, PWPs suggested that the use of instant messaging or emails could be disadvantageous as there would be a difficulty in interpreting words with no other cues (visual, audio, or other):

"I think the disadvantages would be that actually it's a lot more stilted, for example, even when you get an email from somebody, it's quite difficult to pick up exactly what they are meaning"

Jay

"I suppose when it comes to Instant Messaging, or maybe email contact I don't... but for me I feel that would really lack in therapeutic alliance because I suppose you're, you're minimising ways you can build a therapeutic alliance by working on the phone but without even hearing a voice I think it makes it very difficult"

Izzie

However, some saw the benefits in a videoconferencing ('video messaging') method which could improve the accessibility as well as provide a visual element which was the biggest drawback for OTT use with regards to the therapeutic relationship:

"Skyping patients, or anything like that. That's really interesting -. I think that would be great!... because you are almost giving a face-to-face appointment, but you are not there. Fantastic! So that will just be adding a therapeutic alliance to telephone based working, in essence."

Lin

Despite this, some practitioners noted that using these technologies could be *"a bit artificial"* (Glenn) and further suggested that technologies could not replace F2F interaction in therapy:

"I'm quite strongly against all this electronic stuff."

Georgie

Similar to how the OTT way of working may be best suited to assessments, some have suggested that the use of video messaging services could be a good way of introducing them how the therapy is to be set out:

"Skype initially might actually give them the reassurance they need to actually come in to the service."

Ros

(XV) Technology Anxiety: The Practitioner outside the Therapy

As outlined previously, some practitioners noted that patients were unwilling to use the OTT modality as it is a novel method of accessing therapy:

“...cos it’s quite a new way of working for a lot of people, and they will say “Oh I’m not sure about using the phone””

Glenn

It was observed that despite using OTT in clinical practice, some practitioners expressed their own reluctance in utilising outside of their working role:

“I’m (laughing) a bit of a phone-phobic”

Leo

“...strangely enough, I, I don’t really like talking (laughing) on the telephone, em, outside of work, I don’t really like, you know, em, speaking with friends or anything like that on the phone, I’d much rather send a text”

Jay

This also included the reluctance of using other delivery modalities:

*“But like Skype. Because I found even -. Well I can’t even do it with my friends!
(laughs)”*

Glenn

Researcher’s Reflexivity on Interview Phase

As this was my first set of interviews, I was nervous when carrying out the first. Luckily for me, the participants were really enthusiastic about taking part in the project. The first interview was probably the most difficult as I had little expectation of the type of responses I would get. It did, however, provide a benchmark for me as I had learnt a couple of things relating to IAPT that I was not aware of from the materials I had read. The facts I had learnt along the way (not only in the first interview, but in subsequent ones) informed the way I would try to encourage participants to expand on their answers (therefore adapting some of the prompts).

A lot of the participants were very passionate about their work and with regards to the topic of OTT use (or technologies in general) in psychological healthcare some were rather negative about it (perhaps due to their previous work as counsellors, social workers, etc. – these have shaped their expectations of their interaction with patients). I became a little mindful that it was becoming a one sided argument and that I was not getting a balanced viewpoint so I had to prompt them to discuss its potential benefits.

In some of the interviews I was very conscious that participants were very aware about how they were answering the questions. Some would ask me if what they said was what I was looking for. I had to encourage them to continue talking and that I would try to prompt them if they were going off topic. I tried my best to get the participants to speak as openly and as candidly (e.g. using anecdotes) throughout the interview as possible, although some of the answers felt a little too conservative or were phrased in a way that sounded paraphrased from a textbook.

There was one interview carried out where I did feel that I wanted the interview to end as soon as it had begun – namely because it was one of the last interviews to be carried out in the day and it was in a hot room. Therefore, I felt that I did not prompt the participant for further examples or explanations as I perhaps should have done.

Most of the time the interviews were conducted with me sitting opposite the participant, although in one instance I was sat behind a desk and the participant commented that “[it] *felt a bit a like an interview*”. However, I did not think it had any effect on the interview and its flow.

Overall, the interviews went well. I felt all the participants understood the questions and the aims. I also felt I was able to cover all the topics that I initially set out to explore in the interview schedule. I also received positive responses from participants and some were interested in receiving an updated in its findings which I found really encouraging.

4.6 Summary of Results

This chapter presented the results from the data collected in the research project:

The Views of Service Users and their Outcome Measures

From the SUQ, service users provided positive ratings with regards to satisfaction and rapport across both modalities. Service users also rated that their experience of therapy was impacted by the absence or presence of non-verbal aspects of communication; this was also highlighted from the qualitative themes that emerged from the questionnaire (e.g. in relation to the feeling of anonymity). Further themes that emerged explored the use of the over-the-telephone (OTT) modality in removing barriers in accessing psychological therapies (e.g. monetary or scheduling factors). The intensity and frequency scoring also supported these themes (e.g. individuals who lived further away from the IAPT site provided more positive comments relating to the OTT modality than using face-to-face [F2F]).

From the IAPT outcome measures, there was a reduction from first to last symptom scores of all service users irrespective of the utilised modality that was utilised. Moreover, there was a significant difference in the reduction of some symptom scores from users who utilised OTT but this was not evident from the scores of F2F users. It should be noted that the statistically significant findings are not statistically robust due to small sample size that took part.

The Views and Experiences of Psychological Wellbeing Practitioners

From the PWQ, PWPs also provided high satisfaction ratings for both modalities; however, PWPs selected F2F as their preferred modality. The practical benefits of using the OTT modality were highlighted in the ratings (e.g. easier in scheduling appointments). In addition, PWPs noted that therapy was affected by the absence or presence of visual and non-verbal aspects of communication. These two topics were further emphasised as themes in the free-text qualitative sections. These themes explored the effects of the delivery modalities on the therapeutic relationship, barriers to accessing psychotherapies, and clinical practice.

From the PWP Interviews, the questions that were asked in the interviews covered four distinct areas where merge various themes that emerged from the data. The first two related to the effect of treatment modalities on the therapeutic relationship:

- 1) Abstract ideas of the therapeutic relationship – i.e. the ‘essential ingredients’ a therapeutic relationship.
- 2) Concrete experiences – e.g. the need for emotional, embodied and vocal presence and the modalities effect on this.

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The final two areas related to the effect of the modalities on the experiences of the therapist working in the IAPT LI service:

- 3) The structure of the IAPT service (e.g. the 'production line' approach to therapy).
- 4) The views of PWP's on different modalities (e.g. videoconferencing and online therapies).

Chapter 5 discusses the results and utilised previous literature and theoretical concepts to help further understand these findings.

CHAPTER 5: Discussion

5.1 Introduction

This chapter examines the findings from the research project and considers them in the context of previous literature. Theoretical concepts have been introduced to help further understand these results. For example, the model of the Five Therapeutic Relationships by Clarkson (2003), which was defined earlier in section 2.2.3, was used to explore the themes relating to the therapeutic relationship that emerged.

Using the objectives set for the project (see *Box 6*), the findings have been organised into five main topics which will be explored in the following order:

- I. The effectiveness of Telephone versus Face-to-Face as depicted by symptom outcome scores
- II. Telephone therapy and the improvement of access to psychological therapies
- III. The impact of telemedicine on the Therapeutic Relationship
- IV. Attitudes of patients towards the use of the telephone in therapy
- V. Views of practitioners around the use of telemedicine in therapy and the IAPT process

Objective 1: Service User Questionnaire

To analyse the views of service users of treatment modalities in a low-intensity IAPT service

Objective 2: Psychological Wellbeing Practitioners Questionnaire and Interview

To analyse the views and experiences of Psychological Wellbeing Practitioners of different delivery types

Objective 3: IAPT Outcome Database

To analyse service user outcomes using data from the IAPT outcome database

Box 6: Objectives (as outlined in section 2.5)

This project explored the differences in views and experiences in of patients and practitioners, as well as the effectiveness, of using OTT and F2F modalities in psychotherapies. Topic I explores the aims of Objective 3 and the differences between OTT and F2F in relation to the symptom outcome measures collected. Topics II and III were developed from the SUQ, PWQ

and PWP Interviews data, specifically investigating the modalities effect on the therapeutic relationship, that help to achieve aspects set in Objectives 1 and 2. Topic IV discusses the themes which have emerged from the SUQ exploring service user views and experiences in order to aid the achievement of Objective 1. Lastly, topic V investigates the views of PWPs which help to achieve Objective 2.

5.2 Topic I - Effectiveness on Symptom Outcome Measures: Telephone versus Face-to-Face

5.2.1 Symptom Outcome Measures

Objective 3 aimed to analyse service user outcomes using data from the IAPT outcome database. In previous literature, it was established that OTT and F2F psychological interventions provided comparable effectiveness by providing similar reductions in scores of the symptoms scales selected (e.g. Lovell *et al.*, 2006; Fann *et al.*, 2014). The findings from the IAPT Outcome Database part of this project helped to support these trends.

After analysing first and last measures of the IAPT psychometric instruments that constitute the 'Minimum Dataset' (the PHQ-9, GAD-7, W&SAS, and IAPT Phobia Scales), it was observed that across both delivery modalities a large proportion of patient scores had decreased from their first to their last score. Additionally, all scores of F2F users ($n=9$) were reduced to below 'clinical caseness'²⁰ on the PHQ-9, Agoraphobia scale and Social Phobia scale at their last measurement. A range of over 65% to 90% of the scores from OTT users ($n=18$) fell below clinical caseness across all psychometric scales and there was a higher proportion of OTT users whose scores were reduced to below caseness on the GAD-7 and W&SAS than those who had used F2F. These scores also provide some evidence for positive outcomes for the IAPT (e.g. Clark *et al.*, 2009; Hammond *et al.*, 2010), in particular the Step 2 service.

Much of the previous research proposed non-inferiority between the two delivery modalities (e.g. Bee *et al.*, 2008; Mohr *et al.*, 2012). However, when differences in first and last scores were tested for significance, only users of the OTT modality had shown a significant reduction in their scores for the PHQ-9, the GAD-7 and the Social Phobia scale. In addition, from these statistically significant differences, medium-to-large effect sizes were calculated and suggest

²⁰ A reduction of psychometric scores below the clinical cut-off point (see Box 5) suggests the individual has "recovered" (DoH, 2010; Cairns, 2014).

that the improvements in scores were modestly large. In comparison, the reduction of scores from the users of F2F first to last scores was non-significant across all psychometric instruments. These findings provide some support to Lynch *et al.* (1997) whose results suggested that OTT use provided significantly better outcomes than F2F – a finding which has yet to be replicated. It should be noted that due to a Bonferroni correction applied to the results, thus reducing the significance level to 0.4% ($\alpha = .004$), differences from first and last scores of F2F did not reach significance despite reaching significance at the 5% level ($\alpha = .05$). Moreover, this part of the project did not recruit a sufficient sample size to attain statistical power. Therefore these statistically significant results should be interpreted with caution.

5.2.2 Demographic and Therapy Factors

Objective 3 also aimed to investigate whether factors other than the different delivery modalities could play a role in the outcomes of treatment. A logistic regression yielded non-significant results that could suggest that the factors explored (e.g. treatment length, intervention type, age, gender etc.) did not affect whether there would or would not be an improvement²¹ in psychometric scores with relation to either the OTT or F2F modalities. This non-significant result may also be attributed to the small sample involved in the analysis ($N=27$). Sample size tables for logistic regression at the 5% significance level ($\alpha = .05$) were estimated to require a sample size of at least 50 participants (Hsieh, 1989).

It was of interest to note that the patterns presented in the demographic and treatment information collected from participants (please see *Table 30*) were similar to trends described in the data reported by the Health and Social Care Information Centre in their annual IAPT reports for 2012/13 and 2013/14. Akin to the participants sample in this project, over half of the patients who entered and utilised the IAPT service were female, and a majority of the users were of white ethnicity. ‘Depressive disorder’ was the most accounted for diagnosis, and the mean number of sessions for patients was six (HSCIC, 2014a; 2014b).

²¹ In this analysis, an ‘improvement’ was defined as a reduction in psychometric scores from the first to the last recorded. For logistic regression analysis changes were coded in binary and were as follows: 1 = “Yes, a reduction in score” and 0 = “No reduction in score”.

5.3 Topic II - Improving Access to Psychological Therapies

As its name suggests, the main tenet of the “Improving Access to Psychological Therapies” programme is to improve access to mental health services (DoH, 2008a; 2011a). Although the SUQ and PWP questions did not explicitly ask participants about the effect of access in relation to the delivery modalities, one of the prominent themes to emerge from them was that the OTT modality increases accessibility.

5.3.1 Service User Views on Access

Service users suggested that the telephone could help users overcome the treatment barriers that individuals who use the F2F modality may encounter. These barriers could relate to individual differences between the service users (e.g. psychological factors: psychopathology, memory, shyness, the issue of stigma; and physical health issues: mobility). In addition, the telephone was commended assisting in the reduction of practical barriers that increase the difficulty for those attending F2F sessions (e.g. distance, monetary cost, time restrictions due to work and/or childcare commitments). Indeed, it was noted that some service users who lived further away from the IAPT service posed more disadvantages with regards to F2F use (see *Figure 9*). A further advantage expressed by service users was that individuals could be encouraged to access psychological services without encroaching on employment time. This was important for the programme as employment is a key topic in the IAPT initiative – the aim in promoting ‘return to work’ (DoH, 2012).

These findings mirror comments from previous IAPT service users, as well those who have utilised T-CBT, who stated that OTT work was more convenient to use (Bee *et al.*, 2010b; Parry *et al.*, 2011). Additionally, it supports earlier findings that suggest telemedicine can remove issues of scheduling conflicts or timing constraints, and help reduce financial impacts (Lovell *et al.*, 2000; Mohr *et al.*, 2006). However, in this project, one service user participant noted that technical issues could pose a problem; this was also found by King *et al.* (2003) who concluded that technical limitations and any failures in the technology devices could inhibit the usefulness of telemedicine. Nevertheless, the overall consensus from the service user participants regarding OTT use was positive and the comments supported the advantages of telemedicine in help to improve access to qualified therapists where there are limited resources (e.g. King *et al.*, 2003; Newman *et al.*, 2011).

5.3.2 PWP Views on Access

Consistent with perspectives of service users, PWPs also offered support for OTT use with regards to the improvement of access to psychotherapies by removing or reducing treatment barriers. Barriers included: psychological issues, mobility and physical health issues and limitations in ability to travel, finances, and employment leave. PWPs did suggest that F2F work may be more useful for certain individuals who require more time and assistance (e.g. those with learning difficulties and where English is not their first language). These views are mirrored in previous research from IAPT practitioners (e.g. Jones *et al.*, 2013). Gordon (2014) noted similar findings in relation to the views of practitioners around the use of mobile technologies. In the US-based psychotherapy service, with regards to its practicality for both patient and practitioner (e.g. convenience and ease of scheduling sessions).

Some PWPs did express concern that the use of OTT systems may escalate symptoms that service users with agoraphobia, for example, face as it would not require them to leave their space of safety and thus inhibit their likelihood of seeking exposure outside of this space. However, previous literature which explored the effectiveness of OTT therapies for patients with agoraphobia was observed positive effects (e.g. McNamee *et al.*, 1989; Swinson *et al.*, 1995).

5.4 Topic III - Delivery Modalities and the Therapeutic Relationship

When exploring Objectives 1 and 2, one of the main themes that emerged from the data related to the Therapeutic Relationship and how it could be affected by OTT or F2F use. In previous literature, this was highlighted as one of the main issues with regards to the use of telemedicine in therapeutic delivery (e.g. Wootton, 1996; Farrand and Williams, 2010) as it was noted to be an important factor related to patient satisfaction and optimal care (e.g. Ong *et al.*, 1995; Williams *et al.*, 1998). In this study, PWPs also indicated the importance of the therapeutic relationship in therapy and thus this theme was the focus of the PWP interviews.

In this section, the findings are discussed in relation to different therapeutic methods (i.e. cognitive-behavioural, humanistic and psychodynamic) and their approaches to the therapeutic relationship. In addition, the model of the Five Therapeutic Relationships by Clarkson (2003) is used to help understand aspects of the findings (see *Box 7* for a summary).

The Working Alliance

This explores the need for the patient and the therapist to form a co-operative relationship (through shared goals, bonds and agreed tasks).

The Transference/Counter-Transference Relationship

The process of 'transference' and 'counter-transference' could either facilitate or disrupt the therapeutic process.

Reparative and Developmentally-Needed Relationship

The role of the therapist in this relationship is supportive and helps to 'repair' deficiencies in original parenting.

The Person-to-Person Relationship

Emphasis is placed on the relationship being 'authentic' and 'real' with emotional involvement.

The Transpersonal Relationship

This relationship refers to a spiritual connection that is curative and healing. It is impossible to describe.

Box 7: The Five Therapeutic Relationships model (Clarkson, 2003): Brief Summary – see section 2.2.3

5.4.1 'Presence' and 'Human' Interaction: The Importance of Non-Verbal Cues (NVCs)

As expressed in section 2.2.3, a potential barrier in the formation of the therapeutic relationship may be the absence of non-verbal aspects of communication. NVCs were suggested to play a key role in the development of a therapeutic relationship (e.g. Ong *et al.*, 1995; Egan, 2010; Brown, 2012). This was mirrored from both the ratings of service users and PWP that NVCs would have a large impact on their sessions.

PWPs suggested the absence of NVCs and the visual medium removed the 'human' feature of interaction. A 'Theory of Mind' (ToM) is important to successful interaction with others as it allows individuals to interpret mental states, such as desires and intentions, through the behaviour of the other (Slater and Bremner, 2007). This act is sometimes referred to as 'mindreading' (e.g. Baron-Cohen, 1995). Empathy is the ability to infer the states of mind of others, particularly their emotions, and is a related concept to the ToM (Goldstein and Winner,

2012). It is also an important concept in the therapeutic relationship for CBT therapists and PWP (Gilbert and Leahy, 2007; Richards and Whyte, 2009; 2011). Chadwick (2006) suggested that practitioners should be able to convey their understanding of the unique experiences of an individual; however, this may be difficult with limited sensory channels. The development and ability to infer mental states has been postulated in influential work by Baron-Cohen (1995) who noted an innate system that processes social cues.

The service user participants in this project indicated that NVCs (e.g. body language and eye contact) could help to provide more information than using only verbal cues. In the 'mindreading' system, an Eye-Direction Detector (EDD) module detects eyes and eye-like stimuli to assist in interpreting the intentions of the other individual (Baron-Cohen, 1995). Therefore, NVCs (such as eye gaze) are rich in social information (Friesen and Kingstone, 1998) and can allow individuals to infer behaviours (Kleinke, 1986). Without these visual cues, it could be suggested that expressing empathy may be difficult. Indeed, previous literature has noted that eye contact and facial expressions, along with body positioning, are important in assessing emotion (Wootton *et al.*, 2003; Egan, 2010). Moreover, it was suggested that only 5% of emotional behaviour can be expressed verbally, whilst 55% can be conveyed through visual or NVCs (Bensing, 1991) and thus a lot of information could be lost during OTT work.

PWPs were concerned about the lack of ability to convey "*presence*" and that the patient has their undivided attention (they are "100%" with them) with visual cues. Similarly, service users reported that visual cues helped them to 'check for listening' and expressed concerns about being unable to see whether the PWP was listening intently and thus 'taking them seriously', or were distracted throughout the session.

Previous literature suggests that patient perceptions of their therapists can affect their level of engagement in therapy (Wright and Davis, 1994). Ackerman and Hilsenroth (2003) reviewed positive therapist characteristics that can improve the therapeutic relationship and, amongst others, 'being interested' with the issues the patient experienced was noted to be important. In this project, service users also indicated feelings of isolation with the loss of therapist presence. The idea of 'presence' could be akin to the 'Person-to-Person' relationship that Clarkson posits which suggests authenticity and 'humanness' are required when building a good relationship (Clarkson, 2003; Antoniou and Blom, 2003). This may not be present in OTT use.

5.4.2 Faceless Voices: The Role of Anonymity and Privacy

PWPs commented that the lack of visual cues were beneficial for some patients who may prefer to remain anonymous. PWPs also suggested that patient anonymity could increase the amount of information disclosed which was consistent with findings from Hilty *et al.* (2007). In fact, service users from this project reported that they were more open to discussing their issues OTT when compared with F2F; this could be related to the issues of stigma in mental healthcare. Some service users posited that one could be less honest and more closed in the disclosure of some details as the PWP is less likely to recognise this concealment or inhibition using only changes in their voice. This was similar to Parry *et al.* (2011) who found that service users suggested that they were more likely to avoid communicating their true feelings OTT.

Many service users discussed that the lack of visual cues OTT may be beneficial for them as it reduces the concern for the judgements of others; this is related to public-stigma (Vogel *et al.*, 2006; 2007). Service users suggested that the lack of visual cues helps to conceal the reactions of the PWP when they disclosed sensitive and personal information. This contradicted findings that suggest patients may prefer to use NVC feedback from their practitioner in order to gain more information about their problem (Friedman, 1979). In this project, some service users did suggest that it may be useful to attain some form of reaction or feedback from the PWP using the visual medium.

The issue of public stigma (e.g. Vogel *et al.*, 2006; 2007) also helps us to understand the comments by many service user participants who suggested that OTT use alleviates stresses and/or anxieties felt when attending mental healthcare in person. Service users suggested they were not worried about being recognised by someone due to the anonymous nature of OTT.

On the other hand, PWPs had noted that although patient anonymity may be an advantage for some, 'practitioner anonymity' may be a disadvantage. PWPs postulated that patients are reluctant to discuss their issues with a "stranger" and a "faceless voice" and this idea was reflected from service user responses in the SUQ. Ratings from PWPs, who worked with both modalities, suggested that more information was disclosed by patients F2F than OTT. In addition, due to the lack of visual cues, some PWPs also questioned whether OTT users were withdrawing some information in sessions. This helps support the need for each party to experience an 'authentic' 'person-to-person' relationship which can influence the amount of

disclosure possible (Clarkson, 2003). One of the main aims of the therapeutic relationship is promoting safety for the patient (Gilbert and Leahy, 2007) particularly due to the sensitive, and sometimes distressing, information they may reveal. This may be more difficult with anonymity among both parties.

Three phases in the formation of a therapeutic relationship were outlined by Reynolds (2003), the first is 'orientation'. In this stage, the petitioner and practitioner attempt to familiarise themselves with one another to build trust which will hope to lead to the acceptance of the interpersonal relationship. Anonymity within the dyad could have a negative influence and could prevent success in this orientation stage as each party is unable to attain all the information necessary to build trust. The service users from this project suggested that the relationship between them and the therapist could be built quicker when F2F. Therefore, it could be suggested that the presence of visual cues and NVCs are important for the success of this first stage.

In addition to visual cues, the absence of other sensory cues were noted to be important in interaction by PWP and service users (e.g. tactile factors: shaking someone's hand as a greeting; and olfactory: being able to assess patient self-care). Although some service users stated that they could be emotionally consoled by the PWP using only verbal cues, some preferred a degree of close physical proximity (e.g. for the PWP to provide them with a tissue when they felt overwhelmed). It has been suggested that the increase of physical proximity between the therapist and patient could reduce the level of emotional closeness in therapy (Cukor and Baer, 1994). Moreover, the use of touch has been noted as an important method of connecting to another individual (Chadwick, 2006; Brown, 2012) – although it is acknowledged that there may be some potential ethical issues surrounding touch in therapy (Uphoff, 2008). Overall, these factors could help practitioners to build a 'friendly environment' which was found to be important for patients in making them feel comfortable and, in turn, could encourage engagement in therapy (Hilty *et al.*, 2007).

In the training of PWP there is an emphasis on the importance of verbal skills in OTT communication (Richards and Whyte, 2009; 2011). The change in communication styles when using OTT was reported by practitioners in previous literature (e.g. McLaren, 1992). This was also highlighted by PWP in which the OTT modality shifts the focus of their skills onto their verbal competencies (e.g. how they are able to convey all information, empathy, etc.). Service

users proposed that verbal cues were important as they could be emotionally consoled by the therapist using these skills. However, it was noted by PWPs that this focus on verbal skills led them to using a 'telephone voice' which was recounted to have been interpreted as patronising in some instances. PWPs also felt uneasy when speaking OTT as they felt that they came across as rude when they unintentionally interrupted the patient.

Although a few of the service user participants noted concern for privacy in their experience of treatment within the likert-type questions of the questionnaire, this theme did emerge from the open-ended questions regarding their views of the advantages and disadvantages of the delivery modalities. Privacy was often related to the location of the treatment. For OTT users, they felt that being in their own home provided them with security and assurance that other individuals would not know that they attended a mental healthcare session. This was similar to comments by service users in the study by Parry *et al.* (2011) who suggested that they felt safer working OTT as it can be carried out in their chosen location. However, service users in this study also commented that OTT users may be more prone to distractions dependent on the environment in which they chose to take their call but one service user noted that the presence of a PWP may also be a distraction.

5.4.3 Emotional Involvement and Boundaries

In this study, some PWPs suggested it was easier to be less emotionally involved with the patient when using the telephone. It has been suggested that therapists (e.g. CBT) should not self-disclose and remain neutral because doing otherwise is seen as a threat to the relationship (Beutler *et al.*, 2004; Westbrook *et al.*, 2011). In psychodynamic therapies it is important for 'transference' to occur; conversely, the act of 'counter-transference' could be seen to interrupt the relationship (Prasko *et al.*, 2010). Contemporary therapists, however, use the counter-transference in order to understand the emotional relationship with their patient. That is, it is often valuable for the therapist to take part in the therapeutic narrative and to not be detached (Howard, 2008).

For example, in Clarkson's (2003) Five Therapeutic Relationships model, the 'Transference/Counter-Transference' Relationship suggests that therapists should be attuned to the dynamics in the relationship and should appreciate what each individual contributes to the relationship. Moreover, it is suggested that "...*transference is everywhere and unavoidable*" (Clarkson, 2003, p. 79). In cognitive-behavioural approaches, 'transference'

reactions may be similar to the concepts of the internal 'schema' where the experience of an individual could shape how they organise their thoughts and form preconceptions (Moorey, 2014). It has also been suggested that transference occurs in therapy through empathy as it involves the therapist expressing their own understanding of the information offered by the patient in the therapeutic space (Clarkson, 2003). It should be noted that in this study, the PWP views do not suggest that they are emotionally detached from the patients; it could be argued that as CBT and LI therapies (e.g. using the telephone) are time-limited and often brief, there may not be enough time for the PWP and the patient to create a deeper and more emotionally-involved relationship (Moorey, 2014).

As discussed in section 5.4.2, practitioner anonymity OTT was suggested by service user participants as being beneficial because they are unable to see PWP reactions, thus alleviating feelings of public stigma. In contrast, findings have also noted that PWPs regarded the lack of the visual medium to be advantageous through lesser feelings of judgement by patients due to their appearance. Therapist effects are an important aspect to consider in the effectiveness of a therapy (Wright and Davis, 1994; Baldwin and Imel, 2013).

Research often suggests that the appearance of the practitioner may play a role in the level of patient engagement in treatment. For instance, Tall and Ross (1991) noted that patients would provide more favourable satisfaction if the practitioner was of a similar age to themselves. In more general research, appearance may play a role in how people may appraise an individual. In a seminal meta-analysis review by Eagly *et al.* (1991), physical attractiveness was suggested to be related to positive traits (e.g. high level of competency rating for individuals who are more attractive). Perceptions of trustworthiness and a friendly therapeutic style have also been shown to have some relation to the outcome of the therapy (Beutler *et al.*, 2004; Blow, Sprenkle and Davis, 2007). The latter factors could be associated to the importance of building a positive therapeutic relationship which has been suggested to promote safety for the patient (Gilbert and Leahy, 2007). This is more important than the therapeutic approach utilised (Paul and Haugh, 2008b). Nevertheless, there has been little evidence to suggest a link between the demographic characteristics of the therapist (e.g. age, sex or ethnicity) and the outcomes of therapy (Beutler *et al.*, 2004).

In this study, PWPs noted that they felt less confident in some F2F therapy sessions due to perceptions of patients of their level of expertise and experience due to their appearance (i.e.

looking younger than what the patient expected a ‘therapist’ should look like)²². It has been noted that the level of experience of the therapist (e.g. the number of years they have been a therapist) may provide some contribution to therapeutic outcomes (Beutler *et al.*, 2004; Blow *et al.*, 2007). PWPs noted that the removal of the visual medium gave them more confidence when speaking to patients OTT.

PWPs proposed that a further advantage for OTT use was that it allowed them keep within the time boundaries of a CBT session. In contrast, PWPs suggested it was difficult to maintain the structure of therapy in F2F work due to patients often treating the time as a counselling session. This supports similar findings by Jones *et al.* (2013) in which IAPT practitioners reported that it was easier to structure their assessment sessions. Brown (2012) noted that one of the many factors in providing a positive therapeutic relationship was to ensure safe and structured boundaries. The requirement of boundaries is important to the ‘Working Alliance’²³ and to the retention of structure in therapy (e.g. maintaining a focus on goals) (Bordin, 1979; Clarkson, 2003). The completion of tasks (e.g. homework) is an important aspect in CBT (Westbrook *et al.*, 2011).

On the other hand, in this study some PWPs expressed that OTT therapy sometimes felt “hurried”. The focus on protocols and manualisation of therapies has been discussed to have potential implications on the therapeutic relationship. Farrand and Williams (2010) note that CBT session in IAPT Step 2 are time limited, lasting approximately 30 to 40 minutes which Moorey (2014) suggests prevents a deeper emotional bond from forming. In addition, there may be less attention drawn on the expression of the experiences and views of the individual (Chadwick, 2006). It has been suggested that in CBT “...a business-like manner” (Moorey, 2014; p. 139) is often employed and the patient’s issues are placed on an agenda rather than naturally emerging from the therapeutic space through discussions and building of the therapeutic relationship.

5.4.4 Engagement and Self-Efficacy

One aspect that could result from a good therapeutic relationship was patient engagement in therapy. Engagement has been noted to be important in the ‘working alliance’ stage of

²² Please note that patient preconceptions of therapy are further explored in section 5.5.1.

²³ The Working Alliance is based on the bond, shared goals and agreed tasks between the patient and the practitioner (Bordin, 1979). The ‘Working Alliance’ stage from the Five Therapeutic Relationships model is based on this concept (Clarkson, 2003).

therapeutic relationship, particularly in the agreement of goals and tasks (Bordin, 1979; Antoniou and Blom, 2003; Clarkson, 2003). PWP in this project rated the level of engagement relatively high for both modalities. This was further reflected in their comments which often suggested that patients engaged regardless of the modality. PWP attributed increases in patient engagement in OTT work due to the ability to be anonymous. In addition, the flexibility of organising sessions for the convenience of the patient (e.g. at home, during lunch breaks) was another advantage of using the telephone. These were similar issues raised by clinicians regarding the use of cCBT whereby the improved convenience of holding therapy in the home of a patient could increase their willingness to participate in treatment (Stallard *et al.*, 2010).

