Title page provided separately

**ACCESSIBLE SUMMARY**

What is known on the subject?

* There is a move towards the use of new ways of working and delivering mental healthcare, particularly via an increased use of telephone therapies
* Although some studies have noted the advantages of telephone-delivered therapies (e.g. removing access barriers) and reported on equivalent therapeutic effects when compared to face-to-face, there are concerns about how telephone-based therapy adversely affects the therapeutic relationship

What this paper adds to existing knowledge?

* It contributes new knowledge regarding psychological practitioners’ experience and views about using telephone-based therapies and how this affects the therapeutic relationship

What are the implications for research and practice?

* This paper provide data about the new practitioner workforce (IAPT Psychological Wellbeing Practitioners) and adds to a growing area of research regarding their clinical role. It has relevance for mental health nursing, because health services internationally and across the professions are exploring how telehealth can improve heatlhcare.
* This paper suggests that mental health services need to focus on what type of therapeutic relationship their practice facilitates and offer transparency to service users.
* It concludes that telephone work in IAPT can accommodate a working alliance, but not other types of therapeutic relationship, which practitioners and service users hoped for.
* Services need to focus on what facilitates and inhibits deeper therapeutic closeness and connection.

**ABSTRACT**

**Background:** Over-the-Telephone (OTT) delivered psychological therapies as an alternative method to face-to-face (F2F) are becoming more prevalent in mental healthcare. Research suggests a range of benefits of OTT use in therapy but there are growing concerns about its consequences for the therapeutic relationship.

**Aim:** This paper presents IAPT practitioners’ experiences and views of OTT work and its potential effects on the therapeutic relationship.

**Methods:** Completed questionnaires (exploring OTT versus F2F work) which were distributed to IAPT practitioners revealed a concern about the therapeutic relationship in OTT. To explore this further nine in-depth semi-structured interviews with PWPs were conducted and the findings from this qualitative study are reported here.

**Results:** Practitioners noted OTT use facilitated access and flexibility for service users however they expressed some concern over the adverse effect of OTT on the therapeutic relationship.

**Discussion:** Although a working alliance was possible OTT, this research suggests the type of therapeutic relationship formed OTT in a ‘low contact-high volume’ service such as IAPT needs to be better outlined. By addressing this, dissonance which might arise between practitioner aims and the aims of IAPT can be reduced. This research also contributes to wider debates regarding mental healthcare and its provision in the UK.

**KEY WORDS:** therapeutic relationship, e-health, cognitive behavioural psychotherapy, brief interventions

**Relevance statement**

This paper looks at factors which adversely affect the therapeutic relationship in a low intensity IAPT service which is characterised as a 'high volume, low contact' service (increasingly moving to telephone based therapy). Thinking about how the therapeutic relationship is affected by institutional drivers is crucially important to mental health nursing and the well-being of the mental health workforce. This paper offers ways to think about what kind of therapeutic relationship a particular service enables, thus bringing more clarity to the practitioner's role and work with service users.

**INTRODUCTION**

**Improving Access to Psychological Therapies**

Since 2007, a new strategy for the NHS mental healthcare system known as the Improving Access to Psychological Therapies (IAPT) programme has been implemented. Cognitive-Behavioural Therapy (CBT) is the therapeutic method of choice in IAPT due to its evidence base (Layard *et al.* 2006, NICE 2011).Other therapies are available, but they are not as widespread (IAPT 2014).

IAPT works on a stepped care model, with two levels of treatment: Low-intensity (LI) and High-intensity (HI). Recent statistics show that 86% to over 90% of service users are offered LI treatment options on first contact (Delgadillo *et al.* 2012, Mukuria *et al.* 2013).

LI is often characterised as a ‘low contact-high volume’ service (Clark *et al.* 2009). Guided or pure self-help are the most common forms of support accessed in the LI service (Glover *et al.* 2010) and LI work is carried out over-the-telephone (OTT) as well as face-to-face (F2F) (Parry *et al.* 2011, Hammond *et al.* 2012).

