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Personalised treatments in CBT and the therapeutic alliance in IAPT

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Declaration of powers of discretion

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Preface

This portfolio is comprised of three pieces of work, each shedding light on the practice of Cognitive Behavioural Therapy (CBT), and focusing on the relational aspects of the therapy. The first piece of work presented is the empirical research project which explores the therapeutic alliance in an Improving Access to Psychological Therapies (IAPT) setting. Secondly, a literature review is presented that looks at the differences between Compulsive Hoarding and OCD by looking at current treatment types, with a focus on CBT and neuropsychological investigations. Finally, I present a clinical case study which explores working with a client in an eating disorders service and using an adapted version of CBT. In combination, these three sections evidence the core Counselling Psychology competencies (British Psychological Society, 2006). Although the portfolio focuses solely on one treatment modality, its aim is to present a sense of my journey through the Counselling Psychology training and my relationship with CBT.

I began my Counselling Psychology training having completed a Masters qualification at the Institute of Psychiatry. This was my first in-depth exposure to CBT. It was presented in quite a reductionist, simplistic, and clinical manner, and seemed to be hailed as a panacea for all psychological 'disorders'. In my naivety, I was somewhat seduced by the all curing, one size fits all treatment. However, I started to question the whereabouts of the relational element in the CBT textbooks, treatment, and lectures I received. This ignited my interest in the importance that the therapeutic alliance played in CBT.

The research element of this portfolio (section A) used a sequential mixed methods approach to explore the therapeutic alliance in an IAPT setting. Having come from Ireland where state-funded primary care psychological help is virtually non-existent, I could really see the advantage of investing in the mental well-being of a country through an initiative such as IAPT. During my initial literary exploration of IAPT, I was struck by how much of an emphasis was placed on the economic rationale behind the development of the service. The foundations of the initiative are firmly based on cost-effectiveness, productivity of clinicians, and getting a sizeable proportion of service-users back to work. I started to wonder whether there was space for the TA to grow in this streamlined service and in doing so the research question was born.

I was aware of the potential pitfalls of devising the research question solely based on my own opinions or personal experience. I was sceptical that a meaningful TA could be created in such a structured service, bound by the medical model of mental illness. My ambition, therefore, was to focus on the therapists' experiences of the TA in an IAPT setting and for these experiences to guide the quantitative explorations of the data that was to be collected. A mixed methods approach also echoed the pluralistic nature embedded in Counselling Psychology. Rather than base my inquiry on a single epistemological stance, I thought that a mixture of epistemologies would acknowledge the importance of multiple views promoted by our profession. Furthermore, it would provide a platform to compare and contrast the findings of quantitative and qualitative elements of the project. As known, Counselling Psychology places an emphasis on a holistic view of the person and the primacy of the therapeutic relationship. This research project aims to look at the role of the TA from the therapists' and the clients' perspectives through the use of qualitative and quantitative methods.

The second piece of work included in the portfolio (section B) is a critical review exploring whether Compulsive Hoarding should be seen as a subtype of OCD or a distinct separate entity. Rather than pursue this on a theoretical level, it was decided to focus on whether treatments for OCD could be used to help individuals who felt compelled to hoard their belongings, or whether other, more tailored ways of working with this phenomenon were more effective.

This piece of work was written during the first year of the doctorate and, in my opinion, is the most 'diagnostically focused' of the sections. As a result of my time at the Institute of Psychiatry, I was interested in the concept of OCD. During a lecture by Professor Matix-Cols, a researcher and clinician specialising in OCD, he encouraged us to debate whether the subcategories of OCD were overlapping and whether they shared similar symptoms. This sparked my interest in this topic. I was eager to review the literature, specifically drawing on research surrounding treatment types in OCD and hoarding. It is important to bear in mind that this literature review predates the 2013 release of the DSM-V in which hoarding has been classified as a separate entity in its own right. Thus, the literature review was written at a time where there was much debate about the delineation of hoarding from other entities and also significant media coverage (e.g. UK documentaries, newspaper articles etcetera). There would have been scope to develop this literature review in to a research project; however, my

interest in the TA in IAPT surpassed my interest in the topic as the first year of training drew to a close.

The last section in this portfolio (section C) is a clinical case study in which I present an account of working with a client in an eating disorders service. This case study is chosen as it shows how CBT for eating disorders (CBT-E) can be adapted for a client who blames themselves for developing their eating problem. Elements of Compassion Focused Therapy (CFT) are added to the treatment to instigate the client's self-compassion and to them develop a less blaming relationship with her former self. Again, relational elements of CBT were essential in the work with the client and the therapeutic alliance was instrumental in developing trust, compassion, and a collaborative space from which to work. In this way it mirrors some of the concepts explored in the research study. The pluralistic nature of counselling psychology is also highlighted, as the treatment is adapted to suit the needs of the client. This is achieved through the integration of CBT and CFT. The primary aim of this case study was to outline my clinical competence as a Counselling Psychologist, developed during the three years of training. Furthermore, it outlines some of the core strengths I developed as a practitioner while working with this challenging client.

The three sections of the portfolio were completed at different stages during the course of training. I have included the three different sections as firstly they all focus on CBT and highlight the importance of the TA in CBT and adapting CBT to suits the needs of the client, and secondly to show my development as a clinician, researcher, and critical thinker.

References

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The importance of the therapeutic alliance in IAPT: A mixed methods investigation

Abstract

This study used a sequential mixed methods analysis to investigate the importance of the Therapeutic Alliance (TA) in an Improving Access to Psychological Therapies (IAPT) service.

The first part of this study used thematic analysis to analyse data collected from two focus groups, one containing seven qualified IAPT therapists and one containing five trainee IAPT therapists. The qualitative analysis resulted in three super-ordinate themes: 1) The impact of the IAPT trainee experience on the TA, 2) Equality in the relationship versus early IAPT protocol, and 3) Severity of client symptoms and impact on TA.

The second part of this study used a pantheoretical measure of the TA (Helping Alliance Questionnaire-II, Luborsky et al., 1979) along with measures of depression (PHQ-9, Kroenke et al., 2001) and anxiety (GAD-7, Spitzer et al., 2006), to answer three main questions raised by part 1 of the study: (1) Is there be a significant difference in TA scores between trainee therapists and qualified therapists? (2) Does IAPT protocol impact on the early TA? (3)Is symptom severity be correlated with the TA? A fourth question was generated as a result of the literature review: (4) Does early or late TA predict depression and anxiety scores? A total of 18 therapists, nine qualified and nine trainees, and their respective clients (n=37) took part in the quantitative section of the study. Quantitative results showed that there was no significant difference in TA scores between trainee and qualified therapists. Secondly, a strong TA was found across the two groups. Thirdly, symptom severity was not significantly correlated with client or therapist TA scores. Finally, end of treatment client TA scores along with baseline depression and anxiety scores were shown to be predictive of end of treatment change in depression and anxiety levels. Implications for practice and Counselling Psychology are discussed and avenues for future research are suggested.

Prolegomenon

Counselling psychology often finds itself challenging the medical model of mental illness, the sentiments of reductive models of psychological health care, and the 'research directed' (as opposed to "research informed"; Hanley, 2012) manualisation of psychological therapies. The philosophy of counselling psychology is firmly grounded in its humanistic values, something that can somewhat delineate it from its applied psychology counterparts. Strawbridge and Woolfe (2010) suggest that it is these humanistic underpinnings that connect counselling psychology to a human science rather than a model of natural science.

One of the fundamental tenants of counselling psychology, as outlined by Woolfe (1990), is the significant value that is placed on the helping relationship during the therapeutic encounter. This is reflected in the BPS *Accreditation Through Partnership Handbook: Guidance for Counselling Psychology Programmes* (BPS, 2012) which dictates that every counselling psychologist should have a deep "understanding of the therapeutic relationship and alliance as conceptualised by each model studied" (p.15). In the *Accreditation Through Partnership Handbook* the therapeutic alliance is mentioned in terms of theoretical models, personal development, but also in terms of developing (maintaining, and ending) a purposeful therapeutic alliance in the therapeutic work with clients. The *Handbook of Counselling Psychology* (Strawbridge & Woolfe, 2010) suggests that "it is perhaps the focus on the relationship that is particularly significant" (p.4) in delineating counselling psychology from other applied psychologies. Moreover, the Division of Counselling Psychology further echoes this sentiment by acknowledging the profession's "firm value base grounded in the primacy of the counselling/psychotherapeutic relationship" (DCoP, n.d., official website).

Since its official inception as a distinct British Psychological Society (BPS) Division in its own right in 1994, counselling psychology has become more established, particularly within the National Health Service (NHS). However, as society in general further embraces a capitalistic mentality, pressure is being put on mental health services to become more 'cost-effective.' Furthermore, the current structure of the health services is tied to the medical model of mental illness. As suggested by Larsson, Brooks, and Loewenthal (2012), there is a debate as to whether counselling psychologists can retain their philosophical value of nonpathologising in structures that are heavily influenced by a pathologising medical model. These two phenomena, coupled with society's nomothetic stance, have propelled the investment in manualised forms of therapy.

The Labour government's 2005 manifesto (2005) and the subsequent Layard report (Layard et al., 2006) instigated a seven year plan to increase the accessibility of evidence-based psychological therapies to the general population. This report prompted the investment of hundreds of millions of pounds in to Primary Care Mental Health services (see section 1.5 for further details). The Improving Access to Psychological Therapies (IAPT) movement brought about a revolution in health care, training almost 4,000 new practitioners to deliver treatments recommended by the National Institute of Clinical Excellence (NICE) (Department of Health, 2012), the vast majority of "new" trainees being trained in IAPT CBT.

The introduction of IAPT posed various dilemmas for counselling psychologists. For example, in a paper presented at the Annual Counselling Psychology Conference, the then Chair of the division, Pam James (2010), outlined some of these issues. For example, how does the CBT uni-theoretical model fit with the underlying pluralistic philosophy of counselling psychology? Furthermore, James (2010) upholds the counselling psychology view that the understanding that depression and anxiety can have different meanings for different people, and questions whether the IAPT training approaches the issue as one way of working with client issues.

A recent divisional survey (DCoP, 2013) showed that almost 40% of the counselling psychologists who replied stated that their primary employer was the NHS[1]. As IAPT is becoming an increasingly powerful player in the provision of primary mental health service, it is likely that a large proportion of counselling psychologists are employed by IAPT. What does this mean for practitioners coming from a discipline with relationality at its heart? In the *Handbook of Counselling Psychology* Strawbridge and Woolfe (2010) suggest that the 19th and 20th century's turn towards industrial capitalism has increased pressure on resources within health care services. The litigious society in which we live also demands accountability and effectiveness, thus encouraging standardized packages of therapy based on psychiatric definitions of mental disorders. This phenomenon creates a tension between 'being-in-relation' and 'technical expertise' (Strawbridge & Woolfe, 2010, p. 5).

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[1] However, it is important to note that this survey only accounts for 16.6 % of those eligible to participate (499 out of approximately 3,000 members) and was the first attempt by the Division to get detailed information about its members, thus making it somewhat of a pilot project.

As suggested by James (2010), one of the possible solutions for counselling psychologists is to "see the possibility of compromise, become IAPT trained and try to deliver CBT in a relational manner." However, the extent to which IAPT embraces relationality is unclear. Many preconceptions about the relationality of IAPT exist but thus far no research has been conducted in this area.

1. Introduction

As the title suggests, this study aims to explore the importance of the Therapeutic Alliance (TA) in an IAPT context, a primary care service providing mainly Cognitive Behaviour Therapy to service users. It is important to note, for clarity and accuracy, that the therapeutic relationship is a broad term encompassing a multitude of relational areas occurring between the therapist, client, and even the service in which the therapy takes place. The TA is a subset of the therapeutic relationship which focuses specifically on the Bordin's (1979) transtheoretical tripartite goal, task, and bond model. Some academic studies have used the two terms (TR and TA) interchangeably, but, for the reasons outlined above, the author of this study has made every attempt to use the correct term when reviewing the existing literature throughout this document. Before reviewing the existing literature on the TA, it is important to give a brief background on the development of the IAPT initiative and the role of the medical model in the equation. In the following sections, the evolution of the medical model will be presented, followed by the role of the medical model in the manualisation of psychological treatments. Finally, IAPT and the IAPT curriculum will be briefly discussed followed by a review of the literature on the TA in Chapter 2.

1.1 Role of the NHS in the medical model

As this study is located within an NHS setting, it is important to put the recent developments in healthcare into social, economical and political contexts. A brief exploration of the influential stakeholders in the NHS and society's understanding of mental health and well-being will be conducted.

The National Health Service was founded in 1948 in a revolutionary plan to bring good healthcare to all of the citizens of the UK. Since then, healthcare has been seen as a right rather than a luxury to all UK residents (Taylor & Field, 2007). Despite the NHS being a state-funded service, the Department of Health is only one of the players in the decision-making process. The NHS has been shaped by a number of political players, pressure groups, and global trends. Its structure is firmly embedded within the medical model resulting in the medical profession having a large influence over budget and the delivery of care (Ham, 2009). Thus, the complexity of the provision on health care in the UK is a product of the constant interplay between the Department of Health, NHS bodies, pressure groups, and medical businesses.

Radical shifts in the structure of the NHS have happened over the past three decades. The recession and financial hardship in the 80s prompted the government to introduce economic market principles into the NHS (i.e. in the form of an internal market) encouraging competition amongst service providers to increase the effectiveness of the NHS by reducing cost. The 90s saw a reform of the market model and the introduction of the measurement of clinical performance and treatment outcomes. National frameworks such as the National Institute of Clinical Excellence (NICE) came into existence. The new millennium had been defined by the consumer model of health. This is epitomised by the recent introduction of the Any Qualified Provider (AQP) (Department of Health, 2011) model. Again, this has added another major stakeholder, adding to the complexity of the health service. Although the decision making power has shifted in recent years, the processes are still underpinned by the medical model of illness.

In line with this evolution (or possibly "devolution") of the NHS, the cultural perception of mental health has also altered over the last three decades. The medical profession consolidated its power and expertise around 150 years ago when large advances were made controlling infections in a time of empiricism and positivism (Bilton et al., 2002). The professionalisation of a number of medical groups, in particular the Royal College of Physicians, promoted the medical model of illness during this period. The resulting medical model of health regards health as the absence of biological abnormality and assumes that diseases have specific causes and we can be restored to health by personalised treatments. The proliferation of the medical model throughout society has come in for criticism. For example, Illich (1974, 2003) suggests that personal challenges such as pain, death, and mental health difficulties are being pathologised as a result of the medical model. Moreover, Illich (2003) declares the medical model to be an iatrogenic epidemic spreading though society. Whereas social community support was generally provided for the suffering in society, this has now been taken over by medical care. Many have suggested that industrialization has influenced this medicalisation of social support and has resulted in people seeking more and more professional help and medication to deal with their lives (Ham, 2009).

Major political differences exist between the medical model of mental disorders and other social-learning, stress-related models. For example, Albee (2000) argues that the medical model is undoubtedly allied with the conservative view of causation and is supported by the

"ruling class" (p.248). Adopting a social model of mental health would require a radical overhaul of the health system as it would be necessary to end or to reduce poverty with all its associated stresses, as well as discrimination, exploitation, and prejudices as other major sources of stress leading to emotional problems (Albee, 2000, p. 248). Despite the emergence of such critical voices and alternate models of mental health, the medical model still dominates our health care system.

1.2 Manualisation of therapy

The manualisation of therapy is said to have begun in earnest when the concept of 'mental disease' and medical language was incorporated in to the scientist-practitioner of applied psychology in post-second World War America (Addis, Cardemil, Duncan, & Miller, 2006). Since then, the evaluation of psychological treatment in America has been evaluated using drug evaluation methods – namely the Randomised Control Trial (RCT) (Addis et al., 2006). This trend can be seen in the UK also. The Department of Health (1999) prioritised five types of evidence, which are said to constitute legitimate knowledge in the realm of healthcare provision. In order of preference these are systematic reviews with at least one randomised controlled trial, a minimum of one RCT, a well-designed study without randomisation, a well-designed observational study and lastly the opinion of experts, service users and carers. Supporters of manualised therapies have suggested that these forms of scrutiny lead to quality evidence (D. Clark et al., 2009).

Therapy 'efficacy studies' and 'outcome research' trials have prompted a delineation of psychological treatments from one another. This has meant that treatment manuals have started to grow in increasing numbers (Luborsky & DeRubeis, 1984). As the medicalisation of mental health increase, and with the introduction of a gold standard of research in the form of RCTs, the reciprocal relationship between the two started to evolve. Components of a specific treatment became an independent variable which was manipulated in the context of research. Thus, refinements had to be made to describe in detail the specific elements of a treatment. Thus, as the efficacy of specific elements of a treatment started to emerge, the manualisation of treatments continued to increase. A symbiotic relationship was born. Some authors have firmly supported the use of manualised therapies. Duncan and Miller (2006) suggest a number of advantages such as enhancing the internal validity of comparative outcome studies, increase therapists' technical competence, ensure the possibility of replication, and provide a systematic way of training and supervising therapists in specific models. However, the

schoolism that is promoted through the manualisation of therapy has been the focus of research in the past 30 years.

The dodo bird verdict ("every therapy has won and all must have prizes") (Luborsky, Singer, & Luborsky, 1975) was one of the first studies to empirically show the equivalent success of diverse psychotherapies. Meta-analyses have provided further support for the dodo hypothesis (J. Brown, Dreis, & Nace, 1999; Wampold et al., 1997). Further studies have focused on how much of therapeutic outcome can be accounted for by specific therapeutic technique factors. For example, Wampold's (2001) meta-analysis suggested that therapeutic model only accounted for 13% of the impact of therapy. This included general and specific factors. In total, only 1% of change was linked to specific technique. Other studies, such as Jacobson and colleagues (1996), have attempted to dissect certain approaches to see if specific techniques accounted for a variation in outcome measures. In this study, Jacobson and his group (1996) randomly assigned 150 participants diagnosed with major depression to one of three groups (a) treatment using only behavioural activation, (b) behavioural activation plus coping skills related to modify automatic thoughts, or (c) full cognitive treatment (the previous two conditions plus a focus on core dysfunctional schemas). All three conditions were shown to be equal both at the end of treatment and at 6 month follow-up. Thus therapy, in general, appears to be more than just a sum of its parts. However, in the current climate of financial shortcomings, unemployment, and medical accountability, there have been huge movements to refine the provision of mental health care while also widening its access to the general population. The introduction of IAPT was a movement that ticked many of the boxes on the political agenda.

1.3 Manualisation and the IAPT initiative

The development of community-based alternatives to hospital care has been a longstanding objective. Over the last 30 years, mental health services have gone through a radical transformation. As stated in a recent King's Fund Report (Gilburt, Peck, Ashton, Edwards, & Naylor, 2014) the transformation of mental health services stretches back over many years but took place in earnest from the 1980s onwards. There were three distinct phases to the change process: 1) a period of increasingly rapid de-institutionalisation, 2) development of comprehensive models of care including care co-ordination and community service systems, and 3) diversification of service provision and delivery to meet local needs.

Until the 18th century, care of people with mental health problems was mainly a family and community responsibility until the 18th century. The industrial revolution saw the development of a more institutional approach, which evolved still further in the 19th century, and by 1954 there were 154,000 patients in these institutions (Gilburt et al., 2014). The second half of the 20th century saw a fundamental shift in the way people with mental health problems were cared for. Advances in psychiatry and psychological therapies allowed more people to be treated in the community.

During the 90s, governmental fundholding initiatives enabled GP surgeries to hold their own budgets, and many of these practices employed therapists (mainly consellors) according to their view of the needs of their community (Rizq, 2009). Other nonfundholding GP surgeries also opted to employ counsellors through local health authorities. In recent years, national policy has become more supportive of local innovation, with an increasing emphasis on broadening access to mental health services beyond those with severe mental illness. One of the most influential recent policies has been the IAPT programme, which was established in 2005.

The IAPT initiative has meant radical changes to the way mental health professionals work together. Previously counsellors and psychotherapists were working largely in isolation in GP surgeries, with little contact with the rest of the local services. Rizq (2009) suggests that the system changed from "a cumbersome and unnecessarily complex referral system for patients, and a lack of co-ordination between referrers and mental health practitioners" (p.41) to a "streamlined" (p.41) single point of access to the new mental health service. Moreover, the IAPT initiative has enabled patients to self-refer to IAPT services, bypassing the GP completely if desired. As Rizq (2009) suggest, working in local teams has meant a more streamlined approach to 'stepped care' (discussed below), as recommended by in the National Institute for Health and Clinical Excellence (NICE). In summary, the introduction of IAPT has meant a refining of the referral process and an improved access to primary care mental health services for patients.

The IAPT movement began in earnest in 2005 when the Labour Government proposed to increase funding to improve primary care mental health services in the NHS as part of its

General Election Manifesto (2005, p. 64). The subsequent Layard report (Layard et al., 2006) highlighted the need to make evidence-based psychological therapies more available to the large proportion of the population suffering from depression and anxiety disorders. A seven year plan was proposed (Layard et al., 2006) which sought to Improve Access to Psychological Therapies, thus coining the name IAPT. The proposal was driven by the assumption that the programme would pay for itself due to the number of people returning to work thus reducing incapacity costs and boosting financial output. As an economist, Layard focused on how mental health issues could be "cured" quickly and people could return to work, ascribing to the dominant medical model. The Layard report (Layard et al., 2006) proposed a target of 50% recovery rates, a rate that was based on an RCT of CBT versus medication (Paykel et al., 1999). The report also argued that although it is alleged that success rates of therapies used in the 'field' are lower than clinical trials, various 'field' studies of anxiety and depression have shown this not to be the case (for example Hahlweg, Fiegenbaum, Frank, Schroeder, & von Witzleben, 2001; Lincoln et al., 2003; Persons, Roberts, Zalecki, & Brechwald, 2006; Wade, Treat, & Stuart, 1998). As a result, this figure of 50% has been adopted by the IAPT movement (Department of Health, 2008a).

In order to treat an estimated 6 million people with common mental health disorders (Office for National Statistics, 2000), and driven primarily by an economic justification, IAPT was designed using a Stepped Care Model of service delivery (Bower & Gilbody, 2005). Stepped care designs services with respect to symptom severity with Step 1 representing the most mild problems and Step 5 being inpatient, crisis, and complex difficulties (see Needham, 2006 for a full description of this model). According to Turpin, Richards, Hope and Duffy (2008) there are two fundamental principals in stepped care: 1) the 'least restrictive' treatment should be offered in which the least burden as possible is placed on the service-user (Sobell & Sobell, 2000); and 2) Symptom schedules based on patient outcomes should be used in order to make stepped care self-correcting (hence "cost-containment") (Newman, 2000, p. 549). In IAPT, 'caseness' and 'recovery' (i.e. 'depressed' vs 'not depressed') are determined by the patient's score on the 'minimum data set' (MDS). Thus, the MDS is used in IAPT to measure their clinical outcome against the 50% recovery benchmark. Anxiety and depression are measured by the Generalised Anxiety Disorder questionnaire (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) and the Public Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001). These scales are targeted at symptomatology, and define cut-off points to determine levels of severity. The scores on these scales determine whether a person is of 'clinical caseness' (i.e. if they score

above a certain point: 8 for anxiety and 10 for depression). These scales are discussed in more details in section 6 (quantitative method chapter) below.

To add further complexity to the provision of care, and an extra layer to the capitalistic foundations of mental health care provision, a recent initiative called Payment by Results (PbR) has been introduced across NHS services. Supporters of PbR suggest that the model not only encourages clinical outcomes, it incentivises patient choice, service user satisfaction, widening the provision of care to marginalised communities, and encourages a return to work (Mullins & Perton, 2013). According to the recent IAPT pilot study, specific outcomes have been incentivised by this model. However, the 'currency' upon which the PbR is firmly based is wedded to the medical model of recovery. As is to be expected, the most significant weighting (50%) is given to clinical outcome. Other areas, such as 'Patient satisfaction' and 'Patient choice' account for a mere 15% of earnings (see Mullins & Perton, 2013 for 5 "curreny" areas). Thus, the emphasis is still relying exclusively on measures of deficit rather than on improving functioning and growth. However, authors have remained optimistic that social inclusion ideas and practices can be evolved through this model and become embedded in mental health care (M. Clark, 2011). However, it remains to be seen if PbR will lead to "perverse initiatives" (services not seeing complex clients or only seeing people suffering from treatable anxiety etc.) and how these potential perversions can be discouraged (IAPT, 2013a).

IAPT's three- year report (Department of Health, 2012) makes for impressive reading: over 1 million people seen in IAPT services nationwide, more than 680,000 people completing a course of treatment; Recovery rates reported in excess of 45% (approaching those expected from the initial RCTs (see Department of Health, 2008a); and economic gains in terms of employment attainment and retention. This final point of economic gains is one of the main selling points of the IAPT movement, especially in the backdrop of a double-dip recession. For example, as a result of the £400 million invested in talking therapies between 2011-2015, it is assumed that "over £700 million of savings will be made to the public sector in healthcare, tax and welfare gains" (IAPT, 2011a).

However, some have criticised the rationale behind the Layard report proposal (2006). For example Cooper (2009) questions the underpinnings of IAPT:

> "Happiness, prosperity and mental health are here being conflated as though, in practice, social psychologists, economists and medical clinicians are all working towards one common goal – which, for better or worse, is not the case" (p.211)

Cooper (2009) also urges the movement to look at alternative strategies, based on closer integration of community mental health and primary health care.

The achievement of IAPT has also come under scrutiny. Authors have wondered if IAPT's audits follow a robust research methodology as they do not follow an RCT format (B. Cooper, 2009). It is impossible to conduct a double blind RCT of therapy because therapists always know what treatment they are giving, thus affecting outcomes due to the allegiance effect (see Rosenthal, 1966). Others have suggested that a blind eye is turned to the emotional realities of suffering where the NHS 'market for care' has created a 'virtual reality' where targets, outcomes and protocols usurp the patient's psychological needs (Rizq, 2012a, p. 7). Criticisms have also been levelled at IAPT on their reliance on the medical model of illness, rather than the psychological approach. Carey and Pilgrim (2011) believe that IAPT conforms to "the notion of delivering the optimal 'dose of treatment' to those people whose symptom scores are outside the normal range on standardised tests" (p.233). They also suggest that this medical model may be misconceiving, 'presenting symptoms of anxiety or depression' with 'a normal and intelligible variation on experience (human suffering)' (Carey & Pilgrim, 2011, p. 233). Barlow, Allen and Choate (2004) suggest that the medical model has obstructed the development of more appropriate psychological therapies. What's more, the economic rationale driving IAPT seems, in some cases, to be overruling the NICE guidelines. For example, only 27.3% of patients referred to the Pathfinder sites (Department of Health, 2008a) were offered CBT, who in turn received on average 6-7 therapy sessions, under half the amount of sessions recommended by NICE (B. Cooper, 2009).

One area where IAPT stands apart from other NHS mental health services is its provision of training to new recruits. The three year report (Department of Health, 2012) noted that nearly 4,000 "new" practitioners were trained to deliver NICE-recommended treatments – the overwhelming majority being trained in CBT.

1.3.1 IAPT Curriculum

Interestingly, IAPT trainees account for 11% of the IAPT workforce at any one time (IAPT, 2013b), with 5% being trained up as Step 3 workers, and 6% as PWPs (step 2). Academics and clinicians have called into question the layout of the IAPT training on psychotherapy in general. In her review of CBT in Britain, Marks (2012) suggests that the introduction of less orthodox forms of low-intensity therapy are representative of the deprofessionalisation of psychotherapy delivery. Similarly, recent qualitative studies have found seasoned professionals feeling deskilled during Step 3 training (S. Robinson, Kellett, King, & Keating, 2012). Although correspondence with the central IAPT office did not yield any definite figures, the author is aware of numerous 'trainees' who held a D.Psych in Counselling or Clinical Psychology, or were qualified in other relationally orientated therapies, prior to the IAPT training. Interestingly, these qualified professionals were effectively moving from a position of prior expert to current novice (Bowditch & Buono, 2005), a transition that could be seen as a process of deskilling.

As suggested by Strawbridge (2003), the current trend is to celebrate technical expertise over relationality: "'Doing-to' is substituted for a relationship in which 'being with' a person is paramount" (p.20). Thus, Buber's (1958) concept of 'I-thou' is being overtaken by 'I-it'. Some critics have equated the widespread manualisation of psychological therapies to a form of McDonaldisation of sorts (Strawbridge, 2003). McDonaldisation was coined by the sociologist Ritzer (1993) and refers to the controlled, capitalistic, bureaucratic, and dehumanized nature of modern society. Strawbridge (2003) suggests that the four main tenants of McDonaldisation (efficiency, calculability, predictability, deskilling by use of technology [or manuals]) lead to a deskilling of an area of care that defines its practice by relationality. The Handbook of Counselling Psychology (Strawbridge & Woolfe, 2010, p. 16) also equates the standardization and manualisation of therapies to the McDonaldisation movement whereby "complexity is minimized, process routinized and thinking and human contact reduced". What does the manualisation of both therapy and the delivery of therapy mean for the interaction between the therapist and the client? Such rigid structures could potentially impact the ability to construct a therapeutic frame with service users.

1.3.2 Therapeutic frame

Although traditionally a psychodynamic concept, the therapeutic frame is widely accepted as an important factor across modalities. The notion of the therapeutic frame, or structure, is said

to entail the basic conditions, both contractual (time, place, length of treatment) and interpersonal (confidentiality, respect, trust, etc.), created between the client and therapist. This structure aims to provide a secure environment which facilitates the exploration of cognitions, behaviours, and effects which might not otherwise be allowed in a different structure (Spinelli, 1994). Spinelli (1994) highlights some of the paradoxes that exist in relation to the therapeutic frame. The therapeutic frame offers the client increased autonomy, but first requires an "abdication of autonomy" (p.32) as a result of the acceptance of the structure created by the therapist, and possibly the service in which the therapy takes place. Thus, an unequal power base is initially created, skewed towards the therapist, or the service, who may dictate the number of sessions, length of contact, type of therapy offered, and so forth. Many researchers have looked at the importance of flexibility in setting the therapeutic frame (e.g. Gold & Cherry, 1997) and how this promotes positive results in the therapeutic process. Other researches have shown that explicit references to the therapeutic frame and boundaries are an important factor in the maintenance of the therapeutic alliance in therapy (Terraz, de Roten, de Roten, Drapeau, & Despland, 2004). Safran and Muran (2006) speak about how historical rigidity in the therapeutic frame has given way to flexibility in light of the therapeutic alliance.

The therapeutic frame is said to also include the physical environment in which the therapy takes place. Thus, depending on a therapist's orientation, a therapist may refuse to allow any family photos, any personal artefacts, or even allow tissues in the therapy room in case the client feels obliged to cry. However, although no substantive evidence exists between successful outcome and frame issues (Spinelli, 1994), therapists still hold them in high esteem. Spinelli (1994) suggests that frame issues themselves may not be important, but they may have the same effect as the 'magic feather' in the Disney cartoon Dumbo (p.89). The importance placed on therapeutic frame issues may be important to the therapist in order for the 'magic' of therapy to work.

The impact of working within the NHS on the therapeutic frame has been explored by practitioners. Hoag (1992) gives a detailed account of working within a GPs surgery and the subsequent impact on the therapeutic frame. In her analysis, Hoag (1992) explored her own ambivalence in terms of needing to be seen as acceptable and useful to the medical hierarchy in which she works and, at the same time, needing to provide the setting necessary for psychotherapeutic work to take place. Although traditionalists such as Langs (1976) state that

the introduction of any third party would have disruptive consequences on therapeutic outcomes, Hoag (1992) argues for flexibility within the frame and suggests that the adherence to rigidity is seemingly impossible in an NHS service.

What do the radical changes to the structure of the provision of psychological support to service-users mean for the most fundamental aspect of therapy, the client/therapist relationship? The following section will introduce the concept of the therapeutic alliance and how it is conceptualised within CBT. It will then review the body of existing literature focusing on the therapeutic relationship and the therapeutic alliance. As stated previously, as the majority of practitioners in IAPT are trained in CBT, and as all the participants in this project are CBT practitioners, the review will mostly concentrate on studies concerning CBT.

1.4 The evolution of the conceptualisation of the Therapeutic Relationship

The relationship created between a "healer" and "sufferer" has been evident in human culture for hundreds of years (Ellenberger, 1970). According to Gilbert & Leahy (2007), the impact of the relationship between a physician and patient on the healing process was highlighted over two millennia ago by the early Greek physician Hippocrates. The relationship was deemed key to the process of healing and has been the topic of debate and research since. In Ellenberger's (1970) treatise on "The Discovery of the Unconscious", the evolution of the relationship created between a healer and patient is traced from temple healers in the times of the Stoics, Pythagoreans, Epicureans, to possession and exorcism, through to hypnosis and modern conceptualisations of "the rapport" (Ellenberger, 1970, pp. 385–386) between patient and therapist. However, the psychotherapeutic focus on the relationship between the sufferer and the therapist began in earnest in the 19th century, a time in which the Western culture was becoming influenced by the rules of science, philosophy of positivism and the theory of evolution (Gilbert & Leahey, 2007, pp. 4–5).

As suggested by Elvins and Green (2008), a 'genealogy' of modern concepts relating to the therapeutic relationship can be traced back to Freud's (1912/1958) description of transference and counter transference as one of the key aspects of change in psychoanalysis. Many consider Freud to be the first to consider the therapeutic relationship as having a significant influence on the process of therapy (Gilbert & Leahey, 2007). Carl Rogers' (1957) "core conditions" of therapeutic change was the first recognisable attempt to establish concepts of

the therapeutic alliance framework. Since then, the four therapist offered core conditions (empathy, positive regard, unconditionality, and congruence) have been examined with relation to therapeutic outcome (see section 2.2. below), with the clinical importance of patient-perceived therapist empathy being well-established and widely accepted (Bohart, Elliott, Greenberg, & Watson, 2002; L. S. Brown, 2007; Hardy, Cahill, & Barkham, 2007).

1.4.1 The operationalisation of the Therapeutic Relationship – The Therapeutic Alliance

One of the first attempts to operationalise the notion of empathy and rapport within the therapeutic relationship came in the 1960s when Anderson and Anderson attempted to measure this "ideal relation" (Anderson & Anderson, 1962, p. 18). Using Q-sort methodology, 163 client/counsellor behaviours and attitudes were collected and distilled by 69 psychologists and 34 clients to yield a 50-item empathy and rapport scale. This in turn prompted researchers such as Orlinsky and Howard (1975) to delve further into therapeutic factors that influenced outcomes and found constructs such as therapist's credibility and treatment engagement as contributing factors. Three concepts were highlighted by Orlinsky and Howard (1975) which paved the way for other theorists to reconceptualise the phenomenon of the therapeutic relationship. These concepts were: 1) the working alliance, (i.e. the investment of both client and therapist in the process of therapy); 2) empathic resonance; and 3) mutual affirmation.

At similar times, Luborsky (1976) and Bordin (1979) took what was primarily a psychoanalytic concept of the working alliance and argued that the underlying factors could be seen as pan-theoretical concepts rather than being confined to one modality. Bordin (1979) suggested that four common propositions link all genres of psychotherapy, and hence paved the way for a converging conceptualisation of the working alliance, or the therapeutic alliance (TA). The propositions are as follows:

> 1) All genres of psychotherapy have embedded working alliances and can be differentiated most meaningfully in terms of the kind of working alliance each requires.

> 2) The effectiveness of a therapy is a function in part, if not entirely, of the strength of the working alliance.

> 3) Different approaches to psychotherapy are marked by the difference in the demands they make on patient and therapist.

4) The strength of the working alliance is a function of the closeness of fit between the demands of the particular kind of working alliance and the personal characteristics of patient and therapist.

(Bordin, 1979, p. 253)

In turn, Bordin (1979) argued that three features underpin the TA across all psychotherapies: An agreement on goals, tasks, and the development of bonds. In this description, Bordin (1979) emphasises the mutuality of the relationship, rather than the individual contributions for the therapist or client (Hougaard, 1994). Thus, consensus and agreement on goals, tasks and bond are fundamental to the relationship (Hougaard, 1994). As suggested by Bordin, the strength of collaboration between patient and therapist may have more to do with the effectiveness of the therapy than the particular methods chosen (1979). As a result of its pan-theoretical allure, most current conceptualisations and tool for measurement of the therapeutic relationship are based on these pan-theoretical factors (Hardy et al., 2007). However, some critics have argued that this tripartite conceptualisation of the therapeutic relationship fails to acknowledge the importance of client and therapists schemas and potential schematic mismatches between the two (see Leahy, 2007). Other theorists such as Frank and Frank (Frank & Frank, 1991) also refer to the "common active factors" across different models of therapy, which also highlight the importance of empathy and task understanding. In contrast to models of the relationship that emphasised therapist contributions, the alliance construct captures an interactive process and recognises both therapist and client roles (Haverkamp, 2011). In contrast to previous work that focused on the relationship in psychotherapy, the alliance focuses on collaboration and agreement between client and therapist, instead of either therapist contributions or on unconscious processes (Horvath & Bedi, 2002).

Figure 1, adapted from Elvins and Green (2008), gives an idea of how key measures of the therapeutic relationship were developed to test new conceptualisations put forward by authors or to amalgamate different theoretical constructs. However, as a result of the various off-shoots of the "genogram", it is clear that no overall consensus of a model of the therapeutic relationship has emerged and, in turn, this evolution has propagated a wide variety of measures.