Some PWP suggested that the difference in effort expended to attend sessions between the two modalities could affect the likelihood to commit or engage. PWP proposed that patients who 'did not attend' (DNAs) were more likely in OTT work because of the flexible nature of scheduling sessions; thus patients may perceive that another session could be booked easily if they cancelled. However, some PWP also noted that F2F work also has many DNAs due to the treatment barriers F2F patients may encounter. In previous research, it was found that there were fewer participants dropping out of sessions when OTT compared to F2F (Mohr *et al.*, 2008; 2012). DNAs may have implications on the ability for PWP to build a strong therapeutic relationship as it was found that alliance ratings were negatively related to number of sessions missed (Mulligan *et al.*, 2014). Although engagement is an important aspect in therapy, Chadwick (2006) proposed that the aim of the therapist is not only to attaining patient engagement but rather, they should first focus on creating a positive bond.

A recent study suggested that mental health self-efficacy may be important in the success of non-F2F delivered psychotherapies (Clarke *et al.*, 2014). Bandura (1977; 1982) proposed that an individual's expectation of an outcome after a behaviour is carried out and their belief that they are capable of completing this behaviour, influences behaviour change and the maintenance of these changes. Self-efficacy has also been suggested to predict successful health-related behaviour change (e.g. cessation of smoking, uptake of contraceptives, and abstinence of alcohol) (Stretcher *et al.*, 1986). Clarke and colleagues (2014) suggested that those with lower self-efficacy (i.e. those who did not believe they were capable of carrying out the task and/or did not see the task as beneficial) may require more guidance and advice and thus low-contact therapies or non-F2F therapies would be less suitable for these individuals. The factor of self-efficacy has also been noted as a component in social cognition models that

try to explain health behaviours and changes in them (e.g. the Theory of Planned Behaviour [TPB]).

In TPB, the factor of 'perceived behavioural control' is related to self-efficacy (Ajzen, 1991). It suggests that behaviours are influenced by the belief of capability in completing a task. It further suggests that it can influence which activities the individual selects how they prepare for these activities and the effort they put into carrying out the activity (Bandura, 1987). Attitude towards the action and perceived behavioural control were often the most significant variables for explaining intentions for health-related behaviours such as cessation of smoking, clinical screening behaviours, etc. (Godin and Kok, 1996).

PWPs also suggested that the OTT modality promote and enforces patients to attribute symptom improvements internally rather than externally (i.e. the practitioner) and thus would be less dependent on them. Reynolds (2003) outlined the final phase of a therapeutic relationship process as 'Resolution' whereby there is mutual agreement between the two parties that the problem has been reduced or resolved. At this stage, it is expected that patients have gained some autonomy and have a better understanding of their problems. Lam *et al.* (2011) found, from anecdotal participant comments, that the T-CBT programme made them feel "empowered". Thus, it could be suggested that OTT could increase patient autonomy.

5.4.5 Service User and PWP Ratings of the Relationship

On the whole, service user participants who used both of the delivery modalities rated their relationship with the PWP positively. Telephone users provided a larger spread of ratings (from mid- to high satisfaction) whilst F2F users provided consistently higher ratings. However, there were no significant differences found in these ratings. These findings support a recent study which noted no differences in therapeutic relationship scores between F2F and OTT CBT (Stiles-Shields *et al.*, 2014b).

From the PWQ, all of the PWPs provided positive ratings for the amount of empathy they could convey to patients and the overall rapport quality with regards to the delivery modality they worked with. These were similarly found by Jones *et al.* (2013) who explored the views of practitioners on the use of telephone in an IAPT context at the assessment stage. The effect of the modality on the therapeutic relationship was further explored in the qualitative data from

the PWQ and was the main focus in the PWP interviews. A more contemporary study explored the ratings of therapists and patients of the therapeutic alliance in the use of T-CBT for individuals experiencing psychosis and they also noted that therapeutic alliance ratings from T-CBT were comparable with ratings from F2F CBT (Mulligan *et al.*, 2014).

Whilst there were many opposing views, there was consensus in some of the PWPs that strong relationships can be formed regardless of modality. General consensus from service user participants also stated that the relationship (including trust and a good rapport) can be built using any modality. These more positive ratings, however, did not support the findings by Parry *et al.* (2011) who reported that IAPT patients felt 'less connected' to the PWP using the telephone. This is positive to note as, the alteration of the therapeutic relationship has been suggested as one of the main issues relating to telemedicine (e.g. Farrand and Williams, 2010). Furthermore, participants of this study may agree with the idea that the therapeutic relationship is more important than the approach in therapy (e.g. Paul and Haugh, 2008b).

5.4.6 Food for Thought: Clarkson's Model applied to the Step 2 Service

The Five Therapeutic Relationships model by Clarkson (2003) could be used to understand the findings in relation to the therapeutic relationship and its manifestation on OTT work in the LI service of IAPT. Clarkson noted that there is no set method in applying these modalities in therapy and suggested that the context and the needs of the patient are the main influences (please see section 2.2.3 for a brief overview).

It could be postulated that a 'Working Alliance' may be successfully achieved OTT, as well as F2F. This is an essential aspect of the relationship and can be easily applied to the CBT model of therapy – particularly with the importance placed on shared decision making, tasks, and goals which characterises a working alliance (Bordin, 1973; Westbrook *et al.*, 2010). However, due to the absence of visual cues and physical proximity, the 'Person-to-Person' relationship may be difficult to form. Thus, authenticity in the relationship may be difficult to identify and formation of trust may be obstructed due to the anonymity between the patient and the practitioner. Further comments suggested that there are difficulties in articulating and understanding information exchanged without the visual medium.

Patient and practitioner anonymity, as well as time limited pressures found at Step 2, may form barriers that explain why deeper connections such as a 'Transpersonal Relationship' are

less likely to be formed. PWPs commented that patients expressed a need for a “*magic wand*” and a “*quick fix*”. These desires are closely linked to the idea of a ‘Reparative and Developmentally-Needed Relationship’ but were not articulated by service users²⁴. It could therefore be argued that the nature of LI therapy (‘low contact-high volume’), of which some PWPs are dissatisfied with, may not allow for the development or necessity of these two types of therapeutic relationship. Indeed, Moorey (2014) notes the time limited nature of the CBT model (which underpins IAPT therapies) could prevent a deeper emotional connection from being formed.

5.5 Topic IV - Patient Attitudes to Telephone Use

In this section, the attitudes and expectations of patients and their effect on the therapeutic process were explored. For the majority of the treatment aspects that were quantitatively measured within the SUQ, there were no significant differences between the ratings provided by of the modality groups (OTT or F2F). On average, likert scores were positive (including: ratings of overall satisfaction, relationship with PWP and overall comfort). It was of interest to find that the average range of scores provided by OTT users was higher than those of F2F suggesting that they provided a more varied opinion when compared to F2F users.

5.5.1 Perceptions of Therapy and Expectations

From the thematic analysis, some service user participants suggested that F2F therapy may be the more ‘conventional’ mode of delivery of the two types. Participants further commented that F2F was a more ‘legitimate’ or ‘credible’ form of therapy (e.g. “*feels more professional*”) and that their problems may be taken more seriously. One service user felt strongly enough to suggest that being offered the OTT-based treatment meant they were being “*palmed off*”. Others stated that F2F contact felt more “*human*” and that it may not suit those who prefer a more “*personal*” or “*direct*” type of contact – this was also shared by some PWPs. In addition, the majority of the PWPs selected the F2F way of working as the modality that would be most popular with patients. From the thematic analysis, some PWPs suggested that many patients who selected F2F were more reluctant to use OTT because they believe F2F is how therapy is traditionally carried out.

²⁴ It should be noted that the SUQ did not explore aspects of the experiences of service users that were not specifically related to the delivery modalities.

These comments reflect a patient's 'Perceptions of Treatment Credibility'. These perceptions include opinions regarding 'how convincing' and 'how suitable' a certain treatment is for them (Schulte, 2008; Constantino, 2012). These views may also fall into 'Treatment Expectations' which relates to beliefs of what will happen in treatment: the format, duration, therapist roles, etc. (Greenberg, Constantino and Bruce, 2006; Constantino, 2012). These concepts are similar to those conveyed in the TBP model (Ajzen, 1991).

In the TBP, the attitude of the individual towards the health behaviour or action ('behavioural beliefs'), social norms ('normative beliefs'), intentions to carry out the behaviour, and self-efficacy ('perceived behavioural control') affect the likelihood of the individual carrying out the behaviour (Ajzen, 1991; Godin and Kok, 1996; Armitage and Conner, 2001). It has been posited, in the previous literature, that expectations of the patient and beliefs prior to treatment may influence outcomes that include the likelihood of drop out and symptom improvements (Swift, Callaghan and Vollmer, 2011). Therefore, if there is expectancy of therapy being carried out F2F and they are offered OTT only, and if the individual has low self-efficacy (e.g. Clarke et al., 2014) there could be a reduction in the likelihood of engagement and an increase in dissatisfaction. The concept of 'cognitive dissonance' may also play a part in these negative views.

Cognitive Dissonance is a theory developed by Festinger who suggested that people who held inconsistent cognitions were in 'dissonance' (an unpleasant state) which motivates individuals to change their cognitions to reduce this state (Festinger, 1968; Draycott and Dabbs, 1998; Hogg and Vaughan, 2004). Cognitive dissonance has been suggested to affect effort and personal responsibility of patients in psychotherapy (Axsom, 1989). It could therefore be suggested that individuals who expected F2F but received OTT contact may be de-motivated to participate in therapies (hence the negative comments, e.g. "*palmed off*"). It should be acknowledged that PWP's have noted in some cases, patients are able to select which delivery modality they could use, or change the modality and this would amount to no dissonance. Practitioners also suggested that many patients expected counselling therapy rather than CBT, which could also cause some dissonance and lead to further dissatisfaction.

The positive views regarding F2F (and subsequently negative views on OTT) care have previously been noted in an IAPT service user study by Parry *et al.* (2011) who found that some of the participants interviewed were dissatisfied with the use of the OTT modality and these

views were, in part, due to their general dislike the communication method. Bee *et al.* (2010b) also noted that some patients felt a level of scepticism towards T-CBT use as F2F therapy was seen as the norm. Mohr *et al.* (2010) offered that the novelty of OTT and internet contact in therapy may be one of the reasons why some are discouraged from selecting it initially after a larger proportion of their survey participants selected that they were 'more willing' to consider using F2F behavioural treatment over the two alternative methods. Similarly, some PWP participants in this study suggested that because OTT-delivered therapy was still fairly new in formal mental healthcare, patients are less likely to select it as their first choice.

One further theory that could be used to help understand these findings is known as the Technology Acceptance Model (TAM) (Davis, 1989; 1993). The TAM proposes that the success of technologies integrating into a system is affected by user acceptance. It suggests that the following factors play a role in likelihood of technology acceptance and actual usage: (1) perceptions of usefulness, (2) perceived ease of use, (3) attitudes towards the use of technology. The TAM is based on the Fishbein and Azjen's Theory of Reasoned Action (TRA) model (Davis, 1989; 1993). The TRA notes that behavioural intention is dependent on the attitude of the individual regarding behaviours and subjective norms in relation to this behaviour (i.e. what others and experts think and the individual's need to conform to these norms) (Sheppard, Hartwick and Warshaw, 1988).

In the context of the findings of the project, the patients have rated the use of the OTT positively (in some aspects higher than F2F ratings) which could contribute to an increase likelihood of acceptance. On the other hand, preconceived views which suggest F2F is more credible may decrease the likelihood of patient acceptance. It has also been noted that the trust a patient has in the technology may be a major predictor in the acceptance and rejection (Montague, 2010) and thus, if there is some scepticism held by service users over the use of the telephone (e.g. due to cognitive dissonance or anonymity as a barrier to building trust), this may reduce the likelihood of acceptance.

Schulte (2008) proposed that these credible beliefs often change or are enforced through the experience of treatment. This was supported in this study as service users noted that whilst they held initial scepticism where they judged the telephone to be unsuitable, their negative views changed after treatment. PWPs corroborated this as many commented that negative views of patients regarding OTT therapy often changed after use. In IAPT, PWPs are trained to

ensure that they provide a clear set of expectations to patients to ensure these negative effects of presumptions are minimised (e.g. Richards and Whyte, 2009; 2011).

5.5.2 Patient's Individual Differences

In relation to Objective 2, it was noted in previous literature that a number of individual differences could affect the engagement with online-based telemedicine services which included age, educational attainment, ethnicity and gender (Hardiker and Grant, 2009). It has been highlighted that patient effects may be equally influential in the outcome of the therapy alongside the therapeutic relationship (Paul and Haugh, 2008b). In this current study, logistic regressions which explored whether satisfaction ratings were related to demographic features were not implemented as there was a non-significant difference of satisfaction between the two modalities. Instead, the exploratory intensity and frequency scoring results helped to investigate this.

From this exploratory analysis, the oldest age group (61 years and older), provided a considerably higher number of positive comments regarding OTT use in relation to the number of negative comments given. This ratio was higher when compared younger age groups. Furthermore, they also provided more negative statements relating to F2F than positive statements – this trend was seen in reverse for the younger age groups (see *Figure 7*). These results are surprising as it was noted by Hardiker and Grant (2009) that older users of e-health provided lower ratings of satisfaction and helpfulness. In addition, it was also found that those who are older may be less inclined to seek help from mental health services (e.g. Mackenzie *et al.*, 2006; Anderson and Brownlie, 2011). Some PWPs offered similar views in which older individuals may prefer F2F therapy rather than OTT as they believe that this population view F2F as “*proper therapy*”. It could be suggested that this trend in age could be attributed to the advantage of OTT improving access to therapy. Individuals of this age group may face more barriers (e.g. mobility) when seeking treatment than those of a younger ages and thus may be more likely to offer more advantages.

The intensity and frequency scoring was largely similar for both genders. Males gave more disadvantages than advantages for the F2F modality when compared to female service user participants (see *Figure 9*). This was the reverse for OTT and it is posited that this may be due to the increased anonymity aspect that the OTT modality provides. Literature has noted that males are less likely to seek help for health-related issues (Addis and Mahalik, 2003), which

could be attributed to stigma, and thus anonymity OTT could increase the likelihood of men using these health services.

5.6 Topic V - Practitioner Views on Telemedicine and the IAPT Process

5.6.1 Views on the Telephone in Practice

PWPs expressed a mixed view on the use of OTT in practice. They presented varying opinions on the effectiveness of OTT and F2F use on outcomes for patient with some suggesting that F2F users would be “...more likely to recover”; whilst others suggested that they produce similar outcomes.

Overall, PWPs noted that practical aspects of working in therapy were enhanced by the use of OTT. For example, they rated treatment scheduling easier with OTT work than with F2F. This supports practitioner comments from a pilot study by Simpson *et al.* (2001b) who suggested that telemedicine allowed them to schedule sessions more easily. Further practical advantages were also noted by the PWPs of this project, such as: they were able to have more materials on hand, they thought less time was wasted on DNAs, and OTT use allowed them effectively use their time (such as writing notes as they spoke to the individual).

In some instances, PWPs suggested that the removal of the visual aspect was a barrier when presenting diagrams in therapy and thus were difficult to explain (which was mirrored in service user comments). A good level of understanding between the practitioner and patient helps to improve the therapeutic relationship (Martin *et al.*, 2000). Reynolds (2003) stated that one key aspect of the relationship between the individual and the practitioner is the need to understand the problem in order to resolve or reduce it. Indeed, expressing understanding of information and emotions is seen as important within therapy (e.g. Clarkson, 2003; Egan, 2010). The absence of non-verbal and visual aids may also impede the ability to convey it. Waitzkin (1984) suggested that NVCs were related to the level of understanding the patient had of the information given by the therapist.

Some PWPs expressed concerns with the differences in session length between the OTT use and F2F use. Farrand and Williams (2010) note that a CBT session in IAPT Step 2 lasts approximately 30 to 40 minutes. PWPs in this study noted that OTT therapy lasts between 20 to 30 minutes, and sometimes felt “hurried”, whilst F2F was longer. PWPs noted that F2F users

often digressed from the goals and tasks whilst OTT allowed them to retain their time structure. Keeping to the designated time has been noted as a factor which could facilitate a therapeutic relationship (e.g. Paul and Haugh, 2008b). However, a rigid focus on structure has been discussed to have potential implications on the therapeutic relationship, particularly if there is less focus on allowing the individual to express their experiences and views (Chadwick, 2006) although the structure of IAPT Step 2 ('low contact-high volume' approach) may limit this opportunity (Moorey, 2014).

Some PWP's further noted that they felt as though they were working in a 'call centre' environment when working OTT; however, some perceived it as a positive working environment (e.g. due to the social company) when compared to the isolation of a personal office in F2F work. A social and positive working environment could help to reduce the likelihood of burnout which is important in an emotionally-demanding role. This was also noted in a review of mental health staff burnout factors which found that colleague support and feelings of isolation were influencing factors (Farber and Heifetz, 1982; Leiter and Harvie, 1996).

In relation to other modality types, a high proportion of the PWP's suggested that the use of videoconferencing (e.g. *Skype*® or *FaceTime*®) could be useful as these retain the visual and non-verbal aspects by also maintain convenience for the patient. In addition, it could help promote the use of mental health therapies in key demographics (e.g. younger age groups who are more technology-oriented). On the other hand, there were some who were strongly against the use of technologies. What was interesting to note was that some practitioners were resistant in using these technologies (e.g. video chat or even the telephone) in their personal lives.

The theory of TAM (Davis, 1989; 1993) could be applied to help understand the viewpoints of some PWP's. Holden and Karsh (2010) reviewed the use of the TAM within healthcare and suggested that it can be successfully applied to helping predict the likelihood of acceptance of health technologies by clinicians. The findings from this current project could suggest that there would be an increase in the likelihood of acceptance by practitioners due to PWP's noting the telephone's advantage in scheduling flexibilities. However, comments relating to a reluctance of using telephones outside of the work setting could suggest underlying negative perceptions that could potentially affect the likelihood of acceptance.

A number of PWPs suggested that OTT would be a useful method to supplement F2F work which was shared by previous research (e.g. Lovell *et al.*, 2000). A recent study noted that the use of a mobile and web-based interactive application, used adjunct to F2F psychotherapy, helped to enhance engagement and therapeutic alliance (Richards and Simpson, 2014). It may suggest that technology may not be required as a means of ‘replacing’ F2F but could be used to enhance F2F therapy – in the Richards and Simpson (2014) study, the technologies provided reminders and facilitated communication between the therapist and patient outside of therapy.

5.6.2 The Politics of Care in the 21st Century: The IAPT Service

Some surprising themes emerged from the PWP interviews which were not related to using either F2F or OTT. Some practitioners suggested that their role as a PWP was limited and restricted to the purpose of the session (carrying out the CBT-related tasks and protocol) despite them noting that some patients wanted more emphasis on discussing their experiences of their symptoms (i.e. similar to a counselling session).

As previously noted, IAPT Step 2 can be characterised as ‘low contact-high volume’ (Clark *et al.*, 2009) and some PWPs in the study raised issues about the increased focus on targets and goals (e.g. reaching a quota) rather than being driven to help the individual patients. Some PWPs remarked that it felt like a “*production line*”. As explored in the SUQ findings, these views may be understood in the view that PWPs may be in a state of cognitive dissonance which may lead to dissatisfaction in their role and have implications on their commitment to their role (Melone, 1990; Koh and El’fred, 2004). One service user also noted that the service was driven by statistics (similarly describing it as a “*conveyor belt*”).

Within the practitioner and academic community (e.g. ‘*Against and For CBT*’ by House and Lowenthal, 2008), there have been some concerns raised about the IAPT service as a whole²⁵. For instance, the criticism of the overemphasis of CBT in IAPT, promoting the ‘one size fits all’ notion, could potentially limit access to an array of alternative psychological therapies (Wesson and Gould, 2010).

²⁵ Please see section 1.2.4 which outlined some of these concerns.

In addition, an issue commonly raised was the potential over-reliance on the NICE guidelines by the IAPT programme (The Midlands Psychology Group, 2007). The NICE guidelines facilitate the evidence-based practice approach. However, it has been commented that there are some constraints to using the NICE guidelines in mental health. For instance, the guidelines are often for “pure” psychological conditions, but frequently patients present co-morbid or dual diagnoses and thus, in real practice, the guidelines may not be applicable (McQueen, Pennybacker and Doctor, 2010). Findings by Taylor and colleagues (2003) support this as they observed that T-CBT had mixed effects for individuals experiencing depression and OCD.

As was noted when exploring the history of mental healthcare (see section 1.2.1), economic pressures often underlie the need to change policies (Coppock and Hopton, 2000; Rogers and Pilgrim, 2001) and the development of IAPT was of no exception. There have been pressures since the financial crisis of 2007/08 to deliver therapies on a set budget (Yarlagadda *et al.*, 2014) and within the IAPT; this is reflected with utilisation of LI methods that are ‘cost-effective’ in Step 2²⁶ (Bennett-Levy *et al.*, 2010). Despite IAPT meeting its economic targets (Yarlagadda *et al.*, 2014); the debate scrutinises whether there is incompatibility with economic aims set by Lord Layard and the aims of helping those experiencing mental health issues. For instance, it was noted that the aims of the NICE evidence-base and economic aims of IAPT were not compatible (McPherson *et al.*, 2009). The Social Exclusion Unit, SEU (2004) also note that economic goals (e.g. employment) are often not considered as a key objective for people experiencing a mental health condition. In this project, PWPs commented that their main concern for patients was to help them feel better and to remove the symptoms of depression and anxiety rather than the ‘return to work’ aim.

There are also some who question one of Layard’s main tenets underpinning the establishment of the IAPT service in which ‘*life’s miseries*’ are a form of illness and that there is a need to cure it using psychological therapies (McGowan, 2007). The Midlands Psychology Group (2007) suggested that labelling unhappiness as a pathological condition that can be ‘treated’ is unconstructive. They further argued that ‘emotional distress’ is often not a psychological issue (e.g. it could be due to physical pain, etc.). The development of a ‘therapy culture’ where society views a need for certain emotions to be ‘cured’ is a subject of debate (e.g. Furedi, 2004). This culture may be reflected by the application of CBT a wide range of

²⁶ This includes the use of telemedicine which has been noted to be cost-effective (e.g. Bashshur *et al.*, 2000; Whitten *et al.*, 2002; Mohr *et al.*, 2006; Marks and Cavanagh, 2009).

general well-being programmes for: smoking cessation, weight loss, rehabilitation and coping for cardiac conditions, and Type I diabetes (Thomas, 2008).

In addition, a radical point raised by some authors is that mental health and human behaviours are once more becoming progressively 'medicalised'. For example, there are concerns with the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) whereby more individuals are being labelled as 'mentally ill'²⁷ (Watts, 2012). In addition, there is concern that this may lead to a rise in the prescription of drug therapies to individuals experiencing mild depression or bereavement which usually do not require drug treatments (Dowrick and Frances, 2013). In the context of IAPT, the IAPT Phobia Scales were developed in order to capture those who did not meet the criteria of PHQ-9 and GAD-7 (IAPT, 2011b); Glover *et al.* (2011) noted that they were poor in specificity and sensitivity and thus suggesting that these scales may be misdiagnosing those who do not meet the diagnostic criteria of the other outcome measures.

It could be assumed that, due to the roll out of IAPT across England, there would be an increase in CBT availability but a recent study noted that there are still shortages in CBT therapist availability in some geographic areas (Cavanagh, 2014). It should be noted that, these findings may not reflect the number of PWPs as the profession is an emerging mental healthcare role which may not be classed as a 'CBT therapist'. DoH (2012) suggested that the target number of PWPs trained had been met with over 4,000 newly qualified therapists (as of 2012).

Although many critics report the drawbacks of a CBT monoculture in IAPT, findings from demonstration sites and on the first years of the IAPT service have expressed successes in relation to helping individuals gain improvements in their depression and/or anxiety symptoms (e.g. Clark *et al.*, 2009; Glover *et al.*, 2010; Gyani *et al.*, 2012; HSCIC, 2014a; 2014b). It should be noted that there are some within the field who are sceptical of these findings (e.g. Griffiths and Steen, 2013; Griffiths *et al.*, 2013). Nevertheless the programme is providing evidence of increasing access to therapies in the demographic groups that do not usually seek help for psychological issues (e.g. Brown *et al.*, 2014).

²⁷ For example, 'Disruptive Mood Dysregulation Disorder' is considered as a 'medicalised' term for what is colloquially known as "temper tantrums" (Frances, 2012).

5.7 Summary of Discussion

This chapter examined the findings of the project and explored them in relation to the objectives set forming five main topics:

I. The effectiveness of Over-the-Telephone (OTT) versus Face-to-Face (F2F) as depicted by symptom outcome scores

It was found that there was a reduction in symptom scores across both of the modalities supporting previous literature.

II. Telephone therapy and the improvement of access to psychological therapies

PWPs and service users commended the use of the OTT in helping to remove barriers in accessing psychotherapies (e.g. practical and psychological), further supporting previous literature.

III. The impact of telemedicine on the therapeutic relationship

The effect of the modality type on the therapeutic relationship emerged as a major theme in the findings of the SUQ, PWQ and interviews. This was also a main topic discussed in previous literature, particularly due to the absence of visual and non-verbal cues. The loss of the 'humanness' in interaction, the role of patient and practitioner anonymity, the effects on emotional involvement and therapy boundaries and the effect on engagement were discussed.

IV. Attitudes of patients towards the use of the telephone in therapy

In this topic, the effects of patient attitudes to OTT use in psychotherapy (more specifically factors such as their expectations of therapy) were discussed. Furthermore, individual differences were explored within the context of the varying views of different age groups and gender.

V. Views of practitioners around the use of telemedicine in therapy and the IAPT process

This topic discussed how PWPs favoured OTT use with regards to practical aspects of therapy (e.g. convenience) but overall preferred the F2F modality. These findings provided new insight into the understudied topic of practitioner views of OTT modalities. Practitioners also provided comments and critique on the IAPT service with some

professing their dissatisfaction with the numbers-driven goals of the programme. This could be in relation to a dissonance felt as the perceptions practitioners have of their role as someone helping others is contradicted with the main requirements of meeting quotas and benchmarks (i.e. the 'low contact-high volume' approach). This discussion of the research findings has contributed to debates about CBT as the primary therapeutic approach offered in the UK health service, and to debates about the incompatibility of economic aims with the aims of healthcare and the medicalisation of human misery.

The model of the Five Therapeutic Relationships (Clarkson, 2003), and the Theory of Mind (Baron-Cohen, 1995) were used in order to bring this data into conversation with relevant and established theories (in addition to empirical research). To explore expectations and perceptions patients and practitioners have of therapy, the theories of self-efficacy (Bandura, 1977; 1982), cognitive dissonance (Festinger, 1968), the Theory of Planned Behaviour (Ajzen, 1991), and the Technology Acceptance Model (Davis, 1989; 1993) were also used.

CHAPTER 6: Project Limitations, Recommendations for Future Work and Conclusions

6.1 Introduction

In this chapter, limitations to the research are outlined and recommendations for future work are proposed. The chapter closes with the conclusions on the three main objectives and the research question set for this project.

6.2 Limitations

Unfortunately, the sample sizes required for statistical analyses for the quantitative section of the SUQ and the outcome measures from the IAPT Outcome Database (specified in sections 3.3.2 and 3.3.3) were not met. Therefore the results from the statistical analyses were not sufficiently powered and thus any significant results should be treated with caution.

Nevertheless, these findings provided updated knowledge in exploring the differences of delivery modalities, particularly in OTT versus F2F therapies within an IAPT setting.

Statistical power was not expected to be met for the PWQ due to the anticipated small size of the IAPT workforce who could take part in the research project. However, there is very little literature which explores the views and experiences of practitioners, particularly with regards to their views and experiences of OTT and F2F within an IAPT context. Therefore, the findings of the current research project contributed new knowledge to this research area.

Due to time restrictions, I was unable to conduct interviews with service users to explore their views on how the therapeutic relationship could be affected by the delivery modalities. Future research could mirror the PWP interviews on service users to gain more detailed views. It is accepted that a large proportion of the literature focuses on the point of view of the patient. However, there have been few studies investigating the views of service users relating to the therapeutic relationship in modalities outside of F2F.

There were a high proportion of participants in this current research project of White British ethnicity. This may have been due to resource limitations leading to lack of translated materials potentially limiting the available sample outside of this demographic population. It

would therefore be interesting to explore this project with other cultures or ethnicities – especially as one of the key tenets of the IAPT programme is to encourage ethnic minorities to access psychological therapies (DoH, 2008). However, it was acknowledged that the demographic profile of the participants in the sample of this study similarly reflected the demographic profile of those referred to the IAPT service, as reported by the Health and Social Care Information Centre (HSCIC, 2014a; 2014b).

6.3 Recommendations for Future Work

6.3.1 Replicate the Research Project

Improve Statistical Robustness

For future research, it would be of interest to repeat this project on a larger scale and to gain sufficient statistical power. Few studies have explored the use of different modalities with an applied context as much of the literature was investigated through RCTs. It would also be useful to further examine whether the trends which began to emerge from the current research project's data are also evident in a larger sample (e.g. OTT use providing more significant symptom score reductions than F2F use for less complex problems, the different views of OTT versus F2F for different age groups, and the effect of distance from the IAPT sites).

Explore in Different Contexts

The IAPT model has been recently applied to younger age and adolescents (the IAPT Children and Young Persons' Service) (IAPT, 2013) and in the context of the prison service (e.g. Forrester *et al.*, 2014). A project could be developed to examine the views and experiences on the use of OTT and F2F modalities within these populations.

In relation to potential replication of the project at the IAPT Children and Young Persons' Service, it may be of interest to explore the views of younger age groups regarding the use of telecommunication devices in healthcare and whether there are any factors which promote, or are a barrier to their participation and/or engagement in therapy. Previous research regarding the use of T-CBT with adolescents suggests high satisfaction (e.g. Turner *et al.*, 2009; 2014). This will also follow up on the emerging trend of differing views of OTT versus F2F amongst the age groups found in the current research project.

Explore Other Modalities

As online and computer-based delivery modalities (e.g. *Skype*© or *FaceTime*©) are becoming increasingly popular in society and also within healthcare (e.g. due to technology availability), it may be of interest to explore the views of users (both service users and practitioners) of these modalities using a similar methodology. A focus on how these modalities may affect the therapeutic relationship would also be of interest, as video-chat facilities offer the addition of visual cues that the telephone cannot, whilst providing both users with flexibility in their locations.

6.3.2 Explore with the use of Theoretical Models

Exploring Theories of Technology Acceptance/Normalisation

PWPs expressed their reluctance of using some telecommunication methods outside of the therapeutic setting (i.e. they did not like to use *Skype*© or the telephone to contact their friends) and this may contribute to their likelihood of use or acceptance.