Evaluative reports have indicated positive progress for the programme since its implementation (e.g. Glover *et al.* 2010, Gyani *et al*. 2011, 2013, Department of Health 2012). However, IAPT has been critically questioned on particular aspects, for instance its recovery rate claims (e.g. Griffiths & Steen 2013, Griffiths *et al.* 2013) and the lack of service user choice due to the dominance of CBT (Loewenthal & House 2010, Samuels & Veale 2009, Paul & Haugh 2008a, 2008b). The individualism and lack of an emphasis on relationality in CBT has been criticised (Williams 2015) and the political use of IAPT is critically questioned (see Auestad *et al*. 2016).

**Telemental health: new ways of working**

Mental healthcare can be offered in a number of ways: telephone, email, videoconferencing, or internet chat services (APA 2010), this is often described as ‘telemental health’ (TMH) (Hebst *et al.* 2012). Health services internationally are exploring the potential of telehealth to support the management of the growing number of people with long-term conditions (Salisbury *et al*. 2017). Compared to more traditional F2F, TMH holds particular advantages such as alleviating treatment barriers (Hilty *et al.* 2007, Cavanagh 2014, Campos 2009).

**Psychological therapies OTT versus F2F**

OTT psychological therapy sessions have been noted to provide lower attrition rates (Mohr et al., 2008; 2012), as well as increasing the likelihood of antidepressant adherence when compared to F2F usual care (Mohr et al. 2000; Simon et al. 2004). Two-way audio communication (simulating OTT-delivery) provided similar small, but positive, effects when compared to F2F and VC with regards to various psychological concerns (e.g. self-esteem, relationship issues) (Day & Schneider 2002). One study observed more significant depression symptom improvements when compared to F2F (Lynch et al. 1997). However, this was not replicated in a follow-up study by Lynch et al. (2004).

Indeed much of the literature has noted the equivalent outcomes when comparing psychological therapies delivered OTT versus F2F, e.g. in IAPT (Hammond et al. 2012). User satisfaction has also been noted to be comparable to F2F delivery (Hyler et al., 2005; Bee et al., 2008; Turner et al., 2014).

Comparable symptom reductions have been observed in patients with OCD (Lovell et al. 2000, 2006, Turner et al., 2014) and depression (Bee et al. 2008, 2010, Day & Schneider 2002, Datto et al. 2003, Glueckauf et al. 2012, Mohr et al. 2012).

OTT delivery has also been noted to provide similar symptom improvements in more complex psychological conditions such as insomnia (McKay et al. 2004), other areas have provided more mixed results, e.g. addiction; self-reported alcohol abstinence was reported higher OTT than F2F (Bastien et al. 2004). Although eating disorder symptom severity reductions were observed OTT, F2F sessions compared to OTT guided-help had been observed to be more effective with significant reductions in symptoms (Hugo et al. 1999, Palmer et al. 2002).

Furthermore, Telephone-delivered therapies (e.g. T-CBT) have also been implemented outside of healthcare settings such as the workplace which also noted similar effects to F2F support sessions (Bee et al. 2010).

**Mental health nursing and telemental health**

Ellington et al (2013) argue that although TMH adoption can change and improve mental health nursing practice, observations of nurse participation in TMH are limited. Nevertheless, they maintain that mental health is well-suited to TMH for the delivery of care (in addition to direct patient services). Durland, et al (2014) point to the millions of people who suffer from mental health problems worldwide and the inadequate treatment available to them. They reviewed telehealth-to-home interventions which improved quality of life (QOL) and argue that TMH can reduce mental health disparities. Southard et al (2014), for example, examined the effectiveness of a TMH in a hospital emergency department and found that it provided more timely access to mental health evaluations in rural hospital departments. However, Bee, et al (2016) found that professional saw it as a high risk delivery strategy and they argue that there is a need to clarify the role of telephone therapy, understand practitioner views in order to normalise TMH in nursing and allied professional work.