As the quantity of studies focusing on the TA has increased, both meta-analytical studies (Martin, Garske, & Davis, 2000) and theoretical reviews (Elvins & Green, 2008) have highlighted the lack of overall consensus in the conceptualisation and quantification of the TA. Although the overall impact of the TA on outcome is widely accepted (see section 2.1), the individual components of the TA still remain an enigma. Moreover, there seems to be a significant gap in the literature between quantitative exploratory studies and theoretical conceptualisations of the TA. Qualitative exploration of therapist and client experience of the TA, or mixed methods studies (qualitative/quantitative) seem to have been neglected. This study uses Bordin's (1979) pan-theoretical tripartite conceptualisation of the TA, and used a TA questionnaire (Helping Alliance Questionnaire-II, Luborsky et al., 1996) which pertains to this concept. The questionnaire used has both a client and therapist version, underscoring the importance of the collaborative notion of the TA. Furthermore, the three central facets to the TA, goals, tasks, and bonds, are examined using a Likert style questionnaire. Thus, this tool is suitable to use in what is predominantly a CBT service and takes into account the views of both individuals in the relationship, therapists and clients.
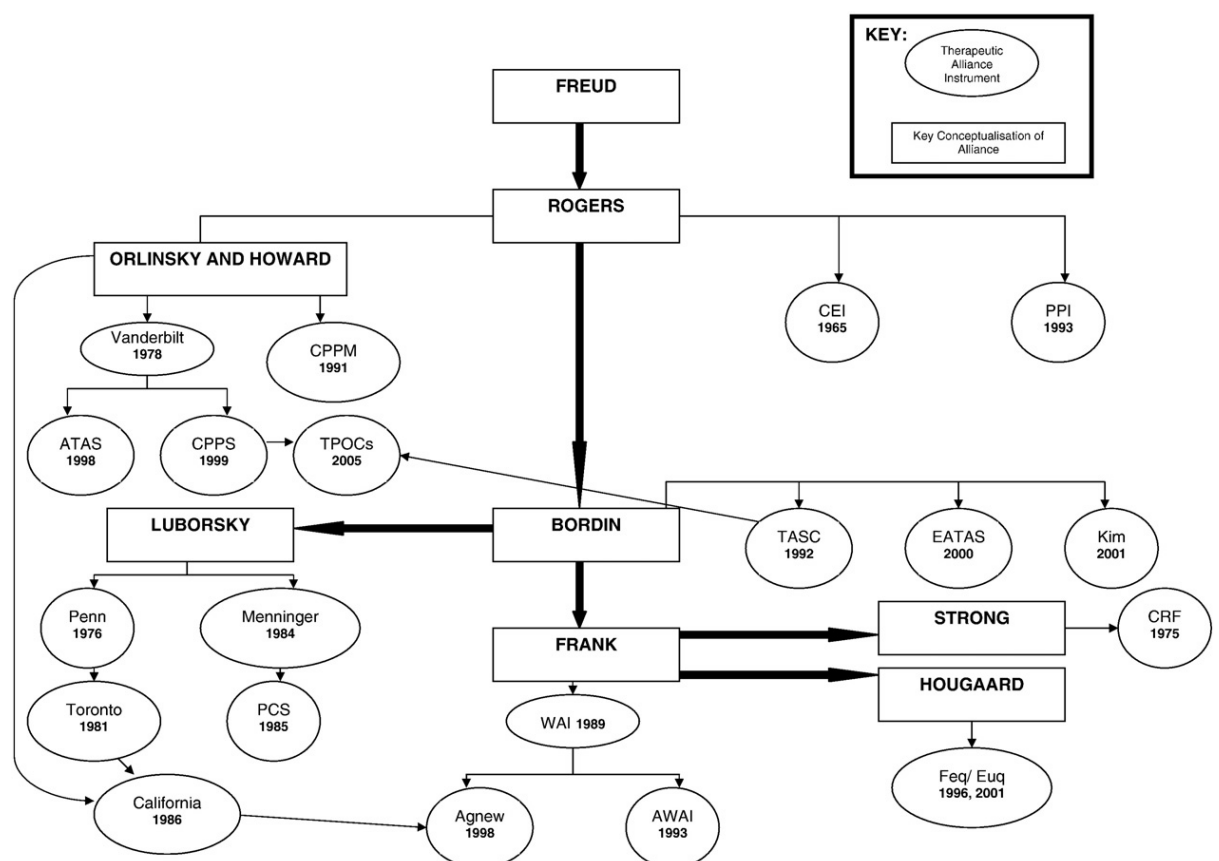
Figure 1 - Genealogy of alliance concepts and scales - adapted from Elvins & Green, 2008 – for expansion of scale acronyms see appendix 1.

1.5 IAPT, CBT, and the therapeutic alliance

Although many think of IAPT and CBT as being synonymous, this is not the case. 25% of the total IAPT workforce (1,440 people) is made up of non-CBT therapists (6%), counsellors (14%), and 'other therapists' (5%) (IAPT, 2013b). However, due to the majority percentage of therapists being classified as CBT therapists, and the fact that all participants in this study used CBT with their clients, it is important to acknowledge CBT as a dominant force in the IAPT movement and therefore to give a brief introduction to CBT and the TA in CBT.

In his seminal textbook, Beck and colleagues (1979) made reference to the Rogerian concept of the 'core conditions' and highlighted "the general characteristics of the therapist that facilitate the application of cognitive therapy… include warmth, accurate empathy and genuineness…" (Beck et al., 1979, p. 45). However, unlike the Rogerian school of thought, they also believed that "…these characteristics in themselves are necessary but not sufficient to produce optimum therapeutic effect" (Beck et al., 1979, p. 45). Although Beck emphasized the therapist's personal skills, he has also hoped that the success of CBT would be its ability to be manualised and replicated by other therapists: "The same therapeutic program used by different therapists does not differ substantially from one to the other" (Beck, 1976, p. 333). However, recent models of the TA in CBT (discussed below) suggests that the TA is a vital factor in the success of the therapeutic process (Hardy et al., 2007), a belief that might be juxtaposed with the manualisation and the rigidity of structures within IAPT.

More recently, CBT models of the therapeutic alliance and therapeutic relationship have started to take in to account various elements such as therapist skill development, interpersonal schemas, and learning strategies. Bennett-Levy (2006) used information processing theory to link therapist development and expertise to the ability to form therapeutic alliance with their client. A pivotal role is given to a reflective system, which enables therapists to reflect and build on their conceptual (declarative) knowledge and procedural skills, especially with regards to the interpersonal aspect of therapy. When reflecting on this model in relation to CBT, Bennett-Levy and Thwaites conclude that "interpersonal skills are intimately related to our personal (self-schema) development and capacity to reflect on our experience" (2007, p. 278). Due to the complexity of the subjective, reflective and personal nature of this model, no quantitative measures have been developed to test the hypothesis. However, qualitative studies have found that based on the self-reflections of participants, the self-practice/self-reflection enhanced case conceptualization

skill by consolidating the Declarative, Procedural and Reflective systems (Haarhoff, Gibson, & Flett, 2011) which in turn have an impact on the therapeutic alliance developed in conjunction with the client.

Transference and countertransference model of CBT has also been of interest to therapeutic relationship studies. Miranda and Andersen (2007) suggest that a person's sense of self is constructed through meaningful relationships with significant-others. Thus, people may re-experience past relationships in their everyday social interactions with others. Transference, defined by Miranda and Andersen "the process by which such mental representations are triggered by social contextual cues and applied to new individuals" (2007, p. 83), may elicit automatic responses such as cognitive inferences, biases and retrieval; affect responses; and evaluative responses such as feeling accepted or rejected by the therapist. A succinct model is not declared, but a social-cognitive model of transference suggests that mental representations of significant others exist in memory, and can be triggered by social interactions, which "leads people to view new others through the lens of pre-existing significant others" (Miranda & Andersen, 2007, p. 65)

Many writers have identified empathy as a central mechanism for affecting therapeutic change (Beck et al., 1979; Rogers, 1957). Researchers and theorists have described empathy as serving various functions, the most frequent of which is that of empathy furthering the development of the therapeutic relationship. Recently, Thwaites and Bennett-Levy (2007) proposed a model of therapeutic empathy with four key elements: Empathic attunement, Empathic attitude/stance, Empathic communication, and Empathy knowledge. Similar to the Bennett-Levy (2006) model, this model highlights the "person of the therapist" and self-reflection as key facets in developing empathy, hence reinforcing the therapeutic relationship.

Finally, having systematically reviewed the literature (Cahill, 2003), Hardy, Cahill, and Barkham (2007) produced a three-phase sequential map of the therapeutic alliance (see figure 2). This model emphasises the therapist–client interactions, and suggest how these interactions influence the three main three developmental processes of the therapeutic alliance: Establishing the relationship; developing the relationship; and maintaining the relationship. Each of the three phases of the developing therapeutic alliance emphasise different skills or qualities that assist the process. For example, Rogerian core conditions, more specifically

empathy, warmth and genuineness, are key in the early engagement process. The authors note that clients highlight the therapist's background, skill and emotional attunement as important factors in the TA, whereas therapists tend to judge the quality of the TA based on the clients' active engagement, participation, and collaboration. These contextual factors are fundamental in establishing a relationship. As Cahill and colleagues point out "the relationship becomes an arena in which therapeutic activity is carried out" (2008, p. 16). The authors suggest that in these cases, a course of therapy longer than six months is often needed to give time for the TR to develop (Hardy et al., 2007), a time scale that seems to be at odds with the current NHS focus on short term, cost effective treatment. Wider contextual factors such as the social class, cultural background as also said to influence the TA. Power dynamics are also subsumed in contextual factors. These are seen as a tool through which client change can be influenced. However the ethics of this when working with a vulnerable group are questioned (Cahill et al., 2008). Understandably, the therapist's understanding of contextual factors also plays a key role in developing and maintaining the TA.

Client factors		Establishing relationship
Contextual factors	Therapeutic meeting(s) → Processes outcomes	Developing relationship
Therapist factors		Maintaining relationship
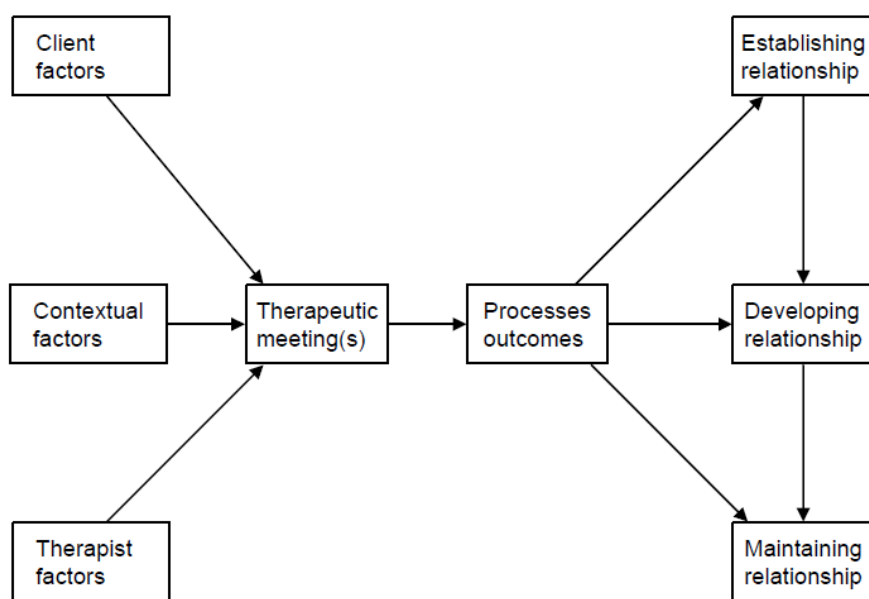
Figure 2 - Hardy, Cahill & Barkham (2007) - Conceptual Map of the Therapeutic Alliance

It is beyond the scope of this project to delve further in to these more recent models, but the author thought it was necessary to mention them in the context of the therapeutic alliance in CBT. Interestingly, as the trend in the health system has been to focus on the manualisation of treatments, more and more textbooks and research trials are emphasising the importance of the TA in the success of therapy. The following sections review some of the recent quantitative and qualitative findings regarding the TA.

2. Literature Review

The TA is one of the most researched areas in psychotherapy. In counselling and psychotherapy research of the TA is said to have over 4,000 papers and dissertations written on it in the last thirty years (M. Cooper, 2008) and more than 24 different scales developed to measure it (Horvath & Bedi, 2002; Martin et al., 2000). As it would be impossible to summarise this immense body of work, this literature review will focus on the areas of the TA that may be influenced by specific structures or protocols within the IAPT setup. Some of the features listed below are unique to the IAPT setup, such as the IAPT training and style of per-therapy clinical interview. Other areas are not unique to IAPT but are dominant themes in the IAPT literature; for example the strict focus on the number of sessions offered. The literature review will highlight some of the main general findings with regards to the TA and outcome research. It will then focus on research that has looked specifically at CBT in relation to concepts such as the Rogerian core conditions. It will then concentrate on the features that are associated with the 'IAPTness' of IAPT, namely: training and TA, the initial assessment process and TA, and a brief summary of research regarding symptom severity and the impact of this on the TA. Where possible, quantitative and qualitative studies will be presented in each section.

2.1 The TA and its relation to outcome

Examining the factors that lead to a positive outcome in psychotherapy has been studied for decades. As a result, the therapeutic alliance has been highlighted as a key contributor to the success of therapy (Horvath & Symonds, 1991; Martin et al., 2000). A recent meta-analysis of 190 independent TA-outcome related studies (Horvath, Del Re, Flückiger, & Symonds, 2011) commented on the robust relationship between the therapeutic alliance and outcome. However, despite its perceived significance within many treatment models, only few studies have examined the therapeutic alliance both across modalities and also within specific treatments.

There have been conflicting reports as to the importance of the alliance across different models of therapy. Two large scale meta-analyses found that the influence of the TA on measures of outcome is not dependent on the type of therapy (Horvath & Symonds, 1991; Martin et al., 2000). However, individual studies comparing two different therapeutic models have found that outcome measure from different therapies may or may not be dependent on TA scores. For example, Krupnick and colleagues (1994) found a significant relationship

between alliance and outcome only for interpersonal therapy, but not for CBT. Another study examining alliance across different treatment modalities found that only some alliance dimensions predicted outcome in brief dynamic therapy, while all alliance dimensions were associated with a positive outcome in CBT (Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998).

In general, studies have indicated that therapists working in 'non-relational' therapies (i.e. CBT) have just as strong an alliance as in more relationally orientated therapies (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Marmar, Gaston, Gallagher, & Thompson, 1989). Furthermore, CBT was found to show higher total alliance scores when compared to other psychotherapies (Raue, Castonguay, & Goldfried, 1993; Raue, Goldfried, & Barkham, 1997). More recent studies have also shown that the TA in CBT has a comparable influence on outcome measures that other more relational therapies, such as IPT (Zuroff & Blatt, 2006). Similarly, Arnow and colleagues (2013) found that the TA was more predictive of outcome in a CBT-style treatment when compared to a Rogerian-style therapy for chronic depression.

Interestingly, when compared to specific CBT techniques, studies have found that the client's experience of the relationship with the therapist has been cited as more helpful than specific CBT techniques that were employed during therapy (Ryan & Gizynski, 1971; Sloane, Staples, Whipple, & Cristol, 1977). Furthermore, high helpfulness ratings of the relationship are often associated with improved treatment outcome (Ryan & Gizynski, 1971). Similarly, when controlling for client characteristics, Klein and colleagues (2003) found that early alliance in CBT significantly predicted subsequent improvement in depressive symptoms.

Although quantitative studies have suggested that the effects of different treatments are similar (i.e. the dodo hypothesis, Luborsky et al., 1975), qualitative studies have attempted explore whether the quantitative equivalence may conceal differences in clients' experiences of change. Nilsson, Svensson, Sandell and Clinton's (2007) interviewed thirty-two patients who had terminated CBT or psychodynamic therapy about their experiences in psychotherapy. Participants who were judged to be satisfied with CBT seemed to perceive themselves and their therapist as motivated and involved in the whole process, referring to a "chemistry" between participant and therapist (Nilsson et al., 2007, p. 558). The ''common factors'', such as a strong therapeutic bond, were present in patients' opinions on what contributed to

change during the therapeutic process. Interestingly the therapeutic relationship was brought up by participants who were dissatisfied with therapy more than those who were satisfied. Dissatisfied participants experienced their therapist as rigid, oppressive and even intrusive. Similar findings were present for both the CBT group and the psychodynamic group.

In recent years the role of specific facilitative elements to the TA have been studied. For example, a great emphasis has been placed on the 4 therapist offered core conditions (as proposed by Rogers, 1957). Both qualitative and quantitative studies have highlighted the importance of these concepts with regards to the TA.

2.2 CBT, core conditions and outcome

Rogers (1957) highlighted certain core conditions that, when present in therapy, are said to be sufficient in bringing about constructive personality change. The four therapist offered core conditions are based on a therapist and a client being in psychological contact in which the client experiences the therapist as empathic, genuine and acceptant (Rogers, 1957). The therapist must be congruent, feel empathic towards the client, and show unconditional positive regard for the client (Rogers, 1957). These Rogerian therapist conditions have been the focus of extensive study in recent years.

The importance of Rogerian core conditions has received substantial support in general psychotherapy outcome studies (Orlinsky & Howard, 1986; Patterson, 1984). For example, Orlinsky and Howard (1986) reported that of the 54 studies they reviewed, 60% found a significant positive relationship between the core conditions and psychotherapy outcome. Moreover, the client's perception of the conditions was more consistent in predicting the outcome of therapy when compared to therapists or independent raters. Clients of therapists who were perceived as warmer and more empathetic had better outcomes independent of level of depression (Burns & Nolen-Hoeksema, 1992).

Further evidence for the impact of the Rogerian principles on therapeutic outcome has been found for CBT for anxiety (Keijsers, Schaap, Hoogduin, & Lammers, 1995; K. E. Williams & Chambless, 1991). Keijsers and colleagues (1995) reviewed therapy sessions of 30 clients and coded therapist and client interactions using a standardised coding instrument (the Coding

System of Interaction in Psychotherapy) at the start of treatment, mid-treatment, and end of therapy. These codes were compared to client end of therapy anxiety levels. An empathic and non-directive stance early in treatment facilitated positive client outcomes. Similarly, Williams and Chambless (1991) asked 33 clients to use the Therapist Rating Scale (K. E. Williams, 1989) to rate their perceptions of the therapist. Clients who perceived their therapists as more empathic showed greater improvement during the course of therapy. Interestingly, client who found their therapist to be self-confident also made significant improvements. These studies (Keijsers et al., 1995; K. E. Williams & Chambless, 1991) together suggest that empathy plays a large role in the formation of the TA and also has an impact on treatment outcomes.

However, not all studies have found the core conditions to be relative to outcome. For example, Beckham (1989) used the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962) to explore the influence of the core conditions in CBT for depression. The alliance was not found to be predictive of response. However, the author critiques his own study by suggesting that the reason for the results may be due to the cohort of therapists used (i.e. in training therapists). Furthermore, the BLRI was given to participants after the first session which may have been too soon for the client to rate levels of perceived core conditions in therapy. Moreover, due to the small sample size (n=32), the generalizability of the study may be questionable.

In general, qualitative studies have also found support for the core conditions in CBT which are said to enhance the TA. In a study using IPA, McManus, Peerbhoy, Larkin and Clark (2010) looked at the patients' experiences of CBT for social phobia. As in other qualitative studies of patients' experiences, the value of the therapeutic alliance in enabling change was highlighted. Participants noted feeling valued and accepted by the therapist, again linking the concept of the Rogerian core conditions (Rogers, 1957) to the therapeutic relationship in CBT. Similarly, Vincent (2012) conducted an exploratory study of asylum-seekers' experiences of CBT for post-traumatic stress disorder (PTSD) using IPA. One of the super-ordinate themes uncovered was 'importance of the therapeutic relationship' in recovery. In this study participants valued being believed, support, confidentiality, and having their normality affirmed. What's more, the study found that participants described their therapists' sincere concern, therapists' non-judgemental stance, and attentive listening with empathy, very important in experiencing genuine compassion. These characteristics were viewed as being consistent with Rogers' (1957) facilitative 'core conditions'. Finally, Shearing, Lee and Clohessy (2011) used an IPA

methodology to analyse interviews with participants who had undergone CBT for PTSD. The study described the importance of developing a trusting therapeutic relationship in helping participants face the experience of reliving. Furthermore, participants valued mutual openness, genuineness, and honesty within the therapeutic relationship. Like the previous study, this bears resemblance to the concept of 'core conditions' (Rogers, 1957).

Within the field of CBT research, empathy has been singled out as an influential factor in outcome analysis. Based on the findings of forty-seven studies, Bohart, Elliot, Greenberg, and Watson (2002) found a medium to large effect size between empathy and therapeutic outcomes. This review also found a stronger relationship between empathy and outcomes in CBT than in humanistic therapies. Cooper (2008) suggests that empathic understanding may be a necessary grounding from which to apply more technical interventions. Authors such as Thwaites and Bennett-Levy (2007) distinguish "therapeutic empathy" from the more common understanding of empathy. They propose that therapeutic empathy can be conceptualised by four key elements: Empathic attunement, Empathic attitude/stance, Empathic communication, and Empathy knowledge. Their model highlights the "person of the therapist" (Thwaites & Bennett-Levy, 2007, p. 598) and the importance of self-reflection in the development of therapeutic empathy. It is believed that therapeutic empathy has both a cognitive and emotional aspect to it; both being of equal importance in the communication of empathy to the client.

With reference to CBT specifically, Burns and Nolen-Hoeksema (1992) examined the direct and indirect impact of empathy on outcome in a large sample of 185 clients receiving CBT for depression. The results of their research showed that the clients of the most empathic therapists (as rated by the clients), improved significantly more than patients whose therapists received the lowest empathy ratings. Similarly, qualitative studies have also uncovered empathy to be an important factor in the development of a therapeutic alliance. For example, themes of flexibility and "involved therapist empathy and supportiveness" (Berg, Raminani, Greer, Harwood, & Safren, 2008, p. 271) were highlighted in a study focusing on clients' experience of CBT for adherence and depression in HIV. A grounded theory study looking at CBT group experiences for eating disorders (Laberg, Törnkvist, & Andersson, 2001) found that participants placed a lot of significance on the therapeutic alliance and seemed to equate treatment with their therapist. The therapist was perceived as "efficient, straightforward, capable, and helpful" (Laberg et al., 2001, p. 168) as was the therapy.

Messari and Hallam (2003) interviewed four inpatients and one outpatient who received CBT and analysed the data using discourse analytic methods (DA: Parker, 1994). The authors found that most participants highlighted the value of a trusting and respectful therapeutic relationship. Participants also emphasised the personal nature of the relationship between "two equal human beings" (Messari & Hallam, 2003, p. 179), who respected and trusted each other. This echoes other findings in alliance literature (e.g. Horvath & Symonds, 1991) that underscored the importance of a collaborative and trusting therapeutic TA. Lastly, Borril and Foreman (1996) used grounded theory in analysing interviews with clients who were asked about their experience of CBT for flying. The client's experienced the therapists as empathic, warm, informal and open. This was seen as a firm contributing factor in establishing a strong therapeutic alliance. Furthermore, the therapist's confidence and optimism increased the participants' confidence in their ability to achieve therapeutic change.

Along with the more relational components of the TA that have been studied, other, more 'technical' factors have also been the focus of research in recent years. As stated previously, a number of these factors seem relevant when focusing on the TA in IAPT: Therapist experience and adherence to a particular model and the TA, training and the TA, pre-therapy assessment interviews and the TA, and pre-therapy symptom severity and the TA.

2.3 Therapist experience, adherence to CBT, and their impact on the TA

Due to the recent inception of IAPT, up to 4,000 new therapists have been trained in IAPT approved therapies (Department of Health, 2012); mainly in CBT. Thus, a large proportion of therapists within IAPT are relatively inexperienced. Therapist experience has been earmarked as a potential factor in clinical outcome studies and also studies focusing on the TA. Some studies focusing on outcome measures only (not TA) have shown that unlike the clients of qualified CBT therapists, anxiety levels in the clients of trainee CBT therapists did not show a significant decrease (Simons et al., 2010). Other studies have tried to assess therapist competence and questioned whether a relationship exists between competence and outcome. In general, studies tend to equate competence with technical skills and adherence to specific models rather than a broader sense of the word (cultural competence, relational competence, emotional competence). This may be due to technical adherence being easier to monitor or rate than other facets of competence.

Strunk, Brotman, DeRubeis, and Hollon (2010) utilised the Cognitive Therapy Scale (Young & Beck, 1988) to assess clinical competence in therapists. Two outcomes measures were used: A self-report measure (BDI-II; Beck, Steer, & Brown, 1996) and a clinician-administered outcome measure (HRSD; Hamilton, 1960). Competence was found to be a significant predictor of evaluator-rated end-of-treatment depressive symptom severity and was predictive of self-reported symptom severity at the level of a nonsignificant trend (Strunk et al., 2010). Similarly, Kuyken and Tsivrikos (2008) looked a competence among therapists providing CBT in an outpatient clinic. Competence was measured by the clinic's director based on his general impression of therapists. The ratings of clinical competence of the 18 therapists who took part in the study significantly predicted post-treatment depression scores after controlling for start of therapy scores. Although there are many studies examining the relation between alliance and outcome, experience and outcome, or technique and outcome, there are relatively few examining the impact of the Alliance X Technique interaction on outcome (Barber, 2009).

Among manualised therapies, there has been an interest both in the degree to which therapists are delivering the theory-specified techniques (therapist adherence), and the skill with which these techniques are applied (therapist competence) (Barber, Sharpless, Klostermann, & McCarthy, 2007; Sharpless & Barber, 2009). One of the most common criticisms about the use of therapeutic manuals is that they might limit the ability of the therapist to connect with patients and to develop a strong therapeutic alliance.

Studies which have specifically evaluated the relationship between the therapist's adherence and the strength of the therapeutic alliance also have conflicting results. For example, some studies focusing on brief-dynamic therapy suggest that high levels of adherence can have a negative impact on the therapeutic alliance and on the treatment outcome (Henry, Schacht, Strupp, Butler, & Binder, 1993; Henry, Strupp, Butler, Schacht, & Binder, 1993). The authors concluded that dictating specific therapist behaviours through the manualisation of therapy may alter other therapeutic variables in unexpected and even counterproductive ways.

There have been mixed reports as to the impact of adherence to CBT on the alliance. Castonguay and colleagues (1996) analysed the results of 30 clients who underwent cognitive therapy for depression. The authors used the Working Alliance Inventory (WAI) (Horvath &

Greenberg, 1989) to measure the TA and the Coding System of Therapist Feedback (CSTF) (Goldfried, Newman, & Hayes, 1989) to measure the therapist's focus on the client's intrapersonal functioning. The analysis showed that the TA was found to be related to improvement. On the other hand, the researchers found that when the client and therapist focused on the client's negative dysfunctional assumptions (i.e. focusing on adherence to cognitive therapy techniques), this was related to an increase in depressive symptoms after therapy. Descriptive analyses suggested that while therapists sometimes increased their adherence to cognitive rationales and techniques to correct problems in the therapeutic alliance, this seemed to worsen the ruptures in the TA. This was equated to disrupting therapeutic outcomes.

In contrast, other studies of CBT have found that higher levels of adherence is related to a stronger alliance (Loeb et al., 2005). In a large-scale study, 154 participants were randomly assigned to CBT or interpersonal psychotherapy (IPT) for Bulimia Nervosa, with each participant completing 19 sessions. Full-length therapy sessions were rated by independent observers for adherence to therapy. An adapted version of the Vanderbilt Therapeutic Alliance Scale (Krupnick et al., 1996) was used to rate the TA. Therapists using CBT were founds to have greater adherence. Across both treatments better adherence was associated with enhanced alliance. Furthermore, a strong early TA was negatively correlated with the frequency of post-treatment purging. However, certain limitations in this study such as poor interrater reliability and the fact that measures were not taken until the 6th session somewhat weaken the conclusions. A study by Trepka, Rees, Shapiro, Hardy, and Barkham (2004) also found that competence, measured by the CTS (Young & Beck, 1988), and TA, as measured by the California Psychotherapy Alliance Scale (Marmar & Gaston, 1988), were positively related to outcome (Beck Depression Inventory). Again, this study adds support for the association between competence and TA.

Finally, a recent meta-analysis of therapist competence and outcome was conducted by Webb, DeRubeis, and Barber (2010). The authors based their selection criteria on the meta-analysis based on the TA and outcome conducted by Martin and colleagues (2000, mentioned above). Interestingly, variability in neither adherence nor competence was found to be related to clinical outcome (Webb et al., 2010). Furthermore, the aggregate estimates for the effects of adherence and competence were very close to zero. The authors conclude that "adherence and competence are relatively inert therapeutic ingredients that play at most a small role in

determining the extent of symptom change" (Webb et al., 2010, p. 207). Finally, they suggest

that due to the large effects of the TA on outcome measures reported in the original study

(Martin et al., 2000), "it may be more important to focus on enhancing the dose of certain

common factors such as the alliance, rather than increasing therapist adherence or

competence" (Webb et al., 2010, p. 207).

With regards to qualitative studies, only one unpublished thesis (Levi, 2010) was found that

looked specifically at therapists' experience of the therapeutic alliance in CBT. This study used

Interpretive Phenomenological Analysis (IPA: Smith, 1996) with a group of eight Counselling

Psychologists who worked in diverse settings using CBT. In this study participants emphasised

the importance of flexibility and creativity within their practice of CBT and positioned

themselves against following manualised treatment. References were made to relating to a

client's reality in a phenomenological way which enabled them to tailor their interventions to

suit the needs of the client. This study was said to echo Arthur's (2001) assertion that

therapists normally adapt models so that they are consonant with their personality and

philosophy in life. Finally, the participants highlighted the influence of the clinical setting

where CBT is practised on the therapeutic relationship. Private practice and public

organisations were contrasted, and the association of CBT with strict time constraints and

guidelines was portrayed. This final point is very relevant to the current study as all therapists

interviewed for the qualitative section of the study all come from the same IAPT primary care

setting.

Taking all of these results together it is not clear whether there is a causal link between

adherence and TA, or whether one is reliant on the other. It is possible that techniques are

effective only in the context of a strong TA, but also that successful therapeutic interventions

increase the strength of the alliance. Research has been conducted to see if it is possible to

enhance the TA, and therefore subsequent outcomes, by giving therapists specific training that

focused primarily on the TA.

2.3 Training and the TA

The outcome research cited above suggests that creating a good alliance is an important

therapeutic task and possibly a prerequisite for successful therapy. However, as stated by

Barber (2009), when training young therapists, most instructors do not ask the trainees to

focus only on the alliance, and most also train their students in the skilful implementation of therapeutic techniques. Rightly or wrongly, therapeutic competence is therefore thought of as being able to implement clinical interventions at appropriate stages during therapy, however others suggest that competence is a multifaceted area in which the TA plays a primary role (Barber, 2009). The author of this study conducted a brief review of the IAPT low-intensity manual and found only one reference to the therapeutic alliance in CBT (Richards & Whyte, 2008) and only 3 references are made about the therapeutic relationship in the high-intensity curriculum (Department of Health, 2008b, 2008c). But can training courses enhance a therapists' ability to create a strong TA?

In recent years researchers have explored if specialised TA training can increase the TA between therapists and clients. Two of the most notable studies investigating whether therapist's can be trained to facilitate a better therapeutic alliance and respond to difficult interpersonal process are the Vanderbilt studies (Henry, Strupp, et al., 1993) and a study by Crits-Christoph and colleagues (Crits-Christoph et al., 2006). Both studies examined the pre/post training effects with a group of qualified therapists. The training given to therapists focused on the alliance; on both the acquisition of therapeutic skills and the therapeutic alliance. Interestingly, both studies came up with different results. Henry and colleagues' (1993) study suggested that although therapists adhered to the treatment manual, there were negative effects on some therapeutic behaviours. For example, therapists showed a significant increase in hostile communication, more authoritative and defensive responding. Furthermore, therapists demonstrated less optimism and support or approval of their patients following the training.

In the Crits-Christoph (2006) study, five qualified therapists were given extra training in alliance-fostering therapy and worked with clients diagnosed with depression for a 16-session period. The training incorporated interpersonal and psychodynamic interventions with techniques for enhancing the alliance based on Bordin's tripartite model of the alliance. Therapists worked with three clients each; one client before, during, and after training. The post-training results showed large increases in the alliance, the effects of which were statistically significant. The training produced small improvements in depressive symptoms but larger improvements in quality of life for the clients. However, due to the small sample size and high initial levels of alliance, and lack of control group, these results have to be held tentatively. Another earlier study by Crits-Christoph's group (1998) also showed that unlike the Henry and colleagues (1993) study, there was no evidence that using treatment manuals

diminished the therapeutic alliance. In fact, during manualised training in supportive-expressive dynamic therapy, cognitive therapy, and individual drug counselling, therapists from each condition received high alliance ratings from patients.

Thus, the differing results between the aforementioned studies may not be representative of the relationship between structured training and alliance. The interaction between training and subsequent TA is likely to depend on a plethora of interpersonal, intrapersonal, and technical factors (Hilsenroth, Ackerman, Clemence, & Strassle, 2002). More research is emerging from the famous Safran Lab (see website: Safran, 2009) in to the possibility of structured training targeting the TA and the impacts on therapy outcome. Leading authors (Muran, Safran, & Eubanks-Carter, 2010; Safran & Muran, 2000) suppose that specialised training which focuses on the exploration of the TA, and ruptures in the TA, would have positive impacts on the outcome of the therapeutic process. Clinicians and researchers now wonder if it is the resolution of TA ruptures that instigate key transformative experience in therapy (Muran et al., 2010). However, other authors are more sceptical. In a review article by Horvath (2004), less than half the studies focusing on alliance training found a positive relationship between the alliance training and perceived alliance by either a client or independent rater. The review also found that positive improvements in alliances were generally due to positive therapist attributes such as flexibility, interest, and warmth (Horvath, 2004). Thus, it seems that further research is needed to identify the interactive elements between therapist and client related to the alliance.

Pre-therapy factors may also play a role in the development of a TA. The triage process in IAPT is quite unique within the NHS as it is commonly a scripted telephone interview assessment lasting from 30 to 45 minutes. Thus, a brief review of the influence on pre-therapy assessment and TA is warranted.

2.5 Pre-therapy assessment and the TA

The TA and outcome research has noted the importance of the TA in early treatment sessions (second through fifth sessions) and its influence on later outcomes. Thus, the early alliance has been said to be an important factor in the success of treatment. In order to keep to the stepped care model, IAPT has incorporated pre-therapy screenings (also known as triage) wherein the severity of client difficulties are assessed and depending on their severity, they

are assigned to step 2 (generally guided self-help), step 3 (generally face-to-face CBT), step 3 counselling, or another form of IAPT approved treatment (such as Dynamic Interpersonal Therapy or Interpersonal Psychotherapy). These assessments are usually conducted over the phone unless an interpreter is needed. During the assessment measure of anxiety, depression, phobia, and personal demographic details are collected. It could be said that the foundations of the therapeutic alliance are built at this phase. Thus, it is important to review some of the literature regarding this phase of treatment.

A number of studies have looked at pre-therapy screenings or interviews with respect to the TA. In a prospective field study of 505 participants, Huber, Henrich and Brandl (2005) asked clients and consultants to rate the quality of the therapeutic alliance after a pre-therapy screening interview. The consultation lasted for 45 minutes, during which the clients were interviewed, advised as to an appropriate form of treatment (inpatient, outpatient, etc.), and referred to the relevant psychological service. None of the clients were seen by the consultants. Clients were followed up after three months and were asked to rate the success of the consultation. In the cases where clients had already started treatment the client/therapist pair rated the TA. Client TA ratings correlated with their retrospective rating of benefit from consultation. Consultant relationship rating correlated with the client's compliance in the referral process. The main finding of the study was that patients who felt a benefit from the pre-therapy consultation also reported significantly higher alliances with their therapists. The authors concluded that if a client feels an initial assessment phase is valuable, irrespective of the time it takes for the client, subsequent alliance levels in therapy are more likely to be sustained. However, due to the large number of clients who dropped out of treatment (25%) it is wondered whether the results that are claimed can be representative of the sample as a whole. The clients who dropped out may have thought that, in retrospect, the initial consultation negatively impacted their subsequent treatment. Thus, the internal validity of the study may have been compromised.

Another prospective study (Mohl, Martinez, Ticknor, Huang, & Cordell, 1991) followed 96 participants who were screen by 4 senior clinicians. The study used a version of Luborsky's Helping Alliance Questionnaire (Luborsky et al., 1980), adapted for use in assessment interviews, to assess the therapeutic alliance between the client and interviewing clinician. The authors showed that intake interviewers who had higher alliance scores were seen as more active, explorative, and respectful when compared to intake interviewers with lower helping

alliance averages. Interviewers who had the highest subsequent client dropout rates were reported as being passive and did not offer the clients any new ways of understanding their problems. Overall, the clients who dropped out early experience a weaker TA with their screening clinician. Clinicians who were perceived as warm, friendly, and facilitating a greater sense of understanding had higher working alliance ratings early in the treatment process.

Both of the studies mentioned above are similar to the IAPT screening model in terms of the length of the interview and the subsequent allocation to a specific treatment (i.e. step 2, step 3 etc.). However, other studies have used a 3 session assessment model based on Finn and Tonsager (1997) and Fischer's (1994) Therapeutic Model of Assessment (TMA). This approach is predominantly relational, client-centred, and emphasises the importance of communicating assessment findings to the clients in a digestible way. In brief, the authors say that the approach aims to use psychotherapy skills, commonly used during the course of treatment, and incorporates them during the assessments phase (Finn & Tonsager, 1997). Research trials have suggested that the TA developed using this prolonged assessment is statistically superior to more traditional information gathering models of assessment. For example, Ackerman, Hilsenroth, Baity, and Blagys (2000) compared 38 participants who underwent the therapeutic model of assessment to 90 participants who had a more traditional information gathering assessment plus a feedback session. The results of this study indicated that participants in the TMA group were significantly less likely to terminate therapy early when compared to the other condition. Furthermore, the TMA model was also found to aid the initial and subsequent TA formed between the therapist and client. The authors concluded that a more extended and in-depth assessment process is useful in helping clients enter and stay in treatment. Furthermore, the "smoothness" of the assessment (as rated by clients) was not the most important factor in the success of the assessment. Rather, the in-depth process and the transfer of information from the assessor to the client were found to be most important to patients. Subsequent longitudinal studies have reported similar results (Hilsenroth, Peters, & Ackerman, 2004).

Taken as a whole, the literature suggests that the assessment seems to be an important factor in preventing early client termination of therapy. Moreover, it seems that a more in-depth, active, client-centred assessment positively influences the development and maintenance of a therapeutic alliance. Hilsenroth and Cromer (2007) have synthesised the empirical results and have derived guidelines for assessment. These are summarised in figure 3 below. However,

these guidelines seem to be at odds with current models of assessment used in the IAPT protocol; an issue that may affect the TA, dropout rates, and treatment outcomes.

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Frame

 Conduct longer, more involved, depth-oriented interviews

 Adopt a collaborative stance toward client

 Speak with emotional and cognitive content

 Use clear, concrete, experience–near language

Focus

 Allow client to initiate discussion of salient issues

 Actively explore these issues

 Clarify sources of distress

 Identify cyclical relational themes

 Facilitate client affect and experience

 Explore uncomfortable feelings

 Explore in-session process and affect

 Maintain active focus on these related topics

Feedback

 Review and explore meaning of assessment results

 Provide client new understanding and insight

 Offer psychoeducation on symptoms and treatment process

 Collaboratively develop individual treatment goals and tasks

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Figure 3 - Summary of clinician activities found to be significantly related to positive therapeutic alliance during the initial interview and psychological assessment - adapted from Hilsenroth et al. 2007

2.6 Pre-therapy severity of impairment and the TA

A number of studies have investigated the impact of clients' symptom severity on the subsequent development of an alliance in therapy. However, the results are somewhat mixed. For example, a study conducted with 120 clients diagnosed with depression compared cognitive therapy (CT), behavioural therapy (BT), and brief dynamic therapy (BDT) (Gaston et al., 1998) in an alliance/outcome study. It was reported that clients reporting more severe

levels of distress have poorer alliances with their therapists. In another large-scale study (n=239) with clients suffering from depression, Zuroff and colleagues (Zuroff et al., 2000) also found that pre-therapy levels of depression were related to poorer alliances.

