Portfolio for Professional Doctorate in Counselling Psychology (DPsych)

Psychologists' experiences of using blended digital therapy with individuals experiencing paranoia: An interpretative phenomenological analysis

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Abbreviations/Acronyms

Abbreviation	Meaning
APP	Web-based/mobile/digital application
bCBT	Blended Cognitive Behaviour Therapy
BPS	British Psychological Society
BDT	Blended Digital Therapy
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behaviour Therapy
CBTp	Cognitive Behaviour Therapy for Psychosis
cCBT	Computerised Cognitive Behaviour Therapy
CGSH	Computerised Guided Self Help
CoP(‘s)	Counselling Psychologist(s)
DHI(‘s)	Digital Health Intervention(s)
DIT	Diffusion of Innovations Theory
DP(‘s)	Digital Platform(‘s)
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
EIP	Early Intervention for Psychosis
FDA	Foucauldian Discourse Analysis
FEP	First-episode Psychosis
HCPC	Health Care Professions Council
IAPT	Improving Access to Psychological Therapies Service
iCBT	Internet-based Cognitive Behaviour Therapy

ICD-10	International Statistical Classification of Diseases and Related Health Problems, tenth revision
IeP(’s)	Individual(s) Experiencing Paranoia
IT	Information Technology
IPA	Interpretative Phenomenological Analysis
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
PAPTRAP	Psychology and Psychotherapy: Theory, Research and Practice Journal
PP(‘s)	Practitioner Psychologist(s)
RCT	Randomised Controlled Trial
RR	Reciprocal Role
RRP(‘s)	Reciprocal Role Procedure(s)
SDR	Sequential Diagrammatic Reformulation
SLaM	South London & Maudsley NHS Foundation Trust
TA	Thematic Analysis
TAU	Treatment as Usual
TCoP	Trainee Counselling Psychologist
TDF	Theoretical Domains Framework
TPP(‘s)	Target Problem Procedure(s)
VR	Virtual Reality

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I look forward to what the future brings for us as we continue to learn, share, and grow.

Declaration

I hereby declare that the work presented in this portfolio is entirely my own, under the supervision of Dr Alison McGourty. Moreover, I grant powers of discretion to the University Librarian to allow the thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Preface

> *"We may not necessarily be aware that change is what we want until we begin to look more closely at ourselves and at the way we have become used to doing things."* (McCormick, 2002, p.3)

This portfolio encompasses three separate pieces of work that evidence the core competencies required to practice as a Counselling Psychologist (BPS, 2018) and demonstrate my journey to achieving these competencies.

The first component presents original qualitative research exploring psychologists' lived experiences using blended digital therapy (BDT) with individuals experiencing paranoia (IeP's). The second component is a publishable paper for a peer-reviewed academic journal. The portfolio ends with a combined case study and process report detailing my use of Cognitive Analytic Therapy (CAT) with a client [redacted]

The three sections of this portfolio are linked by a prevalent theme of **growth after change**. Each section presents circumstances that portray a lived experience of adapting to change, resulting in struggles, anxiety, resilience, habituation, and growth in response to change.

Section A - Research

The research presented explores qualified practitioner psychologists' experience of using BDT with individuals experiencing persistent and distressing paranoia, diagnosed with schizophrenia spectrum psychosis (F20-29 from the *International Statistical Classification of Diseases and Related Health Problems, tenth revision;* ICD-10). Although BDT has various defining features within the current literature, the current study adopts the understanding of BDT as an approach and a method of practicing psychological therapy in which face-to-face work integrates web-based or mobile-based interventions in therapy sessions. This research aimed to understand how psychologists made sense of and experienced their use of BDT and how this experience informed their professional practice and the therapeutic relationship with the IeP. Most studies within the limited literature base on BDT's exploring professionals' experiences of BDT were explored in the context of working with depression or anxiety. The bulk of studies conducted quantitative research. There is a clear gap in the literature regarding

a phenomenological understanding of therapists' experiences using BDT with individuals experiencing complex mental health needs, such as paranoia.

My ambition for this study stemmed from my deep interest in reflective practice and being well-informed as a trainee counselling psychologist about emerging novel therapeutic approaches. Admittedly, BDT was an approach I was unacquainted with and one which my research supervisor introduced me to during the first year of the doctoral programme. I was instantly intrigued by it and yearned to understand what this process felt like and what it meant to the small group of psychologists who had trialled it for IeP's. Although it is exciting to consider the use of novel therapeutic interventions and move with the times, we must ensure we are practicing ethically, safely, and aware of the dynamics that might emerge in BDT sessions. Recently, the Covid-19 pandemic impelled mental health services to swiftly transition to online working and meeting service users virtually, which understandably caused anxiety amongst novice online practitioners. As Anthony (2015) states, the speed at which technology evolves, compared to the speed online mental health services evolve, and the training required to keep up with technology, has become a genuine concern for the profession. These circumstances have only promoted awareness of society's fast-advancing digital era. For psychologists to use digital mechanisms safely within therapy, they must be aware of what to expect and manage this work competently.

Further motivation for this study stemmed from my passion and interest in working with psychosis, including symptoms of paranoia. My clinical placement experience of working in a secondary care psychosis recovery service showed me first-hand the great importance of taking time to build a collaborative, trusting therapeutic relationship with clients. Additionally, my affiliation and resonance with the humanistic philosophical underpinnings of counselling psychology formed part of my work with clients. I was intrigued by my immediate ambivalence towards the third 'electronic entity' existing in BDT sessions, how this might impact the therapeutic relationship, if at all, and how these were experienced and perhaps managed.

The ethos of Counselling Psychology influenced all components of this portfolio. A leading principle of Counselling Psychology is taking the perspective or frame of reference of the other (James, 2018). In the same way, the intention behind this study was to understand each psychologists' experience through the lens of their lived experience. This influenced the choice of Interpretative Phenomenological Analysis (IPA) as the methodology, which emphasises the importance of viewing each participant's experience as unique to them and their social and cultural life-worlds. I intended to use my counselling psychology values to understand the

phenomenological quality of each psychologist's experience of BDT. The study's research questions were the following: (1) How do psychologists experience the use of BDT with IeP's? (2) How do psychologists make sense of their experience of using BDT? (3) How do psychologists experience the therapeutic relationship when using BDT with IeP's?

The theme of growth after change is connected to this research component in that amongst the variety of rich themes that emerged, there existed, for most participants, a prominent experience of anticipatory and initial anxiety towards the use of BDT, which was a new experience. Over time, participants became aware of achieving a sense of safety and respite from the overwhelming duties of planning and delivering sessions when working alongside a digital platform. Participants became aware of how valuable they felt as practitioners offering their clients an extraordinary, bespoke, and novel experience. In turn, this led to professional growth and development in unique ways.

Section B – Publishable paper

The second part is a publishable paper for submission to the Psychology and Psychotherapy: Theory, Research and Practice (PAPTRAP) peer-reviewed journal. I chose this journal as it aims to promote theoretical and research developments in psychological therapies (including both process and outcome research) where mental health is concerned, which fits in well with the purpose of the study. This journal also welcomes qualitative papers, and its audience consists of a wide group of mental health professionals including those who work within the psychosis field, and those who use digital mental health interventions.

The journal article focuses on one of the three superordinate themes named "**Achieving respite and enhanced practice**," one of the novel findings that emerged from the research study introduced in Section A. This theme emphasises the benefits psychologists experienced from the use of BDT, which encompassed providing psychologists respite from the multitude of pressures they experienced from session planning and delivery, and the confidence gained in the quality of therapy being provided to IeP's when using the BDT approach. The therapeutic relationship further experienced enhanced quality of collaboration and equality in BDT, which was influenced by the digital platform's presence. Participants reflected on how they might develop their own routine psychological therapy practice, having learned new, unexpected lessons from BDT use, which further portrayed the running theme of growth after change.

Section C – Combined case study and process report

The final part of the portfolio presents a case study of clinical work using Cognitive Analytic Therapy (CAT) with a young woman, [redacted] The case study presents how therapy with [redacted] developed, my reflective process throughout the work and describes the developing therapeutic relationship between us. It consists of a detailed description of my use of CAT, which was the therapeutic approach deemed appropriate for [redacted]

[redacted]

[redacted]

[redacted]

As psychologists, and as displayed by the case study discussed, it is a necessary process and duty to reflect on the clinical work done with our clients to ensure we can provide safe, ethical, and effective care. An inevitable and essential part of this process consists of reflecting and understanding our reflective processes and struggles that can emerge in professional practice, to enable professional growth and development to occur. Supervision and consistent reflective practice have been a crucial part of my developing process of self-awareness and growth as a trainee counselling psychologist (TCoP), and one that has made me a more confident and competent clinician. These reflective processes were an inspiration to conduct the research study presented in this portfolio. The study aims to provide a space for psychologists' voices, which hopes to assist professionals, training institutions, and policymakers in developing robust competencies for managing blended therapeutic work. Digital technologies are progressively entering the field of psychology; as time goes on, we must be aware of how to manage the therapeutic work with them effectively.

In summary, the overarching theme within this portfolio relates to personal growth that can occur after grappling with change. In many ways, the idea of change from the status quo can cause anxiety and worry, and perhaps create self-doubt in one's capacity to manage the change. All the people involved within the three components of this portfolio experienced some change. My participants experienced and adapted to a change in how they were 'doing' therapy. [redacted] My identity has been shifting and changing throughout my training, and my identity is soon to change from TCoP to qualified psychologist. Throughout this personal journey, I have experienced anxiety, self-doubt, as well as growth and self-assurance through practice and reflection. All these processes consisted of adapting to a form of change and the anxiety and self-doubt that change triggers. However, importantly, they highlight the potential for tolerance and human resilience to manage change and the potential for growth and learning from the aftermath of change.

Section A: Original Research

Psychologists' experiences of using blended digital therapy with individuals experiencing paranoia: An interpretative phenomenological analysis

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Abstract

Various forms of blended digital therapy (BDT) have emerged for psychosis treatment overtime. A recent BDT intervention named ‘SlowMo’ was developed in the United Kingdom for individuals experiencing paranoia (IeP's), diagnosed with schizophrenia-spectrum psychosis.

Psychologists are at the forefront of delivering these interventions and play an important role in their uptake and dissemination. However, psychologists’ subjective experiences of using BDT’s with IeP’s lack the necessary representation in the evidence base. The current study therefore sits within the wider evidence base examining SlowMo and seeks to present an in-depth idiographic analysis of psychologists’ experiences of using BDT with IeP's.

Using Interpretative Phenomenological Analysis, this research studied eight clinical psychologists’ experiences of using BDT with IeP's. Participants were interviewed using semi-structured interviews.

The analysis of data revealed three superordinate themes: (1) "Moulded by one's past", (2) "Struggles of co-facilitation with a digital platform", (3) "Achieving respite and enhanced practice". The themes overall portray how psychologists’ professional identity and ethos of practice before BDT impacted their initial views and attitudes toward BDT. Psychologists described an initial struggle in adapting to BDT, and with this, came the initial struggle of managing the triadic relationship in BDT. Psychologists continuously experienced the need to negotiate their autonomy over session facilitation with the digital platform. Overtime, psychologists experienced the numerous meaningful benefits of using BDT with IeP’s, both for self and for IeP. Psychologists organically reflected on their professional development after BDT, having learnt new, unexpected lessons to take into their own routine practice.

Implications for practice, supervision, and training programs are emphasised. Implications for policymakers within the realm of BDT’s and digital therapeutics are also highlighted.

Chapter 1: Literature Review

1.1 Overview

This research focuses on understanding psychologists' subjective experiences of using blended digital therapy (BDT)[1] with individuals experiencing paranoia (IeP's). This experience is of interest for several reasons. Firstly, specific challenges can emerge for therapists when working with IeP's including a lack of trust that clients develop for their therapists (Bassman, 2000; Deegan, 1997; Kelly, Cohen, & Peters, 2019), and feelings of self-doubt, incompetence, anxiety, and vigilance that therapists experience around eliciting paranoia or negative responses in IeP's (Lawlor, Hall, and Ellett, 2015). These findings are taken from literature examining processes in traditional, one-to-one Cognitive Behavioural Therapy for Psychosis (CBTp), and possibly indicate processes that occur for therapists' when using BDT with IeP's that are currently unknown and need exploration and understanding. The latter part of this chapter demonstrates findings of professionals' reluctance to using BDT's with severe mental health conditions, which further adds interest in the current study.

Secondly, a novel BDT intervention named 'SlowMo' is being trialled for effectiveness with IeP's who have a diagnosis of schizophrenia-spectrum psychosis (F20-29, ICD-10), via a randomised controlled trial (RCT; Garety et al., 2021a). The current study makes up a subsection of the overall analysis of SlowMo's efficacy and future implementation. The experiences of the psychologists who used SlowMo have not been explored, thus being an influence of this study.

Thirdly, professionals, such as psychologists, have the crucial task of promoting and supporting the use of BDT's, as well as adopting this approach themselves (Berry, Bucci & Lobban, 2017). Therefore, it is crucial for practitioners to be aware of good practice and to be trained in and adequately prepared for the use of digital health interventions such as BDT (Goss & Anthony, 2009). This chapter will demonstrate the dearth of research examining psychologists' experiences of BDT use with IeP's, as well as the limited qualitative studies available examining the use of BDT with other mental health conditions.

This chapter presents five sections aiming to explore what is known about this area of interest. The first discusses the emergence, definition, and current understandings of BDT, including

[1] The term "blended therapy" is used at various points throughout this thesis to refer to BDT.

an exploration of the triadic relationship within BDT. The second part explores the existing knowledge and literature on the development, rationale, and research findings behind BDT for psychosis and paranoia. The third part focuses on therapist[2] experiences of working with paranoia and presents the existing research on professionals' perspectives of stand-alone, digital health interventions (DHI's). The fourth part presents a literature review on professionals' perspectives of BDT's. No studies were available exploring psychologists' or therapists' experiences of using BDT for psychosis or paranoia specifically. Therefore, this section mainly reflects the existing research on professionals' perspectives of BDT use for depression and anxiety. In the final section, gaps in the literature, rationale for the present study and relevance to Counselling Psychology will be clarified.

1.2 Blended Digital Therapy (BDT)

1.2.1 Definition and rationale

Information technology (IT) is ubiquitous within our current society, with people now having easy access to smart technologies such as smartphones and wearables (Hollis et al., 2018). Amidst this societal development, mental health providers have capitalized by developing innovative ways of using IT to provide psychological support, otherwise known as digital health interventions (DHI) (Berry, Salter, Morris, James, & Bucci, 2018; Ruwaard & Kok, 2015). DHI's occur when a form of digital technology is involved in the delivery of clinical and/or therapeutic interventions. The method of delivering DHI's is not one-dimensional and can occur in varying fashions, including stand-alone online DHI's, and DHI's that are *blended* with traditional, human-therapist support.

Stand-alone DHI's, such as well-known internet-based CBT (iCBT) or computerised CBT (cCBT) involve no therapist input, are purely self-help, or include brief therapist support (Topooco, et al., 2017). This can include self-help mobile applications (apps), such as those available on the National Health Service (NHS) mental health apps online library (NHS, n.d.). Digital programs based on CBT have been evaluated in over 100 controlled trials with promising results for various mental and somatic disorders over the last 21 years (Andersson, 2016; Ruwaard & Kok, 2015; Topooco et al., 2017).

[2] The term 'therapist' will be used throughout this chapter to refer to practitioner psychologists, as well as psychotherapists.

BDT occurs when face-to-face meetings between a therapist and client involve, and integrate, an adjunct digital platform (DP) [3], such as interactive, web-based digital tools, which facilitate or aid the delivery of clinical material or interventions. Thus, face-to-face, and internet-based interventions are provided within the same space-of-time (Erbe, Eichert, Riper & Ebert, 2017; Titzler, Saruhanjan, Berking, Riper, & Ebert, 2018; Wentzel, van der Vaart, Bohlmeijer, & van Gemert-Pijnen, 2016), and so, there exists a triad, or triadic relationship, between therapist, client, and DP in each BDT session. In BDT practice, clients might additionally be able to access therapy materials, such as recorded messages, at any time using a digital device such as a mobile telephone app, if this is part of the intervention (Fairburn & Patel, 2017; Garety et al., 2021b). Although BDT can be understood and defined in numerous ways (e.g., Hanley, 2017a), the current study adopts the definition that has been detailed thus far for BDT in this segment.

This integration of face-to-face therapy with a DP is known to provide the best of both worlds through the provision of low-threshold, web-based materials, independent of place and time, which can increase a client's sense of ownership, along with upholding the benefits of a strong therapeutic alliance within the face-to-face interaction (Fairburn & Patel, 2017; Kenter et al., 2015; Kip, Wentzel, & Kelders, 2020; Krausz, Ramsey, Wetterlin, Tabiova, & Thapliyal, 2019). A purpose of having a DP in BDT is to make the treatment more efficient, as the DP takes over one or more tasks usually undertaken by the clinician, such as delivery of psychoeducation. The DP has also been found to make treatment more effective, as in the case of virtual reality-based exposure (Freeman et al., 2016; Valmaggia et al., 2016), which is a type of BDT. Thus far, BDT's have been developed and trialled for the treatment of depression, and anxiety respectively, conducted in Germany (Baumeister et al., 2020; Titzler et al., 2018), Amsterdam (Kooistra et al., 2016), and the Netherlands (Kenter et al., 2015; Kip et al., 2020; Kooistra et al., 2016; Mol et al., 2020; van der Vaart et al., 2014). Thus, their high prevalence in European countries is evident.

The face-to-face element of BDT is also thought to be impactful in determining the effectiveness of the BDT treatment. Most systematic reviews for instance have found that offering a form of therapist support during online treatment increases its effectiveness and is associated with higher levels of completion (Andersson & Cuijpers, 2009; Newman, Szkodny, Llera, & Przeworski, 2011; Richards & Richardson, 2012; Spek et al., 2007; van der Vaart et

[3] The term digital platform and digital program will be used interchangeably throughout this thesis to represent the digital platform in BDT.

al., 2014; Wilhelmsen et al. 2013). To assess a client's state of mind for instance, clinicians might rely on face-to-face cues including appearance, body language, and voice quality (Suler, 2016). Thus, the qualities of human-human intimacy, trust, and commitment, which occur within face-to-face work, are made possible and are perhaps an asset within BDT's as opposed to stand-alone DHI's.

1.2.2 The triadic therapeutic relationship

The therapeutic relationship is defined as the interaction and connection between a therapist and client defined through the provision of mental health treatment (Priebe & McCabe, 2008). The therapeutic relationship and dynamics that occur within have taken various stances, for instance in CBT the notion of collaborative empiricism is emphasised, whereby therapist and client engage in active, shared work (Dattilio & Hanna, 2012). Thus, there is a problem-solving partnership in which old ways of thinking and acting are compared and weighed against alternative, new ways (Moorey & Lavender, 2019). Psychoanalysis has focused on the peculiarities of the relationship that develops between therapist and patient conceptualised as transference and countertransference (Lemma, 2016).

A unique quality of BDT is the existence of a triadic interaction between DP, therapist, and client. The focus might either be on the human-human interaction or on the DP in the room (Erbe et al., 2017), shifting occasionally from one and the other. It is curious what might be occurring within this three-way encounter during BDT sessions. Authors have suggested that there exists a relationship that clients might create with the DP and therapist respectively, which might have significant implications for the therapeutic and relational dynamics occurring within the therapy session, and for formulations that are constructed during the therapy (Bucci, Schwannauer, & Berry, 2019a). This triadic relationship has been depicted by Figure 1.1, where the direction of the arrows represents the direction of one entity experiencing a relationship with the joining entity. Suler (2016) suggests computers play a neutral role in therapy, as they do not have emotions and so do not act or react out of pain, impulsivity or fluctuating emotions triggered by the conversation in the room. And so, within this figure, it is implied that the DP is not able to experience a relationship with the other entities in the room.