**Psychological practitioner views and experiences of telemental health**

TMH is a predominant feature of LI therapy and exploring LI practitioner views of TMH enables us to clarify its impact on care. Previous research has highlighted views of health professionals regarding the use of TMH potential implications (e.g. Richards *et al*. 2006 on the use of telephone contact in a collaborative care plan for patients with depression; Stallard *et al*. 2010 on computerised-CBT), however few have explored health professional views on TMH and the therapeutic relationship (e.g. Gordon 2014 on the use of mobile telephone devices). Although other studies exploring the use of videoconferencing (telepsychiatry) have provided evaluative ratings (e.g. McLaren *et al*. 1996) as well as some qualitative feedback from health professionals (e.g. Doze *et al.* 1999, Simpson *et al.* 2001b), there is limited qualitative research on the use of the telephone in psychological therapies and only one study about clinician experiences and attitudes towards telephone triage in IAPT (see Jones *et al*. 2013). There are no studies exploring telephone use and clinician views of the therapeutic relationship in the context of IAPT.

The limited research available indicates that health professionals have offered relatively mixed views on TMH. Previous studies have shown that the therapeutic relationship and satisfaction was rated comparably by patients regardless of delivery modality – F2F or OTT (Day & Schneider 2002, Reese *et al.* 2002, Lingley-Pottie & McGrath 2006). However, practitioners have reported concerns about the threat to the therapeutic relationship especially since embodied co-presence is absent (Richards *et al.* 2006, McLaren 1992, Simpson *et al.* 2001b).

**This research**

As noted previously, there is a lack of research in IAPT about OTT.

This research addresses a gap in these findings and has relevance for the adoption of TMH in other services, because it focuses on the implications of TMH for the therapeutic relationship which is core to mental health nursing and practice.

This paper will report on one aspect of a larger project on OTT versus F2F therapy in an IAPT LI service. The larger study included a questionnaire which was completed by service users and practitioners in five IAPT services across the South West of England (from April 2013 to June 2014). It included quantitative and qualitative questions about OTT versus F2F therapy. Service users were also given the option to consent to the use of their outcome measures to compare F2F and OTT work. One of the predominant issues raised by both service users and PWPs in their respective surveys was about how OTT work might compromise the therapeutic alliance. PWPs were also recruited for one-to-one in-depth interviews after the survey data was analysed.

**METHODS**

**Design:** Critical realism (Maxwell 2012, Gorski 2013) informed the philosophical position adopted in this study and a qualitative design was used. Holloway and Wheeler (2010) explain that qualitative research focuses on the way people interpret and make sense of their experiences and the world in which they live. Qualitative research enables us to reflect and inform practice, because it privileges the participant’s experience (see Frankel & Devers 2000) which quantitative studies cannot easily do. Thus practice based evidence and practice inquiry (Rolfe 2006) is centrally important in health research, alongside quantitative work.

**Participants:** LI Psychological practitioners working in one of the five psychological services who adopted the IAPT programme in the South West of England were invited to take part in the PWP Questionnaire (PWQ) between April and November 2013. Practitioners had worked with either one or both of the modalities under study (OTT or F2F). Trainee PWPs or Psychological Practitioners were excluded. At the time of recruitment, it was estimated that there were approximately 50 practitioners eligible to participate. Due to the expected small sample size, demographic data were not collected. Thirty PWQs were returned and analysed. These participants were later invited to the interview study of which nine consented to take part.

Guest *et al*. (2006) found that the infrequency of novel theme emergence was noted between six to twelve interviews.

**Data Collection:** A one-to-one semi-structured interview method was used (Singleton & Straits 2012) in order to explore the experiences of each participant in depth (Firth & Gleeson 2012) and it allowed for the opportunity to clarify and elaborate on ideas raised by participants (Stangor 2007) in the survey (see Appendix A for interview schedule).