Conversely, other studies have found little or no difference between symptom severity and therapeutic alliance. Another study by Gaston and colleagues (1991) again compared 3 treatment types (CT, BT, and BDT) in a study involving older adults with a diagnosis of depression. No difference was found between symptom severity and strength of alliance. Other studies of short-term psychotherapy have also yielded similar results (Joyce & Piper, 1998). However, some authors have suggested that the overall weak link between symptom severity and alliance may be due to skewed results (Horvath & Bedi, 2002). Horvath and Bedi (2002) suggest that clients with more severe symptoms are more likely to drop out of treatment and therefore would not be included in many of the published studies. On a similar note, type of disorder has also been linked to strength of alliance.

There have been some reports linking specific psychological problems with difficulties developing a strong TA during therapy. For example, clients diagnosed with borderline and other interpersonal difficulties generally have lower alliance scores during treatment (Hersoug, Høglend, Monsen, & Havik, 2001). Furthermore, traits such as perfectionism have been shown to have moderating effects on the TA (Zuroff et al., 2000). However, other large scale studies have found that client characteristics such as chronicity, social functioning, and history of abuse and/or neglect are not correlated with the early alliance (Klein et al., 2003). In summary, the literature on patient characteristics that contribute to the alliance is relatively small, with few replicated findings (Constantino, Castonguay, & Schut, 2002).

2.7 The aim of the current study – Introducing the research question

As was shown by the review of the literature, there are a large number of studies examining the therapeutic alliance in CBT and other therapies. This study aims to explore the importance of the therapeutic alliance in an IAPT setting through the use of different epistemological lenses (discussed in the next chapter). A sequential qualitative→quantitative design will be used in this study. A qualitative analysis will be conducted which will aims to highlight the opinions of IAPT therapists regarding the TA, and possible challenges to the TA in IAPT. The quantitative part of the study will use Bordin's (1979) pan-theoretical concept of the TA to

explore therapist and client TA during treatment to see the strength of the relationship at different time points during the course of therapy.

The author does not believe that collecting both qualitative and quantitative data will lead to a specific 'answer', but may generate new information by looking at how data collected from these diverse methods can be in a dialogic relationship with one another. Thus, the 'problem' under scrutiny is multifaceted and cannot be 'solved' in the traditional manner, but only approached and approximated, by taking on a necessarily multifaceted approach. The next section is a brief reflection outlining how the research question was derived. As it is a reflective piece, it was decided to use the first person.

2.7.1 Initial research reflections

"We are born out of relationship, nurtured in relationship, and educated in relationship" (Cottone, 1988, p. 363)

My first clinical placement was at a counselling service within a GP surgery in North West London. It was a voluntary service managed by a qualified Counselling Psychologist but run by trainee therapists. This service had been in existence for 20 years but, due to the impending arrival of IAPT, the GPs in the surgery felt it necessary to disband the service and go with IAPT. Desperate to complete my first year client hours I applied for an IAPT placement.

The seeds of this research project were sewn when my I started at this IAPT service. I was aware of the controversy surrounding IAPT; the successes, the criticisms, and the on-going turf wars between services. However, my experience of the service was very difference to what I expected. My supervisor was a Counselling Psychologist and was very attuned to the relational aspects of the therapeutic processes. This seemed to be in contrast to the criticisms I had heard of IAPT being bandied about by colleagues and clinicians. Although I was part of an IAPT service, I was only working there one day a week and was aware that my experience might be very different from those who worked there on a permanent basis. Thus, I knew that I wanted to give the clinicians in the IAPT service a voice in my project. Rather than solely basing my research on the existing literature, I felt it was important to be guided by the people whose reality was working full time for an IAPT service. Another important factor in doing this research was to make use of the data IAPT was collecting. As part of my IAPT placement, I was obliged to collect various pieces of data (minimum data set) as part of treatment. However,

there is little apparent research activity in IAPT and there are seemingly few articles being published on the data set. Authors have questioned whether there is a moral issue here at stake: thousands of therapists collecting data in every session, potentially using clinic time, and using the client's time (Murphy, 2013). Thus, I felt that it was important to make use of this underutilised data.

Getting to know the therapists and the service, I was fascinated to find out if IAPT was more than a sum of its parts. Thus, I went in to this project knowing what I wanted to find out, but finding it difficult to conceive of a way of doing it. Eventually, after much deliberation, a sequential mixed methods design was thought to be the best method of attack.

3. Epistemology and Methodology

3.1 Overview

Researchers' claims about the nature of reality, how we know it (epistemology), what values go into it (axiology), and the processes for studying it (methodology), are key considerations for research (Crotty, 1998). In this section the concept of 'scientific research' and the 'scientist-practitioner' will be explored followed by some of the difficulties posed by mixed strategy research. Authors have argued that combining research strategies may lead to a more pluralistic psychology (W. E. Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005), and may yield more penetrative research findings as a direct consequence of epistemological diversity. Following that, the epistemological positioning for each part of the research (qualitative [Part 1] and quantitative [Part 2]) is discussed.

3.2 Research Question

As discussed in the introduction, the "therapeutic alliance" is a multifaceted and complex phenomenon. In order to explore the TA in the context of a specific NHS service (IAPT) and a specific (yet equally multifaceted) therapeutic model (CBT), a mixed method design was employed. Although quantitative and qualitative methods have differing epistemological foundations, it is the dialogic relationship between the two that may produce a more nuanced position to this complex phenomenon. Hence, the purpose of the current study was two-fold. Firstly, through the use of qualitative methods, explore the therapist's view of the use of the TA in IAPT. The emerging data was used to construct a quantitative exploration that would speak to the qualitative data. The following research questions were explored in this study:

Qualitative:

1) What are the therapists' views of the therapeutic alliance in IAPT?

2) Does the IAPT training influence the TA?

3) Is there a difference between therapist and client perceptions of the TA in IAPT?

Quantitative:

1) Would there be a difference in TA scores between the trainee and qualified groups at session two and end of treatment?

2) Would a strong early TA present in both groups? Would there a significant difference between early and late TA between the two groups?

3) Would symptom severity relate to therapist and client TA scores?

4) Would the TA (therapist versus client perception) predict outcome in depression and anxiety?

In order to appreciate the diverse nature of quantitative and qualitative epistemologies, a brief overview of the evolution of mixed method design thus follows.

3.3 Mixed Methods Research - Introduction

3.3.1 'Scientific' research and the 'scientist-practitioner'

Positivistic viewpoints in "psychology" can be linked back to the notion that science would be able to provide all the answers to living and the human condition, as proposed by Bacon in the 17th century (Bacon, 1627 cited by van Scoyoc, 2010). Logical positivism assumes the position that all knowledge is based upon empirical observation and assisted by the use of logic and mathematics (van Scoyoc, 2010). During the history of psychology, many have been drawn towards this reductive view of the human condition. The concept of l'*homme moyen,* or 'the average man', was proposed by Quetelet in which he suggested that the betterment of society would be achieved through the statistical analysis of social knowledge from which we would better understand the human condition (Quetelet, 1835, cited by Coven, 2003). The positivistic beliefs which were popular at the time saw psychology move from a specialism within philosophy to an experimental science (Farr, 1983).

Due to the logical positivist movement that ensued, the scientific method was tied to the verifiability principle which promotes hypothesis testing and states that a theoretical statement is only valid if it can be empirically tested and verified (van Scoyoc, 2010). However, this positivistic view of science poses difficulties when looking at concepts such as intersubjectivity or, in the case of this research, the therapeutic alliance. As Rennie (1994, p. 235) suggests, "the study of the person poses challenges that are not encountered when studying the physical and biological world." In the 'physical sciences', subject-object dualism is paramount for objective empirical research. In contrast, the subjective world of individuals is very different.

Within the field of 'human science' further delineations have been made between 'hard' data (which usually takes the form of numbers which are statistically analysed) and 'soft' data (e.g. interview data, which usually is in the form of text). Cultural trends have in the past prioritised 'hard' data and thus define science and science-based research in very narrow terms, effectively discriminating against qualitative research (Robson, 2011). Rennie (1994) suggested that psychologists contributing to humanistic thought had been marginalised and were only accepted by attempting to fuse humanism with more positivistic method in psychology and the natural sciences. The Division of Counselling Psychology also commented that "the logical positivist approach, whilst so widely adopted within scientific research, effectively dismissed all metaphysical and also theological statements as meaningless, along with phenomenology" (van Scoyoc, 2010). Thus, alternative methods of analysis were necessary to tap in to the subjective inner world of the person, rather than concentrating solely on uncovering the 'truth' in theories.

As stated by Robson (2011): "Rejection of the use of natural science methods need not carry with it a rejection of a scientific approach." Qualitative epistemologies such as postmodernism rejected the uncritical acceptance of concepts such as 'rationality', 'progress through science' and 'general truths' (Robson, 2011, p. 16) that were sought by modernists. Similarly, existentialists such as Heidegger attempted to refocus the Western assumptions about objective truths back to the fundamental questions of 'being' (van Scoyoc, 2010). Epistemologies such as Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2003) attempt to explore how participants are making sense of their personal and social world; their subjective experiences. Similarly, other qualitative methodologies such as Grounded Theory (GT; Charmaz, 2003) celebrate each individuals unique viewpoint and reject the notion of the possibility of one unifying truth.

The Handbook of Counselling Psychology and the Health and Care Professions Council state that counselling psychologists are 'scientist-practitioners' (Health and Care Professions Council, 2010; Strawbridge & Woolfe, 2010). Counselling Psychology, a discipline underpinned by humanistic values and principles, is said to argue for a scientist–practitioner model that is "practice-led, phenomenologically-focused, respectful of diversity and interested in the uncovering of subjective truths" (Woolfe & Dryden, 1996, cited by Lane & Corrie, 2006, p.21). Thus, the values of Counselling Psychology are generally wedded to qualitative explorations of data.

In the current climate the demands for psychological assessment, treatment and diagnosis in society requires counselling (and clinical) psychologists to adhere to the Boulder model of the scientist practitioner (see Rennie, 1994), an incorporation of the natural science approach into clinical and counselling psychology. Hence, this study's aim was to 'speak two languages' - to speak to the NHS 'recovery' model by speaking about outcome measures (quantitative element of the study), whilst also speaking to the humanistic, phenomenological underpinnings of counselling psychology by exploring the views of practitioners working within IAPT.

3.3.2 Mixed methods research and Pragmatism

Traditionally, research has been undertaken using either a qualitative methodology or a quantitative methodology. This section will briefly outline quantitative and qualitative concepts and argue that a pluralist pragmatic approach might provide a procedure that utilises both approaches in a single study.

3.3.2.1 Positivism/Postpositivism vs Constructionism/ Interpretivism

Historically, quantitative methods are derived from objectivism (or premised on Cartesian dualism) as an epistemology and adheres to positivism as at theoretical perspective (Crotty, 1998). Frels and Onwuegbuzie (2013) state that positivists conceive of a singular reality that can be discovered and observed. Quantitative purists suggest that it is possible for the observer to be detached and separate from the entities that are being observed (Johnson & Onwuegbuzie, 2004). This is akin to the way scientists study physical phenomena. Nagel (1989, cited by Johnson & Onwuegbuzie, 2004) suggests that quantitative purists believe that is it possible for the results of quantitative research to be objective, time- and context- free generalisations which hold reliability and validity. Guba and Lincoln (1994) suggest that positivistic research takes place "as through a one-way mirror" (1994, p. 110). Furthermore, replicable findings are said to be "true" (Guba & Lincoln, 1994, p. 110). Thus, one can uncover that which is true and real by the correct use of the scientific method (Guba, 1990).

Postpositivism shares some similarity with the positivist hypothetico-deductive method of positivism. Slife and Williams (1995) state that knowledge is based on (a) determinism or

cause-and-effect thinking, (b) reductionism, by narrowing and focusing on selected variables to interrelate, (c) observations and measures of variables and (d) the testing of theories that are continually refined. From an ontological perspective, reality can be approximated but we can never find the absolute truth (Guba & Lincoln, 1994). The objectivist standpoint of post positivism suggests that: "replicated findings are probably true (but are always subject to falsification)" (Guba & Lincoln, 1994, p. 110). Unlike positivism whose aim is to uncover 'the truth', post-positivism's goal is to "test, falsify and thereby improve our imperfect models of reality" (Yardley & Marks, 2004, p. 4).

The concept of positivism is rejected by qualitative purists (also labelled constructivists and interpretivists by Johnson and Onwuegbuzie (2004)). Guba and Lincoln state that: "Realities are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based ... and dependent for their form and content on the individual persons or groups holding the constructions" (1994, pp. 110–111). Thus, qualitative purists may hold a non-positivistic, relativist ontology which "emphasises the diversity of interpretations that can be applied to [the world]" (Willig, 2001, p. 13). Purists contend that time- and context free generalisations are an impossibility and an unwelcome concept (Johnson & Onwuegbuzie, 2004). From an epistemological perspective the researcher and the object of investigation are said to be interactively linked in which the findings are "literally created as the investigation proceeds" (Guba & Lincoln, 1994, p. 111). Hermeneutical and dialectical concepts are employed as methodological tools (Guba & Lincoln, 1994). Thus, qualitative purists subscribe to the idea that there is no such thing as a single objective reality and believe that "subjective inquiry is the only kind possible to do" (Erlandson, Harris, Skipper, & Allen, 1993, p. xi).

3.3.2.4 Pragmatism

Many other research paradigms have made advances in recent years such as postmodernism, poststructuralism, and critical researchers within these broad frameworks (Teddlie & Tashakkori, 2009). However, positivism, postpositivism and constructivism/interpretivism still dominate social sciences research in terms of epistemological debates, methodological textbooks and research conducted (Teddlie & Tashakkori, 2009). As outlined above, these main paradigms (or worldviews) are presented as being fundamentally opposed (Creswell & Plano Clark, 2007).

Authors have been eager to differentiate between methodological purists, situationalists and pragmatists (W. E. Hanson et al., 2005). As summarised by W.E. Hanson and colleagues (2005), purists believe that qualitative and quantitative methods are mutually exclusive in terms of epistemological and ontological underpinnings. Both quantitative purists and qualitative purists view their paradigms as the most appropriate paradigm for research (Johnson & Onwuegbuzie, 2004). The incompatibility thesis, discussed by Howe (1988), puts forward the argument that qualitative and quantitative research paradigms, including their associated methods, cannot be reconciled; "The one [paradigm] precludes the other just as surely as belief in a round world precludes belief in a flat one" (Guba, 1987, p. 31). Thus, positivism/postpositivism and constructivism/interpretivism are traditionally seen as being fundamentally opposed paradigms (or worldviews) (Creswell & Plano Clark, 2007), and therefore were seen as incompatible.

Unlike methodological purists, situationalists suggest that both qualitative and quantitative methods have value but that certain methods are more suitable in specific circumstances. These two positions differ from pragmatism that declares that "regardless of circumstances, both methods may be used in a single study" (W. E. Hanson et al., 2005, p. 226).

In an attempt to build a framework that acclimates the varied nature of Mixed Methods Research (MMR), researchers have proposed various ways of conceptualising it. Creswell and Plano Clark (2007, pp. 26–28) describe three alternative stances on the paradigm issue: 1) The 'best' worldview for MMR; 2) Multiple dialectical worldview; 3) Varying types of worldviews depending on the type of design. Other authors list up to four different frameworks (Greene, Benjamin, & Goodyear, 2001, pp. 28–30). The approach most commonly linked to MMR is pragmatism (Teddlie & Tashakkori, 2009, p. 7).

It has been proposed that by emphasising the means of solving practical problems, we can sidestep the debate about "the existence of objective ''truth''', or the "value of subjective perceptions" (Wheeldon, 2010, p. 88). Pragmatism offers an alternative to the either/or "dualisms" of positivism/postpositivism and constructivism (Biesta, 2010, p. 96) by focusing on the problem to be researched and the practical outcomes of the research undertaken (Creswell & Plano Clark, 2007, p. 26; Feilzer, 2009). Pragmatism asserts, philosophically, that a single ''real world'' can exist in which all individuals have their own unique interpretations of

that world (Feilzer, 2009; Morgan, 2007; Wheeldon, 2010). Furthermore, these singular and multiple realities are open to empirical inquiry (Feilzer, 2009). Ultimately, using various approaches, pragmatism is concerned about "what works," and, of note to counselling psychologists, values both objective and subjective knowledge (Cherryholmes, 1992).

Whereas the qualitative approach and quantitative approach rely on inductive reasoning and deductive reasoning respectively, pragmatism relies on abductive reasoning. Morgan describes this method of connecting theory to data as "reasoning that moves back and forth between induction and deduction—first converting observations into theories and then assessing those theories through action" (2007, p. 71). This can be seen in MMR studies that adopt a sequential design where the deductive results from a quantitative approach can serve as inputs to the inductive goals of a qualitative approach (Morgan, 2007). Similarly, this study aims to further the deductive knowledge gained from the quantitative results regarding the TA and outcome measures (depression, anxiety and social adjustment) and use this as an input to inform the qualitative focus groups. Morgan also suggests that "this movement back and forth between different approaches to theory and data does not have to be limited to combinations of methods within a single project" (Morgan, 2007, p. 71). Thus, researchers do not have to "be the prisoner of a particular method or technique'' (Robson, 1993, p. 291 cited by Feilzer, 2009, p.8).

A lot has been written about the 'paradigm wars' between philosophical standpoints leading to the notion of the 'incompatibility thesis' (Howe, 1988). However, some authors have proposed that the delineation between phenomena as being either objective or subjective are specifically as a result of political divisions among social scientists (B. Hanson, 2008; Morgan, 2007). What's more, pragmatism calls into question the dichotomy of positivism and constructivism. Hanson (2008) and Johnson and Onwuegbuzie (2004) suggesting that both methods share many similarities in their approach to inquiry. Feilzer also suggests that they "are not different at an epistemological or ontological level" (Feilzer, 2009, p. 8).

The relationship between the researcher and research process is also a source of contention in MMR. The concept of "complete objectivity" in quantitative approaches and "complete subjectivity" in qualitative approaches is difficult to envision (Morgan, 2007, p. 71). However, pragmatism in MMR proposes that the researcher assumes an intersubjective approach,

emphasising the duality of subjective and objective positionings. As outlined by Morgan (2007) quality MMR demands that the researcher works between frames of reference, rather than purely prioritising one frame over the other, switching between general knowledge and subjective experience. Furthermore, Tashakkori and Teddlie (2003) argue that the research question should be of primary importance, more important than either the theoretical lens that underlies the method.

3.3.3 Pragmatism and Counselling Psychology

A similar 'paradigm war' has been taking place within the field of counselling psychology. The attempt to bring counselling and psychology in to a single applied psychology can cause an epistemological tension. For example, McLeod (2011) states that counselling derives meaning from describing, interpreting and understanding subjective experiences, whereas on the other hand, psychology is built on the scientific method that aims for objective understandings (Lange, 2009 cited in Hanley, Cutts, Gordon and Scott, 2013).

As pointed out by Hanley and colleagues (2013) there is a friction evident between 'objective' and 'subjective' understandings of 'truth' when fusing the tenets of counselling and psychology. Counselling psychology overcomes these tensions by subscribing to a form of practical epistemological pluralism. Pluralism's philosophical assumptions can be defined as "the doctrine that any substantial question admits a variety of plausible but mutually conflicting responses" (Rescher, 1993, p. 79). Similar to postmodernist thinkers, it has been argued that the goal of consensus causes ethical problems, rejecting difference and celebrating similarity (M. Cooper & McLeod, 2007). Thus, pluralism in counselling psychology states that "a multiplicity of different models of psychological distress and change may be 'true' and that there is no need to try and reduce these into one, unified model" (M. Cooper & McLeod, 2007, pp. 136–137). What's more, the Division of Counselling Psychology's guidelines for professional practice highlight the fundamental importance of pluralism in the profession suggesting that therapy must seek "to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing" (Division of Counselling Psychology, 2008, pp. 1–2). As stated by Kasket (2012, p. 66) "Just as there are many ways of approaching a client's difficulties, there are many avenues to exploring a research topic" which again highlights the importance of pluralism both in research and practice.

Authors have hypothesised as to why there is a lack of mixed methods research in counselling psychology: philosophical reasons (epistemological issues, objectivity-subjectivity dualism) or ontological reasons (the nature of reality), as named by Frels and Onwuegbuzie (2013). However, other authors have suggested that methodological, epistemological and even ontological stances do not need to prevent researchers from analysing both quantitative and qualitative data (Onwuegbuzie, Johnson, & Collins, 2009).

3.4 Epistemological positioning: Which methodological tools can facilitate an exploration of the outlined research questions?

As stated in the previous sections, this project will take a pluralistic epistemological stance. In doing so it is accepted that although qualitative and quantitative research have irreducibly different epistemological standpoints, interesting and insightful results can emerge if these two positions are placed in a dialogic relationship to one-another. It is this multi-faceted, epistemic dialectic that may yield a more nuanced position (or yield a complex, multi-faceted picture) to a complex problem while also producing a worthwhile and productive dialogue.

3.4.1 Epistemology for Part I – Qualitative Section

As suggested by Willig and Stainton-Rogers (2008, p. 7) the 'turn to language' (as opposed to traditional positivist underpinnings) allows researchers to analyse and deconstruct concepts that underpin psychological knowledge. Researchers are now said to be:

> "… asking questions about the social and/or psychological structures and processes which may generate the themes which are identified in participants' accounts, and they interrogate existing psychological theories in the light of qualitative data" (Willig & Stainton-Rogers, 2008, p. 8)

As Part 1 of the research aimed to explore the therapists' views of the therapeutic alliance in IAPT, it was felt that the most pragmatic yet optimum epistemological positioning for data collection would be a critical realist standpoint.

Realist research assumes that

> "there are certain processes or patterns of social and/or psychological nature that characterise and/or shape the behaviour and/or the thinking of research participants, and that these can be identified and conveyed by the researcher" (Willig, 2012, p. 67)

Added to that, critical realism acknowledges both individual constructions of experience and also how the wider social context forms those meanings (Braun & Clarke, 2006).

As IAPT is a multifaceted service with therapists from a wide range of backgrounds (Counselling Psychology, Clinical Psychology, CBT therapists, Occupational therapists etcetera) it was important to try to represent people from these backgrounds in the study. However, as the study was interested in the importance of the therapeutic alliance in IAPT, rather than on an individual basis, it was thought that focus groups and thematic analysis were the most suitable form of data collection and analysis both from an epistemological and pragmatic point of view.

When utilising thematic analysis, many epistemological considerations have to be made before the data is analysed. For example, thematic analysis can be an essentialist method or a constructionist method. What's more, themes or patterns within data can be identified in an inductive, 'bottom up' way or in a theoretical or deductive, 'top down' way (Braun & Clarke, 2006). Moreover, another decision revolves around the 'level' at which themes are to be identified: at a semantic or explicit level, or at a latent or interpretative level (Boyatzis, 1998). This project used an essentialist, inductive, semantic form of thematic analysis (Braun & Clarke, 2006). With a semantic approach, the themes are identified within the explicit or surface meanings of the data and "the analyst is not looking for anything beyond what a participant has said or what has been written" (Braun & Clarke, 2006, p. 84). Braun and Clarke's (2006) style of thematic analysis was used to analyse the data collected. For an outline of the analytic process see appendix 2.

An essentialist/realist approach enables the researcher to "theorise motivations, experience, and meaning in a straight-forward way, because a simple, largely unidirectional relationship is assumed between meaning and experience and language … [as] language reflects and enables us to articulate meaning and experience"(Braun & Clarke, 2006, p. 85). Similarly, Potter and Wetherell (1987, p. 34) suggest that discourse can be treated "as a relatively unambiguous pathway to actions, beliefs or actual events" where meanings are believed to come from within each individual. Although the semantic level usually involves identifying surface themes that are presented in the data, it is still important to progress to an interpretative phase where

the researcher attempts to theorise the significance, broader meanings and implication of the themes (Patton, 1990).

3.4.1.1 Thematic Analysis and its virtues

Willig (2008) states that qualitative research allows the researcher to tap into the perspectives and interpretations of participants facilitating the generation of new understandings. What's more, unlike quantitative analysis which may on occasion discard outliers, idiosyncrasies unveiled in qualitative research are given equal importance in gaining an understanding of a phenomenon. Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data (Braun & Clarke, 2006). It is said to offer "an accessible and theoretically flexible approach to analysing qualitative data… [and is] a useful and flexible method for qualitative research in … psychology" (Braun & Clarke, 2006, p. 77). Moreover, Boyatzis (1998) suggests that thematic analysis not only reports data but interprets various aspects of the research topic.

As thematic analysis is a flexible research tool, it is not inextricably tied to any one epistemology (Braun & Clarke, 2006). Thus, it has the potential of uncovering "rich and detailed, yet complex account of data" (Braun & Clarke, 2006, p. 78). Thus, it is important to define a specific epistemological standpoint before analysing the data in order to prevent the analysis from becoming part of the "anything goes" critique of qualitative research methods (Antaki, Billig, Edwards, & Potter, 2003). Thus, as discussed above, this project used an essentialist, inductive, semantic form of thematic analysis.

3.4.1.2 Criticisms of Thematic Analysis

One of the main criticisms of thematic analysis is that, unlike other phenomenological tools, it is more likely to miss out on more nuanced data (Guest, MacQueen, & Namey, 2011). Others have criticised thematic analysis for having "limited interpretative power" (Braun & Clarke, 2006, p. 97). Furthermore, unlike biographical approaches (e.g. narrative analysis), consistencies and contradictions from an individual account cannot be obtained, thus losing a sense of continuity (Braun & Clarke, 2006). What's more, unlike discourse or conversation analysis, thematic analysis does not allow the researcher "to make claims about language use, or the fine-grained functionality of talk" (Braun & Clarke, 2006, p. 97). These alternative methods (narrative analysis, conversation analysis) along with IPA were also considered as

methods of analysis. However, as outlined above, the study is interested in a collective representation of the importance of the TA in IAPT and thus a more descriptive and general analysis was deemed appropriate.

3.4.1.3 Issues of validity and reliability in qualitative research

Qualitative research attempts to use the data collected in its entirety. Willig (2008) suggests that validity and reliability may be compromised through the transformation of data into different mediums, for example verbatim transcriptions of audio recordings. Willig suggests that terminology to evaluate the "scientific value of quantitative research in psychology", for example reliability, validity, representativeness, generalizability, and objectivity "are not, in their current form, meaningfully applicable to qualitative research" (2008, p. 149).

Authors have included seven different considerations to insure trustworthiness in qualitative research (Elliott, Fischer, & Rennie, 1999; Henwood & Pidgeon, 1992), with many similar and overlapping concepts. These are: The importance of fit; Integration of theory; Reflexivity; Documentation; Theoretical sampling; Sensitivity to negotiated realities; Transferability. Willig (2008) points out that the assumption that the researcher and the topic of research are not independent entities. Thus 'objectivity' is not a meaningful criterion for judging qualitative research. She summarises the similarities and distils the guidelines in to the following:

> "'good practice' in qualitative research requires the systematic and clear presentation of analyses, which are demonstrably grounded in the data and which pay attention to reflexivity issues. In addition, such work is characterized by an awareness of its contextual and theoretical specificity and the limitations that this imposes upon its relevance and applicability" (Willig, 2008, p. 152)

However, other authors have argued that terms such as validity and reliability stem from quantitative research, which in turn has different epistemological underpinnings than qualitative research, and therefore question the use of these terms in a qualitative context (E. N. Williams & Morrow, 2009). The concept of "trustworthiness" in qualitative research has been put forward instead of the term 'validity' (E. N. Williams & Morrow, 2009). Three distinct guidelines have been suggested by Williams and Morrow (2009):

(i) data integrity, which entails the provision of clear guidelines to allow research replicability; (p. 576)

(ii) "balance between participant meaning and researcher interpretation", highlighting the importance of reflexivity and triangulation; (p. 576)

(iii) "clear communication and application of findings", related to clarity of report. (p. 576)

These criteria were repeatedly returned to throughout the research process in order to enhance research trustworthiness. For example, focus group participants were given the opportunity of reading over the transcripts following transcription. Furthermore, they were all asked to comment on the themes extracted from the data following analysis. To further minimise researcher bias analyses of qualitative focus groups were also verified by the research supervisor and triangulated using existing literature. All 3rd party views were taken on board and informed data analyses as per recommendations by Williams and Morrow (2009).

3.4.2 Epistemology for Part II – Quantitative questionnaires

As previously mentioned, although the TA in CBT has been shown to be a predictor of the success (i.e. outcome measures) of therapy (Castonguay et al., 1996), there seems to be a paucity of literature regarding the TA in IAPT. Thus, in order to further explore the qualitative results and to take a nomothetic rather than ideographic stance, it was essential to have a quantitative component to the study. This would also enable the research to compare results within IAPT to other quantitative TA studies that have been conducted (e.g. Castonguay et al., 1996).

Thus, a postpositivist epistemological stance will be taken for Part 2. Postpositivism suggests that an objective reality exists which researchers should seek to uncover or understand (Yardley & Marks, 2004). However, the concept of absolute truths are discredited by postpositivists as they suggest that the researcher can only lay claim to a partial "objective reality" (Ponterotto, 2005, p. 129). Other authors also comment on the impossibility of eliminating subjectivity from our knowledge of the world (Robson, 2011)

.. human intellectual mechanisms are flawed and that life's phenomena are basically intractable, and therefore, one can never fully capture a "true" reality. (Ponterotto, 2005, p. 129)

A postpositivist stance allowed the research to investigate the TA as a specific phenomenon reduced to a set of variables that could be measured objectively, in this case in the form of a questionnaire. The use of a questionnaire gave participants a concrete template from which to rate their experience allowing a sense of uniformity in conceptualising what the TA is. Given the epistemological positioning outlined, questionnaires were deemed a suitable means for data collection while not assuming that a 'true' reality can be reached.

3.4.2.1 Criticisms of quantitative methods

A postpositivistic view has been criticised by some authors as being unrealistic in real work research (Robson, 2011). For example, "objectivity" may be difficult to achieve if the researcher is inextricably linked to the research topic, when the researcher has (or develops) an emotional involvement (Robson, 2011, p. 23). Furthermore, critics of the nomothetic approach suggest that it is an overly simplistic and reductionistic standpoint and that important information is lost when trying to uncover a generalisable "truth" (Ebel, 1967). What's more, many have noted the lack of isomorphism between its measures and "reality" (see Krenz & Sax, 1986, p. 58).

Some critics have also argued that in subscribing to a purely positivistic approach "psychology has reduced the individual to the status of a passive receptacle" (Darlaston-Jones, 2007, p. 20). However, postpositivists do not subscribe to the "naïve realist view of positivism" (Robson, 2011, p. 23) and are aware that it is impossible to know things in the world directly without taking into account issues such as distinguishing language and observation, that theoretical concepts do not have an equal correspondence with observed reality, and that facts and value cannot be separated (Robson, 2011, pp. 21–23).

3.4.2.2 Issues of validity and reliability in quantitative research

Reliability is commonly defined as the extent to which repeated measurements of the same questionnaire yield consistent results (Testa & Simonson, 1996). Validity is often defined as the extent to which a measurement actually measures what it purports to measure (Testa & Simonson, 1996). As part two of the study adheres to a postpositivist viewpoint, it was necessary to scrutinise the reliability and validity of the measures used. Thus, comments on specific measures internal consistency, test-retest reliability, and validity are commented on in the method section.

3.5 Linking Part I and Part II

If, as House (1994) suggests, the choice of method is based on the purpose of the research rather than solely on epistemological politics, the combination of methods can be utilised to gain a broad and diverse range of knowledge that can be integrated it provide a richer understanding of the phenomenon under scrutiny. The aim of Part II of this study was not to achieve an objective, simple truth, but rather to gather information which could be used to explore the focus group findings.

4. Qualitative Method

4.1 Part 1 – Exploring clinicians' understanding and use of the Therapeutic Alliance in IAPT

As analyses regarding the TA in IAPT had not been conducted before, the qualitative design aimed to gain a richer understanding of the therapists' view and use of the TA in IAPT. As it was exploratory in nature, it was decided to use thematic analysis as the method of analysis for the qualitative section of this study. Largely due to pragmatic reasons (time, money, resources), it was unfeasible to conduct a more phenomenologically based analysis to accompany the quantitative section. Ideally it would have been extremely interesting to conduct semi-structured interviews with each of the therapists and clients that took part in the quantitative section and, perhaps, use IPA to explore their experience of the therapeutic alliance with the respective other. It was decided that two focus groups would be run and a thematic analysis used to analyse the resulting data. This in turn would guide the quantitative research question to be explored. The following section will discuss the design of the study, the development of the interview schedule, piloting the interview schedule, inclusion criteria, recruitment strategy, and sample size.

4.1.1 Designing Part I of the research

Once thematic analysis had been identified as an approach compatible with the aims of the research and also the epistemological positioning adopted, it was necessary to decide on the most suitable method for data collection.

Focus groups are said to be a popular and widely used method in qualitative research across the social sciences (Wilkinson, 2008). Although the method dates back some 75 years, only within the last 15 years has it has become popular in psychology as qualitative research (Wilkinson, 2008). This method continues to be used extensively today in the areas of health education and health promotion (Basch, 1987) as well as research in counselling psychology training and practice (Cross & Watts, 2002).

As highlighted by Wilkinson (2008) the researcher's role in conducting the focus groups is to act not as an interviewer, but as a moderator who facilitates group discussion and actively encouraging group members to interact with each other. Focus groups are said to be a good choice of method when the purpose of the research is to elicit people's own understandings,

opinions or views (an essentialist research question). Although it may seem counterintuitive, it has been shown that people tend to be less inhibited in revealing intimate details in the context of a group discussion (Frith, 2000). Thus, the group context may facilitate the exploration of sensitive or personal topics and support personal disclosures (Wilkinson, 2008).

Typically, the focus group discussion is audiotaped and the data is transcribed and then analysed by conventional qualitative techniques such as thematic analysis (Braun & Clarke, 2006). The informal group discussion is usually based around a series of questions (the focus group 'schedule' – see section 4.1.2, 4.1.3 and appendix 3 below).

Authors have highlighted differences between using homogeneous (where participants share key feature) and heterogeneous (where participants are different) groups, giving advantages and disadvantages (J. B. Brown, 1999; Willig, 2008). As this study was taking place within an IAPT service it was inevitable that the focus group would be a pre-existing, homogenous group. As a result managing potential conflicts, issues of confidentiality, and the domination of "extreme views" (N. Robinson, 1999, p. 909) were of extreme importance during the interview. What's more, it is common for "groupthink" (J. B. Brown, 1999, p. 115) to occur in homogenous groups. Thus, it was important to make sure that the less articulate members of the group were encouraged to share their views.

As suggested by Stewart, Shamdasani and Rook (2007) , "there is a considerable difference between not knowing very much about a particular phenomenon and not knowing what you want to learn" (p. 52). Questions serve as the agenda for the group discussion. Two general principles are said to be fundamental when developing an interview guide: i) Questions should be ordered from the more general to the more specific (from unstructured to the specific), and ii) questions should be ordered by the relative importance to the research agenda, with the most important question being covered at the start (Stewart et al., 2007, p. 61). Thus an Interview Schedule was formulated using existing guidelines (Stewart et al., 2007) and reviewed by the research supervisor (see section 4.1.2 and 4.1.3 below).

4.1.2 Developing the interview schedule

The importance of selecting appropriate questions for focus groups has been highlighted by many authors (e.g. Krueger, 1998). An interview schedule has been suggested to add focus to the group. A semi-structured schedule allows the researcher to engage with what the participant is saying, and explore any interesting related areas that arise. The questions for the interview schedule were developed as a result of my own experience of working in an IAPT setting, discussions with colleagues, discussions with Counselling Psychologists in IAPT, and from reading about the therapeutic alliance in CBT.

It was decided against asking about the core conditions of therapeutic change as outlined by Rogers (1957). Participants in the study do not necessarily come from a counselling psychology background and, although 'empathy' is a common construct used in CBT, specific person-centred concepts such as 'congruence' and 'unconditional positive regard' may not have been known by all participants, thus excluding some from the discussion. A lot of debate and deliberation was given to choosing the correct wording of the questions for the schedule. It was decided not to specifically refer to these concepts unless they arose naturally in the discussion. Furthermore, the Freudian concept of 'transference' and 'counter-transference' (1912/1958) was also not referred to in the focus group schedule for similar reasons. There were two main reasons for this decision. First, the use of these concepts and phrases might have imposed a specific vocabulary and style of thinking onto the participants. This would hinder the attempt of getting rich data generated primarily by the participants themselves. Moreover, in using this kind of language, participants may have felt that their knowledge was being assessed. This might have forced participants to search for the 'correct' answer rather than report their opinions.

The fact that this research is being conducted within an IAPT setting is one of the main contributions of this work. Therefore, it was deemed necessary to refer to the IAPT training that the participants undertook (or were undertaking). Interestingly, a recent qualitative counselling psychology thesis exploring the therapist's experience of the therapeutic relationship in CBT (Levi, 2010) found an emergent master theme of "working within a setting" running through the interviews. Thus, as all participants in this study were all employed by IAPT, it was decided to ask specifically about working within an IAPT setting.

4.1.3 Piloting the interview schedule

A preliminary draft of the interview schedule was constructed and piloted with two fellow Counselling Psychologists in training who had previous experience of working in an IAPT setting (prior to training). Feedback about the interview process and the focus group schedule was given by the two participants. Its content was neither transcribed nor analysed. A final draft of the schedule was devised with help from the research supervisor. The final draft of the schedule contained less leading or suggestive questions (Krueger, 1998), and an 'introduction' section was added to the schedule. A copy of the interview schedule can be found in appendix 3.

4.1.4 Inclusion criteria

Therapists who had completed at least 9 months of IAPT training were invited to take part in the research. As CBT is the predominant therapy in IAPT, IAPT trained therapists are required to use this modality in treatment. Non-CBT therapists are a minority in IAPT with only 14% of the national IAPT workforce consisting of non-CBT workers (IAPT, 2013b). Furthermore, only 25% of those non-CBT therapists are employed on a full time basis (IAPT, 2013b). IAPT Counsellors come from a wide variety of backgrounds and are not necessarily wedded to a particular model of psychotherapy. It was thought that counsellors' perception and use of the TA may have been different to that of IAPT trained therapists (see Hill & Knox, 2009). Thus, their focus on the therapeutic alliance on both an individual level and a theoretical level may vary a lot more when compared to IAPT trained therapists.

4.1.5 Recruitment strategy

All participants were recruited through the Barnet, Enfield and Haringey (BEH) IAPT service. After consultation with the Research and Clinical Governance Lead for Barnet, Enfield and Haringey IAPT and the primary academic supervisor, it was agreed that the researcher would attend a team meeting of each of the BEH IAPT teams to promote the study and to answer any concerns or questions that the team members may have had. All four teams in the BEH IAPT service were visited (Barnet IAPT Team, Enfield IAPT Team, Haringey East IAPT Team, Haringey West IAPT Team).