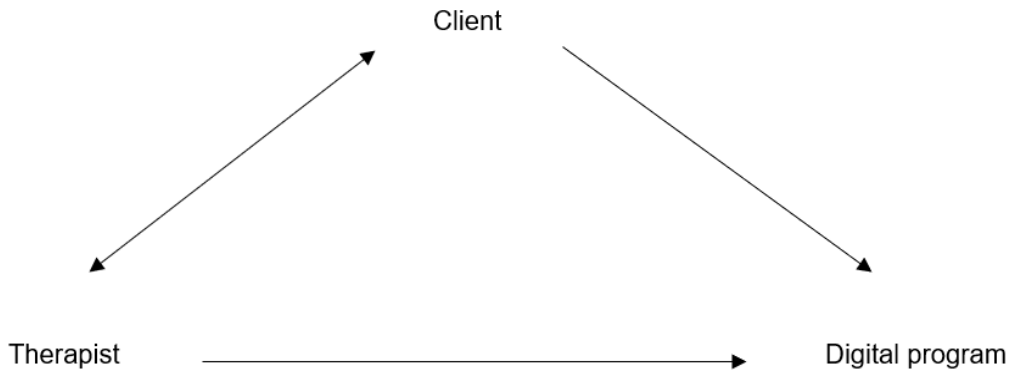

Figure 1.1: The Triadic Relationship in BDT.

Although there exists no available literature examining the triadic relationship in BDT, several studies touch on the dynamics and processes that might occur within separate sections of the triad in stand-alone DHI studies, and on the therapeutic relationship, which are explored next.

1.2.2.1 Client-DP

Suler (2016) writes about the neutral role the DP holds, bringing with it a consistent calm and patience and comfort to clients. He compares the digital system to the analytic neutrality that psychoanalytic clinicians use to encourage transference reactions, thus making the computer program the perfect 'blank screen' for the client's projections (Suler, 2016). Clients experiencing social anxiety or paranoia might feel more comfortable at first in engaging with an entity that they know is not human. Those on the autistic spectrum are thought to be relieved by the consistency, predictability, and lack of emotional reactivity of the DP (Berry et al., 2018).

Bucci et al., (2019a) present an interesting idea regarding the possible attachment representation the DP holds for the person. Just as adults internally represent internal working models of the relationships formed with others and project these representations onto individuals they relate with, similarly, the internal representations of the relationships and networks the platform represents might facilitate the bond with the DP. Factors such as the responsivity to the data entered in a digital app, the tailored responses, consistency of advice and the use of illustrative characters might all enhance the relationship the individual forms with the DP being used (Cavanagh & Millings, 2013). Clients have reported feeling heard, understood, and respected by the DP in CCBT programs for instance (Cavanagh, Belnap, Rothenberger, Abebe, & Rollman, 2018), and qualitative research has found that young people

display sentimental and anthropomorphic views towards their mobile phone (Fullwood, Quinn, Kaye, & Redding, 2017).

Studies examining attitudes towards stand-alone DHI's of clients with early psychosis found the DP more accessible across space and time compared with receiving information and support from clinicians. Creating a safe distance from a clinician also facilitated openness and honesty about distressing experiences and empowerment (Bucci et al, 2018a). However, it is notable that in the same study by Bucci et al. (2018a) clients also viewed apps as potentially invalidating and described the need for clinician involvement. Similarly, Bendelin et al. (2011) found patients perceived iCBT as both positive and motivating, however some missed having a real-life conversation with a therapist and felt pressured by the high intensity and short duration of the treatment program.

1.2.2.2 Client-Therapist and Therapist-Client

The therapeutic alliance has been found as the greatest predictor of therapeutic outcome (Bordin, 1979; Horvath, De Re, Flückiger, & Symonds, 2011; Martin, Garske, & Davis, 2000; Shattock, Berry, Degnan, & Edge, 2018). For clients experiencing psychosis, for instance, the bond with the therapist is of particular significance due the likelihood that they have had early traumatic experiences, thus impacting on their adult relationships and difficulties in engaging with services (Kreyenbuhl, Nossel, & Dixon, 2009; Shattock et al, 2018; Varese et al., 2012).

Current literature present insightful implications and considerations for the therapists' presence in BDT. For instance, the presence of the therapist when offering DHI's is purported to add crucial emotional reactions that a DP cannot provide, such as understanding and empathy (Suler, 2016). The human-human, therapist, and client interaction is suggested to offer the opportunity to think about oneself and others in terms of mental states and engage in mentalisation (Fonagy & Target, 2006; Kircher et al. 2009). Clients on occasion require support to understand therapeutic techniques, which can be illustrated by the therapist within face-to-face contact, thus purporting the importance of the human-therapist presence (Månsson, Ruiz, Gervind, Dahlin, & Andersson, 2013). Furthermore, iCBT studies on depression treatment have found that participants were motivated to persist with iCBT when their need for relatedness and connectedness was satisfied with intermittent consultations with a therapist. Thus, working with the DP alone was not seen as preferrable (Wilhelmsen et al., 2013).

1.2.2.3 Therapist-DP

DP's have a distinct ability to provide a visual representation of usually hidden or abstract experiences such as behavioural activity, emotional states, and cognitive appraisals. By making these visible through the screen, a shift might be encouraged in how emotional and physical states are conceptualised, expressed, and represented, as they are now visible knowable and thus manageable for service-users (Bucci, et al., 2019a; Morrison, 2015). This might imply the supportive nature of having an adjunct digital tool in sessions to visually portray abstract therapeutic messages.

Compared to humans, computers can carry out tasks efficiently, precisely, and quickly, with considerable capacity for memory storage (Suler, 2016). Mental health practitioners have been found to accurately detect deterioration in only 21.4% of people. Consequently, digital assessment tools could provide the support needed for accurate detection during the assessment process (Hatfield, McCullough, Frantz, & Krieger, 2010). Furthermore, DP's have been suggested to mediate the potential for "therapist drift" (Månsson et al., 2013; van der Vaart, et al., 2014) a phenomenon whereby therapists end up not adhering to their treatment manual or protocol and has been highlighted as an obstacle to effective CBT (Waller, 2009).

Evidently, there is a quality of support that therapists might experience from the presence of a DP within BDT, however, there are also barriers and challenges that therapists experience within this relationship explored later in this chapter. The literature presented in this section has mainly been extracted from studies examining stand-alone DHI's in which therapist and DP are not always present together with client through consecutive sessions. Thus, it is evident that more research is required to understand the nature of the triadic relationship in BDT where all three entities sit together each session.

1.2.3 UK national recommendations

Since the year 2006, the National Institute for Health and Care Excellence (NICE) guidance for adults with persistent subthreshold depressive symptoms, or mild to moderate depression, has recommended cCBT as a treatment option (Mayor, 2006; NICE, 2009). NHS England has also commissioned the assessment of therapist supported DHI's for depression and anxiety, so they can be adopted for use across the NHS Improving Access to Psychological Therapies (IAPT) services (NICE, 2019).

The recent Covid-19 pandemic in the year 2020, caused frontline providers working with individuals presenting with psychosis, and other community services such as Early Intervention for Psychosis services (EIP's), to shut-down temporarily and offer services through virtual means (Kopelovich, & Turkington, 2020). Ever since, services seem to have a new-found openness to facilitating sessions via digital means. For instance, a recommendation that was produced for EIP's since the Covid-19 pandemic by the UK's South London & Maudsley NHS Foundation Trust (SLaM) includes the embedding of e-health technology in the detection, assessment, and care of EIP patients (Jauhar et al., 2021). According to the NICE guidelines and the NHS Five Year Forward plan (NHS England, 2014), we can see the evidence base growing towards including more digital/computer-based therapies for various conditions. It is apparent therefore that services within the UK's NHS are moving with the times and therapy provision is becoming more inclusive towards the use of digital mediums, and thus BDT's.

A majority of the existing stand-alone DHI and BDT studies focus on anxiety and depression treatment. The next segment delves into the literature base exploring the literature base on stand-alone DHI's and BDT's for psychotic disorders, with a focus on paranoia, to gain a thorough understanding of what is known about this area.

1.3 BDT for Paranoia

1.3.1 Development and rationale for DHI's for psychosis

The DSM V (APA, 2013) classifies schizophrenia spectrum and other psychotic disorders as abnormalities in one or more of five stated domains, one of these being delusions. Delusions are key beliefs that are not amenable to change when considering conflicting evidence. They can include persecutory delusions, which is the belief that one is going to be harmed or harassed by another (APA, 2013). The term "paranoia" is used clinically and in everyday language to describe the tendency of some individuals to experience distressing fears about other people intentionally wanting to cause harm to them (Bentall & Sitko, 2020; Freeman et al., 2005). It is one of the most common symptoms of schizophrenia-spectrum disorders, and paranoia is known to lie on a continuum ranging from experiencing fleeting ideas, to more persistent beliefs otherwise known as persecutory delusions (Garety et al., 2017).

The development of psychological interventions for psychosis has accelerated over the last two decades (Hardy et al., 2018), and includes family interventions, CBTp, and EIP (Johns, Peters & Kuipers, 2007; Tarrier & Taylor, 2014). NICE recommends CBTp as the evidence-

based psychological intervention for psychosis, including paranoia (NICE, 2014), and CBTp has been found to improve psychotic symptoms, including paranoia, when added to treatment as usual in large clinical trials (Turner, Burger, Smit, Valmaggia, & van der Gaag, 2020).

Despite these points, the dissemination of CBTp has faced challenges in the form of access, engagement, adherence, and effectiveness (Freeman et al., 2013; Garety et al., 2017; Haddock et al., 2014). Paranoia is known to cause significant distress and disruption to an individual's life. The knock-on effect is an increased use of mental health services, need for inpatient admissions, and high costs to mental health care providers (Garety et al., 2017; Schizophrenia Commission, 2012). Accessing face-to-face psychological support can be challenging for those with severe mental health difficulties such as those experiencing paranoia (Berry et al., 2018; Garety et al., 2021a). Treatment for psychosis is time sensitive, and delays can lead to increased inpatient care for relapse (Bucci et al., 2019b). Within the NHS, costs of face-to-face therapy, lack of trained staff, time, and caseload pressures lead to a lack of availability for clients to access timely support (Berry, Lobban, & Bucci, 2019; Fisher, Manicavasagar, Kiln, & Juraskova, 2016; Ince, Haddock, & Tai, 2016). Stigma further adds to the barriers these clients experience in accessing necessary treatment (Berry, Lobban, Emsley, & Bucci, 2016; Clement et al., 2015). Over the last few years, we have also witnessed ardent debate relating to the endorsement of CBTp as evidence-based practice being oversold (McKenna & Kingdon, 2014) and authors have claimed there to be no evidence that CBTp was effective in well-conducted trials (Lynch, Laws, & McKenna, 2010). Furthermore, a meta-analysis concluded that the therapeutic effect for CBTp was in the small range (Jauhar et al., 2014).

Due to these access and dissemination issues, improvements in implementation are viewed as urgently required (Hardy et al., 2018). Recent years have seen an influx of DHI's for consideration in mental and psychological health-care delivery, to address the size and scale of these clinical and economical challenges. Such mechanisms of treatment delivery have been introduced as they can be more accessible, potentially less-stigmatising, flexible, and bespoke (Hollis et al., 2015; Hollis et al., 2018; Mohr, Weingar, Reddy, & Schueller, 2017), and harness the potential for improving health-related outcomes and reducing costs. This view of increasing access through the utilisation of DHI's further falls in line with the policy undertaking of the 'NHS Five Year Forward View' (Bucci, et al., 2019a; NHS England, 2014). There is a possibility that offering DHI's, such as BDT's, might be transformational for people experiencing psychosis to access treatment early, and to be offered choice and control over

the way they access mental health support (Berry et al., 2019; Stovell, Wearden, Morrison, & Hutton, 2016).

The last sixteen years has witnessed the development of various forms of DHI's, both stand-alone and BDT's, for various symptoms of psychosis (Alvarez-Jimenez et al., 2014; Bucci, et al., 2019a; Firth & Torous, 2015; O'Hanlon et al., 2016). These DHI's have emerged in the UK and internationally using various methods including web-based platforms (Gottlieb, Romeo, Penn, Mueser, & Chiko, 2013; Hardy et al., 2018), virtual reality/avatars (Chan, Ngai, Leung, Wong, 2010; Craig et al., 2018; Freeman et al., 2016; Rus-Calafell, Garety, Sason, Craig, & Valmaggia, 2018), and smartphone apps (Ben-Zeev, et al., 2014; Lim et al., 2020; Schlosser et al., 2018). Importantly, DHI studies have examined feasibility, usability, and acceptability (O'Hanlon et al., 2016). Results have shown high acceptability with reports of people successfully using the internet and mobile phone to manage their mental health (Alvarez-Jimenez et al., 2014; Bell & Alvarez-Jimenez, 2019; Berry et al., 2017; Berry et al., 2019; Bonet et al., 2018; Bucci et al., 2018a; Ennis, Rose, Denis, Pandit, & Wykes, 2012; Lal et al., 2015; O'Hanlon et al., 2016; Torous, Friedman, & Keshavan, 2014; Steare et al., 2021).

Examples of stand-alone DHI's for psychosis have included "Actissist", a CBT-informed self-help app, which showed promise for improving outcomes related to psychotic symptoms and mood (Bucci, et al., 2018b; Bucci, et al., 2019a). "PRIME" is a further smartphone app aiming to improve motivation and quality of life in young people with Schizophrenia, which resulted in positive effects (Schlosser et al., 2018). Although such findings are encouraging, limitations of stand-alone DHI's have also been found within research studying their acceptability and implementation. The phenomenon of the "digital divide", the gulf between those who have access to a computer and internet, and those who do not (Hollis et al, 2015), is a well-known limitation. Smartphone app use, for instance, has been suggested to be more sustainable with clinician support for EIP patients (Steare et al., 2021).

Intriguing findings were presented by Aref-Adib et al.'s, (2019) systemic review, which provide both useful understandings of the DHI literature, and rationale for the development of BDT for psychosis. The review found that psychosis or bipolar disorder diagnosed DHI users were more likely to complete an intervention when supported by staff. A barrier for clients with psychosis was the complexity of the DHI, particularly for those with lower premorbid IQ, or lower IT skills. Importantly, the review found sceptical beliefs about DHI's from patients and clinicians as a barrier to engage. For staff, a lack of IT skills, and general resistance to change were further barriers. These findings are important as they imply the necessity of

understanding the attitudes of clinicians in charge of delivering these interventions. These findings provide a good basis of knowledge, however a deeper and subjective understanding of these barriers for instance might provide an understanding of how they might be mediated. Aref-Adib et al, (2019) highlighted the paucity of evidence relating to organisational and process factors affecting implementation for DHI's. They hypothesised that the lack of reporting, evaluation, and thought around implementation might reflect the limited establishment of DHI's for psychosis or bipolar disorder, compared to common mental health problems, such as depression and anxiety.

Although there are some barriers located in the research, there is a clear rationale for DHI's for psychosis like BDT's. As demonstrated in this segment, approximately the last 15 years have seen the development and emergence of DHI's for psychosis, particularly those that have been stand-alone, with or without brief therapist support. Developments and research into BDT's for psychosis, and more specifically paranoia, are currently in their infancy (Aref-Adib et al., 2019; Hardy, Ward, & Garety, 2021). Thus, the next segment seeks to explore the existing knowledge we have on BDT's developed for various symptoms of psychosis in general.

1.3.2 BDT's for psychosis

BDT's for psychosis have emerged over time in varying formats. A prominent form has involved the use of virtual reality (VR) as an adjunct digital tool to face-to-face interventions in the assessment and treatment of psychosis. This has included the treatment of auditory verbal hallucinations as studied in the AVATAR therapy trial (Craig et al., 2018; Rus-Calafell, et al., 2018). This approach was found to be more effective in reducing the severity of persistent auditory verbal hallucinations with a large effect size after twelve weeks of treatment, than supportive counselling (Craig et al., 2018). VR has further been used as an adjunct to face-to-face meetings in studies with participants experiencing paranoia, which resulted in a significant decrease in delusional conviction (Freeman et al., 2016).

Depp, Perivoliotis, Holden, Dorr, and Granholm (2019) developed and investigated a single-session, in-person intervention called the CBT2go app augmented by mobile interactions for individuals with serious mental illness (those diagnosed with schizophrenia or bipolar disorder), which found a small effect on general symptomatology favouring the CBT2Go and self-monitoring conditions over treatment as usual (TAU; Depp, et al., 2019). The Horyzons platform was a further multicomponent DP for young people with first-episode psychosis (FEP),

which found that the blended aspect increased accessibility, continuity, consolidation and strengthening the relationship between young person and clinician (Valentine et al., 2020).

Measuring effect sizes and accessibility have formed a great part of the evidence base for BDT's developed for psychosis and findings have been promising (Hardy et al., 2021). One such BDT intervention for paranoia has been produced and tested via a RCT in the UK and will be explored next.

1.3.3 BDT for paranoia - 'SlowMo'

SlowMo is a UK-developed, BDT treatment program that aims to support IeP's through a tailored intervention targeting the specific mechanisms that research has shown to play a causal role in paranoia, including thinking habits recognised as 'fast thinking' (Garety et al., 2015; Garety et al., 2021a; Kahneman, 2011; SlowMo, 2021; Ward & Garety, 2019). Fast thinking is characterised by focusing on too little information, known as 'jumping to conclusions', and belief inflexibility (Hardy et al., 2021; Ward & Garety, 2019).

The method through which SlowMo sessions are conducted are consistent with the defining features of BDT highlighted in section 1.2.1. SlowMo consists of face-to-face therapy sessions between therapist and client (an IeP), supported by a DP, in the form of an interactive, web-based app, hosted on a touchscreen laptop device. SlowMo contains an additional digital component; a mobile telephone device with a personalised digital app, pre-installed for client use in daily life as part of behavioural experiments, and for therapy homework exercises outside of the 'clinic room' (Garety et al., 2021b). The delivery of SlowMo is designed as a BDT, in that the DP is used within face-to-face meetings between client and therapist, to facilitate the delivery of eight protocolised, sixty-to-ninety-minute sessions, within a twelve-week timeframe (Garety et al., 2021b). Thus, there exists a triad between therapist, client, and DP in each SlowMo session, with therapist and client regularly alternating their interactions between one another, and with the DP. Delivery of SlowMo is flexible, with sessions added where helpful, for example, the splitting of the DP modules across separate meetings (tailored to individual preference and engagement), and the addition of 'out of clinic' behavioural work to promote mobile app use and therapy generalisation to the real world (Garety et al., 2017; Garety et al., 2021b; Garety & Hardy, 2017; Hardy et al., 2018).

The DP presents interactive features including information, animated vignettes of other individuals who have experienced paranoia, games, and personalised content, which is

synchronised with the client's mobile telephone app (Garety et al., 2017; Garety et al., 2021b; Garety & Hardy, 2017; Hardy et al., 2018). Therapy sessions were delivered locally to the client at convenient locations of their choosing, including team bases, clients' homes, general practices or other local centres (Garety et al., 2017; Garety et al., 2021b; Garety & Hardy, 2017; Hardy et al., 2018). Part of the SlowMo therapeutic program is for out-of-clinic behavioural work to take place in the 'real world' to promote therapy generalisation. These would occur using the client's mobile telephone device and its synchronised content from in-clinic sessions. This behavioural work was assisted by the therapist and carried out in the client's local area, guided by their goals. It typically involved testing out the SlowMo strategies using the mobile's digital app in locations such as town centres, local cafes, pubs, and markets (Garety et al., 2021b).

So far, the SlowMo BDT intervention has been tested in a mixed methods design RCT to test the hypothesis that changes in fast-thinking mediate changes in the primary outcome of paranoia severity. Furthermore, service-users were interviewed to examine if the SlowMo platform has acceptable rates of usability, acceptability, and adherence (Garety et al., 2017). Results from the RCT demonstrated that SlowMo did not produce significant improvements in the primary measure of paranoia at 24 weeks. However, a beneficial effect of SlowMo on paranoia was indicated at an earlier point on the primary measure, and on self-reported persecution and observer-rated paranoia at 12 and 24 weeks (Garety et al., 2021a). Furthermore, SlowMo was found to overcome the digital divide associated with age and ethnicity (Hardy et al., 2021). Black people and older patients were found to be less confident of mobile phones prior to SlowMo, however, these differences did not translate to their experience, paranoia outcomes, or adherence comparable across groups (Garety et al., 2015; Hardy et al., 2021).