**Data Analysis:** Thematic Analysis was used to analyse this data (Braun & Clarke 2006) deploying both inductive and deductive coding. Deductive questions were informed by previous research (e.g. Galinsky *et al.* 1997, Miller & Weissman 2002, Yellowlees *et al.* 2003, Stallard *et al.* 2010). Inductive questions were derived from the qualitative data provided by 45 service users and 37 PWPs who completed the free-text questions in their respective survey. These questions are outlined in Table 1. The data analysis process involved the research team generating codes which formed the basis for thematic maps which we checked worked across the whole dataset. We worked primarily inductively with the data, although our interview questions were deduced from the literature as well as PWP survey results. There were seven themes which emerged from the data. Criteria appropriate for assessing qualitative research was followed using Guba and Lincoln’s (2005) criteria for assessing the trustworthiness of data and our reporting adheres to the COREQ guidelines (Tong et al, 2007).

[Insert Table 1 and 2 here]

**Ethics:** Research ethics help to protect and safeguard the welfare of research participants (Beauchamp & Childress 2009). This research project was approved by an NHS Ethics Committee (REC ref: 12/EE/0463) and all data was handled in accordance with the *Data Protection Act 1998.* In the presentation of results, pseudonyms were applied to each participant. However, as well as observing correct procedural ethics, this project was mindful about relational ethics which concern the way in which the bond formed between researchers and participants is respected and honoured (Ellis 2005).

**Reflexivity:** A reflexive relation to the research refers to the way in which *“...researchers turn a critical gaze towards themselves”* (Finlay 2003, p. 3). One of the researchers (JT) wrote an auto-ethnographic piece in order to critically question his own stance as a ‘polite researcher’ reluctant to settle any for or against IAPT debates. The two university based researchers (JB and DC) had experience in undertaking qualitative research and of F2F therapeutic work and were mindful about their own preconceived ideas about OTT versus F2F therapy. One of the main ethical challenges in this work revolved around the question of how to present views of the IAPT service which might be construed as critical, without questioning the integrity of practitioners working in it.

**RESULTS**

**The therapeutic relationship and embodied presence**

Most of the practitioners cited the therapeutic relationship as the *“…most essential part of the job”* [Kelly]. This was variously described as a relationship of trust, boundaries, respect, openness and humanness. Ros described a therapeutic relationship as one in which she could implicitly say *“I’m 100% with you”* and the majority of practitioners suggested that F2F allows for a deeper connection between them and the patient:

*“…you can see that I’m, I’m listening, I’m, you know, 100% with you, my focus is never anywhere else but on what you are telling me about“[*Ros]

This emotional co-presence depended on embodied co-presence.Ollie referred to feeling like *“a disembodied voice”* in OTT work and others suggested that OTT could feel depersonalising:

“*It feels more personal to me, so you know, I’ve seen their face, they’ve seen my face”.* [Ollie]

Practitioners also noted the importance of physical co-presence in facilitating rapport:

*“…you can pick up on the, the, subtle, a subtle sense of distress”* [Ollie]

Practitioners also suggested that being with a patient in the room enabled them to assess the person as a whole more*:*

*“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]

But they also pointed to the way in which F2F work allowed patients to assess their practitioners:

*“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]

Some practitioners noted that there were benefits to being anonymous, for them and patients. Leo said that in F2F work *“You need to look like a therapist”* and Jay supported this by saying *“you put on that professional front”*. Some of the PWPs felt that their relative youth made this problematic:

*“…would (the patient) be thinking what experience have they got? How can they help me when they’re 20 years younger than me”* [Georgie]

However, it should be noted that not all PWPs believed the use of the telephone was a huge disadvantage. Some noted that their initial reservations (*“little bit sceptical when I first started”* [Jay]) changed after using it. However, many practitioners suggested that OTT contact might be better suited to the assessment stage of the LI process rather than for care and treatments.