Rather than recruiting for the qualitative and quantitative sections separately, it was decided that therapists willing to participate in the quantitative section would be invited to take part in the preceding focus groups. During the meeting the researcher presented each therapist with

Figure 4 - Recruitment strategy flow chart
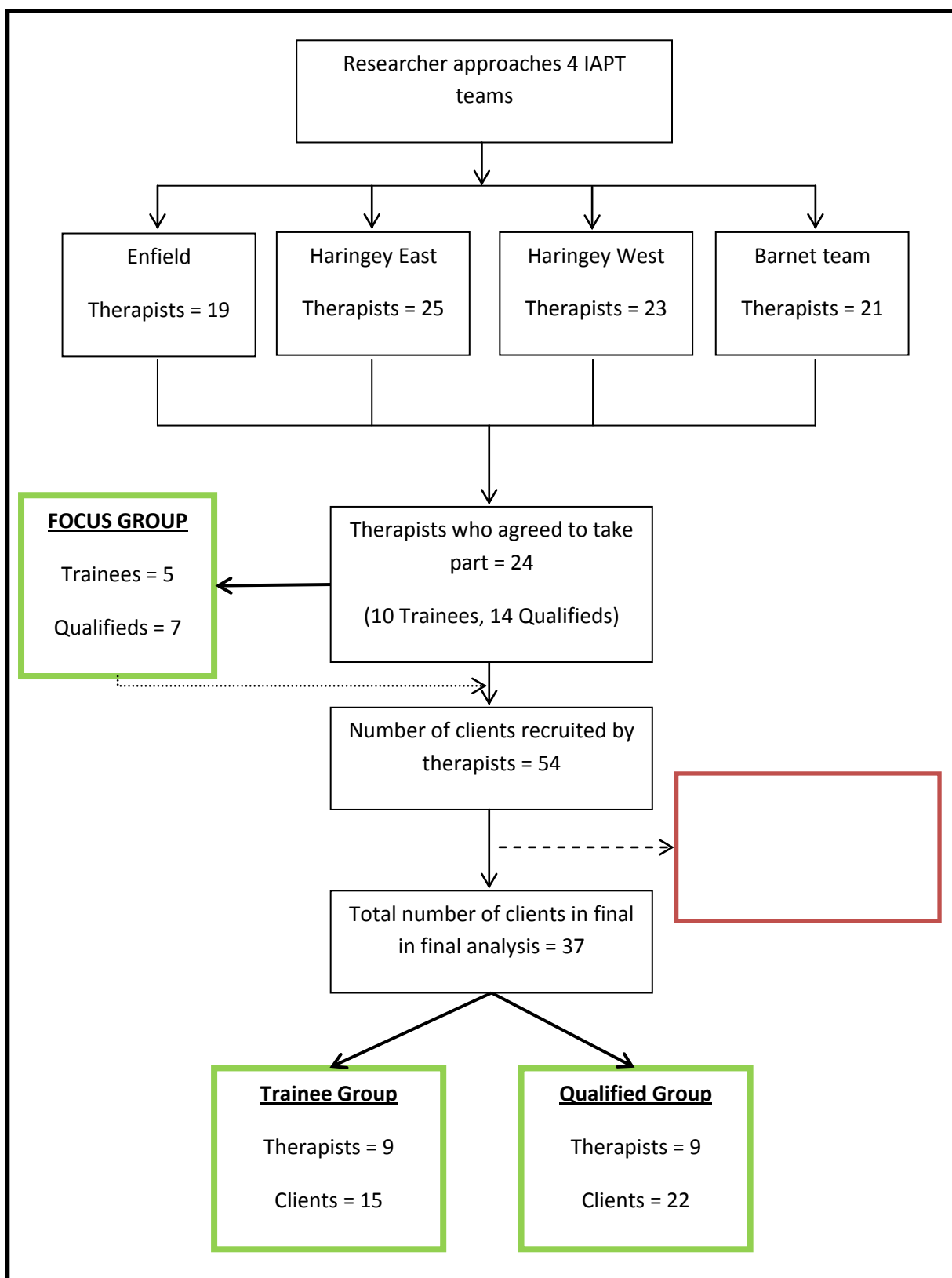
a 'project pack'. The pack had two distinct sections: a therapist section and a client section. The therapist section contained an invitation letter (see appendix 4), an information sheet (see appendix 5), and a consent form (see appendix 6). Electronic copies of the documents were also sent to the therapists. Therapists wishing to participate in the study were asked to complete the consent form and return either a hard copy or an e-copy to the researcher. Therapists were also given the quantitative TA questionnaire that would be used.

Each therapist that was willing to taking part in the study was asked to recruit as many clients as possible and was given enough hard copies to recruit 3 clients. Extra hard copies of materials were provided in each of the IAPT bases so therapists could recruit all willing clients. The client section of the 'project pack' contained an invitation letter (see appendix 7), an information sheet (see appendix 8), and a consent form (see appendix 9), and the therapeutic alliance questionnaire (client version and therapist version). Figure 4 shows an outline of the recruitment and process of the study.

4.1.6 Sample size

Opinion varies regarding the optimum size of a focus group. Some authors have recommended up to twelve participants (Stewart & Shamdasani, 1990) whereas others suggest five to ten (Morgan, 1998). Wilkinson (2008) suggests that focus groups involve between four and eight participants. Thus, to adhere to the minimum criteria recommended, it was decided that two focus groups would be run, each containing at least five participants.

The groups were split in to two distinct sets: Those who had been through the IAPT training (referred to as qualifieds hereafter) ,and those who had completed 9 months (out of 12) of the IAPT training and were still in training (referred to as trainees hereafter). Due to their stage of training, it was thought that the two groups might have differing views on the TA in IAPT. Thus, it was essential that two separate groups be constructed. Also, it was thought that keeping the junior and senior members apart could potentially promote more candid discussions about the use and the understanding of the TA in each distinct group. Moreover, as qualifieds tend to supervise trainees within IAPT, it was thought that mixing the groups could put supervisees and supervisor in the same group, something that may have caused power differences within the group. It was thought that this could have led participants to be less open and honest in the discussion.

4.1.7 Participant characteristics

4.1.7.1 Trainee focus group

In total 5 trainee therapists took part in the focus group. All participants were female. The average age of the participants was 31.8 years (range 27 to 35). The average length of time working in IAPT was 2.9 years (1 to 5 years) and had been working for an average of 3.7 years (range 1 to 6 years) as therapists. The participants had an average of 6.1 years of experience working in the field of mental health (range 5 go 9 years). The group contained one qualified Clinical Psychologist, one qualified Counselling Psychologist, two people with MSc in mental health, and one person who held a postgraduate diploma in CBT. All were currently in IAPT training.

4.1.7.2 Qualified focus group

A total of 7 (4 female) qualified therapists took part in this focus group. The age range of the participants was between 27 and 39, with an average age of 32.3 years. The participants had been working within IAPT for an average of 2. 6 years (range 2 to 3 years) and had been working for an average of 4.1 years (range 2 to 6 years) as therapists. Participants had been working in the mental health field for an average of 7.6 years (range 3 to 13 years). There were two qualified Clinical Psychologists, one qualified Counselling Psychologist, one person who held an MSc in Counselling Psychology, one qualified social worker, and two participants who held postgraduate diplomas in CBT in the group. All had completed IAPT training.

4.1.8 Process of analysis

The analysis comprised of a number of stages as suggested by Braun and Clarke, (Braun & Clarke, 2006) firstly becoming familiar with the data by reading and re-reading the overall group of responses. Statements were highlighted and additional comments were made to note the key point/s made in the data. The aim was to assist the process of identifying emerging themes. A number of initial emerging patterns were noted before the findings were then split into two groups relevant to collection times of the data in order to determine if the initial broad themes were evident across both *pre* and *post* intervention as this links to the original research question. Across the two groups, initial codes were generated to outline how and where patterns began to occur. At this stage the coding was based purely on explicit

statements (participants' actual words) within the data in order to reduce researcher influence or interpretation of any implicit meaning in the findings.

The data was worked through line-by-line to match each relevant statement to the emerging themes. After distinct themes were identified, this process began to include some more implicit meanings within the data although much of the data was explicit in its nature. A tally of theme prevalence across the data was also collated at this stage. This process was repeated several times whilst the overall categories and emerging sub-themes were considered and re-considered until there became a clear distinction. Themes without a strong prevalence or reoccurrence (classified as less than three occurrences in either group) were eliminated.

At this point the original aim of the study was considered directly alongside the identified categories to ensure the emerging themes addressed the research question. Based on the emerging themes, consideration was then given to the overarching patterns and the extent to which they acknowledged the participants' opinions of the therapeutic alliance in an IAPT setting. Final themes were decided on and clarity on what each described were noted. These themes were checked over by the research supervisor in order to reduce research any possible researcher bias, and a thorough description of the results was then written as detailed below.

4.1.9 Ethical considerations

Research ethics are defined by the BPS (2011, p. 5) as "the moral principles guiding research from its inception through to completion and publication of results." The underlying principles that inform this code of ethical psychological research practice are: respect for the autonomy and dignity of persons, scientific value, social responsibility and maximising benefit and minimising harm (British Psychological Society, 2011, p. 7). The current study was conducted in line with these principles and the associated ethical guidelines provided by the BPS (2011).

No major ethical issues were expected to arise due to participation in the focus groups. A research proposal with copies of proposed Letter of Invitation, Participant Information Sheet, and Consent Forms were submitted to City University for ethical approval. Since the study used a sequential design, both Part 1 and Part 2 of the study were submitted in the same document. Once university approval was granted an NHS Ethics Application was submitted for

approval to the NHS Westminster Research Ethics Committee (REC). Following the REC meeting a list of minor amendments and clarifications were compiled and sent to the researcher. These were completed and full approval was granted (**REC 12/LO/0634**). Further information about the ethical approval is provided in section 6.1.6 below.

5. Qualitative Results

This section looks to examine narratives of the two focus groups of IAPT professionals discussing their opinions on the TA in IAPT. The three broad super-ordinate (or level 2) themes are presented and illustrated, along with the associated subthemes that emerged from the analysis. The themes (and subthemes) are organised according to the data-driven fashion which reflects the bottom-up, inductive approach taken in the analysis. Furthermore, themes are identified within the explicit or surface meanings of the data. Patton (Patton, 1990, cited in Braun & Clarke, 2006), recommends that the analysis process should progress from description to interpretation, "where this is an attempt to theorize the significance of the patterns and their broader meanings and implications" (Braun & Clarke, 2006, p. 84).

The data presented follows the style in which the focus groups were conducted (see appendix 3 for the interview schedule), moving from the broad subject matter concerning the therapists' opinions of the important components of the TA, to the more focused and contextualised questions about the therapists' reality of working with the TA in IAPT.

The three main themes that emerged from the analysis are:

1. The impact of the IAPT trainee experience on the TA.

2. Equality in the relationship versus early IAPT protocol.

3. Severity of client symptoms and impact on TA.

An analytic narrative was constructed and extracts from the transcripts are presented to illustrate the themes. Each quote will be followed by a reference to the focus group in which the quote is taken, the participant code, and also a line number from the transcript (e.g. "I have some ideas about CBT and mental health" 2, P3, L69). As the focus groups were conducted in a particular order, the qualifieds focus group is labelled 1 and the trainee focus group is labelled 2. Thus, from the example above, 2 refers to the focus group (in this case, trainee focus group), P3 refers to participant number 3, and L69 is the 69th line in that transcript.

5.1.1 The impact of the IAPT trainee experience on the TA

During the course of the focus groups, both sets of participants were asked about their experiences of IAPT training. This super-ordinate theme contains three different but interrelated sub-themes, specifically: Therapist Background, Training Content, and Therapist Agenda in Training. Across the two focus groups, all but one of the participants mentioned IAPT training. Understandably, the trainee focus group made more references to IAPT training, with more emergent themes arising over the course of the focus group. The qualified group made reference to the content of the IAPT training, but did not refer to their previous experience of being a trainee. Thus, the two groups differed in terms of the themes that arose.

5.1.1.1 Extent of therapists' experience and the TA

The majority of participants in the focus groups made reference to the extent of previous professional training and experience and the impact this may have on the TA. The trainee group (group 2) made specific references to their stage of training and highlighted their initial thoughts about working with clients as a trainee.

> "… as a trainee, you get a case and you assess somebody and you're like: Their problems are quite bad, maybe they should be seen by a qualified." (2, P3, L127-128)

> "If Christine Padesky was with you, you would just be cured instantly on the first handshake!" (2, P3, L125)

In contrast, qualified HI therapists commented specifically on their core professional training and how this is synthesised in working with clients in IAPT.

> "I think for me I have been lucky enough, and fortunate, to be able to use my autonomy in therapy, and … to integrate my counselling psychology skills with CBT, use it in a way that feels containing for the client and for me. I think I'm fortunate in that way." (1, P1, L689-692)

Trainees seemed to fantasise that qualified IAPT therapists were more competent in working with clients, thus creating a stronger TA. Interestingly, there was only a slight difference in the

amount of experience between the two groups. Each group contained a qualified Clinical Psychologist, a qualified Counselling Psychologist, and the majority had at least a Masters level qualification relating to therapy. The trainee group as a whole seemed to question their own ability and implied that the client's complexity played a major role in their ability to help the client and establish a good TA. This issue did not emerge in the qualified focus group, which suggests that the levels of confidence differed between the two groups. Both groups were asked about the role of the TA in IAPT training. The content of training was discussed by both groups. However, the trainees also commented on their experience of being a trainee and how they linked this to the therapeutic alliance.

5.1.1.2 The TA within IAPT training

There was a mixture of opinions about the amount of time that was spent focusing on the therapeutic relationship or the therapeutic alliance in IAPT training. The general consensus was that the training spoke about the TA in CBT at the start of training and again at the end of training (usually in the form of a process report for HI trainees). However, there was little reference to the TA during the middle of training which tended to be technique focused.

> "So it's been a bit at the beginning, then lots and lots of technique, and now it's about process." (2, P1, L511-512)

> "I'm thinking of each of the disorders we have done. I don't know how much in each of those lectures that they will then focus on the therapeutic relationship ... I think in things like PTSD we probably talked about it a bit more." (2, P2, L513-516)

Moreover, some of the therapists felt that there was a difference between the CBT taught during IAPT training and the CBT that they experienced or read about elsewhere, with technique being emphasised over process in the IAPT training.

> "I think then that emphasis within IAPT, especially when they do the training, is not necessarily how we work; it is on technique and model rather than the process. The reality is that if you look at proper CBT, it does take in to account the therapeutic relationship. It works with it on a sessional basis." (1, P1, L54-57)

This subtheme was also present in the trainee focus group.

> "It [the TA] has probably been brought up but it's not a huge focus. It's all technique and intervention really, isn't it?" (2, P2, L516-517)

Again, IAPT training was seen to be more technique focused rather than process focused. It could be interpreted that the TA is neglected during large parts of the training. However, both groups acknowledged that training did sometimes focus on the TA and the TA was the focus of tasks and coursework.

> "And it's even rated on the CTS-R [Cognitive Therapy Scale Revised] so. The therapeutic relationship, it is part of the .. the Step 3 training was inclusive of that." (1, P1, L707-709)

> "In my impression it tends to be a balance. Because at the beginning we had these two [lectures], and [a talk] about ending the therapy one as well. We had [a talk] about therapist rupture. I think this covers some." (2, P4, L523-524)

When asked what other elements might help trainees to feel more confident about the TA (trainee group only), two specific requests were made. One of the trainees thought it would be a good idea that all therapists attend therapy themselves to experience what it is like to be in the role of the client. There were mixed reactions to this; some in support, and some suggesting that supervision can be sufficient to process what it is like from the client's perspective.

> "… be useful as well is having therapy yourself, as a therapist … I think would be quite useful. Definitely … And I think you learn, from going to therapy, a lot as well. I wish it was part of the training as well that we received therapy … you [would] experience how it is sitting there in that role, being the patient, being the one who needs help. I think, being on the other end, also. Because there is a power relation, isn't there? I think it is quite important to know a bit more about the power relationship." (2, P4, L525-542)

The other request was for time to be allocated for peer supervision, where trainees would be able to focus solely on the therapeutic relationship and alliance with their colleagues.

> "Maybe if there was a dedicated time to, like a peer-supervision, where you could discuss more about relationship, the therapeutic relationship, something like that. It's all about how much time we've got, it's an intensive course, so .. em .. don't know." (2, P2, L576-578)

This idea seemed to be welcomed by the other member in the group. However, the issue of a lack of time to fit extra peer-supervision session arose as trainees already felt that the training was very intense and time consuming.

5.1.1.3 The trainee "agenda" in therapy

Another area that was felt to impact the TA was the 'therapist's agenda' during training. Trainees commented that they had a list of course requirements to fulfil and made reference to this in relation to the TA.

> "It is really uncomfortable having this slightly separate agenda in the back of your mind ... I can see the CTSR [as] a list of things I have to fulfil … It slightly removes you from that interaction, and that is a really uncomfortable thing." (2, P3, L106-109)

Trainees were very mindful of the course they were undertaking and how they had a specific agenda during sessions that could potentially be in conflict with the client's agenda. One trainee spoke about the difficulty of being fully present with a client as they were somewhat preoccupied with the requirements of the course. Again, it could be interpreted that the training is more technique rather than process focused.

However, there was a sense that this distraction was a temporary phase, and that although the course was seen as being very intense, trainees were confident that they would be able to focus more on the process elements of therapy post-qualification.

> "Well it is meant to be 18 months, and they have squeezed it in to a year, so it is a lot." (2, P1, L559)

> "But that's just right now; it will finish!" (2, P3, L109-110)

> "So that's where your focus lies [CTSR], unfortunately. So hopefully once that's ... you still have to get the tasks right, but that becomes more natural and you get better at the whole process of what's happening in the session as well." (2, P1, L149-151)

Other trainees commented on how some of the course requirements were making them more aware of the TA during sessions. The final piece of coursework that HI therapists have to undertake for their final University portfolio is a process report.

"Certainly, what I'm getting out of the process report, and actually just, I'm quite, whilst it's still a piece of course work you need to do. I'm actually enjoying thinking about: Why am I doing that? Where has that come from? What does that say about me? And it has definitely made me more aware in the room with a client, how they react to me." (2, P1, L548-551)

"We did a process report as well. So I'm not complaining. So if you had a background which is inclusive of these kinds of issues in therapy, I mean they give you the opportunity to .. they give you the platform to use that knowledge." (1, P1, L709-711)

This topic came up a number of times during the trainee focus group, and the qualified focus group, and in general was referred to in a positive way.

5.1.2 Equality in the relationship versus early IAPT protocol

During the course of the focus groups participants were asked for their opinions about the most important elements of the therapeutic relationship and the therapeutic alliance. Participants were also asked to speak freely about the therapeutic relationship in IAPT. This theme emerged as participants contrasted the elements of the TA that they thought as fundamental with the IAPT service protocol that had to be followed as an IAPT therapist.

5.1.2.1 Perceived impact of protocol on TA

The triage process in IAPT arose out of the participants' opinions about the importance of equality in the therapeutic process. The groups spoke about how the triage process could potentially affect the TA. Participants gave examples of some of the questions they were obliged to ask during the triage process:

"What's your sexuality? I've just met you, but who do you sleep with?! … I really find that offensive on behalf of the patients." (1, P4, L548-551).

The participants were conscious of how intrusive the triage process was on potentially vulnerable clients. Others commented on how asking questions about sexuality, ethnicity, and marital status could be quite a "burden" (1, P6, 567) on the client.

Other participants spoke about the stage at which the demographic data collected and wondered if it might affect the initial TA formed with the client.

> "I think over the course of therapy, naturally, it's perfectly fine to pick it up [demographic information] when you have built an alliance, but I think initially screening!!" (1, P4, L586-587)

In general, there was a consensus that requesting this type of personal information before any firm therapeutic alliance was formed could have a detrimental impact on the client's relationship to the service, and subsequent therapeutic alliances they would be required to form.

Six out of the seven participants in the qualified focus group commented on the idea of power dynamics during triage.

> "… there is a real power imbalance. The client feels they are not going to get therapy unless they answer all these questions." (1, P4, 600-601)

Again, in relation to the triage process, others commented on the complex social narratives that clients could potentially be struggling with. One participant noted how difficult it might be for a client to tell a stranger over the telephone about their sexuality and ethnicity.

> "Do you know I was aware that this might be something where they feel like they are not normal or whatever, you know? So many complicated social constructs around sexuality, racial identity, religions that's a 'normal', you know, it could be a defence against all of these other questions that might make them trigger all thoughts." (1, P6, L581-584)

It was wondered whether vulnerable clients would be able to provide this information without feeling pressurised or exposed. Again, there was a consensus that addressing these complex constructs during therapy may be extremely beneficial for the client, but the timing of the collection of this sensitive information at such an early stage was questioned. A number of participants commented that the clients may feel obliged to answer personal and potentially revealing questions and may assume that the provision of therapy depending on their answering or not of the demographic questions.

Participants also spoke about other aspects of the IAPT protocol, for example having to write to the client's GP after the first session, and wondered what impact that may have on the TA.

> "Why do I have to write to the GP? So I always make a point in saying that I'll write to the GP, as little as possible, tell me if you don't want me to put something in. So that could affect the alliance." (1, P4, L611-612)

> "I mean, all those kinds of things are putting people in a place where they don't trust you when you walk in to the room." (1, P7, 615-616)

Therapists worried about the potential trust issues that writing to a client's GP may cause. This service protocol could undermine the TA built between the client and therapist and subsequently have an impact on the efficacy of therapy as a whole.

Participants compared and contrasted the idea of a non-judgemental stance and equality within the therapeutic alliance with the IAPT protocol. Although having a non-judgemental stance and being mindful of the power dynamics within therapy, therapists raised concerns about the triage process and how this process may be quite intrusive for vulnerable clients. There was an impression that therapists thought the triage process was quite pejorative, judgemental, and skewed the power dynamics. Thus, as a result of the IAPT protocols, it was felt that the early TA may be compromised in therapy. Another area arising in the focus group, and linked to the IAPT process, was the time constraint and targets employed by IAPT.

To add to the above, groups spent time discussing the reduced number of sessions they were required to offer clients at the start of therapy, despite recommendations by the NICE guidelines.

> "I think because we ask .. the whole traditional idea of the relationship and the traditional idea of assessment is that it takes about 4 sessions. It takes a while to warm up, get to know us, all this kind of thing. And yet, in IAPT, we need it right from the get go. We need all the information right from the beginning because we've only got so many session. So we are kind of implying the relationship is there when it's kind of not, at the beginning." (2, P1, L154-158)

> "What's been a problem has been the targets and the lack of time, and the length of therapeutic contracts not being long enough. So there's a sense of an artificial element to everything." (1, P1, L694-696)

Instead of following the recommended number of sessions recommended by NICE for depression and anxiety, services have asked HI therapists to offer only 6 sessions to each client entering the service, which could be extended to 12 if necessary. All of the therapists expressed feeling quite uncomfortable about this. They highlighted the strain it puts on the TA from the beginning of therapy, and also the pressure the therapist feels to quickly produce results. References were made to the forced nature of the TA as a result of this time pressure. The idea of the TA being quite "artificial" was highlighted by a number of therapists across both focus groups.

Therapists also discussed the different reactions that individual clients can have to the number of sessions offered.

> "Sometimes they'll say: 'oh my gosh, I've only got 12 sessions'; and get really freaked out by that, whereas some might say: 'alright, I've got 12 sessions, right, I really have to make the most of it'. So it really is individuals, isn't it?" (2, P2, L178-180)

> "There is a strong emphasis on .. in the first session saying: We'll have 6 sessions initially and see where we're at. And that can be really overwhelming and can kind of develop a bit of a rupture. Because they're thinking: I've got so much going on, there is no way you can do this, deal with this in 6 sessions." (2, P3, L189-192)

> ".. offering a client 6 sessions I think is so uncontaining. And for some of the clients it's fine, but for half of them I just feel it's just .. straight away rupturing the alliance in a way because how can they open up? Be vulnerable?" (1, P4, L381-383)

In some cases, the therapists said that the limited amount of sessions had a positive impact on the TA as the client had to be more open in session. On the other hand, therapists also said that the time limitations cause significant ruptures and force clients to drop out or withdraw from therapy and the TA. Therapists seemed to imply that certain clinical presentations responded positively to the concept of 6 sessions, whereas others found it uncontaining. The feeling of being uncontained could potentially demoralise or demotivate the clients.

Finally, both groups discussed how IAPT's clinical targets had altered in recent years. There was a feeling within the group that the focus of IAPT had shifted away from achieving certain

outcomes based on the MDS levels of recovery (e.g. a client's scores decreasing to below 10 on the PHQ-9, or below 8 on the GAD-7), and was now focused on achieving a certain number of contacts per service.

> "Outcome is less of an issue now. In other services I've spoken to .. other IAPT services, people on my course .. the only numbers they are interested in is … through-put and number of contacts. And you know, they are doing all sorts of things to try and make .. to increase the number of contacts. Really, kind of, dodgy things." (1, P2, L340-348)

Again, there was a sense of the TA being neglected as a result of this recent shift in focus.

However, members in each of the groups made many references to the specific IAPT teams in which they worked, and said that they felt protected from these targets.

> "I think partly we have been protected here from that kind of stuff; partly because we don't have enough clinic space." (1, P5, L355-356)

> "You're right, we have been protected, but I think as a service we are a good service here. All the clinicians are very respectful, very knowledgeable and .. they look out for the benefit and they care of the client, rather than meeting those .. ticking boxes." (1, P1, L377-379)

There was a sense that therapists felt able to focus more on the clients with whom they were working rather than focus on 'ticking boxes'. The therapists felt largely protected, but were aware of the impending pressures of the IAPT targets. Overall, therapists felt that the pressures of IAPT would have a negative impact on the strength of the TA that they would be able to offer, especially when they may have to offer clients with chronic depression or anxiety 6 sessions. These views were in contrast to the therapists' opinions on the importance of equality in the therapeutic relationship.

5.1.2.2 The perceived importance of humanistic principles in the TA

In both groups, when talking about elements that bolster the TA, therapeutic stance or a way of being was frequently referred to. Therapists in both groups mentioned Rogerian or humanistic principles such as a non-judgemental stance and empathy.

> "It is really, really important to stick to the, you know, Rogerian principles: Being open, non-judgemental, giving them the space is quite important." (2, P4, L35-37)

"… you have to focus on the relational aspects, or the emotional aspects, the humanistic aspects of the work. Empathise with them." (1, P1, L224-226)

Therapists felt that these Rogerian principles were essential in forming a therapeutic alliance with their clients. These seemed to be the fundamental building blocks on which the TA was built. Participants highlighted the non-judgemental aspect of the therapeutic process as a vital piece in establishing a therapeutic alliance.

Throughout the two groups there was a general focus on seeing the client and the therapist as equals. This took the form of collaboration and respecting one another's areas of expertise:

"I like that idea that the therapeutic relationship, or .. therapy is where two people come together with problems, and hopefully the therapist has less problems" (2, P1, 89-90)

"… this idea of collaboration, and you know: I have some ideas about CBT and mental health difficulties, but you're the expert on your problems right now; and really .. coming back to that idea, that it is a two way street." (2, P3, L69-71)

Another participant agreed with this, adding:

"I always try to be collaborative. But not collaborative it terms of: 'right, this is your pill, this is your tablet. Let's see how we can fit you in it.' Not like that. Collaborative in terms of help them make sense of the model. See if it suits their needs … But then you have to be mindful of the power issues that might be taking place." (1, P1, L218-227)

Therapists from each group were consistent in emphasising the notion of collaboration being a two way process: shared understandings, knowledge and goals. The therapeutic process was not seen as a 'doing to' but rather a 'collaborating with' the client. The idea of potential power dynamics and how they may influence the relationship were implied in some of these examples. Therapists were keen to equalise any therapist/client power dynamics and highlighted the importance of the collaborative relationship. However, the therapists' sensitivity to the power dynamics in session can be juxtaposed with their opinions on the pre-therapy power dynamics created by the IAPT process.

5.1.3 Severity of client symptoms and impact on TA

When thinking about the therapeutic alliance in IAPT, participants questioned whether there would be a connection between the clients' presentation or symptom severity and the TA. References to these constructs were made during the focus groups. It was felt that a client's previous experiences would influence the client's experience of the TA.

> "You could have someone who had a history of childhood sexual abuse: 'I'm broken, no-one understands me' and all that kind of thing that's going to massively impact, and it's not necessarily reflecting just the relationship." (2, P1, L482-484)

> "I wondered if it makes a difference in terms of the presentations you get. For example, maybe was it from someone who has real interpersonal issues, or social anxiety, or something like that, she might find you distant and things like that. But for someone who comes with panic and hasn't got that, maybe she has experience with that. So, it does depend on, maybe it might depend on the presentation as well. Distrust maybe." (2, P4, L467-471)

As outlined above, some participants felt that traumatic experiences such as sexual abuse might impact how the client relates to others, and might negatively influence the TA scores on a quantitative measure. As a result, the group called into question the differences between the therapists' experience of the TA compared to that of the clients'.

One participant mentioned how some clients may find participating in relationships difficult.

> "I saw someone this week for the first time who you can just see that relationships are difficult for him. People knowing things about him are difficult for him. Even though he's walking in to a therapy session!" (1, P7, L19-20)

In summary, therapists in both focus groups wondered if symptom severity would negatively impact the focus group. Although the therapists may feel like they were facilitating a positive TA, they wondered if the client might perceive the relationship in a different way because of their level of depression, anxiety, or past negative experiences.

5.1.4 Summary

The three super-ordinate themes discussed above were recurrent in all the focus groups. In general, the TA was commonly depicted as an important facet of therapy and the therapeutic process. The TA was viewed in a number of ways. In its simplest form it was depicted as an essential relationship between two equals, the therapist and the client. There was a general consensus that the TA was an essential part of the therapeutic process, an area vital for symptom improvement.

The three super-ordinate themes that arose posed a question about the therapeutic alliance. Firstly, a difference arose between the two groups in terms of their current stage of professional development. The trainee group wondered if their ability to form a strong TA was influenced by the necessary adherence to course demands, in particular the obligation to follow the CTSR in each session. This, they felt, prevented them from focusing as much attention as they would have liked to on the TA.

Secondly, the client's first impressions of IAPT, specifically referring to the telephone triage, was seen as quite a burden on vulnerable clients; an experience that might potentially damage the TA. Furthermore, clinicians also wondered how the initial offering of 6 sessions to clients with chronic difficulties may influence the TA.

Finally, the groups wondered if the client's perception of the TA may be affected by symptom severity or presenting issues. This, they felt, may not be in line with the therapist's perception of the TA.

In light of the themes uncovered by the qualitative analysis, the quantitative section was designed to explore some of the aforementioned subjects. These are outlined in the following section.

6. Quantitative Method

6.1 Part 2 – The impact of the Therapeutic Alliance in IAPT

As stated previously, qualitative focus groups influenced the design of the quantitative element of the project. The effect of the therapeutic alliance on outcome measures has not been explored in an IAPT setting. Thus, a quantitative measure of the TA was collected along with depression and anxiety scores, firstly to explore the TA between the trainee and qualified groups, and secondly to see if a relationship exists between the TA and the outcome measures collected.

6.1.1 Designing Part I of the research

As a result of the qualitative analysis, and previous studies using the HAq-II (Luborsky et al., 1996) which focused on the therapeutic alliance and outcomes measures (de Roten et al., 2004; Escudero, Friedlander, Varela, & Abascal, 2008; Johansson & Eklund, 2006; Kramer, de Roten, Beretta, Michel, & Despland, 2008; Lindgren, Werbart, & Philips, 2010), it was decided that the TA would be measured at the start of therapy (session 2) and again at the end of therapy. This would enable the researcher to observe changes in the TA over the course of therapy. Furthermore, this would also enable the researcher to see if TA scores at the start or the end of therapy related to scores of Depression and Anxiety during the treatment.

At the start of treatment therapists who were willing to take part in the study approached their respective client and gave them a letter of invitation to take part in the study, an information sheet outlining the study and a consent form (detailing their rights to withdraw from the study). It was also made clear that a decision not to take part would not affect their treatment. If the client was willing to take part in the study the TA questionnaire (HAq-II; Luborsky et al., 1996) was completed by the therapist and client at the end of session 2 and again at the end of treatment. Therapists and clients were instructed to place completed questionnaires in self-sealing envelopes addressed to the researcher. This would prevent both parties from seeing each other's answers. Therapists would then send all completed questionnaires to the researcher via internal post. No reward was offered for the completion of questionnaires.

6.1.2 Selecting appropriate questionnaires

It is usual practice for IAPT therapists to administer questionnaires measuring symptoms of Depression (Patient Health Questionnaire, PHQ-9) and Anxiety (General Anxiety Disorder questionnaire, GAD-7) at the start of every session to measure changes during the preceding week. A brief scale measuring the TA was administered along with the usual questionnaires at the start of treatment (week 2) and again at the end of treatment.

6.1.2.1 Helping Alliance Questionnaire II (HAq-II)

The therapeutic alliance was measured by the Revised Helping Alliance Questionnaire (HAq-II) (HAq-II; Luborsky et al., 1996). This questionnaire is a two-part questionnaire which is completed by both the therapist and the client (see appendix 10 and 11). Although other questionnaires, such as the Working Alliance Inventory (Horvath & Greenberg, 1989) and the California Psychotherapy Scales (CALPAS; Marmar & Gaston, 1988), used independent raters as well as therapist and client questionnaires, studies have shown that therapist ratings corresponded with the ratings of independent observers to a high degree (Allen, Tarnoff, & Coyne, 1985). Moreover, in terms of convergent validity, the HAq-II demonstrated high convergence with another widely used self-report measure of alliance, the CALPAS total score (Luborsky et al., 1996). Furthermore, the client's rating of the therapeutic alliance has been consistently shown as the best predictor of therapeutic outcome (Horvath, 2005). Thus, this two part therapist and client questionnaire was selected over more laborious scales with an independent rater element.

6.1.2.2 Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 (see appendix 12) is a widely used scale that rates the severity of low/depressed mood. The PHQ-9 scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day). As a severity measure, the PHQ-9 score can range from 0 to 27. This scale is used to monitor change in symptoms over time and cut-off of 10 or above is recommended for distinguishing between clinical and non-clinical populations (D. M. Clark et al., 2009). Internal reliability of the PHQ-9 is excellent, with a Cronbach's α of 0.89 (Kroenke et al., 2001). The PHQ-9 has been used in previous studies exploring the correlation between depression and the therapeutic alliance (Ilgen et al., 2009) and therapeutic relationship styles (Ciechanowski et al., 2006).

6.1.2.3 Generalised Anxiety Disorder-7 (GAD-7)

The GAD-7 (see appendix 13) is a self-reported questionnaire for screening and severity measuring of generalized anxiety disorder (Spitzer et al., 2006). This Likert-style scale has seven items, which measure severity of various signs of generalized anxiety. Severity is indicated by the total score, which is made up by adding together the scores for the scale all seven items. Like the PHQ-9, this scale is used to monitor change in symptoms over time and cut-off of 8 or above is recommended for distinguishing between clinical and non-clinical populations (D. M. Clark et al., 2009). Although the GAD-7 scale was originally developed to screen for generalised anxiety disorder, it also has satisfactory (albeit lower) sensitivity and specificity for detecting other anxiety disorders (Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007). The internal consistency of the GAD-7 has shown to be strong, with a Cronbach's α of 0.92 (Spitzer et al., 2006).This scale has been validated in the general population (Lowe et al., 2008) and has been used in previous studies assessing outcome measures of CBT in an IAPT setting with adult populations (D. M. Clark et al., 2009).

6.1.2.4 Data screening

As the PHQ-9 and GAD-7 were taken from the IAPT database, a full set of data was received. For the HAq-II questionnaires that were returned, the dataset was screened to check for data entry inaccuracies and missing values. None of the TA questionnaires returned had more than 1 question unanswered (i.e. all had at least 94.7% of the answers completed). For any questionnaire that was missing one value, the average for the remaining questions were calculated and input in place of the missing value (Field, 2009).

6.1.3 Inclusion criteria

6.1.3.1 Therapists

As stated above, therapists who had completed at least 9 months of IAPT training were invited to take part in the research.

6.1.3.2 Clients

All therapists willing to take part in the study were asked to recruit as many of their clients as possible. Two exclusion criteria were applied: 1) If the client needed an interpreter during

treatment; 2) If the therapist thought the TA questionnaire would disrupt the therapeutic process for the client. These two ethical considerations are discussed in section 6.1.6 below.

6.1.4 Recruitment strategy

As stated above, all four BEH IAPT teams were visited by the researcher. Each therapist that was willing to taking part in the study was asked to recruit as many clients as possible and was given enough hard copies of the 'project pack' (as discussed above) to recruit 3 clients. Electronic versions of all the documents were also sent to the therapists.

6.1.5 Sample characteristics

6.1.5.1 Sample size

In order to estimate the sample size for section 2, a power analysis was conducted using GPower software (Faul & Erdfelder, 1992). This analysis suggested that in order to detect a large to medium effect size, a cohort of around 38 clients would be needed. It was estimated that such group size would provide a 95.3% chance of detecting a large effect size.

6.1.5.2 Participants

Having approached 108 eligible therapists, a total of 24 therapists agreed to take part in the study. Each therapist was asked to invite as many clients as possible. This resulted in 54 clients entering the study. Out of these 54 clients, 37 clients completed all questionnaires at time 1 (second session) and the end of treatment, and were therefore included, along with their therapists (n = 18), in the final analysis.

6.1.5.2.1 Therapists

A total of 18 therapists were included in the final analysis. A large proportion of the sample was female (n=15; 83.3%). The age of therapists in this sample ranged from 27 years to 39 years. The mean age of participants was 31.72 years (SD=3.16). The educational background of the sample varied, with the majority of respondents holding either a D.Psych (or equivalent) (33%) or a masters (33%) level qualification, and the remainder holding a Postgraduate diploma (33%) in a psychological therapies based subject. 50% per cent had completed IAPT

training and 50% per cent were trainees. On average, the participants had been working as therapists for 4.56 years (*SD*=1.68), and 6.81 years (*SD*=1.97) in the field of mental health. The mean length of time working in IAPT was just over 3 years (*M*=3.22, *SD*=1.37). The trainee group and the qualified group are compared in the results section (section 7.1.3).

6.1.5.2.2 Clients

Clients included in the study (n=37)

A large proportion of the sample was female (73%). The age of clients in this sample ranged broadly from 21 years to 67 years. The mean age of participants was 39.89 years (*SD* = 13.66). Just over half of the sample reported their ethnicity as White British (64.9%). Around 10% reported their ethnicity as Asian, 8% as White European, 5% as White Other, 5% as Black Caribbean and 5% Black African. Just over half of the sample were single (54%), 29% married or in a civil partnership and the remaining 16% separated or divorced.67.5per cent reported themselves as being employed on a full-time or part-time basis. Around one fifth of the sample were either unemployed or on benefits. The remainder of the sample were retired (5.4%) or students (5.4%).