BDT's such as the SlowMo intervention show promising results. However, there exists a clear research gap currently on understandings of psychologists' experiences of BDT use for IeP's specifically, which is also the case for SlowMo. O'Hanlon et al. (2016) highlight the importance of understanding and addressing likely implementation challenges for more complex technology-based treatments. Considering therapists hold important occupational and political roles in the dissemination of technology-assisted treatments, it is important to understand their attitudes toward DHI's like BDT's (Carper, McHugh, & Barlow, 2013; Lovejoy, Demireva, Grayson, & McNamara, 2009; Schuster, Pokorny, Berger, Topooco, & Laireiter, 2018).

Studies have found that despite the advantages of BDT's, actual in practice implementation can be challenging, partly due to the barriers experienced by therapists, and the skills training required to use technology must be delivered to foster capability (Berry et al., 2017; Feijt, de Kort, Bongers, & IJsselsteijn, 2018; Kip et al., 2020). Thus, clinician involvement in the development and evaluation of BDT's are essential for the successful incorporation of new technologies in clinical practice (O'Hanlon et al., 2016). With such innovative mechanisms of therapy delivery developing, accompanied by an expectation on services and clinicians to implement these at a relatively fast pace with individuals experiencing serious mental health issues, such as paranoia, it would be crucial then to understand and learn from the therapists that have used them.

1.4 Therapist experiences

1.4.1 Working with IeP's

The previous segment highlighted the dearth of research on therapist experiences of using BDT with IeP's. As no studies exist on this phenomenon, it seems conducive to understand what we know about therapist experiences of working with IeP's for context. As there is limited literature on experiences of working with IeP's, and paranoia is a symptom of psychosis, this segment will include literature on psychosis and paranoia.

Lawlor et al., (2015) found that therapists can report feelings of self-doubt or incompetence, anxiety, and vigilance around eliciting paranoia or negative responses in their clients with psychosis and paranoia symptoms. Specific challenges for therapists when working with IeP's include their lack of trust in response to the previous oppression clients may have faced by mental health systems, past trauma, or victimisation (Bassman, 2000; Deegan, 1997; Kelly, Cohen, & Peters, 2019). Furthermore, there is a tendency for clients with psychosis to hold a different view of their problems and abilities than their therapists, which in turn might result in a client–therapist relationship that is fragile and riddled with potentials for rupture (Amador & Johanson, 2000; Hasson-Ohayon, Kravetz & Lysaker, 2017; Themistocleous et al., 2009).

Chadwick (2006) highlights the concept of therapist anti-collaborative modes which include (1) "*Failure*" (2) "*Risk to self*" (3) "*Risk to client*" and (4) "*Organisational beliefs*" (see Chadwick, 2006, p.22). Chadwick claims that these modes threaten relationship building with clients experiencing distressing psychosis, and drive therapist anxiety. Each mode is made up of therapist beliefs, feelings, and behavioural urges around a theme. All modes are played out

interpersonally with clients, potentially developing vicious cycles. For instance, therapists can often feel anxious in the early stages of work, which results from implicit assumptions and beliefs therapists hold about how therapy should progress, thus threatening collaborative working (Chadwick, 2006), and perhaps feeling like a failure if this does not happen.

These findings are important as they show how impactful therapists are in the direction the therapy takes dependent on their beliefs about their competence, and perhaps the stage of experience that they are at. Furthermore, as stated in the introduction, these findings show the strong possibility for therapist anxiety, stress, and responsibility taken in sessions when working with IeP's, which inspires the need to understand how therapists feel using BDT, a novel intervention with IeP's, to then understand how to support therapists effectively.

1.4.2 Attitudes toward stand-alone DHI's

The current segment seeks to understand what is currently known about therapist perspectives and attitudes towards stand-alone DHI's for various mental health presentations, including psychosis.

Since their origin, DHI's have provoked polarised clinician reactions; from careful optimism and appropriate caution (Goss & Anthony, 2003; Goss & Anthony, 2009; Goss, Robson, Pelling, & Renard, 1999; Lago et al., 1999; Pelling & Renard, 2000) to dismissive scepticism in the face of something unfamiliar (Goss & Anthony, 2002; Goss & Anthony, 2009; Reynolds & Morris, 2002).

For established practitioners, one's professional growth and identity development might impact their ease with adapting to a new approach comfortably. This might be because professional development necessitates the creation of a therapeutic style that is congruent with one's identity and personality characteristics, including ethical values and attitudes (Skovholt & Starkey, 2012), which develop overtime. Therefore, therapists might find themselves negotiating diverse and competing ideologies informing research activity, clinical practice (Hanley & Amos, 2017), and national guidance. Relatedly, the theoretical stance of the therapist has also determined the attitude the therapist has towards DHI's. Having a psychodynamic stance has mainly led to negative attitudes and having a CBT stance to positive attitudes towards stand-alone DHI's (Perle et al., 2013; Schröder et al., 2017; Wangberg, Gammon & Spitznogle, 2007). Socio-cultural factors also play a part. For instance, regional differences exist in the knowledge and acceptance of DHI's as stakeholders in

countries with more advanced eHealth services are found to have more positive attitudes to DHI's (Topooco et al., 2017).

Counselling Psychologists (CoP's) were found to raise concerns about online practice due to worries that sufficient levels of intimacy cannot be reached within online therapy (Hanley & Reynolds, 2009). Similar findings emerged in a qualitative investigation of mental health professionals' views of UK designed smartphone app, "Actissict" for people experiencing psychosis, who expressed concern that DP's lacked the nuance, warmth, and empathy a human can offer in easing distress (Bucci et al., 2019b). Interestingly, there exist concerns and fears for some professionals that their work will be replaced by technology, which might explain the low acceptance of web-based interventions (Andersson, & Titov, 2014; Bucci et al., 2019a; Bucci et al., 2019b; Caspar, 2004). Furthermore, staff working in rural areas, and studies exploring staff perceptions of DHI's when working with children and young people have expressed caution towards using DHI's for severe and complex cases (Sinclair, Holloway, Riley & Auret, 2013; Stallard, Richardson, & Velleman, 2010; Vigerland et al., 2014), which might include IeP's.

A further stand-alone DHI study within the psychosis field conducted by Kumar et al., (2018), aimed to establish the feasibility of implementing a smartphone app and affiliated web-based dashboard called the 'LifeData system' in community outpatient early psychosis clinics in Northern California. The app was used as an adjunct tool in between regular psychology sessions, but the results were discussed in sessions using the technology. Early psychosis clients and treatment providers, who included therapists, trainees, case managers, psychiatrists, employment specialists, and family advocates, filled out satisfaction surveys at study end regarding usability and acceptability of the app. The main findings discovered the providers' significant interest and openness in incorporating new technologies for enhancing care. Barriers noted were the regular requirement of staff aid to resolve technical glitches, which caused frustration amidst providers. Although a limitation of this study is that it used a sample of providers who were from varied professions, it provides useful knowledge in terms of both acceptability and barriers of DHI use.

Steare et al. (2021) further explored EIP service user and clinician perceptions on the acceptability and usability of a supported, self-management, UK smartphone app named 'My Journey 3'. This was a qualitative study using semi-structured interviews with twenty-one EIP service users who had access to My Journey 3 as part of a feasibility trial, and with thirteen EIP service clinicians supporting with app use. Data were analysed using a deductively driven

thematic analysis. The findings asserted that many EIP clinicians did not prioritise supporting service users with their use of the app over clinical priorities to achieve mandated service targets. This is akin to previous studies, such as Granja, Janssen, and Johansen, (2018) which found that additional workload was a key implementation barrier. Furthermore, Steare et al.'s (2021) study found that acceptability was also linked to clinicians' confidence with the technology, and so recommendations from the study were for tailored clinician training.

Recent studies understanding the barriers to implementing DHI's in mental health care have found therapists' lack of knowledge, skills, resources, and time, as a barrier for implementation of DHI's (Bucci et al., 2019b; Drozd et al., 2016; Kivi et al.,2015; Kurki, Koivunen, Anttila, Hätönen, & Välimäki, 2011; Nordgreen, & Havik, 2011). Added to this is an absence of professional leadership, terminology, and professional standards, causing this field to be diffused, unstructured and perplexing (Barak, Klein, & Proudfoot, 2009; Lovejoy et al., 2009). Consequently, therapists also face the complexity of assessing the appropriateness of technology treatments for each of their clients, which can be daunting (Lovejoy et al., 2009).

Conversely, therapists have experienced crucial benefits from the use of stand-alone DHI's. Research comparing therapists' experiences of online iCBT (with minimal therapist involvement) to face-to-face therapy found that iCBT aided therapists to achieve focus and structure of sessions due to the manual the program offers (Bengtsson, Nordin & Carlbring, 2015). Interestingly, such manuals or set-programs have been experienced as a safety measure for therapists, making them feel secure and believe that they are offering evidence-based material that would yield results. Many participants have even described iCBT as providing a less exhausting experience (Bengtsson et al., 2015).

Schueller, Washburn & Price (2016) studied US and Canadian mental health providers' interest in using web and mobile-based tools in their practices. The client group was not specified in the study. Common challenges that were highlighted were the comorbidity and complexities of client presenting issues, which could shift and change through treatment. They recommended technology solutions to be easy to use so there would be no added burden on providers. The main preferences included the use of a structured tool with minimal provider involvement, which was seen as alleviating providers' burden. Overall, providers seemed unwilling to endorse technology-based resources unless the value added to clinical practice is clear (Schueller et al., 2016). There is a strong emphasis therefore for technology being used to be facilitative for the practitioner's clinical work. However, what we do not get an understanding

of in this study is if the client population they were using the interventions with were an influencing factor at all.

Within the stand-alone DHI literature, there exists a dearth of literature on therapist experiences of using these approaches with IeP's. Nevertheless, stand-alone DHI's have been in existence longer than BDT, and the studies covered provide important understandings of professional's perspectives of DHI's and provide interesting opportunities to compare with the literature on BDT's.

1.5 Literature review on professionals' perspectives of BDT

1.5.1 Literature Search

As highlighted thus far, no studies exist exploring therapist experiences of using BDT with IeP's and studies that seek the experience of one participant population, such as psychologists, is vastly limited, as most studies tend to include mental health professionals of various specialisms. Therefore, my literature search sought both quantitative and qualitative studies on professionals' experiences and perspectives of using BDT (interventions that matched the definition of BDT stipulated in section 1.2.1 of this chapter) for various mental health issues.

To execute this literature review, I used the resources of CityLibrary (City, University of London's online library platform), and carried out a broad literature search from January 2000 to May 2021, to cover the period that these studies emerged. I used several databases and journals including PsycINFO, PsycArticles, Google Scholar, EBSCO, and Counselling Psychology Quarterly to find studies examining: (1) mental health professionals' experiences of using BDT, in which the professionals' support was provided either face-to-face, virtually, or a combination of both, (2) using quantitative, qualitative, or mixed methodologies, (3) conducted in the UK or internationally (4) were published in English. I used specific key words and search words for this literature search including 'blended therapy', 'blended intervention', 'digital health intervention', 'digital therapy', 'therapist supported', 'paranoia', 'psychosis', 'therapist', 'clinician', 'psychologist', 'perspective', or 'experience'. To increase chances of retrieving relevant literature, different combinations of phrases were used when searching.

The search mainly yielded results for studies examining mental health professionals' use of BDT for depression, and anxiety. Studies focusing on client experiences, iCBT, or cCBT programmes and interventions that did not meet BDT criteria (defined in Section 1.2.1 of this

chapter) were excluded. Furthermore, there were no studies researching therapist experiences of using BDT where the face-to-face therapist support was provided by virtual/online means only. To date there have been minimal studies examining the effectiveness of BDT interventions delivered via telehealth and not face-to-face on a large scale in real-world settings (Etzelmueller, Radkovsky, Hannig, Berking, Ebert, 2018; Lungu et al., 2020; Vis, et al., 2015). Therefore, the following literature review includes professionals' perspectives of BDT use, where the human-therapist support is provided either completely in-person, or, via an alternation of online and in-person sessions.

1.5.2 Attitudes and Acceptance towards BDT

Studies have commonly examined mental health professionals' attitudes and acceptance towards BDT's. Arguably, this might be due to their positions as gatekeepers of patient treatment choice (Du, Quayle, & Macleod, 2013). Thus, knowing how therapists, and mental health professionals perceive BDT would be important to aid its dissemination. Evidently, the evidence base leans more towards quantitative methodologies. A great portion of the research into mental health professionals', including therapists', experiences or perspectives of BDT's have been conducted internationally (outside of the UK), mainly offering BDT programs for anxiety, depression, or a combination. This will be demonstrated in the current segment.

Topooco et al., (2017) used an online survey in eight European countries, France, Germany, Netherlands, Poland, Spain, Sweden, Switzerland, and the UK, to explore mental-health stakeholders' knowledge and acceptance towards iCBT and BDT, and expectations when considering the integration of DHI's into regular care services in the treatment of adult depression. The participants included stakeholders such as care providers, trainees, funders, and technology developers who engaged with the E-COMPARED project. Participants indicated advantages and barriers of the implementation of DHI's into regular care. The main advantage indicated was the improved cost-efficiency and low feasibility of delivery within the care system was indicated as the primary barrier. iCBT and BDT had higher levels of acceptance for milder forms of depression, with BDT holding a considerably higher acceptance in comparison to iCBT. 55% of participants perceived BDT as suitable for moderate depression, and 22% found it suitable for more severe cases. Stakeholders portrayed an overall preference of BDT over web-based interventions. Crucial to note is that this study recruited a variety of professionals, and therapists, or psychologists were not specified as part of the sample. Therefore, this might limit generalisability of the findings to therapists who would be using BDT's. Nonetheless, we gain important understandings and insight into the potential

reticence stakeholders feel towards BDT as a suitable mode of therapy provision for more severe mental health presentations.

The findings present interesting considerations regarding practitioners in different countries and the varying attitudes they hold towards BDT's. Countries where e-mental health services had been more integrated, named "frontrunners", of which the UK is one, reported greater knowledge and more positive attitudes towards DHI's compared to others (Topooco et al., 2017). In addition, CBT was noted as the dominant model of psychotherapy adopted in frontrunner countries. This was seen to be interplaying with participants positive attitudes, since the bulk of existing BDT's incorporate CBT models (Topooco et al, 2017).

Like Topooco et al. (2017), Schuster et al., (2018) conducted a study where they compared attitudes towards stand-alone DHI and BDT using an online survey. Their study aimed to understand ninety-five Austrian psychotherapists' evaluations of stand-alone, web-based interventions, and BDT's, and to identify commonalities and differences in attitudes toward both formats. Furthermore, they aimed to test the impact an 8-minute video clip presenting the content of web-based and BDT interventions and their evidence base would have on participants. The study claimed to represent therapist attitudes in surroundings with less advanced eHealth services. Participants were from varied professional specialisms and were identified as mental health professionals ranging from psychologists, social workers, nurses, university professors and others randomly selected through email invitation.

Schuster et al.'s results showed that there was an increased perception of disadvantages for stand-alone web-based interventions, and practitioners viewed BDT's as contemporary and flexible. The effect of the information video was found to be negligible. The main advantages therapists perceived of BDT were the management of risk issues facilitated by the face-to-face component of BDT. However, participants also reported a very high therapist-based effort expectancy due to the expectation that workload would increase when using BDT. Mental health professionals were therefore evaluated as having a neutral to cautious attitude towards BDT, with overall preferences of BDT over stand-alone web-based platforms. The result must be read with caution however, as over 50% of the sample was made up of professionals whose occupations stemmed from varying professional backgrounds, which limits external validity. Although this is the case, the results might have also benefitted from the heterogeneity, thus accumulating various perspectives on survey results (Schuster, et al., 2018). There was also a chance for selection bias considering the study was conducted online, thus missing out data from potentially tech-averse therapists. This study also does not specify the client population

the sample work with, and so it is hard to ascertain if the nature of the clients these participants work with had any influence on their findings.

Baumeister et al., (2020) conducted a study in Germany with aims to assess licensed and trainee psychotherapists' acceptance of BDT, the effectiveness of an acceptance facilitating intervention (AFI) on participants, and to identify effect moderators. Just over 1% of participants had prior knowledge and experiences of BDT use. The AFI was a 5-minute video intending to positively influence attitudes towards BDT. The researchers conducted an experimental study with a balanced (1:1) randomization scheme, and an exploratory analysis using a linear regression model to examine, and identify, potential moderators to the effect of the AFI on participants' acceptance. Results of the explorative analysis revealed that AFI effect on acceptance was almost doubled for psychodynamic psychotherapists showing that the AFI displayed positive effects on psychotherapists´ acceptance towards BDT. Furthermore, their explorative analysis revealed a subpopulation of psychotherapists using depth psychology showing lower than average acceptance for BDT. The findings suggest that acceptance in more sceptical therapists can be mediated using AFI's in training, but they might not be sufficient to further increase acceptance of psychotherapists who are open to this approach. The randomised sample selection added to the strength and rigour of the study (Gray, Grove, & Burns, 2013) however, once again the study's sample is not representative as the therapists to opted in from the study's invitation might have had a bias towards being digitally open. This study adds important information about type of training that can facilitate BDT acceptance, however, does not add great depth to revealing in-depth subjective understandings of therapist attitudes toward BDT.

van der Vaart et al., (2014) explored the possibility of blending online therapy with face-to-face therapy in the treatment of depression in secondary mental health care in the Netherlands and included both patients with depression and therapists as their sample. Attitudes, preferences, and current experiences with (online) therapy were studied amongst therapists and clients. A Delphi method was used to find consensus on suitable blended protocols (content, sequence, and ratio). Twelve therapists and nine patients completed the surveys. Results showed that BDT was positively perceived among all respondents, because it was perceived as enhancing the patient self-management. Most respondents felt practical therapy components such as psychoeducation, could be provided online, whilst process-related components such as discussing thoughts and feelings should be supported face-to-face. Interviews also showed that tailoring treatment to individual patients was seen as essential in secondary mental health care, due to the severity and complexity of their problems.

This study's findings are supported by several meta-analyses and other reviews of cCBT programs for anxiety and depression in adults, which found larger effect sizes for programs incorporating therapist support compared to those that did not (Andersson & Cuijpers, 2009; Newman et al., 2011; Spek et al., 2007). Crucial to note is the possibility for self-selection bias in van der Vaar et al.'s (2014) study, as the sample of therapists and participants might have had more positive attitudes to BDT's than non-responders. The data also must be interpreted with care, as it might not be translated to different target populations or to different services such as primary care, forensic services, or specialist services such as psychosis services.

These studies show the interest European researchers from various countries take in understanding professionals' attitudes, with a significant interest in measuring acceptance towards BDT's vs. stand-alone DHI's. This is important, as it highlights an initial knowledge gap that existed regarding professionals' relationship with BDT's. Given that this is a novel mode of therapy delivery, understanding professionals' attitudes and acceptance can inform the likelihood of BDT uptake and dissemination, whilst also informing organisations about training needs as Baumeister et al., (2020) portrayed. Limitations of these studies also need to be highlighted. As these studies were all quantitative in nature, many of the factors studied were pre-conceived by the researchers. For instance, acceptance is a pre-determined measure of attitude, which does not provide us a detailed understanding of other facets of experience. Furthermore, these studies recruited a variety of professionals who had little-to-no lived-experience of using BDT and were mainly providing anticipatory perceptions of BDT use. Thus, these studies might not show how professionals felt about BDT use in real-life, and the potential factors at play within the triadic relationship.

1.5.3 Barriers & facilitators

The use of BDT's in routine care is still rare (Titzler et al., 2018). This low uptake of BDT's has inspired researchers to understand barriers and facilitators for their implementation.

Becker and Jensen-Doss (2013) conducted a quantitative analysis of survey data from a sample of mental health clinicians including social workers, family therapists, and mental health counsellors in the USA, to examine therapist-level barriers to the use of BDT. Respondents reported on their access to technology and computer fluency, in addition to completing the 'Computer-Assisted Therapy Attitudes Scale' (CATAS), a measure of therapist attitudes. The results revealed therapists' positive attitudes towards computer-assisted

therapies, however, also expressed concern that rapport would be damaged by using technology, thus not improving treatment outcomes. Predictors of positive attitudes included greater general openness toward new treatments, greater comfort with computers, and easier access to technology at work. Results suggested therapists may be likely to integrate computer-assisted therapies into their clinical practice, however, they vary both in their ability and willingness to use these tools. Furthermore, results indicated that therapists with lower general openness, and those who identified as more process oriented, may have been sceptical of the benefit of BDT's, alike Baumeister et al.'s (2020) findings. The study provides important implications pertaining to the link between therapist orientation and their view of BDT, and the importance of the therapist's comfort, accessibility, and acquaintance technology use. The high sample size also adds to the validity of findings. However, nearly a tenth of the sample reported no access to a computer, and 6.8 % reporting no access to any technological equipment, this might imply that the results portray assumptions of BDT rather than lived experience of having used it.