**The therapeutic relationship and auditory presence**

Although the majority of participants said that F2F work facilitates therapeutic rapport, they did not say that empathy was impossible in OTT work. Various strategies were used in order to convey emotional presence and empathy:

*“…change of the tone of voice, so I would use a sort of softer tone of voice… being aware of silence”* [Jay]

*“…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]

However, this change of to a softer tone of voice could also be experienced as a cliché or inauthentic:

*“…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]

**“*Proper therapy”* or life coaching?**

Many of the practitioners suggested most patients are unaware of what the LI cognitive-behavioural approach involves. The fact that OTT could not be used to offer a listening service was cited as confusing to service users:

*“They are used to being able to give their monologue… story, uninterrupted”* [Ollie]

This can perhaps be due to preconceived ideas about psychological therapy, primarily the perception that it is similar to counselling:

*“…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]

In contrast, a common view amongst the practitioners was that they have more of a teaching role:

*“…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]

Although PWPs saw their role as educative, they did not see it as didactive. Georgie felt that most patients wanted to *“get a quick fix”* and Izzie said:

“*…they’re coming to you for the answers, and that’s quite important that you try and break that a bit I think”.*

It was important to the PWPS that service users felt *“empowered to make those changes”* [Izzie]– in the context of a collaborative relationship:

*“…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]

Leo added that practitioners “*don’t have a magic wand, there is no magic pill*” and thus positioned their work outside of a medical or pharmacological model. Izzie also pointed to the way in which the emphasis on collaboration could be surprising for some service users.

**Widening access: democratising therapy?**

PWPS 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]

This is because OTT work allows for work constraints, childcare responsibilities, transport difficulties, mobility problems and specific mental health difficulties like agoraphobia. Lin also pointed to the gendered nature of preference for F2F or OTT work and said that men preferred OTT 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]

**The nuts and bolts: bureaucratising therap**y

Some PWPs pointed to the logistical problems with OTT work, for example, the telephone number might be *“… completely wrong”* [Ollie], service users might not be contactable and the practitioner might be preoccupied with a previous caller outside of their designated session time. Some PWPs said that F2F contact may consume a lot of their working time, specifically if they had to travel to the patient.

On a similar note, one practitioner stated that OTT is used as a means of contact when a patient was unable to attend or had cancelled their appointment:

*“…try and be flexible and if a patient can’t make it, we can do a telephone one”* [Ollie]

Practitioners said 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]

**Time for therapy: *“that time pressure”***

Despite some of the advantages which PWPs could see in OTT work for service users, many were concerned about the time allocated:

*“…the 20/25 minutes is very short”* [Lin]

*“…one of the biggest pressures on an alliance can be that time pressure”* [Jay]

Moreover, given the PWP caseload OTT work mitigated against properly remembering who they were speaking to:

*“I’ve got a massive caseload and I’ve probably assessed 900 people…even if I’ve got 165 on my caseload-which I have- and I think ‘Oh my goodness, what am I doing with this person?’ Take a deep breath, look at their notes, and then I’ll do like that (snaps fingers) and I’ll think, ‘I know what the plan was’.*” [Leo]

*“Less cues to remember someone with the telephone working”* [Jay]

**Therapy in the 21st century: *“production line therapy”***

Although PWPS welcomed working with a structure or protocol, they also pointed to the restricted nature of 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]

Ollie said that *“I don’t buy the idea that one size fits all”* and Kelly also said the service may *“try and fit the patient into the PWP boxes a little bit”*. Some practitioners also pointed to the lack of choice offered to service users.

For Georgie, the needs of the service contradicted the needs of service users:

*“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”*

Most practitioners noted that service users perceived F2F work to be more ‘traditional’ and in some instances the more ‘effective’ form of therapy offered.

**DISCUSSION**

**The therapeutic relationship and embodied presence**

Many authors have argued that the therapeutic relationship is more important than the therapeutic approach utilised (Paul & Haugh 2008b, Martin, et al 2000). What characterises a successful therapeutic relationship has been discussed by many authors (Chadwick 2006, Egan 2010) and there are different methods for measuring it (Horvath & Greeberg 1989).

Seminal work by Clarkson (2003) posits that there are five ‘types’ of therapeutic relationship (a working alliance, the transference/counter-transference relationship, the reparative and developmental relationship, the person-to-person and the transpersonal relationship). This research suggests that OTT can compromise some types of therapeutic alliance.