A future project could be used to examine what factors may affect acceptance of technologies in psychological therapies and within the IAPT context. This project pragmatically selected a mixture of deductive and inductive methods to take an exploratory view of patient and practitioner opinions on the use of OTT psychotherapies. It may be useful to explore these factors utilising a deductive approach and apply theoretical models – specifically those that could be collected under the term: “*Science and Technology Studies*” (Pope et al., 2013, p. 3). For example the Technology Acceptance Model (TAM) which explores how the factors of ‘perceived usefulness’, ‘perceived ease of use’ and ‘attitude towards use of technology’ can affect acceptance of new technologies and its actual usage in a system (Davis, 1989; 1993).

PWPs suggested that patients may be less inclined to utilise the telephone as it may be seen as a novel method of engaging with therapy. As well as acceptance, the factors that could affect the normalisation of technologies in everyday use may be useful to examine. An alternative model explores this and is known as the Normalization Process Theory (NPT). This theory explores how Information Communication Technologies (ICTs) can become embedded in day-to-day routines. The actions of individuals and groups – human agency – are examined in this

model (how they implement, embed and sustain the use of these new practices) (May *et al.*, 2009; May and Finch, 2009). This theoretical approach has been applied to the exploration of healthcare technologies such as eHealth (McEvoy *et al.*, 2014) and thus could be applied to the use of telecommunication technologies in IAPT.

Exploring Concepts of the Therapeutic Relationship in IAPT

Clarkson's (2003) model of the Five Therapeutic Relationships was used to help understand the views of service users and practitioners regarding the effect of OTT on the therapeutic relationship. A future project could investigate this delineation of the therapeutic relationship within an IAPT context. This may be through the use of in-depth interviews to explore which of the therapeutic relationship types are used, how they are built, and/or whether there are aspects which pose as barriers (e.g. the use of the telephone).

Furthermore, it may be of interest to study these different therapeutic relationships in the context of LI Step 2 service and in HI Step 3 services to compare the findings from both services. It was suggested that characteristics of OTT therapies and, by extension, the LI service, could be barriers for the formation of deeper connections (e.g. the Transpersonal Relationship).

6.3.3 The Politics of Care: Exploring the New Worker Force (PWPs)

A strong theme which emerged from the data related to more general comments about the IAPT service from some practitioners (*XII: Therapy in the 21st Century: "Production line therapy"*) – this could be explored further, outside of the delivery modalities context. As an emerging psychological therapy workforce, their views may provide insight and allow further understanding of the profession (e.g. job satisfaction, staff turnover, etc.) which could be useful in informing recruitment and training.

6.4 Conclusions

I will first summarise some conclusions on the three main objectives set for this project and close with comments on the research question.

Objective 1: To analyse the views of service users of treatment modalities in a low-intensity IAPT service

Overall, service users rated over-the-telephone (OTT) and face-to-face (F2F) modalities positively. For example, median ratings were high for satisfaction, relationship rating, helpfulness rating, and likelihood to recommend.

But in relation to the use of the OTT modality, service users expressed both benefits and weaknesses. For example, they noted that the absence of visual cues and non-verbal communication had both advantages and disadvantages. An advantage was suggested to be useful in establishing patient anonymity which could lead to more information disclosure. The disadvantages posed were that service users felt limited in gaining feedback from PWPs without visual cues, and it was also more difficult to explain issues OTT.

Service users commended the increase in access to therapies and the flexibility that the OTT modality offered by removing access barriers that F2F users may face (e.g. cost, distance, time and work commitments, and issues relating to stigma). These views were reflected in their comments around F2F treatment, in which these barriers were the biggest disadvantage. On the other hand, service users communicated that one of the main advantages of F2F therapy was the presence of visual and non-verbal cues.

Service user perceptions of 'what therapy is' were also noted. Some service users suggested that their expectation of psychological therapies were that it was normally delivered F2F and this led to the initial scepticism of OTT use – possible due to dissonance with their expectancy of therapy not being met. However, they further commented that these initial reservations were reduced after using the telephone.

Objective 2: To analyse the views and experiences of Psychological Wellbeing Practitioners of different delivery types

Psychological Wellbeing Practitioners (PWPs) highlighted a preference for F2F; a high proportion selected it as their modality of choice. On the other hand, PWPs highlighted a mixed opinion and critical view with regards to OTT use.

Practitioners noted that one of the main advantages of using the telephone with patients was its ability to improve accessibility to therapies (e.g. removing barriers). In addition,

practitioners valued the practical benefits that the telephone could provide (e.g. flexibility in scheduling). Practitioners critiqued the absence of non-verbal and visual cues with the telephone modality and it was emphasised that that this would be an issue for both them and the patient. Some noted that a difficulty in explaining information OTT where a diagram or visual concept was involved.

Moreover, practitioners reported that the absence of sensory cues (such as visual, and even tactile and olfactory) could be a barrier in building “*presence*” due to their anonymity and this could have implications on the therapeutic relationship. However, some practitioners suggested that this form of anonymity was an advantage particularly if they felt that they were being judged by the patient, which subsequently affected their confidence working in therapy. Interestingly, a number of practitioners noted that a therapeutic relationship can be successfully built regardless of the modality.

Results also indicated that some practitioners had a critical view with regards to the IAPT programme. There were particular concerns with the emphasis and pressures of meeting a particular quota of patients. This approach in practice may inhibit the development of deeper connections in a therapeutic relationship, especially if practitioners see individuals as a number, rather than as a person. This apparent dissatisfaction from some may be due to a dissonance in what they perceived to be the aims of their role compared with the aims of the programme (i.e. aims of care compared with an economic/number-driven aim). Critical views in relation to the IAPT programme, including debates surrounding the suitability of CBT as a de facto therapeutic approach, and whether an economic goal is a suitable one for mental health, have been raised in previous literature. These findings add a different insight into this ongoing debate.

Objective 3: To analyse service user outcomes using data from the IAPT outcome database

Overall, the findings suggested that both F2F and OTT use provided similar beneficial outcomes for the IAPT service users who took part in the research project. It was found that both OTT and F2F modalities provided comparable symptom improvements (i.e. symptom score reductions) for service users across all psychometric instruments (PHQ-9, GAD-7, W&SAS, and IAPT Phobia Scales). For OTT users, there was a significant difference in first and last scores for the PHQ-9, GAD-7 and Specific Phobia scores which was not evident from the scores of F2F

users. The findings from this research project helped to support previous research which concluded that therapeutic outcomes of OTT therapies were beneficial. The findings may also suggest that OTT use provided more significant reductions in symptoms than F2F therapies but it is noted that these statistically significant findings should be treated with caution due to a small sample size used in the analysis.

The effect of demographic (e.g. age, gender) and treatment characteristics (e.g. number of sessions) could not be explored due to insufficient data points. However, it was of interest to find that the profile (both demographic and treatment characteristics) of the sample within this current study reflected the profiles of patients across the IAPT service.

Research Question

To summarise, the research question was as follows:

Does the modality in which an intervention is delivered (telephone versus face-to-face), within the IAPT low-intensity service, affect practitioners' views of its effectiveness, as well as patients' satisfaction and therapeutic outcomes?

The findings from this research project found that the modality does affect practitioner views. Practitioners were positive with regards to the use of a F2F approach but were critical of the use of OTT and its effect on the therapeutic relationship – a topic that was raised in previous evaluations of telemedicine use. Patient views were more positive for both treatment modalities. Access to treatment and the implications of the absence of visual cues were topics highlighted by patients. The results found that therapeutic outcomes for both F2F and OTT therapies were positive supporting previous telemedicine literature. It was also observed that OTT users had significant reductions in some psychometric scores compared with F2F users. However, the sample sizes involved in the project may limit this inference.

To conclude, these findings offer an original contribution to knowledge about views and experiences of using telemedicine within the IAPT service. In particular, it offers new understanding on the use of OTT in IAPT and its implications of the therapeutic relationship. This is a currently understudied topic but one of importance as the therapeutic relationship is usually considered central to therapy. The findings have also provided data about the new practitioner workforce (PWP) and added to a growing area of research regarding them (e.g.

Green *et al.*, 2014; Altson *et al.*, 2014). This research also contributes important insights to wider debates regarding mental healthcare and its provision in the UK.

The trends and results from this research project have helped to cultivate further questions and future research topics that may be explored – e.g. the application of theoretical models to the therapeutic relationship in the context of IAPT, as well as models of technology acceptance and normalisation from the field of Science Technology Studies. The rise of technologies in society will have an impact upon the way people work and utilise services (e.g. in healthcare²⁸) and it is essential that research is used to explore the consequences. Overall, this research project has added further insight to this ever-expanding field.

²⁸ Healthcare technologies and innovations are presented and discussed in The King's Fund's annual International Congress on Telehealth and Telecare (<http://www.kingsfund.org.uk/topics/telecare-and-telehealth>).

CHAPTER 7: My Autoethnography

7.1 Introduction

This chapter presents a personal account of my experiences throughout the research project and the implications of these experiences on how I approached my findings using an autoethnographic approach. The chapter first briefly outlines the methodology, and it will close with the autoethnographic piece entitled *'My Journey as a Polite Researcher'*.

7.2 Autoethnography is...

7.2.1 Overview

Autoethnography is a *"...method that connects the autobiographical, and personal to the cultural, social and political"* (p. xix); 'auto' relating to the *self* and 'ethno' relating to *culture* (Ellis, 2004). It is one of the newest qualitative research methodologies established, which requires researcher reflexivity that rigorously explores the subjective lived experience of the author in relation to the context or the culture of the study (Ellis, 2004; Grant, Short and Turner, 2013). The researcher and the researched are effectively one and the same; the researcher is not trying to be 'the insider', they are 'the insider' (Duncan, 2006; Grant *et al.*, 2013). Autoethnographic pieces enable both members and outsiders of the culture the autoethnographic piece is situated in to better understand this culture (Ellis, Adams and Bochner, 2011).

7.2.2 Methodology

The autoethnographic approach can be likened to literary writing (Wall, 2008). They are highly personalised pieces and evocative accounts which can range from short stories, personal essays or journals. These can also involve dialogue, and can present concrete actions and emotions, as well as representations of embodiment, spirituality and self-consciousness (Ellis, 2004).

An autoethnographic piece is usually written in the first person but the author may wish to use second person in moments that may be too difficult to describe (Ellis, 2004; Ellis *et al.*, 2011; Grant *et al.*, 2013). Some pieces may utilise multiple sources of 'evidence' to accompany it and

enhance understanding; for example, photographs, drawings, etc. (Duncan, 2006; Muncey, 2005). In addition, they analytically explore the experiences and perceptions of the author and how it engages within the context of the culture, exploring the relationship between the personal and the cultural (Ellis *et al.*, 2011; Grant and Zeeman, 2012; Grant *et al.*, 2013).

Significant moments or ‘epiphanies’ are often explored and expressed in an autoethnography (Ellis *et al.*, 2011). These accounts can also be therapeutic for the author and it allows them to immerse themselves in the context producing a narrative which deeply explores the knowledge gathered to enhance understanding – i.e. it allows the author to analyse their experiences and how it related to the outside context. These reflexive pieces can engage with the reader, rather than produce statements, and can draw the reader in and immerse them within the story that is being told (Ellis, 2004; Wall, 2006; Grant, 2010a; Grant and Zeeman, 2012). It can enable those who are reading it to understand the culture under study better, through the eyes of a similar individual (Ellis *et al.*, 2011).

There are ethical implications to consider when writing an autoethnography. ‘Relational ethics’ (see *section 3.4.2*) play a large role in autoethnographies particularly when writing about others. The researcher has a duty to consider who they are writing about and the implications for those connected to them, especially when discussing sensitive topics and particularly if what is described provide identifiable characteristics (Ellis, 2004; Ellis *et al.*, 2011).

7.2.3 Debates surrounding the autoethnographic approach

As previously noted in *section 7.2.1*, Autoethnography has been noted to be more aligned to the ‘artistic’ end of the science-art continuum (Grant, 2010b); it can be described as interplay of the arts and sciences but the main arguments surround whether it can approach a topic in a manner that is either ‘too artful and not scientific’, or ‘too scientific and not artful’ enough (Ellis *et al.*, 2011). This method of writing has been criticised and described as “*self-indulgent and narcissistic*” (Coffey, 1999 as cited in Holt, 2003, p. 3) and too individualised (Duncan, 2006).

The paradigm debates within the social sciences²⁹ can highlight these critiques of autoethnography. Autoethnographies can explore how personal experiences (subjective thoughts, emotions, past experiences and motivations) can influence how research is

²⁹ The paradigms are further discussed in *section 3.2.1*

undertaken; it links to the overarching debate about whether objectivity can be truly maintained in research, particularly when the research involved humans (Holloway and Wheeler, 2002; Ellis *et al.*, 2011).

There have also been criticisms towards the ‘rigour’ of the approach in attaining ‘truth’; more specifically, on its ‘reliability’, ‘validity’ and ‘generalisability’ (Duncan, 2006). In respect to its ‘reliability’ it is the credibility of the author and whether what was described did happen; ‘validity’ is similar to reliability in the aspect of whether if what was described is true, how useful is it to the reader; and finally, ‘generalisability’ relates to whether readers are able to relate to the author of the autoethnographic piece (Ellis *et al.*, 2011).

These three concepts are arguably quantitative concepts and thus when discussing rigour, it may be more useful to discuss it in terms of qualitative concepts of rigour (e.g. ‘credibility’, ‘confirmability’, etc. – Guba, 1981; Lincoln and Guba, 1985; 1986³⁰). The insight and conclusions drawn from autoethnographic pieces can provide useful insight in similar circumstances, providing it is understood within its context: time, location, nature of the experience (or research) and the individual whose point of view is presented (Duncan, 2006). Overall, autoethnographies should be viewed as pieces that enable understanding and commentary rather than focus on ‘accuracy’ of ‘facts’ and the ‘truth’ (Ellis *et al.*, 2011).

7.3 My Research Journey as a Polite Researcher

In this autoethnography, I take a look back on my time as a PhD researcher which has been an experience that has been interesting, rewarding, long and (in some parts) frustrating. In this autoethnographic piece I take ‘snapshot moments’ to help contextualise the approach I took as a researcher. These are salient memories and reflections from my experiences that help to illustrate and highlight certain thoughts, feelings and emotions which may have influenced me as a researcher.

Writing this chapter was difficult for me and has taken me longer than I would have liked. I admit this delay was mainly down to my initial annoyance towards this task – I was initially frustrated about having to do this and was I reluctant to complete this. “*Why?*” you may ask? Well I guess it was something I never thought I would *have* to do. It was not something I wanted to do. I never really intended to bring *me* into the project. Arguably, the ‘Reflexivity’

³⁰ These are further explored in *section 3.2.2*

part of the PhD in *section 4.5* did aim to explore *my* experiences during the PWP interviews and how these may have ‘affected’ the way I interpreted my results or tackled the topic. As I discuss later in this chapter, in hindsight I believe I could have written my reflexivity section up more fully. My supervisors did their best to encourage me but they knew that I was not comfortable and they could only push me as far as I wanted to go I had also completed an enormous amount of data collection and analysis and embarking on collecting and examining reflexive data was daunting.

So here I shall attempt to write an autoethnographic piece (‘attempt’ being an operative word as I did not know where or how to begin). I recounted some of my experiences to help resolve why I have taken this approach to research and I have organised it into three broad themes which emerged:

- (1) My academic background and how it influenced my perception of ‘research’
- (2) My experiences as a ‘researcher in training’
- (3) My experiences as an outsider

The text within the dotted-line boxes represents the snapshots I have recalled [which help to illustrate these themes](#).

Viva exam and its aftermath: Amending my thesis to include an Autoethnographic piece

I had prepared and prepared and prepared myself. This was it. It’s taken me almost five years to get to this stage and I’m finally at the moment which confirms whether or not I had done enough to be awarded that ‘PhD’. Before it seemed so elusive, as if this day was never going to come; now it was in touching distance.

I thought I was ready to defend my research. I mean, the actual viva didn’t go smoothly but it certainly wasn’t the horrible mess that my imagination could conjure up during those sleepless nights. I quite enjoyed the conversation. No one outside of my supervision team and those involved in my research had seemed particularly interested when I would talk about my research so it was nice to spend some time doing just that. When I was called “polite”, it caught me off-guard, I got a little confused; to me I had no reason to believe why this was even a bad thing.

I looked up the Oxford English Dictionary's definition of 'Polite' and it said: "*Having or showing behaviour that is respectful and considerate of other people*" with synonyms including: *well mannered, civil, courteous, respectful, deferential, well behaved, well bred, gentlemanly, ladylike, chivalrous, gallant, genteel, cultivated, gracious, urbane, well brought up; tactful, considerate, thoughtful, discreet, diplomatic*"³¹

When I was questioned about this approach, it felt like a criticism. I didn't know how I could defend it because I believed that being 'polite' was a good approach to take. So I felt a little lost. I felt as though it had undermined all I knew about, or thought I knew about, doing 'research'. It wasn't flagged previously that this approach may not have been appropriate. It made me question myself, I thought: *Should I have taken a side of the IAPT debate? Was I wrong to sit on the fence and be the mediator?*

So I sat in front of my computer for long periods of time staring at a blank Microsoft Word document with the cursor flashing at me, trying to think what to say. I would say the first day was fruitless, I was frustrated still. It took a couple of days of racking the brain and a couple of long walks before I finally started, I took a pad of paper, sat on the sofa, put my headphones in my ear (the song: "*Roar*" by pop songstress Katy Perry – it was apt, it is cheesy but catchy, it was something motivating to begin with) and began scribbling down notes, bullet points, annotations, anything that looked remotely like words and tried to unpack the *why* of my 'politeness'. The more I thought about it, certain aspects became a little clearer.

My Academic Background: My view of "Research"

In section 3.2.1 I provided an overview of the 'Paradigm wars' between Positivism and Interpretivism, between the qualitative and the quantitative approaches. When I started this research journey all I had ever used was the quantitative approach. I had a 'Bachelor of Science' in Psychology. This meant I knew and was taught to investigate psychological phenomena by use of manipulating a situation and then by measuring it. I recall a 'Research Methods' class when the lecturer suggested to the effect that "*all outcomes must be operationalizable*" i.e. it has to be *measurable*. Numbers were always important to the subject, and by extension to my understanding of the subject.

³¹ see: <http://www.oxforddictionaries.com/definition/english/polite>

Academic and applied psychology can be described “...as a modern, Western practice of classification, calibration, and control, psychology is a discipline based on administrative technologies of surveillance” (Burman, 1997, p. 788). Moreover, it takes a positivistic view of sciences where it claims objectivity or ‘disinterest’; prediction, control, validity and replicability were important aspects (ibid, 1997).

What is this thing called ‘Qualitative research’?

My research project took me out of my comfort zone. As a student of Psychology, all I’ve ever known (or thought I knew) about research was how to test a hypothesis using quantitative measurements. I only wanted to use numbers, scales and symptom scores in my research project. This ‘want’ perhaps stemmed from my perceptions of what I think ‘scientific’ research is. I wanted my work to be as ‘scientific’ as possible. I wanted to be considered ‘scientific’. I loved the sciences, I was good at science. One of my biggest regrets was not taking it further in my education; “*if only I had taken Chemistry at A-Level*” sets in my mind every so often. In Psychology, there is a debate questioning whether or not it is a science. This ‘want’ may also be in relation to proving a point to my friends who do not favourably view Psychology or the ‘social’ sciences.

Another aspect of this want and desire was that I also wanted to feel at ease, at home, on familiar ground. I have been told by my supervisors and my manager that I’m ‘conscientious’. It’s true; I like to do a lot of checks and balances, I am mindful of things I need and want to find out. I like to know that I’m doing is the right thing, I’m always vigilant and try to prepare for a twist and turn (sometimes this works, many times [i.e. often] it doesn’t) but it eases my anxiety of failing. I guess the quote by Benjamin Franklin³² sums my perspective: “*By failing to prepare, you are preparing to fail*”. For me, statistical analysis had boundaries; it had a right way and a wrong way to do it, and I was comfortable with these boundaries.

When my supervisors introduced me to the world of qualitative research, I wasn’t happy at first. I had no idea how I was ‘supposed’ to use it or how I could or would approach it. Personally I’d like to think I’m a fairly open-minded person, I like trying new things (e.g. food – I love food) and I like to experiences new things (e.g. I like to travel – currently finances are

³² According to a quick *Google* search

restrictive – but I like to experience new places, see the sights), but here I was hesitant.

Despite this hesitance, I took the suggestion on board and went to investigate it.

I'd like to point out that I didn't think I was ever *against* the idea of qualitative research, I don't think it ever really crossed my mind. I knew very little about it; my discomfort was taking on this new approach. I mean, I knew there were *extremely* big flaws in using only numbers in Psychology (especially when the aspects and phenomena you are trying to investigate are not tangible) but again these probably didn't cross my mind initially – it's how I was trained.

When questioned about what I was really investigating, it quickly dawned on me that I needed to think beyond the numbers, so I knew the only way was qualitative research. As I read around the subject I slowly (well what I mean is *very slowly*) began to take some interest. I must say that one aspect of research, which I know is a 'big deal' but I personally didn't care for, was the conflict of the paradigms. My 'stereotypical' view of qualitative research was definitely a positivist's one but I didn't think my views were as fervent as the views of others. I was thankful that there was something known as mixed methods research and the view of critical realism and a pragmatic approach. I discovered I was comfortable with being pragmatic. I wanted to use tools to *do* the research, not to *think about* doing the research.

Dipping my toes in the world of the qualitative world was interesting, to say the least. As I've said numerous times (because I felt this numerous times), I was uncomfortable with the approach. Unlike statistical analysis, the lines between a 'right way' and 'wrong way' were blurred.

I laughed at myself when I recalled the first time I carried out thematic analysis. My first draft clearly showed it wasn't written by someone who was totally committed to the qualitative way of research. It was presented so clinically, it felt very cold [*as I type this, I've got this version of my preliminary analysis on screen*]. This was a huge learning curve for me; I wanted to make sure I was 'doing it correctly', that I could easily find 'errors' in where I went wrong – the quantitative self was taking over. During the supervision meeting my supervisors effectively (but in the nicest way possible) told me it wasn't how to approach thematic analysis.

Afterwards I went back to the completed questionnaires. I changed the way I looked at it and I definitely felt different, I engaged with the topic a bit more; the data 'spoke' to me (it was as if

the participants were there speaking to me). Before all I saw were tables of quotes ready to be organised, a systematic approach. From then on, I felt a little more at ease with the data.

Statistical analysis has all these mathematical rules that e.g. I must treat numbers in a certain way, but to a certain extent (and within reason) I was 'freer' with words. Despite this 'breakthrough' in understanding, I still cannot describe myself as fully comfortable or can confidently claim to be a 'master' of thematic analysis, there are still doubts in my head questioning whether I approached my work 'correctly' – I guess I can never let my quantitative 'me' take a break. I mean I did take a job in the Office for National *Statistics*; it seems I'm constantly drawn to numbers.

So like my Psychology degree taught me, I was to stay detached and to not interfere when observing or studying the phenomena. This is one factor which influenced my need to take a *neutral position*, my aim was to stay *detached* from the debate, and to not take sides because this was what the psychologist and my quantitative 'me' had known about research. It was my quantitative self who wanted to view things 'objectively'; it was my Psychologist training that told me not to get involved. I guess I was involved in my own little mini-Paradigm war, but in this case the quantitative and positivist side of me was winning.

During my undergraduate studies I was aware of qualitative methods but there was never much emphasis of this in the content of the degree. In fact, some undergraduate research methods textbooks would often highlight the disadvantages of certain approaches which used qualitative data, cautioning that the data would be open to "*researcher bias*" as it can be interpreted differently by different people (e.g. Stangor, 2007), or that subjective views are difficult to control and can 'confound' the results of the study. Of course different interpretations are true and the qualitative approach may be judged less rigorously in the eyes of a quantitative approach, but there are qualitative concepts of rigour that ensure confidence in your findings (e.g. Guba, 1981; Lincoln and Guba, 1985; 1986). In Psychology, '*control of as many of the variables as possible*' was emphasised. Objectivity and measurement were important: numbers, statistics, and seeing changes in symptom scales were essential to what I knew of research.

I should point out that Psychology, although it has arguably utilised a mainly 'narrow' paradigm focus of positivism; has been noted to be currently in the process of a paradigm shift

from a dominance of quantitative methods towards a balanced approach alongside qualitative methods (Ponterotton, 2005). The subjective is now becoming increasingly important in psychology theories and practice, e.g. humanistic approaches which reject the importance of objectivity and empiricism that behaviourism advocated, not focussing on the importance of 'being human' (Cave, 1999; Leahy, 2004; Maltby *et al.*, 2007). As discussed in *section 1.2.1*, there are movements within mental health care which emphasise the de-medicalisation of mental health, a less paternalistic approach in care, distancing from objective measurement and towards the subjective narratives stories of experiences to help better understand the issues.

Taking on a 'more Qualitative' challenge: The PWP Interviews

About two thirds of the way through the project it became evident that my quantitative side of my project was not going to meet the 'target' I planned. The ground below me became pretty unstable (again – *see below about how I started this PhD journey*) – the aspect I was most comfortable with wasn't going the way I planned it (and you know how I like to try to plan!) and so an approach I was only just breaking into was about to play a much bigger role. At that moment I didn't know that this was actually a big opportunity. The PWP interviews were another challenge that would test my quantitative 'me' but at the same time develop my qualitative 'me'. Now looking back at it, it was a fantastic challenge and I was so happy to take it on.

My reflexivity piece wasn't really very 'reflective'. My supervisors have told me that they could tell that I was reluctant to elaborate on it more fully. They were right; it felt alien to talk about *me* and my thoughts. Looking back at *section 4.5*, it definitely feels a little lacklustre. I would like to take this second opportunity to reflect on the interviews and experience of doing the PhD again.

~

Overall, the experience was positive. I think it was mainly down to the individuals who participated in the interviews. They were genuinely very nice and were actively interested in the project – they were co-operative and spoke as much as I could have hoped for. So it was a very positive experience for me. I learnt so much more than I could've done by reading a text book or using some sort of quantitative satisfaction measure.

I think from the nine PWP's I interviewed I felt I was being told the same thing: Initially, most weren't comfortable or happy with using the telephone but as they became more familiar with it, becoming part of their working day, they're now less critical of it. It was actually more 'positive' than I anticipated. I had spoken to various people (academics, including my supervisors, and practitioners) who had a lot of concerns about IAPT – from this I thought I would get a barrage of negativity but it was actually quite the opposite. Yes, there was clear passion in some of the participants but it didn't feel threatening, or anything like that. I clearly acknowledged this passion and discussed this with them further. Some of them, even without me asking them to, would try to balance their views with the opposing viewpoints – perhaps this was so they didn't seem too critical or too one-sided – maybe it was for my benefit as I introduced it as an exploration of both the advantages and disadvantages. I did find that those who had other mental health practitioner training (e.g. counselling) were perhaps more vocal and critical and this was noticeable, again they weren't threatening or anything but I felt they had more to discuss. I would summarise the participants as 'optimistic' – looking forward they acknowledged that technologies will *eventually* help them in their day-to-day work. They stated that more does need to be understood about it in the context of therapy which is probably why they were quite keen to take part.

I did sympathise with the PWP's who mentioned how uncomfortable they were being judged on their appearance and age; that looking young meant you had very little experience. Judgements based on appearances are quite personal. I've experienced this numerous times. It's damaging and aggravating when someone assumes something because of my appearance. I feel some people don't take me as seriously as I do look much younger for my age (which I am told is an advantage when I'm much older). This is probably emphasised by my less-than-towering height. So with all this, I am usually pretty conscious about how I present myself and how others see me. When I was about 10 years old, there was an incident when an older kid (who was *obviously* really small-minded) highlighted my 'different' racial appearance with a derogatory comment [*I would prefer not to repeat it here, but let's say it began with a 'ch' and rhymed with 'pink'...*] – I quickly pointed out that they got the wrong Asian country – nevertheless this really shocked me (even now, recalling it).

This was probably the first (but not the last time) I've experienced some form of racial discrimination; thankfully, this occurrence is few and far between and I have been fortunate

enough to live in a community where my ethnicity isn't remarked on for being different. It's sometimes strange to have this picked up on as I don't feel any different to any of my friends. I wholly sympathised and empathised with the PWP's and their discomfort with judgements. It was therefore important that I communicated this in my thesis that the telephone could help alleviate this type of stressor as no one should have to be immediately judged because of the way they appear – yes it is a fact of life, but it was a positive for me that technology could help stop this type of judgement.

The qualitative 'me' is still young, in relation to the quantitative 'me'; it has only been drawn out of me and fleshed out during this PhD journey. I still have much to learn. I did contemplate how to interpret the qualitative data. I had thought: *"should I give more weight to views from individuals who were more passionately critical, more vocal about one side of the debate?"* but my quantitative 'me' possibly won in regards to wanting to maintain a more balanced view and to only inform the debate, not to get involved. So despite this 'freedom' with words I felt, my other 'me' wanted to retain control of this freedom. This was probably backed by the ethical implications of taking on an agenda despite the project being sold to the participants as an exploratory study (which it was and still is), it would then feel like I was deceiving them, that I was taking their views and selecting only the aspects which support one side of the debate.

As I stated I wanted to *inform* the debate, rather than to be within the debate, taking one side. At university, it was all about having a balanced argument – by presenting both the positives and critical views of the IAPT programme and telemedicine I believe I was accomplishing what I had been taught.

A 'researcher in training': I'm fulfilling the criteria to achieve a PhD, right?

"Accomplishing what I had been taught" – I took on this approach because I was doing what I thought was necessary for the research project. The last five years have been hard and draining enough, doing this PhD has not been a 'walk in the park' (not that I expected it be either). As I recalled, the criticism of me being a 'Polite' researcher and direction to add this autoethnographic piece was difficult to digest and it mildly alarmed me. The addition made me question myself and what I had done: *Did I not do enough to achieve a PhD? Did I approach this all wrong?*

Why did I choose to do a PhD?

The very question I've repeatedly asked myself throughout this whole experience. I'd left university June 2010 and I was unsure what I wanted to do with my recently achieved Psychology degree. I thought I had a number of options open to me: 1) take the steps to become a Clinical Psychologist, 2) to be involved in some Psychology research, 3) go into teaching, or 4) apply for any other graduate job that seemed mildly interesting to me.

I attempted option 1 several times by applying to several Assistant Psychologist positions – these were and are notoriously difficult to attain and this was made even more difficult as I hadn't had any volunteering experience at this point. I had investigated option 2 briefly before I left university and thought it could be another route into becoming a practicing psychologist so I'd been searching on various websites for research assistant posts or research studentships related to the Psychology discipline or explored a mental health topic.