Clients who were excluded from the study (n=17)

Of the 17 clients who were not included in the final analysis, 4 client/therapist pairs gave end of treatment data only (i.e. no TA score taken after session 2), 5 clients dropped out of treatment completely and did not return to the service, 5 clients dropped out of the study (but completed treatment), 1 client was referred to another service, 1 client had to pause treatment due to personal circumstances, 2 clients had their treatment paused as their therapist was on extended sick leave.

Table 1 - Descriptive statistics - Comparing those included in the final analysis to those who were not included - Baseline Depression, Anxiety, Client TA scores, Therapist TA scores, and Client Age

		N	Mean	Std. Deviation	Std. Error Mean
Baseline Depression	Included in final analysis	37	13.08	6.751	1.110
	Not included in final analysis	17	13.82	6.473	1.570
Baseline Anxiety	Included in final analysis	37	11.62	5.823	.957
	Not included in final analysis	17	13.29	5.193	1.260
Baseline Client TA scores	Included in final analysis	37	99.73	9.851	1.619
	Not included in final analysis	10	95.30	12.111	3.830
Baseline Therapist TA scores	Included in final analysis	37	88.11	6.814	1.120
	Not included in final analysis	13	85.31	6.550	1.817
Age	Included in final analysis	37	39.89	13.664	2.246
	Not included in final analysis	17	33.76	11.734	2.846

Note: Depression scale ranges from 0 to 29 (with higher scores indicating higher levels of depression); Anxiety scale ranges from 0 to 21 (with higher scores indicating higher levels of anxiety); TA scale ranges from 19 to 114 (with higher scores indication a stronger TA)

There was no significant difference between the clients who returned a full data set and those who did not in terms of baseline depression ($t(52)=-.380$, $p=0.70$), anxiety ($t(52)=-1.01$, $p=0.32$), and age($t(52)=1.60$, $p=0.12$). Furthermore, no significant difference was found for baseline client TA scores ($t(45)=1.20$, $p=0.24$) and baseline therapist TA scores ($t(48)=1.29$, $p=0.20$). See table 1 for descriptive statistics for the two groups (included vs not included).

6.1.5.4 The IAPT context

To contextualise the analysis, it is important to give a brief background to some of the 'IAPT protocol' referred to in the analysis section. The protocols that are mentioned are not necessarily unique to IAPT, but, when put together, may differentiate IAPT from other NHS mental health services, giving IAPT a certain feel or flavour.

Triage: Each client entering the Barnet, Enfield and Haringey IAPT service must go through a triage (i.e. telephone screening/assessment) process, which generally takes 15 to 30 minutes. Both qualifieds and trainees must complete a certain number of these telephone screenings each week. This is generally the first point of verbal contact a client will have with the service. Clients are asked about their current problems, complete the 'Minimum Data Set' (MDS) questionnaires, and are then allocated to the Step 2 waiting list, Step 3 CBT waiting list, Step 3 counselling waiting list, or, if deemed unsuitable for the service, clients are "Stepped Up" to another service (e.g. psychosis, personality disorders, sever risk issues etc.).

Measurement: Unlike other services, the MDS is completed after each and every therapeutic contact with the client. The MDS consists of brief measures of depression, anxiety, social adjustment, and phobia scales. Information about the client's employment status, benefits status (i.e. Jobseekers allowance, statutory Sick Pay etc.), and prescribed medication is also recorded. The data is collected after every session to ensure that pre- and post- measures of treatment are always collected for audit, evidence, and commissioning purposes. In this case, participants referred to the MDS that was completed as part of the triage process.

Correspondence with other professionals: In general, GPs are copied in to all correspondence that IAPT has with the client. Furthermore, other professionals that may be involved with caring for the client (e.g. social services etc.) may also be included in the correspondence. An end of therapy report is generally sent to all parties involved.

6.1.6 Ethical considerations and Methodological reflexivity

As per University protocol a research proposal was compiled, together with all appendices (appendix 3-13 below), and submitted to City University for approval. Furthermore, since the therapists would work for the National Health Service (NHS) and clients would be seen in an

NHS setting, NHS ethical approval was also obtained from the National Research Ethics Service (NRES) Committee London – Westminster (**REC 12/LO/0634**). Two ethical considerations were highlighted by the NRES committee: 1) the exclusion of non-English speakers, and 2) disruption to the therapeutic process due to the TA questionnaire. A verbal presentation of the ethical rationale behind these two concepts were presented to the NRES committee and subsequently accepted. These issues are briefly discussed below.

No harm was expected as a consequence of completing the questionnaire. All participants were provided with the Participant Information Sheet (appendix 8) outlining the nature of the research and were given the option to remain anonymous. Consent forms were also used detailing the participants' right to withdraw (appendix 9).

As BEH IAPT is spread over two trusts (BEH and Whittington Health), it was necessary for the researcher to apply for two separate Research and Development (R&D) clearances following NHS clearance. Clearance was given by BEH Mental Health Trust (R&D Ref: **12MHS43**) and by the Whittington Health Trust (R&D Ref: **2012/25**).

6.1.6.1 The exclusion of non-English speakers

A number of ethical considerations arose when deciding whether to include or exclude service users who require interpreters. The BPS guidelines on working with interpreters (British Psychological Society, 2008) highlight the importance of being aware of how power differentials (which may have originated in the country of origin, or through political and social conflict) may affect the relationship between the therapist, interpreter and client. Similarly, interpreters have been seen as an addition to, or enhancement of, the therapeutic encounter. Studies have suggested that interpreters may add to the therapeutic encounter at a micro (direct translations) and macro (therapist learning about cultural specific idioms of distress, world views etc.) level (British Psychological Society, 2008; Tribe & Thompson, 2009). Importantly, for this study, the vast majority of reports and papers have acknowledged that the addition of an interpreter affects the therapeutic encounter, be that in a positive or negative way: "Working with an interpreter as a conduit also makes you dependent on another person, and this can change the dynamic of the meeting" (British Psychological Society, 2008, p. 9). Moreover, many theorists have argued that it is through language that individuals construct reality. Thus, language not only transmits meaning, but can also alter

'meaning' and 'knowledge' at a cultural, societal and individual level (see, for example, social constructionism, Burr, 1995).

It was decided that non-English speakers would be excluded from the study as the aim of the project was to explore the 'traditional' therapeutic dyad, and not a more complex three-way therapeutic relationship. A separate study would be necessary to facilitate the exploration of triadic therapeutic encounters.

6.1.6.2 Disruption of the therapeutic process due to the HAq-II

Although the use of questionnaires is a common occurrence in IAPT the researcher thought it necessary to leave it to the therapists' judgement not to offer a client the questionnaire if they thought that the client was not in a 'good place'. No clients were to be asked if they were actively suicidal. This message was relayed to all therapists. However, this may have created a selection bias as non-suicidal clients were only selected. The researcher was aware that some client may have felt overwhelmed by having to complete too many questionnaires. Thus, all therapists agreed to emphasise that this was a voluntary exercise when they were handing out information to their clients. This information was also included in the clients' participant information sheets (see appendix 8). Furthermore, both therapists and client were aware that they could withdraw from the study at any time and that this would not affect their treatment.

6.1.6.3 Methodological reflexivity

As this section is a reflective piece, it will be written in the first person.

Undertaking a mixed methods research was a challenge for me. Not only was I attempting to integrate qualitative and quantitative data in to one study, I was also trying to conduct the research in a place when I had been a trainee for a number of years. As a researcher it is essential that I am aware of the impact the research may have on my practice. For example, I may feel more of a pressure to develop a solid therapeutic relationship in the early stages of therapy. This could lead to me neglecting more structured, manualised aspects of CBT. Thus, it will be important to keep a reflexive journal during this period to reflect on the continuous work and research and how they may impact on each other. With regards to the qualitative research, thematic analysis involves a number of choices which need explicitly to be considered and discussed (e.g. inductive analysis v theoretical analysis). Braun and Clarke

suggest that these questions should be considered before analysis (and sometimes even collection) of the data begins. They also suggest that "there needs to be an ongoing reflexive dialogue on the part of the researcher or researchers with regards to these issues, throughout the analytic process" (2006, p. 82). Inductive analysis is classified as a data-driven process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions. However, as with other forms of qualitative analysis, "the researchers cannot free themselves of their theoretical and epistemological commitments, and data are not coded in an epistemological vacuum"(Braun & Clarke, 2006, p. 84). This again emphasises the importance of a reflexive component to be conducted during the collection and analysis phases. I found the reflexive journal to be a great help while designing the interview schedule. It allowed me to reflect on the questions that I wanted to ask each of the groups. These reflections were extremely useful when I met with my supervisor and colleagues following the pilot phase. It enabled me to create more neutral questions so that the data would emerge more naturally. Likewise, bringing my reflections to supervision also helped during the analysis phase of the project. Such reflections throughout the research process helped me to negotiate my identity as a counselling psychologist embarking on a mixed methods research study and I perhaps have as Rawson (2006) advocates, added my "own unique contribution to the development of research methodology" (p.250).

7. Quantitative Results

7.1.1 Quantitative Questions

The qualitative analysis posed some interesting questions that could be explored from a quantitative perspective. In total, three focus group generated questions were explored through the quantitative data. A fourth question was derived from the literature review that was conducted for this project.

Question 1:

The first theme uncovered (the impact of the IAPT trainee experience on the TA) was explored by comparing the TA in the trainee group with the TA in the qualified group. It was hypothesised that there would be a significant difference between the TA in the two groups, with the trainee group achieving a lower TA than the qualified group.

Question 2:

The second qualitative theme suggested that the IAPT protocols, in particular the telephone triage and number of sessions offered, may result in a weak early alliance. This could be explored by looking at early TA levels of TA and comparing them to other studies using the same TA measure. Furthermore, the TA tends to improve over time as a result of therapy, a very large significant difference between early and late TA may be suggestive of a weak early TA. Also, weak early TA scores may be indicative of both the TA between the client and therapist, but also between the client and their experience of the service up to that point. The author acknowledges that this is very exploratory and hypothetical in nature. This is discussed further in the Discussion chapter (see 8.2). Results for question 4 (see below – regression analysis) may also shed some light as to whether early TA scores or late TA scores are more useful for predicting outcome.

Question 3:

The third theme covered suggested that therapists thought that symptom severity may play a role in the TA. This was explored by the quantitative data by seeing if there was an association between a client's initial depression and anxiety scores, and the subsequent TA that was developed.

Question 4:

As a result of the literature review that was conducted, the researcher decided to explore a fourth and final question. Generally, studies involving the TA focused on whether the client's or therapist's ratings of the TA would act as predictors of outcome. The qualitative analysis seemed to suggest that the therapists felt that their perception would be a more accurate reflection of the therapeutic alliance and thus would be a better predictor of outcome. However, this differs from the wider literature. Thus, a regression analysis (using depression and anxiety as outcome measures) was used to explore this question.

In summary, the following questions were explored:

1) Would TA scores in the qualified group be stronger than TA scores in the trainee group?

2) Given the nature of the early IAPT processes, would it be possible to establish a strong early TA? Also, would early TA scores show a strong significant difference from end of therapy scores?

3) Would there be an association between clients' initial symptom severity and subsequent TA?

4) Would therapist TA scores be a stronger predictor of outcome measures when compared to client TA scores?

7.1.2 Layout of quantitative results

Firstly, as the dataset comprises of participants from the trainee group and qualified group, analyses of the differences between the two groups are reported (section 7.1.3). Then, each question (question 1, 2, 3, and 4 above) is presented in a separate section of its own (section 7.1.4, 7.1.5, 7.1.6, and 7.1.7 respectively). In each section the parametric assumptions for the data are explored before the results are presented.

7.1.3 Those included in the study - Comparing the two groups – Trainees vs. Qualified IAPT therapists

Before any analyses were conducted, it was important to ascertain if there were any differences between the two groups: trainees and qualifieds.

7.1.3.1 Therapists (n=18)

To check if there were differences between the therapists in the two groups, independent sample t-tests were used. The groups did not differ on number of years working as a therapist $t(16) = -1.13$, p = .27, number of years working in the field of mental health, $t(16) = -1.15$, p = .27, age, $t(16) = -.22$, p = .83, or number of years working in IAPT, $t(16) = -1.03$, p = .32. See table 2 for means and standard deviations for both groups.

Table 2 - Independent samples t-test - comparing therapist experience between groups (Trainees and Qualifieds)

	Trainees (n=9)		Qualifieds (n=9)		
	M	SD	M	SD	*t-test*
Years working as a therapist	4.11	1.24	5	2	*ns*
Years working in field of mental health	6.28	1.52	7.33	2.29	*ns*
Years working in IAPT	2.89	1.65	3.56	1.01	*ns*
Age of therapists	31.56	2.56	31.89	3.82	*ns*

Note: M=Mean, SD=Standard Deviation

Furthermore, both groups had identical levels of qualifications. In each group 3 therapists held a Doctorate in Counselling Psychology (or equivalent), one therapist had a Doctorate in Clinical Psychology, two therapists had an MSc in Counselling Psychology, and the remainder had a postgraduate diploma in CBT.

7.1.3.2 Clients

It was important to find out if baseline measures of depression and anxiety differed between the two groups. An independent t-test was conducted to ascertain if differences were present. No between group differences were found for baseline depression (t(35)=0.283, p=0.779), baseline anxiety (t(35)=0.265, p=0.792), or age (t(35)=-1.984, p=0.06). However, although age of participants was approaching significance, this has not been a factor in previous studies of TA and outcome so it was not a cause for concern. See table 3 for a summary of these results.

Table 3 - Independent samples t-test - comparing baseline levels of depression and anxiety between, and age between the two groups (Trainees vs Qualifieds)

	Trainees (n=15)		Qualifieds (n=22)		
	M	SD	M	SD	*t-test*
Baseline Depression scores	13.47	5.70	12.82	7.50	*ns*
Baseline Anxiety scores	11.93	5.05	11.41	6.40	*ns*
Age	34.67	13.32	43.41	13.04	*ns*

Note: M=Mean, SD=Standard Deviation; Depression scale ranges from 0 to 29; Anxiety scale ranges from 0 to 21

7.1.4 Question 1 – Is there a difference in TA scores between the Trainee and Qualified groups at session two and end of treatment?

The first question aimed to explore if there was a significant difference between the TA in the two groups, the trainee group and the qualified group. It was hypothesised that the trainee group would achieve a lower TA than the qualified group. To test for normality, a Kolmogorov-Smirnov (K-S) test and a Shapiro-Wilk (S-W) test were performed on the data (see Table 4).

Table 4 - The Komogorov-Smirnov (K-S) and Shapiro-Wilk (S-W) tests for Normality for Time 1 and Time 2 Client and Therapist TA

	Trainee Group			Qualified Group		
Client Time 1 TA scores	Statistic	df	Sig.	Statistic	df	Sig.
K-S	.18	15	.20	.14	22	.20
S-W	.91	15	.19	.89	22	.02*
Therapist Time 1 TA scores						
K-S	.13	15	.20	.14	22	.20
S-W	.93	15	.28	.96	22	.38
Client Time 2 TA scores						
K-S	.15	15	.20	.16	22	.18
S-W	.91	15	.12	.88	22	.01*
Therapist Time 2 TA scores						
K-S	.18	15	.20	.13	22	.20
S-W	.87	15	.04*	.96	22	.55

*p<0.05

The S-W test for Client Time 1 TA and Client Time 2 in the qualified group appears not to be normally distributed. Furthermore, Therapist Time 2 in the trainee group also appears not to be normally distributed. Thus, this finding suggests that the sampling distribution might have also been non-normal and therefore a non-parametric was used (Mann Whitney test).

Time 1 client TA scores in the trainee group (*Mdn*=101) did not differ significantly from time 1 client TA scores in the qualified group (*Mdn*=103), U=130, *z*=-1.09, *ns*, r=-0.18. Also, there was

no significant difference between time 1 therapist TA scores in the trainee group (*Mdn*=89) when compared to the qualified group (*Mdn*=90), U=158, *z*=-0.22, *ns*, r=-0.04.

At time 2 the two groups, trainee (*Mdn*=108) and qualified (*Mdn*=104.5) did not differ significantly in terms of client TA scores, U=142, *z*=-0.72, *ns*, r=-0.12. Similarly, there was no significant difference between time 2 therapist TA scores in the trainee group (*Mdn*=97) when compared to the qualified group (*Mdn*=94.5), U=129, *z*=-1.10, *ns*, r=-0.18.

Overall, there was no significant difference between the trainee group and the qualified group in all 4 measures of the TA (time 1 client and therapist scores, and time 2 client and therapist scores). This indicates that an equally strong TA was established in both groups. As the clients in each group were equally matched in levels of depression, anxiety, and age, it suggests that the trainee therapists achieved as good an alliance as the qualified therapists. Thus, adherence to the "therapist agenda" may not impact on the TA.

7.1.5 Question 2– Was a strong early TA present in both groups? Was there a significant difference between early and late TA between the two groups?

The second question was explored by seeing if there was a large significant difference between time 1 and time 2 TA scores for both the therapist and the client. As the K-S and S-W tests (above) showed that part of the data was not normally distributed, a non-parametric test (Wilcoxon signed-rank test) was chosen.

For the trainee group, client Time 2 TA scores (*Mdn*=108) were significantly higher than client Time 1 scores (*Mdn*=101), *z*=-3.30, p=0.001, r=-0.60. Also, therapist Time 2 TA scores (*Mdn*=97) were significantly higher than Time 1 scores (*Mdn*=89), *z*=-3.16, p=0.02, r=-0.58. Both results showed a large effect size (r=-0.61 and r=-0.58 respectively) (see Field, 2009, p.550 for effect size equation).

For the qualified group, client Time 2 TA scores (*Mdn*=104.5) were not significantly higher than client Time 1 scores (*Mdn*=103), *z*=-1.64, p=0.10, r=-0.25. Therapist Time 2 TA scores (*Mdn*=94.5) were significantly higher than therapist Time 1 TA scores (*Mdn*=90), *z*=-2.84, p=0.005, r=-0.43, with a medium to large effect size (Field, 2009, p.550).

In summary, the trainee group showed a significant improvement in TA scores for both therapists and clients. The qualified group only showed a significant improvement in therapist TA scores only. Interestingly, the clients TA in the qualified group did not change significantly between the start of treatment and the end of treatment. It may be worth noting that the median time 1 client TA scores in the qualified group was slightly higher than the median time 1 client TA scores in the trainee group (*Mdn*=103 vs *Mdn*=101). It may be that the qualified therapists established a stronger initial TA with client and therefore the TA scores do not change as much as trainee group. Also, the differences may be due to the small number of participants in the study.

In response to the initial question asked, the initial client TA scores in both the trainee and qualified groups were high when compared to other studies using this measure of TA (HAq-II) (e.g. Escudero et al., 2008; Johansson & Eklund, 2006; Lindgren et al., 2010). This would suggest that it is possible to achieve a strong TA in an IAPT setting and that early alliance may not be affected by early IAPT protocol.

7.1.6 Question 3 – Does symptom severity relate to therapist and client TA scores?

The final focus group question to be explored was to see if there was a significant relationship between pre-therapy levels of Depression and Anxiety. Two correlation analyses were conducted, one for each group (trainees and qualifieds). No significant correlations were found between pre-therapy Depression and Anxiety scores, and subsequent TA scores. See table 5 and 6 for results.

Table 5 - Correlation between pre-therapy Depression and Anxiety and subsequent TA scores - Trainee Group

Trainee Group (n=15)	Client TA Time 1	Client TA Time 2	Therapist TA Time 1	Therapist TA Time 2
Pre-therapy Depression scores	.43	-.04	-.17	-.37
Pre-therapy Anxiety scores	.19	.01	-.06	-.20

Note: No significant results

Table 6- Correlation between pre-therapy Depression and Anxiety and subsequent TA scores - Qualified Group

Qualified Group (n=22)	Client TA Time 1	Client TA Time 2	Therapist TA Time 1	Therapist TA Time 2
Pre-therapy Depression scores	-.33	-.25	.14	.04
Pre-therapy Anxiety scores	-.21	-.21	.25	.12

Note: No significant results

7.1.7 Question 4 – Does the TA (therapist versus client perception) predict outcome in depression and anxiety?

The fourth and final question was explored by using a multiple regression to see which perspective (therapist or client) would be a better predictor of outcome. This question was interested in whether client and therapist TA scores (Independent Variables; IV) would predict a change in depression and anxiety. Thus, the Dependent Variables (DV) in this section are the changes in clinical outcome measures (depression and anxiety) between session 1 and the end of treatment. It was decided to use the 'change' scores instead of the end of therapy scores as a change score would indicate the level of improvement rather than just using an end of therapy score. For example, 'client A' could start treatment scoring a maximum score on the depression scale (27) and end therapy with a score of 17, and 'client B' could start therapy with a score of 18 and drop one point to 17. If end of therapy measures were used, these two clients would be ranked the same, whereas by using 'change scores' the improvement can be noted (e.g. -10 for 'client A' and -1 for 'client B'). The Independent Variables (IV) are TA scores. The means and standard deviations for each DV are presented in table 7.

As there were no significant differences reported between the two groups in terms of TA scores or baseline depression and anxiety scores, it was decided to merge the two groups. Also, the higher number of participants would also decrease the probability of getting type I

and type II errors (Field, 2009). Furthermore, authors recommend approximately 10 participants per IV (Field, 2009; Miles & Shevlin, 2001). As we are testing 4 IVs in this study the whole group (n=37) would be a more accurate fit.

Firstly, tests of normality are explored. Then, in order to ascertain if similarities exist between the IVs and end of treatment depression/anxiety scores, IVs, DVs, and DVs and IVs, correlations between these measures are presented. Finally, to see if any of the IVs in this study (TA scores at Time 1 and Time 2) predict changes in depression and anxiety, two separate backward multiple linear regressions were carried out for the two outcome measures (Change in Depression and Change in Anxiety).

Table 7 - Descriptive statistics for change in Depression and Anxiety between session 1 and end of treatment

	Change in Depression	Change in Anxiety
N=37		
Mean	-6.54	-6.11
Std. Error of Mean	1.05	0.99
Median	-6.00	-5.00
Std. Deviation	6.39	6.01

7.1.7.1 Tests of normality and homogeneity of variance for multiple linear regression

To test for normality, a visual check of the histograms and Q-Q plot data for each of the dependent variables was conducted. The frequency distributions for all of the DVs appeared normal. To confirm this finding, tests of normality were carried out to confirm normality of distribution in both of the DV. The Kolmogorov-Smirnov (K-S) test and the Shapiro-Wilk (S-W) test were performed on the dependent variables (see Table 8).

Table 8 -The Komogorov-Smirnov (K-S) and Shapiro-Wilk (S-W) tests for Normality for the Dependent Variables (Depression and Anxiety)

Change in depression	Statistic	df	Sig.
K-S	.09	37	.20
S-W	.97	37	.42
Change in Anxiety			
K-S	.14	37	.09
S-W	.94	37	.06

The K-S is the standard goodness of fit test and the S-W is generally used for samples less than 50. Both K-S and S-W tests show that the dependent variables are normally distributed for both groups.

7.1.7.2 Bivariate correlations between Dependent variables, Independent variable, and between Dependent and Independent variables

7.1.7.2.1 Correlations between the IVs

The correlations amongst the four measures of the TA (client TA time 1 (cTA1); client TA at end of treatment (cTA2); therapist TA time 1 (tTA1); therapist TA end of treatment (tTA2)) were examined. These are presented in Table 9.

A large positive correlation was found between cTA1 scores and cTA2, $r = .72$, $p = 0.002$, suggesting that high scores at the start of treatment indicated high scores at the end of treatment. According to Field (2009, p. 234), correlations between the IVs in this model are below .9 which suggest that multicollinearity is not a pressing cause for concern. This may be an issue if these two scores (cTA1 and cTA2) are left in the final model in the regression analysis. A moderate positive correlation was also found between therapist TA scores at time 1 and therapist TA scores at end of treatment, $r = .59$, $p = .02$. All other correlations are non-significant, ranging between .001 (cTA1 and tTA1) and .28 (cTA2 and tTA2).

Table 9 - IV Intercorrelations – Client and therapist TA scores at session 2 and end of treatment

N=37	1	2	3	4
1. Client TA Time 1	-			
2. Client TA Time 2	.72**	-		
3. Therapist TA Time 1	.001	.11	-	
4. Therapist TA Time 2	.10	.28	.59*	-

** p < 0.01, * p < 0.05

7.1.7.2.2 Correlations between DVs

A strong positive correlation was found between two of the DVs in this study, namely change in depression and change in anxiety, r = .88, p < .0001. This indicates that greater changes in depression scores were associated with greater changes in anxiety scores. See table 10.

Table 10 - Correlation between DVs (Change in Depression and Change in Anxiety) for Trainee group and Qualified group

	Change in anxiety
Change in Depression	.88**

** p < 0.01, * p < 0.05

7.1.7.2.3 Correlations between DVs and their respective time 1 measures

To see if any relationship existed between initial levels of depression and anxiety, and subsequent change in each of those scores, each time 1 score was matched with their respective change scores (i.e. depression time 1 was paired with its DV, change in depression scores). Both DVs were found to have a significant moderate negative correlate with their respective time 1 values. See table 11. Given that a high score on depression or anxiety has the potential to substantially reduce when compared to lower starting scores, this correlation

was expected. As a result, it was decided that time 1 scores should be entered along with the IVs in the linear regression model to control for the potential variance in scores.

Table 11 - Correlation between DV and respective Time 1 measure for Trainee group and Qualified group

Trainee Group

	Depression Session 1
Change in depression	-.60**

	Anxiety at Session 1
Change in Anxiety	-.54**

** p < 0.01, * p < 0.05

7.1.7.2.4 Correlations between DVs and IVs

No significant correlations were found between change in depression score and the predictor variables, nor were any correlations found between change and anxiety scores and the predictors (apart from DV and respective Time 1 score, as discussed above).

7.1.7.3 Backward Multiple Linear Regression

As there were a number of potential predictor variables (IVs) from which to predict the outcome, and as some of the predictors were correlated with one another, a backward multiple linear regression was used to find the predictors that had most influence on the clinical outcome measures. The backward regression technique enters all of the predictor variables into the analysis in a single step, and then removes them one at a time based on pre-selected removal criteria. This study chose the selection criteria inclusion $p < .05$ and exclusion $p > .06$. It has been said that backward selection can be better than forward selection if there are variables that are jointly good predictors, but not individually (Lunt, 2008).

Two backward linear regressions were conducted – one for each of the DVs (change in outcome measures). As stated previously, to account for variance in initial scores of

depression, anxiety, and social adjustment, it was decided that time 1 values should be input as predictors for their respective DV (i.e. depression time 1 was entered as a predictor for change in depression).

As there was more than 1 regression being conducted in this study, a Bonferroni correction was applied to the significance value of each linear regression. A Bonferroni correction is a procedure that adjusts a researcher's test for significant effects, relative to how many repeated analyses are being done. As there are 2 separate DVs being tested through separate linear regressions, the significance criteria for this model was revised from $p < .05$ to $p < .025$ (i.e. .05 divided by 2).

7.1.7.3.1 Regression using Depression as DV

All 5 potential predictor variables (the 4 TA scores and depression scores at time 1) were entered at the initial step of the model. The predictors with the highest non-significant regression coefficient were excluded in subsequent steps. A full regression table for depression can be found in appendix 14.

In total, there were 4 steps in the backward regression for the qualified group. This yielded two significant predictors of change in depression scores: Depression at time 1, and Client TA scores at Time 2 ($R^2 = 0.44$, F(2,34) = 13.15, $p < .001$). A summary of the final step is presented in table 12.

Table 12 - Regression Analysis Results from Final Model; Change in Depression as Outcome Variable

Variable	B	SE B	β	R Square	Adjusted R Square
Client TA Time 2	-.20	.09	-.29*		
Depression Session 1	-.62	.11	-.65**	.44	.40

Note: ** p<.001, * p < .05

Together, these two predictors account for 50% of the variation in the change in depression scores. The strongest predictor was Depression scores at time 1 (β = -.65), followed by Client end of therapy TA scores (β = -.29).The adjusted R^2 suggests that these two scores, when generalised, would account for 40% of the variance in outcome (i.e. if the model was derived from the population rather than this sample). Overall, the goodness of fit of the model increased from model 1 (R^2 = 0.441, F(5,31) = 4.89, p = .002) to the final model (R^2 = 0.436, F(2,34) = 13.15, p < .001).

Interestingly, removing the three non-significant IVs (Therapist TA scores at time 1 and 2, and client TA time 1 scores) had a minimal effect on the R^2 value. This suggests that the vast majority of the influence on change in Depression scores can be accounted for by the two IVs (Depression at Time 1 and Client TA scores at Time 2) left in the final model. Moreover, the adjusted R^2 increased from .35 in the initial model to .40 in the final model, suggesting that when generalised to the wider population, the final model would have a bigger influence on change in Depression scores than the initial model. Figure 5 and 6 show the relationship between the DV and the two predictor variables.

Figure 5 - Partial regression plot - Change in Depression vs Depression scores at session 1

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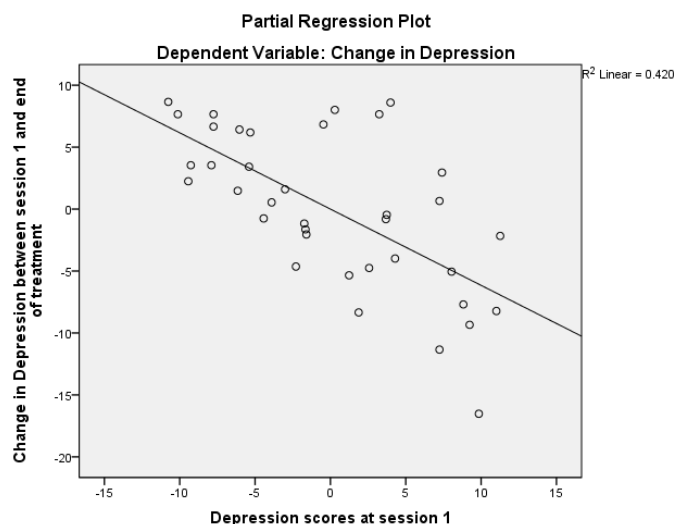
Figure 6 - Partial regression plot - Change in Depression vs Client TA scores at end of treatment
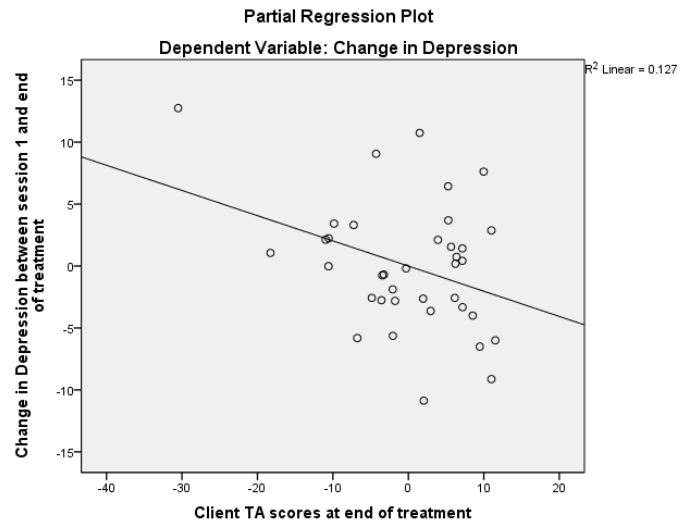
Statistical Assumptions for Backward Regression – Change in Depression as DV

In the final mode, the VIF values are well below the threshold for concern (i.e. 10; Myers, 1990 cited by Field, 2009). As the average VIF is not substantially greater than 1 and the tolerance values are above .2, multicollinearity is not an issue in this model (Field, 2009, p. 242). Furthermore, as stated above, all correlations between the IVs and the IVs and DV in this model are below .9 which suggest that multicollinearity is not a cause for concern(Field, 2009, p. 234). Homoscedasticity was examined via several scatterplots, which indicated reasonable consistency of spread through the distributions. Thus, the model appears to be accurate for the sample and potentially generalizable to the population.

5.2.7.3.2 Regression using Anxiety as DV

Like the depression regression, all 5 potential predictor variables (the 4 TA scores and anxiety scores at time 1) were entered at the initial step of the model. Full regression tables can be found in appendix 15.

There were 4 steps in the backward regression. Two significant predictors of change in Anxiety scores were found: Anxiety at time 1 and Client TA scores at Time 2, (R^2 = 0.40, F(2,34) = 11.55, p < .001). A summary of the final step is presented in table 13.

Table 13 - Regression Analysis Results from Final Model; Change in Anxiety as Outcome Variable

Variable	B	SE B	β	R Square	Adjusted R Square
Client TA Time 2	-.21	.08	-.34*		
Anxiety Session 1	-.58	.13	-.59**	.40	.37

Note: ** p<.001, * p < .05

The strongest predictor was Anxiety scores at time 1 (β = -.58), followed by client end of therapy TA scores (β = -.34).The adjusted R^2 suggests that these two scores, when generalised, would account for 37% of the variance in outcome (i.e. if the model was derived from the population rather than a sample).

Similar to the depression regression, removing the three non-significant IVs (Therapist TA scores at time 1 and 2, and client TA time 1 scores) had little impact on the R^2 value. Thus, the vast majority of the influence on change in Anxiety scores can be accounted for by the two IVs (Anxiety at Time 1 and Client TA scores at Time 2) left in the final model. Again, baseline Anxiety scores had a stronger influence on the model (β = -.58) than Client end of therapy TA scores (β = -.37). Figure 7 and 8 shows the relationship between the DV and the two predictor variables.

Figure 7 - Partial regression plot - Change in Anxiety vs Anxiety scores at session 1
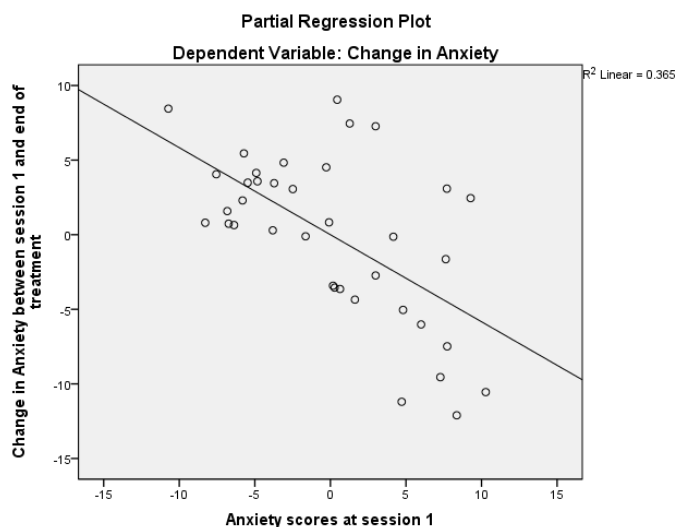
Figure 8 - Partial regression plot - Change in Depression vs Client TA scores at end of treatment
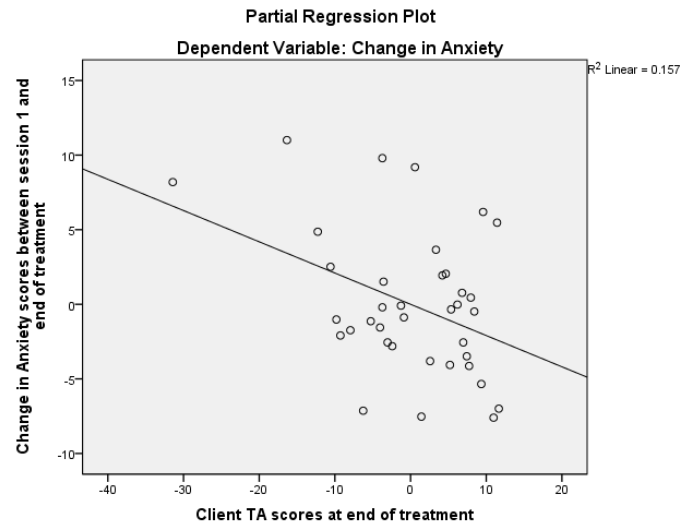
Statistical Assumptions for Backward Regression – Change in Anxiety as DV

All of the necessary assumptions were met for the regression analysis. There is independence of observations tested with the Durbin-Watson test. The values were not less than 1 or greater than 3, thus the residuals are uncorrelated (Field, 2009). By looking at the scatter plots produced by the regression analysis, the data showed homoscedasticity. Finally, as the average VIF was not substantially greater than 1 and the tolerance values were above .2, multicollinearity is not an issue in this model (Field, 2009, p. 242).

7.1.7.3.3 Summary of regression results

A large positive correlation existed between client TA scores at time 1 and client TA scores at end of treatment. This suggested that higher client TA scores at the start of treatment were indicative of higher client TA scores at the end of treatment. This was also found with the Therapists' views of the TA, but only to a moderate extent. Both DVs in this study (change in Depression and change in Anxiety) were found to have a significant moderate negative correlate with their respective time 1 values. Thus, the higher the time 1 score, the greater the change in depression or anxiety. Both DVs were found to have significant correlations with one-another, indicating that a greater change in Depression scores were generally accompanied by changes in Anxiety scores.

In total two backward linear regressions were conducted. The general assumptions (K-S test, homoscedasticity, and multicollinearity) were met for all models. In both groups, baseline scores for either depression or anxiety were all found to be significantly correlated with their respective change in outcome measures. Furthermore, these baseline scores were found to be significant predictors of the respective change in outcomes scores.

Interestingly, Client TA scores at end of treatment (Time 2) were found to be a predictor of both depression and anxiety scores. Therapist TA scores at Time 1 or 2 were not significant predictors of change in depression or anxiety scores. In contrast to general findings and recent meta-analyses (Martin et al., 2000), early client TA scores were not the strongest predictor of outcome when compared to end of therapy scores. These results are discussed further in the following section.

8. Discussion

This chapter summarises the research findings and reflects on their broader significance. Each of the four research questions outlined in the results section will be discussed and contextualised in relation to existing research. Then, the delimitations of the current research are briefly discussed before outlining the implications for practice and Counselling Psychology. Finally, a reflective section containing personal, methodological, and professional issues concludes the research.

8.1 Summary of findings and their relation to current research

There are no other studies known to the author that have looked at the TA in IAPT. Unlike the majority of other research investigating the TA in therapy, this study employed a sequential mixed methods design. As outlined in the methods and results chapters, the quantitative portion of this research was designed to answer four questions. These questions were derived from a combination of (1) gaps in knowledge, as identified by a review of literature, and (2) concerns of practitioners, as identified by focus group data. In the following subsections, each of these four questions are is revisited in turn, via (1) summary of the results, (2) discussion of how the results add to or contrast with previous research, and (3) suggestions for future research that may further elucidate and illuminate the area.