Titzler, et al., (2018), unlike most of the evidence base, conducted qualitative research on barriers and facilitators to the implementation of BDT for depression. The study used semi-structured interviews with five therapists who took part in the German study arm of the European E-COMPARED trial. The therapist participants completed university degrees in psychology and were undergoing further training in advanced clinical CBT practice. The blended CBT (bCBT) program consisted of six therapy modules on an online platform, a mobile app, as well as six face-to-face sessions with a therapist. The interview guide was developed in accordance with the theoretical domains framework (TDF), which is known to provide a robust theoretical basis for implementation studies, and good coverage of reasons for implementation problems (Atkins et al., 2017) which fit with the study's aims. Data was analysed through qualitative content analysis drawing on inductive and deductive approaches.

Twenty-nine barriers and thirty-three facilitators were identified. In terms of barriers, the study found that therapists had concerns about data safety and the absence of a clear concept as to how BDT can be embedded in the health care system. Barriers also included technical problems that resulted in anger and frustration and distracted the therapy process. All therapists demanded more autonomy around decisions on how to use BDT and more customizability of the online modules. They rejected the 'one size fits all' approach, and therefore objected to the approach's lack of individualisation. All therapists noted several disease-related contraindications, such as severe depression, which were deemed unsuitable for BDT (Titzler et al., 2018). Similar findings emerged in the aforementioned studies by

Topooco et al. (2017) and van der Vaart et al., (2014), where higher scepticism seemed to be shared for the use of BDT's for clients with more severe symptomatology. These are important implications for BDT's for more severe presentations such as paranoia.

Titzler et al. (2018) highlighted facilitators that included therapists' appreciation for the online modules as a useful complement to psychotherapy provision. All participants also reported advantages for patients including empowered self-management skills and self-efficacy, which has been echoed by participants in van der Vaart et al. (2014). Further facilitators pointed out were timesaving experienced in face-to-face sessions, and therapists' access to a digital therapy tool kit. After using the BDT approach, the therapists felt ready and willing to use it in the future. This is supported by findings previous studies where therapists' lack of experience was felt to be a hindering factor to the implementation of DHI's for depression (Drozd et al., 2016). Titzler et al.'s findings provide important data on lived experience, as these therapists were providing retrospective accounts of their experiences. Limitations of this study include potential limited transferability of the findings to therapists working in community services as the study participants had all provided their accounts from using BDT in the E-COMPARED research trial.

Mol et al., (2020) provide further insight to this area. This is a qualitative study which used data triangulation in the context of questionnaires, focus groups, and semi-structured interviews with therapists. The aim was to study the usability, satisfaction, and promoting or hindering factors to the use of bCBT in routine care for patients with depression within outpatient's specialist service in the Netherlands. The rationale provided for understanding in-depth knowledge of therapists' perspectives was to optimise the uptake of bCBT. The sample of therapists consisted of CBT-trained psychologists, mental health nurses, and psychiatrists, all trained in the use of the online platform prior to, or during, the research period. Eighty-four percent of participants had experienced the delivery of bCBT, whilst the remainder had no experience. The authors used descriptive analyses for the quantitative data and thematic analysis for the qualitative data.

Findings showed that therapists expressed an overall satisfaction with providing bCBT to patients with depression and the perceived usability of the online platform was sufficient. Reported advantages of bCBT included the focus and pre-set structure that the DP offered, which made therapists and their patients more adherent to the protocol and contained therapist drift. In terms of barriers to providing bCBT, a lack of ongoing support for technical and clinical issues, and insufficient training or guidance on how to work in a blended way were noted (Mol

et al., 2020). The emphasis on sufficient training is echoed by findings in other studies thus portraying its significance for therapists (Brown et al., 2013; Kenter et al. 2015; Whitfield & Williams, 2004).

Interestingly, therapists with bCBT experience reported different views on safety, flexibility and personalization of the protocol, patient eligibility, and therapeutic relationship than therapists who lacked experience. For example, non-experienced therapists assumed that there were many reasons why patients would be ineligible for bCBT, such as severe depressive symptoms (Mol et al., 2020). This is supported by Feijt, et al., (2018) who showed that there are different barriers and facilitators depending on the level of therapist experience with online services.

It is possible that selection bias might have occurred in this study as the sample were identified through their team managers, and other team members. However, as a qualitative study, a strength could include the varied professionals' involvement, which allows for a depth of understanding of views of bCBT use from various professionals' perspectives depending on their socio-cultural views.

Although measuring facilitators and barriers evidently provides crucial information, categorising measures in this binary fashion places a precedence on the types of experiences being asked of participants. Therefore, what lacks from the evidence base is a more nuanced, phenomenological understanding of participant experiences. Noticeable so far within acceptance studies and those examining barriers and facilitators is that minimal studies include participants who have actual lived experience of using BDT's, thus the evidence base mainly provides data on anticipations or presumptions about BDT use.

1.5.4 Adherence & competence

A quantitative study conducted in the USA by Brown et al., (2013) examined the relationships between therapist variables, CBT competence, and adherence, and clinical outcomes of computer-assisted CBT for anxiety disorders named "CALM", delivered by novice therapists in a primary care setting. Participants included various professionals such as social workers, nurses and one psychologist. Findings showed that higher CBT competence was associated with better clinical outcomes when assisted by the DP, whereas CBT adherence was not. Additionally, CBT competence was inversely correlated with years of clinical experience, and trended down as the study progressed, although this was not significant. The study highlighted

the value of initial training for novice therapists as well as booster training to limit declines in therapist adherence (Brown et al., 2013).

It is evident from this literature review so far that studies seeking to understand professionals' perspectives of BDT specifically have predominantly used quantitative methodologies, with Mol et al., (2020) and Titzler et al., (2018) presenting qualitative studies mainly using thematic analysis. Many recruited a variety of mental health professionals from various specialisms, the majority of whom had no prior experience of using BDT's. As represented so far, inquiries into therapist attitude, acceptance, and intention to treat with these tools has greatly made up the evidence base of professionals' use of BDT's so far (Titzler et al., 2018) which are all pre-determined measures of experience. We therefore lack a subjective and phenomenological understanding of professionals' lived experience of using BDT's. And as already highlighted, we have a lack of knowledge on how BDT practice is experienced with IeP's. As various studies have postulated so far, professionals tend to view BDT as unsuited for patients with a greater severity of mental health issues, implying that their perspectives are shaped by client related factors. This suggests the need to know about how professionals experience BDT use with IeP's, and importantly psychologist experiences are warranted being that they hold important positions in terms of uptake and BDT dissemination.

1.6 The Present Study

1.6.1 Research rationale, aims and questions

The Health and Care Professions Council's (HCPC) 'Standards of Proficiency' (HCPC, 2015) stress that practitioner psychologists should practice safely and effectively within their scope of practice and should not practice in areas where they are not proficient to do so. Recommendations stipulated in the British Psychological Society's (BPS) "Practice Guidelines" (BPS, 2017), and "Code of Ethics and Conduct" (BPS, 2018) echo this, as they encourage practitioner psychologists to consider advances in the evidence base, maintain technical and practical skills, and knowledge, and to be aware of one's limits in competence. Goss, & Anthony (2009) add that in addition to the exciting possibilities innovative therapeutic practices bring, there is reason to be cautious due to dangers and pitfalls for ill-informed or novice practitioners.

So far within the evidence base of therapists' experiences of BDT, specific elements of experience have been studied: barriers and facilitators, attitudes and acceptance, preference

between stand-alone and BDT's, and effects of CBT adherence and competence on outcomes of BDT. Clearly, such evidence provides important knowledge about this novel and fast developing form of therapy practice. However, the nature of the aims listed, and the methods used in these studies provide us insights on a descriptive level, and measure predetermined factors of experience (e.g., acceptance). This lacks phenomenological depth. Furthermore, the bulk of these studies measure participant preconceived ideas of BDT, rather than retrospective accounts of having used BDT in real life, which would be crucial knowledge for therapists hoping to use BDT's to learn from to improve their practice. Of all the studies reviewed, only Topooco et al, (2017) included part of their sample from the UK, so we lack potential important socio-culturally derived perspectives from professionals based in the UK, and how they feel about BDT practice. Furthermore, none of the studies explored the application of BDT with clients experiencing any form of psychosis, including paranoia symptoms.

This study aims to fill these gaps of knowledge by studying how UK psychologists experience the use of BDT for paranoia and will use Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) to gain a rich phenomenological understanding of these experiences, which as evidenced is lacking from the evidence base. The SlowMo BDT intervention has been trialled in a RCT (Garety et al., 2021a) and the current study is using IPA as a sub-study to contribute to the overall suite of papers on the SlowMo intervention. This is recommended as diverse research approaches (e.g., quantitative, and qualitative) are combined to provide richer foundations of knowledge related to both process and outcomes of psychological therapy (Hanley & Amos, 2017), which the present study hopes to achieve.

This research further aims to understand how psychologists made sense of, and experienced, their use of BDT, and how this experience informed their professional practice and the therapeutic relationship with their clients, in this case, IeP's. Thus, the present study's research questions include the following: (1) how psychologists experience the use of BDT with IeP's who have a diagnosis of schizophrenia-spectrum psychosis (2) how psychologists make sense of their experiences of BDT use; and (3) how psychologists experience the therapeutic relationship when using BDT with clients experiencing paranoia.

1.6.2 Relevance for Counselling Psychology

Exploration of psychologists' experiences of BDT use has been neglected in the psychosis literature, and without such insights, there is a risk of failing to engage therapists in coproducing solutions. We further miss out on understanding ways that we might increase clinician

confidence and familiarity with BDT's (Bucci et al., 2019b) and any implications for training requirements and guides for therapists who might be new to BDT's (ten Napel-Schutz et al., 2017). As Kasket (2012) suggests, CoP's are particularly interested in producing research that is motivated toward improving professional practice. Thus, with the speed at which technology is developing and digital therapeutic interventions attempting to develop with it, it is crucial that CoP's are at the forefront of the development of these therapeutic interventions. As Hanley (2021) states, "*it is better to be proactively involved in these changes, rather than have them creep up on the profession and be surprised by an unchangeable tide*" (p.496).

Counselling psychology, rooted in humanistic values, prizes a search for understanding than universal truths, and is defined by a concern in individual subjective experience, and appreciating the complexity of difference (Rafalin, 2010). Although the participants will be Clinical Psychologists (further specified in the methodology chapter), the insights they can provide will be valuable for CoP's to understand and learn from, particularly if BDT's are viewed as different or opposing Counselling Psychology's humanistic value base. The learning from this research might also support CoP's, governments, researchers, and stakeholders within the mental health profession around the implementation of effective BDT practice, how to build therapist competence, and what elements to consider in the future developments of BDT's and in the training and supervision required (Drozd et al., 2016) to ensure we are practicing safely and ethically.

Chapter 2 – Methodology

2.1 Overview

This chapter conveys the methodological basis for the study in a chronological order. The first part provides various rationale that were considered behind the adoption of a qualitative methodological stance, and the eventual adoption of IPA as the methodology. Thereafter, research procedures will be detailed, along with addressing ethical considerations. The chapter will end with a segment on personal reflexivity.

Throughout this chapter, both methodological and epistemological reflexivity have consciously been interwoven within relevant segments. Reflexivity can be used to demonstrate rigour, coherence, and credibility of the study (Frost & Kinmond, 2011). Engaging in reflexivity allows the researcher to understand how they might be implicated in the research and its findings, and how our own reactions to the research context and the data led to certain insights and understandings (Willig, 2013). As Frost and Kinmond (2011) explain, reflexivity further shows awareness of the context in which the research took place and its impact on the data gathered. The researcher aims to portray these elements transparently throughout.

2.2 Rationale for adopting a qualitative approach

Principally, the objectives of the research influenced the decision to adopt a qualitative approach. The study's focus of inquiry is idiographic in nature, seeking to understand the individual participant's subjective experience of using BDT with IeP's, and the meaning they attribute to these experiences. The study intends to understand how individual experiences are informed by language, culture, and societal underpinnings. The study is not seeking to identify cause-effect relationships, or to predict outcomes. Thus. it was deemed counterproductive to employ a quantitative, hypothetico-deductive approach, which tests an explicitly formulated hypothesis and makes predictions about the world (Langdridge, & Hagger-Johnson, 2013). Instead, a methodology was required which could encourage participants to express themselves as freely and openly as possible (Willig, 2013).

Qualitative methodologies are inductive, thus oriented toward discovery and process and are more concerned with deeper understandings of the research problem in its unique context (Tuli, 2010; Ulin, Robinson, and Tolley, 2004). They are interested in understanding how

people make sense of the world and how people might manage certain situations (Willig, 2013). Qualitative methods are also known to be effective at examining processes and are ideal for understanding psychotherapy processes in depth (Hill, 2005; Hill, Thompson, & Williams, 1997). Therefore, adopting a qualitative methodology was seen to fulfil the main objectives of the research, as well as complement the ethos of counselling psychology, (Morrow, 2007; Rafalin, 2010), which was important as the study further aims to generate implications for the counselling psychology profession and practices.

A further consideration was the methodological gap that exists as represented by the literature review chapter. The limited availability of qualitative research is clear, and there exists a gap of phenomenological understanding of psychologists' subjective experiences of using BDT for IeP's. Thus, the current study aims to fill this gap. Research outcomes for the use of SlowMo have been tested thus far through a quantitative RCT design (Garety et al., 2017; Garety et al., 2021a). We risk limiting knowledge and understanding on the phenomenon being questioned if research is restricted to a single paradigm of a quantitative, positivistic nature (Fossey, Harvey, McDermott, & Davidson, 2002; Higgs & Titchen, 1995). Therefore, a qualitative design was assessed to complement and contribute to the overall suite of papers gathered thus far for the SlowMo, BDT intervention for IeP's.

The research methodology selected for this study further depended on the paradigm that guided the research activity. More specifically, beliefs about the nature of reality and humanity (ontology), the theory of knowledge that informed the research (epistemology), and how that knowledge may be gained (methodology) (Ponterotto, 2005; Tuli, 2010). This is explicitly explored in the next segment as further rationale for the choice of qualitative enquiry, and for the choice of IPA specifically.

2.3 Research Paradigm

2.3.1 Philosophical underpinnings

Researchers must be aware of, and make explicit, their fundamental assumptions about the world, which include the assumptions made about research and the view we take of what the data collected represents (Willig, 2013). These fundamental assumptions are otherwise known as the 'research paradigm' (Denzin & Lincoln, 2011; Ponterotto, 2005), and it is formulated by the researcher's epistemological, ontological, and methodological premises (Denzin & Lincoln, 2011). This is important, given that every research question is underpinned by a set of

ontological and epistemological assumptions. The researcher's choice of data collection, method, and analytic strategy therefore needs to be compatible with the epistemological orientation of the study (Willig, 2013). Explicitly stating my own epistemological position intends to illuminate the kind of knowledge this research aims to create, thus, clarifying the choice of methodology (Crotty, 1998).

Ontology explores the study and nature of being and reality (Guba & Lincoln, 1994; Ponterotto, 2005) and ontological positions are described as either 'realist' or 'relativist'. A realist ontology asserts that the world is made up of social, psychological, and material structures, or objects, which have cause–effect relationships with one another. The realist researcher assumes that these mechanisms can be identified and exist separate from the knowledge or awareness that we may have of them (Denzin & Lincoln, 2011; Willig, 2012a; Willig, 2013). In contrast, a relativist ontology asserts that there exists a diversity of interpretations that can be applied to the world, and so, there can exist multiple realities constructed from individual perspectives which are all equally credible (Maxwell, 2012; Willig, 2013). Researchers adopting a relativist lens thus reject the existence of a single true reality (Ponterotto, 2005).

Epistemology is the study of knowledge, knowledge acquisition (what can be known, and how), and denotes the relationship between the knower (participant) and would-be knower (researcher) (Willig, 2013). Thus, in research, the kind of knowledge a methodology aims to produce depends on its epistemological position (Willig, 2013). Epistemological positions can range from 'radical relativist' to 'naïve realist' in which three broad types of knowledge can be produced: '*realist knowledge'*, '*phenomenological knowledge'* and '*social constructionist knowledge'* (Madill, Jordan, & Shirley, 2000; Willig, 2013, p.15). Within the naïve realism position, researchers would contend that there is but one true reality that is identifiable and measurable, and therefore, might choose research methods that lean towards gathering positivistic knowledge, for example, conducting tightly controlled experimental studies (Ponterotto, 2005). In contrast, a researcher adopting a radical relativist position may interview a small sample of participants for longer periods of time and contend that there are multiple meanings of a phenomenon (multiple realities) and everything is socially constructed, thus rejecting the idea of a single reality (Pilgrim, 2016). Considering there exist these varying ontological and epistemological positions, it is crucial for researchers to detail the research paradigm that most coincide with the study aims, and their own worldview as researcher.

2.3.2 Critical Realism

In accordance with the aims of this study, and with my own ontological and epistemological viewpoint, I realise that my beliefs are characterised by ontological realism and epistemological relativism (Archer, 2002), which define my critical realist stance.

By retaining ontological realism, I am assuming there is a real world that exists independently of our perceptions, theories, and constructions, thus reality is *"mind-independent"* (Pilgrim, 2019, p.3). In relation to the current study, I believe that BDT (an approach to practicing and delivering psychological therapy where the integration of DT(s) in face-to-face meetings is a requisite) and paranoia (a psychological phenomenon) exist, regardless of culture, views, or awareness of these phenomena. I believe that psychologists will have experienced the use of BDT with IeP's in unique ways, and psychological processes occur and affect psychologists when using BDT with IeP's that can be understood. Consequently, I acknowledge that experiencing the use of BDT as an approach of practicing and delivering psychological therapy exists, even if participants were not to provide an account of this in the study, which matches the realist ontological aspiration of the study.

Epistemological relativism assumes that our understanding of this world is a construction of our own perspectives and standpoint (Maxwell, 2012). Therefore, we construe the world we live in, reflect on, and talk about (Pilgrim, 2019), and realities are mediated by power relations that are socially and historically constituted within each participant's experience (Ponterotto, 2005). Within this approach, all theories about the world are grounded in a worldview, and all knowledge is partial, incomplete, and fallible (Maxwell, 2012; Ponterotto, 2005). I believe that experiencing the use of BDT with IeP's can be complex and understood in distinctive ways, depending on the individual making sense out of it and their socio-cultural, spiritual, biological, economic life experiences (Bhaskar, 1978). This study adopts the position of epistemological relativism as there is no possibility of attaining a single 'correct' or universal understanding of how participants experience the use of BDT with IeP's (Maxwell, 2012; Pilgrim, 2019; Willig 2013).

Further, critical realism seems aligned with Counselling Psychology principles (Raskin, 2002) which are defined as being concerned with the individual's subjective experience, appreciating the complexity of difference, and valuing a search for understanding (Rafalin, 2010). With these points considered, as well as my identity as a TCoP hoping to produce implications for counselling psychology through research, it was concluded that critical realism was most fitting

to my worldview, as well as to the aims of the study. In line with these considerations, the methodology chosen for this study was IPA, as its philosophical underpinnings were found to coincide with the critical realist stance, and thus with the objectives of the study. This will be clarified next.

2.4 Theoretical Framework of IPA

IPA is an approach to qualitative research informed by three key philosophical underpinnings: phenomenology, hermeneutics and idiography (Smith, et al., 2009). In this segment, I will describe these philosophical underpinnings and continue to explore how they have informed my decision to pursue this methodology for the current study.