As for the other two options, I did actually lay down some foundations for option 3: I had carried out two weeks of volunteering at two secondary schools and a college in the summer term of 2010 and I had organised to work one-day-a-week at a secondary school during the autumn term to help me prepare for my interview for my PGCE course application in Secondary Science. Teaching was an option that I thought I could do, and I loved science at school (and still do love the sciences – as I've probably said somewhere else in my thoughts). For option 4, there were actually very few jobs on the market which drew any interest from me – my job searches were so broad and unfocussed that that these searches would give me a bit of a headache.

I felt there was a pressure on me from my parents (who disapproved of me taking Psychology in the first place) to use my degree, and to some extent there was also pressure from myself as I had just spent three years of my life working hard to achieve this degree in a field I was still very much interested in; *"it had to have a use!"* I thought. At this point I had also just moved back in with my parents and money was an issue. I needed a position with some monetary reward so I felt pressured into finding a position that either paid me or that had a short training period which led to some form of paid employment. There was an air of optimism when I was successful at getting the doctoral studentship as I thought I could have the best of both worlds – teaching and research. In addition, with the foundations of my Psychology

degree, I thought I had a good stead in my understanding of how I was to approach carrying out this research.

So I return to my original question: *Why did I do this?*

- One, to get more training in research: I wanted more experience in carrying out research, doing research first hand seemed like a great way of achieving it.
- Two, I had an interest in mental health and psychology: The topic had to be something I had some interest in and carrying on within mental health after my Psychology degree seemed like a good starting point.
- Three, it provided me with better employment potential: A PhD on my CV would potentially open lots of doors and provide me with lots of options in future.
- Four, it financially it made sense: It provided me a stipend to live from and I could not afford to fund a PhD myself so the studentship was an opportunity I felt I could not waste – *when else would I get another chance like this?*
- Five, it allowed me to (potentially) fulfil a promise I made to myself: Back in college, I told my Psychology teacher that *'one day I hoped to be a reference in a text book or be referenced by someone'*. It sounded a little silly at the time to me but I guess this opportunity may bring me one step closer to this. Plus to be given the honour of calling yourself *'Doctor'* is something I never thought I would have been able to do!

So as I explored previously, my academic background in Psychology has heavily influenced how I positioned myself within the project. However, undertaking a PhD meant that I was a *student* of research. I was 'in training' and had relatively little experience so naturally, I followed what I thought was required of me. Throughout the process, I have felt that my supervisors have been happy with my progression and what I have demonstrated and applied. I have been described as 'conscientious' and have done my best to ensure I have completed all that has asked and expected of me in order to fulfil the requirements of the PhD. Perhaps I never fully *lived* the research – as it got increasingly difficult I think I treated it more like a *job*, a *task* to complete before I could enjoy or progress to the next level. Frame and Allen (2002) discussed the views of the 'purpose of PhD training'. Their summary stated that it was a method in 'preparing' individuals for career in research or academia. This is in sync with some of my reasons why I took on this journey: it was a method of doing something (hopefully research-based) in the future, to help improve myself in a technical sense.

“Education – from primary level through to university – has been presented as the most effective answer to a range of society’s gravest ills” (De Botton, 2012, p. 101)

De Botton (2012) argues that ‘education’, within the Western definition of education, does not actually *teach* its students about how to live to life and it does not teach ‘wisdom’. Indeed, he notes that the purpose of education (e.g. in the context of modern universities) essentially feeds people with knowledge and theories in a fixed length of time that is usually shorter than the many years it took for the original discoverer to discover and explain it (often a one hour lecture would summarise a lifetime of work). It was therefore a method of saving time, and saving ‘students’ from the many *many* errors the original founders would encounter. Peason and Brew (2010) discusses the pressures on research students in completing a PhD and research education in general. They noted that students are expected to complete this education in the minimum set time, with the aim of achieving a competency-based skill set for future employment with less focus on their contributions to knowledge.

These do ring true from my experiences of research. For me, I focussed a lot on *how* I carried out tasks, the administrative work that went with the research, rather than spending more of my time truly discussing the deeper implications of what I was carrying out. Indeed, the word limit of a thesis would prevent me from fully considering every implication. However, what I thought I was doing enabled me to complete the set criteria required for a PhD.

De Botton (2012) discusses how ‘Western intellectuals’ are often focussed on the *truth*, instead of how it is conveyed. He noted that many people are dubious of an individual who is eloquent with their words – in some cases they are perceived to be *“barren notions with honeyed words”* (p. 125). In my terms, this is someone who could ‘talk the talk’, but would not be able to ‘walk the walk’. The importance is placed on someone being correct. This aspect of education played a role in the underlying weariness towards the use of the qualitative approach – to me, I initially did not understand how the subjective could help me understand something. Numbers and statistics were taught to be as generalisable and they could tell you something almost immediately (i.e. it’s reduced = it’s a symptom improvement = treatment was positive!), but often they cannot be contextualised because they are a set of numbers measured at a point in time.

To me, what De Botton and others suggest is that what is often taught is not how it is in practice. Giampapa (2011) noted that researchers often rely on their theoretical and methodological knowledge to prepare them with *“being in the field”* (p. 132) but this is far more difficult when actually carrying out the research. In my experience, my education did not fully prepare for exploring the world of humans i.e. in a practical sense and in considering all ethical implications which may manifest. Nevertheless, my education did equip me with the knowledge of methods, practical elements of *how* I could do the research, it helped to guide me but it had its limitations. One major aspect was it did not fully help me to fully consider what my true approach to the paradigm debate was – *was I claiming to be something that I was not?*

Research as an Outsider: It's out of my hands

Feeling so out of control!

Never have I ever felt like a true outsider when doing this research. I could neither identify myself as a 'patient' or as a 'practitioner'. I had no experience or involvement in IAPT or even mental health. At the start of the research journey, I couldn't even identify myself as a 'researcher'; to me I was still a 'student'. I believed this feeling of being on the outside, this 'outsider status', helped to enforce this distanced, neutral position I adopted – I was keen and willing to be open to everything I was going to be finding out.

Because I was effectively an outsider I couldn't do much practically during the data collection phase – I had to rely on the PWPs to make contact with service users and to be the gatekeepers. At times this was difficult, I didn't realise how having very little direct involvement in the distribution of the questionnaires and collection of the IAPT scores was going to be so trying. There was a point where I would check my post pigeon hole up to three times a day in a hope there would be a questionnaire return. I would regularly be looking at and sending e-mails or speaking to someone from an IAPT site over-the-telephone asking how distribution was going.

I had so much initial control in the planning stages but when I actually implemented the project, I had no control. It was practically and emotionally frustrating – I was fully reliant on the actions of others and there was nothing else I could do. As this was the only way I could do it and it had to be done this way, I ended up having to begrudgingly accept the situation for what it was.

During this project, I felt like an outsider. When I began this project I had not encountered IAPT before. I learnt a lot about it through the reading material but I had never practised in mental healthcare as a practitioner, nor have I experienced anything in my life that required me to need to access this type of service. I have only had some experience of what it is like through speaking to others about it – academics, practitioners and patients who held pretty different views about it. I felt that because of my lack of first-hand experience, I could not have an opinion of it. Bridges (2001) discussed particular debates relating to observing a community or culture as an outsider. A point often raised is the one in which ‘true’ insiders of a community are the only ones who can properly represent the experience of that community. I fully believed that there is a limit on finding out how you truly feel about something without first-hand experience. Let me take my earlier example of using qualitative research methods; had I accepted on face-value the views of my Psychology peers and my friends, I would have been much more resistant to using qualitative research and not been able to fully appreciate the uses of this research approach.

I should make it clear that at no point had anyone criticised me with regards to being an outsider but this was a view that I had taken to heart. Being an outsider felt like a barrier to me. I am sure most of us have been in a situation where someone has been critical of something you have done (e.g. at work) and you have had that thought to yourself: *“Who are you to tell me that what I am doing is wrong? Have you tried or experienced what I have done? No? Well then you have no right to talk about it like this, go away”* (in some cases stronger language is possibly needed in the final sentence).

Being an outsider in the Faculty

I have always felt a bit different from most of the PhD students in the Health Sciences Faculty. For one, most of my colleagues had practised in their health discipline (e.g. physiotherapy, nursing, occupational therapy, etc.) but I started ‘fresh from’ my undergraduate degree. Some had life experiences and genuine interest in the topic they were about to study – some had experienced it first hand or had a family member who was experiencing or had experienced it. Most importantly, many from my cohort were studying topics outside of mental health or Psychology. It made the journey feel a little lonelier in that respect. It sometimes made me question whether I had what it takes to do a PhD, or whether I was doing it for the right

reasons. I felt a little fraudulent at times as I didn't think I had the authority to talk about something because I only had my undergraduate experience to back it up.

To me, 'being an outsider' was the crux of *the why* I took on a 'polite' and careful approach. It seems rather cowardly, but I wanted to protect and shield myself from this type of criticism but I know how frustrating this kind of critique is. Reflecting on a more personal note, I think I wanted to be accepted and liked. Like many people, I want to avoid rejection. Maslow's hierarchy of needs (as cited in Maltby *et al.*, 2010) proposes the need of 'love' and 'belonging'. Rejection and conflict were types of interactions with others that I wanted to avoid. I did not want to be rejected by the practitioners, by the academic community for being polarising, especially when I still did not have all the facts at my disposal. I noted previously that I felt the need to be 'scientific' because of what other people thought.

When I was growing up I was always taught to always be courteous to anyone despite what may be said, to avoid conflict. However, in an argument, I would always like to balance the views out, to point out the contrary to what was said, to make them think – e.g. when I was called a derogatory term for someone of Chinese origin, I quickly pointed out that I was of Filipino heritage. I tend to keep feelings hidden especially with the more negative emotions, I find that burying these feelings is my way of avoiding conflict, I will only express something when I am confident enough of the facts, I know there is a solid counter argument, or an 'escape route'. Because losing is difficult, I am a sore loser and I punish myself. The rejection is not pleasant. Rejection is difficult; in my personal life, I have been rejected by people close to me for who I am and I have been hurt by this. My professional, my employment, and my academic life need some acceptance, optimism, a balanced viewpoint, not a one-sided view.

Most importantly, this cautious approach is especially poignant because I am discussing or making a statement about a person's life – their health, lifestyle and employment. To me it was not a bland or vanilla way of research but it was an ethical approach. I presented myself as being open to all ideas (which I am and wanted to practice); to then advocate a feeling either way would have felt deceptive. In the case of the PWPs, I had built a great rapport with some of the clinical leads from each of the IAPT sites. Most of them were very helpful to me and were so positive about the project. I think this need to be neutral, emotionally, is down to not wanting to 'hurt' them by association with where they work.

Chapter 7: My Autoethnography

During the interviews, I had been told of practices which others may be seen as careless (see my relational ethics *section 3.4.2* for more information) despite this, I did not think was my intention to adopt a view that it was 'bad practice'. Perhaps my lack of experience in the practical field made me naïve to these practices or perhaps, like I discussed in my relational ethics section, I viewed it in the context of the IAPT programme – I clearly presented the debates within the programme in this thesis – indeed some PWPs suggested that the *job role* had prevented them for going beyond what they wanted to do in terms of care: to assess and/or discuss with someone topics beyond the given protocol in a session.

Yes, there were some concerning issues with how some of them may present themselves professionally (e.g. putting feet on the table, not feeling like they need to make an effort to present themselves) but their work and intentions to help people, their passion for their work was extremely admirable – there is also a degree of understanding felt, there is so much at stake with their roles, there is so much stress associated with this type of work (because, let's face it, people do not go into these roles for a 'pay cheque') so they cannot be 'perfect' at all times. Not everything can go to plan. For the patients, many stated in the 'Other Comments' box about how the treatment they used was 'amazing' and 'really helped them – they really wanted this form of help. It felt wrong for me to reduce or ignore this feedback for the sake of a critical view or to be an 'authority' to tell them that what they thought was good is actually not good – it seemed hypocritical of me if I were to do this.

In addition to being an outsider and considering my approach, the research process was practically made even more difficult because I had little in the way of control with the progression of the project during the data collection phase. I would not like to think I was a 'control freak', I see myself as very organised and ensuring everything would happen as I expected or planned. I am a dab hand with a financial planning Excel spreadsheet for the scenario that I intend to plan whether it is moving in with my partner or planning a holiday, saving up to buy our first house; the 'good old faithful' spreadsheet ready and waiting to help me try to plan for the future.

During an undergraduate Health Psychology lecture I had learnt about the 'locus of control' by Rotter (1966; 1975) and back then the questionnaire suggested that I held an 'internal' locus of control (i.e. someone feels they can personally control it, rather than rely on outside forces). Doing this PhD was the opposite of this. Certain aspects were outside of my control and it was

difficult to experience this: the restarting of the PhD project, the lack of control during the data collection stage, the shift from quantitative data dominance to a more qualitative focussed approach. The loss of control or the perception that control is lost is often noted as a stressor, an antecedent in certain psychological phenomena. For instance, work place stressors (e.g. Marmot *et al.*, 1991) or the role it plays in health behaviours (e.g. Wallston, 1992; Norman and Bennett, 1995). Indeed, my experiences had made me wearier, more guarded, needing control. I therefore believed *how* I presented my PhD was one of the few things I could truly control – I guess there were actually more subconscious forces which influenced my approach.

How I started and then re-started this research journey

December 2010:

I had only been a doctoral research student for around three months when I was given news that was incredibly difficult to comprehend at the time: my original supervisor was leaving the university and was to take her research to another institution, the project my research studentship was attached to. Upon being informed of this, I vividly recalled the first meeting of all the doctoral research students from the faculty who started around October 2010 and someone (I do not remember who exactly) cautioned: *“Your research journey will never be straightforward”*. They were so right. This was to be my first (of many that I soon realised) tests of being a researcher. I was ‘fresh out of university’; I had completed my Psychology degree May-June 2010 and was unsure about what I wanted to do with this new found knowledge and appreciation for mental health. I applied for a studentship and was fortunate enough to be selected. I was extremely new and naïve to the situation I really did not know what to do. It was something I did not expect to happen. I felt so insecure about my future at the university; I felt let down by the system because it transpired that my original supervisor had known there was a possibility they may move to a different university (before I started) so I couldn’t understand why I was accepted when there was already this instability. I was really unhappy. I wanted to quit. Thankfully, I was (eventually) convinced to stay on and devise another piece of research. I began with one supervisor but I personally didn’t feel we ‘clicked’ and I eventually started work with my current supervisors.

January, February and March 2011:

It was a brand new year and I was feeling much more optimistic. I still didn’t know what I wanted to do. After a couple of meetings the idea of a project situated within the Improving

Access to Psychological (IAPT) programme was suggested by my supervisors because the low-intensity training for PWP's was being delivered in the Faculty. I was intrigued and began reading about it. To me, through my Psychology graduate eyes, it sounded like a great idea for an NHS mental health programme. However, after speaking to some other people (including my supervisors), there was clearly a more mixed feeling about it; this intrigued me. I took on the IAPT idea and wanted to find something to investigate which was more familiar to me. My original studentship project involved the use of a telephone support system which was interesting to me because I wanted to know more about how alternatives to face-to-face help can help others. The future is heading towards the use of new technologies and I take on a view of embracing it, although in some cases with some caution – hence my need to explore its effectiveness and impact. Someone mentioned IAPT's use of telephone therapy and I ran with it. I wanted to carry out something that ran in a similar vein to my original studentship – it was slightly comforting knowing that the previous months' work was not completely wasted. After deciding to compare it with more 'traditional' face-to-face work, my research journey had there and then just begun.

So why am I polite?

After carrying out this research, I am still open to all sides of the debate and as I write this autoethnography you will notice I am still having trouble voicing a strong opinion or trying to ensure I have a justification for why I have said something. I personally still do not feel comfortable 'taking a side'. I admit that after this whole journey there is part of me who doubts the IAPT programme. But it is not strong enough for me to tell all my friends and family not to use it. When I began, I thought IAPT was a great idea. Now, I might proceed with a little more caution (e.g. knowing that it only uses one approach because I do not agree with a 'one size fits all' policy with regards to the dominance of CBT) (e.g. Loewenthal and House, 2010). I fully acknowledge the debates surrounding IAPT (e.g. Shedler, Pietroni, *et al.*³³). However, at the same time I do acknowledge the positive findings regarding some outcomes (e.g. Hammond *et al.*, 2011) and it has had some positive feedback from service users (e.g. in this project, as well as other studies such as Parry *et al.*, 2011).

I wanted my work to engage in the *whole* debate. I did not begin this research journey on the question to prove something; I was not 'for' or 'against' anything. Here I have taken the

³³ The Limbus Critical Psychotherapy Conference held in November 2014 aimed to discuss these debates (see footnote 5 in section 1.2.4 for more information)

balanced stance by presenting both sides of the coin fairly and openly. Appearing 'on the fence' in a debate which (currently) has no 'true' right and wrong was important for me because I myself do not know which side I identify myself in. I do present the debates surrounding the context in which my findings have come from it is for those who are actively participating in the debate who are now able to take my findings and discussion and use it to their needs to strengthen and improve credibility in their case. My overall view is that I would rather someone win an argument fairly and openly, with all the facts at their disposal, and to be as *polite* and *respectful* as one can be in an argument.

Returning to the main question of this chapter – it seems numerous factors have played some role in my interpretation or my approach. The more I thought about, the less it seemed like it was a conscious, but more subconscious forces which affected my decisions. I initially split this autoethnographic piece into three broad themes but they had a common thread running through them – the culture of learning and education.

It would be my education that would influence my approach to research, what I was taught about research guided me to be 'distanced'. 'Me' as a Psychology student and 'me' as a quantitative researcher were the main drivers of this approach and the 'me' as a qualitative researcher was drowned out – it is still young and relatively inexperienced. In the context of 'research training', university education can often provide information that often does not prepare a researcher when they actually 'do' the researching. This unpreparedness can be highlighted from the consequences of being an outsider.

Becoming an outsider also played a big part in my research journey – I was mindful to not step on toes, to strive to be accepted and to be liked by 'members' of the context I was studying (IAPT practitioners and service users). Group membership and being accepted is acknowledged to be important for humans, for their psychological development (e.g. Maslow) and as social beings. Being positive and not being too critical of people was a decision which would help me practically (more people were co-operative in helping) and to fulfil the required ethical requirements of how to conduct a research study with humans (e.g. not to deceive).

So in sum, it seems I place myself as a *student*, as someone who is 'in training', someone who is still young, in order to carry out research 'correctly' or how I was taught it. This was further emphasised by my role as an outsider, I felt naive. I did not want to do 'the wrong thing', to

not be rejected, to be criticised. All in all, it was these factors which have made me cautious and less bold; therefore the 'polite researcher'.

Reflecting back on reflecting back: My afterthoughts on Autoethnography

At the start of this 'autoethnographic journey' I was very negative (which I seemed to have reiterated throughout). Nevertheless, I went along for the ride.

Looking at this experience and my views, I felt echoes with the participants in my study with respect to my experiences (of doing it) challenging my preconceived ideas (my initial resistance). At first, I had initial scepticism about this exercise (like they did with using the telephone), but as I did it (scribbling notes down, thinking about it in the context of me as a research student), I slowly began to understand the point of it – of course I knew what it was trying to ask of me, but I kept resisting, thinking it wasn't necessary – it was most likely because I didn't actually know what the 'what' was at this point.

It has actually been quite therapeutic. It was an interesting exercise, and once my negative viewpoint dissipated, I ended up quite liking the experience. The autoethnographic piece helped to further develop and extend 'me' as a critically reflexive thinker. After the viva and during the supervision meetings which followed, I began to gather my thoughts. My supervision meetings helped me to contextualise my personal experience of being a PhD student in discussions about the status of different types of historically situated knowledge. Overall, I got to understand myself a little bit more.

It was freeing to explore 'me' but even I as bring this to a close (because this method is still so new to me) I still have those niggling anxieties about being a non-expert and an outsider to this approach. I still have doubts of whether I've done this the 'right' way, when there probably isn't actually a set way! Rather than just accepting it and *doing* it, I now understand *why* I had taken this approach but it's undeniable that my psychological and quantitative background, as well as the culture of being in education, being in training, being a student, still and will play a big role in how I view research. Perhaps when I (hopefully) have that PhD certified this view will change: "*hey, I'll listen to you because I know you know what you're talking about because you've experience it, got the t-shirt [the PhD]*". So I won't be the *student* anymore; I can call myself a *researcher*.

APPENDIX A: QUESTIONNAIRE QUESTION RATIONALES

Appendix A1 - Service User Questionnaire Questions

This appendix outlines the rationale for each question utilised in the Service User Questionnaire (SUQ). The table below presents the summary of all the questions included. The 'Rationale Page' column in the table specifies the location in this appendix. Please note that some questions were paired as they covered the same issue but were phrased in relation to which modality the patient experienced (either face-to-face or telephone). See *Appendix B1* for the full questionnaire.

Question Number	Question	Rationale Page(s)
Section A		324 - 331
1	Was your first contact/assessment with the service made...?	324
2	Which of the offered recovery programmes did you select?	325
3	Approximately how many sessions (not including your assessment) did you have?	325
4	How was your recovery programme delivered? (Not including your assessment)	325
5	Approximately how many of the face-to-face and telephone sessions did you have? <i>(If answered 'Both' in Q4)</i>	325
6	How much information did you want to give to your health professional when face-to-face/on the telephone with him/her?	325
7	When face-to-face with your health professional, how well did you think he/she listened to you and the information you provided?	326
8	How well were you able to explain the information to your health professional when face-to-face with him/her?	326
9	During your face-to-face sessions, how well did you think your health professional had understood everything you discussed?	326
10	How well did you think you were able to understand the information given to you by your health professional when face to face with him/her?	326
11	When face-to-face with your health professional, how likely were you to ask him/her to further explain the information they had given to you?	327
12	How comfortable did you feel during a face-to-face session?	328
13	In face-to-face sessions, how would you describe your relationship with your health professional?	328
14	Did you have any concerns over privacy when you provided information to your health professional in person (face-to-face)?	328
15	What level of concern did you feel? <i>(If answered 'Yes' to Q14)</i>	328

Appendix A1 – Service User Questionnaire Question Rationale

16	Did you think seeing your health professional in person had an effect on your sessions?	329
17	How much effect did it have on your sessions? <i>(If answered 'Yes' to Q16)</i>	329
18	Do you feel using a face-to-face-delivered recovery package was helpful?	329
19	How likely are you to recommend a face-to-face-delivered recovery package to others?	330
20	How would you use a face-to-face-delivered recovery package again?	330
21	How satisfied were you talking face-to-face to your health professional?	330
22	Have you used another mental health service before <IAPT service name>?	330
23	How was your previous recovery programme delivered? <i>(If answered 'Yes' to Q22)</i>	330
24	<i>If your previous programme was not delivered face-to-face,</i> How did the previous programme compare to this face-to-face-delivered one?	330
25	How much information did you want to give to your health professional when speaking on the telephone with him/her?	326
26	When speaking with your health professional using the telephone, how well did you think he/she listened to you and the information you provided?	326
27	How well were you able to explain the information to your health professional when speaking on the telephone with him/her?	327
28	During your telephone-delivered sessions, how well did you think your health professional had understood everything you discussed?	327
29	How well did you think you were able to understand the information given to you by your health professional when speaking on the telephone with him/her?	327
30	When you were on the telephone to your health professional, how likely were you to ask him/her to further explain the information they had given to you?	327
31	How comfortable did you feel during a telephone-delivered session?	328
32	In telephone-delivered sessions, how would you describe your relationship with your health professional?	328
33	Did you have any concerns over privacy when you provided information to your health professional over-the-telephone?	328
34	What level of concern did you feel? <i>(If answered 'Yes' to Q33)</i>	328
35	Did you think not being able to see your health professional in person had an effect on your sessions?	329
36	How much effect did it have on your sessions? <i>(If answered 'Yes' to Q35)</i>	329

Appendix A1 – Service User Questionnaire Question Rationale

37	Do you feel using a telephone-delivered recovery package was helpful?	329
38	How likely are you to recommend a telephone-delivered recovery package to others?	330
39	How would you use a telephone-delivered recovery package again?	330
40	How satisfied were you talking over-the-telephone to your health professional?	330
41	Have you used another mental health service before <IAPT service name>?	331
42	How was your previous recovery programme delivered? (If answered 'Yes' to Q41)	331
43	If your previous programme was not delivered over-the-telephone, How did the previous programme compare to this telephone-delivered one?	331
Section B		332 - 333
(i)	What do you think are the advantages of using telephone delivery?	
(ii)	What do you think are the disadvantages of using telephone delivery?	
(iii)	What do you think are the advantages of using face-to-face delivery?	
(iv)	What do you think are the disadvantages of using face-to-face delivery?	
(v)	Are there certain characteristics that you have which may affect a decision in choosing a face-to-face-delivered or telephone-delivered recovery programme? (e.g. distance, demands of childcare, beliefs, etc.).	
(vi)	Any other comments?	
Section C		334 - 335
1	Age	
2	Gender	
3	Ethnicity	
4	Do you currently have any dependent children in your household?	
5	Employment question	
6	What is your highest attained level of education?	
7	Approximately how far is Steps 2 Wellbeing from where you live?	

Service User Questionnaire Summary and Rational Contents

SUQ: Section A

Q1 Was your first contact/assessment with the service made...?

[multiple-choice] (a) ...Face-to-Face, (b) ...Over-the-telephone, (c) ...Other (please state), (d) ...I did not have an assessment at the start

The first question helped to differentiate the delivery modality used in the assessment and treatment phases of the IAPT pathway; this is because the research question and objectives aimed to explore the differences between *treatment* modalities (F2F versus OTT).

Q2 Which of the offered recovery programmes did you select?

The second question helped to meet Objective 1(b) as the type of CBT-based treatment programme the patient has used may be a factor that could affect their satisfaction ratings. The programme options are those listed in the IAPT Commissioning and Implementation documents (DoH, 2008a; 2008b). It should be indicated that the most common programme is Guided Self-Help (DoH, 2008a).

Q3 Approximately how many sessions (not including your assessment) did you have?

This question also helped to fulfil Objective 1(b) as the number of sessions may affect the satisfaction ratings and attitudes of patients.

Q4 How was your recovery programme delivered? (Not including your assessment)

Question 4 provided information regarding the delivery modality type used by the patient. This was fundamental to carry out the investigation which explores the differences between the delivery modalities (OTT and F2F).

Q5 *If answered 'Both' in Q4*

Approximately how many of the face-to-face and telephone sessions did you have?

After meeting with the service leads from IAPT sites involved, it was highlighted that some service users experience the use of both OTT and F2F modalities. It was therefore important to accommodate for those who have had experience of both modalities in Question 4. This question had the same aims as Question 3.

The following questions have been paired as they cover the same issue but are phrased in relation to which modality the patient has experienced:

Q6 How much information did you want to give to your health professional when face-to-face with him/her?

Q25 How much information did you want to give to your health professional when speaking on the telephone with him/her?

These questions explored whether the modality type could affect the amount of information a service user was willing to disclose to their health professional. Previous research suggested that using telemedicine modalities elicited more information from the patient (Haas *et al.*, 1996). In addition, it was reported that those who used telemedicine raised more personal issues (McLaren *et al.*, 1996) and felt less inhibited in disclosing information. It was explained that the ‘impersonal nature’ of telemedicine (e.g. not being able to see the other person) may be a factor (Harrison *et al.*, 1996).

Q7 When face-to-face with your health professional, how well did you think he/she listened to you and the information you provided?

Q26 When speaking with your health professional using the telephone, how well did you think he/she listened to you and the information you provided?

Questions 7 and 26 relate to whether the patient had felt that the health professional had listened to them and the information they provided. The therapeutic relationship has been shown to be related to therapeutic outcomes (e.g. Krupnick *et al.*, 1996) and research suggests that Telemedicine could affect this relationship (e.g. Farrand and Williams, 2010). Ong *et al.* (1995) suggested that a good therapeutic relationship includes ‘good manners’. It could be argued that ‘to be listened to’ is a fundamental aspect of ‘good manners’. Additionally, attentive listening was noted to be a factor that influences a positive relationship (Brown, 2012). Respect and trust between the therapist and the patient is important in a good working alliance (Bordin, 1979; Wright and Davis, 1994) and being listened to could be an aspect of respect.

Q8 How well were you able to explain the information to your health professional when face-to-face with him/her?

Q9 During your face-to-face sessions, how well did you think your health professional had understood everything you discussed?

Q10 How well did you think you were able to understand the information given to you by your health professional when face to face with him/her?

- Q11** When face-to-face with your health professional, how likely were you to ask him/her to further explain the information they had given to you?
- Q27** How well were you able to explain the information to your health professional when speaking on the telephone with him/her?
- Q28** During your telephone-delivered sessions, how well did you think your health professional had understood everything you discussed?
- Q29** How well did you think you were able to understand the information given to you by your health professional when speaking on the telephone with him/her?
- Q30** When you were on the telephone to your health professional, how likely were you to ask him/her to further explain the information they had given to you?

The questions presented above (8 to 11, 27 to 30) relate to factors which may affect the ability of the patient and health professional to understand the information exchanged. Questions 8 and 27 asked participants how well they were able to explain the information given to the health professional. Questions 9 and 28 asked how well they believed their health professional understood the information they provided. Questions 10 and 29 asked participants to express the amount of information that was provided to them by the health professional on the scale. Finally, questions 11 and 30 asked participants to rate the likelihood that they sought clarification on the information that was given by the health professional.

Previous studies have found that patients were able to express information about mental health issues to their practitioner clearly which helped to successfully fulfil their needs of undertaking treatment (Hilty *et al.*, 2007). However, it has been suggested by Smith *et al.* (1981) that physical distance between the patient and health professional related to the level of understanding; the further they were apart, the less was understood. A lack of understanding of mental health related information could result in adherence and compliance³⁴ being modified (Miller, 2003). In addition, Westbrook *et al.* (2011) suggested that helping one another to understand what was being conveyed in sessions contributed to a positive therapeutic alliance. Chadwick (2006) noted that a good therapeutic relationship should ensure that understanding is shared between the patient and therapist.

³⁴ It is acknowledged that this medical model-based language is not consistent with the collaborative approach deployed in IAPT but this is the language utilised in these papers; the term 'engagement' may be better placed in the context of this current project.

Q12 How comfortable did you feel during a face-to-face session?

Q31 How comfortable did you feel during a telephone-delivered session?

These questions asked the participant to rate their comfort levels during their F2F and/or OTT sessions. McLaren *et al.* (1996) observed that those using telemedicine found it a 'comfortable experience' and this was also presented by Kirkwood *et al.* (2000). It was further shown that participants who used telemedicine expressed that the comfortable environment helped them to convey their thoughts more freely (Hilty *et al.*, 2007). In F2F CBT, patients expressed that they wish to feel comfortable in the setting of their talking therapy (Wright and Davis, 1994).

Q13 In face-to-face sessions, how would you describe your relationship with your health professional?

Q32 In telephone-delivered sessions, how would you describe your relationship with your health professional?