8.1.1 Question 1 – Is there a difference in TA scores between the Trainee and Qualified groups at session two and end of treatment?

This research question arose from a theme in the qualitative portion of this research study. Group members highlighted the experience of being a trainee in IAPT and the possible potential impact this had on the quality of the TA created between the trainee therapist and the client. The trainee group felt that they had a separate agenda at the backs of their minds when they were seeing clients, mainly centred on closely following the Cognitive Therapy Scale – Revised (CTS-R). Adhering to this scale was a key part of the trainees' course and all trainees needed to score above a certain mark on the CTS-R in order to prove their competence in CBT and pass their course. The trainee group suggested that having an alternative agenda "slightly removes you from that interaction [the TA]" (2, P3, L106-109). The qualified group did not have this pressure as they had completed their CBT training and were not obliged to submit any tapes to be assessed by the CTS-R. Based on focus group data that indicated different

levels of concern regarding the formation of the TA, it was hypothesised that the strength of the TA would differ between the two groups on quantitative measures.

Quantitative data, however, demonstrated no significant difference between the trainee group and the qualified group across the four measures of the TA (time 1 client and therapist scores, and time 2 client and therapist scores). In other words, the trainees' supposition that their 'agenda' would negatively impact the TA was not supported in the quantitative findings. Thus, it may be the trainees' levels of confidence or self-perception of competence that may lead them to think that they are unable to create as strong a TA in comparison to the qualified group. This is explored in more detail in comparison to existing research below.

Summary of previous research

Bennett-Levy and Beddie (2007) note that one of the fundamental tenets of psychotherapy education and training is that competence is related to positive patient outcomes. As stated previously, research generally tends to equate competence with adherence to a specific model. The majority of literature focusing on therapist competence in CBT has suggested that outcomes are strongly linked to competence (Kuyken & Tsivrikos, 2008; Shaw et al., 1999; Strunk et al., 2010). Moreover, competence has also been correlated with a stronger TA (Trepka et al., 2004). However, in some instances, technical adherence can be at the cost of the strength of the TA (Henry, Strupp, et al., 1993). Some studies have shown that alliance focused training can significantly increase the therapist's ability to establish and maintain stronger therapeutic alliances during therapy (Crits-Christoph et al., 2006). What's more, results have shown that increases in the alliance corresponded with improvements in depressive symptoms and improvements in quality of life for the clients (Crits-Christoph et al., 2006). Studies assessing the effect of adherence to CBT on the TA have provided mixed results; some studies showing that strict adherence to CBT protocols have yielded a more positive TA (Loeb et al., 2005), whereas others show the opposite (Castonguay et al., 1996).

It is widely acknowledged that psychotherapy training is a stressful process (Bennett-Levy & Beedie, 2007) and the stress of training in a cognitive therapy course in the UK has been highlighted in a number of articles (S. Robinson et al., 2012; Worthless, Competent, & Lemonde-Terrible, 2002). Trainees' stress levels and levels of confidence fluctuate during structured training. Studies using a mixture of 'objective' measures, such as the CTS-R, and self-report findings have found that there is a disconnect between trainees' self-perception of

proficiency and these objective measures (Bennett-Levy & Beedie, 2007; Perlesz, Stolk, & Firestone, 1990).

Contrasts or additions to previous research

This is the first study to look at the TA in IAPT with respect to trainees and qualified IAPT therapists. Firstly, it was shown that there was no significant statistical difference between the two groups in terms of years working as a therapist, years working in the field of mental health, and years working within IAPT. Furthermore, the qualifications that therapists had were identical with each group having three therapists with a Doctorate in Counselling Psychology (or equivalent), one therapist with a Doctorate in Clinical Psychology, two therapists with MScs in Counselling Psychology, and the remainder having postgraduate diplomas in CBT. Thus, the only noted difference between the two groups was that one group was currently in IAPT training and the other group was not. Although both sets of therapists in each group were equally matched, trainees may have felt lacking in therapeutic skills, which may have caused them to doubt their ability to create a strong TA with their client. The TA scale in the current study does refer to specific tasks such as creating collaborative goals, however the 'Bond' aspects of the scale are given equal weighting; both technical and relational aspects of the TA are acknowledged. The quantitative results did not find any significant difference between TA scores when the two groups were compared.

The findings of Perlesz and colleagues (1990) and Bennett-Levy and Beddie (2007) may give some idea as to the difference in the qualitative and quantitative results in the current study. A self-perception of competence plateau is evident in the literature reviewed (Bennett-Levy & Beedie, 2007; Perlesz et al., 1990). The more the trainees become aware of the tasks that they have to complete, or standards they have to achieve, the more they realise what they do not yet know. This awareness can negatively influence a trainees self-perceptions (Bennett-Levy & Beedie, 2007). Other authors have also noted that trainees' reliance on external judgement of their performance decreases as they develop more of an internal sense of expertise (Skovholt & Ronnestad, 1992).

Although the quantitative data shows that the trainees and qualifieds were equally good at creating a TA, the trainee therapists' lived experience suggested that they felt less competent in creating and attending to the TA. Authors such as Milne (2009) argue that de-skilling is a

common and necessary aspect of learning and development for trainee therapists. This process can create room for new ways of thinking about clinical material and situations. Grant, Townsend, and Sloan (2008) suggest that trainees transition from a stage of unknowing to a perceived "conscious incompetence" (S. Robinson et al., 2012). However, this is usually a temporary phase which is lifted when the trainee transitions into a fully qualified therapist. It may be that the trainee's self-perception of competence may have made them feel that they were inferior to the qualified group and were less free to develop a strong TA. The quantitative data, however, suggests that both groups were equally good at developing a strong TA.

This study adds support for the use of multi-method studies in psychology. If only one method of analysis was used the results would have yielded different findings. For example, if this study only explored the therapists' experience of the TA in IAPT it would have been concluded that the trainee group felt less competent and doubted their ability to create a strong TA. The trainees' doubts about their ability may have been earmarked as a cause for concern and the researcher may have questioned the impact of a potentially 'weak' TA on outcomes and service provision. However, by adding the quantitative section, it was possible to look at the quantitative data that explored this concept. Likewise, if only a quantitative study had been conducted, it would have been concluded that trainees create an equally strong TA in IAPT when compared to qualifieds. As a result, the trainees' lived experience would have been neglected. This study shows the advantage of placing two different epistemologies in dialogical relationship with one another. Instead of having one 'answer', the two differing positions uncovered multiple views of the same phenomenon, namely the TA in IAPT training.

Future research

A number of different approaches could be employed to explore the difference between trainees versus qualifieds in IAPT. The concept of trainees' self-perception of competence and the impact on the TA could be explored. Future studies could use similar scales that were used by Bennett-Levy and Beedie (2007) such as the Cognitive Therapy _Self_-Rating Scale (a modified self-assessment version of the supervisor-rated CTS-R, as mentioned by trainees in this study) to see if there was a correlation between the trainees' self-perceptions of competence and their ratings of the TA. This would enable a direct comparison to be made with other studies assessing trainees' self-perceptions of competence (Bennett-Levy & Beedie, 2007), and to see if there is an interaction between self-perceptions of competence and TA.

Another interesting area for research would be to compare CBT training as part of a Counselling Psychology course to the IAPT training. Again, using the method suggested above, one could explore whether a more relationally focused delivery of CBT training would have an influence of TA outcome scores and also trainee therapists' self-perceptions of competence.

8.1.2 Question 2 - Was a strong early TA present in both groups? Was there a significant difference between early and late TA between the two groups?

The second theme that arose from the qualitative data was the perceived pressures of IAPT and the possible impact the IAPT protocol might have on TA. Participants in both focus groups suggested that the "burden" placed on clients during the triage process may have had an impact on TA scores. Although there was no way of knowing if specific elements of the IAPT service that could have had a potential impact on the TA, it was decided to look at baseline levels of the TA to see if a strong TA was developed in light of the concerns raised in the qualitative component of the study. Scores on the TA questionnaire (HAq-II; Luborsky et al., 1996) range from a minimum of 19 to a maximum of 114 with higher scores suggesting a stronger alliance. For the trainee group the baseline therapist TA scores showed an average of 87.3 and baseline client TA scores were 98.8. For the qualified group baseline therapist TA scores averaged at 88.7 and baseline client TA scores were 100.4. In order to compare these rates to other studies, the most referenced CBT studies that used the HAq-II are listed in table 14, along with Luborsky's (1996) original study.

When compared to the original HAq-II study (Luborsky et al., 1996), baseline TA scores in this study are very similar. Furthermore, they are higher than all of the comparison CBT studies (Benítez, Zlotnick, Gomez, Rendón, & Swanson, 2013; Johansson & Eklund, 2006; Rieu et al., 2011). As there was no control group in this study, it is impossible to say if TA scores would be significantly higher or lower in different services. This is discussed further below.

Next, the results showed that the trainee group showed a significant improvement in TA scores for both therapists and clients. The qualified group only showed significant improvement in therapist TA scores. Clients' TA scores in the qualified group did not change significantly between the start of treatment and the end of treatment. This may be due to the

initial strong TA scores in the qualified group. Furthermore, the lack of a significant difference may be due to the small number of participants in the study.

Table 14 - Average HAq-II score for original HAq-II study and most referenced CBT studies using HAq-II

	Population	Number of participants	Client or therapist score	Start of therapy HAq-II scores (Average)	End of therapy HAq-II scores (Average)
Original HAq-II study					
Luborsky et al. (1996)	Substance misuse	246	Client	97.9	100.7
			Therapist	88.0	93.5
CBT Studies					
Benitez, Zlotnick, Gomez, Rendon & Swanson (2013)	PTSD	8	Client	n/a	107.4
			Therapist	n/a	n/a
Johansson & Eklund (2006)	Primary care (multiple)	122	Client	92.5	n/a
			Therapist	82.6	n/a
Rieu et al. (2011)	Depression	22	Client	95.7	97.6
			Therapist	80.3	87.4

HAq-II = Revised Helping Alliance questionnaire; Minimum score 19, Maximum score 114 – higher scores indicate a stronger alliance.

Summary of previous research

Previous research has explored some of the concepts that arose in the focus groups, with much research focusing on the influence of assessment on subsequent treatment effectiveness. As noted by Huber, Henrich and Brandl (2005), a good experience or good relationship with the assessor during mental health assessments did not necessarily generalise to a subsequent relationship with the client's therapist. The opposite of this could also hold; if a client had a bad experience or poor alliance with their assessor this would not necessarily predict a poorer relationship with their future therapist. This would indicate that the alliance is an interactive construct that results from a specific dyad and varies from situation to situation. Other studies using longer pre-therapy assessments have found that a more extended and in-depth assessment process increases the likelihood of clients staying in therapy and positively influences the development and maintenance of a therapeutic alliance (Ackerman et al., 2000; Hilsenroth et al., 2004).

Contrasts or additions to previous research

Despite all the concerns that arose in the focus groups about the IAPT structures and protocol having a potentially negative impact on TA, therapists still managed to create a strong TA. It is also possible that because of the IAPT protocol a strong TA was created. All the participants in this study were experiencing therapy for the first time. There may have been a sense of relief that they were finally able to speak to a mental health professional about their problems. Furthermore, participants could have found the assessment screening quite reassuring in that they would be referred to the appropriate professional for their difficulties.

The focus groups uncovered therapists' concerns that the early IAPT protocol could negatively impact the subsequent TA. This could be interpreted as IAPT protocol potentially impacting the therapeutic frame. However, the quantitative findings suggest that it is possible to establish a strong TA in IAPT. Therapists may be hypersensitive to potential pre-therapeutic 'intrusions' on therapy. The therapists' conception of 'intrusions' may have little impact on the therapeutic frame (Hoag, 1992; Spinelli, 1994). The issue of intrusiveness on the therapeutic frame was also discussed in the first chapter of this study. Whereas traditionalists like Langs (1976) suggested that any imposition to the therapeutic frame would have disruptive consequences on the therapeutic outcomes (and supposedly the TA), other authors like Hoag (1992) suggested that it was virtually impossible to maintain a rigid therapeutic frame in NHS settings

and that in her vast experience, flexibility did not impact subsequent outcomes. Spinelli's (1994) "Dumbo's magic feather" effect with regards to the therapeutic frame could be seen to be echoed in this study.

Future research

Unfortunately, this study was unable to directly answer the focus group concerns regarding the impact of the IAPT protocol on the TA. It was impossible to know how certain processes, for example the triage assessment, impacted the TA during therapy. Since the triage process plays such an important role in IAPT, future studies should explore the client's experience of the triage process. Quantitative research could use scales to assess the impact the triage process had on a client's levels of motivation, optimism for treatment, positive or negative opinions of the service, and whether a positive experience in these domains could influence future therapeutic alliance with the client's subsequent therapist.

Adding a control group would also be a positive addition. For example, assessing early service protocol across similar services and exploring any possible impact on TA or outcome scores would also be useful. Acquiring part-time IAPT therapists who also worked in similar services (or private practice) working with comparable client groups would be a relatively robust way of exploring the influence of 'protocol' on TA and outcome. However, it would be important to explore whether any differences were due to the therapists' experience of working for a particular service, or a client's experience of the service protocols such as assessment.

8.1.3 Question 3 – Does symptom severity relate to therapist and client TA scores

In the final theme that emerged from the thematic analysis, therapists questioned whether symptom severity and the client's presentation might have an impact on the subsequent TA. Therapists questioned whether more severe presentations would result in lower TA with clients. No correlations were found between pre-treatment levels of depression and anxiety and subsequent TA scores. This suggests that there is no strong association between symptom severity and TA scores in this population.

Summary of previous research

There have been mixed results regarding the impact of clients' symptom severity on the subsequent development of an alliance in therapy. Studies have found that symptom severity in depression is associated with poorer alliances in trials of Cognitive Therapy and CBT (Gaston et al., 1998; Zuroff et al., 2000). However, other studies have found little or no difference between symptom severity and therapeutic alliance (Gaston et al., 1991; Joyce & Piper, 1998). Other client factors such as attachment style (Eames & Roth, 2000), perfectionism (Zuroff et al., 2000), and interpersonal factors (Blatt, Zuroff, Quinlan, & Pilkonis, 1996) have been noted as potentially mediating the strength of the TA during treatment. However, conflicting reports have been published in recent years in which chronicity, social functioning, and history of abuse and/or neglect have not been correlated with the early alliance (Klein et al., 2003).

Contrasts or additions to previous research

The findings of this study support recent large-scale studies concerning symptom severity and TA. For example, Arnow and colleagues' (2013) CBT for depression study found that baseline global functioning did not predict subsequent alliance. Similarly, Klein and colleagues (2003) also noted that baseline depressive symptomatology did not affect later alliance scores. Likewise, a recent study of 270 outpatients suggested that diagnostic variables do not predict the quality of the therapeutic alliance (Hersoug, Monsen, Havik, & Høglend, 2002).

Future research

In this study, no significant correlations were found between symptom severity and TA. As a result of using a quantitative methodology, the finer processes of the therapeutic encounters are lost in the generalised findings. For example, as the focus group analysis found that the therapists believed that symptom severity influenced the TA, they may have been inclined to focus more on the TA with more distressed clients. Thus, it would be worthwhile for future research to explore this issue. A mixed methods analysis could explore if therapists focused more or less on the TA with clients who reported significant symptom severity. A TA measure such as the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962) could be used to see if certain subsets of the TA like empathy were different with more distressed clients.

As stated above, there is evidence that some other variables that were not assessed in this study, such as perfectionism (Zuroff et al., 2000), attachment style (Eames & Roth, 2000), and hostility (Muran, Segal, Samstag, & Crawford, 1994) might be associated with the alliance. Hence, it would be interesting to see if these factors play a role in mediating the TA with IAPT service-users.

8.1.4 Question 4 - Therapist versus client perception of the TA as a predictor of outcome

The final question explored in this study was devised from the literature review. The majority of studies conducted regarding the TA have focused on the impact of the TA on therapeutic outcomes. In this study, a regression analysis was conducted to see if any measures of the TA would significantly predict outcome. As question 1 and question 2 suggested that there were no major significant differences between the two groups, the trainee and qualified groups clients were merged for the regression analysis. Correlations indicated that client TA scores at the start of treatment and the end of treatment were highly correlated. Likewise, therapist TA scores at time 1 and time 2 showed statistically significant correlations. Interestingly, client and therapist time 1 TA scores were not significantly correlated. However, client and therapist TA scores at time 2 were shown to be significantly correlated. This suggests that by the end of therapy there was a stronger association between the TA scores between the clients and therapists. Clients tended to rate the TA higher at both time points.

Separate regressions for depression and anxiety were conducted. In both regressions, baseline scores for either depression or anxiety were all found to be highly correlated with their respective change in outcome measure. Furthermore, end of therapy client TA scores were found to be a predictor of both depression and anxiety scores. Therapist TA scores were not found to predict change in depression or anxiety scores across the two groups. These results indicated that a client's initial level of distress (gauged from a depression or anxiety questionnaire) plus the client's end of treatment perception of the TA account for up to 40% of the variance in change in depression or anxiety scores.

Contrasts or additions to previous research

This study adds further support to current knowledge that clients tend to rate the TA higher than their therapists. A recent meta-analysis unveiled similar results (Horvath et al., 2011). Several studies have found that clients tend to rate the TA more highly than their respective

therapists. For example, Fitzpatrick, Iwakabe, and Stalikas (2005) used forty-eight dyads of trainee therapists and their respective clients. Analysis found that there was a divergence between client and therapist ratings of the alliance. Furthermore, only client ratings of the alliance were significantly correlated with positive session impacts. Similarly, Bachelor and Salame (2000) studied the difference in TA across 30 qualified therapist and client dyads. The authors did not find any significant correlations in clients' or therapists' alliance ratings at any stage during therapy. The authors did notice that the alliance did change during different phases of therapy. These results have also been noticed in a recent meta-analysis by Tryon and colleagues (2007) with clients rating the alliance as stronger than their therapists across 52 studies. The current study lends support for these findings.

One might think that the correlation between client and therapist ratings should be stronger as they are both reporting on the same phenomenon, albeit from a different perspective. In this study, the difference between the therapists' and clients' ratings may be due to the therapist and client having a different perception of the interaction. As all the clients in this study were experiencing therapy for the first time, they did not have a benchmark with which to gauge the therapeutic relationship. Conversely, therapists have experienced a therapeutic alliance with previous clients and may rate their alliances with the clients in this study relative to those with previous clients. Some authors have suggested that a state versus trait conceptualisation of the TA may account for the difference between therapists' and clients' perspectives. Authors such as Kivlighan and Shaughnessy (1995) have questioned whether the client is as sensitive to temporal changes in the alliance as therapists are. Thus clients may experience the alliance as "traitlike phenomena" (Kivlighan & Shaughnessy, 1995, p. 348) where they assume the relationship between themselves and the therapist to be a constant factor in therapy. Conversely, because of prior experiences of therapeutic encounters, therapists may perceive the TA as more of a statelike phenomenon in which it changes over the course of therapy. For example, TA research has shown that the TA can follow a quadratic, or high-low-high, course when moving from one phase of therapy to the next, or when dealing with therapeutic ruptures (e.g. Gelso & Carter, 1994; Kivlighan & Shaughnessy, 2000). Thus clients' and therapists' assessment of alliance development may be divergent across treatment.

In contrast to general findings and recent meta-analyses (Martin et al., 2000), early client TA scores in the current study were not the strongest predictor of outcome when compared to end of therapy scores. However, other CBT studies have shown that substantial amounts of

outcome variance were uniquely accounted for by alliance scores (Gaston et al., 1991). The direction of the TA-outcome link has also come under scrutiny. Theorists have attributed this phenomenon in to three possibilities: i) A positive TA generates subsequent symptom change, ii) symptom change may positively influence the perception of the TA, or iii) both the TA and outcome have reciprocal influence on each other (Arnow et al., 2013; Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000). The findings of the current study must be interpreted with caution because the significant relationship between discharge alliance and outcome might have been confounded by therapy benefits. For instance, prior studies have found that the therapeutic alliance increased after sudden gains in treatment outcome (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Thus, therapeutic alliance and outcome can be seen as synergistic or reciprocal in their relationship. In the current study, as the client's symptoms of depression and anxiety decreased, they might have been more productively engaged in treatment hence leading to a better outcome. To address this issue, future studies should measure alliance more frequently and examine whether changes in alliance predict changes in future outcome. Future studies should use a larger number of participants and monitor TA and outcome measures throughout treatment to analyse if early improvement may predict future outcome.

Future research

There has been a vast number of studies conducted examining the influence of the TA on outcome yielding no less than 3 meta-analyses in the past 25 years. With the vast amount of data IAPT collects, and the fact that it is largely dominated by a small number of IAPT-approved therapies (CBT, IPT, DIT, Counselling for Depression), there is the potential to meet the high targets set by Crits-Christoph and colleagues (2011) who recommend a sample of 3,000 clients be sought to adequately explore certain therapist variables. For example, by adding a TA questionnaire to the IAPT MDS, it would take one London IAPT service less than 6 months to reach this target. If the TA was measured on a session by session basis, studies on this scale would be able to in explore the trajectory of the TA over time; whether it develops in a linear, erratic, or quadratic pattern (e.g. Gelso & Carter, 1994; Kivlighan & Shaughnessy, 2000).

Finally, future mixed methods studies should also involve the client's voice rather than just focusing on the therapist's perception of the TA. There have been detailed reviews regarding therapist characteristics and techniques impacting the therapeutic alliance in a positive or

negative way (Ackerman & Hilsenroth, 2003, 2001), however, clients are largely neglected in this area. TA and outcome studies refer to certain client characteristics, which are generally pathologised in the form of symptoms or issues, and their role in mediation or moderating TA scores. However, the therapist's 'symptoms' or 'issues' are never referred to. A qualitative exploration of the person-person TA, rather than therapist-symptom, would enlighten the quantitative findings. As is known, the role of the therapist and client are equally important in the formation of an alliance. Thus, both viewpoints should be studied in equal measures.

8.2 Delimitations of the current study

As this study was done alongside the other requirements of the Professional Doctorate (client hours, supervision hours, exams, essays, case reports, practical examinations, etcetera) the design of the project had pragmatic restrictions. This section will briefly discuss these restrictions.

Firstly, a theme that was omitted from the qualitative focus groups will be presented. This theme was not included in the results section as it did not specifically relate to the development of the TA in IAPT, and there was no way of elaborating on it with the quantitative methodology employed in this study. However, the themes are relevant to the project as a whole and by including it, it gives a bigger voice to the participants who took part in the study.

Recording outcomes in IAPT

As stated in the methodology, all participants who attended the focus group had seen the materials that were to be used in the current study. Participants were asked for their opinions about potentially using the HAq-II with clients. One of the main criticisms of the HAq-II was the use of 'therapy speak.' Both groups made reference to this. Therapists wondered if the phrases used in the questionnaire would be difficult for participants to understand.

> "It is very 'therapy speak.'" (2, P5, L446)

Concerns were also raised that the questionnaire seemed to have a high reading age. Thus, therapists wondered if the questionnaire respondents would reflect the general population of BEH, or would it bias the selection due to the reading age.

"So this probably reflects a relationship of a well-educated client, rather than everyone who enters the IAPT service, I would argue." (2, P1, L454-455)

Upon reflection, the questionnaire did have a high reading age. Using this measure in an area where literacy may be lower than other parts of the country may have excluded some participants. A simplified version, or a version with a further explanation of certain psychological terms ("unprofitable exchanges") may have been more accessible to all clients.

Both focus groups wondered if there was an additional selection bias. Some therapists wondered if their clients might answer the questionnaire because, possibly at an unconscious level, they would be trying to please the therapist, rather than wanting to take part in the study.

"In order for them to take part in the project, they judge it on their therapeutic relationship as well, whether they want to do that or not. So basically, because, maybe most of them would do it because they think want to help that particular therapist" (2, P4, L435-437)

Like all voluntary studies, this is a common concern. It may have been the case that clients who wanted to please their therapist, or clients who felt comfortable with their therapist after the first session, could have been more inclined to complete the questionnaire. If the questionnaire was mandatory, this may have controlled for this concern.

Finally, some therapists wondered whether the process of handing the questionnaire back to the therapist in a sealed envelope had an effect on the way the client answered.

"I mean I wondered ... how much of an effect it would have on the client handing it back to me, so I do wonder, I do wonder actually, if the client can be really honest." (1, P4, L494-496)

The concern raised here was one that was noted by the author at the start of the project. The use of sealable, self-addressed envelopes was an attempt to control for this. As a result of the financial constraints of the project, it was not possible to provide the clients and therapists with stamps or other means of returning the questionnaires. Future studies could see if there is a significant difference between clients' scores on questionnaires returned to their therapist versus questionnaires returned directly to the researcher.

Participants in the focus group made substantial statements about how improvement was measured in IAPT. The idea of trying to quantify a person's state of being was highlighted by these participants. This criticism was levelled at both the MDS questionnaires and the TA questionnaire that was going to be used in this study.

> "What I think is interesting is that you are still trying to quantify a qualitative kind of element. And I think that's hard. I mean, for me it was a little bit hard. Because a lot of bias when it comes to scoring something" (1, P1, L503-505)

Some participants highlighted how they have seen the MDS fail to pick up on the client's clinical reality. Three participants gave examples from their own work where a client reported feeling much happier, was more engaged with life, but this did not translate to the MDS. Some participants suggested that more qualitative measures should be used, rather than IAPT relying solely on quantitative data.

> "In terms of outcome, The MDS are ok, but nowhere sufficient. They don't capture the clinical reality. They give you an idea, but not good enough. They are not sufficient." (1, P1, L422-423)

> "Actually, people keep saying her whole life has turned around, she's got this big understanding, but her scores haven't changed at all. If anything, you know, they are so low it's just .. but she just couldn't be happier. She was able to go on holiday for months on end, all of her anxiety is different, and it is .. actually her outcomes don't show any of that." (1, P3, L458-461)

IAPT's support of the medical model is highlighted in these quotes. Although the MDS contains a questionnaire about general social functioning, the Work and Social Adjustment questionnaire (WASA; Mundt, Marks, Shear, & Greist, 2002), the 'success' or effectiveness of IAPT is based on the PHQ-9 and the GAD-7. Participants felt that the WASA was somewhat tokenistic as it does not seem to be reported in many of the main IAPT reports. Likewise, the WASA does not seem to be included as a earning variable in the Payment by Results scheme (Mullins & Perton, 2013), unlike the PHQ-9 and the GAD-7.

There was a general consensus that TA had a positive impact on outcome, although this was not always reflected on the MDS. Other participants wondered if the TA could be seen as an outcome, rather that solely relying on levels on depression or anxiety. Again, participants highlighted IAPT's focus on diagnosis and wondered if there were other ways of measuring the impact of therapy on clients.

> "I think my subjective experience would be that it does have a massive impact, but it doesn't always reflect on the MDS." (1, P7, L398-399)

> "I think that the relationship itself could be an outcome, rather than think whether it predicts outcome. Kind of, what you're saying could be: 'you've experienced connection with someone that has challenged you, understood; and you felt kindness, and soothing, and safety.' I think, so, ya in and of itself it is an outcome isn't it?" (1, P4, L437-440)

These criticisms are clear limitations of the study and of IAPT's reliance on the medical model. Although quantitative measures aim to capture some form of 'objective' and generalisable reality, the participants questioned this concept. Interestingly, the TA as an outcome measure was suggested in the final quote. This shows the importance the majority of the therapists placed on the TA.

The following sub-sections will explore more general limitations of the study such as a lack of a control group, potential confounding variables, and the sample size.

Lack of a control group

This study was interested in exploring the TA in an IAPT setting. However, some of the themes that arose in the focus group questioned whether the 'IAPT-ness' of IAPT had an impact on the TA. This project was unable to directly explore this concept as there was no control group. The main reason for this was the time restrictions placed on this project. One of the few ways of monitoring the impact of 'IAPT-ness' on the TA would be to create a control group to ascertain if the TA is higher or lower in other similar services. Suggestions for future studies that include a control group have been briefly discussed in the previous section (8.1).

Potential confounding variables

Data collection is one of the fundamental tenets of IAPT. It enables services to demonstrate effectiveness, to increase accessibility, and to monitor the extent to which IAPT workers and services are providing evidence-based treatments (IAPT, 2011b). As stated previously, data is collected from service-users during each and every session. Thus, the author of this study was mindful of placing additional pressure of service-users and IAPT therapists alike. For this reason, the local BEH IAPT Research and Development committee advised to limit the number of questionnaires used in this project. As a result, it was not possible to collect other therapy factors that might also have influenced the therapeutic alliance and outcome. For example, empathy, warmth and positive regard of the therapist (Keijsers, Schaap, & Hoogduin, 2000), or therapeutic alliance and patient motivation (Huppert, Barlow, Gorman, Shear, & Woods, 2006). Likewise, positive outcome expectancies for both the client and therapist could also play a significant role in both the alliance and outcome (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011). These confounds are an inherent limitation of limited, self-report measures. Ideally, these confounds should be either controlled for or investigated as mediators/moderators in future studies.

Number of participants

Like the majority of studies with quantitative components, this study had a modest sample size. Although the researcher put a huge amount of time and effort in to recruiting the maximum amount of participants, it was extremely difficult to recruit therapists. This is understandable as all therapists in IAPT have a very large caseload. Furthermore, the administration work that goes along with seeing clients is also considerable. In general, this study was at the mercy of time constraints and the reality of the workload of IAPT for potential therapist participants. Although this project recruited the number of participants suggested in the power analysis (see chapter 1), other authors have questioned the "therapist variable" in alliance/outcome research; the impact specific therapists may have on the alliance. Based on the findings of their study regarding this topic, Crits-Christoph and colleagues (2011) recommend that a sample of 3,000 clients (50 therapists each treating 60 patients) would be necessary to accurately assess the therapist-level alliance/outcome relationship. However, the number of participants in this study compares well to previous research. Overall, the limitations of the project could be starting points for future work conducted in the area of TA research.

8.3 Implications for general practice and Counselling Psychology

Although previous qualitative studies have explored trainees' experience of IAPT (S. Robinson et al., 2012), this is the first study that directly compares IAPT trainees with qualified IAPT therapists with regards to the TA. This study adds to the literature regarding trainees' self-perception of competence (Bennett-Levy & Beedie, 2007) and suggests that although trainees may have as much experience as qualifieds, the group of trainees interviewed in this study indicated that they may still feel inadequate when it comes to developing a TA with clients. The findings of this study could potentially increase confidence levels of trainee IAPT therapists, many of whom may be Counselling Psychologists.

There have been many criticisms of IAPT in recent years (Rizq, 2012a; Rizq et al., 2010). The previous Chair of the Division of Counselling Psychology questioned how relationality is promoted in IAPT (James, 2010). One of the solutions offered was for Counselling Psychologists to become IAPT trained and try to deliver CBT in a relational manner (James, 2010). This statement could imply that the TA was somewhat compromised in IAPT. The results of this study suggest that both IAPT trainees and qualifieds can achieve a strong initial TA. In general, ratings of the TA tend to increase over the course of treatment. The quantitative results of this study show that the TA is a vital part of IAPT, a finding that may alter Counselling Psychology's perception of the lack of relationality in IAPT. It may encourage more Counselling Psychologists to undertake IAPT training, work as IAPT therapists, or to supervise IAPT therapists.

This study also acts as a source for debate with regards to the TA in IAPT. The general, sweeping statements made about 'IAPT' (e.g. "the perversion of care" in IAPT; Rizq, 2012a) may not be true of specific services. It shows that although the focus group participants suggested that the IAPT training was more technique focused rather than process or relationally focused, quantitative results showed that both trainees and qualifieds were able to create a strong TA. The Gestalt concept that the whole is greater than the sum of its parts (e.g. Greenberg, 1979) may also be true for IAPT: IAPT may be more than a sum of techniques, protocol, and 'CBT therapists'. The findings of this question suggest that therapists do acknowledge the importance of the TA in CBT and are mindful of how protocol may impact the TA. However, the quantitative data suggests that IAPT therapists can achieve a good TA despite their concerns about the intrusions of the service.

As seen in the qualitative analysis, therapists' beliefs were contrary to previous studies regarding symptom severity and TA. It is important for clinicians to be aware that level of distress does not impair the development of a therapeutic alliance in IAPT. It is possible that therapists may feel a sense of hopelessness when working with clients with high depression and anxiety scores. The results of this study may be positive encouragement for therapists working with clients who report high levels of anxiety or depression as it is still possible to establish and maintain a strong therapeutic alliance with these service-users.

Finally, the outcome of this research suggests that the client's perception of the TA is the strongest predictor of outcome. Therapist and client perceptions of the alliance, particularly early in treatment, do not necessarily match. As suggested by Horvath and colleagues (2011) misjudging the client's felt experience of the alliance (i.e., believing that it is in "good shape" when the client does not share this perception) could render therapeutic interventions less effective. Active monitoring of the clients' alliance throughout treatment, rather than solely focusing on outcome measures as happens in IAPT, may be a good gauge to ascertain if treatment is agreeing with the client.

In this study, the later alliance being the strongest predictor of outcomes may highlight the reciprocal role of these two concepts. The development and fostering of the alliance is not separate from the techniques or interventions that are used during therapy with the client. The TA is influenced by all the aspects of therapy and is an inseparable part of everything that happens in therapy. As suggested by numerous authors, the therapist does not "build alliance", rather, they work collaboratively with the client in such a way that forges a mutual understanding with regard to the goals and tasks of therapy, facilitating the bond between the two (Horvath & Bedi, 2002; Horvath et al., 2011). The data, qualitative and quantitative, collected and analysed in this study adds further support for the collaborative nature of the TA. This is important for practice as, in a sense, the 'doing-to' concept of the alliance is replaced with the 'being-with' (Buber, 1958).

The IAPT movement has been very well publicised and criticised since its inception. There have been many glowing summaries of IAPT, such as the 3-year report (Department of Health, 2012), and also a number of theoretical essays and critical reflections on IAPT (Murphy, 2013;

Rizq, 2012a, 2012b). However, the inner workings of the IAPT setup still remain relatively elusive. This study provides qualitative and quantitative analysis of data collected from an IAPT setting. In doing so, it attempts to answer some of the questions raised in these articles, for example how a group of therapists, both trainees and qualifieds, experience the TA in IAPT, and whether it is possible to create a strong TA in IAPT. One of the fears raised by Counselling Psychologists is that the IAPT brand of CBT may not be practiced in a relational way (e.g. James, 2010). However, the levels of TA seen in this study would suggest that the therapists in IAPT achieve a strong relationship.

Another contribution that this study makes is its focus on in-training therapists. It is important for trainees to be aware of the fluctuations in levels of self-confidence during training, a normal stage of training. An awareness of the influences may be helpful in accepting that although in-training IAPT therapists may feel this way, their skills as therapists are evident and effective, as shown by the quantitative section of this study. This could also be applied to Counselling Psychology training, with these feelings being accentuated as training comes to an end (Benett-Levy & Beedie, 2007). What's more, this information is also useful for supervisors who can highlight the positives of trainees' work, rather than collude with the self-critical mindset of trainees, where, as noted by Benett-Levy and Beedie (2007) and echoed in this study, trainees may have a feeling that the bar is always just out of reach. Having an awareness of this may prevent trainees becoming disillusioned or deskilled, especially in IAPT where trainee therapists can have as much experience as qualifieds, as shown in this study.

This study also highlights the difference between the therapists' and clients' views of the TA. In general, the clients tended to rate the relationship more positively than the therapists. Thus, if a client reports a lower alliance rating, this could indicate to the therapists that therapy is not progressing well. Also, this study touched on the theme of manualisation of therapy. Although trainees felt slightly removed from the relationship as a result of having the CTS-R in the back of their mind, they still were able to achieve a strong initial TA with their clients. This may be preliminary evidence that manualised therapies can be practiced in a relational way.

Overall, this project highlighted the disparity between the therapists' concerns for the TA in IAPT and the quantitative results. The results may tentatively support Spinelli's (1994) claim that the therapeutic frame is not hugely significant for clients and could be an example of a

"Dumbo's feather" for therapists (as discussed in the introduction). However, with the introduction of Payment by Results (Mullins & Perton, 2013) and Any Qualified Provider (Department of Health, 2011), frame issues might start to become more of an issue for therapists rather than clients, and could potentially have an impact on the TA. This project could be seen as a baseline study of the TA in IAPT, and could be a reference point to see if further NHS restructuring may impact on this essential element of therapy.

8.4 Conclusions and reflections

The IAPT initiative is probably the single biggest change in Primary Care Mental Health services since the inception of the NHS in 1948. IAPT is beginning to dominate the provision of primary mental health service with 150 of the 151 PCTs in England commissioning an IAPT service (Department of Health, 2012). In total, there are 240 IAPT services around the country (Department of Health, 2012). As stated in the introduction, a recent divisional survey (DCoP, 2013) found that almost 40% of respondents' primary employer is the NHS. Thus, it is likely that a large proportion of Counselling Psychologists are employed by IAPT. A 2009 IAPT report (Aldridge & Duffy, 2009) stated that 16% of the High Intensity IAPT workforce were qualified Clinical Psychologists, and 6.7% were qualified Counselling Psychologists. This number is likely to have increased over the last 4 years, with more and more newly qualified Counselling Psychologists opting for trainee positions in IAPT. Thus, this research is very relevant for Counselling Psychologists.

The manualised and structured nature of IAPT has been criticised by leading psychologists (B. Cooper, 2009; Rizq, 2012a). A recent report commissioned by King's College London on the statutory regulation and the future of professional practice in psychotherapy and counselling (McGivern, Fischer, Ferlie, & Exworthy, 2009) suggested that the IAPT initiative had moved from being an individual/client relationship to (organisational) productivity. What's more, the report claimed that "the emotional aspects of mental health work were felt to be marginalised" (McGivern et al., 2009, p. 6). As numerous meta-analyses have shown, the TA has been earmarked as a fundamental contributor to the success of therapy (Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000). This study was an attempt to explore this essential therapeutic ingredient and to see whether the TA was at risk in IAPT.

The following sections are reflective pieces written by the author which aim to give a brief background to the study and briefly explore the design of the study. As the reflections are personal in nature, the author though it best to use the first person.

Research reflections

"We are born out of relationship, nurtured in relationship, and educated in relationship" (Cottone, 1988, p. 363)

My first clinical placement was at a counselling service within a GP surgery in North West London. It was a voluntary service managed by a qualified Counselling Psychologist but run by trainee therapists. This service had been in existence for 20 years but, due to the impending arrival of IAPT, the GPs in the surgery felt it necessary to disband the service and go with IAPT. Desperate to complete my first year client hours I applied for an IAPT placement.