2.4.1 Phenomenology

Phenomenology is a philosophical approach to the study of experience; hence phenomenologists are committed to thinking about how we come to understand what our experiences of the world are like (Smith et al., 2009). The aim of a phenomenological analysis is not to investigate 'the truth' about participant experience of a phenomenon, rather, to illuminate experiential phenomena and to understand the participant's unique interpretation of their experience within the context of their 'lifeworld' (Willig, 2012b), which is coherent with epistemological relativism.

Overtime, phenomenology has shifted to an interpretative inquiry influenced by philosopher Martin Heidegger, who emphasised the person's intersubjectivity as a central factor of phenomenology (Smith et al., 2009). This influences the point that researchers must acknowledge, and explore, the ways in which they are implicated in the construction of meaning when examining research data. Thus, this requires the researcher to be highly reflexive throughout the process of analysis to understand how researcher's assumptions emerge as they engage with the data, and how their investment in the research shapes the understanding of the material (Willig, 2012b).

Our being-in-the-world is seen as perspectival, temporal, and in-relation-to something, thus, the interpretation of peoples meaning-making is central to IPA (Smith et al., 2009). When adopting a phenomenological lens in research, participants are perceived to be inevitably influenced by their lived social-cultural contexts, including culture, gender, employment or wellbeing of the people or groups experiencing the phenomenon. Therefore, researcher

interpretations of participant experiences are conducted in relation to these contextual influences to allow a deeper understanding of the experience to emerge (Flood, 2010; Mackey, 2005; Matua & Van Der wal, 2015).

To understand another's experience requires a process of engagement and interpretation on the part of the researcher, linking IPA to a hermeneutic perspective (Smith, 2011), which will now be explored.

2.4.2 Hermeneutics

The second theoretical underpinning of IPA is hermeneutics, which is the theory of interpretation. Heidegger presents the idea that appearance of a phenomenon has a dual quality; visible meaning and concealed or hidden meaning, and to seek this meaning, we need to interpret (Smith et al 2009).

A goal of hermeneutic inquiry is to identify participants' meanings of the phenomenon from a blend of the researchers' understanding of the situation and what participant data state (Matua & van der Wal, 2015; McConnell-Henry, Chapman, & Francis, 2009; Wojnar & Swanson, 2007). This process of meaning-making requires the researcher to exercise qualities of openness, empathy, and reflexivity (Finlay, 2008; Matua & van der Wal, 2015; Wertz, 2005).

There is an important consideration in IPA that researcher interpretations are grounded inevitably in the interpreter's pre-understanding of the data, which are impossible to transcend (Finlay, 2008; Heidegger, 1962; Humble & Cross, 2010; Matua & van der Wal, 2015), and the integration of these pre-understandings are considered to be valuable guides that make research more meaningful (Humble & Cross, 2010; Lopez & Willis, 2004; Matua & van der Wal, 2015). However, priority is primarily placed on the new object presented in the data than our preconceptions (Smith et al., 2009). This process is part of the 'double hermeneutic' of IPA, in which the researcher is making sense of the participant, who is making sense of the phenomenon under question (Langdridge, 2007; Smith & Osborn, 2003). Thus, the researcher in IPA is viewed as crucial to discovering meaning and in co-constructing knowledge with participants.

Therefore, hermeneutic phenomenologists do not 'bracket' but are aware of their preconceptions and how they might impact the interpretation of the phenomenon and continue to be aware of their preconceptions that are prompted throughout engagement with participant data (Smith et al., 2009). This requires the researcher to be frank with themselves about the

likely consequences of preconceptions and engage openly in reflexivity about how they might influence interpretation (Smith et al., 2009). This has been demonstrated in section 2.12. of this chapter.

Heidegger described a second process of interpretation, the 'hermeneutic circle' of understanding (Streubert & Carpenter, 2011). This process encourages researchers to work with their data in a dynamic, iterative, and non-linear manner, examining the whole in-light-of its parts, the parts in-light-of the whole, and the contexts in which the whole and parts are embedded (Eatough & Smith, 2017). Both hermeneutic approaches to enquiry were employed in this study by adopting an empathic stance, wherein I imagined what-it-is-like to be the participant's shoes, and on the other, I also probed for meaning which participants might have been unwilling or unable to do themselves (Eatough & Smith, 2017).

2.4.3 Idiography

A third influence on IPA is idiography, which is concerned with the particular (Smith et al., 2009). This means that an idiographic approach does not aim to make claims at the group or population level, but instead there is a commitment to detail and depth of analysis, and to understanding how particular experiential phenomena have been understood from the perspective of particular people in a particular context (Smith et al., 2009). An idiographic method produces insights via the intensive and detailed engagement with individual cases. Thus, IPA is seen to be idiographic in its commitment to analyse each case, in a corpus, in detail (Smith et al., 2009; Smith, 2011). Importantly, experience is examined in its own terms, and not according to predefined categories or systems (Smith et al., 2009). IPA functions by providing, first, an in-depth account of each case, before moving to look for patterns of convergence and divergence across cases (Eatough & Smith, 2017). This analytic procedure is further demonstrated in section 2.10.

2.5 IPA's link with critical realism

IPA's emphasis on phenomenology acknowledges that the understanding of a participant's lived experience of the phenomenon is always mediated by the context of cultural and socio-historical meanings (Shinebourne, 2011). The emphasis on double-hermeneutics acknowledges that the way data is interpreted is dependent on how I as the researcher will interpret the data and come closer to understanding the participants subjective experience (Smith et al., 2009). These concepts coincide with the critical realist paradigm, which

acknowledges the existence of many different realities that are influenced by the unique history and context of each participants lived experience, but which can only be apprehended and measured imperfectly by the researcher (Pilgrim, 2019). The compatibility between IPA and critical realism therefore greatly encouraged the decision to adopt IPA for this study.

2.6. Consideration of other methodologies

The choice of IPA emerged once other possible methodologies were considered, which I will now discuss.

2.6.1 Thematic Analysis (TA)

TA is a method used to identify, analyse, and report patterns (themes) within data (Braun & Clarke, 2006). Although analysing and reporting patterns within data can be conducive to accumulating important and valuable data on a phenomenon, the present study is seeking an understanding of the phenomenon beyond establishing commonalities and differences between participant experiences. As noted in chapter 1, much of the qualitative analyses existing on the phenomenon have already used thematic and content analysis methods (e.g., Mol et al., 2020; Titzler et al., 2018). Thus, IPA was seen to add a depth of information on the experiential meaning of the phenomenon for participants which is currently lacking.

TA as a tool for data analysis does not provide the researcher with a clear theoretical basis for their research means (Willig, 2013). IPA in this case was more appealing as the methodology to incorporate for this study as it had close links with the critical realist paradigm, and it provided a clear theoretical basis of phenomenology, hermeneutics and idiography, which fit with the research aims.

2.6.2 Foucauldian Discourse Analysis (FDA)

FDA focuses on the power that language holds and believes that words can be used to build the social world and hold power over conduct in society (Willig, 2008). FDA focuses on the linguistic resource's participants draw on to provide accounts of experience (Smith, 2011). FDA was not considered appropriate for this study as it offers a critical analysis of the structure of context, and the underlying assumptions of language, rather than providing a detailed experiential account of the person's involvement in the context, and their sense making of it (Smith et al., 2009). Although both IPA and FDA are linguistically based approaches and

concerned with the close reading of participants' reports, the rationale behind both approaches are different (Smith, 2011).

IPA researchers seek understanding about how participants make sense of their experience whilst FDA seeks to examine what participants say to learn about how they are constructing accounts of experience (Smith, 2011). Thus, IPA is closer to the aims of the current study which requires the researcher to make sense of the different ways participants makes sense and observe the phenomenon being examined (Willig, 2013). The investigation of language/discourse is only one aspect amongst several others that could be observed and interpreted through IPA. Discourse is also seen to construct reality and not reflect it and lacks the cognitive and affective reactions that IPA can include in the process of research (Smith et al., 2009).

2.7 Rationale for choosing IPA

I have highlighted the consideration of other methodologies and how these did not fit with the aims of the study, and the complementary relationship between IPA and my epistemological and ontological stance of critical realism has thus far been highlighted. I will therefore further summarise points that were considered in the choice of IPA for this study.

IPA was considered most suitable as it is conducive to the exploration of psychologists' meaning and sense-making of their experiences due to the phenomenological, hermeneutic, and idiographic commitments of IPA. The phenomenological philosophy was seen to be particularly apposite to the intentions of the study. IPA offers a rich source of ideas about how to examine and comprehend the lived experiences of psychologists who had used BDT with IeP's. IPA tends to deal with subjects that matter to people, and that might change or influence how they think of themselves and their place in the world. It aims to conduct examinations that enable experience to be expressed in its own terms than predefined categories (Smith et al., 2009).

It was evident from the literature search on professionals' perspectives of BDT's (presented Chapter 1) that professionals are found to have varying attitudes and perspectives of BDT, however, most of these insights were gathered from pre-determined measures of experience, for instance acceptance. Working with IeP's also influenced deep, meaningful affect and processes for therapists. BDT use was therefore considered to be a phenomenon that matters to psychologists who use it, and that it might hold unique meaning, feelings and influences on

psychologists using BDT with IeP's. Consequently, IPA flexible data collection, and philosophical underpinnings was seen to permit experiential and idiosyncratic understandings and offered the important consideration of participant socio-economic factors that could influence experience. This type of in-depth, subjective understanding was seen to be greatly missing from the evidence base and was of personal interest to myself as researcher and TCoP.

The hermeneutic philosophy of IPA was assessed to be strongly aligned with the research aims to interpret and understand in-depth meaning of how psychologists experienced the use of BDT with IeP's. Adopting an interpretative approach meant that I as researcher would be part of the process of meaning, discovery, and knowledge co-construction with the participant, which was viewed as a strength of the IPA to aid further in-depth understandings to arise. Adopting a position of the hermeneutics of empathy and questioning within the double hermeneutic process in IPA was a further influence, as the research aim was to understand and draw out participant experiences and meaning of experience in their own subjective and idiographic terms, and not to use theoretical perspectives from outside, as positivistic research tends to do (Smith et al., 2009).

2.8 Limitations of IPA

Although the use of IPA can generate detailed and rich descriptions of participant experiences of a situation or event, it can suffer from some practical and conceptual limitations (Tuffour, 2017; Willig, 2013). These will now be specified alongside ways they were mitigated.

Firstly, IPA is known to give unsatisfactory recognition to the integral role of language (Willig, 2008), however, meaning making in IPA is also known to take place in the context of linguistic features, including narratives and metaphor to gain insight on experience (Smith et al., 2009). This will be demonstrated in chapter 3 of this thesis, in which the analysis of data aims to show how language was used to gain rich interpretative understandings of participant data.

IPA has been criticised regarding its accuracy in capturing experiences and meanings than just opinions. Thus, the criticism centres around if participants and researchers have the required skills to successfully communicate the nuances of experience (Tuffour, 2017). This was mitigated by engaging in the detailed analytic strategy stipulated in Smith et al. (2009). As previously mentioned, I paid particular attention to linguistic features and non-verbal communication. Furthermore, I ensured that the interviews were participant-led, and I offered

time and space for topics to be expanded upon. At the end of each interview, space was offered for participants to add any further aspects of their experience that they felt had not been covered through the interview process.

IPA has also been criticised for limiting understanding as it does not add *why* participant experiences occur, and why there may be differences between individuals' phenomenological representations (Tuffour, 2017; Willig, 2013). As Smith et al., (2009) stipulate, IPA uses hermeneutic, idiographic, and contextual analysis to understand the socio-cultural qualities of experience, which I aimed to demonstrate throughout each chapter. Furthermore, the idiographic nature of IPA was felt to organically present 'why's' of participant experiences through their unique sense-making of the phenomenon.

Lastly, it has been suggested that the role of cognition in phenomenology is not understood and aspects of phenomenology are not compatible with cognition (Willig, 2008). Smith et al., (2009) contend that IPA does have its own model of cognition which includes a range of layers of reflective activity forming a focus of phenomenological inquiry (Smith et al., 2009). These include awareness, consciousness, and rumination. The consideration of these qualities of cognition, as well as others stipulated by Smith et al., were brought into the analysis of findings in this study.

2.9 Procedures

2.9.1 Participant recruitment

To ensure that the sample was consistent with IPA's orientation, it was selected purposively, and recruitment occurred through volunteer and snowball sampling. Contact with participants was assisted via my research supervisor as gatekeeper, who is a qualified CoP, and a past member of the SlowMo research team and trial therapist. This meant that my supervisor had direct contact with the potential participants who met inclusion criteria for this study. The consent for contact was received by my supervisor and/or directly via my university email.

The gatekeeper first notified the SlowMo team of my study. Once global interest was received by potential participants, the gatekeeper organised a meeting with the SlowMo team, where I was offered the opportunity to deliver a recruitment presentation (appendix A). The purpose was to introduce myself, as well as present the necessary information on the study to further aid in informing their decision to participate. This meeting was also an opportunity for potential

participants to ask any questions they had on the research or participation. The information provided in my presentation matched the information included in the study's consent form (appendix B) and information sheet (appendix C). The delivery of this presentation also formed part of research ethical practice of gaining informed consent, as it provided participants with an understanding of what to expect from the interviews, as well as establishing that participation would mean the use of verbatim extracts in the findings and published reports (Smith et al., 2009). My supervisor was also present at this initial meeting. All participants were aware of my supervisor's identity and knew her personally. I informed participants that my supervisor and any academic members of staff or supervisory groups would have access only to anonymised data for the purpose of auditing or assessing my work.

During this presentation, I also ran through the interview schedule to ensure potential participants were aware of the nature of the questions that would be covered (Smith et al., 2009), further forming part of informed consent procedures. I clarified that they could grant their consent to participate after two weeks, and consent was not being sought during the presentation. This group presentation was further intended to allow familiarising with myself as researcher and with the interview process.

Personal contact between researcher and participants over a period is known to aid deeper insight and depth to the phenomenon being studied (Tuli, 2010). This initial meeting thus allowed me to initiate the formation of a researcher-participant relationship, which was hoped to aid the production of rich data. The study's information sheet and consent form were provided to the potential participants towards the end of this initial meeting. These forms contained my contact details in case any further information was required.

Once informed consent was received, I arranged a convenient time and place to meet for the interview with each consenting participant and sent them the demographic questionnaire (appendix D), which they were reminded was not compulsory to complete for participation.

2.9.2 Struggles with recruitment

I experienced minor struggles during the recruitment process. The main struggle experienced was recruiting psychologists who were often busy due to their various professional duties. As a result, there was an occasion in which a member of the SlowMo team did show interest in participation via email, however, after various email exchanges attempting to formalise an interview date, I did not receive any further response. I attempted to reach out to this individual

only once after receiving no response, as I was conscious of not wanting to coerce their participation. I therefore accepted the lack of response as their withdrawal of interest to participate.

2.9.3 Participants

In IPA, homogeneity of experience is sought, rather than homogeneity of individuals (Smith et al., 2009). As the primary concern of IPA is with detailed accounts of individual experience, it is recommended to keep the sample size small, with typical numbers being between four and ten participants (Smith et al., 2009). Therefore, a relatively small, reasonably homogenous group of participants were recruited in keeping with the idiographic commitment of IPA. This was facilitated to allow for the examination of convergence and divergence of the data in detail (Smith et al., 2009). As the experience being explored in the current study is rare, being that there is only one SlowMo BDT intervention designed for IeP's in the UK, this defined the boundaries of the sample that could be recruited (Smith et al., 2009) and the boundaries of the inclusion criteria (highlighted in segment 2.9.5).

The study sample consisted of eight, doctoral-level qualified, clinical psychologists, practicing in the UK, who had further advanced CBTp training. The decision was made to keep to eight participants to ensure in-depth analysis could occur, and to honour the idiographic commitment of IPA and the interest of the study. All participants had delivered the SlowMo BDT intervention to (an) IeP('s) across NHS settings in the UK, including London, Sussex, and Oxford, where the SlowMo trials were conducted. During interviews, all participants declared having delivered the SlowMo BDT intervention to at least one IeP during the SlowMo RCT. The IeP's who received the BDT intervention as part of the RCT had a diagnosis of schizophrenia-spectrum psychosis (F20-29; ICD-10) and experienced distressing, persistent (>=3 months) paranoia (Garety et al., 2021a). The sample of psychologists varied in the length of time each had used the SlowMo BDT intervention (see demographic table 2.1), and in the number of IeP's they used SlowMo with.

2.9.4 SlowMo BDT: Intervention overview & psychologist processes

The psychologists' SlowMo training involved an initial orientation to the webapp and protocol (identifying module-by-module targeted processes and associated troubleshooting), followed by one to two supervised training cases. The DP's modular webapp provided the structure

allied to the comprehensive clinical protocol, which facilitated the psychologists' training (Ward et al., 2022).

The delivery of the SlowMo program was flexible, with sessions added where deemed helpful. For example, psychologists could split web app modules across separate meetings in line with client preference and engagement, and 'out of clinic' behavioural work would be added and organised between psychologist and client to promote mobile app use and therapy generalisation to the real world (Garety et al., 2017; Garety et al., 2021b; Garety & Hardy, 2017; Hardy et al., 2018).

During the SlowMo RCT, the intervention followed a clinical trial manual that was consistent during the trial, which the psychologists followed. The psychologists delivered therapy sessions locally to their client('s) at convenient locations of their choosing, including team bases, patient's homes, general practices or other local centres (Garety et al., 2017; Garety et al., 2021b; Garety & Hardy, 2017; Hardy et al., 2018). 'The out of clinic' behavioural work was assisted by the psychologist and carried out in the client's local area, guided by their goals, using the mobile app and its synchronised content from in-clinic sessions. It typically involved testing out the SlowMo strategies and the mobile app in locations such as town centres, local cafes, pubs, and markets (Garety et al., 2021b).

Before SlowMo therapy began, the psychologists' task was to meet the client for an initial introduction and orientation to the SlowMo BDT approach. The psychologist delivered the DP's modular structure consistently, but tailored content throughout sessions as clients interacted with the DP's materials and tasks (Garety et al., 2021b). SlowMo's session structure, as presented in Ward et al. (2022), consisted of building the meta-cognitive skill of noticing thoughts and thinking habits, specifically fast and slow thinking during early sessions. Each module could be undertaken in just one session or delivered over more than one session, according to client need and preference. All DP modules included interactive features providing information (through narration or recurring vignettes), games and personalised content. In Module 1, clients create personalised worry bubbles and build colourful, safer thought bubbles, designed to promote engagement. In Module 2, the message that thinking slowly can help in dealing with difficult situations and fears about other people is presented. The psychologists reinforce this normalising message through sharing examples of their own fast thinking. Module 3 highlights benefits of learning to slow down. Module 4 facilitates the identification of 'safer thoughts' as part of slowing down. Module 5 focuses on understanding the impact of mood and considering ways of feeling safer in daily life. Module 6 outlines the potential role of

past experiences in worries about others. Module 7 introduces the confirmation bias and encourages the practise of noticing new information and identifying alternative, less distressing explanations. Module 8 involves a review of the therapy (including the personalised 'messages to self' recorded at the end of each module) to consolidate the habit of slowing down (Ward et al., 2022).

2.9.5 Inclusion criteria

The following were the inclusion criteria which related to the purpose and aims of the study:

- Participants had to be involved as trial therapists in the SlowMo RCT with the role of delivering the SlowMo BDT intervention to IeP's.

- Participants had to be qualified, Clinical or Counselling Psychologists practicing in the UK.

- Participants had to be fully trained in the use of SlowMo and identify as having used the SlowMo BDT intervention with at least one IeP.

- Both male and female psychologists were approached, and participants were not excluded based on age or cultural background.

2.9.6 Exclusion criteria

The only exclusion criterion for participation was related to proficiency in the English language to ensure participants could converse freely about their experience. No other restrictions were placed on the inclusion criteria to foster a wider spectrum of observations (Smith et al., 2009).

2.9.7 Participant demographics

Table 2.1 presents demographic information collected from the psychologists who took part in this study. The demographic information hopes to compliment the upcoming analysis segment. As the SlowMo team psychologists are well-known within the psychology profession, have published multiple papers related to the SlowMo RCT, and have close working relationships with one another, therefore being somewhat aware of one-another's demographics, this table

has intentionally been assembled using ranges rather than exact digits to portray participant demographics. This is to further preserve each participants' anonymity as far as possible.