Questions 13 and 32 asked the participant to rate the rapport felt with the health professional. Concerns about the effect of telemedicine affecting the therapeutic relationship have been raised by some authors (e.g. Miller, 1973; Bashshur, 1995; Ong *et al.*, 1995); as described in section 2.2.3, the therapeutic relationship is an important factor in therapeutic outcome (e.g. Bordin, 1979). However, some studies of the perspectives of service users have suggested that the therapeutic relationship was not affected (Bose *et al.*, 2001).

Q14 Did you have any concerns over privacy when you provided information to your health professional in person (face-to-face)?

Q15 *If answered 'Yes' to Q14*
What level of concern did you feel?

Q33 Did you have any concerns over privacy when you provided information to your health professional over-the-telephone?

Q34 *If answered 'Yes' to Q33*
What level of concern did you feel?

These questions related to the issue of privacy and security of information exchanged between the service user and health professional in telemedicine. Within CBT practice, Wright and Davis (1994) noted that patients expressed a desire for the therapist to provide a physically safe,

private and confidential setting. Privacy has been highlighted as an issue within telemedicine by some authors (e.g. Haas *et al.*, 1996; Starr, 1999) and by some practitioners (Stallard *et al.*, 2010). However, Harrison *et al.* (1996) found that participants who had used telemedicine had no concerns about their privacy being infringed when using telepsychiatry. These were similarly noted from the feedback of patients by Doze *et al.* (1999).

Q16 Did you think seeing your health professional in person had an effect on your sessions?

Q17 *If answered 'Yes' to Q16*
How much effect did it have on your sessions?

Q35 Did you think not being able to see your health professional in person had an effect on your sessions?

Q36 *If answered 'Yes' to Q35*
How much effect did it have on your sessions?

These questions explored whether the participant believed that visual and non-verbal cues could affect their sessions. It has been stated by Cukor and Baer (1994) that one disadvantage of telemedicine is the lack of the visual medium. It was further illustrated that 5% of affective or emotional behaviour was communicated non-verbally (Bensing, 1991) and thus the lack of such information could be a limiting factor on OTT-delivered treatments. Additionally, the level of physical closeness could affect satisfaction rates and understanding. Non-verbal cues were also rated highly in importance (Larsen and Smith, 1981; Smith *et al.*, 1981).

Q18 Do you feel using a face-to-face-delivered recovery package was helpful?

Q37 Do you feel using a telephone-delivered recovery package was helpful?

These questions asked service users how helpful they believed the modality of the treatment they used was. In previous literature, Cavanagh *et al.* (2009) asked their participants whether cCBT was helpful and had a lasting effect to which 35% stated it was 'very helpful' and 54% reported it to be 'quite helpful'. In addition, Reese *et al.* (2002) found that patients rated the helpfulness of OTT psychotherapy similarly to F2F counselling.

Q19 How likely are you to recommend a face-to-face-delivered recovery package to others?

Q38 How likely are you to recommend a telephone-delivered recovery package to others?

These questions queried the likelihood that participants would recommend the treatment modality to others. In previous studies, over 70% of participants who had utilised telemedicine would recommend it to others (Rohland *et al.*, 2000). Cavanagh *et al.* (2009) showed that between 25% and 39% of their participants ‘agreed’ or ‘strongly agreed’ to recommending cCBT to others.

Q20 How would you use a face-to-face-delivered recovery package again?

Q39 How would you use a telephone-delivered recovery package again?

Questions 20 and 39 asked whether the participants would use their treatment modality in future. It was earlier found by Harrison *et al.* (1996) and Kirkwood *et al.* (2000) that service users expressed an interest in using telemedicine for future treatment.

Q21 How satisfied were you talking face-to-face to your health professional?

Q40 How satisfied were you talking over-the-telephone to your health professional?

Objective 1(a) aimed to explore the satisfaction ratings and views of service users on their use of different treatment modalities. Questions 21 and 40 fulfilled this objective as it asked participants to rate their satisfaction of the modality type they used in treatment. Satisfaction ratings are the most commonly reported outcome measure in previous studies of telemedicine (e.g. McLaren *et al.*, 1996; Mair and Whitten, 2000; Kirkwood *et al.*, 2000; Browne *et al.*, 2006) and from these studies, the feedback was mainly positive.

Q22 Have you used another mental health service before <IAPT service name>?

Q23 *If answered ‘Yes’ to Q22*

How was your previous recovery programme delivered?

Q24 *If your previous programme was not delivered face-to-face,*

How did the previous programme compare to this face-to-face-delivered one?

Q41 Have you used another mental health service before <IAPT service name>?

Q42 *If answered 'Yes' to Q41*

How was your previous recovery programme delivered?

Q43 *If your previous programme was not delivered over-the-telephone,*

How did the previous programme compare to this telephone-delivered one?

These questions covered comparisons of current modality type to previous treatments.

Cavanagh *et al.* (2009) found that 83% of those who utilised cCBT rated it better or as good as previous psychological treatments.

Participants were instructed to answer two out of the three questions if the previous modality type was different in order to fulfil the aims of comparing the two different modality types (i.e. F2F versus OTT). If the questions asked to compare the previous treatment regardless of whether it was different or the same, those who may have utilised telephone treatment and compared it with previous telephone treatment (or F2F with F2F) might have been likely to base comparisons on how a *service* delivered the treatment and not how the *modality* may have affected the delivery of this treatment. This was also the reason why those who have experienced both modalities in IAPT were not asked to complete this part of the questionnaire.

SUQ: Section B

Section B, entitled 'In Your Own Words', contains six open-ended questions that aimed to fulfil Objective 1(c): *"What are patients' views on face-to-face and telephone therapy in their own words?"*

All participants were asked to complete this section. It opens with a brief introduction that helped inform the participants of the aims and purpose of this section and the questions that would follow:

"I am very interested in hearing people's own opinions on the use of different types of treatment (face-to-face or telephone) in mental healthcare.

It would be very helpful if you could please answer the following questions in as much detail as you wish."

The first four questions asked participants their own opinions about the advantages and disadvantages of using OTT-delivered treatments and using F2F-delivered treatments:

- **What do you think are the advantages of using telephone delivery?**
- **What do you think are the disadvantages of using telephone delivery?**
- **What do you think are the advantages of using face-to-face delivery?**
- **What do you think are the disadvantages of using face-to-face delivery?**

Previous authors have investigated the potential advantages to telemedicine. Galinsky *et al.* (1997) provided some evidence which suggested that telemedicine could help to overcome treatment barriers (e.g. the cost and time spent going to treatment). In addition, it was noted that it could help those who believe it is stigmatising to have a mental health issue, and also those who may not be able to attend treatment due to high anxiety levels (Rosenblum, 1969; Miller, 1973; Yellowlees *et al.*, 2003). Telemedicine could also help those where mental healthcare provision is scarce and/or it is too far for them to travel to access help (King *et al.*, 2003; Hilty *et al.*, 2007). On the other hand, the disadvantages of telemedicine could be its effect on the therapeutic relationship (e.g. Miller, 1979; Cukor and Baer, 1994).

The next question helped to fulfil Objectives 1(b): *"Do factors other than modality type affect patients' satisfaction ratings?"* as well as Objective 1(c).

- **Are there certain characteristics that you have which may affect a decision in choosing a face-to-face-delivered or telephone-delivered recovery programme? (e.g. distance, demands of childcare, beliefs, etc.).**

This question explored whether some participants believe that certain demographic factors (e.g. ethnicity, beliefs, children, geographical location, etc.) may affect their use of telemedicine and also why this may be the case. Previous studies such as Galinsky *et al.* (1997) and Hardiker and Grant (2009) have suggested that some treatment barriers and demographic factors may inhibit a person from using F2F treatment, e.g. the demands of childcare, their socioeconomic status, and education attainment, etc. Other factors (such as attitudes) could also affect this uptake.

The final question: ‘Any other comments?’ gave participants a chance to provide any other thoughts they may have had about telemedicine that was not covered in Section A.

SUQ: Section C

Section C ('About You') consists of seven questions that are multiple choice or short answer input. Question 7, in this section, was personalised to correspond with the name of the IAPT site that the service user utilised. All participants were asked to complete this section which provided general demographic data concerning the study sample. Statistical analysis was used to help explore whether certain demographic factors are associated with satisfaction rates and attitudes towards a certain treatment modality (e.g. as demonstrated by Hardiker and Grant, 2009). This data helped to fulfil Objective 1(b).

The rationale behind gaining information regarding the level of education attainment and employment status was to help infer socioeconomic status (SES). Hardiker and Grant (2009) observed that SES may affect the uptake or acceptability of telemedicine or eHealth services. Further to this, Galinsky *et al.* (1997) also suggested that SES may be seen as a treatment barrier. However, asking patients to provide details on their SES cannot be explicitly stated as it may cause offence. Braveman *et al.* (2005) noted that it is difficult to attain pure SES ratings due to the number of factors which affect it. Thus, the questionnaire asked participants to provide details on education attainment and current employment status. It must be stressed that SES was not exclusively measured and could only be *inferred* from the data collected.

In the UK, employment status is one of the main indicators used by the Office of National Statistics (ONS) (2010) to determine the socioeconomic group of an individual. However, a more recent report suggested that other factors, alongside economic factors (e.g. property capital, employment and salary), can help to establish the socioeconomic group of the individual. These indicators include the "social capital" of an individual (this is inferred from the professions of friends, family, and acquaintances of the individual) and their "cultural capital" (inferred from the type of leisure activities an individual involves themselves with) (Savage *et al.*, 2013).

Hardiker and Grant (2009) further presented that educational attainment is also another factor that can influence the ability of a patient to enter into a telemedicine programme and thus it was also explored independently.

The inclusion of questions pertaining to distance from the IAPT site and dependent children relate to the evidence which suggests these factors are treatment barriers (e.g. Galinsky *et al.* 1997; Miller and Weissman, 2002; Swinton *et al.*, 2009). The 'demands of childcare' factor was

inferred from whether the participant declared that they have ‘dependent children’ (children less than 16 years) in their household and would be more likely therefore to require childcare (Department for Work and Pensions, 2009).

The question about gender was due to previous findings by Cavanagh *et al.* (2009) who demonstrated that female participants had rated cCBT more positively than male participants. The question asking the age of the participant was due to mixed findings which have reported that, in comparison to younger participants, those who were of older ages rated internet-delivered treatments to be less helpful (Hardiker and Grant, 2009). On the other hand, Cavanagh *et al.* (2009) noted that satisfaction ratings between different age groups did not differ significantly. Finally, ethnicity was asked as Hardiker and Grant (2009) also found that white ethnicity groups were more likely to engage with internet-delivered treatments in comparison to non-white ethnicity groups.

Options for each question were chosen on the basis of existing questionnaires and results published by the ONS and the Centres for Disease of Control and Prevention (CDC):

- Ethnicity group choices were taken from the ONS (2001) criteria for how to present ethnic and national groups in data;
- Education level attainment and employment status choices were adapted from the questions utilised within the *Behavioral Risk Factor Surveillance System Survey Questionnaire* (CDC, 2008) and the *2011 UK Census* (ONS, 2011).

Appendix A2 - PWP Questionnaire Questions

This appendix outlines the rationale for each question utilised in the PWP Questionnaire (PWQ). The table below presents the summary of all the questions included. The 'Rationale Page' column in the table specifies the location in this appendix. Similar to the SUQ, some questions were paired as they covered the same issue but were phrased in relation to which modality the patient experienced (either face-to-face or telephone). See *Appendix C1* for the full questionnaire.

Question Number	Question	Rationale Page
Section A		338 - 344
1	What treatment modality do you mainly work with	338
2	In general, how would you rate the likelihood that patients will engage with the recovery package when communicating with them over-the-telephone?	338
3	When communicating with a patient over-the-telephone, how likely will he/she carry out what is required of their recovery package?	339
4	How satisfied are you with patients' progress if their recovery package is delivered over-the-telephone?	339
5	How would you rate the likelihood that patients will relapse after using a recovery package delivered over-the-telephone?	340
6	When supporting patients over-the-telephone, how much information were they willing to provide you?	340
7	During telephone-delivered sessions, how easy was it to understand the information given by patients?	340
8	How much information did you feel you were able to give to patients when using telephone delivery?	340
9	How well did you feel you were able to explain the information to patients when using telephone delivery?	340
10	How would you rate patients' understanding of the information you provided using the telephone modality?	340
11	How would you rate the likelihood that patients would ask you to explain, in further detail, the information you provided them when using the telephone modality?	341
12	In general, how comfortable do you feel during a telephone-delivered session?	342
13	How would you rate the level of empathy you were able to provide patients when communicating over-the-telephone?	342

14	Do you think the absence of visual and non-verbal information can have an effect on your sessions?	342
15	<i>If answered 'Yes' to Q14</i> How do you think it can affect your sessions?	342
16	How would you rate your rapport with a patient when using telephone delivery?	343
17	How easy did you find it to schedule treatment sessions when using the telephone modality?	343
18	How satisfied are you using the telephone as a treatment modality?	343
19	Is this your preferred treatment modality of working?	343
20	<i>If answered 'No' to Q19</i> Which is your preferred treatment modality?	343
21	How would you rate the likelihood that a patient will engage with the recovery package when communicating with them face-to-face?	339
22	When communicating with a patient face-to-face, how likely will he/she carry out what is required of their recovery package?	339
23	How satisfied are you with patients' progress if their recovery package is delivered face-to-face?	339
24	How would you rate the likelihood that patients will relapse after using a recovery package delivered face-to-face?	340
25	When supporting patients face-to-face, how much information were they willing to provide you?	340
26	During face-to-face-delivered sessions, how easy was it to understand the information given by patients?	341
27	How much information did you feel you were able to give to patients when using face-to-face delivery?	341
28	How well did you feel you were able to explain the information to patients when using face-to-face delivery?	341
29	How would you rate patients' understanding of the information you provided using the face-to-face modality?	341
30	How would you rate the likelihood that patients would ask you to explain, in further detail, the information you provided them when using the face-to-face modality?	341
31	In general, how comfortable do you feel during a face-to-face-delivered session?	342
32	How would you rate the level of empathy you were able to provide patients when communicating face-to-face?	342
33	Do you think the presence of visual and non-verbal information can have an effect on your sessions?	342
34	<i>If answered 'Yes' to Q33</i> How do you think it can affect your sessions?	342

Appendix A2 – PWP Questionnaire Question Rationale

35	How would you rate your rapport with a patient when using face-to-face delivery?	343
36	How easy did you find it to schedule treatment sessions when using the face-to-face modality?	343
37	How satisfied are you using face-to-face as a treatment modality?	343
38	Is this your preferred treatment modality of working?	343
39	<i>If answered 'No' to Q38</i> Which is your preferred treatment modality?	343
40	Which of the two treatment modalities you work with do you prefer?	344
41	If service users were given a choice, which treatment modality do you think would be the most popular?	344
Section B		345
<ul style="list-style-type: none"> Please write down (in as much detail as you wish) your reasons for the ratings you provided in Section A 		

PWP Questionnaire Summary and Rationale Contents

PWQ: Section A

Q1 What treatment modality do you mainly work with?

The first question provides information about the modality type used by the health professional. This was extremely important as the primary aim of the investigation was to look at differences between treatment modalities (OTT and F2F). As indicated in section 3.3.2, service users may have experience of using both OTT and F2F modalities and this was also true for PWPs, thus it was important that the 'Both' option was available.

Similar to the SUQ, the following questions are paired as they explore the same issue but are phrased in relation to the delivery modality. However, unlike the SUQ, some likert scales were reversed to prevent 'yea-saying' (Streiner and Norman, 1995); the pilot study for the PWQ feedback (see the following *Pilot Study* section) suggested that it would be a useful tactic in order to prevent participants from answering the scales with the same number.

Q2 In general, how would you rate the likelihood that patients will engage with the recovery package when communicating with them over-the-telephone?

Q21 How would you rate the likelihood that a patient will engage with the recovery package when communicating with them face-to-face?

These questions asked the PWP whether or not patients were more likely to engage with the treatment when using either F2F or the OTT modality. It was important for PWPs to help patients engage with the treatment (Richards and Whyte, 2009). However, Miller (2003) noted that aspects of patient engagement (in terms of adherence and compliance) can be affected by utilising telemedicine. Chadwick (2006) cautioned that practitioners should aim to build a relationship first and focus on the patient, instead of focussing on the act of ‘trying to get a patient to engage’.

Q3 When communicating with a patient over-the-telephone, how likely will he/she carry out what is required of their recovery package?

Q22 When communicating with a patient face-to-face, how likely will he/she carry out what is required of their recovery package?

Question 3 and 22 related to whether, in the experiences of the PWPs, patients were likely to follow what is needed to be completed by patients during their recovery package (e.g. completing homework). Stallard *et al.* (2010) presented that health practitioners were concerned about non-completion and drop outs when utilising cCBT. These questions follow on from the aims of questions 2 and 21

Q4 How satisfied are you with patients’ progress if their recovery package is delivered over-the-telephone?

Q23 How satisfied are you with patients’ progress if their recovery package is delivered face-to-face?

These questions asked participants whether they were satisfied with the progress of the patients when they were using the modality in question. Harrison *et al.* (1996) found that practitioners commented that they were satisfied with how a patient progressed when using telemedicine. On the other hand, practitioners also commented that it could be difficult to detect changes in the symptoms of the patient when using self-help treatments (MacLeod *et al.*, 2009).

Q5 How would you rate the likelihood that patients will relapse after using a recovery package delivered over-the-telephone?

Q24 How would you rate the likelihood that patients will relapse after using a recovery package delivered face-to-face?

These questions asked participants to rate the likelihood that patients would relapse when using a particular modality. Evidence from telemedicine treatments (such as cCBT) has shown that beneficial effects continue 6-months post-treatment (e.g. Proudfoot, 2004); thus, it was of interest to gauge their views of the therapeutic effectiveness using a particular modality and whether it can provide an enduring effect.

Q6 When supporting patients over-the-telephone, how much information were they willing to provide you?

Q25 When supporting patients face-to-face, how much information were they willing to provide you?

These questions explored the amount of information a PWP perceives a patient provides them. This was in relation to previous literature which suggested that more personal information is shared by the patient in a telemedicine setting (McLaren *et al.*, 1996; Stallard *et al.*, 2010). Moreover, some patients felt less inhibited using telemedicine and thus expressed more to their health professional (Harrison *et al.*, 1996).

Q7 During telephone-delivered sessions, how easy was it to understand the information given by patients?

Q8 How much information did you feel you were able to give to patients when using telephone delivery?

Q9 How well did you feel you were able to explain the information to patients when using telephone delivery?

Q10 How would you rate patients' understanding of the information you provided using the telephone modality?

- Q11** How would you rate the likelihood that patients would ask you to explain, in further detail, the information you provided them when using the telephone modality?
- Q26** During face-to-face-delivered sessions, how easy was it to understand the information given by patients?
- Q27** How much information did you feel you were able to give to patients when using face-to-face delivery?
- Q28** How well did you feel you were able to explain the information to patients when using face-to-face delivery?
- Q29** How would you rate patients' understanding of the information you provided using the face-to-face modality?
- Q30** How would you rate the likelihood that patients would ask you to explain, in further detail, the information you provided them when using the face-to-face modality?

The questions presented above (7 to 11 and 26 to 30) relate to factors which may relate to ability of the patient and the practitioner in understanding the information communicated when using a particular modality. Questions 7 and 26 related to the perceived amount of information, provided the patient, understood by the practitioner. Questions 8 and 27 looked at the perceived amount of information they could communicate to the patient. Questions 9 and 28 asked how able they were to explain this information as fully and clearly as they could have. Questions 10 and 29 asked the PWP to rate level of understanding a patient had on the information provided by them. Finally, questions 11 and 30 explored whether the telemedicine modality, in the experience of the PWPs, could affect a patient from actively seeking clarification about the information they had given.

Smith *et al.* (1981) found that physical distance is related to level of understanding of information provided by the health professional and thus telemedicine may affect the amount that is being understood. This is an important issue as the level of understanding, especially from the perspective of a therapist could result in an effect on adherence and compliance (Miller, 2003). Westbrook *et al.* (2011) also suggest that the perception and ability of the therapist to understand the problem presented by the patient is very important in building a good therapeutic relationship. Chadwick (2006) also noted the importance of shared

understanding (including information and emotional aspects) between the patient and practitioner for a positive therapeutic relationship to be built.

Q12 In general, how comfortable do you feel during a telephone-delivered session?

Q31 In general, how comfortable do you feel during a face-to-face-delivered session?

These questions asked participants to rate the level of comfort they felt during either F2F or OTT sessions. Simpson *et al.* (2001b) found that some health professionals rated the telemedicine setting to be comfortable.

Q13 How would you rate the level of empathy you were able to provide patients when communicating over-the-telephone?

Q32 How would you rate the level of empathy you were able to provide patients when communicating face-to-face?

A rating of the empathy levels and compassion perceived towards the patient using a particular modality was asked. Bashshur (1995) suggested that components such as empathy can be lost when using telemedicine. Health professionals also expressed concerns about the ability to communicate empathy to patients when utilising cCBT (Stallard *et al.*, 2010).

Q14 Do you think the absence of visual and non-verbal information can have an effect on your sessions?

Q15 *If answered 'Yes' to Q14*

How do you think it can affect your sessions?

Q33 Do you think the presence of visual and non-verbal information can have an effect on your sessions?

Q34 *If answered 'Yes' to Q33*

How do you think it can affect your sessions?

Similar to the SUQ, questions that related to whether the presence or absence of visual and non-verbal cues can have an effect on sessions were asked. It was suggested that there was a 'loss of presence' between the patient and health professional during telemedicine sessions (Simpson *et al.*, 2001a; 2001b). Additionally, McLaren *et al.* (1996) suggested that it would be

difficult to detect emotions. Westbrook *et al.* (2011) also suggested that it was important to use non-verbal information to help detect disruptions in a therapeutic relationship.

Q16 How would you rate your rapport with a patient when using telephone delivery?

Q35 How would you rate your rapport with a patient when using face-to-face delivery?

Questions 16 and 35 asked participants to rate their rapport with patients when using the modality they worked with. The therapeutic relationship and the effect telemedicine may have on it has been expressed by many studies (e.g. Stallard *et al.*, 2010) and also by some authors (e.g. Bashshur, 1995; Miller, 2003). However, there have been a number of studies which have reported that the level of rapport was not affected and was positive during the use of telemedicine tools (e.g. Harrison *et al.*, 1996).

Q17 How easy did you find it to schedule treatment sessions when using the telephone modality?

Q36 How easy did you find it to schedule treatment sessions when using the face-to-face modality?

It has been suggested that telemedicine can make record keeping and administration easier in practice (King *et al.*, 2003). Harrison *et al.* (1996) noted that it is easier to arrange appointments when using telemedicine. Therefore, it was of interest to explore whether these applied in an IAPT setting.

Q18 How satisfied are you using the telephone as a treatment modality?

Q37 How satisfied are you using face-to-face as a treatment modality?

Stallard *et al.* (2010) observed that health professionals gave an overall positive rating on practicing with telemedicine (in particular cCBT). Therefore it was of interest to find out the overall satisfaction from PWPs when using their modality type.

Q19/38 Is this your preferred treatment modality of working?

Q20/39 *If answered 'No' to Q19/Q38*

Which is your preferred treatment modality?

Q40 Which of the two treatment modalities you work with do you prefer?

Objective 2(a) sought to explore which of the modalities PWPs prefers to work with the most. Health professionals (e.g. CBT Therapists) returned positive ratings towards telemedicine tools (e.g. cCBT) (e.g. Stallard *et al.*, 2010). Thus it was of great interest to find out the preferences of PWPs. It should be noted that those who work only with either F2F or OTT delivery answered questions 20 and 39, or 19 and 38, respectively. However, those who have worked with both only answered question 40. This accommodated for those who have worked with both as questions 20 and 39 would not be applicable and it was important to find out the modality preference of all the PWPs.

Q41 If service users were given a choice, which treatment modality do you think would be the most popular?

This question looked at the perception of the patient preference the health professional had between the two modality types. This assisted in inferring the attitude of the health professional towards the two.

PWQ: Section B

In Section B (also entitled as ‘In Your Own Words’), participants were asked to provide reasons for their given ratings in the previous section. This free-text question included prompts to help participants answer the question. These prompts asked them to “...*consider benefits and difficulties that may affect the patient and your relationship with them*”. It also asked participants to consider how past experiences may have affected their opinion. This section aimed to realise themes and provide further insight into particular factors and reasons as to why health professionals may prefer a certain treatment or modality type. This helped to fulfil Objective 2(c) which explores how practitioners explain their views and treatment modality preference. The purpose of Section B is similar to the aims set out by MacLeod *et al.* (2009) and Stallard *et al.* (2010): to explore health practitioner views of using certain treatment types (e.g. self-help and cCBT, respectively).

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APPENDIX B: SERVICE USER QUESTIONNAIRE PACK

Appendix B1 - Service User Questionnaire

SERVICE USER QUESTIONNAIRE

Exploring the effectiveness of different treatment modalities (telephone versus face-to-face) and an analysis of patients' and practitioners' views of these in an IAPT low-intensity service

SECTION A: About Your Recovery Package

1. Was your first contact/assessment with the service made...? *Please tick only one*
 - Face-to-Face
 - Over the Telephone
 - Other (please state): _____
 - I did not have an assessment at the start

2. Which of the offered recovery programmes did you select?
 - Brief Cognitive Behavioural Therapy (CBT)
 - Computerised Cognitive Behavioural Therapy (cCBT)
 - Guided Self-Help (with a manual/book/text & therapist contact)
 - Pure Self-Help (with a manual/book/text *only*)
 - Behavioural Activation
 - Prescribed Exercise/Physical Activity
 - Psychoeducational Group / Classes
 - Other (please state): _____
 - I am not sure
 - I do not remember

3. Approximately how many sessions (not including your assessment) did you have?

4. How was your recovery programme delivered? (Not including your assessment)
Please tick only one
 - Face-to-Face
 - Over the telephone
 - Both

5. *If answered 'Both' in Q4*
Approximately how many of the face-to-face and telephone sessions did you have?
Face to Face: _____
Over the telephone: _____

Referring back to Q4:

If answered Face-to-Face please only answer Q6 to Q24, then continue to Sections B & C

If answered Telephone please only answer Q25 to Q43, then continue to Sections B & C

If answered Both please answer Q6 to Q21 and Q25 to Q40, then continue to Sections B & C

Please mark only one for each question

6.	How much information did you want to give to your health professional when face-to-face with him/her?						
I wanted to give very little information	1	2	3	4	5	I wanted to give a lot of information	
7.	When face-to-face with your health professional, how well did you think he/she listened to you and the information you provided?						
He/she did not listen very well	1	2	3	4	5	He/she listened very well	
8.	How well were you able to explain the information to your health professional when face-to-face with him/her?						
Not Very Well	1	2	3	4	5	Very Well	
9.	During your face-to-face sessions, how well did you think your health professional understood everything you discussed?						
He/she did not understand it very well	1	2	3	4	5	He/she understood it very well	
10.	How well did you think you were able to understand the information given to you by your health professional when face-to-face with him/her?						
I did not understand everything	1	2	3	4	5	I understood everything	
11.	When face-to-face with your health professional, how likely did you want to ask him/her to further explain the information they had given to you?						
I was very likely to ask for an explanation	1	2	3	4	5	I was very unlikely to ask for an explanation	

12. How comfortable did you feel during a face-to-face session?

Very Uncomfortable	1	2	3	4	5	Very Comfortable
--------------------	---	---	---	---	---	------------------

13. In face-to-face sessions, how would you describe your relationship with your health professional?

A very bad one	1	2	3	4	5	A very good one
----------------	---	---	---	---	---	-----------------

14. Did you have any concerns over privacy when you provided information to your health professional in person (face-to-face)?

Yes

No

15. If answered Yes to Q14
What level of concern did you feel?

Large amount of concern	1	2	3	4	5	Minimal amount of concern
-------------------------	---	---	---	---	---	---------------------------

16. Did you think seeing your health professional in person had an effect on your sessions?

Yes

No

17. If answered Yes to Q16
How much effect did it have on your sessions?

Very large effect	1	2	3	4	5	Very minimal effect
-------------------	---	---	---	---	---	---------------------

18. Do you feel using a face-to-face-delivered recovery package was helpful?

Very unhelpful	1	2	3	4	5	Very helpful
----------------	---	---	---	---	---	--------------

19. How likely are you to recommend a face-to-face-delivered recovery package to

others?						
Very unlikely to recommend	1	2	3	4	5	Very likely to recommend
20. How likely would you use a face-to-face-delivered recovery package again?						
Very unlikely to use again	1	2	3	4	5	Very likely to use again
21. How satisfied were you talking face-to-face to your health professional?						
Very unsatisfied	1	2	3	4	5	Very satisfied

Referring back to Q4:

*If answered **Both** please continue to **Q25***

*If answered **Face-to-Face** please continue to **Q22***

Please mark only one for each question

22.	Have you used another mental health service before Southampton Steps 2 Wellbeing?					
	<input type="checkbox"/> Yes					
	<input type="checkbox"/> No					
23.	<i>If answered <u>Yes</u> to Q22</i> How was your previous recovery programme delivered?					
	<input type="checkbox"/> Face-to-Face					
	<input type="checkbox"/> Telephone					
	<input type="checkbox"/> Internet					
	<input type="checkbox"/> Other (please state): _____					
24.	<i>If your previous programme <u>was not delivered face-to-face</u></i> How did the previous programme compare to this face-to-face-delivered one?					
Much worse	1	2	3	4	5	Much better

Referring back to Q4:

*If answered **Face-to-Face** please continue to **Section B***

Please mark only one for each question

25. How much information did you want to give to your health professional when speaking on the telephone with him/her?							
I wanted to give very little information	1	2	3	4	5	I wanted to give a lot of information	
26. When speaking with your health professional using the telephone, how well did you think he/she listened to you and the information you provided?							
He/she did not listen very well	1	2	3	4	5	He/she listened very well	
27. How well were you able to explain the information to your health professional when speaking on the telephone with him/her?							
Not Very Well	1	2	3	4	5	Very Well	
28. During your telephone-delivered sessions, how well did you think your health professional understood everything you discussed?							
He/she did not understand it very well	1	2	3	4	5	He/she understood it very well	
29. How well did you think you were able to understand the information given to you by your health professional when speaking on the telephone with him/her?							
I did not understand everything	1	2	3	4	5	I understood everything	
30. When you were on the telephone with your health professional, how likely did you							

want to ask him/her to further explain the information they had given to you?						
I was very likely to ask for an explanation	1	2	3	4	5	I was very unlikely to ask for an explanation
31. How comfortable did you feel during a telephone-delivered session?						
Very Uncomfortable	1	2	3	4	5	Very Comfortable
32. In telephone-delivered sessions, how would you describe your relationship with your health professional?						
A very bad one	1	2	3	4	5	A very good one
33. Did you have any concerns over privacy when you provided information to your health professional over the telephone?						
<input type="checkbox"/> Yes						
<input type="checkbox"/> No						
34. If answered <u>Yes</u> to Q33						
What level of concern did you feel?						
Large amount of concern	1	2	3	4	5	Minimal amount of concern
35. Did you think not being able to see your health professional in person had an effect on your sessions?						
<input type="checkbox"/> Yes						
<input type="checkbox"/> No						
36. If answered <u>Yes</u> to Q35						
How much effect did it have on your sessions?						
Very large effect	1	2	3	4	5	Very minimal effect

43. *If your previous programme was not delivered over the telephone*
How did the previous programme compare to this telephone-delivered one?