The seeds of this research project were sewn when my I started at this IAPT service. I was aware of the controversy surrounding IAPT; the successes, the criticisms, and the on-going turf wars between services. However, my experience of the service was very difference to what I expected. My supervisor was a Counselling Psychologist and was very attuned to the relational aspects of the therapeutic processes. This seemed to be in contrast to the criticisms I had heard of IAPT being bandied about by colleagues and clinicians. Although I was part of an IAPT service, I was only working there one day a week and was aware that my experience might be very different from those who worked there on a permanent basis. Thus, I knew that I wanted to give the clinicians in the IAPT service a voice in my project. Rather than solely basing my research on the existing literature, I felt it was important to be guided by the people whose reality was working full time for an IAPT service. Another important factor in doing this research was to make use of the data IAPT was collecting. As part of my IAPT placement, I was obliged to collect various pieces of data (minimum data set) as part of treatment. However, there is little apparent research activity in IAPT and there are seemingly few articles being published on the data set. Authors have questioned whether there is a moral issue here at stake: thousands of therapists collecting data in every session, potentially using clinic time, and using the client's time (Murphy, 2013). Thus, I felt that it was important to make use of this underutilised data.

Getting to know the therapists and the service, I was fascinated to find out if IAPT was more than a sum of its parts. Thus, I went in to this project knowing what I wanted to find out, but finding it difficult to conceive of a way of doing it. Eventually, after much deliberation, a sequential mixed methods design was thought to be the best method of attack.

Reflection on the design of the project

"It is the therapist, not 'the therapy', which is the instrument of change" (Butler & Strupp, 1986, p. 37)

In my opinion, the greatest strength of this project is that it tried to combine two epistemological positions when looking at the same phenomenon. I did not want to create specific research targets solely based on a literature review; rather, I sought to find out how the TA is viewed in IAPT from the 'inside', by the people who work in an IAPT service day-in, day-out. Dividing the trainees from the qualifieds was initially done in the hope of creating a more equal focus group dynamic; to prevent supervisors and supervisees from attending the same focus group. I was interested in the experience of IAPT training and thought that the two groups would have different views on it, but I was struck by the themes that arose surrounding the IAPT training.

Taking a single epistemological and methodological stance would have yielded very different results. For example, if only a quantitative analysis was conducted then the nuanced experiences of the therapists would have been neglected. Likewise, if the discussion and conclusions of the study were solely based on a qualitative investigation, it could have been concluded that the TA may be at risk in IAPT which could be seen as potentially impacting the foundations of psychological care.

The aim of mixing the qualitative and quantitative sections of the study was not to clarify or to simplify; it aimed to position two opposing worldviews in dialogic relation to one another. As implied in the epistemology chapter (chapter 3), the foundations of Counselling Psychology are built on an open, understanding, and critical framework. Its pluralistic nature is opposed to dogmatic worldviews and enables practitioners to respect difference and revel in complexity. I hope that this is echoed in the nature of this work.

Like all good social science research, this project raised more questions than it answered. As suggested by Professor Spinelli (2013) in this year's Division of Counselling Psychology conference, if Counselling Psychology continues to place inflexible methodological rules and conditions on research and practice the division and members will "become ever more manualised and less and less open to the uncertain possibilities of human encounter." During the conference I began to reflect on my own research project. I questioned the reductionist ways in which the quantitative questionnaires aimed to 'measure' something so complex as the human relationship, or the human condition. Likewise, I wondered how an interview or focus group could do anything more than scratch the surface of constructs so complex and multi-faceted as the therapeutic relationship. Many of the 'hard sciences' (physics, mathematics, chemistry) are starting to use chaos theory and complexity theory as a starting point, and this has gathered supporters in the field of social sciences (Gregersen & Sailer, 1993; Spinelli, 2013).The constructs under scrutiny here may be closer to chaos therapy rather than the traditional petri-dish style of experiment. The multi-modal examination of the TA in IAPT is an attempt to acknowledge the complexity of the phenomenon under scrutiny.

Twenty years ago, Hill and Corbett (1993) suggested that a paradigmatic shift had taken place in Counselling Psychology research. Qualitative methods had become increasingly popular in the study of process and outcome in Counselling Psychology. One of the reasons that Counselling Psychologists have given for this is the similarities in the underlying principles of both the qualitative paradigm and clinical practice (Silverstein, Auerbach, & Levant, 2006). A recent survey by the DCoP (DCoP, 2012) showed only two out of 71 thesis projects that employed a quantitative element in their research. One questions whether the paradigmatic shift has shifted to the opposite side, neglecting the usefulness of quantitative research. I would argue that in an area of flux like mental health care in the NHS, it is important to be able to communicate with all parties involved in the service-provision for clients; being able to communicate with those who value quantitative data and those who believe in the importance of the unique experience of the individual. I believe that a mixed methodological approach to research is far closer to the Counselling Psychology ethos of pluralism (Kasket, 2013). As is hopefully seen in this project, multiple views of 'reality' provide interesting intersections, contradictions, and may also add to the existing debate surrounding IAPT.

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List of Appendices

Appendix 1 - Genealogy of alliance concepts and scales - adapted from Elvins & Green, 2008 – Scale acronyms and references

Barrett-Lennard's relationship inventory (BLRI) (Barrett–Lennard, 1986)	Barrett-Lennard, G. T. (1986). *The relationship inventory now: issues and advances in theory, method and use.* In L. S. Greenberg & W.M. Pinsof (Eds.), The psychotherapeutic process: a research handbook (pp. 439–467). New York and London: Guilford Press.
Counseling evaluation inventory (CEI) (Linden, Stone & Shertzer, 1965)	Linden, J., Stone, J., & Shertzer, B. (1965). Development and evaluation of an inventory for rating counseling. *Personnel and Guidance Journal*, 44, 267–276.
Therapy session report scales (TSRS) (Orlinsky and Howard, 1966)	Orlinsky, D. E., & Howard, K. I. (1966). *Therapy Session Report (Form T and Form P)*. Chicago: Institute of Juvenile Research
The counselor rating form (CRF) (Bachelor, 1987)	Bachelor, A. (1987). The counseling evaluation inventory and the counselor rating form: their relationship to perceived improvement and to each other. *Psychological Reports*, 61(2), 567–575.
The Penn alliance scales (Luborsky, 1976)	Luborsky, L. (1976). *Helping alliances in psychotherapy*. In Claghorn (Ed.), Successful psychotherapy (pp. 92–116). New York: BrunnerMazel
Vanderbilt scales (Gomes-Schwartz, 1978)	Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: prediction of outcome from process variables*. Journal of Consulting and Clinical Psychology,* 46, 1023–1035.
Toronto scales (Marziali et al., 1981; Marmar, Horowitz, Weiss, & Marziali, 1986)	Marziali, E., Marmar, C., & Krupnick, J. (1981). Therapeutic alliance scales: development and relationship to psychotherapy outcome. *Journal of Nervous and Mental Disease,* 172, 417–423. Marmar, C. R., Horowitz, M. J.,Weiss, D. S., & Marziali,

	E. (1986). *The development of the therapeutic alliance rating system.* In L. S. Greenberg & W.M. Pinsof (Eds.), The psychotherapeutic process: a research handbook (pp. 367–390). New York and London: Guilford Press.
Menninger alliance rating scale or collaboration scale (Allen, Newsom, Gabbard, & Coyne, 1984)	Allen, J. G., Newsom, G. E., Gabbard, G. O., & Coyne, L. (1984). Scales to assess the therapeutic alliance from a psychoanalytic perspective. *Bulletin of the Menninger Clinic,* 48, 383–400.
Psychotherapy status report (PSR) (Frank and Gunderson, 1990)	Frank, A. F., & Gunderson, J. G. (1990). The role of the therapeutic alliance in the treatment of schizophrenia. Relationship to course and outcome. *Archives of General Psychiatry,* 47, 228–236.
Patient collaboration scale (PCS) (Svensson & Hansson, 1999)	Svensson, B., & Hansson, L. (1999). Relationships among patient and therapist ratings of therapeutic alliance and patient assessment of therapeutic process: A study of cognitive therapy with long term mentally ill patients. *Journal of Nervous and Mental Disease,* 87(9), 579–585.
California scales (CALPAS) (Marmar et al., 1989)	Marmar, C. R., Weiss, D. S., & Gaston, L. (1989). Towards the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 1, 46–52.
Therapeutic bond scales (TBS) (Saunders et al., 1989)	Saunders, S. M., Howard, K. I., & Orlinsky, D. E. (1989). The therapeutic bond scales: psychometric characteristics and relationship to treatment effectiveness. *Psychological assessment: A Journal of Consulting and Clinical Psychology,* 1, 323–330.
Working alliance inventory (WAI) (Horvath and Greenberg, 1989)	Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology*, 36, 223–233.

Child psychotherapy process measures (CPPM) (Smith-Acuna, Durlak,& Kaspar, 1991)	Smith-Acuna, S., Durlak, J., & Kaspar, C. (1991). Development of child psychotherapy measures. *Journal of Clinical Child Psychology,* 20, 126–131.
Child's perception of therapeutic relationship (CPTR) (Kendall, 1994)	Kendall, P. C. (1994). Treating anxiety disorders in children: results of a randomised controlled trial. *Journal of Consulting and Clinical Psychology,* 62, 100–110.
Therapeutic alliance scales for children (TASC) (Shirk and Saiz, 1992)	Shirk, S. R., & Saiz, C. C. (1992). Clinical, empirical and developmental perspectives on the therapeutic relationship in child psychotherapy. *Development and Psychopathology,* 4, 713–728.
Treatment alliance scales (TAS) (Sarlin, 1992)	Sarlin, N.S. (1992). *Working relationships in the treatment of adolescent inpatients: Early treatment predictors and associations with outcome*. Dissertation Abstracts International.
Adapted psychotherapy process inventory (PPI) (Gorin, 1993)	Gorin, S. (1993). The prediction of child psychotherapy outcome: Factors specific to treatment. P*sychotherapy,* 30(1), 152–158.
Adolescent working alliance inventory (AWAI) (Di Giuseppe et al., 1996; Florsheim et al., 2000)	Di Giuseppe, R., Linscott, J., & Jilton, R. (1996). Developing the therapeutic alliance in child-adolescent psychotherapy. *Applied and Preventive Psychology,* 5, 85–100. Florsheim, P., Shotorbani, S., Guest-Warnick, G., Barrett, T., & Hwang, W. C. (2000). Role of the working alliance in the treatment of delinquent boys in community based programs. *Journal of Clinical Child Psychology,* 29, 94–107.
Helping alliance scales (HAS) (Priebe & Gruyters, 1993)	Priebe, S., & Gruyters, T. (1993). Role of the helping alliance in psychiatric community care: a prospective study. *Journal of Nervous and Mental Disease,* 181(9),

	553–557.
Empathy and understanding questionnaire (EUQ) (Green et al., 2001)/family engagement questionnaire (FEQ) (Kroll & Green, 1997)	Green, J., Kroll, L., Imre, D., Frances, F. M., Begum, K., & Gannon, L. (2001). Health gain and predictors of outcome in inpatient and day patient child psychiatry treatment. *Journal of the American Academy of Child and Adolescent Psychiatry,* 40, 325–332.
	Kroll, L., & Green, J. M. (1997). Therapeutic alliance in inpatient child psychiatry. Development and initial validation of the family engagement questionnaire. *Clinical Child Psychology and Psychiatry*, 2(3), 431–447.
Barriers to treatment participation scale (Kazdin et al., 1997)	Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997). Barriers to treatment participation scale: evaluation and validation in the context of child outpatient treatment. *Journal of Child Psychology and Psychiatry,* 38(8), 1051–1062.
Therapist alliance focus scale (TAFS) (Molinaro, 1998)	Molinaro (1998). *Development and validation of a new measure of therapist focus on alliance related content.* Dissertation Abstracts International, 58(10), 5651B.
Adolescent therapeutic alliance scale (ATAS) (Johnson et al. 1998)	Johnson, S., Hogue, A., Diamond, G., Leckrone, J., & Liddle, H. A. (1998). *Scoring manual for the Adolescent Therapeutic Alliance Scale (ATAS).*Philadelphia: Temple University Unpublished manuscript.
Agnew relationship measure (ARM) (Agnew Davies, Stiles, Hardy, Barkam, & Shapiro, 1998)	Agnew Davies, R., Stiles, W. B., Hardy, G. E., Barkam, M., & Shapiro, D. A. (1998). Alliance structure assessed by the Agnew Relationship Measure (ARM). *British Journal of Clinical Psychology,* 37, 155–172.
Child psychotherapy process scales (CPPS) (Estrada and Russell, 1999)	Estrada, A., & Russell, R. (1999). The development of the child psychotherapy process scales (CPPS). P*sychotherapy Research,* 9, 154–166.

Family therapy alliance scale (FTAS) (Pinsof, 1999)	Pinsof, W.M. (1999). *Family Therapy Alliance Scale-Revised.* Unpublished Manuscript. The Family Institute, Evanston IL.
Early adolescent therapeutic alliance scale (EATAS) (Johnson, 2001).	Johnson, S. (2001). *The therapeutic alliance with early adolescents: introduction of an instrument.* Dissertation Abstracts International, 61(10), 5567B.
Kim alliance scale (Kim et al., 2001)	Kim, S. C., Boren, D. M., & Solem, S. L. (2001). The Kim alliance scale: Development and preliminary testing. *Clinical Nursing Research*, 10, 314–331.
System for observing family therapy alliances (SOFTA) (www.softa-soatif.net) (Friedlander et al., 2006)	Friedlander, M. L., Horvath, A. O., Cabero, A., Escudero, V., Heatherington, L., & Martens, M. P. (2006). System for observing family therapy alliances: a tool for research and practice. *Journal of Counseling Psychology,* 53(2), 214–224.
The therapy process observational coding system — alliance scale (TPOCS) (McLeod & Weisz, 2005)	McLeod, B. D., & Weisz, J. R. (2005). The therapy process observational coding system-alliance scale: measure characteristics and prediction of outcome in usual clinical practice. *Journal of Consulting and Clinical Psychology,* 73(2), 323–333.
Scale to assess therapeutic relationship (STAR) (McGuire-Snieckus, McCabe, Catty, Hanson, & Priebe, 2007).	McGuire-Snieckus, R., McCabe, R., Catty, J., Hanson, L., & Priebe, S. (2007). A new scale to assess the therapeutic relationship in community mental health: STAR. *Psychological Medicine,* 37, 85–95.

Appendix 2 – Phases of thematic analysis

Description of the process – Adapted from Braun and Clarke (2006)

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

---

Appendix 3 – Interview schedule

Introduction

- Thank participants for coming.

- Give participants Consent Form.

- Explain the way the focus group will be conducted (e. g 'I will ask you to think about a few topics regarding the TA, ask some questions about your relationship with them. There are no right or wrong answers, just talk as freely as you feel comfortable with. If at any time you would like to stop the interview, you can let me know.')

- Ask participant if they have any questions

- Ask participant to sign the Consent Form

- Ask participant to not mention the clients' name or any other identifying information. Explain that if that happens, this part of the interview will be deleted and not transcribed.

- Ask participant if I can turn tape recorder on.

1. General therapeutic relationship in CBT

In the way that you practice CBT, what is the role of the therapeutic relationship?

How would you describe in your words the most important elements of your relationship with your clients?

2. Development of relationship over time

Do you think that your relationship with your clients changes over the course of therapy, in the way that you practice CBT? If so, in what way?

Prompts: How would you describe your relationship with your clients in the beginning of therapy? Middle? End?

3. IAPT

In your experience, how much emphasis is placed on the TA in IAPT training?

What is it like working with the TA in IAPT?

4. Questionnaire

Questionnaire based on Bordin's theoretical division of the alliance into "goals, tasks, and bonds,"

Do you think the questionnaire missed out on a particular aspect of the TA that you felt should have been included?

Following the recording:

Ask participant if they want to add anything

- Round up the interview and thank participant for their time and information

- Ask participant if I can turn tape recorder off

- Ask participant how they found the interview

- Ask participant if they have any questions about the interview or any issues that the interview might have raised for them.

CITY UNIVERSITY LONDON

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

The Whittington Hospital NHS
NHS Trust

Researcher: Brian Sreenan,

                City University London

                Brian.Sreenan.1@city.ac.uk

Invitation to participate in our study:

'The importance of the therapeutic relationship in an IAPT setting: A mixed methods analysis'

You are invited to participate in a postgraduate research project conducted by Brian Sreenan under the supervision of Dr. Courtney Raspin from the Department of Counselling Psychology at City University London. We are interested in examining the therapeutic relationship (also called the therapeutic alliance, or working alliance) in an IAPT setting. Every current IAPT service user in the Barnet, Enfield and Haringey IAPT service has been contacted to take part in this study. Your participation in this study will consist of filling 2 questionnaires in total – one at the start of treatment (Session 2) and one at the end of treatment. The questionnaires usually take about 2-3 minutes to complete. **Neither you nor your client will see each others responses**. Furthermore, we may contact you to participate in a 50 minute focus group (along with 4 - 5 of your colleagues).

The enclosed information sheet gives full details of the study. The study has received full ethical approval from the NRES Committee London – Westminster (Ref: **12/LO/0634**). Any personal details you provide to us will be made anonymous and your answers will remain strictly confidential. Data will be stored on a password protected computer but there will be no way of identifying you from this. If you do not wish to participate or if you change your mind and decide that you no longer want to take part, you may withdraw from the study at any time.   You will not have to give a reason and this will not affect you rights in any way. If you have any questions now or later please feel free to ask the researcher. I would like to thank you in advance for your time and cooperation with this study.

If you require further information about participating please contact Brian Sreenan at Brian.Sreenan.1@city.ac.uk.

Yours Sincerely,

_____

Brian Sreenan

B.A., PGDipPsych, MSc.

City University Student in D.Psych Counselling Psychology

Barnet, Enfield and Haringey **NHS**
Mental Health NHS Trust

The Whittington Hospital **NHS**
NHS Trust

CITY UNIVERSITY
LONDON

'The importance of the therapeutic relationship in an IAPT setting: A mixed methods analysis'

Please read this for more information regarding participation in our research

Participation is entirely voluntary

Version 1 – Therapist Information Sheet 18/11/11

Part 1

Invitation

We would like to invite you to participate in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. *Part 1 tells you the purpose of this study and what will happen to you if you decide to take part. Part 2 give you more detailed information about the conduct of the study.* Please ask us if there is anything that is not clear or if you would like more information. If you decide to take part in the study you will be given a copy of this information sheet to keep and will be asked to sign a consent form.

What is the purpose of the study?

The study is part of an educational project conducted at City University London by Brian Sreenan and Dr. Courtney Raspin. We are hoping to learn more about the relationship built between the therapist and client during the course of therapy. This is referred to as the Therapeutic Relationship.

Why have I been invited?

We are inviting all clients attending face-to-face Cognitive Behaviour Therapy (CBT) in the Barnet, Enfield and Haringey Increasing Access to Psychological therapies (IAPT) service.

What is CBT?

CBT is a talking therapy. It can help people who are experiencing a wide range of mental health difficulties. What people think can affect how they feel and how they behave. This is the basis of CBT. During times of mental distress, people think differently about themselves and what

happens to them. Thoughts can become extreme and unhelpful. This can worsen how a person feels. They may then behave in a way that prolongs their distress.

CBT practitioners help each person identify and change their extreme thinking and unhelpful behaviour. In doing this, the result is often a major improvement in how a person feels and lives (please see www.babcp.com for more information).

Why is this study taking place?

We are hoping to learn more about the relationship built between the therapist and client during the course of therapy. We are interested to find out if the therapeutic relationship can have an impact on the success of therapy in an IAPT CBT service.

Do I have to take part?

It is up to you to decide whether or not to join the study. We will describe the study (below) and reply to any questions you may have. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time without reason or penalty.

What will happen to me if I take part?

If you decide to take part, you will be asked to fill out a brief questionnaire at two stages during therapy (after session 2 and at the end of treatment). The questionnaires should take about 3 minutes to complete. You will be asked to place the questionnaires in a sealed envelope which will be provided. Your therapist **WILL NOT** see any of your questionnaires.

What are the possible disadvantages and risks of taking part?

There are no risks to the individuals taking part.

What are the possible benefits of taking part?

The information we get from this study will help us understand the Therapeutic Relationship built up during the course of therapy. It is hoped that the study will contribute to the ongoing development of psychologically based therapies.

What happens when the research study stops?

Data from this study will be reported as part of a doctoral degree undertaken by Brian Sreenan. You may withdraw your data from the project at any time up until it is used in the final report in September 2013. At this time you will be offered a summary of the completed study.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in total confidence. Further details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What if relevant new information becomes available?

You will be notified immediately in the event this study is stopped for any reason.

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

You are free to withdraw from the study and at any time without reason or penalty. Any data that is not identifiable to the research team may be retained.

What if there is a problem? *(Continued from Part 1)*

If you have any concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (please email Brian Sreenan at Brian.Sreenan.1@city.ac.uk in the first instance). If you remain unhappy and wish to complain formally, NHS Direct (0845 4647) can advise on complaints procedures.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the Barnet, Enfield and Haringey NHS Trust, but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate). Please note City University London insurance indemnity will apply.

Will my taking part in this study be kept confidential? *(Continued from Part 1)*

Everything you tell us will remain completely confidential within the limits of the law. Anonymity will be ensured by assigning you with a code number. All information provided by you will then be labelled using this number to ensure that sensitive data will not be directly identifiable to you. Code numbers will be stored on a security encrypted, password protected computer. Consent forms and administrative records will be retained in a locked cabinet in the researcher's office. Only the principle research will have access to personal data and information relating to this study. Please note you have the right to check the accuracy of data held about you and correct any errors. In line with normal procedure, data will only be used for this study and will be destroyed 7 years after its completion.

What will happen to the results of the research study?

Results from this study are intended to be published. We are only interested in the broad scientific results of the study and not in any particular individual's data. You will not be identified in any report or publication.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by the Westminster Ethics Committee (Ref: 12/LO/0634). The study has also been reviewed by the chief supervisor (Dr Courtney Raspin) and has been approved by the City University Ethics Board.

Further information and contact details

If you would like to receive independent information or advice about your rights as research participant you can contact the Patients Advice and Liaison Service (PALS) at Barnet and Chase Farm hospital on 020 8216 4924. Please use the contact details below if you would like more specific information about this study, advice as to whether you should participate or if you are unhappy with any aspect of the study after you participated:

- Brian Sreenan: Brian.Sreenan.1@city.ac.uk

- Dr. Courtney Raspin: Courtney.Raspin.1@city.ac.uk

Thank you for considering participating and taking the time to read this sheet.

Appendix 6 – Consent form – Therapist version

CITY UNIVERSITY LONDON

Participant Identification Number for this trial: _____

CONSENT FORM Therapists - Version 1 – 19/03/12

Title of Project: The importance of the therapeutic alliance in an IAPT setting: A mixed methods analysis

Name of Researcher: Brian Sreenan.   Research Supervisor: Dr Courtney Raspin

Please initial box

1. I confirm that I have read and understand the information sheet dated 18/11/11 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason or legal rights being affected.

3. I understand that I *may* then be randomly selected and approached to take part in a focus group.

   Please check this box if you do NOT wish to be approached about a focus group.

4. If I am selected to take part in the focus group, I am happy for my personal quotes to be used in the final report. I understand that my name will NOT be linked to these quotations in the final report.

5. I agree to take part in the above study.

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Name of Person taking consent   Date   Signature

Appendix 7 – Invitation – Client version

Researcher: Brian Sreenan,

                City University London

                Brian.Sreenan.1@city.ac.uk

Invitation to participate in our study:

'The importance of the therapeutic relationship in an IAPT setting: A mixed methods analysis'

You are invited to participate in a postgraduate research project conducted by Brian Sreenan under the supervision of Dr. Courtney Raspin from the Department of Counselling Psychology at City University London. We are interested in examining the therapeutic relationship (also called the therapeutic alliance, or working alliance) in an Increasing Access to Psyhological Therapies (IAPT) setting. Every current IAPT service user in the Barnet, Enfield and Haringey IAPT service has been contacted to take part in this study. The Barnet, Enfield and Haringey IAPT service are in full support of this research. Consent to invite participants to take part in the study was given by Dr. Lorna Fortune, Research and Clinical Governance Lead for Haringey Enfield & Barnet IAPT services.

Your participation in this study will consist of filling out one questionnaire at two different stages – one at the start of treatment (session 2) and one at the end of treatment. The questionnaires usually take about 2-3 minutes to complete. Each questionnaire will have a 'client code' instead of your name in order to make the questionnaires anonymous. Your questionnaires will be treated with the utmost care at all times. Please note, **your therapist WILL NOT see any of your responses**. Only the principle researcher will see any responses.

The enclosed information sheet gives full details of the study. The study has received full ethical approval from the NRES Committee London – Westminster (Ref: **12/LO/0634**). Any personal details you provide to us will be made anonymous and your answers will remain strictly confidential. Data will be stored on a password protected computer but there will be no way of identifying you from this. If you do not wish to participate or if you change your mind and decide that you no longer want to take part, you may withdraw from the study at any time. You will not have to give a reason and this will not affect your treatment in any way. If you have any questions now or later please feel free to ask the researcher.

If you require further information about participating please contact Brian Sreenan at Brian.Sreenan.1@city.ac.uk.

Yours Sincerely,

Brian Sreenan

B.A., PGDipPsych, MSc.

City University Student in D.Psych Counselling Psychology

CITY UNIVERSITY LONDON

Barnet, Enfield and Haringey **NHS**
Mental Health NHS Trust

The Whittington Hospital **NHS**
NHS Trust

'The importance of the therapeutic relationship in an IAPT setting: A mixed methods analysis'

Please read this for more information regarding participation in our research

Participation is entirely voluntary

Version 3 – Client Information Sheet 30/08/2012

Part 1

Invitation

We would like to invite you to participate in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. ***Part 1 tells you the purpose of this study and what will happen to you if you decide to take part. Part 2 give you more detailed information about the conduct of the study.*** Please ask us if there is anything that is not clear or if you would like more information. If you decide to take part in the study you will be given a copy of this information sheet to keep and will be asked to sign a consent form.

What is the purpose of the study?

The study is part of an educational project conducted at City University London by Brian Sreenan and Dr. Courtney Raspin. We are hoping to learn more about the relationship built between the therapist and client during the course of therapy. This is referred to as the Therapeutic Relationship.

Why have I been invited?

We are inviting the therapists of all clients attending face-to-face CBT therapy in the Barnet, Enfield and Haringey IAPT service.

Do I have to take part?

It is up to you to decide whether or not to join the study. We will describe the study (below) and reply to any questions you may have. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time without reason or penalty.

What will happen to me if I take part?

If you decide to take part, you will be asked to fill out one questionnaire at two stages during therapy (after session 2 and at the end of treatment). The questionnaires should take about 3 minutes to complete. You will be asked to place the questionnaires in a sealed envelope which will be provided. Your client **WILL NOT** see any of your questionnaires. You may also be asked to take part in a focus group with 4-5 of your colleagues. This is expected to last 50 minutes at a convenient location.

What are the possible disadvantages and risks of taking part?

There are no obvious disadvantages to the individuals taking part.

What are the possible benefits of taking part?

The information we get from this study will help us understand the Therapeutic Relationship built up during the course of therapy. It is hoped that the study will contribute to the ongoing development of psychologically based therapies.

What happens when the research study stops?

Data from this study will be reported as part of a doctoral degree undertaken by Brian Sreenan. You may withdraw your data from the project at any time up until it is transcribed for use in the final report in September 2013. At this time you will be offered a summary of the completed study.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. If you agree to take part in a focus group meeting it is important that you know that these groups will be tape recorded for later transcription and analysis, and the tapes will then be destroyed. In the transcription you will be assigned an identifying number so that your comments cannot be linked to you personally. Once the tapes are destroyed there will be no way to link you to anything you have said. Anonymous quotations from the focus groups may be used in reporting the study. However, every attempt will be made to ensure that you will not be identifiable from the quotes.

Further details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What if relevant new information becomes available?

You will be notified immediately in the event this study is stopped for any reason.

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

You are free to withdraw from the study and at any time without reason or penalty. Any data that is not identifiable to the research team may be retained.

What if there is a problem? *(Continued from Part 1)*

If you have any concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (please contact Brian Sreenan by email at Brian.Sreenan.1@city.ac.uk in the first instance). If you remain unhappy and wish to complain formally, NHS Direct (0845 4647) can advise on complaints procedures.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the Barnet, Enfield and Haringey IAPT NHS Trust, but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate). Please note City University London insurance indemnity will apply.

Will my taking part in this study be kept confidential? *(Continued from Part 1)*

Everything you tell us will remain completely confidential within the limits of the law. Anonymity will be ensured by assigning you with a code number. All information provided by you will then be labelled using this number to ensure that sensitive data will not be directly identifiable to you. Code numbers will be stored on a security encrypted, password protected computer. Consent forms and administrative records will be retained in a locked cabinet in the researcher's office. Only members of the research team will have access to personal data and information relating to this study. Please note you have the right to check the accuracy of data held about you and correct any errors. In line with normal procedure data will only be used for this study and will be destroyed 7 years after its completion.

What will happen to the results of the research study?

Results from this study are intended to be published. You will not be personally identified in any report or publication, but anonymous quotations may be used, as described above.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by the NRES Committee London – Westminster (Ref: **12/LO/0634**). The study has also been reviewed by the chief supervisor (Dr Courtney Raspin) and has been approved by the City University Ethics Board.

Please use the contact details below if you would like more specific information about this study, advice as to whether you should participate or if you are unhappy with any aspect of the study after you participated:

- Brian Sreenan: Brian.Sreenan.1@city.ac.uk

- Dr. Courtney Raspin: Courtney.Raspin.1@city.ac.uk

Thank you for considering participating and taking the time to read this sheet.

Appendix 9 – Consent form – Client version

CITY UNIVERSITY LONDON

Participant EMIS number for this trial: _____

CONSENT FORM Clients - Version 1 – 19/03/12

Title of Project: The importance of the therapeutic alliance in an IAPT setting: A mixed methods analysis

Name of Researcher: Brian Sreenan.   Research Supervisor: Dr Courtney Raspin

Please initial box

1. I confirm that I have read and understand the information sheet dated 18/11/11 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study.

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Name of Person taking consent   Date   Signature

Appendix 10 – The Helping Alliance Questionnaire – Revised (HAq-II) – Therapist version

THE HELPING ALLIANCE QUESTIONNAIRE

Therapist Version

INSTRUCTIONS: These are ways that a person may feel or behave in relation to another person -- their patient. Consider carefully your relationship with your patient, and then mark each statement according to how strongly you agree or disagree. **Please mark every one**.

Session #: _____ Client PCMIS Number: _____

Therapist Name: _____ Client Name:_____

	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
1. The patient feels he/she can depend upon me.	1	2	3	4	5	6
2. He/she feels I understand him/her.	1	2	3	4	5	6
3. The patient feels I want him/her to achieve the goals.	1	2	3	4	5	6
4. At times the patient distrusts my judgment.	1	2	3	4	5	6
5. The patient feels he/she is working together with me in a joint effort.	1	2	3	4	5	6
6. I believe we have similar ideas about the nature of his/her problems.	1	2	3	4	5	6
7. The patient generally respects my views about him/her.	1	2	3	4	5	6
8. The patient believes the procedures used in his/her therapy are not well suited to his/her needs.	1	2	3	4	5	6
9. The patient likes me as a person.	1	2	3	4	5	6

		1	2	3	4	5	6
10.	In most sessions, we find a way to work on his/her problems together.	1	2	3	4	5	6
11.	The patient believes I relate to him/her in ways that slow up the progress of the therapy.	1	2	3	4	5	6
12.	The patient believes a good relationship has formed between us.	1	2	3	4	5	6
13.	The patient believes I am experienced in helping people.	1	2	3	4	5	6
14.	I want very much for the patient to work out his/her problems.	1	2	3	4	5	6
15.	The patient and I have meaningful exchanges.	1	2	3	4	5	6
16.	The patient and I sometimes have **un**profitable exchanges.	1	2	3	4	5	6
17.	From time to time, we both talk about the same important events in his/her past.	1	2	3	4	5	6
18.	The patient believes I like him/her as a person.	1	2	3	4	5	6
19.	At times the patient sees me as distant.	1	2	3	4	5	6

Appendix 11 – The Helping Alliance Questionnaire – Revised (HAq-II) – Client version

THE HELPING ALLIANCE QUESTIONNAIRE

Client Version

INSTRUCTIONS: These are ways that a person may feel or behave in relation to another person -- their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree. **Please mark every one**.

Session #: _____ Client PCMIS Number: _____

Therapist Name: _____ Client Name:_____

	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
1. I feel I can depend upon the therapist.	1	2	3	4	5	6
2. I feel the therapist understands me.	1	2	3	4	5	6
3. I feel the therapist wants me to achieve my goals.	1	2	3	4	5	6
4. At times I distrust the therapist's judgment.	1	2	3	4	5	6
5. I feel I am working together with the therapist in a joint effort.	1	2	3	4	5	6
6. I believe we have similar ideas about the nature of my problems.	1	2	3	4	5	6
7. I generally respect the therapist's views about me.	1	2	3	4	5	6
8. The procedures used in my therapy are not well suited to my needs.	1	2	3	4	5	6
9. I like the therapist as a person.	1	2	3	4	5	6
10. In most sessions, the therapist and I find a way to work on my problems	1	2	3	4	5	6

	together.						
11.	The therapist relates to me in ways that slow up the progress of the therapy.	1	2	3	4	5	6
12.	A good relationship has formed with my therapist.	1	2	3	4	5	6
13.	The therapist appears to be experienced in helping people.	1	2	3	4	5	6
14.	I want very much to work out my problems.	1	2	3	4	5	6
15.	The therapist and I have meaningful exchanges.	1	2	3	4	5	6
16.	The therapist and I sometimes have **un**profitable exchanges.	1	2	3	4	5	6
17.	From time to time, we both talk about the same important events in my past.	1	2	3	4	5	6
18.	I believe the therapist likes me as a person.	1	2	3	4	5	6
19.	At times the therapist seems distant.	1	2	3	4	5	6

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

The Whittington Hospital NHS
NHS Trust

Appendix 12 – Patient Health Questionnaire (PHQ-9)

Patient Health Questionnaire (PHQ-9)

Session: _____ Client PCMIS Number: _____

PHQ- 9

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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 a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ9 total score			

Appendix 13 – Generalised Anxiety Disorder (GAD-7) Questionnaire

Generalised Anxiety Disorder (GAD-7) Questionnaire

Session: _____ Client PCMIS Number: _____

GAD-7

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD7 total score			

Appendix 14 – Full regression table; Change in Depression as Outcome

N=37	B	SE B	β	R	Adjusted R^2	ΔR^2
Step 1						
(Constant)	25.33	14.67				
Client TA Time 1	.031	.136	.048			
Client TA Time 2	-.21	.16	-.30			
Therapist TA Time 1	-.01	.15	-.01			
Therapist TA Time 2	-.04	.13	-.06			
Depression Session 1	-.62	.13	-.65**	.66	.44	
Model 2						
(Constant)	24.80	12.33				
Client TA at Time 2	.02	.13	.04			
Therapist TA Time 1	-.21	.15	-.30			
Therapist TA Time 2	-.05	.11	-.06			
Depression Session 1	-.62	.13	-.65**			.000
Model 3						
(Constant)	25.52	11.72				
Client TA Time 2	-.18	.10	-.26			
Therapist TA Time 1	-.05	.11	-.07			
Depression Session 1	-.62	.13	-.65**			-.001
Model 4						
(Constant)	22.76	10.02				
Client TA Time 2	-.20	.09	-.29*			
Depression at Session 1	-.62	.12	-.65**	.44	.40	-.004

Note: ** p<.001, * p < .05

Appendix 15 - Full regression table; Change in Anxiety as Outcome

N=37	B	SE B	β	R^2	Adjusted R^2	ΔR^2
Step 1						
(Constant)	20.19	13.14				
Client TA Time 1	.085	.124	.147			
Client TA Time 2	-.294	.144	-.473*			
Therapist TA Time 1	-.021	.139	-.025			
Therapist TA Time 2	.049	.119	.074			
Anxiety at Session 1	-.584	.138	-.592**	.42	.32	
Model 2						
(Constant)	19.17	11.02				
Client TA Time 2	.08	.12	.14			
Therapist TA Time 1	-.29	.14	-.46*			
Therapist TA Time 2	.040	.10	.06			
Anxiety at Session 1	-.59	.14	-.59**			.000
Model 3						
(Constant)	21.40	9.38				
Client TA Time 2	.073	.11	.13			
Therapist TA Time 1	-.27	.12	-.43*			
Anxiety at Session 1	-.58	.13	-.59**			-.003
Model 4						
(Constant)	22.68	9.08				
Client TA Time 2	-.21	.08	-.34*			
Anxiety at Session 1	-.58	.13	-.59**	.40	.37	-.007

Note: ** p<.001, * p < .05

Chapter B – Critical Literature Review

Compulsive hoarding: A subtype of OCD or separate disorder? Exploring the success of CBT-style treatments and neuropsychological approaches

Prolegomenon

This literature review was written in my first year of training. I had come straight from a Masters degree in in Institute of Psychiatry and had somewhat of a fascination with neuropsychology and epidemiology. I chose to write on this topic as one of my first clients I worked with after starting this Doctorate had been diagnosed with OCD/Hoarding. At this stage in my career I was quite reliant on following manuals and would avidly read up about treatment types and current research. I was struck with how my client's presentation differed from other subtypes of OCD. This became somewhat of an 'obsession' and I decided to put my reading 'compulsion' to good use and start to construct a literature review. Unfortunately, the client dropped out of treatment after a session or two and I did not have the opportunity to work with him for very long.

Earlier this year the DSM-V was published. Hoarding was included under the "Obsessive-Compulsive and Related Disorders" chapter but, due to the available data, it was reclassified as a disorder in its own right. The literature reviewed in this section played an important role in delineating Hoarding from OCD and the DSM-V notes that "available data do not indicate that hoarding is a variant of obsessive-compulsive disorder" (DSM-V, 2013, p.7).

I decided to keep the literature as is to give a snapshot of my thought processes during first year. Reading back on the document I noticed how much 'clinical' language is used. Also, the subjective experience of sufferers of Hoarding is largely neglected, mostly due to the lack of qualitative research that has been done in this area, but also because my fascination with neuropsychology, diagnosis, and categorisation. I feel like I have evolved as a research and a practitioner in the subsequent years and hope this document gives an indication of my starting point on this journey.

1. Introduction

Although hoarding has been relatively neglected in terms of clinical and research evidence, evidence supporting compulsive hoarding as a separate disorder form of OCD has begun to emerge across a divergent range of research methods, including brain imaging (Pertusa et al., 2008) and genetics (Samuels et al., 2007). However, this paper will focus primarily on the recent studies involving neuropsychology (Hartl et al., 2004; Grisham, Brown, Savage, Steketee, & Barlow, 2007; Lawrence et al., 2006), cognitive models of compulsive hoarding (Frost & Hartl, 1996; Himle & Franklin, 2009; Steketee & Frost, 2007) and treatment studies (e.g. Abramowitz, Franklin, Schwartz & Furr, 2003; Steketee, Frost, Tolin, Rasmussen, & Brown, 2010) to explore the differences between people diagnosed with hoarding behaviours and participants with other symptoms of OCD.