Gender			
Female	7		
Male	1		
Ethnicity			
White			
	British	4	
	Any other white background	4	
Other Ethnic Group		0	
Number of years' experience as a practicing psychologist			
< 5	**5 - 11**	**12 - 17**	**18 - 23**
Adrian	Dana		Matilda
Laura	Cristina		
Amy	Frances		
Jordan			
Length of time using blended therapy for paranoia (years)			
0.5 - 1	**>1 to 1.5**	**>1.5 to 2**	**>2 to 2.5**
Amy	Adrian	Jordan	Dana
	Matilda	Frances	
	Laura	Cristina	
Key:	< = Less than > = Greater than		

Table 2.1: Participant demographic information

2.9.8 Pilot interview

A pilot interview was conducted with my research supervisor as the pilot interviewee. This was decided as she met inclusion criteria as a past trial therapist and site coordinator within the SlowMo RCT, and so this emerged as an ideal opportunity to test and refine the initial interview schedule, practice my interview skills, and ensure that the interview questions would offer participants the opportunity to openly share their experiences.

The pilot helped me gather important reflexive awareness of the struggle I experienced around feeling a need to ask every question, including every prompt in the schedule. I attributed this to my anticipatory worries about not getting enough rich data or missing important questions. This anxiety in turn took me away from being fully present with the pilot interviewee, to notice both their spoken and unspoken words, as I was so invested in achieving a 'good interview'.

I decided after to make modifications to my interview technique, as also indicated in my discussions with my supervisor after the pilot. It was insightful to hear her experience of being in the interviewee's seat, and the advice she provided to take my time with the interview, allow the participant more spaces of silence, and to modify one of the interview questions, as it seemed to be generating repetitive data. I applied this feedback by making modifications in my interview technique which included not needing to ask every prompting question, using my counselling psychology skills to prompt further insight into the issues my participants brought up, and not rigidly following the interview schedule. A slight modification was made to the interview schedule in altering one question to maximise the effectiveness of the questions, and to avoid generating repetitive data.

It was important to consider how to utilise the data gathered from the pilot. Through multiple discussions with my supervisor, it was decided that due to several contextual factors involved in interviewing my supervisor that were likely to shape both the data and the analysis of the data, the pilot data would not be included in the final analysis. This pilot interview was different in many ways from the other interviews as my supervisor would have had a significant position in influencing my write up as she had the task of checking over my chapter drafts, and prior to the pilot, my supervisor was aware of my research questions and my initial reflexive process, as these were reflected on in supervision sessions.

2.9.9 Interview schedule

Semi-structured interviews were evaluated as appropriate for this research endeavour. These questions can be modified according to participants responses (Smith & Osborn, 2003) which fit in with the phenomenological and idiographic endeavours of IPA. The interviews gave both a structure to ensure the main areas of the research questions could be covered and allowed flexibility for participants to go in-depth in areas of their choosing. The questions and prompts were prepared through my initial drafting of a mind-map diagram consisting of all the areas considered relevant to the phenomenon whilst not being too directive.

The modified semi-structured interview schedule (Appendix E) began with warm-up questions, which encouraged relatively descriptive accounts of the participants experiences, perceptions and opinions of psychological therapy and working with IeP's, as well as understanding their motivations for participating. The intention behind this was, as suggested by Smith et al., (2009), to allow participants to become comfortable with talking, and with the interview process, and to allow participants to begin setting the parameters of the topic. The questions then became broader, expansive, and open, focusing in on the research question and intending to encourage clients to talk at length (Smith et al., 2009). They were intentionally kept broad to minimise any imposition on the participant of my understanding of the phenomenon (Smith et al., 2009) and to allow participants to lead the direction of interviews in accordance with their individual experiences. I added a specific question around the therapeutic relationship in BDT as this was missing from the initial interview schedule (pre-pilot), and this was seen to add richer data as it was part of the objectives of the research.

The interview schedule contained open-ended, non-directive questions, including discretionary prompts (in red), which followed Willig's (2013) recommendation for specific questions to be used to encourage participants to elaborate on points already mentioned.

2.9.10 Interview procedure

Before commencing each interview, I asked each participant if they fully understood the information provided within the consent form and information sheet and provided space for any questions. Participants were then asked to sign the consent form manually. The consent form contained all information regarding researcher and supervisor contact details, the purpose of the study, anonymity, and the right to withdraw at any time without penalty. I provided each participant with the demographic questionnaire and reminded them of their right to opt-out of providing any demographic information. At the start of the interview, and once the recorder was switched on, additional verbal informed consent was requested to audio record the interviews. Once interviews ended, I checked-in with how participants were feeling and if they had any questions for me with regards to the study. They were then provided with a debrief sheet (Appendix F).

Face-to-face interviews were deemed appropriate as they would have allowed rapport to be developed and gave participants the space to think, speak and be heard (Smith et al., 2009). They also allowed me to use my Counselling Psychology training to respond in a validating

and empathic way to participants, and to witness any important manifestations of body language and non-verbal cues, which could allow my analysis to be multi-dimensional.

Exceptions to face-to-face interviews had to be made to accommodate two participants. One was held virtually by Skype, and the other by telephone. These adjustments were made for participant convenience due to substantial travel distance to meet face-to-face. The telephone interview took place (instead of Skype) as on the day of interview, the participant experienced technical issues and could not meet online.

Duration of interviews ranged from 30-90 minutes. Interviews took place in pre-booked rooms within each participant's respective NHS work base. In the one Skype interview, the participant attended virtually from their home. This was in-line with each participant's preference and ensured that any potential travel limitations that participants had due to busy work schedules and/or the inconvenience of travelling long distances could be eliminated.

Within all interviews, I was aware of time pressures that existed. I had interviewed the participants during their workdays, albeit these times were pre-scheduled and agreed, there were occasions in which participants would inform me that they had impromptu professional meetings to attend after the interview and so these conditions might have had an impact on the level of depth we could go into. It is important to note however that most participants, seven out of eight, had the availability of at least an hour, which was the suggested amount of time on the recruitment documents provided. Seeing participants in their clinical settings might have been an environmental stimulus for being clinical and formal in their interview responses, which was noticed when analysing transcripts. Upon reflection, it might have been beneficial to organise interviews in an establishment that is outside their work environment. To mitigate this, I would remind participants that I was interested in their experiences, and how they felt at the start and during interviews.

At the inception of this research journey, my anxieties were mainly related to my interview technique. As previously mentioned, I felt the need to follow the interview schedule in a systematic fashion, asking every question (even prompting question) so that I could manage my fear of missing 'something' out, or not gathering enough data. I applied my learning from supervision, further reading I did on IPA, and IPA peer supervision groups by using the interview schedule more as a guide, rather than a tool that dictated the course of the interview. I also memorised my interview schedule as suggested in Smith et al. (2009) which supported

me to be present with the participant during interviews, to follow their spoken word, and construct the interview prompts in line with their emerging train of thought.

As interviews commenced my confidence grew, and my interview technique advanced, allowing deeper, richer interviews to emerge. My questioning process was refined based on being receptive to novel and unexpected topics and issues introduced by participants, and I followed these with my participants (Eatough & Smith, 2017). I noticed myself being able to probe spontaneously at certain points of the interviews to allow deeper reflection on intriguing features. Invitations to be more analytical were introduced as participants began to ease into the interview.

With regards to the power dynamic, I wondered how this felt for the participants; whether it was challenging or brought discomfort to be in the position of participant, when usually they are inhabiting the position of researcher/ research manager and clinician. I was curious if this affected how vulnerable participants felt they could be in front of me, impacting how deep they would go with their process. Furthermore, participants were aware that their transcript extracts would be used in the write up and the piece might end up being published. Therefore, they might have been influenced to be tentative in their reflections as other professionals in the field, along with their SlowMo trial colleagues and coordinators, would have access to the publication.

2.9.11 Data-collection & storage

As emphasised throughout this chapter, the aims of this research were to invite and offer participants a space to offer rich, detailed, first-person accounts of their experiences to meet the studies aims, questions and interests. Structured interviews were not considered appropriate as they would have investigated the phenomenon within the limits of the questions asked, and questions would have been formulated from my own preconceptions about the phenomenon. This would have been contradictory to the aims of the research. Resultantly, semi-structured interviews were used based on Smith et al.'s (2009) recommendations for IPA, which could facilitate free and lengthy reflection directed by the participant.

Interviews were recorded using an encrypted digital recording device (Dictaphone), and all participants were asked for their verbal consent to be recorded prior to switching the device on, and again when the device was switched on. The recordings and anonymised transcriptions were stored in a password-protected, encrypted file, on a laptop hard-drive, and

recordings were deleted from the Dictaphone. Paper documents have been digitised and stored on a laptop password-protected, encrypted file, and paper versions subsequently destroyed.

All interviews were transcribed verbatim to prepare for the subsequent data analysis. Non-verbal communication was also transcribed to bring to life the participants' accounts as well as being mindful of Finlay's (2006) bodily disclosure in research. To protect anonymity, the participants' names were changed as well as other names and places that may be mentioned throughout the interview. Participants were given the opportunity to choose their own pseudonyms.

2.9.12 Ethical considerations

This research complied with the BPS and HCPC ethical guidelines regarding research (BPS, 2014; HCPC, 2016). Ethical "start-up criteria" (Smith et al., 2009) for this research included application and confirmation of ethical approval from the psychology department at City, University of London which was received (Appendix G).

Informed consent was obtained from participants prior to participation, and information on the study was provided to participants verbally prior to conducting any interviews (as specified in section 2.9.1). Opportunity was provided before interviews began for participants to ask any questions they might have. Information sheets were also provided to participants prior to interview and all participants were offered time and space on the day of the interview to re-read the information sheet before the interview started. I reminded participants that their anonymity would be preserved, and pseudonyms would be used throughout interview transcripts and in the final write up. I further reminded them that although direct quotes would be used in the final thesis write up, and in any journal publication, all identifying information would be anonymised or removed.

The participants' needs took precedence over the research process and participants were reminded verbally, and via the information sheets and consent forms, that if at any time they wished to withdraw from the study their participation would not be pursued. I further reminded participants that they held the right to refuse to answer any questions. Copies of consent forms were retained by each respective participant and me.

All participants were adult, qualified psychologists, without mental health impairments and the nature of the interview questions were not deemed as sensitive. Therefore, physical, or psychological risks to participants during the data collection process were not anticipated. Nevertheless, although this was the case and participants were not considered vulnerable adults, the risk that interviews could be distressing was not excluded. To mitigate this risk, participants were informed of their right not to reveal personal information, to take breaks, or withdraw at any time, and interviews were conducted as sensitively as possible. If participants indicated not wanting to discuss a particular topic, this request was respected. Furthermore, a verbal debriefing was delivered to each participant after the interview process to discuss the experience of participating, and to scan for any unanticipated negative effects. Participants received a paper and electronic copy of the debriefing sheet at the end of the interview. This included information regarding the nature of the study and research supervisor contact details should participants wish to withdraw from the project or raise any issues regarding the conduct of the interview.

All signed paper documents were digitised, assigned a unique numerical code, and stored in an encrypted, password protected laptop hard drive folder. All transcripts were anonymised from creation and securely stored in an encrypted, password protected folder on a laptop hard drive, along with interview recordings, for which file names were assigned a unique numerical code to preserve anonymity. After the research is complete, the data gathered for this research will be archived securely for 10 years in accordance with City, University of London's statutory requirements, after which they will be destroyed

As mentioned earlier in this chapter, my supervisor was a trial therapist and site coordinator within the SlowMo RCT. Therefore, careful consideration had to be made to ensure participant identities could be protected within supervision sessions. Furthermore, it was necessary to mitigate the risk of analysis being influenced by the opinions my supervisor formulated from her own experiences in the SlowMo trial, and of personally knowing the participants through her work in the trial. To manage this, participant pseudonyms were used in supervision meetings if needed, and supervisory feedback on my analysis of the data was sought after draft coding had been completed for all interviews and again after I had completed a first draft of the master table of themes. No significant changes were advised by my supervisor to the coding or themes I created, and so any influence from her personal experiences were further minimised.

2.10 Analytic strategy

Smith et al. (2009) provide six "steps to analysis" in line with IPA's idiographic commitment: *(1) Reading and re-reading; (2) initial noting; (3) developing emergent themes; (4) Searching for connections across emergent themes; (5) Moving to the next case; (6) Looking for patterns across cases.* To conduct the analysis, I followed this step-by-step approach and will reveal the depths of this process in this segment.

Reading and re-reading: I began the analytic process inductively to understand the meanings of participants accounts. I started this by listening to each interview recording several times and after doing so, began electronically typed transcriptions of all spoken words, laughs, and false starts. Prosodic features of interviews were included in transcripts. Examples of these included pauses and changes in the pitch and tone of the participant's voice. These features were depicted through stating the specific prosodic feature in within square parentheses such as "[pause]" and "[high-pitched tone]". I included these prosodic features as they could reveal the participants emotional states**.**

The next step was to review each transcript multiple times to immerse myself in the original data (Smith et al., 2009). The starting phase of analysis brought with it a multitude of ideas and possible connections that I was drawn to making. To manage this, I recorded any significant recollections of interview experience, and transcript observations in a separate notebook to help me focus on the data at hand at this phase of analysis.

Initial noting: Next, each transcript was transferred into a table format, and I undertook a line-by-line analysis of the transcript in which semantic content, language and personal reflexivity were examined on an exploratory level, and tentative interpretations were made relating to emerging concepts (Smith et al., 2009). These exploratory comments were typed under the heading '*coding'* in an adjacent column to the transcript (Appendix H). Coding was categorised and colour coded into descriptive ("D"), linguistic ("L"), conceptual ("C") and decontextualised ("DX") comments, as suggested in Smith et al., (2009), using the stated acronyms throughout the coding to indicate the type of comment it was. A coding key was positioned at the top of the transcripts. At this stage of analysis, I noticed my initial overwhelm with the possibilities of interpreting the data. I also noticed my confusion and frustration at points when participant accounts would cover the technicalities of the DP or of psychological theory behind paranoia, particularly as I was trying to remain attentive to the experiential and empathic understanding of participant experiences. These initial struggles with the data were noted in my reflexive

journal to reduce some of the 'noise', allowing me to focus on the data (Smith et al., 2009). This also allowed me a chance to flag to myself that I might need to return to these points to further understand the meaning of using technical language and what it meant for participants to discuss experience in this way. As I moved through each transcript, I made note of similarities, differences, and contradictions (Smith et al., 2009).

Developing emergent themes*:* Next, I used the initial coding to produce a concise statement which represented the psychological essence of the piece, reflecting each participants original words and thoughts, and my interpretations. This manifested the hermeneutic circle. The emergent themes were inputted in a third column named "*emergent themes"* which was added to each participant's digitally created analysis table to the right-hand side of the '*coding'* column (Appendix H).

Searching for connections across emergent themes: Emergent themes were extracted and listed on a blank electronic document in the order they came up to examine the connections between them. Themes were moved around and organised to form clusters of related themes. This was aided through using clustering methods in Smith et al. (2009) including, but not limited to, 'abstraction' (placing like-with-like) which was most used, 'subsumption' (emergent theme acquiring super-ordinate status), 'polarization' (clustering themes which have oppositional relationships) and 'function' (examining the specific function of emergent themes within the transcript). During this clustering process, I continuously referred to the raw data in the transcripts to make sure the connection between cluster group and the participants meaning was congruent. At this stage, I also disregarded emergent themes which had a weak evidence-base, and which did not relate to the research questions. Once themes were clustered, I created a graphic representation of the clustered emergent themes, supported by transcript extracts, and the cluster's assigned superordinate theme title for each participant (appendix I).

It is worth noting that the experiences participants had of using BDT with IeP's were experienced within the context of a RCT. Therefore, emergent themes that were related specifically to how participants experienced RCT's were discarded, to stay in line with the study's research questions. However, it is unavoidable that participant experiences of using BDT will be interwoven and shaped by the context and setting in which it occurred, in this case being a trial-therapist in a RCT, even if participants did not make this explicit or clear in their accounts.

Moving to the next case: I then moved to the next participant's transcript and repeated the process. It was important to do justice to its individuality, so I noted the ideas that emerged from the analysis of the case before in my reflexive journal to help me stick to the idiographic commitment of IPA and to not allow past interview transcripts to influence the reading of new data (Smith et al., 2009).

Looking for patterns across cases*:* In this final stage, each participant's cluster themes tables were compared to determine master themes. I did so by compiling each participant's cluster themes together in a separate table and compared each to one another to seek any connections. This also led to the relabelling of some themes. Themes which answered the research questions, which were potent, and which had clear evidence within the raw data were selected. A master table of themes with example quotes across all cases (Appendix J) was created, containing the final superordinate themes and sub-themes connecting the group. Smith et al. (2009) also suggest that for IPA studies with a larger sample size (over six participants), measuring recurrence of themes across cases is important, and can enhance the validity of the findings of a large corpus. Thus, for this study, the recurrence of each sub-theme was counted and specified in the master table of themes.

During the process of analysis and interpretation, I ensured that I stuck to an iterative process. I moved back and forth through phases and considered a range of ways of thinking about the data, rather than working through the steps in a linear fashion (Smith et al., 2009). This was important, as it helped me think of my relationship with the data, and I noticed this shifting each time I engaged with it in accordance with the hermeneutic circle. Particularly as BDT is a new phenomenon for me, I did not have enough knowledge on the details of the DP, so I lacked knowledge in the more technical aspects of using the DP which participants would occasionally discuss. Therefore, when first engaging with the data, I noticed I would become quite lost or confused when participants would discuss the technicalities of SlowMo. By engaging with re-reading of the data, and comparing across cases several times, I could eventually construct an empathic understanding of the data to then construct the themes. As mentioned earlier in this chapter, I aimed throughout the analytic process to interpret the data through a hermeneutic process of empathy and questioning (Larkin, Watts, & Clifton, 2006; Smith, 2004; Smith et al., 2009).

I decided to re-visit each participant's emergent themes tables several times with fresh eyes, to ascertain if my initial interpretations could be viewed through a more empathic lens, and to ensure I was not stretching the meaning of participants' words too far, as this was a worry for

me. I noticed over time how my reading of the data became less descriptive, and more interpretative. I felt at times easily drawn to participants who spoke in a less technical and emotive manner like Laura or Matilda, as their data felt easier to comprehend and more relatable. It is possible this could have influenced how I approached their data in comparison to others. I remained conscious of this once I noticed it happening and offered more time to look at transcripts that might have felt harder to analyse.

Working with a large corpus in this study meant that the analysis of each case could not be detailed and so emphasis shifted more to assessing the key emergent themes for the whole group (Smith et al., 2009). In the findings chapter, it will be made apparent how different participants manifested the same superordinate theme in different ways. Thus, there was a constant need to negotiate convergence and divergence, commonality and individuality when engaging with interpreting and writing up the analysis of findings (Smith et al., 2009).

As I was engaging with data analysis, I noticed the overwhelm I experienced at the amount of rich data I was working with, and the pressure I felt to give justice to this data and to the participants who provided it. I worried about interpreting things 'wrongly' and that I might misunderstand what my participants were saying. In my original engagement with the data, I found myself being tentative about the interpretations I was making, as I knew this research could be published and would be disseminated amongst participants and other professionals. I brought these anxieties to my research supervision. These were exceedingly helpful in reminding me to continue to reflect on these anxieties as well as to bracket potential biases that were arising for me as I interpreted the data. Conducting audits of my analytic procedure with my supervisor separately also encouraged my confidence in the direction I was taking with the analysis.

2.11 Dissemination

The findings of this research will be disseminated and available to the public on the City, University of London database. Findings will also be disseminated more widely through journal publications and academic conferences. As stipulated in the participant information sheet (appendix C) participants will be sent copies of the research findings if they request these. I will inform all participants by email once the research has been completed that the findings will be made available to them at their request.

2.12 Personal reflexivity

Methodological and epistemological reflexivity were consciously woven through this chapter to provide a chronological understanding of the reflexive process that was taken at each stage of the research process, as well as an understanding of my epistemological stance that inevitably shapes the analysis of findings. An understanding of my personal reflexivity will be presented, to provide a deeper understanding of my thoughts and feelings during the data collection and analysis process (Kasket, 2012).