**Much
worse**

1

2

3

4

5

**Much
better**

Thank You
Please continue to [Section B](#)

SECTION B: In Your Own Words

I am very interested in hearing people’s own opinions on the use of different types of treatment (face-to-face or telephone) in mental healthcare.

It would be very helpful if you could please answer the following questions in as much detail as you wish. Please continue onto a separate sheet if necessary.

What do you think are the advantages of using telephone delivery?

What do you think are the disadvantages of using telephone delivery?

What do you think are the advantages of using face-to-face delivery?

What do you think are the disadvantages of using face-to-face delivery?

Are there certain characteristics that you have which may affect a decision in choosing a face-to-face-delivered or telephone-delivered recovery programme? (e.g. distance, demands of childcare, beliefs, etc.)

Any other comments?

Thank You
Please continue to [Section C](#)

SECTION C: About You

Please answer as many questions as possible. If you do not wish to answer certain questions, please leave them blank.

1. Age _____

2. Gender Male Female

3. Ethnicity

White	Mixed	Asian or Asian British	Black or Black British	Other Ethnic Groups
<input type="checkbox"/> English / Welsh / Scottish / Northern Irish / British. <input type="checkbox"/> Irish. <input type="checkbox"/> Other White background (Please state). _____ _____	<input type="checkbox"/> White and Black Caribbean. <input type="checkbox"/> White and Black African. <input type="checkbox"/> White and Asian. <input type="checkbox"/> Other mixed background (Please state). _____ _____	<input type="checkbox"/> Indian. <input type="checkbox"/> Pakistani. <input type="checkbox"/> Bangladeshi. <input type="checkbox"/> Chinese. <input type="checkbox"/> Other Asian background (Please state). _____ _____	<input type="checkbox"/> African. <input type="checkbox"/> Caribbean. <input type="checkbox"/> Other Black background (Please state). _____ _____	<input type="checkbox"/> Arab. <input type="checkbox"/> Other ethnic group (Please state). _____ _____

4. Do you currently have any dependent children in your household?
 Yes
 No

5. Are you currently...

<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed
<input type="checkbox"/> Unemployed (for more than 1 year)	<input type="checkbox"/> Unemployed (for less than 1 year)
<input type="checkbox"/> A Homemaker	<input type="checkbox"/> A Student
<input type="checkbox"/> Retired	<input type="checkbox"/> Unable to work
<input type="checkbox"/> Never worked	<input type="checkbox"/> Long-term unemployed

6. What is your highest attained level of education?
 No qualifications
 Secondary/Middle School
 Sixth Form/Upper School
 Undergraduate degree
 Postgraduate degree
 Specialist qualification

7. Approximately how far is Steps 2 Wellbeing from where you live?

- | | |
|---|---|
| <input type="checkbox"/> Less than 1 mile | <input type="checkbox"/> 1 to 5 miles |
| <input type="checkbox"/> 6 to 10 miles | <input type="checkbox"/> 11 to 15 miles |
| <input type="checkbox"/> 16 to 20 miles | <input type="checkbox"/> More than 20 miles |

Thank You for taking your time to complete this survey

Appendix B2 - Service User Participant Information Sheet

SERVICE USER INFORMATION SHEET

Exploring the effectiveness of different treatment modalities (telephone versus face-to-face) and an analysis of patients' and practitioners' views of these in an IAPT low-intensity service

My name is Joshua Turner and this project will be for my research doctorate (PhD) at the Faculty of Health Sciences, University of Southampton.

Mental healthcare is now using different ways of delivering support and treatment, other than face-to-face, to patients (e.g. via telephone). A good example of this is the use of telephone delivery by <<IAPT_service>>. This service is part of a new NHS programme known as 'Improving Access to Psychological Therapies' (or IAPT) that is currently being put into practice across England. It is therefore important to explore what impact using the telephone may have on patients and practitioners in comparison to more traditional methods (e.g. face-to-face).

You are invited to take part in this study which will be exploring views from those who have used <<IAPT_service>>'s services. Before you decide whether you would like to take part in this study, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and please contact me if you require any more information.

What is in this 'Information Pack'?

It should contain the following:

- x1 Service User Information Sheet (this sheet)
- x1 IAPT Database Consent Form
- x1 copy of the Service User Questionnaire
- x2 Pre-paid Return Envelopes

What is the purpose of the study?

This project has 4 main objectives:

- (1) I would like to gain patients' perspectives of using psychological services (telephone and/or face-to-face) provided by <<IAPT_service>>. This will be done by using the 'Service User Questionnaire'.
- (2) I would like to gather information on demographic characteristics (e.g. age and gender) and how these could affect patients' views. This will also be collected through the 'Service User Questionnaire'.

- (3) I would like to explore the scores from routine assessments (e.g. anxiety levels, etc.) carried out at each appointment to help find out whether using a telephone or face-to-face treatment provides any differences in these scores. These will be collected from <<IAPT_service>>'s database.
- (4) I would like to collect demographic characteristics (e.g. age, gender, ethnicity, employment status, etc.) from <<IAPT_service>>'s database. This will help to investigate whether such characteristics affect differences (if any) between telephone and face-to-face treatment.

Why have I been chosen?

You have been invited as you fall into one of the groups who have used a treatment delivered either face-to-face, by telephone, or both within the <<IAPT_service>>.

Do I have to take part?

No. It is up to you to decide whether or not to take part. Only by returning the questionnaire and/or the completed consent form will it mean that you consent to take part in this study.

What will happen to me if I take part?

If you decide to take part, there are 2 parts to this project. You can decide to take part in one or both parts of this project.

- The 'Service User Questionnaire':

You will not need to provide your name in this questionnaire as each one will have a unique code printed on it so your answers will remain anonymous. The questionnaire will take you between 15 and 25 minutes to complete.

Please complete and return once you have finished with the services from <<IAPT_service>> or as soon as possible. Please put this into the envelope marked "Questionnaire".

The questionnaire has 3 sections:

- 'About Your Service' will ask you about your views on the type of treatment you used (face-to-face and/or telephone-delivered).
- 'In Your Own Words' is a series of short answer questions about your thoughts on using either a telephone-delivered or a face-to-face programme. You can write as much or as little as you wish.
- 'About You' will ask you to provide demographic information (e.g. age, etc.). If you do not wish to answer a certain question in this section, please leave it blank.

- The 'IAPT Database':

The scores from routine assessments (e.g. anxiety levels, etc.) carried out at each appointment, along with your demographic information (e.g. age, gender, etc.) will be analysed for this project. These will be taken from <<IAPT_service>>'s database.

Your name will not be used and data will not be identifiable. No personal conversations with your health professional will be used in this research.

If you are willing to allow your data from the routine assessments to be analysed please sign the 'IAPT Database Consent Form'. Please put this into the envelope marked "IAPT Database Consent Form" and post it separately from the completed questionnaire.

It would be extremely helpful if you could return this form as soon as possible.

What are the possible benefits of taking part?

Unfortunately, there is no direct benefit to you for your participation in this study. However, it is hoped that your participation and comments will assist in future research on using different ways to deliver treatment in mental healthcare (e.g. via telephone, internet, etc.).

What are the possible disadvantages of taking part?

This questionnaire will not ask intrusive questions because it will not ask about your personal life. It will only ask about your experiences of using face-to-face and/or telephone treatment. The only disadvantage from taking part in this study is the time you will need to complete the questionnaire.

Will my taking part in the study be kept confidential?

Yes. All the information collected in this study will be kept confidential. Data will be kept in accordance with the Data Protection Act 1998.

The completed questionnaires and analysis will only be seen by myself and will be kept securely at the University of Southampton. <<IAPT_service>> will not have access to your answers.

What happens if I change my mind?

You do not have to complete and/or return the questionnaire and/or the consent form if you wish to withdraw from the study. To ensure that all data collected in project is completely anonymous to me; there will be no possible way to withdraw your

questionnaire once it has been returned to me. This also applies if you have returned the IAPT Outcome Database Consent Form.

What happens if there is a problem?

If you have any concerns about this study you should contact [REDACTED]
[REDACTED] by telephone [REDACTED], by fax: [REDACTED]
[REDACTED], by email [REDACTED], or by post: [REDACTED]
[REDACTED]
[REDACTED]

If you remain unhappy and wish to complain formally, Dr Martina Prude can provide you with details of the University of Southampton Complaints Procedure. For more information please visit: <http://www.soton.ac.uk/corporateservices/rgo/>.

Who has reviewed the study?

This study has been reviewed by the peer review system at the University of Southampton and the National Health Service National Research Ethics Service.

Who can I contact?

If you would like further information please don't hesitate to contact me by email: [REDACTED] or by telephone: [REDACTED]. You can also contact me by post: [REDACTED]
[REDACTED].

Alternatively, you can also contact my supervisors **Dr. Joanne Brown** and [REDACTED]
[REDACTED] by email or by telephone [REDACTED]
[REDACTED] for further information.

**Thank you for taking the time to read this sheet
Please keep this information sheet for future reference**

Appendix B3 - IAPT Database Consent Form

IAPT DATABASE CONSENT FORM

Exploring the effectiveness of different treatment modalities (telephone versus face-to-face) and an analysis of patients' and practitioners' views of these in an IAPT low-intensity service

Name of Researcher: Mr. Joshua Turner
Name of Supervisor(s): Dr. Joanne Brown & Dr. Diane Carpenter
University of Southampton Study Ref(s): RGO Ref – 8599
ERGO Ref – 2232
NHS National Research Ethics Service Ref: 12/EE/0463

Please tick which delivery type your sessions used (not including your assessment):

Face-to-Face

Over the telephone

Both

Please initial the box(es) if you agree with the following statement(s) and sign below:

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.
2. I would like to participate in the 'IAPT Database' part of this project. I understand that the scores from the scales I filled out during my sessions and my demographic information will be used as part of this research.
3. I understand that all data collected will be made anonymous and kept confidential.
4. I agree to my data being used in this part of the research project with the understanding that the data from my recovery sessions will be used only for the purpose of the study.

Once completed, please send this in the "IAPT Database Consent Form" envelope enclosed in this pack.

Name (BLOCK CAPITALS)

Date

Signature

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**APPENDIX C: PSYCHOLOGICAL WELLBEING PRACTITIONER
QUESTIONNAIRE PACK**

Appendix C1 - PWP Questionnaire

PSYCHOLOGICAL WELLBEING PRACTITIONER QUESTIONNAIRE

Exploring the effectiveness of different treatment modalities (telephone versus face-to-face) and an analysis of patients' and practitioners' views of these in an IAPT low-intensity service

SECTION A: About Your Modality

1. What treatment modality do you mainly work with?

Telephone

Face-to-Face

Both

If answered:

Telephone: Please only answer Q2 to Q20 and Q41 in Section A

Face-to-Face: Please only answer Q21 to Q39 and Q41 in Section A

Both: Please only answer Q2 to Q18, Q21 to Q39, Q40 and Q41 in Section A

Please mark only one for each question

2. In general, how would you rate the likelihood that patients will engage with the recovery package when communicating with them over the telephone?

Very unlikely to engage	1	2	3	4	5	Very likely to engage
-------------------------	---	---	---	---	---	-----------------------

3. When communicating with patients over the telephone, how likely will he/she carry out what is required of their recovery package?

Very likely to carry out the required tasks	1	2	3	4	5	Very unlikely to carry out the required tasks
---	---	---	---	---	---	---

4.	How satisfied are you with patients' progress if their recovery package is delivered over the telephone?					
Very unsatisfied with their progress	1	2	3	4	5	Very satisfied with their progress
5.	How would you rate the likelihood that patients will relapse after using a recovery package delivered over the telephone?					
Very unlikely to relapse	1	2	3	4	5	Very likely to relapse
6.	When supporting patients over the telephone, how much information were they willing to provide you?					
Very little information	1	2	3	4	5	A large amount of information
7.	During telephone-delivered sessions, how easy was it to understand the information given by patients?					
Very easy to understand	1	2	3	4	5	Very difficult to understand
8.	How much information did you feel you were able to give to patients when using telephone delivery?					
Very little Information	1	2	3	4	5	A large amount of Information

9. How well did you feel you were able to explain the information to patients when using telephone delivery?

Very well 1 2 3 4 5 Not very well

10. How would you rate patients' understanding of the information you provided using the telephone modality?

Did not understand anything 1 2 3 4 5 Understood everything

11. How would you rate the likelihood that patients would ask you to explain, in further detail, the information you provided them when using the telephone modality?

Very unlikely to ask for clarification 1 2 3 4 5 Very likely to ask for clarification

12. In general, how comfortable do you feel during a telephone-delivered session?

Very uncomfortable 1 2 3 4 5 Very comfortable

13. How would you rate the level of empathy you were able to provide patients when communicating over the telephone?

Very high level of empathy 1 2 3 4 5 Very low level of empathy

14. Do you think the absence of visual and non-verbal information can have an effect on your sessions?

Yes

Telephone

If answered Telephone in Q1 please go to Q41

Please mark only one for each question

21.	How would you rate the likelihood that a patient will engage with the recovery package when communicating with them face-to-face?	
Very likely to engage	1 2 3 4 5	Very unlikely to engage
22.	When communicating with a patient face-to-face, how likely will he/she carry out what is required of their recovery package?	
Very unlikely to carry out the required tasks	1 2 3 4 5	Very likely to carry out the required tasks
23.	How satisfied are you with patients' progress if their recovery package is delivered face-to-face?	
Very satisfied with their progress	1 2 3 4 5	Very unsatisfied with their progress
24.	How would you rate the likelihood that patients will relapse after using a recovery package delivered face-to-face?	
Very likely to relapse	1 2 3 4 5	Very unlikely to relapse
25.	When supporting patients face-to-face, how much information were they willing to provide you?	
A large amount	1 2 3 4 5	Very little

of information							information
26.	During face-to-face-delivered sessions, how easy was it to understand the information given by patients?						
Very difficult to understand	1	2	3	4	5		Very easy to understand
27.	How much information did you feel you were able to give to patients when using face-to-face delivery?						
A large amount of information	1	2	3	4	5		Very little information
28.	How well did you feel you were able to explain the information to patients when using face-to-face delivery?						
Not very well	1	2	3	4	5		Very well
29.	How would you rate patients' understanding of the information you provided using the face-to-face modality?						
Understood everything	1	2	3	4	5		Did not understand anything
30.	How would you rate the likelihood that patients would ask you to explain, in further detail, the information you provided them when using the face-to-face modality?						
Very likely to ask for clarification	1	2	3	4	5		Very unlikely to ask for clarification
31.	In general, how comfortable do you feel during a face-to-face-delivered session?						
Very comfortable	1	2	3	4	5		Very uncomfortable

32. How would you rate the level of empathy you were able to provide patients when communicating face-to-face?

Very low level of empathy 1 2 3 4 5 Very high level of empathy

33. Do you think the presence of visual and non-verbal information can have an effect on your sessions?

Yes

No

34. If answered Yes to Q33
How do you think it can affect your sessions?

Very positively 1 2 3 4 5 Very negatively

35. How would you rate your rapport with patients when using face-to-face delivery?

A very bad one 1 2 3 4 5 A very good one

36. How easy did you find it to schedule treatment sessions when using the face-to-face modality?

Very easy to schedule 1 2 3 4 5 Very difficult to schedule

37. How satisfied are you using face-to-face as a treatment modality?

Very unsatisfied 1 2 3 4 5 Very satisfied

Referring back to **Q1**:

If answered **Both** please go to **Q40**

If answered **Face-to-Face** please continue to **Q38**

Please mark only one for each question

38. Is this your preferred treatment modality of working?

Yes

No

39. *If answered No to Q38*

Which is your preferred treatment modality?

Face-to-Face

Telephone

*If answered **Face-to-Face** in Q1 please go to Q41*

Please mark only one for each question

40. **Which of the two treatment modalities do you prefer to work with?**

Face-to-Face

Telephone

*If answered **Both** in Q1 please continue to Q41*

Please mark only one for each question

41. **If service users were given a choice, which treatment modality do you think would be the most popular?**

Face-to-Face

Telephone

Other (please state): _____

Thank You
Please continue to Section B

SECTION B: In Your Own Words

In the box below, please write down (in as much detail as you wish) your reasons for the ratings you provided in Section A. Please continue onto another sheet if needed.

You may want to consider the potential benefits and difficulties that may affect your service users, as well as your past experiences of using the modalities (including how long you have used the modality for). Also, how this may affect your relationship with patients.

Thank You for taking your time to complete this survey.

Appendix C2 - Practitioner Information Sheet

PRACTITIONER INFORMATION SHEET

Exploring the effectiveness of different treatment modalities (telephone versus face-to-face) and an analysis of patients' and practitioners' views of these in an IAPT low-intensity service

My name is Joshua Turner and this project will be for my research doctorate (PhD) at the Faculty of Health Sciences, University of Southampton.

Mental healthcare is now using different ways of delivering support and treatment, other than face-to-face, to patients (e.g. via telephone). A good example of this is the use of telephone delivery by <<IAPT_service>>. This service is part of a new NHS programme known as 'Improving Access to Psychological Therapies' (or 'IAPT') that is currently being put into practice across England. It is therefore important to explore what impact using the telephone may have on patients and practitioners in comparison to more traditional methods (e.g. face-to-face).

You are invited to take part in a study which will be exploring views from those who are part of the Step 2 therapeutic team within <<IAPT_service>>. Before you decide whether you would like to take part in this study, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and contact me if you require any more information.

What is in this 'Questionnaire Pack'?

It should contain the following:

- x1 Practitioner Information Sheet (this sheet)
- x1 copy of the Practitioner Questionnaire
- x1 Pre-paid Return Envelope

What is the purpose of the study?

I would like to gain Psychological Wellbeing Practitioners' perspectives about their experience of working with different treatment delivery types (namely face-to-face and/or telephone delivery) and whether you think these have an impact on the treatment sessions with patients. In order carry this out, you will be asked to complete the 'Practitioner Questionnaire'.

Why have I been chosen?

You have been invited as you fall into one of the groups who have had experiences with delivering a telephone-based, a face-to-face treatment or both.

Do I have to take part?

No. It is up to you to decide whether or not to take part. The return of the questionnaire implies your consent to take part in this project.

What will happen to me if I take part?

You will not need to provide your name in the questionnaire as each one will have a random unique code printed on it so your answers will remain anonymous. The questionnaire contains 2 sections and will take approximately 30 minutes to complete:

- *Section A* will ask you about your views on the type of treatment you mainly work with (face-to-face and/or telephone-delivery).
- *Section B* is a free-text question which will ask you to give reasons for the ratings and the views you have expressed in Section A. You can write as much detail as you wish to include. If you run out of room, please continue onto a separate piece of paper.

It would be extremely helpful if you could return the completed questionnaire, using the return envelope, as soon as possible or by **enter return date**.

What are the possible disadvantages of taking part?

The only disadvantage from taking part in this study is the time you will need to complete the questionnaire.

What are the possible benefits of taking part?

Unfortunately, there is no direct benefit to you for your participation in this study. However, it is hoped that your participation and comments will assist in future research on using different ways to deliver treatment in mental healthcare (e.g. via telephone, internet, etc.).

Will my taking part in the study be kept confidential?

Yes. All the information collected in this study will be kept confidential. Data will be kept in accordance with the Data Protection Act 1998. The completed questionnaires and analysis will only be seen by myself and will be kept securely at the University of Southampton. <<IAPT_service>> will not have access to your answers.

What happens if I change my mind?

You do not have to complete and/or return the questionnaire if you wish to withdraw from the study. To ensure that all data collected in project is completely anonymous to me; there will be no possible way to withdraw your questionnaire once it has been returned.

What happens if there is a problem?

If you have any concerns about this study you should contact [REDACTED]
[REDACTED] by telephone: [REDACTED], by fax: [REDACTED]
[REDACTED], by email: [REDACTED], or by post: [REDACTED]
[REDACTED]

If you remain unhappy and wish to complain formally, Dr Martina Prude can provide you with details of the University of Southampton Complaints Procedure. For more information please visit: <http://www.soton.ac.uk/corporateservices/rgo/>.

Who has reviewed the study?

This study has been reviewed by the peer review system at the University of Southampton and the National Health Service National Research Ethics Service.

Who can I contact?

If you would like further information please don't hesitate to contact me by email: [REDACTED] or by telephone: [REDACTED]. You can also contact me by post: [REDACTED]
[REDACTED]

Alternatively, you can also contact my supervisors [REDACTED] and [REDACTED]
[REDACTED] by email or by telephone [REDACTED] or
[REDACTED] for further information.

***Thank you for taking the time to read this sheet
Please keep this information sheet for future reference***

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**APPENDIX D: PSYCHOLOGICAL WELLBEING PRACTITIONER
INTERVIEWS**

Appendix D1 - PWP Interview Information Sheet

PWP INTERVIEW INFORMATION SHEET

Exploring the effectiveness of different treatment modalities (telephone versus face-to-face) and an analysis of patients' and practitioners' views of these in an IAPT low-intensity service

My name is Joshua Turner and this project will be for my research doctorate (PhD) at the Faculty of Health Sciences, University of Southampton.

Mental healthcare is now using different ways of delivering support and treatment, other than face-to-face, to patients (e.g. via telephone). A good example of this is the use of telephone delivery by <<IAPT_service>>. This service is part of a new NHS programme known as 'Improving Access to Psychological Therapies' (or 'IAPT') that is currently being put into practice across England. It is therefore important to explore what impact using the telephone may have on patients and practitioners in comparison to more traditional methods (e.g. face-to-face).

You are invited to take part in a one-to-one interview to explore your views and thoughts of working with patients over the telephone, face-to-face or both. Before you decide whether you would like to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and contact me if you require any more information.

What is the purpose?

I would like to gain more in-depth perspectives from Psychological Wellbeing Practitioners about their experience of working with different treatment delivery types (namely face-to-face and/or telephone delivery) and how these may have affect treatment sessions with patients. This phase of the project is a development from a previous stage of the project (The PWP Questionnaire) that you may or may not have participated in.

Why have I been chosen?

You have been invited to take part as you fall into one of the groups who have had experiences with delivering psychological treatments over the telephone and face-to-face.

Do I have to take part?

No. It is up to you to decide whether or not to take part in the interview. If you do wish to take part, you will be given this information sheet to keep and asked to sign a consent form.

What will happen to me if I take part?

If you decide to take part and have signed the Consent Form, please contact me by email: [REDACTED], to arrange a convenient time with you for the interview.

It will last approximately 1 hour and, on agreement with your line manager, will take place in a private room at <<IAPT_service>>.

The interview will be conducted face-to-face and will be audiotaped so that what you say will be recorded accurately; you will be informed when you are being recorded. I will also take notes during the interview.

In the interview open-ended questions will be asked to help explore your overall experience of interacting with service users over the telephone and in person. Topics may cover the delivery type's effects on the therapeutic relationship, patient attitudes, etc.

All answers and data (audio recordings and transcriptions) will be kept anonymous during data collection, analysis and write up.

What are the possible disadvantages of taking part?

The only disadvantage from taking part in this interview is that it will take approximately an hour of your time.

What are the possible benefits of taking part?

Unfortunately, there is no direct benefit to you for your participation in this study. However, it is hoped that your participation will assist in future research on using different ways to deliver treatment in mental healthcare (e.g. via telephone, internet, etc.).

Will my taking part in the study be kept confidential?

Yes. All the information collected in this interview will be kept confidential. Data will be kept in accordance with the Data Protection Act 1998. Recordings, transcriptions, interview notes and analyses will only be accessed by myself and will be kept securely at the University of Southampton. <<IAPT_service>> will not have access to your answers.

What happens if I change my mind?

If you consent to taking part in the interview, you may withdraw from the study at any time. You can stop the tape and/or discontinue the interview at any time. All interview data (audio recording, transcriptions and notes) will not be used in the study. You will not need to give a reason and withdrawal will not affect your employment.

What happens if there is a problem?

If you have any concerns about this study you should contact [redacted]
[redacted] by telephone: [redacted], by fax: [redacted]
[redacted], by email: [redacted], or by post: [redacted]
[redacted]

If you remain unhappy and wish to complain formally, Dr Martina Prude can provide you with details of the University of Southampton Complaints Procedure. For more information please visit: <http://www.soton.ac.uk/corporateservices/rgo/>.

Who has reviewed the study?

This study has been reviewed by the peer review system at the University of Southampton and the National Health Service National Research Ethics Service.

Who can I contact?

If you would like further information please don't hesitate to contact me by email: [redacted] or by telephone: [redacted]. You can also contact me by post: [redacted]
[redacted]

Alternatively, you can also contact my supervisors [redacted] and [redacted]
[redacted] by email or by telephone [redacted] or
[redacted] for further information.

***Thank you for taking the time to read this sheet
Please keep this information sheet for future reference***

Appendix D2 - PWP Interview Consent Form

PWP INTERVIEW CONSENT FORM

Exploring the effectiveness of different treatment modalities (telephone versus face-to-face) and an analysis of patients' and practitioners' views of these in an IAPT low-intensity service

Name of Researcher: Mr. Joshua Turner

Name of Supervisor(s): Dr. Joanne Brown & Dr. Diane Carpenter

University of Southampton Study Ref(s): RGO Ref – 8599
ERGO Ref – 2232

NHS National Research Ethics Service Ref: 12/EE/0463

Please initial the box(es) if you agree with the following statement(s) and sign below:

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.
2. I would like to participate in the PWP interview. I understand that my answers and feedback will be used as part of this research.
3. I understand that this interview will be audio recorded to ensure what I say is documented accurately and that all data collected (recordings, transcripts and notes) will be made anonymous and kept confidential.
4. I understand that I can stop and withdraw from the interview at any time and that all data collected will not be used and will be destroyed.

Interviewee Name (BLOCK CAPITALS)

Date

Signature

Researcher Name (BLOCK CAPITALS)

Date

Signature

Appendix D3 – Interview Schedule

INTRODUCTION <BEFORE RECORDING>

Hello, my name is Josh Turner and I'm a researcher from the Faculty of Health Sciences, University of Southampton.

Thank you for taking part in this interview.

Would you like me to briefly summarise the project again?

- I would like to expand on a previous phase of the project (The Practitioner Questionnaire) and further explore Psychological Practitioners' perspectives of working with different delivery types, namely face-to-face and telephone.

This interview may last up to an hour and I would like to cover 12 questions. I may also be taking some notes.

Firstly,

- Have you read through the Participant Information Sheet?
- Do you have any further questions about the study?
- Have you signed the Consent Form?

I will now turn the tape recorder on.

<DURING RECORDING>

PARTICIPANT ID: IN0 _____

DATE: __ / __ / 20__

I'd like to start off with a general question...

(01) Could you tell me about your role as a Psychological Practitioner and what drew you to the profession?

- *How long have you worked as a Psychological Practitioner?*
- *Do you work one-to-one or in group sessions with patients?*
- *What type of therapy/intervention do you mainly work with?*
- *Which of the two delivery types do you mainly work with?*
- *(If relevant) How does working as a Psychological Practitioner compare with your previous role?*

Thank you, I'd like to move onto my next topic...

(02) Could you tell me about your experiences of working with patients over the telephone and the factors that could affect your interaction with them?

- *What factors, when face-to-face, affect how you interact with a patient?*
- *How do they affect the interaction and session?*

(03) And could you tell me about the positives and negatives of working with patients face-to-face?

- *What factors, when talking over the telephone, affect how you interact with a patient?*
- *How do they affect the interaction and session?*

Thank you, I'd now like to talk about the concept of the therapeutic relationship...

(04) Drawing on your experiences, could you describe to me what a ‘therapeutic relationship’ means to you?

- ***If this is difficult to answer, could you tell me about a time with a client when the therapeutic relationship was strong?***
- *Can you explain what it was that made it feel so?*
- ***Could you tell me a situation with a client when the therapeutic relationship wasn’t strong?***
- *Could you explain why this may have happened?*
- *What do you think are the key factors involved in building a strong therapeutic relationship with the patient?*
- ***Does using the telephone affect the therapeutic relationship?***
- *Why do you think it does/does not?*
- *Can you give me an example?*
- ***Does being face-to-face affect the therapeutic relationship?***
- *Why do you think it does/does not?*
- *Can you give me an example?*
- ***Could you tell me how you think patients would describe what a ‘therapeutic relationship’ means to them?***
- *What they think is a strong one or not so strong one?*

Thank you, I’d now like to move onto my next topic...

(05) Many of the interventions used in IAPT are based on Cognitive-Behavioural principles, in your experience, is the delivery of these therapies better suited over the telephone or face-to-face?

- *Are patients more (or less) focussed on goals and the tasks when you meet face-to-face?*
- *Are patients more (or less) focussed on goals and the tasks when you speaking over the telephone?*
- *Why might this be the case (or might not be the case)?*
- *Could you give an example of this?*

OK, I’d now like to move onto my next topic about patient’s expectations and perceptions...

(06) From your experience, what do most patients initially expect from a face-to-face intervention?

- *Did they give any reasons why they felt that way?*
- *If so, what were they?*
- *Are there any demographic characteristics which respond positively or negatively to face-to-face interaction than others?*
- *Do you find these attitudes change over time?*
- *If so, why do you think they change?*

(07) In contrast, what do most patients initially expect from when using the telephone?

- *Did they give any reasons why they felt that way?*
- *If so, what were they?*
- *Are there any demographic characteristics which respond positively or negatively to more telephone interaction than others?*
- *Do you find these attitudes change over time?*
- *If so, why do you think they change?*

(08) What are patients' perceptions and experiences of you as a practitioner when interacting with them over the telephone?

- *Does it have any impact on how you might deliver a therapy?*

(09) And what about their perceptions and experiences of you as a practitioner when face-to-face?

- *Does it have any impact on how you might deliver a therapy?*

Thank you, we're now coming to the last 3 questions of the interview, I'd like to ask...

(10) Have your views about therapeutic delivery types changed from when you first started working as a Psychological Practitioner?

- *If so, what has changed?*
- *Why have these changed?*
- *If not, what hasn't changed?*
- *Why have these not changed?*
- *(If relevant) Do these views differ from previous roles?*

(11) And, in your experience, between face-to-face and telephone, which delivery type have you found to be most effective in helping clients with their problems?

(In terms of recovery or symptom improvements/patient satisfaction)

- *Is the therapeutic relationship central to this or not?*
- *Why might this be the case?*
- *What are your reasons?*
- *In your experiences, how do other health professionals view these treatment delivery methods (including the telephone)?*

And Finally...