Parry *et al.* (2011) reported that IAPT clients felt ‘less connected’ to the PWP when OTT. Indeed various authors have argued that non-verbal signs can suggest openness and relaxation (Bensing 1991; Wootton *et al.* 2003) and enable the practitioner to intuit the client’s ‘felt sense’ (Egan 2010).

Moorey (2014) argues that the time-limited nature of the CBT model could prevent a deeper emotional connection from being formed. Farrand and Williams (2010) note that a CBT session in IAPT LI lasts approximately 30 to 40 minutes, but PWPs in this study noted that OTT therapy lasts between 20 to 30 minutes, and sometimes felt *“hurried”.*

PWPs in this researchproposed that patients who ‘did not attend’ (DNAs) were more likely in OTT, suggesting that engagement had been compromised. Unsurprisingly, Mulligan *et al.* (2014) found that alliance ratings were negatively related to number of sessions missed. However, Mohr *et al.* (2008, 2012) noted that there were fewer participants dropping out of sessions when OTT, compared to F2F DNAs, and Hilty *et al.* (2007) also found that service users were more open to discussing their issues OTT when compared with F2F. We therefore need to be cautious about concluding that OTT ***only*** adversely affects the therapeutic relationship. For example, a recent study suggested that mental health self-efficacy may be important in the success of non-F2F delivered psychotherapies (Clarke *et al.* 2014). Lam *et al.* (2011) found that the T-CBT programme made service users feel *“empowered”****,*** because theyattributed change to their own self-determinationrather than reliance on the relationship or practitioner.

A high proportion of the PWPs suggested that the use of videoconferencing could be useful as it is visual, convenient and can appeal to key demographics (e.g. younger age groups who are more technology-oriented). Some PWPs suggested that technology could be used to enhance F2F therapy (a finding from Richards & Simpson’s, 2014, research).

The Technology Acceptance Model (Davis 1993) 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. Normalization Process Theory (May *et al.* 2009) also explores how novel technologies can become embedded in day-to-day routines and this research suggests that TAM could usefully be deployed in mental health services promoting TMH.

**The politics of care in the 21st century: The IAPT service**

Within the clinical and academic community (House & Lowenthal 2008), there has been concern about the overemphasis on CBT in IAPT which might lend itself more easily to OTT work, potentially limiting access to an array of alternative psychological therapies (Wesson and Gould 2010). Economic pressures often underlie the need to change mental health policies (Coppock and Hopton 2000; Rogers and Pilgrim 2001) and there have been pressures since the financial crisis of 2007/08 to deliver therapies on a set budget (Yarlagadda *et al.* 2014). In this project, PWPs commented that their main concern for patients was to help them feel better rather than meet the ‘return to work’ aim. Some PWPs also felt as though they were working in a ‘call centre’ environment when working OTT. However, this did offer social support. This research contributes to Steel *et als.* (2015) study on IAPT workforce burnout which cited in-session feelings and work demands and autonomy, as contributory factors.

This paper does not seek to settle the ‘for or against’ argument, but instead to raise important questions about the strengths and weaknesses of the IAPT service, the future of TMH and practitioner and service user well-being. The PWPs in this study did express concern over the adverse effect of OTT on the therapeutic relationship, but they did not say that this meant that no working relationship was possible.

**What this study adds to the international evidence**

This paper contributes new knowledge about psychological practitioners’ experience and views about using telephone-based therapies and how this affects the therapeutic relationship. This has relevance beyond the IAPT setting, because TMH is being explored in health services generally and the findings from IAPT can inform the development of TMH in mental health and social care generally.

Research in IAPT is sparse with regards to practitioner views of OTT use. Hammond *et al.* (2012) looked into the effectiveness of F2F versus OTT in the IAPT service (rather than practitioner views of OTT work) and Parry *et al.* (2011) explored patient views of LI therapies, in general (but there was no specific focus on OTT use). Jones *et al.* (2013) looked at PWP views of using OTT in triage, but this was not compared to their views of F2F therapy versus OTT. Jones *et al.* (2013) also reported initial worry about OTT use which, in some cases, changed after experience of use. There have also been some critical accounts of working in the LI service and utilising OTT delivery (Binnie 2015)which raise questions about the well-being of the IAPT workforce and this is a key priority for the psychological healthcare profession (see BPS 2016). A recent study explored healthcare professional views on the use of T-CBT in a HI setting and particular concerns of information miscommunication, therapy ruptures and patient disengagement were presented (Bee *et al*. 2016).