Initially, the idea of including technology in therapy deeply intrigued me. Throughout my professional experience, I had never heard of this approach, it was never taught in psychology courses, and when speaking about this with colleagues, I was often met with expressions of bewilderment, sometimes even appal. Frankly, it provoked initial suspicion in me; that the inclusion of technology might negatively impact the collaborative therapeutic relationship, which is so crucial when working with IeP's. I immediately noticed the internal discomfort at engaging with a phenomenon, which in some respect, clashed with my humanistic principles of practice as a TCoP. I wondered if the approach could cause emotional distancing in the therapeutic relationship, or be anxiety provoking for clients, and leading. It was therefore crucial, as I began this research process, to make note and reflect on these thoughts and suspicions and to openly address these in supervision, so I could approach the data openly and empathically.

As a TCoP, I noticed my resonance with the psychologists' experiences, particularly their determination to provide a 'good' therapeutic experience for their clients, and the anxiety and self-doubt that could follow with these standards. I also felt surprised by my own changing attitude towards BDT, from initial scepticism, to one of openness and wanting to defend this intriguing approach to therapy provision. This will further be discussed in my reflexivity section in the discussion.

Whilst gathering interview data and engaging with their analysis, I was also involved in a trainee clinical placement in a psychosis recovery service (not associated with any of the participants). As this topic is exploring experiences of a therapeutic approach with IeP's, my 'insider' identity as a TCoP meant that I remained attentive to noting in my reflexive journal certain assumptions I would make due to my preconceived ideas of 'what therapy should be', along with inferences I made in line with what I had learnt from other psychological models of practice, such as psychodynamic principles. For instance, I noticed, particularly at the start,

analysing some of the relational dynamics that participants highlighted through the lens of transference and countertransference, which would have led me to read the data more ‘suspiciously’ than ‘empathically’ (Smith et al., 2009). I was quick at the start to bracket these assumptions I made so that I could be aware of the part of my interpretations that were impositions, so I could approach my interpretation of participants experiences empathically and thus adhere to IPA’s phenomenological base.

Chapter 3: Findings

3.1 Overview

This chapter provides a detailed account of the themes produced by the analysis of data gathered on psychologists' experiences of using BDT with IeP's[4]. Each superordinate theme is explored by providing an introductory summary outlining what the theme entails through its respective sub-themes. Thereafter, a description of how it applies to each participant is presented via transcript extracts to keep to the phenomenological and idiographic commitments of IPA (Smith, et al., 2009).

All identifying information have been altered to preserve anonymity. Whilst the superordinate themes aim to capture distinct aspects of the experience, it is worth noting that these are not mutually exclusive, and there will be considerable overlap occurring between and within themes. I have highlighted where this occurs throughout the chapter. One theme does not systematically progress to another, rather the way each participant portrayed these experiences were as though they could shift between each other and occur at the same time.

To stay as close as possible to the language used by participants within my analysis, participants' routine therapy practise outside of BDT will be referred to as "routine therapy", and the DP will be referred to as DP or "platform" interchangeably. Empty square brackets […] signify data removed from quotations. Non-italicised wording within square brackets provides clarification, and ellipsis points. [Pause] indicates pauses in the participants' narratives. Quotes are followed by participant pseudonym and line number in square brackets. E.g. [Cristina:254] represents Cristina, line 254 of the transcript.

The superordinate themes portray participants experience and management of their initial encounter with BDT, which was a new experience, and how they managed the multiple demands of BDT sessions. Participants would dip into their past professional experiences often during interviews, to then make sense out of their thoughts and feelings about BDT. The themes cover the dynamics of working with a DP, as well as exploring how they experienced

[4] All psychologists continually altered the language used to describe IeP's they worked with during the SlowMo RCT, using the terms "clients", "people", "chap" and "participants". For brevity and simplicity's sake, I will use the acronym IeP or client(s) interchangeably throughout this chapter to refer to IeP's whom the psychologist participants delivered the SlowMo intervention to during their participation in the SlowMo RCT.

the therapeutic relationship with their clients within the triad in the therapy room. Participants share their observation of clients' responses to BDT as a crucial part of formulating their feelings towards BDT. Finally, psychologists organically reflected on their learning and growth post-BDT.

The superordinate themes generated are presented in the diagram below, with their corresponding subthemes:

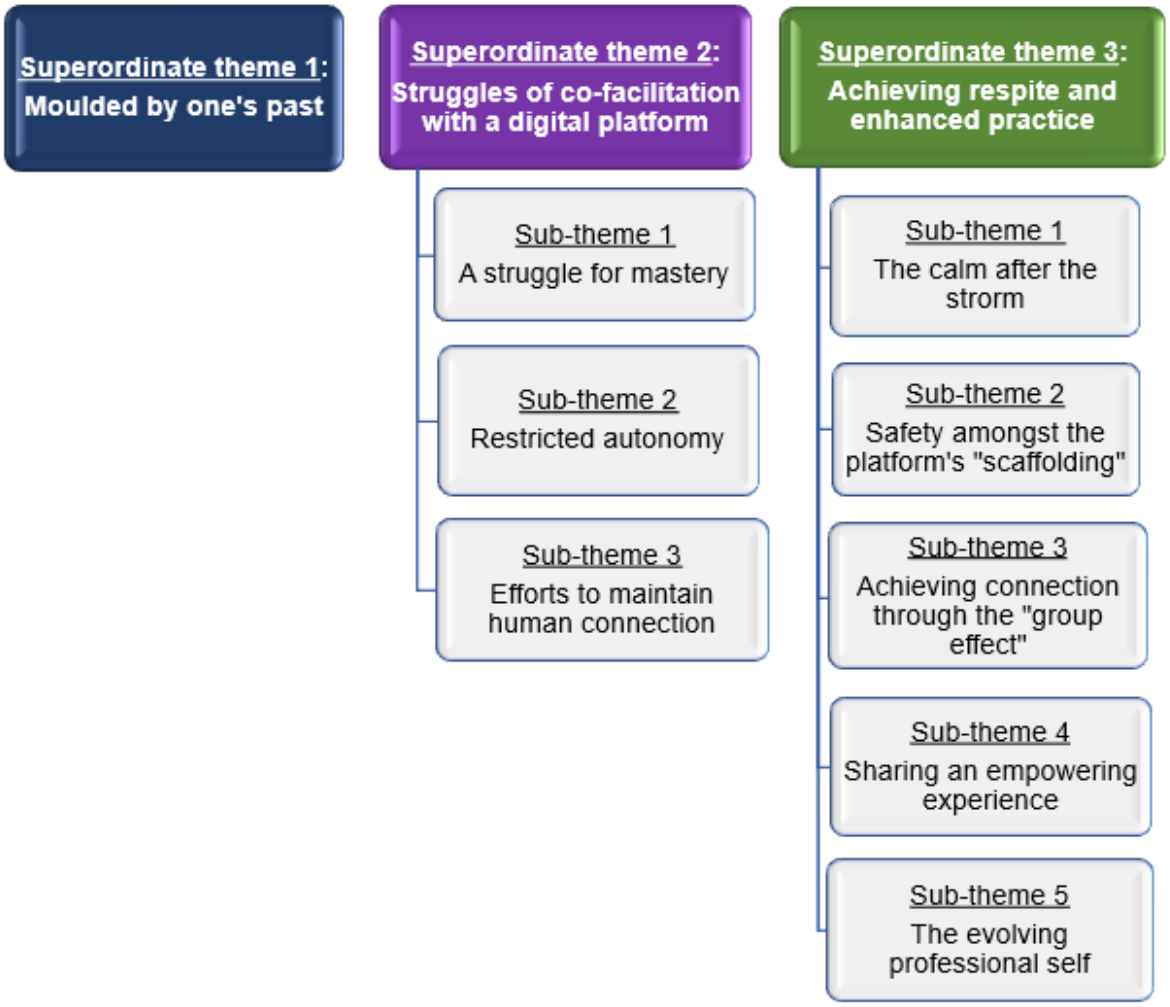

Figure 3.1: Diagram of themes

3.2 Superordinate Theme 1: Moulded by one's past

This is a stand-alone theme that emerged organically during interviews and portrays how participants made sense of their BDT experiences. The theme reveals participant attitudes,

perspectives, and feelings toward BDT, mainly experienced in anticipation of its use, and at the start of using BDT with IeP's. All participants seemed to reflect on their past professional experiences, established values, and ethos behind their routine practice as shaping these initial feelings and presumptions about BDT.

Participants who had early experiences of using, training in, or supporting stand-alone DHI's, or past experiences of delivering targeted interventions in research trials seemed to experience a sense of openness, confidence, and comfort with using BDT. Thus, experience seemed to equip psychologists with the knowledge and practice to tolerate and manage the pressures of BDT. For others, established ethos and personalised methods of practicing therapy differing from the requirements of BDT practice, triggered anxiety, scepticism, and frustration at the start.

Amy and Jordan describe their initial caution and worries:

> *I think my expectations of what a blended therapy would be, I would have been quite cautious of it for all sorts of reasons. Reasons both relating to my own practice, and the idea of bringing technology into therapy sessions. [Amy:649-651]*

> *That* [BDT] *was a struggle for me initially, because usually when I'm working with somebody, I might not use the computer at all. And so, I'm used to focusing more on their body language and what's going on in the room, what we're talking about. [Jordan:104-108]*

> *It's not something that I've ever done before, and initially, I think I was quite sort of sceptical of it 'cause I was thinking "*it's very structured is this really gonna fit for people*?" [Jordan:234-235]*

Amy describes a state of anticipatory caution, whilst Jordan describes a psychological struggle and scepticism when first contemplating the use of BDT and when using it. Both make sense of their feelings through reflecting on their pre-established, and personalised ways of practicing therapy before BDT, which shaped their initial experiences of BDT.

These extracts seem to portray Amy and Jordan's initial stressors and concerns of adapting to a new way of practicing therapy, triggered by concerns of an added pressure the presence of the DP brought. Both perceived a potential for dissonance occurring between BDT practice

and their personal values and methods of practice. And, as Jordan adds, a potential for dissonance between the targeted BDT intervention and her client needs. These initial fears of dissonance seemed to cause initial anxiety, worry, and scepticism. Amy and Jordan, in unique ways discuss the anxieties of a change occurring to their status quo (built from routine practice) when using BDT. Amy's use of "*bringing technology into therapy"* depicts an outside unfamiliar entity introduced into therapy, potentially perpetuating her initial anxiety. Jordan reflects on her routine therapy practice, in which she places great importance on focusing on the immediacy of her encounter with her clients, which could be potentially disturbed by the addition of a "*computer*". Both share their experiences in the past tense, implying a change in perspective occurred toward BDT overtime, which is further explored in "Achieving respite and enhanced practice".

Established principles and values of one's practice when working with IeP's, before BDT, was further reflected on by Adrian:

> *I think you've got to show that you understand people's* [client's] *experiences, and that you get it, and that you, you feel it, and you know how difficult it is for them before they're willing to kind of trust you with trying to do something different with it. [Adrian:41-46]*

> *I spend quite a lot of time focusing on that relationship and really trying to build rapport and um, empathy, and, for people's* [client's] *experiences. [Adrian:48-50].*

Adrian portrays a sense of determination and deep value she holds for the process of building a therapeutic relationship. She emphasises the need for time and effort to develop a strong therapeutic relationship. Adrian expresses her views of BDT through the lens of her professional values:

> *I think umm, we often sort of get all excited about different tools and techniques. Um, but when you don't have a-a basic, kind of, connection, or an empathy- and I think this is particularly key for people with psychotic disorders* [pause]. *If you don't have that kind of rapport, it's very, very difficult to move forward with anybody. [Adrian:34-40]*

> *I see this* [BDT] *as another tool. You know, I see it as another strategy. [Adrian:194]*

Adrian presents the challenges and efforts required to proceed towards positive therapeutic change with clients experiencing "psychotic disorders". Her expression of "*get all excited*" might display her frustration and a dismissal of the use of BDT, as her experience of BDT might not align with her pre-established principles of practice. Interestingly the language participants used to describe the DP exposed further their views towards BDT use. Adrian refers to the DP as "*another tool*". This might be interpreted as a minimisation of the DP in BDT, which might further emphasise the precedence that remains for Adrian toward her original, established methods and values of working with IeP's.

Alternative perspectives were shared by participants who had experienced the use of stand-alone digital tools in the past, and those who emphasised the longevity of their career as a point of strength and confidence to their BDT use. Cristina for instance reflects on her early training experience as greatly shaping her confidence and openness toward BDT:

> *I think the fact that I, that I from the beginning, or since I had my training as a psychologist, I was open to include technology, this has had an impact on pretty much always having a good experience with using technology and face-to-face therapy. [Cristina:238-240]*

Cristina emphasises the importance of her openness toward BDT and early training experiences in shaping her positive experience of BDT and her confidence and positivity towards using BDT. She expands:

> *[…] because I had contact with technology and I brought it to sessions, and I had the good bits of both worlds, face-to-face and technology, maybe that's why I presented as a very positive experience, I don't know. [Cristina:246-249]*

> *I think attitudes towards blended therapy are also, you know, there is an influence of the experience you have had with that before. If it didn't work, or if something went wrong, or if you crossed paths with a client that was not happy, and you thought* "oh well this is going to be a mess*" then you are not that open to use blended therapy, I think. […] My opinion, my opin- yeah, I was open, it was part of my training, so yeah. [Cristina:273-278]*

Cristina's past exposure to using DHI's at her choosing influenced her comfort and familiarity of practicing BDT in the present. Akin to Amy's extract above, Cristina emphasises a

dissociation between technology and therapy through the metaphor "*both worlds*". The division of worlds between technology, and therapy, and the need to unite these might convey the skill and effort required to integrate both.

3.3 Superordinate Theme 2: Struggles of co-facilitation with a DP

This theme explores the initial emotional and psychological struggles of using the BDT approach, as well as struggles that were faced whilst facilitating sessions with the DP. Participants' shared experiences of adapting to, and processing, working with a DP in BDT where control over session direction would regularly shift between psychologist and DP. These processes triggered states of anxiety, frustration, and a psychological struggle, which was particularly heightened at the start of their BDT experiences. The three sub-themes that follow were formulated by the following experiences: (1) self-doubt and a pressure to competently use the DP when first using BDT, (2) a constant shifting and re-negotiation of control over session direction with the DP, (3) the recognition that psychologists themselves held the crucial responsibility to monitor and care for the IeP whilst co-facilitating the session with the DP.

3.3.1 A struggle for mastery

Participants reflected on what it was like to initially adapt to the triadic relationship in BDT, and the subsequent responsibilities and pressures of appropriately and competently managing this new, three-way process. This theme contributed to the struggles of co-facilitation with a DP as it portrayed the initial experiences of anxiety and stress when participants managed the added responsibility of working with, and competently managing the use of the DP, as well as managing their high standards and expectations of self to provide good therapy.

Participants described what initially seemed like a plethora of responsibilities when managing the DP and the client in BDT sessions. There was a clear determination and pressure, perhaps influenced by participants cultural views of the profession and by the RCT context, to be clear and precise in their delivery of therapy and to master the use of BDT swiftly. Participants high standards of practice and a desire to provide good quality therapy for IeP's were attitudes they experienced in routine therapy (before BDT) and carried into their BDT use. Thus, a struggle for mastery was experienced pre-BDT, and was exacerbated at the start of BDT use.

At the core of the theme is participants' experiences of high pressure and anxiety to master BDT delivery and highlights the different behavioural strategies participants used to cope with

this anxiety. The word '*struggle'* was chosen to portray the great efforts made, challenges experienced along the way, and anxieties experienced in the pursuit to master their practice of BDT with IeP's. Additionally, using BDT with IeP's seemed to trigger a need to be sensitive, vigilant, and protective towards their clients, from any distress by BDT, or by themselves and their anxiety.

Matilda is a psychologist who identifies herself as an experienced professional: "*I've worked in psychosis for many, many years." [Matilda:337].* She reveals her experiences of vulnerability and struggle as well as expectations of self which seemed to exist prior to BDT:

> *I would hope that I wouldn't drift a lot in terms of the interventions that I carry out. I would hope that I would be able to focus on the issues that is important to discuss each session. Uh, but I know that, you know, I'm not immune to it. [Matilda:306-308]*

> *I think we all at the back of our minds, all of us therapists have this kind of um imposter syndrome, so we all question ourselves from time to time [Matilda:334-335]*

Matilda's hopes and expectations to not '*drift'* away from the target of her therapeutic interventions suggests the importance she places on the focus and accuracy of her practice, and thus her expectations for self. Matilda highlights her vulnerability to fallibility - the risk that she might lose focus and follow other avenues that sessions demand. She further expands on the vulnerabilities she and other therapists can occasionally experience in terms of self-doubt and questioning one's competence through her use of "*imposter syndrome*". She generalises imposter syndrome, rather than talking in the first person, perhaps portraying a need to emotionally distance herself from these vulnerabilities to manage their discomfort.

Similarly, Laura expresses her standards of practice that existed pre-BDT:

> *[…] being a good therapist involves a lot of different things for me [Laura:163]*

> *So, having the theory and the rationale behind your treatment really clearly in your head, and then also being able to communicate that really, really clearly. [Laura:167-168]*

Clarity of knowledge and precision of therapy delivery are paramount for Laura. Her emphasis on these standards of practice is portrayed by the repetition of "*really*" "*clearly*". Laura

organically mentioned the notion of being a "*good therapist*" (this was not prompted or brought up by the interviewer), which might portray an ideal and expected standard of practice she carries with her professionally and is continually struggling and striving toward achieving.

Matilda's self-doubt seemed to follow her into her initial encounter with BDT:

> *When it came to start doing the therapy I thought "*Oh my goodness, will I be able to do this*"* [laughs] […] *[Matilda:368-371]*

> *You have to remember to do all these things, which are quite a lot of things. And if you're not used to working with computers and mobile phones, it's a lot of new information to take in. And I'm not averse to technology at all,* […] *so it doesn't have to do with that. It's just the novelty of it, and the sheer fact that there's so many things to deal with. So that creates anxiety because you think "*I don't only have to deliver this therapy appropriately according to the manual, I also have to make sure the technology is working really well, and I also have to look professional and not look anxious, and aggravate, you know, this client, or anything like that*". [Matilda:404-411]*

Initial stress and overwhelm are evident in Matilda's experience of BDT. These are mainly linked to a doubt in her ability to cope with the multitude of demands of BDT practice. Matilda emphasises on the plethora of responsibilities and the novelty of BDT as triggers to her initial "*anxiety*". There also seems to be, at the core of these extracts, the high standards and expectations for self to master the delivery of BDT, as well as maintaining her composure and not exposing or projecting her anxieties onto her clients. These multiple pressures might have been experienced as a state of emotional overwhelm at the start of her experience, as she was striving to master BDT. Furthermore, her need to look "*professional*" vs. "*anxious*" portrays a further expectation of self, of her exterior impression needing to look robust and confident, which might have been incongruent with her inner self-state of self-doubt and anxiety. This might depict Matilda's need to compartmentalise during BDT sessions to regulate her emotional state to portray a competent professional image for her clients.

Planning for BDT sessions seemed an important part of Laura's process of adapting to and mastering BDT use:

> *It* [BDT] *gave me the chance to rehearse. Especially on my training case, I would go through the computer session for that session, so I had it fresh in my mind exactly what the case study was going to say, exactly the kind of points, and how. And that let me have an idea in the room about timing. I felt I was kind of better as a therapist* [laughs] *because I had that rehearsal time. [Laura:156-160]*

Laura describes a sense of relief she experienced through preparing and meticulously revising the BDT sessions to be delivered. Accuracy and precision of practice seem important for Laura and helps us understand the values behind her practice. Her preparatory efforts for BDT sessions, particularly at the start, might indicate the initial anxiety she experienced about her competence to deliver BDT well. We get a sense of the efforts Laura made as part of her struggle to achieve mastery over BDT practice and to manage her anxiety of not being a good therapist if she didn't deliver BDT accurately. Thus, initial exposure to BDT triggered the need to strive and struggle for mastery to experience self-assurance.

Amy on the other hand experienced initial anxiety over her competence with technology use:

> *it um it took me a bit longer than I would have liked, but yeah, I think that was something I felt quite worried about in the beginning. 'cause I'm not the most technologically savvy of people [Amy:129-133]*

Amy does not consider herself to be well versed with the use of technology which seemed to be the source of her anxiety. She seems to criticise the length of time it took her to adapt to the DP, which might depict both her expectations-of-self, as well as her initial struggle and stress over mastering the use of the DP in BDT.