(12) What are your opinions on the use of other technologies for delivering psychological therapies?

(e.g. internet-therapy, videoconferencing)

- *What do you think are the advantages and disadvantages of them?*
- *Do you think these technologies affect the therapeutic relationship?*
- *If so / if not, how do you think it does / does not?*

DEBRIEF

<END RECORDING>

Thank you again for taking the time to take part in this interview
Do you have any questions for me?

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APPENDIX E: REC and R&D DOCUMENTS

Appendix E1 - NHS Ethics Committee Favourable Opinion Letter



Health Research Authority

NRES Committee East of England - Cambridge Central

Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Telephone: 01223 597685
Facsimile: 01223 597645

11 October 2012

Mr Joshua Turner
MPhil/PhD Student
Faculty of Health Sciences
Building 45
University of Southampton
SO17 1BJ

Dear Mr Turner

Study title: An exploration of the effectiveness of different treatment modalities (telephone versus face-to-face) and the analysis of patients' and practitioners' views of these in an IAPT low-intensity service.

REC reference: 12/EE/0463

Thank you for your letter of 9th October 2012, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

Confirmation of ethical opinion

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

Ethical review of research sites

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

Conditions of the favourable opinion

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

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

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

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

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

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

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

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

The following changes should be made to the participant information sheet (both versions)

- You should mention that the return of the questionnaire implies consent the Committee advises that this goes in the section entitled " do I have to take part"
- You mention informing authorities if information comes to light that suggests there is a risk to participants but as the questionnaires are anonymised this will not be possible so should be removed
- You have suggested that it would be possible to withdraw if the participant had the questionnaire code. The Committee suggest that it might be better to just say that because the questionnaires are anonymous it is not possible to withdraw them once they have been returned. This ensures total anonymity throughout the study

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of insurance or indemnity	- University of Southampton - Research Insurance Letter	09 August 2012
Investigator CV	- Joshua Turner	
Letter from Sponsor	- Dr Martina Prude	23 July 2012
Letter from Statistician	- Correspondence (via email) with the Faculty Statistician	
Other: Summary of Results Request Form (Appendix G)	May 2012 Version 1.0	
Other: - Dr Diane Carpenter (Academic Supervisor)		29 June 2012
Other: - Joanne Brown (Academic Supervisor)		
Participant Consent Form: - Practitioner (Appendix F)	May 2012 Version 1.0	

Participant Consent Form: - Service User (Appendix E)	May 2012 Version 1.0	
Participant Consent Form: IAPT Database Consent Form	1.0	01 October 2012
Participant Information Sheet: Service User	1.1	01 October 2012
Participant Information Sheet: Practitioner	1.1	01 October 2012
Protocol	1.1	01 October 2012
Questionnaire: - Psychological Wellbeing Practitioner (Appendix B)	May 2012 Version 1.0	
Questionnaire: - Service User (Appendix A)	May 2012 Version 1.0	
REC application	Submission code:104513/364522/1/576	19 September 2012
Referees or other scientific critique report	- University of Southampton (Faculty of Health Sciences)	20 May 2012
Response to Request for Further Information	Josh Turner	09 October 2012

Statement of compliance

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

After ethical review

Reporting requirements

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

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

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

Feedback

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

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

12/EE/0463

Page 4

12/EE/0463 **Please quote this number on all correspondence**

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

Yours sincerely

[Redacted signature]

Chair

Email: [Redacted]

Enclosures: *"After ethical review – guidance for researchers"*

Copy to: [Redacted]

Appendix E2 - R&D Letter: Solent NHS Trust

Solent 

NHS Trust

2nd Floor Adelaide Health Centre
Western Community Hospital Campus
William Macleod Way
Southampton
Hampshire, SO16 4XE
T: 023 8060 8925
E: Research@solent.nhs.uk

Ref: SW / cl

24th January 2013

Mr J Turner
MPhil / PhD Student
Faculty of Health Sciences
University of Southampton
Building 45
Highfield
Southampton, SO17 1BJ

Dear Mr Turner

Study Title: Exploring Effects of Treatment Modalities (Face to Face vs. Telephone)
R&D No.: SR/004/13
CSP No.: N/a

In accordance with the Department of Health's Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opinion from an ethics committee and permission from the Department of Research and Development (R&D) prior to commencement.

Solent NHS Trust has reviewed the documentation submitted for the above research study and I am pleased to confirm NHS permission. The Sites where you are permitted to undertake the research are listed in the attached appendix. The addition of a new site(s) **must be notified** to Solent Research by submitting an SSI form and for PICs, a revised R&D Form.

I would like to bring your attention to the attached list of conditions of approval and specifically to:

- a) The mandatory requirement to record the recruitment for all sites within this Trust onto the e-dge™ database (**information about this is attached**).
- b) The mandatory requirement to report annually to the Trust on the study progress, and submit all publications resulting from the study to Solent NHS Trust for them to share with patients and staff.
- c) The understanding that your study will be subject to monitoring and / or audit by the research team.



INVESTOR IN PEOPLE

Solent NHS Trust Headquarters
Adelaide Health Centre, William Macleod Way, Millbrook, Southampton SO16 4XE
Telephone: 023 8060 8900 Fax: 023 8053 8740 Website: www.solent.nhs.uk

Documents Reviewed

Document	Version	Date
Protocol	1.2.1	18/12/12
Participant Information Sheet – Service User	1.2	11/10/12
Participant Information Sheet – Psychological Wellbeing Practitioner	1.2	11/10/12
Consent Forms	1.2	12/12/12
Indemnity / Insurance		09/08/12
Sponsors Letter		23/07/12
CV – Chief Investigator		20/09/12
Questionnaire: - Psychological Wellbeing Practitioner	1.0	01/05/12
Questionnaire: - Service User	1.0	01/05/12
Service manager approval email		23/01/13

I wish you every success with your study. If you require support or assistance at any time with the involvement of Solent NHS Trust in this study, please don't hesitate to contact us.

Yours sincerely



Head of Research & Clinical Audit



Solent NHS Trust Headquarters
 Adelaide Health Centre, William Macleod Way, Millbrook, Southampton SO16 4XE
 Telephone: 023 8060 8900 Fax: 023 8053 8740 Website: www.solent.nhs.uk

Appendix E3 - R&D Letter: Isle of Wight NHS Trust

Isle of Wight 
NHS Trust

RM&G Office
Planned Clinical Directorate
St Mary's Hospital
Newport
Isle of Wight
PO30 5TG

Direct Tel No (01983) 552354
Direct Fax No (01983) 534095
Email: alexandra.punter@iow.nhs.uk

10 January 2013

Mr Joshua Turner
MPhil/PhD Student
Faculty of Health Sciences, University of Southampton
Building 45
University of Southampton
SO17 1BJ

Dear Joshua

Student Research: An exploration of the effectiveness of different treatment modalities (telephone versus face-to-face) and the analysis of patients' and practitioners' views of these in an IAPT low-intensity service

I am writing formally to confirm research governance approval to the above project, following completion of local governance checks.

We note that NRES Committee East of England - Cambridge Central has granted ethical approval, which applies to all NHS sites taking part in the study, and the University of Southampton has accepted the role of Sponsor.

In accordance with our Trust Policy for R&D, I draw your particular attention to the following:

- In the event of a serious adverse event, which is linked to your research study, you must report any occurrence using the Trust's Incident Reporting Procedure.
- You will be required to provide a periodic report of progress with your research to the R&D Committee. As a minimum, you should state whether the study achieved its objectives, the main findings, and arrangements for publication or dissemination of the research, including any feedback to participants

I wish you every success with your study.

Yours sincerely



Research Management and Governance Manager

cc: Dr Joanne C Brown, Academic Supervisor, University of Southampton
Dr Diane T Carpenter, Academic Supervisor, University of Southampton

Appendix E4 - R&D Letter: Dorset HealthCare University NHS Foundation

Dorset HealthCare 
University NHS Foundation Trust

St Anns Hospital
69 Haven Road
Canford Cliffs
Poole
Dorset
BH13 7LN
Web:

www.dorsethealthcare.nhs.uk

Mr Joshua Turner
Faculty of Health Sciences
University of Southampton
Highfield Campus
University Road
Southampton
SO17 1JB

30 January 2013

Dear Mr Turner

Re: Exploring effects of treatment modalities (face-to-face vs telephone)

Thank you for submitting the above research project to the Dorset Healthcare University NHS Foundation Trust Research & Development department NHS permission to proceed at Bournemouth & Poole.

I am pleased to inform you that NHS permission to proceed for the above research was granted for Dorset Healthcare University NHS Foundation Trust on 7 November 2012.

NHS permission was granted on the basis described in the application form, protocol and supporting documentation.

You should notify the Research & Development Office, (R&D) within the same timeframe of notifying the REC and any other regulatory bodies, of the following:

- Amendments (including changes to the local research team) in accordance with guidance on IRAS
- Progress reports
- Changes to the status of the study
- End of study reports

Please do not hesitate to contact the R&D Office on 01202 492128 if you require any additional information or support.

I wish you every success with your research project

Yours sincerely



Research Manager



Appendix E5 - R&D Letter: Salisbury NHS Trust (Letter of Transfer)

Salisbury **NHS**
NHS Foundation Trust

Salisbury Research Support Service
Block 24 SDH South
Salisbury District Hospital
Salisbury
Wiltshire
SP2 8BJ
Telephone: (01722) 425026
Email: stef.scott@salisbury.nhs.uk

17th April 2013

Mr Joshua Turner
Faculty of Health Sciences
University of Southampton
Highfield Campus
University Road
Southampton
SO17 1JB

Dear Mr Turner

CSP number:	Not applicable
REC number :	12/EE/0463
UKCRN ID number:	Not applicable
Title	Exploring effects of treatment modalities (face-to-face vs telephone)
RDMC number (new local reference number):	74/2012/2013

I write to inform you that as of 1st April 2013 the Research Support Service Salisbury, at the above address, will be assuming responsibility for the research management and governance of the above study on behalf of Dorset Healthcare University NHS Foundation Trust.

Please note your current NHS permissions are still valid. Any future correspondence should be addressed to Louise Bell (louise.bell@salisbury.nhs.uk) at the Research Support Service Salisbury.

Yours faithfully,



Head of Research

Appendix E6 - Solent Mind Approval

Josh Turner - M.Phil/Ph.D Student
Faculty of Health Sciences
University of Southampton
Building 45, Room 0047
Highfield Campus
University Road
Southampton,
SO17 1JB

Date: 2 August 2013

Dear Josh,

I am writing to confirm that the board of directors for Solent Mind iTalk has given permission for your research project to be conducted.

Your research is 'An exploration of the effectiveness of different treatment modalities (telephone versus face to face) and the analysis of patients' and practitioners' views of these in an IAPT low intensity service'. This research is taking place now.

The sub group of the full board, called People and Quality is where approval was formally recorded which was held on 22nd May. The minute's number 4.1 is where the approval is formally recorded. We can make this available to you if essential to your requirements (as it obviously contains other commercially sensitive information).

Please do not hesitate to contact me directly if you require any further information. I look forward to seeing your research once it is published.

Yours sincerely,


Director of Services
Solent Mind.



Solent

28 The Avenue
SOUTHAMPTON
SO17 1XN

Tel: 023 8033 4977
Fax: 023 8020 8902



Tel: 023 8033 4977 Fax: 023 8020 8902
E: info@solentmind.org.uk W: www.solentmind.org.uk

Registered Office: 28 The Avenue, Southampton, Hampshire, SO17 1XN
Charity Registered No: 1081116 Registered with Limited Liability in England and Wales No: 4864588



Appendix E7 - University of Southampton Sponsor Letter



Mr Joshua Turner
School of Health Sciences
University of Southampton
University Road
Highfield
Southampton
SO17 1BJ

RGO REF - 8599
School Ethics Ref - 2232 - ERGO

09 August 2012

Dear Mr Turner

Public Liability Insurance

Project Title An Exploration of the Effectiveness of Different Treatment Modalities (telephone versus face-to-face) and the Analysis of Patients' and Practitioners' Views of these in an IAPT Low-Intensity Service

Participant Type:	No Of Participants:	Participant Age Group:	Notes:
Patients	250	Adults	
Healthy volunteers	50	Adults	

Thank you for forwarding the completed questionnaire and attached papers.

Having taken note of the information provided, I can confirm that this project will be covered under the terms and conditions of the above policy, subject to written informed consent being obtained from the participating volunteers.

If there are any changes to the above details, please advise us as failure to do so may invalidate the insurance.

Yours sincerely



cc File

Appendix E8 - University of Southampton Insurance Indemnity Letter



Mr Joshua Turner
School of Health Sciences
University of Southampton
University Road
Highfield
Southampton
SO17 1BJ

23 July 2012

Dear Mr Turner

RGO Ref: 8599

Project Title An Exploration of the Effectiveness of Different Treatment Modalities (telephone versus face-to-face) and the Analysis of Patients' and Practitioners' Views of these in an IAPT Low-Intensity Service

I am writing to confirm that the University of Southampton is prepared to act as Research Sponsor for this study under the terms of the Department of Health Research Governance Framework for Health and Social Care (2nd edition 2005).

http://www.dh.gov.uk/en/Aboutus/Researchanddevelopment/Researchgovernance/DH_400211

I would like to take this opportunity to remind you of your responsibilities under the terms of the Research Governance Framework Medicines for Human Use Act 2004 if conducting a clinical trial.

We encourage you to become fully conversant with the terms of the Research Governance Framework by referring to the Department of Health document which can be accessed at:

<http://www.legislation.gov.uk/uksi/2004/1031/contents/made>

<http://www.legislation.gov.uk/uksi/2006/1928/contents/mad>

The University of Southampton fulfils the role of Research Sponsor in ensuring management, monitoring and reporting arrangements for research. I understand that you will be acting as the Principal Investigator responsible for the daily management for this study, and that you will be providing regular reports on the progress of the study to the Research Governance Office on this basis.

Please also familiarise yourself with the Terms and Conditions of Sponsorship on our website:

[http://www.soton.ac.uk/corporateservices/rgo/media/TCSpons%20\(CTIMP\)%20V2%2022011.do](http://www.soton.ac.uk/corporateservices/rgo/media/TCSpons%20(CTIMP)%20V2%2022011.do)

[http://www.soton.ac.uk/corporateservices/rgo/media/TCSpons%20\(Non%20CTIMP\)%20V2%20022011.doc](http://www.soton.ac.uk/corporateservices/rgo/media/TCSpons%20(Non%20CTIMP)%20V2%20022011.doc)

In this regard if your project involves NHS patients or resources please also be reminded that you may need a Research Passport to apply for an honorary research contract of employment. Information can be found on our website:

<http://www.soton.ac.uk/corporateservices/rgo/respassport/about.htm>

(...continued overleaf)

Please send us a copy of your NHS REC and Trust approval letters when available.

**Please do not hesitate to contact me should you require any additional information or support.
May I also take this opportunity to wish you every success with your research.**

Yours sincerely



Appendix E9 - Substantial Amendment Favourable Opinion Letter



Health Research Authority

NRES Committee East of England - Cambridge Central

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Tel: 0115 8839435
Fax: 0115 8839294

29 January 2014

Mr Joshua Turner
MPhil/PhD Student
Faculty of Health Sciences, University of Southampton
Building 45
University of Southampton
SO17 1BJ

Dear Mr Turner

Study title:	An exploration of the effectiveness of different treatment modalities (telephone versus face-to-face) and the analysis of patients' and practitioners' views of these in an IAPT low-intensity service.
REC reference:	12/EE/0463
Amendment number:	
Amendment date:	09 January 2014
IRAS project ID:	104513

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Protocol	1.3.1	27 January 2014
Participant Information Sheet: PWP Interview	1.0	16 December 2013
Covering Letter		09 January 2014
Participant Consent Form: PWP Interview	1.0	16 December 2014
Notice of Substantial Amendment (non-CTIMPs)		09 January 2014
Interview Schedules/Topic Guides	1.1	16 December 2013
Query Answer		27 January 2014

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

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

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

12/EE/0463:	Please quote this number on all correspondence
--------------------	---

Yours sincerely



Chair

E-mail: NRESCommittee.EastofEngland-CambridgeCentral@nhs.net

Enclosures:

List of names and professions of members who took part in the review

Copy to:



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**APPENDIX F: SERVICE USER QUESTIONNAIRE – THEMATIC
ANALYSIS**

Theme Name	Description	Examples		
		Face-to-Face	Telephone	General
Building a 'Connection'	<p><i>Service users discussed the potential effects of a treatment delivery modality on their relationship with the PWP.</i></p> <p><i>Some commented on their relationship and the building of the relationship – both positive and negative.</i></p> <p><i>Rapport</i></p>	<p>SU0040 I think you do need to have some face to face contact to establish rapport & trust Telephone only would not do this</p> <p>Build up trust and rapport – can look in their eyes</p> <p>SU0476 Build up a relationship</p>	<p>SU0334 I feel more connected to the person and get the feeling they are more connected to me.</p> <p>SU0476 Although you have a person's name it all feels very anonymous</p> <p>SU0476 Verbal signals can build up trust</p>	<p>SU0040 I think a mix of both would be useful once trust established</p> <p>SU0696 I felt that if I was relying on someone to advise and guide me I needed to build some sort of relationship in order to go forward.</p>
	Emotional Support	<p>SU0282 More relaxed and friendly</p> <p>SU0334 For some people it might be too personal</p> <p>SU0476 Can be reassured when needed</p>	<p>SU0239 Health professionals can only use words for consoling someone who is upset</p> <p>SU0260 Felt like an intense but normal situation to be in</p>	<p>SU0696 I felt that if I was relying on someone to advise and guide me I needed to build some sort of relationship in order to go forward.</p>
'Understanding and Disclosing'	<p>Understanding</p> <p><i>The interaction between the patient and PWP was often commented to be better in face-to-face.</i></p>	<p>SU0250 It builds up a much better understanding between patient & practitioner.</p> <p>SU0123 Better to understand and explain concepts</p>	<p>SU0504 I found it difficult to clearly explain my problems and after a session remembered or thought more clearly they had to go over things again in the next appointment</p>	

	<p>Disclosing</p> <p><i>The amount and level of personal information they would disclose to their PWP was affected by how their therapy was delivered.</i></p>	<p>SU0250 Although it may be sometimes painful it is much more difficult to put up a wall of defence against some of the issues that may be causing or adding to your state of mind.</p> <p>SU0260 Body language and eye contact missing may have disclosed a little more info initially face-to-face depending on how comfortable I felt.</p>	<p>SU0278 I know I can talk freely and he won't judge me.</p> <p>SU0459 Felt able to talk more easily about personal matters</p> <p>Not to be as honest and often as required</p> <p>SU0547 enables to open up.</p>	
<p>'See who you are talking to'</p>	<p>NVCs</p> <p><i>The loss of the visual aspect in telephone therapy has been noted to have some implications in therapy</i></p>	<p>SU0334 face-to-face everybody can see if you "direct", feel bored or tired</p> <p>SU0547 See who you are talking to</p> <p>SU0239 Full comms (see/hear/listen)</p>	<p>SU0675 The assessor cannot see your face for your expression and mood.</p> <p>SU0260 Body language and eye contact missing may have disclosed a little more info initially face-to-face depending on how comfortable I felt.</p>	
	<p>Check for listening</p> <p><i>Service users suggest that they primarily use the visual medium to check if the PWP was listening to their concerns/worries</i></p>	<p>SU0260 Probably useful not to see them writing notes as you speak</p> <p>SU0334 face-to-face everybody can see if you "direct", feel bored or tired</p>		

	<p>Reactions</p> <p><i>Similar to the use to check for listening, many patients suggested that they either preferred if they could or that they did not want to see the PWP reactions after they discuss their problems.</i></p>	<p>SU0265 You can see the therapists body language/reactions to what you say and you know whether or not they are listening to you.</p> <p>SU0476 - Reactions can be seen + read if silences</p>	<p>SU0278 I know I can talk freely and he won't judge me.</p> <p>SU0476 - Cannot see how what you are saying is being received if it is your turn to speak or if you should stop speaking,</p>	
	<p>Visual Cues for Explanation</p> <p><i>The use of the visual medium was important to them as they believed that seeing them communication would enforce the message that they wanted to convey - much of which may not be available when using the telephone.</i></p>	<p>SU0547 Sometimes may be difficult to explain yourself</p> <p>SU0239 As a high percentage of communication is via Body Language, the healthcare professional "may" lose some of the communication/messages being (attempted) to be given.</p>	<p>SU0110 Some people may find it hard to express an emotion without that person being able to see them.</p> <p>SU0265 It is easier to explain things face to face than over the telephone.</p>	
<p>'Verbal Signs'</p>	<p>Comments regarding the use of only verbal interaction and how this could be limiting in some cases.</p>	<p>SU0476 Can be reassured when needed</p> <p>Reactions can be seen + read if silences</p> <p>SU0547 Not likely to get cut off mid-sentence</p>	<p>SU0334 My English is not as good and I pronounce wrong sometimes</p> <p>SU0476 is your turn to speak or if you should stop speaking</p> <p>Verbal signals can build up trust</p>	

<p>'I would not be able to attend'; barriers to treatment</p>	<p>Physical health <i>Certain delivery types may be more suitable for individuals with certain physical health conditions as these can affect their ability to attend sessions.</i></p>	<p>SU0250 Although I prefer face to face it is sometimes difficult for me to attend due to severe spinal problem.</p> <p>SU0179 I have a brain injury. I need face to face</p>	<p>SU0310 Convenient for people with mobility issues</p> <p>SU0123 May be helpful if one of the parties had mobility issues and could not attend in person</p>	
	<p>Psychological health <i>Psychological and emotional factors may affect their ability to attend sessions.</i></p>	<p>SU0250 Patients that have deep depression may find it difficult to make the effort to attend an appointment at a set given time.</p> <p>SU0738 As suffering panic attacks would have been stressed by finding office, parking space, waiting, etc.</p>	<p>SU0110 For those who might feel uncomfortable talking face to face with someone, a phone conversation would put that person at ease.</p> <p>SU0476 You don't have initial shyness on first "meeting"</p>	
	<p>Monetary Cost <i>Aspect relating to monetary cost of undertaking treatment/support.</i></p>	<p>SU0265 Problems of having to arrange time out from work to get appointments and seeking employers permission.</p> <p>SU0701 Travel restrictions (no car)</p>	<p>SU0040 Convenient, no travel costs or time used</p> <p>SU0260 Easy to fit into work day as well as day off</p>	
	<p>Other <i>Issues related to telephone equipment may be a barrier</i></p>		<p>SU0110 Technological interference</p>	

<p>Location: 'My comfort zone'</p>	<p>Location</p> <p><i>Aspects relating to travelling, location and distance which may affect the uptake of psychological therapies</i></p>	<p>SU0278 Transport and traveling, would mean more time needed.</p> <p>SU0061 For me personally I cannot see any disadvantages but for others I can see that there would be such as other commitments (work, children etc) and some people aren't able to travel to sessions</p>	<p>SU0040 Can choose a place convenient to client</p> <p>however if live in a remote area could be useful to have telephone help</p> <p>SU0110 Don't have to travel to an appointment.</p>	
	<p>Comfort</p> <p><i>Service users commented, when discussing telephone use, that the ability to carry out or hold a session in a location of their choosing was largely beneficial.</i></p> <p><i>Many commented on the comfort and positive effects on mood when carrying out therapy in their location of choosing (e.g. at home).</i></p>	<p>SU0310 Can make patient feel more comfortable</p> <p>SU0485 Being a little self conscious in an unfamiliar environment</p> <p>SU0123 Patient may feel hostile in an unfamiliar environment</p>	<p>SU0459 More relaxed and therefore more receptive when in comfort zone of my own home</p> <p>I believe telephone delivered therapy is an excellent concept and leaves one feeling comfortable and safe in one's own home</p>	
	<p>Distractions</p> <p><i>Comments on whether one can be distracted when on the phone or in ones' own location (e.g. home).</i></p>	<p>SU0260 Probably useful not to see them writing notes as you speak</p> <p>SU0547 No distractions which can occur on telephone</p>	<p>SU0334 On phone you can do other things while you speak and be distracted</p>	

	<p>Physical Proximity</p> <p><i>Comments on being in the same room as the practitioner during therapy</i></p> <p><i>(can link to NVCs, Explanation, Therapeutic Relationship: Emotional support)</i></p>	<p>SU0231 I feel more relaxed in the presence of another person than I do alone</p> <p>SU0715 Human contact / interaction.</p>	<p>SU0389 I don't feel you can properly communicate without physically being with someone as you lose body language etc.</p>	
Time: 'It's Convenient'	<p>Time and Scheduling</p> <p><i>Convenience and flexibility (the adaptability) of a modality to around the patient's lifestyle (work and childcare commitments). This also includes the lack of adaptability for face-to-face.</i></p>	<p>SU0265 Problems of having to arrange time out from work to get appointments and seeking employers permission.</p> <p>SU0278 Transport and traveling, would mean more time needed.</p>	<p>SU0040 Can use a time convenient to client time</p> <p>SU0250 Telephone delivery enables therapist to start treatment much quicker.</p>	<p>SU0265 It is very difficult to arrange therapy out of office hours</p>
	<p>Therapeutic Time</p> <p><i>Service users have noted that face-to-face delivery may allow them more time to discuss their concerns and issues. Although scheduling issues (for the clinic) may be evident.</i></p>	<p>SU0476 Have time to work through problems or concerns</p> <p>Limited to times when room + counsellor at surgery are available</p>	<p>SU0715 useful for quick catch up sessions,</p> <p>Not good for a normal session</p>	
The 'Mental health taboo'	<p><i>The barrier/issue of stigma when seeking mental health treatment may be present in face-to-face treatment by alleviated by the use of telephone delivery</i></p>	<p>SU0040 fear of being recognised,</p> <p>SU0459 Embarrassment</p> <p>Fear of being recognised by other persons while in premises</p>	<p>SU0260 Reduced my anxiety about being seen at mental health care</p> <p>SU0459 No embarrassing eye contact</p>	<p>SU0701 mental health is such an important issue that often carries a taboo</p>

	<p>Anonymity & Privacy</p> <p><i>The increase in privacy and anonymity (along with confidentiality) in telephone support has been noted to be positive</i></p>	<p>SU0040</p> <p>privacy, fear of being recognised,</p> <p>Some people would not be able to have the privacy they would need to get the most out of the service</p>	<p>SU0040</p> <p>Total privacy especially if live in a small community or work in NHS where know a lot of people & could be known where you are attending</p> <p>Sometimes easier to speak to a faceless person.</p>	<p>SU0701</p> <p>Family members may find out where I'd gone, whereas it's easier to sneak in a 30 minute conversation!</p>
<p>Feeling 'Palmed Off'</p>	<p><i>Expectations and attitudes towards certain delivery modalities (e.g. what they believe to be 'therapy')</i></p>	<p>SU0250</p> <p>Personally I much prefer the face to face consultation.</p> <p>SU0334</p> <p>I prefer speak/talk face-to-face, because I can explain myself with "hands" as well.</p>	<p>SU0110</p> <p>For those who might feel uncomfortable talking face to face with someone, a phone conversation would put that person at ease.</p>	
<p>'The assessor can...'; Practical factors for practitioners</p>	<p><i>General comments regarding practical factors for PWP's in-sessions</i></p>	<p>SU0675</p> <p>Possibly a risk factor for the assessor as they do not know the mood of the patients.</p>	<p>SU0110</p> <p>Technological interference.</p> <p>SU0239</p> <p>The healthcare professionals able to have better output or "see more patients"</p>	
<p>'Making the effort'; Part of the treatment process</p>		<p>SU0250</p> <p>Although it may be sometimes painful it is much more difficult to put up a wall of defence against some of the issues that may be causing or adding to your state of mind.</p>	<p>SU0696</p> <p>Not being required to make the effort to go out</p> <p>SU0715</p> <p>Too easy to stay shut in at home.</p>	

APPENDIX G: PWP QUESTIONNAIRE – THEMATIC ANALYSIS

Theme Name		Description	Examples		
Main Theme	Sub-Theme		Face-to-Face	Telephone	General
Forming and maintaining rapport		<p><i>Comments regarding the therapeutic relationship and how this may or may not be affected when using a delivery modality.</i></p> <p><i>Empathy</i></p> <p><i>Aspects regarding emotion and conveying empathy to patients.</i></p>	<p>PW3800</p> <p>I also feel more empathy F2F</p>	<p>PW0044</p> <p>Rapport is great – again, it is down to the verbal competences, being empathic and showing understanding.</p> <p>PW0058</p> <p>It is also easier to feel less involves/affected by a person’s distress when delivering telephone sessions, especially when working in a busy office.</p>	
		<p><i>Rapport</i></p> <p><i>Their general relationship and rapport when using a specific delivery modality.</i></p>	<p>PW0009</p> <p>Benefits to face to face – rapport is easier to form & maintain</p> <p>PW0083</p> <p>is easier to develop a stronger therapeutic alliance.</p>	<p>PW0002</p> <p>I find it easy to build a rapport with patients on the phone</p> <p>PW0013</p> <p>I feel that I am still able to establish a good rapport with clients over the telephone</p>	<p>PW0052</p> <p>If you are going to get rapport it can be done either way</p> <p>Some patients & therapists will not gain rapport regardless of modality</p>

<p>Visually see the patient</p>		<p><i>Non-Verbal Aspects</i></p> <p><i>This general theme involves all visual aspects of communication that may be lost due to the use of the telephone delivery modality.</i></p> <p><i>Non-verbal communication which may be useful in communication and building a successful therapeutic relationship, as well for the explanation of information.</i></p>	<p>PW0007 Face to face I find easier to screen for risk due to the non-verbal signs elicited by the patient</p> <p>Face to face easier to display appropriate level of empathy to visual signs</p> <p>PW0013 but it is easier to be more empathic face to face, as you are able to make use of facial expressions which I feel is very important in showing empathy</p> <p>PW0019 Face to face appointments allow the clinician to gain further information from non verbal cues and presentation.</p>	<p>PW0007 Telephone harder to pick up on body language, emotions.</p> <p>PW0009 lack of non-verbal skills (important in conveying empathy, warmth and in assessing risk)</p> <p>PW0013 but it is easier to be more empathic face to face, as you are able to make use of facial expressions which I feel is very important in showing empathy</p> <p>PW0019 Clients often feel more comfortable offering more information about themselves over the phone, without noticing non-verbal reactions from the practitioner</p>	<p>PW0042 in my opinion communication is more than verbal</p> <p>PW0100 In my experience I feel the visual cues are very important when engaging with a patient (i.e. body language, nonverbal).</p>
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		<p><i>Patient Perceptions</i></p> <p><i>The view from PWPs in which they feel less judged by the patient if there is no visual contact. Less judgement on factors such as: Age, level of experience, general appearance.</i></p>		<p>PW0079</p> <p>We do not get to visually see what our pts look like and they don't see us either. I think this has a really positive effect on both PWPs + pts making judgements about each other. It is very easy to make negative judgements about others because of their appearance, which then influence our behaviours.</p>	<p>PW0002</p> <p>I am a young practitioner and often get comments made about my age or level of experience when meeting patients face to face. This is therefore not an issue when speaking to patients on the phone.</p>
		<p><i>Visual Prompts</i></p> <p><i>Comments relating to the use of session materials, diagrams, etc. to help improve comprehension of information.</i></p>	<p>PW0019</p> <p>it is often easier to explain using diagrams and other visual aids (for those with learning difficulties or where English is not their first language</p>	<p>PW0013</p> <p>over the telephone as there is not the opportunity to use visual prompts</p> <p>PW0082</p> <p>Visual materials can still be used in telephone work by sending things in advance</p>	<p>PW0044</p> <p>Not really because we send out worksheets so the patient still has the visual material and if they don't, we instruct them on how to draw it</p>

Verbal Competencies		<i>The awareness of using verbal cues and communication to establish a good rapport and convey empathy with the use of Visual aspects.</i>		PW0044 Empathy is easy, it comes naturally but a lot of it is about tone of voice and actually speaking over the phone makes you really work on your verbal communication skills because you can't rely on the non-verbal.	
Clients engage well with both modalities		<i>Comments regarding whether a patient can fully engage in sessions when on a particular modality.</i>	PW0057 Face to face does potentially involve more commitment from the patient e.g. time off work, clinical care, cost to get there and this can also impact on the commitment to treatment.	PW0009 some patients don't treat sessions as appointments (more DNAs)	PW0007 I think similar problems with engagement are seen across both modalities PW0019 I find that clients engage well with both modalities
	Understanding and Following Tasks	<i>Understanding The effects of using telephone and PWP's ability to ensure that the patient has understood the information given.</i>	PW3800 facial expressions very useful in identifying if people understand and are happy to do the work	PW0057 it is easier to show the patient a graph and draw it out whilst talking + the visual impact aids the understanding.	PW0013 It can also be more difficult to gauge the client's understanding without seeing their face.