This paper focuses specifically on TMH and the therapeutic relationship in LI IAPT characterised as a ‘high volume, low contact service’. It uniquely raises the question of how TMH affects the therapeutic relationship. It has found that Clarkson’s (2003) definition of a ‘Working Alliance’ may be successfully achieved OTT because of the importance placed on shared decision making, tasks, and goals which characterises a working alliance (Bordin 1979, Westbrook *et al.* 2010). However, forming a spiritual connection (the transpersonal relationship) or the person to person relationship (authenticity and congruence) may be compromised OTT in a time-limited service and indeed in other services which have limited resources.

Although a working alliance was possible OTT, this research suggests IAPT services (and mental health services more generally) need to be clearer about what type of therapeutic relationship the service can facilitate, thus reducing dissonance for practitioners and service users alike. This dissonance arose for both parties in this research when they thought that they could work in a counselling relationship which might facilitate different types of therapeutic connection. IAPT services could also identify the therapeutic impact of different types of therapy which it offers. Cahill, et al (2013), for example, looked at service user experiences of therapy with mental health nurses and clinical psychologists. They found that service users only found two out of 13 impacts of therapy were different. They reported higher levels of awareness with psychodynamic therapy compared to higher levels of problem solution in CBT. Overall, they conclude that this supports the influence of common rather than specific factors in therapy effectiveness in mental health nursing.

Our research findings suggest that services could be more explicit about the type of therapeutic relationship that they can facilitate thus leading to more collaborative and transparent relationships between service users and practitioners. This research also contributes to wider debates regarding the well-being of the mental health workforce who often hope to work with a particular type of therapeutic relationship, but find that service drivers make this difficult.

**Limitations and recommendations for future work**

Although this paper reports on a small sample size, there is very little literature which explores the views and experiences of IAPT practitioners, particularly with regards to their views and experiences of OTT and F2F work. It would be interesting to work with a larger sample size, explore views about the therapeutic relationship in other contexts (IAPT in CAMHS, etc.) and explore the role of new technologies and their acceptance in the future IAPT service. It would also be worthwhile to explore how the therapeutic relationship is co-created in interpersonal therapies in IAPT (Interpersonal Therapy, Dynamic Interpersonal Therapy and Counselling for Depression) and compare LI with HI IAPT work.

**CONCLUSION**

This research offers an original contribution to knowledge about experiences of OTT therapies within the low intensity IAPT service. Practitioners noted that one of the main advantages of using the telephone with service users was improved access and flexibility. However, their main concern was the adverse consequence of OTT for the therapeutic relationship. This concern may have arisen from a dissonance between practitioner aims and the aims of the programme. The findings add to a growing area of research regarding their well-being and understanding of their role (e.g. Green *et al.* 2014, Altson *et al.* 2014). This research also contributes to wider debates regarding mental healthcare and its provision in the UK.

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**APPENDIX A: PWP Interview Schedule/Questions**

1. Could you tell me about your role as a Psychological Practitioner and what drew you to the profession?
2. Could you tell me about your experiences of working with patients over the telephone and the factors that could affect your interaction with them?
3. And could you tell me about the positives and negatives of working with patients face-to-face?
4. Drawing on your experiences, could you describe to me what a ‘therapeutic relationship’ means to you?
5. 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?
6. From your experience, what do most patients initially expect from a face-to-face intervention?
7. In contrast, what do most patients initially expect from when using the telephone?
8. What are patients’ perceptions and experiences of you as a practitioner when interacting with them over the telephone?
9. And what about their perceptions and experiences of you as a practitioner when face-to-face?
10. Have your views about therapeutic delivery types changed from when you first started working as a Psychological Practitioner?
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)
12. What are your opinions on the use of other technologies for delivering psychological therapies?