1.1 OCD

Obsessive–compulsive disorder (OCD) is a complex and heterogeneous psychiatric disorder characterized by obsessions and compulsions. Obsessions are unwanted ideas, images, or impulses which repeatedly enter an individual's mind (Veale, Freeston, Krebs, Heyman, & Salkovskis, 2009). Although recognized to be self-generated, they are often experienced as egodystonic (Heyman, Mataix-Cols, & Fineberg, 2006) and are acknowledged by the patient as unreasonable or excessive (Veale et al., 2009). Compulsions are repetitive behaviours or mental acts which are often intended to neutralize anxiety provoked by the obsessions. They can be overt (e.g. checking that a door is locked) or covert mental acts (e.g. mental repetition a specific phrase). These rituals are often driven by rules that must be applied rigidly. Attempts to resist the compulsion are met with increasing anxiety, which is generally relieved as soon as the person gives in to the compulsion. In order to qualify for the diagnosis, the symptoms must be considered disabling, for example, cause marked distress or interfere with a person's everyday routine (APA, 2000).

1.2 Epidemiology

OCD can result in significant disability, and the World Health Organization rates it as one of the top 20 most disabling diseases (Mataix-Cols, van den Heuvel, van Grootheest, & Heyman, 2009). Although the severity of this disorder is acknowledged, it often remains undetected and undiagnosed for a significant period of time. A recent study found that the mean delay from

onset of symptoms to receiving treatment was 14 years, although younger patients tended to access treatment sooner (Cullen et al., 2008).

Studies have shown that up to 90 per cent of the normal population experience unwanted, intrusive thoughts with the same content as people with OCD (Rachman & de Silva, 1978; Salkovskis & Harrison, 1984). Epidemiological studies indicate that OCD is a critical widespread condition (De Mathis et al., 2006) with lifetime prevalence rates of this disorder 0f 0.25–3% (Heyman et al. 2001; Zohar, 1999). Other studies have reported 6-12month prevalence rates of approximately 1% (Bebbington, 1998; Ruscio, Stein, Chiu, & Kessler, 2010).

1.3 OCD as a Heterogeneous disorder

The symptoms of OCD are heterogeneous to the extent that two individuals with the same diagnosis can display completely different nonoverlapping symptom patterns (Mataix-Cols, Rosario-Campos, & Leckman, 2005). However, symptoms of OCD have been shown to group in particular ways. Historically, investigators have attempted to categorise the OCD phenotype into separate homogeneous strands. For example, the distinction between *folie du doute* ("madness of doubt") and *délire du toucher* ("delusion of touch") was made by Farlet as far back as 1869 (Hantouche & Lancrenon, 1996; Cited by Mataix-Cols, 2006, p.84). More recently, factor and cluster-analytical studies have identified at least four relatively independent and temporally stable symptom dimensions: (1) contamination obsessions and washing/cleaning compulsions; (2) aggressive, sexual and religious obsessions and related compulsions (often checking); (3) obsessions concerning a need for symmetry or exactness, ordering/arranging, repeating, and counting compulsions; and (4) hoarding and collecting obsessions and compulsions (Leckman et al., 1997; Mataix-Cols, Rauch, Manzo, Jenike, &Baer, 1999). Furthermore, for decades researchers have distinguish "washers" from "checkers" (Khanna & Mukherjee, 1992) and other symptom-based clusters in exploratory research (Khanna, Kaliapernmal & Channabasvanna, 1990) and therapeutically orientated trials (Abramowitz, Franklin, Schwartz & Furr, 2003). Other authors have chosen to group sufferers into a continuum, for example, insight (Foa & Kozak, 1995) or impulsivity (Hoehn-Saric & Barksdale, 1983).

1.4 Delineating Hoarding from OCD

Interestingly, the DSM-IV-TR (APA, 2000) does not explicitly mention compulsive hoarding as a symptom of OCD. However, studies have reported high rates of hoarding and saving-related obsessions and compulsions in patients with OCD (Rasmussen & Eisen, 1992; Hanna, 1995). For example, studies of clinical OCD samples indicate a frequency of hoarding in 18–40% of adults and children/adolescents (Frost, Krause & Steketee, 1996; Mataix-Cols, Nakatani, Micali, & Heyman, 2008). Furthermore, hoarding and saving-related obsessions and compulsions are included in standard, widely used OCD assessments, such as the Yale-Brown Obsessive Compulsive Scale symptom checklist (Goodman et al., 1989) and the Obsessive–Compulsive Inventory-Revised (OCI-R) (Foa et al., 2002).

Factor and cluster analytical studies have consistently identified a separate hoarding factor in large samples of OCD patients (Mataix-Cols et al., 2005). Bloch and colleagues (2008) completed a meta-analysis of 21 studies containing over 5000 individuals from across the world suffering from OCD which confirmed that hoarding is an independent factor, both in adult and child and adolescent samples (Bloch, Landeros-Weisenberger, Rosario, Pittenger, & Leckman, 2008).

The nosological status of hoarding is said to remain unresolved with the term not explicitly covered in either DSM–IV (American Psychiatric Association 1994) or ICD–10 (World Health Organization 1992). Hoarding as a symptom of obsessive–compulsive personality disorder (OCPD) is evident in the DSM-IV (Wu & Watson, 2005). However, Gaston and colleagues (2009) argue that available evidence opposing this classification is widely available. For example, hoarding severity does not correlate with the severity of OCPD symptoms with only 15–45% of hoarders meeting the criteria for OCPD (Samuels et al., 2002; Steketee & Frost, 2003). Studies suggest that clinically significant compulsive hoarding occurs in up to 5% of the population, twice the rate of OCD and almost four times the rate of disorders such as bipolar disorder and schizophrenia (Pertusa et al., 2010).

Pertusa and colleagues (2010) suggest that approximately half of patients who meet criteria for compulsive hoarding syndrome have comorbid OCD (clinically significant obsessive-compulsive symptoms other than hoarding) although the majority of patients with compulsive hoarding syndrome plus OCD are phenomenologically comparable with those who do not have

comorbid OCD. An earlier paper by Pertusa and colleagues (2008) noted that in some patients with compulsive hoarding plus OCD there were special characteristics that were clearly associated with "obsessional themes" (Pertusa et al., 2008, p.1294). Thus, it is unclear whether these cases of hoarding should be considered a primary symptom dimension of OCD or a behaviour that is secondary to other OCD symptom dimensions. As a result, the authors (Pertusa et al., 2008) also raise the question whether the symptom dimensions of OCD should be defined based on the observable behaviour (e.g., washing, hoarding) or the motivation driving these behaviours (e.g., fear of harm, fear of losing things, etc.).

Frost and Hartl (1996) proposed a set of criteria for compulsive hoarding syndrome. These have been used in subsequent studies have used these criteria to categorise compulsive hoarding in research. Both treatment and neuropsychological studies have used these guidelines to delineate hoarding from other OCD subtypes.

(1) The acquisition of and failure to discard a large number of possessions that seem to be useless or of limited value;

(2) Living spaces sufficiently cluttered so as to preclude activities for which those spaces were designed;

(3) Significant distress or impairment in functioning caused by the hoarding.

(Frost & Hartl, 1996, p.341)

Only a handful of neuroimaging studies have examined the neural correlates of compulsive hoarding in specifically selected samples. Preliminary studies to date implicate fronto-limbic circuits in the mediation of compulsive hoarding (Pertusa et al., 2010). This contrasts with the more likely involvement of frontal-striatal loops in OCD (Saxena & Rauch, 2000). Interestingly, fronto-limbic circuits have been implicated in compulsive hoarding samples with (An et al., 2009) and primarily without (Tolin, Kiehl, Worhunsky, Book & Maltby 2009) OCD. Neuroimaging studies suggest involvement of similar fronto-limbic networks (distinct from OCD) but results must be taken as very preliminary. The two hoarding studies mentioned are limited by small sample sizes. Furthermore, the mixture of hoarding with and without OCD remains a major confound until more is known about wider brain structures. As noted by a prominent neuroscientist, neuroimaging should be regarded as a correlational technique that allow researchers to understand neurophysiological bases of behaviours under study but not

necessarily their cause (Mataix-Cols et al., 2009). Thus, it is also important to look at the role of neuropsychology in assessing these frontal pathways implicated in compulsive hoarding.

2. Neuropsychology of Hoarding

A small number of studies have begun to examine neuropsychological function in compulsive hoarding. As memory problems have been hypothesized to underlie compulsive hoarding behaviour (Frost & Hartl, 1996), Hartl and her team (2004) compared individuals with severe compulsive hoarding (n=22, 4 of whom met criteria for OCD) to 24 matched 'normal' control subjects using by two measures of learning and memory that required strategic planning and organization for successful performance. The authors found that the hoarding group had poorer delayed visual and verbal recall and used less effective organizational strategies for visual recall compared with 24 healthy controls. These individuals also reported significantly less confidence in their memory and a greater level of worry concerning the potentially catastrophic consequences of forgetting. Importantly, the results remained significant after the exclusion of the four participants who also met criteria for OCD (Hartl et al., 2004). One limitation is the relatively small size of both the patient and control samples. Furthermore, the authors make reference to the fact that many of the clinical hoarding measures were designed specifically for the study and had not been validated. Thus, some caution is needed when interpreting results from this study.

Grisham et al. (2007) studied a group of patients with compulsive hoarding (n=30) and compared the results with a mixed clinical group (n=30) and a nonclinical community group (n=30). This study used a battery of valid and replicated scales such as the Wechsler Abbreviated Scale of Intelligence Subtests (WASI) and the Visual Memory Span (VMS) test. Overall, the hoarding patients demonstrated slower and more variable reaction time, increased impulsivity, greater difficulty distinguishing targets and non-targets, and poorer spatial attention relative to comparison groups. Furthermore, multiple regression analyses demonstrated that slower reaction time and increased impulsivity were significantly related to hoarding symptoms after controlling for the effect of depression, schizotypy, and OCD symptoms. This study, however, has a number of limitations. The authors suggest that a lack of a screening questionnaire to assess for any history of neurological problems or medical conditions that may have impacted cognitive function (e.g., Parkinson's disease) was not used (Grisham et al., 2007, p.1481). Moreover, the study did not include a nonhoarding OCD comparison group. Thus, conclusions cannot be drawn on whether weaknesses in this group

are associated with hoarding specifically or OCD more generally. Also, comorbid symptoms of OCD in the clinical control group were fewer than those in the hoarding group. As was expected, comorbid disorders were high in the hoarding group thus adding another confounding variable to take into account when interpreting the results.

In attempting to delineate mediating neural mechanisms involved in different OCD symptom dimensions, Lawrence and colleagues (2006) used the Iowa Gambling Task (IGT) and the Wisconsin Card Sorting Test (WCST) to test decision making and set shifting respectively to see if there was a difference between patients with OCD and controls. Previous tests using the IGT and skin conductance found that continued risk taking is frequently accompanied by a reduced ability to generate skin conductance responses prior to choosing cards from

high-risk decks (i.e. decks of cards that are fixed to generate big wins and losses), especially in groups of people who are classified as being impaired decision makers (Bechara & Damasio, 2002). Autonomic signals are said to provide useful information that guides decision making (Bechara & Damasio, 2002). Lawrence and colleagues measured skin conductance responses in conjunction with the gambling task. One-quarter of the OCD group were reported to have prominent hoarding symptoms, as measured by the Yale-Brown Obsessive Compulsive Scale (Y-BOCS). Participants with hoarding symptoms showed impaired decision making on the IGT as well as reduced skin conductance responses. The findings indicate that the hoarding symptom dimension of OCD may impair neuropsychological task performance which may be caused by disruptions in frontal brain regions (Lawrence et al., 2006). However, the relatively small sample size, particularly for the skin conductance response data, is a severe limitation in this study. Furthermore, because of the large number of independent variables included by the authors in the regression analyses, the results may have been subject to statistical errors (e.g. type 1 errors). Interestingly, Grisham et al. (2007) found their hoarding group had an equivalent performance on the IGT compared to non-hoarding OCD patients and healthy controls. There may be a fundamental difference between the hoarding groups in the two studies (Lawrence et al., 2006 and Grisham et al., 2007) as Grisham's (2007) study reported hoarding as their principal (and in some cases only) OCD symptom, whereas Lawrence and colleagues (2006) selected a subgroup of patients with additional hoarding symptoms from a group of patients diagnosed with OCD. Grisham et al. (2007) speculate that patients whose primary psychiatric symptom is compulsive hoarding have a somewhat different aetiology and clinical presentation than OCD patients with additional hoarding symptoms.

It is difficult to draw firm conclusions from these preliminary reports. Studies are hindered by methodological differences. As seen, one of the main differences between the two studies mentioned above is the sample population.

Whereas Grisham and colleagues (2007) used a relatively 'pure' hoarding sample, Lawrence et al. (2006) used mainly clients diagnosed with OCD with only a minority of participants indicating that hoarding was their primary problem. Comorbid symptom of OCD may have influenced the neuropsychological results in the studies. Thus, neuropsychological investigations comparing hoarding individuals with and without OCD are needed. As noted below, the debated distinction between hoarders with OCD versus hoarders without OCD symptoms further complicates treatment studies.

3. OCD Symptom type as predictors of outcome for treatment

Perhaps one of the most important reasons for questioning whether hoarding is a 'symptom', OCD subtype, or separate entity to OCD, is that the various symptom factors of OCD have been reported to differ in their response to treatment. The efficacy of cognitive behaviour therapy for OCD has been well established in controlled trials and is the primary recommended treatment by the NICE guidelines (NICE, 2005). However, a significant number of patients still remain unimproved or drop out from treatment. As a result, symptom presentation has received growing empirical attention as studies have revealed significant differences in treatment response rates.

3.1 Checking v Cleaning

Earlier studies such as Foa et al. (1983; Cited in Keeley, Storch, Merlo, & Geffken, 2008) found no predictive relation between type of ritual and treatment outcome comparing washing versus checking rituals. Randomised control trial studies have suggested that checking rituals may respond less well to cognitive behaviour therapy (Basogl Lax, Kasvikis & Marks, 1988). Other more recent studies have found no differences in outcome between washers and checkers for ERP/CBT (Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002) and behavioural therapy (Abramowitz et al., 2003). Mataix-Cols and colleagues (2005) suggest that it is often assumed that participants with 'pure' obsessions and mental rituals respond less well to classic behavioural interventions. However, data supporting these assumptions is sparse. Finally, a fear of contamination or overt ritualistic behaviours have been reported to predict greater

treatment gains resulting from behavioural therapy by some authors (Buchanan et al.,1996 cited in Keeley et al., 2008, p.121).

3.2 Sexual/Religious Obsessions

Rufer, Fricke, Moritz, Kloss and Hand (2006) used the Y-BOCS symptom checklist and found a trend for sexual/religious obsessions to be associated with poorer outcome following and average of 9 weeks of intensive CBT (which consisted of36 individual session and group sessions). Patients with sexual and religious obsessions tended to respond less frequently, although statistical significance was not reached. However, approximately 70% of the patients in the study received antidepressants (mostly SSRIs) in addition to CBT which may have been a significant factor in outcome results. No control group was put in place to test the effect of pharmacotherapy as a unitary entity. Thus, in the abovementioned studies (Abramowitz et al., 2003; Mataix-Cols et al., 2002; Rufer et al., 2006) ERP/CBT for cleaning and checking have been found to be quite effective in reducing these symptoms and predicting a positive response to treatment.

3.3 Hoarding

It has been noted by many authors that there is a paucity of literature on CBT that specifically targets compulsive hoarding. The majority of studies use assessment tools like the Y-BOCS to delineate hoarding from other OCD symptoms. Recent studies suggest that patients with hoarding symptoms in particular may be more treatment resistant (Mataix-Cols et al., 2009). Quantitative reviews have found that people diagnosed with hoarding have a poor compliance with and response to CBT (Ball, Baer & Otto, 1996). Ball and colleagues (1996) also comment that there may be a tendency to describe only the primary symptom under treatment even if participants present with multiple symptoms. Overall, little empirical evidence is available from studies of large patient samples.

The next section will introduce the two main models of treatment for hoarding (ERP/CBT and Specialised CBT) and present some of the largest and well-conducted trials along with their limitations. Additionally, the final section will look briefly at a Multimodal (psycho- and pharmaco-therapy) treatment for OCD and Compulsive-Hoarding as it remains as one of the largest studies conducted in OCD/Compulsive hoarding research.

4. Models of Hoarding and Treatment trials

4.1 Exposure with Response prevention (ERP/CBT)

Himle and Franklin (2009) describe ERP as 'a collection of treatment techniques that were borne from behavioral theory' (Himle & Franklin, 2009, p.29). The mechanisms of this form of treatment are described as "(a) extinction (or habituation) resulting from systematic exposure to fear-related stimuli and prevention of escape or neutralizing behaviors, and (b) alterations of fear-related beliefs and memory structures resulting from exposure to corrective information" (Tolin, 2009, p. 40).

ERP is broken down into two sections of direct therapy. The first step is to treat the obsessive behaviours by introducing controlled exposure. Participants are exposed either directly or indirectly to the situations, objects or places that trigger the obsession and heighten anxiety. The aim of this stage is to promote exposure to the obsessive trigger in small doses in order to decrease the amount of experienced anxiety. Habituation to the trigger will enable participants be able to control the level of anxiety. The second stage of ERP centres on the prevention of the compulsion that follows the obsession. Healthy behaviours replace the initial compulsions to perform the rituals. Ultimately the ideal outcome is for the patient to control the urge to perform ritualistic behaviours. Generally ERP/CBT is are broken in to six steps: 1) Psychoeducation, 2) Self-monitoring, 3) Instruction to decrease avoidant and compulsive behaviour, 4) Instruction to stop attempting to control internal events, 5) Deliberately doing things that are scary and avoided, 6) Encourage new ways of thinking (Tolin, 2009). This model has been used in numerous studies involving treatment for compulsive hoarding and OCD (Abramowitz et al., 2003; Mataix-Cols et al., 2002).

4.1.1. Trials using ERP/CBT

Abramowitz and colleagues (2003) used a large sample of 132 OCD patients which included a good proportion of men to women (70:62 respectively) with an age range from 18 to 65 years. The clinicians used two diagnosticians to assess the patients for OCD. All patients received ERP/CBT involving 15 treatment sessions. Consistent with the researchers' hypothesis, the hoarding cluster of patients displayed more severe post treatment OCD symptoms compared with all other patients. However, there are a number of limitations with this well conducted study. Almost half the participants had DMS-IV (1994) criteria for comorbid diagnoses, the

majority having depressive or anxiety disorders. Furthermore, almost two-thirds of the participants were receiving SRIs such as fluvoxamine both prior to and during the trial. Thus, although analysis indicated that the percentage of patients using medication did not differ across symptom clusters, it is difficult to delineate the effect of psycho- versus pharmaco-therapy in the study as a result.

Using a dimensional approach Mataix-Cols and colleagues (2002) aimed to assess whether identified OCD symptom dimensions were associated with treatment compliance and response to BT for OCD. 153 OCD outpatients were randomised to receive 10 weeks of treatment by (1) ERP guided by a computer and a manual (2) ERP guided by a behaviour therapist, or (3) relaxation guided by audiotape. OCD severity was assessed with the self-rated 10-item Y-BOCS severity scale. Interestingly, hoarding compulsions were over-represented in the trial because of a television programme on OCD where a hoarder detailed her battle with compulsive hoarding. Up to 3-month follow-up, OCD patients improved almost as much when ERP was guided by a computer as by a clinician, and both approaches were superior to control relaxation treatment. The results showed that 27% patients with hoarding obsessions and/or compulsions dropped out from the trial prematurely compared to 12% patients without hoarding symptoms. Furthermore, only 25% of hoarders responded to treatment compared to 48% of non-hoarders. Only 2% of patients responded to the placebo/(relaxation) treatment which suggests that relaxation treatment does not have any significant treatment benefit for the majority both hoarders and non-hoarders. The reasons for hoarders not complying with ERP remain elusive. This study suggests that patients with hoarding symptoms may have more difficulty complying with treatment (whether clinician- or computer-guided ERP or relaxation) than other OCD patients. Mataix-Cols and colleagues (2002) hypothesise that due to the ego-syntonicity of hoarding, clients are less likely to feel that their behaviours are having a severe enough impact on their lives and therefore do not feel motivated to change. Also, comorbidity with other difficulties such as anxiety, depression, and interpersonal issues also complicate treatment, potentially decreasing the likelihood of completing treatment (Mataix-Cols et al., 2000; Frost et al., 2000). Other accounts of unsuccessful BT in patients with hoarding symptoms may be due in part to their propensity to drop out earlier from treatment. Mataix-Cols and colleagues (2002) suggest that the Y-BOCS symptom checklist is currently scored according to the presence or absence of each specific symptom of OCD. They argue that because each patient can score in one or more of the checklist categories, an instrument that measures these symptoms dimensionally would be preferable. However, as mentioned before, other authors (e.g. Abramowitz et al., 2003) used cluster analysis alongside the Y-BOCS the

variance of factors is partitioned among several sources. Using this method may have increased the efficacy of the scale in the present study. Mataix-Cols and colleagues (2002) also suggest that the Y-BOCS inter-rater reliability needs to be more precise to avoid the possibility that different raters score its symptoms differently. The authors question whether participants who performs washing rituals in a rigid sequence, but not because of fears of contamination, should score in the washing or the symmetry categories of the checklist, or both?" (p.261). Put simply, should participants be categorised according to the act they perform, or the underlying reasons for completing the act. A consensus has not been reached between studies.

As mentioned previously, Rufer and colleagues (2006) conducted a relatively large study containing 104 participants with OCD as confirmed by a mini neuropsychiatric Interview for DSM-IV and ICD-10 diagnoses (Lecrubier et al., 1997) with all patients treated with multimodal CBT including therapist led in vivo exposure and response management (cognitive restructuring) followed by self-exposure and self-imposed response management without the therapist. Furthermore, participants were assessed with the clinician-rated Y-BOCS. Defining response to CBT as at least a 35% decrease on the Y-BOCS total score logistic regression revealed that patients with hoarding symptoms at baseline were significantly less likely to become treatment responders as compared to patients without these symptoms. Furthermore, higher mean scores on the hoarding dimension predicted poorer response to CBT even after controlling (statistically) for possible confounding variables such as pre-treatment Y-BOCS scores, Beck Depression Inventory scores and concomitant medication. There are a number of limitations with this study. As outlined in the report 56% of participants fulfilled the criteria for one or two comorbid Axis I disorders. No reference was made to the association between comorbidity and association (or lack thereof) with Y-BOCS dimensions. No structured clinical interview for Axis II disorders was performed. Furthermore, over 70% of the sample was receiving concomitant pharmacological treatments (mostly SSRIs) which were not controlled for (except statistically), although the authors argue that the study was representative of "clinical practice in the treatment of in-patients with severe OCD" (Rufers et al., 2006, p.445). Finally, the study lacks follow-up data that would be valuable in evaluating the effect of long-term CBT outcome measures in response to OCD symptom dimensions as outlined by the Y-BOCS.

Evidence fully supporting the efficacy and effectiveness of ERP/CBT for compulsive hoarding is contentious. The majority of trials show a high drop-out rate and a more tailored form of therapy may be necessary.

4.2 Specialised CBT Model for Compulsive Hoarding

A specialised model of CBT for Compulsive Hoarding was developed by Frost and Hartl (1996) and manualized by Steketee and Frost (2007). The model presumes that problems with acquiring, saving, and clutter result from:

(1) personal vulnerabilities that include past experiences and training, negative general mood, core beliefs, and information processing capacities, which contribute to (2) cognitive appraisals about possessions, which in turn result in (3) positive and negative emotional responses that trigger (4) hoarding behaviors of clutter, acquiring, and difficulty discarding/saving.

Steketee & Frost (2007, p.14)

The behaviours are reinforced in a number of positive and/or negative ways. For example, pleasurable, positive reinforcement may arise from saving and acquiring possessions whereas the avoidance of negative emotions of grief, fear, or guilt may result in negative reinforcement.

As mentioned previously, three types of information processing deficits have been associated with compulsive hoarding. Some of these deficits are also said to be found in other forms of OCD. These information processing deficits include deficits in decision-making, deficits in categorization/organization, and difficulties with memory functions (Frost & Hartl, 1996). It has been suggested that when deciding whether or not to discard a possessions, hoarders the thought of being without the item is thought about most often whereas the cost of saving the item or the benefit of not having it (e.g. health, space etc) is rarely considered (Frost & Hartl, 1996). This also adds to the indecisiveness symptom reported in compulsive hoarding. For example, Warren and Ostrom (1988; cited in Frost & Hartl, 1996, p.343) suggest that a fear of making mistakes may be behind the tendency to avoid making and/or postponing decisions about possessions. Another cognitive process related to hoarding is categorization. Each

possession is said to be seen as totally unique (in its own category). Therefore no other possession can substitute for it. As a result, this increases the value and importance of each item and as a result increases the need for the owner to keep it (Saxena & Maidment, 2007). In addition to deficits in decision-making and categorisation, the third deficit in Frost and Hartl's (1996) cognitive behavioural model of compulsive hoarding related to memory. Two aspects of memory are implicated in the model: a lack of confidence in memory and the overestimation of the importance of remembering or recording information (Frost & Hartl, 1996). Both of these elements of memory lead to patients keeping objects in plain view so as to keep track of what is owned and known. The authors also suggest that plain-view categorisation meant that compulsive hoarders did not have to rely on memory to know what possessions were owned (Frost & Hartl, 1996). Whereas some authors suggest that hoarders save possessions for non-sentimental reason (APA, 1994), others suggest that there is an emotional attachment to possessions (Frost & Hartl, 1996). Frost and Hartl (1996) also suggest that compulsive hoarders may infuse their possessions with human-like qualities and the removal or use of their possessions could lead to a feeling of a loss of control over their environment (Frost et al., 1995 cited in Frost & Hartl, 1996).

Finally, people suffering from compulsive hoarding frequently display anosognosia (deficit of self-awareness). Recent studies suggest that family and friends tend to rate the person's hoarding behaviour significantly higher than the person diagnosed with hoarding (Tolin, Fitch, Frost & Steketee, 2010). Poorer insight in hoarders was equated to showing less distress about the hoarding. Thus, results suggest that compulsive hoarding is characterized by poor insight into the severity of the problem (Tolin et al., 2010). The overall model is depicted in figure 1. This model is intended to depict the full spectrum of hoarding facets seen across clients.

4.2.1 Trials using Specialised CBT for Compulsive Hoarding

In the first pilot of this specialised treatment strategy (Frost & Hartl, 1996), Hartl and Frost (1999) reported the treatment to be a success in a single patient study.
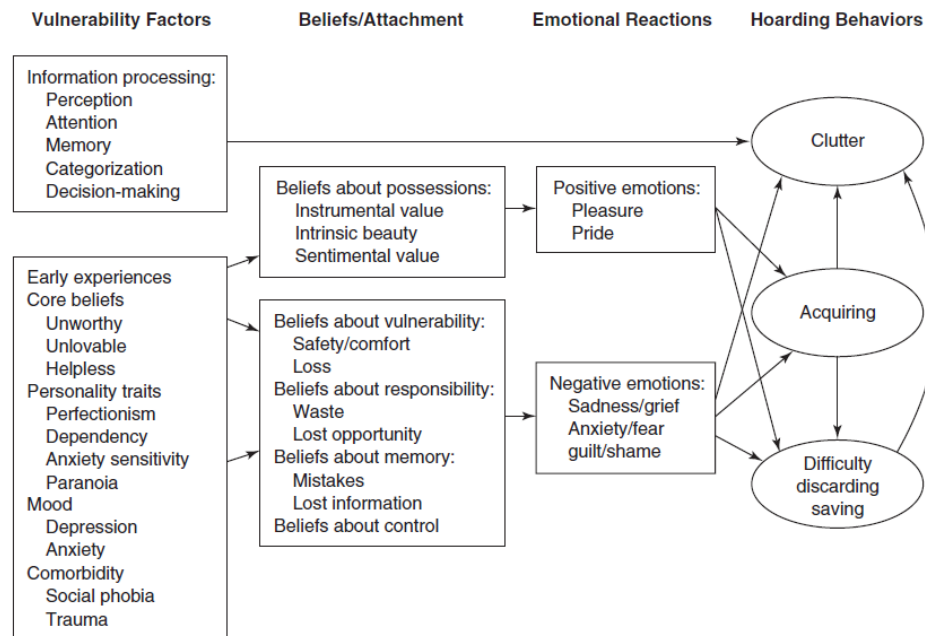
Vulnerability Factors   **Beliefs/Attachment**   **Emotional Reactions**   **Hoarding Behaviors**

Information processing:
  Perception
  Attention
  Memory
  Categorization
  Decision-making

Early experiences
Core beliefs
  Unworthy
  Unlovable
  Helpless
Personality traits
  Perfectionism
  Dependency
  Anxiety sensitivity
  Paranoia
Mood
  Depression
  Anxiety
Comorbidity
  Social phobia
  Trauma

Beliefs about possessions:
  Instrumental value
  Intrinsic beauty
  Sentimental value

Beliefs about vulnerability:
  Safety/comfort
  Loss
Beliefs about responsibility:
  Waste
  Lost opportunity
Beliefs about memory:
  Mistakes
  Lost information
Beliefs about control

Positive emotions:
  Pleasure
  Pride

Negative emotions:
  Sadness/grief
  Anxiety/fear
  guilt/shame

Clutter

Acquiring

Difficulty
discarding
saving

Figure 9 - Steketee & Frost's (2007, p.15) cognitive behaviour model of compulsive hoarding

Following 9 months of treatment, indecisiveness, hoarding, and OCD symptom severity were all reduced. A second study (Steketee & Frost, 2000) examined the efficacy a combination of specialised group CBT sessions and individual home visits over a 20 week period. The study found that five of the seven patients had noticeable improvement, with significantly reduced acquisition of items, increased awareness of irrational reasons for saving, and improved organizational skills (Steketee & Frost, 2000). What's more, treatment continued for several of these patients for up to 1 year, with continued improvement. This pilot also highlighted the needs to address difficulties with patient motivation and involve family members in order to promote progress and reduce risk of relapse and paved the way for larger trials of this model.

Subsequently, waitlist-controlled trials of CBT for hoarding have been conducted and have produced some interesting results. Steketee and colleagues (2010) investigated a multicomponent model of CBT for hoarding based on a model proposed by Frost and Hartl (1996) and manualized in Steketee and Frost (2007). Participants with clinically significant hoarding (n=46) were randomly assigned to CBT or waitlist conditions. Treatment included education and case formulation, motivational interviewing, skills training for organizing and problem solving, direct exposure to nonacquiring and discarding, and cognitive therapy. Semi-structured interviews (Hoarding Rating Scale-Interview; Tolin, Frost & Steketee, 2010) and self-report questionnaires (Saving Inventory-Revised; Frost, Steketee, & Grisham, 2004) were used

in assessing participants. Results found that after 12 weeks, participants receiving multicomponent CBT benefited significantly more than the control group on hoarding severity and mood with moderate effect sizes. After 26 sessions of CBT, participants showed significant reductions in hoarding symptoms with large effect sizes for most measures. At session 26, 71% of patients were considered improved on therapist clinical global improvement ratings and 81% of patients rated themselves improved; 41% of completers were clinically significantly improved. This well conducted RCT study found no significant baseline differences for gender, age, ethnicity/race, marital status, employment, anxiety or depression between the two groups (CBT and waiting list). Comparisons of treatment completers (n=36) to noncompleters (n=11) at baseline on demographic variables and hoarding severity also indicated no significant differences in age, gender, race, marital status, or employment, or mood state. Moreover, participants with a diagnosis of substance misuse within the last 6 months, receiving concurrent psychotherapy, or receiving psychiatric medication were excluded from the study, thus eliminating some potential confounding factors. However, as the population used was a largely white, well-educated adult sample, it is questionable whether the findings would generalise to more diverse populations. Also, the study did not use independent assessors blind to treatment condition which may have affected the results. This study suggests that multicomponent CBT was effective in treating hoarding. However, like other studies, treatment refusal and compliance remain a concern. As this is not a long-term follow-up study the durability of gains remains unclear. Overall, the specialised CBT methods employed in this study appear to improve upon standard ERP/CBT applied in earlier studies. However, as there was no ERP control group, this conclusion must be interpreted with caution. Furthermore, the 'multicomponent' aspect of this trial makes it unclear as to what specific components of the treatment contribute to the overall benefits.

4.3 Multimodal (psycho- and pharmaco-therapy) Treatment for OCD and Compulsive-Hoarding

Although not all studies concur, recent trials suggest that combination of medications and CBT is superior to either modality alone for OCD (Hohagen et al., 1998). As seen above, many studies have included concomitant medication with psychological interventions. Many multimodal treatment studies have tried to assess the efficacy of pharmaco- and psycho-therapy when comparing compulsive hoarders with participants with OCD with no hoarding behavioural patterns.

One of the largest studies conducted was done by Saxena and colleagues (2002) in which 190 OCD patients were treated over a 6 week period consisting of intensive CBT, medication, and psychosocial rehabilitation. Using the Y-BOCS, twenty of the 190 patients (11%) were identified as having the compulsive hoarding syndrome and the sample was split in to two groups (compulsive hoarders and nonhoarding OCD patients) and symptom severity and response to treatment was assessed. Frost and Hartl's (1996) cognitive-behavioural model of hoarding was used for the compulsive hoarding treatment group. Following treatment, both groups displayed significant improvements as assessed by the Y-BOCS. The two groups had similar pre-treatment Y-BOCS score, comorbid depression scores and medication did not differ significantly between groups. However, the hoarding group had higher pre-treatment anxiety scores, was significantly older and had significantly more women in the group. Difference in improvement between the two groups was significant even when age, gender and duration of treatment were controlled for. However, less than half of the hoarding group improved significantly. Again, this study is not without limitations. For example, symptoms were not rated by independent or blind raters. The authors conclude that "while the compulsive hoarding syndrome appears to be a distinct, more disabling, variant of OCD that does not respond as robustly to treatment, it may still improve significantly with intensive, multimodal treatment tailored to its specific features and associated deficits" (Saxena et al., 2002, p.21). However, different styles of CBT were used for the hoarding groups and the non-hoarding group thus questioning whether hoarders were less likely to respond to treatment or whether the treatment is ineffective for this population. Furthermore, since global Y-BOCS scores were used for pre- and post-treatment analysis, it is possible that the improvements in the hoarding group may have been due to improvements on other OCD symptoms and not specifically hoarding. The authors also suggest that long-term follow-up trials are needed to assess whether the improvement seen in the hoarding group continue to hold following treatment (Saxena et al., 2002).

5. Conclusion

As seen in this review, in recent years a nascent body of knowledge has begun to emerge across a divergent range of research studies (primarily quantitative) including neuropsychology (Hartl et al., 2004; Grisham et al., 2007; Lawrence et al., 2006), cognitive models of compulsive hoarding (Frost & Hartl, 1996; Himle & Franklin, 2009; Steketee & Frost, 2007) and treatment studies (Abramowitz, 2003; Steketee et al., 2010). Extensive literature searches revealed a paucity of qualitative studies on Compulsive Hoarding. Within the context of poor responsivity

to intervention, qualitative research on the chronic negative impact of compulsive hoarding on both carers and partners is also an increasing area of interest (Wilbram, Kellett & Beail, 2008). However, little or no qualitative research exists on clients' experiences during and after treatment. Analysis like this may be able to shed light on the most useful aspects or motivating factors of the various types of treatment available.

The majority of the qualitative literature explores how individuals understand and make sense of their hoarding behaviours. Interpretive-phenomenological analysis has been used to investigate such phenomenological questions and concerns, in the effort to give greater clarity regarding the "lived experience" of hoarding (e.g. Kellett, Greenhalgh, Beail & Ridgeway, 2010). However, as so few studies have been conducted, the manner in which people who hoard make sense of their own hoarding behaviours still requires "clarification, articulation and enunciation" (Kellett et al., 2010, p. 143). Interestingly, this particular study found pre-existing cognitive themes with respect to the act of hoarding (perfectionism) and also unveiled new, previously unexplored themes which may require more detailed research attention and provide more information on this complex disorder. The potential usefulness of the investigative nature of qualitative studies is neglected and poorly representative in research.

Compulsive hoarding, which correlates with increased comorbidity and has consistently been associated with poor treatment response to both medications and cognitive behaviour therapy, still remains an elusive entity which is yet to be fully understood. Much research remains to be done, starting with the development of better instruments of measure that fully capture the complex phenomenology of the disorder (e.g. replacing the Y-BOCS). However, subtyping OCD and compulsive hoarding into smaller, mutually exclusive entities could be an endless process. Mataix-Cols and colleagues (2005) suggest that both OCD and compulsive hoarding should be conceptualised "as a spectrum of potentially overlapping syndromes that can co-occur in any given patient" (p. 234). Thus, the aetiology or manifestation of the disorder may remain a complex, multifaceted construct. An increase in phenomenological understanding may significantly assist treatment methods and conceptualisations.

Finally, and more importantly, much research is needed to refine existing treatments or develop new treatments to meet all patients' needs. Many patients have trouble complying with or responding to conventional treatments. It is unclear whether this is due to comorbid

symptoms of OCD, the ego-syntonic nature of hoarding, or different reasons. Thus, a large scale, well conducted study is needed. For example, it would also be extremely useful to conduct a blind and controlled study using three distinct groups of participants: Hoarders without OCD, Hoarders with comorbid OCD, and a client groups with disorders who also show hoarding symptoms (e.g. ADHD; Hartl, Duffany, Allen,Steketee & Frost, 2005). A waiting list group and a concurrent medication group could also be used in each category. Both specialised CBT for compulsive hoarding (Steketee & Frost, 2007) and ERP/CBT (Himle & Franklin, 2009) could be used as treatment types. This may add valuable information about appropriate treatment types for different client groups suffering from compulsive hoarding. Furthermore, a longitudinal study (5-year follow-up) would be extremely useful to determine if changes in hoarding as a result of treatment are lasting.

There are numerous pieces of research needed to enhance knowledge on this intricate disorder, for example research on the development of these behaviours in normal populations across the life span. Mataix-Cols and colleagues (2005) suggest that the study of the various dimensions of both OCD and hoarding should be viewed from evolutionary and developmental perspectives. This, in turn, would reinforce the notion that the symptoms are "extreme and time consuming versions of anxious intrusive thoughts and harm-avoidant behaviours that are common to most of us" (p. 236). The adaptive occurrence of these symptoms can be seen during periods of life in which a heightened sensitivity to threats is present. Ultimately, this viewpoint may also provide therapists with a greater empathic understanding of their client's situation as the various symptoms may resemble aspects of the therapist's own internal experiences (Mataix-Cols et al., 2005).

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