	<p><i>Following Comments in which PWPs suggest a difference in patients completing tasks when using the telephone modality.</i></p>	<p>PW0273 It is also easier to check whether patients have done their homework!</p>	<p>PW0007 people follow guided self help more closely using this modality</p>	
<p>Disclosure and Honesty</p>	<p><i>PWP's commented on the amount of information an individual will disclosure (or whether they are telling the truth) during a session.</i></p>	<p>PW0087 benefit from disclosing more face-to-face.</p>	<p>PW0013 I find they tend to disclose more</p> <p>PW0019 Clients often feel more comfortable offering more information about themselves over the phone</p> <p>PW0024 More open on the phone as little judgement</p> <p>PW0044 I think patients are given a lot of info. The same as they would be face to face.</p>	

<p>Decreased Practitioner Dependence</p>		<p><i>Two PWP's commented on the use of the telephone of modality to improve the internal locus of control of patients, decrease external attributions and improvement of self-management</i></p>		<p>PW0083 When a patient improves they are more likely to attribute the improvement to themselves rather than to the practitioner</p> <p>PW0096 they see the service as providing immediate answers as opposed to teaching techniques if the GP has told the patient what they think they need</p>	
<p>Improves Access</p>		<p><i>The view that the use of the telephone modality can help increase treatment/support uptake. This is the aim of the IAPT service.</i></p>	<p>PW0065 am acutely aware of the importance of having face to face sessions to enhance accessibility for this vulnerable group.</p>	<p>PW0009 Benefits to telephone = improves access (especially if transport, mobility or childcare is a concern), can be more flexible in booking appointments</p> <p>Access to more challenging (childcare, etc.)</p>	

Individual Circumstance	<i>Physical Health</i> <i>Patients with physical health issues that may find difficulty in accessing support/sessions.</i>	PW0065 am acutely aware of the importance of having face to face sessions to enhance accessibility for this vulnerable group.	PW0065 However, I have found that telephone can be useful intervention for these people with mobility issues.	PW0065 it is useful to have the choice for patients / predominantly new with patients with a disability of some kind
	<i>Mental Health</i> <i>Psychological or mental health factors which may affect the ability for some to access support/sessions.</i>	PW0047 Face-to-face can work well for some patients, for example, those with learning difficulties/language difficulties or diversity needs.	PW0047 Telephone appointments can be more suitable for patients experiencing anxiety symptoms as they can find it difficult to get to talk on the phone let alone attend face to face appointments.	
	<i>Lifestyle Factors</i> <i>Comments regarding life situations patients may be in (e.g. those who have work or childcare commitments).</i>	PW0009 time consuming for working adults PW0047 those who are working and can't/are scared to take time off.	PW0019 clients can take calls at home looking after children or at work PW0079 telephone working is a lot more practical for those who work.	PW0019 I find that clients engage well with both modalities, although better when the chosen modality fits their lifestyle and expectations.

	<p><i>Other</i></p> <p><i>General comments regarding individual differences and situations which may affect the uptake of treatment/support when utilising a certain modality.</i></p>	<p>PW0087</p> <p>Face to face is probably much preferable for certain groups: e.g. the deaf, older adults.</p>	<p>PW0048</p> <p>Concern is minimal for telephone working with people who have some form of complication – e.g. learning difficulty, English as second language, etc.</p>	<p>PW0058</p> <p>Often the factors which affect the success of treatment, engagement, relapse etc seem to be more about specific individual issues rather than because of the modality.</p>
Location, the Economic Climate and Availability	<p><i>Location</i></p> <p><i>The location of the treatment and how one can feel comfortable at home.</i></p>		<p>PW0019</p> <p>Telephone can be flexible for the time of appointment and the location</p>	
	<p><i>Money</i></p> <p><i>General savings in money (e.g. taking time off work, travel costs).</i></p>	<p>PW0047</p> <p>For some I think it can increase non attendance especially in a restricted economic climate when people can't afford to get to appointments of those who are working and can't/are scared to take time off.</p>	<p>PW0033</p> <p>I feel that telephone work can provide patients with a lot more flexibility and saves time & money for both service and patient (travel time).</p>	

	<p><i>Time</i></p> <p><i>The convenience and flexibility of booking sessions and support over the telephone. This includes the quick access for support. These factors help telephone sessions fit into many more of the patient's schedules (e.g. work and childcare commitments).</i></p>	<p>PW0009 attending appointments can be time consuming for working adults</p> <p>PW0047 For some I think it can increase non attendance especially in a restricted economic climate when people can't afford to get to appointments of those who are working and can't/are scared to take time off.</p>	<p>PW0009 can be more flexible in booking appointments</p> <p>PW0019 Telephone can be flexible for the time of appointment and the location (clients can take calls at home looking after children or at work).</p> <p>PW0021 however telephone support can be more time saving for the client</p> <p>PW0033 I feel that telephone work can provide patients with a lot more flexibility and saves time & money for both service and patient (travel time).</p>	
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<p>'Clients tend to choose or prefer...'</p>	<p><i>PWP recount of patient choices and views of a delivery modality when offering a choice between face-to-face and telephone.</i></p> <p><i>PWP's experiences of patient views on particular delivery modalities (usually prior and after use).</i></p>	<p>PW0013 most of my work was face to face individual. I think that clients preferred this choice</p> <p>PW0019 Clients tend to choose face to face if offered because they believe this is how 'therapy' is provided.</p> <p>PW0052 I would say some people initially prefer the idea of F2F support</p>	<p>PW0002 I find that most service users can be initially sceptical about telephone treatment, but often realise its effectiveness quickly.</p> <p>patients say they are surprised by the effectiveness of telephone interventions and would recommend it to others.</p> <p>PW0019 Clients often feel more comfortable offering more information about themselves over the phone</p>	<p>PW0009 When I have offered the choice between telephone and face to face appointments, patients have preferred face to face.</p> <p>I think telephone appointments should be offered and provided if wanted by I disagree with not offering face to face appointments. Especially when this is the patients preference.</p>
	<p><i>The views of other healthcare professionals regarding psychological therapy delivery.</i></p>	<p>PW0057 The current service tends to use face to face more as GP's prefer it</p>		

<p>'Talking to a stranger'</p>		<p><i>Anonymity and Privacy</i></p> <p><i>The use of the telephone modality promotes anonymity for the patient when discussing their issues which can have a positive effect</i></p>		<p>PW0002 often people find the anonymity a helpful thing – so they can open up more without fear of judgement.</p> <p>PW0009 anonymity (some patients have preferred this)</p>	
		<p><i>Stigma</i></p> <p><i>The use of telephone delivery increases anonymity and thus stigma in treatment is reduced.</i></p>		<p>PW0002 so they can open up more without fear of judgement.</p> <p>PW0019 Clients often feel more comfortable offering more information about themselves over the phone, without noticing non-verbal reactions from the practitioner</p>	

Scheduling and delivering treatment		<p><i>Scheduling</i></p> <p><i>PWP's comment how the modality type can affect the ease in which appointments/sessions can be booked</i></p>	<p>PW0044</p> <p>Our equipment isn't great for face to face which often means that at the end of the day we have all contacts to write up – this is very time consuming! Over the telephone you can write them up as you go – this is a factor in my preference.</p>	<p>PW0009</p> <p>Also, it is difficult to organise and plan for sessions as post is often slow to arrive – as a consequence, patients often need to complete a questionnaire over the phone which eats into session time.</p>	
		<p><i>Delivering</i></p> <p><i>Comments relating to how the telephone modality fits the timing boundaries of a session.</i></p> <p><i>PWP's comment on how the modality type can affect how sessions can be implemented (see sub-themes).</i></p>	<p>PW0007</p> <p>Face to face I find people are more likely to give me more story & focus less on the diagnostic problems</p> <p>PW0013</p> <p>face to face individual. I think that clients preferred this choice, although as a practitioner I found it challenging – keeping to boundaries of time mostly</p>	<p>PW0013</p> <p>Personally, I find that one of the main benefits in doing telephone work is that it lends itself more to the short time frames (20 minutes) that we work in for individual treatments.</p> <p>PW0044</p> <p>Not really because we send out worksheets so the patient still has the visual material and if they don't, we instruct them on how to draw it</p>	<p>PW0057</p> <p>However again it is down to how it is discussed, and the more a practitioner uses it the more they can become confident in it.</p> <p>PW0047</p> <p>I have found it easier to deliver treatments over the phone and that these are a more effective use of time.</p>

		<p><i>Other</i></p> <p><i>Comments regarding the implementation of sessions for PWP's and their day-to-day working.</i></p>		<p>PW0027</p> <p>I prefer telephone working as I can complete majority of my admin and multitask whilst on the telephone.</p>	<p>PW0044</p> <p>Working on the telephone also allows good team working and peer support which is really important given the pressures of our job, face to face working is far more isolated.</p>
<p>Explaining information: Having 'resources to hand'</p>		<p><i>Explaining Information</i></p> <p><i>How treatment modalities can affect PWP's ability to explain information. This is mainly due to the lack of visual cues for those using the telephone modality.</i></p>		<p>PW0013</p> <p>I feel that it can be harder to provide explanations – i.e. in explaining CBT or a particular intervention</p> <p>PW0021</p> <p>the same information is conveyed over the telephone which would normally be given face to face.</p>	<p>PW0057</p> <p>However again it is down to how it is discussed, and the more a practitioner uses it the more they can become confident in it.</p>

		<p><i>Session Resources</i></p> <p><i>Commenting on the use of visual resources – these can be sent in advance in some cases, again to improve the ability to explain information to patients.</i></p>	<p>PW0057</p> <p>it is easier to show the patient a graph and draw it out whilst talking + the visual impact aids the understanding.</p>	<p>PW0009</p> <p>Also, it is difficult to organise and plan for sessions as post is often slow to arrive – as a consequence, patients often need to complete a questionnaire over the phone which eats into session time.</p> <p>PW0013</p> <p>over the telephone as there is not the opportunity to use visual prompts</p>	
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APPENDIX H: PWP INTERVIEWS – THEMATIC ANALYSIS

Theme Name	Description	Examples
(I) Essential ingredients: "The Therapeutic relationship to me is..."	<i>This theme discussed the essential ingredients of the therapeutic relationship</i>	<p>most essential part of the job IN00032</p> <p>...the heart of the relationship the foundation is the therapeutic alliance with somebody IN00058</p>
(II) Emotional Presence: "I'm 100% with you" / "I don't feel I can be 100%"	<i>This theme discussed the feeling and need of total presence and undivided attention and how the modality could affect this.</i>	<p>I want them to know that they've got my undivided attention IN00058</p> <p>I think you can deliver the whole package and being in the room with somebody, I don't think anything is going to beat that IN00058</p>
(III) Embodied Presence: "There's something about seeing the person"	<i>Discusses the importance of visual cues – as well as other sensory cues (olfactory and tactile) to feel more connected with the patient and how the modality can affect this 'connection'</i>	<p>...they can't see your facial expressions, and obviously we are an extremely emotional eer, being aren't we? IN00042</p> <p>...face to face interaction with somebody being able to see what's not being said, the body language, and obviously you can't capture that over the telephone IN00058</p>

(IV) Vocal Presence: "You can have a telephone voice"	<i>Discusses the use of verbal competencies to account for lack of visual presence</i>	Over the telephone where it's more the tone of your voice that, that will carry your feelings through IN00029 ...reflecting, paraphrasing, the person over the phone knows that you are actually listening and you are getting it... it's very important to check in to make sure that you are with the patient and have got it right IN00058
(V) Faceless Voice: "It's just a voice at the end of the day"	<i>Discusses the use of the telephone modality and how they feel they are just a 'disembodied voice'; also explores the idea of anonymity and its advantages and disadvantages</i>	you are a disembodied voice IN00029 It's like when I don't see you talking, it's just a voice at the end of the day.... it's as blunt as it might sound, it's a voice and it's words IN00087
(VI) Professional Demeanours: "You need to look like a therapist"	<i>Discusses how practitioners present themselves over the telephone or face-to-face and this can differ and why this may be positive or negative for them as practitioners (e.g. the removal of pressure from patient judgement).</i>	You need to look like a therapist IN00092 I think they want someone who is going to be able to listen, um. I think they like to think that the person they are seeking is knowledgeable. I think age can come into things. IN00087

(VII) Patient Expectations: "They assume that we are counselling"	<p><i>Practitioners discussed patient expectations for a need of a "quick"/medical treatment, many also expect a counselling session and to be directed. This contrasted from how practitioners described their role (i.e. teaching, guiding).</i></p>	<p>So sometimes patients see this word "Counsellor" there and they have that expectation of you in Doctor's surgeries IN00029</p> <p>...they're talking to therapists who don't prescribe (sniffs), I say that it's CBT so we use self-help IN00029</p>
(VIII) Patient Commitment: "There's a big onus on them to turn things around"	<p><i>Discusses how the delivery modality can affect the commitment of patients' engagement and likelihood of attendance in sessions.</i></p>	<p>...there's a big onus on them to, to turn things round, and obviously that's what cognitive behavioural therapy is IN00058</p> <p>...over the telephone, there's a lot less effort involved... IN00092</p>
(IX) Improving Access: Democratising Therapy	<p><i>Discusses the benefits of telephone use in increasing the access for many who may have not been able to before.</i></p>	<p>But, from a telephone point of view, er, from a service perspective, we are being able to support so many more people for this time IN00042</p> <p>...it's really helpful, because, er, patients, er are working and they can speak to you in their lunch hour IN00029</p>

(X) The Nuts & Bolts: Bureaucratising Therapy	<i>Discusses how the delivery modality affects practical aspects of work</i>	It's difficult to get hold of people obviously but that's not the working over the phone, that's just a fact that you are on the phone constantly, so people can't get hold of you, you can't get hold of people. IN00042 ...if you are spending an hour travelling somewhere, that's a hell of a lot of time IN00042
(XI) Time for Therapy: "That time pressure"	<i>Discusses the significance of time pressure on the practitioners and that modality may not be the main factor</i>	I would say modality is irrelevant, time is the relevant factor... IN00042 ...telephone work is very hurried because it's half an hour IN00092 ...on face-to-face you can have more time IN00042
(XII) Therapy in the 21st Century: "Production line therapy"	<i>Discussion of the IAPT service in general and how their roles may be affected or how they perceive the service and its aims.</i>	...there's a very set practice that you have to follow with this role. very structured, um, and there are specific limitations on what you can and can't do IN00042

(XIII) Practitioner Preference: Telephone vs. Face-to-Face	<i>Discussion of practitioners' preference between telephone and face-to-face</i>	<p>In this theme, practitioners provided their opinion on whether they had a preference, if any, on using the telephone or face-to-face. A lot of practitioners highlighted the disadvantage of using the telephone, namely in treatment:</p> <p>I – personally I don't like it. Um, that's my personal feeling...</p> <p>IN00087</p>
(XIV) Practitioner Preference: Other Delivery Modalities	<i>Discussion of practitioners views on other delivery modalities</i>	<p>...there may be people who you know, might struggle just using the technology or using the Skype, and those kind of things.</p> <p>IN00032</p> <p>...instant messaging texting, I think that could probably work quite well, eeerm, but I think that would depend on the speed of typing for em, you know, for the patient and also for the practitioner</p> <p>IN00059</p>
(XV) Technology Anxiety: The Practitioner outside the Therapy	<i>Discussion of technology anxiety felt by some practitioners outside of working with the telephone modality</i>	<p>I'm (laughing) a bit of a phone-phobic</p> <p>IN00092</p> <p>But like Skype. Because I found even -. Well I can't even do it with my friends! (laughs)</p> <p>IN00084</p>

APPENDIX I: Psychological Wellbeing Practitioner (PWP) Training Overview

Note

This training specification is abridged from the '*Reach Out: National Programme Educator Materials to Support the Delivery of Training for Psychological Wellbeing Practitioners Delivering Low Intensity Interventions*' (Richards and Whyte, 2009; 2011).

Module 1 – Recognition

Engagement and Assessment of Patients with Common Mental Health Problems

1.1 Overview

Psychological wellbeing practitioners delivering low intensity interventions assess and support people with common mental health problems in the self-management of their recovery. To do so, they must be able to undertake a patient-centred interview which identifies both the person's main difficulties and areas where the person wishes to see change and / or recovery, and which makes an accurate assessment of the risk the person poses to self or others.

Psychological wellbeing practitioners need to be able to engage patients and establish a therapeutic alliance while gathering information to begin assisting the patient to choose and plan a collaborative treatment programme. They must have knowledge of mental health disorders and the evidence-based therapeutic options available, and be able to communicate this knowledge in a clear and unambiguous way so that people can make informed treatment choices. This module will, therefore, equip workers with a good understanding of the incidence, prevalence and presentation of common mental health problems and of evidence based treatment choices.

Skills teaching will develop workers' core 'common factors' competences of active listening, engagement, alliance building, patient-centred information gathering, information giving and shared Decision-making. This module will be run in parallel with module 2 and is 15 days in total in face to face teaching and role play and 10 days of additional directed study where you will complete tasks as set by the module team to consolidate the theory.

1.2 Learning outcomes

1. Demonstrate knowledge, understanding and critical awareness of concepts of mental health and mental illness, diagnostic category systems in mental health and a range of social, medical and psychological explanatory models.

2. Demonstrate knowledge of and competence in using ‘common factors’ to engage patients, gather information, build therapeutic alliances, manage the emotional content of sessions and grasp the patient’s perspective or worldview.
3. Demonstrate knowledge of and competence in patient-centred information gathering to arrive at a succinct and collaborative definition of the patient’s main mental health difficulties and the impact these have on their daily living.
4. Demonstrate knowledge of and competence in recognising patterns of symptoms consistent with diagnostic categories of mental disorder from a patient-centred interview.
5. Demonstrate knowledge of and competence in recognition and accurate assessment of the risk posed by patients to themselves or others.
6. Demonstrate knowledge of and competence in the use of standardised symptom assessment tools and other psychometric instruments to aid problem recognition and definition and subsequent decision making.
7. Demonstrate knowledge of and competence in giving evidence-based information about treatment choices and in making shared decisions with patients.
8. Demonstrate understanding of the patient’s attitude to a range of mental health treatments, including prescribed medication and evidence based psychological treatments.
9. Demonstrate competence in accurate recording of interviews and questionnaire assessments using paper and electronic record-keeping systems.

1.3 Assessment

There are three assessment components to module 1 testing skills competency, reflective practice and depth of learning. All of the assessments can be undertaken at undergraduate (HE6) or postgraduate (HE7) level as determined by the programme lead following review of your academic qualifications and experience. Module 1 is however always assessed at undergraduate level due to University regulations, regardless of which pathway you are on. All components of the assessment must be passed to be able to pass the module.

1. A standardised role-play scenario where trainees are required to demonstrate skills in engagement, information gathering, information giving and shared decision-making. This will be filmed and assessed by the programme team using the following marking criteria. You will be given either a pass or fail for this piece of work with feedback.

Each section is weighted and the middle two sections (interpersonal skills and information gathering) must be passed independently. A missing risk assessment is an automatic fail.

Module 2 – Recovery

Evidence-based low-intensity treatment for common mental health problems

2.1 Overview

Psychological wellbeing practitioners delivering low intensity interventions aid clinical improvement through the provision of information and support for evidence-based low-intensity psychological treatments and regularly used pharmacological treatments of common mental health problems. Low-intensity psychological treatments place a greater emphasis on patient self-management and are designed to be less burdensome to people undertaking them than traditional psychological treatments. Examples include guided self-help and computerised cognitive behavioural therapy (CCBT).

Support is specifically designed to enable patients to optimise their use of self-management recovery information and pharmacological treatments and may be delivered through face-to-face, telephone, email or other contact methods. Workers must also be able to manage any change in risk status. This module will, therefore, equip workers with a good understanding of the process of therapeutic support and the management of patients individually or in groups, and also support families, friends and carers. Skills teaching will develop workers' general and disorder-defined 'specific factors' competences in the delivery of CBT-based low-intensity treatment and in the support of medication concordance.

2.2 Learning outcomes

1. Critically evaluate a range of evidence-based interventions and strategies to assist patients to manage their emotional distress and disturbance.
2. Demonstrate knowledge of and competence in developing and maintaining a therapeutic alliance with patients during their treatment programme, including dealing with issues and events that threaten the alliance.

3. Demonstrate competence in planning a collaborative low-intensity psychological and / or pharmacological treatment programme for common mental health problems, including managing the ending of contact.
4. Demonstrate in-depth understanding of, and competence in the use of, low-intensity, evidence based psychological interventions for common mental health problems.
5. Demonstrate knowledge of and competence in low-intensity basic, intervention-specific, problem-specific and meta-CBT competences such as behavioural activation, exposure, CBT based guided self-help, problem solving and the individualisation of CBT approaches.
6. Critically evaluate the role of case-management and stepped-care approaches to managing common mental health problems in primary care, including ongoing risk management appropriate to service protocols.
7. Demonstrate knowledge of and competence in supporting people with medication, in particular antidepressant medication, to help them optimize their use of pharmacological treatment and minimise any adverse effects.
8. Demonstrate competency in delivering low-intensity interventions using a range of methods including face-to-face, telephone and electronic communication.

2.3 Assessment

There are three assessment components to module 2 testing skills competency, reflective practice and depth of learning. All of the assessments can be undertaken at undergraduate (HE6) or postgraduate (HE7) level as determined by the programme lead following review of your academic qualifications and experience. All components of the assessment must be passed to be able to pass the module.

1. A standardised role-play scenario where trainees are required to demonstrate skills in engagement, information gathering, information giving and shared decision-making. This will be filmed and assessed by the programme team using the following marking criteria. You will be given either a pass or fail for this piece of work with feedback. Each section is weighted and the middle four sections (interpersonal skills, information gathering, information giving and shared decision making) must be passed independently. A missing risk assessment is an automatic fail.

Module 3 – Respect

Values, policy, culture and diversity

3.1 Overview

Psychological wellbeing practitioners delivering low intensity interventions must operate at all times from an inclusive values base which promotes recovery and recognises and respects diversity. Diversity encompasses the range of cultural norms, including personal, family, social and spiritual values, held by the diverse communities served by the service within which the worker is operating. Workers must respect and value individual differences in age, sexuality, disability, gender, spirituality, race and culture.

Workers must also take into account any physical and sensory difficulties people may experience in accessing services and make provision in their work to mitigate these. They must be able to respond to people's needs sensitively with regard to all aspects of diversity, and must demonstrate a commitment to equal opportunities for all and encourage people's active participation in every aspect of care and treatment. Workers must also demonstrate an understanding and awareness of the power issues in professional / patient relationships and take steps in their clinical practice to reduce any potential for negative impact these may have.

This module will, therefore, expose workers to the concepts of diversity, inclusion and multiculturalism and equip them with the necessary knowledge, attitudes and competences to operate in an inclusive values-driven service.

3.2 Learning outcomes

1. Demonstrate knowledge of, commitment to and action based on a non-discriminatory, recovery oriented values base to mental health care.
2. Demonstrate respect for individual differences in age, sexuality, disability, gender, spirituality, race and culture, and show that these differences are valued.
3. Demonstrate knowledge of and competence in responding to people's needs sensitively with regard to all aspects of diversity, including the use of translation services.
4. Take into account any physical and sensory difficulties patients may experience in accessing services and if required refer to appropriate services.
5. Demonstrate knowledge of and a commitment to equal opportunities for all and encourage people's active participation in every aspect of care and treatment.

6. Demonstrate awareness and understanding of the power issues in professional / patient relationships.

3.3 Assessment

There are three assessment components to module 3 testing clinical planning, reflective practice and depth of learning. All of the assessments can be undertaken at undergraduate (HE6) or postgraduate (HE7) level as determined by the programme lead following review of your academic qualifications and experience. All components of the assessment must be passed to be able to pass the module.

1. A practical clinical planning scenario where trainees are required to demonstrate skills in preparing for the care of people with a variety of needs from a variety of diverse groups. The basic marking structure is shown below and the module lead will explain how this is to be marked at the beginning of the module.

Module 4 – Reflection

Working within an employment, social and healthcare context

4.1 Overview

Psychological wellbeing practitioners delivering low intensity interventions are expected to operate in a stepped-care, high-volume environment carrying as many as 45 active cases at any one time, with workers completing treatment of between 175 and 250 patients per year. Workers must be able to manage caseloads, operate safely and to high standards and use supervision to aid their clinical decision-making. Psychological wellbeing practitioners need to recognise their own limitations and direct people to resources appropriate to their needs, including step-up therapy; and they must focus on social inclusion – including return to work or other meaningful activity – as well as clinical improvement. To do so they must have knowledge of a wide range of social and health resources available through statutory and community agencies.

They must have a clear understanding of what constitutes high-intensity psychological treatment and how this differs from low-intensity work. This module will, therefore, equip workers with an understanding of the complexity of people’s health, social and occupational

needs and the services, which can support people to recovery. It will develop workers' decision-making abilities and enable them to use supervision and to recognise when and where it is appropriate to seek further advice or for the patient to access a signposted or step-up service. Skills teaching will develop workers' clinical management, liaison and decision-making competences in the delivery of support to patients, particularly where they require intervention or advice outside the core low-intensity evidence-based individual or group interventions taught in module 2.

4.2 Learning outcomes

1. Demonstrate competence in managing a caseload of people with common mental health problems efficiently and safely.
2. Demonstrate knowledge of and competence in using supervision to assist the worker's delivery of low-intensity psychological and / or pharmacological treatment programmes for common mental health problems.
3. Appreciate and critically evaluate a range of employment, occupational and well-being strategies to help patients manage their emotional distress and disturbance.
4. Demonstrate knowledge of and competence in gathering patient-centred information on employment needs, well-being and social inclusion.
5. Demonstrate an appreciation of the worker's own level of competence and an understanding of how to work within a team and with other agencies with additional specific roles which cannot be fulfilled by the worker alone.
6. Demonstrate a clear understanding of what constitutes high-intensity psychological treatment and how this differs from low-intensity work.
7. Demonstrate knowledge of and competence in liaison with and signposting to other agencies delivering employment, occupational and other advice and services.
8. Critically appraise how the complex systems of community, statutory and voluntary sector provision of services work together.

4.3 Assessment

There are three assessment components to module 4 testing skills competency, reflective practice and depth of learning. All of the assessments can be undertaken at undergraduate (HE6) or postgraduate (HE7) level as determined by the programme lead following review of your academic qualifications and experience. All components of the assessment must be passed to be able to pass the module.

1. A standardised role-play scenario where trainees are required to demonstrate skills in preparing for and using supervision. This will be filmed and assessed by the programme team using the following marking criteria. You will be given either a pass or fail for this piece of work with feedback. Each section is weighted and the information giving section must be passed independently.

Assessment of Practice/Clinical Competencies

5.1 Overview

The National curriculum includes a number of clinical practice outcomes, which must be achieved by trainees in order to successfully complete the programme. Trainees need to have a suitably qualified clinical supervisor (whom has completed the supervisors training through an accredited institution) who can assess the trainee's competence in clinical practice. The University provides an electronic version of the assessment of practice document (AoP), which can be found on Blackboard and needs to be completed by the trainee in conjunction with their supervisor.

5.2 Learning outcomes

1. Formulating and recording mental health care assessments appropriate to the identified needs of patients.
2. Demonstrating the common factor competences necessary to develop individualised therapeutic alliances that enable patients (and where appropriate their carers) to be purposefully involved in a partnership of care.
3. The identification and management of patients' emotional distress and disturbance through the use of interpersonal skills and evidence-based interventions.
4. Demonstrating the techniques necessary to develop and maintain individualised therapeutic alliances that enable patients (and where appropriate their carers) to be purposefully involved in a partnership of care.
5. High quality case recording and systematic evaluation of the process and outcomes of mental health interventions, adapting care on the basis of these evaluations.
6. The effective engagement of people from a range of social and cultural groups in low-intensity treatments.
7. Demonstrating the ability to engage with groups representing diverse cultural communities to improve the knowledge and understanding of different cultural values.

8. Where appropriate, displays competence in the use of face-to-face and telephone translation services for people whose first language is not English.
9. The effective management of a case load to ensure prompt and efficient access to care for patients on the worker's caseload including referral to step up and signposted services.
10. Demonstrating the ability to use regular scheduled supervision to the benefit of effective case management and personal development.
11. Integration of worklessness and employment initiatives into daily clinical practice to the benefit of all patients.

5.3 Assessment

Assessment and confirmation of clinical competencies will primarily be assessed within the trainee's service/clinical area by the approved supervisor. It is therefore the trainee's responsibility to ensure that appropriate time is allocated to both the completion of the document and within supervision sessions. The University will provide both a formative and summative assessment point where the document will be submitted for feedback from the University team. These submissions are fixed and non-submission will result in a fail being recorded on the students record, except for the formative submission where instead the University team will provide no feedback, unless there are special considerations logged as per the Faculty guidance. Successful completion of the AoP is a requirement of the programme and a fail will represent a fail for the programme as a whole.

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