More specifically to using BDT with IeP's, participants shared the care, sensitivity, and conscientiousness they held toward IeP's and were highly vigilant toward wanting to make BDT a helpful experience for them. However, Laura specifically shares a state of hypervigilance she experienced at the start of BDT use with IeP's:

> *I think my automatic response to anything with people with paranoia is scanning through,* "Is there anything they could see as a threat?", "What will I have to do to try and reassure them?" *Um, so I'm already like in that detection mode. [Laura:388-392]*

Laura shares the lengths she goes to, to avoid any distress being imposed on IeP's. There is a certain sensitivity to a fragility of "*people with paranoia*" that can be interpreted from this extract, which explains her worry, but also a sense of duty to protect. This is shown by "*detection mode*" which portrays her state of hypervigilance. This might also be an example of the way in which Laura gains control and manages her own anxiety when first using BDT as BDT was a new experience, and with that, came uncertainties around adverse effects on IeP's.

Cristina was in the minority of participants who did not share the anticipatory anxiety of using BDT as others did:

> *If I wouldn't have had this experience* [using DHI's] *at the very beginning of the, of my career, maybe I wouldn't have been that positive, maybe I would have felt distressed by the fact that I have to deal with too many things [Cristina:240-242]*

Cristina seems to be answering an underlying question that was not prompted or asked in the interview: "*Why is my experience different to others*?", implying that she might have noticed her sense of positivity, or confidence with BDT, compared to the anxiety and worries of other psychologists using the same BDT intervention. She bases her positive experience of BDT on her past exposure to DHI's (as in "**Moulded by one's past**") which she might be feeling a sense of gratitude towards.

3.3.2 Restricted Autonomy

Sub-theme 2, "**Restricted autonomy**" and sub-theme 3, "**Efforts to maintain human connection**" overlap with one another and focus on the experiences of facilitating sessions with the DP in BDT. The DP consisted of a targeted intervention, which psychologists, evidently, had a responsibility to fulfil the delivery of. Therefore, participants could commonly feel either restricted by the need to allow the DP to lead session facilitation and planning, whilst also feeling at times able to take control and choose the direction of sessions, describing this overlap of experiences.

Restricted autonomy is focused on first. All participants expressed struggles with feeling a need to withdraw their control and autonomy over session content and direction in BDT, as they felt an obligation to follow the DP's targeted interventions for paranoia treatment accurately. This triggered frustration and helplessness in the participants whilst facilitating sessions. Further struggles and a sense of anxiety occurred when DP malfunctions took place,

as the program was a crucial part of facilitating BDT. This sense of reliance on the program left psychologists feeling stuck and unable to proceed without the DP, eliciting feelings of anxiety, overwhelm, and frustration.

The obligation to abide by the platforms structure despite one's preference was described by most participants. Frances describes a sense of restriction:

> *With the e-tool you kind of have to go through all of it, you can't just escape a bit* [laughs]. *[Frances:105-106]*

> *[…] you can feel a bit tied to it [Frances:205]*

Both extracts illustrate Frances's duty and obligation ("*you have to"*) to abide by the DP's instruction, and thus experiences her ability to be autonomous in sessions as restricted. This is depicted by her expression of "*tied to it*". She appears to be describing an internal struggle; on the one hand, the obligation to follow the program, on the other, her occasional desire for freedom from its restraint ("*escape a bit*"), perhaps to lead sessions in her preferred way. This might have brought about feelings of helplessness when co-facilitating BDT sessions. Her laugh seems to appear incongruent with the experience she is sharing, and instead, seems to make light of it. This might indicate a parallel process of Frances's emotional control during her experience of working with the DP, which is then also reflected in her retelling of it.

Dana and Jordan express similar dilemmas but focus on the frustrating potential for dissonance between the DP's target and structure and the client's needs:

> *[…] I guess the potential is for a kind of, you know, dissonance between what this therapy is targeting, and what the person might want therapy to be about. I think that's the risk. Uh, I haven't had that experience too much, but I think that's a risk. But I think, you know, there's a risk to a therapeutic relationship where the person feels the way the session is sort of, yeah, its leading [Dana:333-338]*

> *[…] occasionally you think well actually there might be different ways of working with this other issue that might work better in this context. So that's, that's a slight frustration. [Dana:470-471]*

> *When clients were kind of saying "*oh no I don't really get it, that it's not really helpful to me*" um then I would feel more stuck kind of "*hm where do we go now*" because this is the therapy, this is what it looks like. Um, so I suppose that's where* [pause] *um, I guess the blended therapy can be a little inflexible in that sense, 'cause you've got the sort of set sessions and set topics, and I suppose if a client doesn't get on board with one of those topics, or doesn't seem to make sense for them, there's not an awful lot of room to sort of go off course and change it, or see if you could do the different way. [Jordan:186-192]*

Dana seems to experience a dilemma when the prior knowledge and expertise that he brings to sessions causes him to wonder if there might be an alternative therapeutic intervention to target various issues his client's might bring to therapy. However, there is an implication that Dana might feel unable to follow a separate intervention to that of the DP in BDT, which portrays the restriction to his autonomy. He is aware of the risk this poses to damaging the relationship between himself and his client which causes frustration. Similarly, Jordan shares a scenario in which she experienced dissonance between her duty to follow the DP's interventions in BDT, and the varying needs of her client. She describes herself feeling stuck between these two processes occurring, which might bring a feeling of anxiety and helplessness when she is feeling unable to "*go off course*" from the DP's targeted direction.

The precedence the DP took in directing and facilitating sessions is evident amongst all participant experiences. Without it, there was a risk of the dissolution of therapy which led to feelings of anxiety, stress, helplessness, and frustration, portrayed respectively by Matilda, Cristina, and Laura:

> *If you don't have the computer working you can't have the session, 'cause the session is in the computer, the vignettes are in the computer, the writing down then appears on the phone, but starts off with the computer. So, all of that is in the computer. [Matilda:425-427]*

Restricted autonomy is reflected here in Matilda's extract, where she emphasises the impact of program malfunctions on suspending therapy sessions. The precedence the program takes in the co-facilitative relationship is evident by her repetition of "*in the computer*" and thus her reliance on the DP being functional. This extract might elicit the sense of pressure or anxiety Matilda holds considering her clear awareness of the risks that are present if the technology

were to fail. Laura shares a similar experience linked to program malfunction and a resultant feeling of overwhelm and helplessness:

> *The kind of frustration when the page isn't loading. Or, you don't know how you're going to get the internet in a team base you've just travelled an hour to get to. And um, that kind of stuff can kind of bring you kind of crashing down to earth. [Laura:438-440]*

There is a clear strain on Laura to have the DP functioning, showing the importance the DP holds in facilitating and directing sessions and the reliance Laura has on it. The risk of malfunction seems to trigger anticipatory anxiety for Laura when travelling to different locations due to an uncertainty/unpredictability of internet connection availability. Her metaphor "*crashing down to earth*" illustrates the sudden chaos, overwhelm and helplessness Laura might experience when the platform is inaccessible or malfunctions. Without the DP, it seems the psychologist is restricted in moving forward to facilitate sessions. Linguistically, it seems Laura experiences a struggle in articulating this experience of overwhelm portrayed by her repetitive use of "*kind of*". This struggle to articulate her vulnerability might link with what was portrayed in a struggle for mastery, where it was evident that psychologists like Matilda worked very hard not to show their struggles or anxieties in sessions to their clients. These observations combined seem to further posit the idea that being professional, strong, and competent are crucial qualities of being a psychologist, and with this might come a sense of pressure.

Restrictions were also faced when clients were not versed in using technology:

> *[…] sometimes I found myself going through the basics of a smartphone* [laughs]*. So how to open it and how to work with the app blah blah rather than doing the therapy itself. So, I think that was kind of a challenge. [Cristina:79-83]*

Cristina faces a "*challenge*" and a restriction in her autonomy to move forward with therapy when her clients were unsure of how to use technology. Cristina found herself adopting a role of teaching clients about technology instead of fulfilling her role as a psychologist ("*rather than doing the therapy itself*"). This shift in her job role seems to depict part of a struggle she experienced in working with the DP, as she occasionally had to withdraw from her usual role and responsibilities to cover tasks that might not have felt as important as being a therapist and *doing* therapy. For instance, her use of "*blah blah*" further depicts the monotony and frustration she holds when needing to shift her usual work as therapist, to training about

technology use. Her use of laughter might further resemble a safe way to manage retelling an experience that potentially felt uncomfortable or frustrating.

Within the restriction in autonomous decision making that has been covered so far, many also developed an alternative way of viewing and working with the DP which enabled them to make autonomous decisions in BDT. Matilda explores this:

> *I would read it* [the DP] *as guidance rather an expectation to do that, and within the guidance there's flexibility. [Matilda:475-476]*

Dana summarises this overlap between restriction and autonomy further:

> *My observation is that that I've, I've found it possible to sort of uh use the central tenets of the SlowMo and use it as a springboard to look into other aspects of the persons difficulties um (pause) and you know that's been mostly OK. But I guess there are just sometimes where the specific targeted, the specific targeted interventions the person's sort of rapid thinking style is not really applicable. [Dana:183-187]*

As Matilda and Dana share, their use of the DP and perspective of it was more of a "guide" or a tool to help "springboard" and facilitate necessary conversations in line with client needs. Therefore, they might feel a greater sense of relief and comfort in using the DP as a support system than one that is inflicting control over sessions and removing their ability to take control when needed. This is further explored in the upcoming sub-theme "**Efforts to maintain human connection**".

3.3.3 Efforts to maintain human connection

This theme centres around psychologists' responsibility and duty to observe and adapt sessions to their clients, as well as using their human traits to maintain client engagement and connection. As highlighted in restricted autonomy, the participants did not always feel the DP's clinical interventions were relevant. Thus, the psychologists automatically adopted a crucial role of adapting and individualising session materials as far as possible to their client's experience. This was done to facilitate a helpful experience for clients. The participants therefore had to take an active stance in directing sessions and had to exercise their autonomy in service to their clients, to adapt sessions to their needs. This would mean that the

psychologist would need to remain alert to the shifts and changes in client emotional states, as well as their spoken word, whilst holding the responsibility of facilitating the DP's interventions.

Participants highlighted the struggles with attention, memory, and potential for their clients to be distracted by voice hearing experiences that IeP's could experience. And so, participants held the important role of using their human qualities of attentiveness, care, empathy, and being emotionally attuned as crucial to engaging IeP's in BDT, as well as adapting the structure of sessions to meet their needs. This would occur particularly when they noticed their client's becoming disconnected or feeling unsafe within BDT.

Laura highlights the importance of her human-presence in BDT:

> *Because you're interspersing it with talking, with discussing like how the cases* [DP vignettes] *kind of relate to them or not, whether they have anything in common with the case examples, they begin to see that actually it is personalised, and it isn't just going to be um, yeah, this kind of cold material that doesn't relate to their life. [Laura:107-112]*
>
> *I think people realise that its interactive, that they're getting a therapist who's a human. [Laura:665]*

At the core of Laura's experience here is the process of establishing and maintaining a collaborative working relationship with her clients, which establishes connection between Laura and client in BDT. Her use of "cold" to describe the DP material is significant, as it might imply the sense of "warmth", human kinship, and thus connection which Laura's presence brings. There is an important quality of synergy that Laura describes occurring between herself and client within discussions about the DP materials with clients, which further builds this connection. What this also suggests is that the humanity of the therapist is a crucial component for sessions to be helpful for clients. What is meant by humanity here, is the ability of a human-therapist to notice in the client qualities that the computer would not be able to.

Frances for instance stresses the importance of the therapist in BDT as well as the extra efforts needed to engage clients in the DP material:

I guess as a therapist you're- part of your work is about I guess help- working together with them to see what does fit for them and being able to pull out the things that they do identify with and then helping them to take that away from the session rather than getting lost in something that […] doesn't feel relevant for them and getting bogged down on that. [Frances:134-138]

You just have to work a bit harder; you can't let the tool do the talking, which you wouldn't anyway, but you know what I mean. It kind of, yeah, having to work a bit harder [laughs]. [Frances:533-535]

Frances clearly establishes the value in her presence to support the delivery of the materials on the platform and in the collaborative working experience and thus connection she facilitates with the client. Frances stresses on the extra effort needed on her part to engage her clients in the intervention. The platform in BDT thus cannot exist and function in isolation, it needs to be applied and adapted by a human presence.

Adrian brings up the important issue of working with IeP's experiencing disconnection with her and with the DP interventions:

[…] I think that I felt like I was perhaps doing more, umm [pause] to-to show them [clients] *that I understood what was going on than I, than I may have done in a different setting. Because they were saying umm you know "*it's way more complicated than that*" or "*you don't know me very well*" that kind of stuff. [Adrian:254-258]*

Adrian is referring to new clients she met at the start of BDT treatment. She highlights the importance of her presence in BDT to "*show*" her empathy and share her understanding of these clients, who evidently experienced a dissonance with Adrian. This might have been experienced by Adrian as an added pressure to work harder and portray her understanding to re-gain their trust and connection. She manages her client's rejection of the DP materials through compensating by showing more empathy than she would in her routine practise. This idea might symbolise the importance that Adrian gave to her own presence in BDT, where she could provide that human compassion that the DP could not provide, but also portrays the potential frustrations, challenges, and risks of working alongside the DP.

Adrian shares instances of taking charge and using prior knowledge and expertise in sessions:

> *I have the framework of SlowMo to kind of guide the gennerralll theme of the session. But then depending on what people are saying, I'll bring other materials of, you know, knowledge or techniques that I've used before that kind of fit in with that. [Adrian:440-444]*

Adrian points out a crucial role for the therapist; that of adapting the platform materials to the clients, making this usable for them depending on their unique needs. Adrian adds the value her prior experience and knowledge brings as an additional support for clients.

This importance of the therapists' human presence is illustrated in Jordan's reflections:

> *I guess I had to sort of slow the pace down for some clients compared to others and have longer sessions, because it would take longer; they would need multiple sort of- we would need to repeat the audio and things, we'd need to go through things a lot more because they'd find it hard to kind of concentrate on the discussion we were having and looking at the computer as well. [Jordan:477-481]*

Jordan highlights her clients' individual needs which needed to be catered for, and she empathises with their various struggles during BDT. She portrays the crucial role she played in BDT, as well as the care and efforts she made in attuning with the client's needs, and then catering for them. For instance, clients might have varying abilities of concentration and attention. This therefore relays the importance of her human-presence alongside the DP, to carefully observe shifts in her clients' emotional states for instance, to then "*slow the pace down*" and provide care.

Psychologists described a need to remain alert to IeP's who expressed worries about the DP and adapted sessions to help reinstate a sense of safety and connection, as described by Cristina:

> *Just putting a, you know, a word* [when clients were required to insert personal reflections in the DP] *was enough, we knew what we meant. But the fact that it is connected to internet, although you can explain is very secure, some, um, yeah, it kind of fits on paranoid thoughts. So that, that was another, yeah, kind of challenge. [Cristina:104-110]*

Cristina is aware and attentive to her client's discomfort towards the DP, which presumably required discussion and an ability to attune herself to her client's cognitive and emotional states in BDT. Perhaps at the heart of this extract is the quality of symbiosis that Cristina established with her client: "*a word was enough, we knew what we meant*". This extract represents the extra efforts, and perhaps struggle, that psychologists experienced in adapting BDT to their clients and to help them feel at comfort. Although not explicit, she highlights the value in her presence to establish collaborative working with her client.

3.4 Superordinate theme 3: Achieving respite and enhanced practice

This theme was highly prominent, given great emphasis, and weaved through all participant accounts. It reveals participants' multitude of positively valued experiences of using BDT, which when brought together, represented a sense of respite achieved from sharing session facilitation with the DP, and a sense of increased confidence that the therapy that participants were providing through BDT was of enhanced quality.

Most participants reflected on qualities of growth and enhanced practice through the application of BDT over time. One emergent theme across cases considered how psychologists felt they mastered the use and delivery of BDT through time and constant practice, which boosted their confidence. Another emergent theme, which emerged organically, was participants' self-reflections post-BDT. They explored unexpected learning and how they felt changed or unchanged by the BDT experience.

The central felt experiences shared by all participants were feelings of relief and increased confidence whilst using BDT. Participants seemed to gain more time and space to focus on the therapeutic relationship with the client. They also gained time and space for intrapsychic recovery and reflection during sessions, whilst the DP delivered its interventions. Most participants experienced enhanced equality and cohesion within the therapeutic relationship in BDT, which seemed to be aided by the presence of the DP in the room. Furthermore, the use of the DP seemed to empower IeP's, which was somewhat a pleasant realisation for participants.

Finally, BDT offered an opportunity for participants to provide a novel, bespoke, and extraordinary therapeutic experience to IeP's. Participants seemed to feel empowered in response. They felt confident that BDT was a positive and empowering therapeutic experience

shared with IeP's, something that participants felt IeP's did not always have access to in their lives.

3.4.1 The calm after the storm

Over half the participants describe the use of BDT as a process of learning and adapting through exposure and application over time. The calm after the storm reflects psychologists' process of overcoming their initial 'storm' of emotions and stressors when using BDT. There is a clear shift in emotional state from anxiety, pressure and stress explored in "**a struggle for mastery"**, to mastery, confidence, and calm over time. Consequently, there is an overlap and expansion on "**a struggle for mastery**" through "**the calm after the storm**". It is the first sub-theme to portray a facet of participants' experiences of enhanced practice.

Achieving enhanced BDT practice overtime was experienced by most participants, as described by Matilda:

> *After you do it a few times, then you'll know the program back to front, and front to back. It's straightforward. [Matilda:497]*

This extract reveals Matilda's sense of confidence, clarity, and familiarity that comes with regular application of BDT, to the point where BDT was experienced as simple. The way Matilda speaks about her own experience in the second person might depict her certainty that using and mastering BDT is a transferrable skill, which anyone can achieve.

Jordan reveals a similar experience:

> *I think it's just the fact that we were using computer, an app and all, that it made it feel more complicated initially. But actually, when you break it down, it's not, and when you feel more confident, you feel more familiar with using the technology. Yeah, actually, it becomes second nature [Jordan:295-298]*

There is a sense of calm and growth Jordan has experienced from familiarising herself with BDT use. Through taking a retrospective view of her initial reaction to BDT, Jordan empathises with her past-self and rationalises her initial experience of BDT as confusing. We see a shift from her past self to her present self-state, now experiencing confidence in her use of BDT, so much so that it has become habitual.

Amy also engages in a retrospective view of her first encounter with BDT to reflect on her shift in emotional state and perspective over time:

> *[…] I also thought that people might be quite worried about the technology but that hasn't really been a problem. Delivering the blended therapy has definitely challenged my assumptions and my expectations. [Amy:132-140]*

> *I guess at the beginning maybe there were times where the, the kind of platform hindered me slightly, and I'd be busy worrying about the platform more than I would be n-now. Um, but I think that in any therapy that you're delivering, when you're training, and you're learning, there's always a learning curve. [Amy:412-418]*

It is clear in Amy's extract that she has noticed her progressive development of confidence in using BDT. She also highlights how her exposure to BDT allowed her to challenge some of her negative presumptions of BDT (portrayed by "**moulded by one's past"**), thus showing a further sense of growth overtime. Her shift from past anxiety to growth and confidence can be seen by the way she rationalises and normalises her initial anxiety.

Overcoming anticipatory anxiety and achieving confidence in BDT required exposure to the participant's feared situation:

> *Um* [laughs] *my first thought I have to say, was, because I've never worked with people with paranoia before using blended therapy […] and I was a little bit like, "*oh I wonder how people will take the technology element*". 'Cause people can feel quite paranoid about technology. Um, and I was really interested that actually that wasn't the problem people had. [Laura:374-380]*

Akin to Amy, Laura seems to have challenged her initial worries around how IeP's would experience BDT. Her initial hypervigilance portrayed in "**a struggle for mastery**" seems to have dissipated as her initial assumptions were challenged through practice overtime. Though it is not explicit in this account, Laura might have felt relieved by this discovery and encouraged to feel more comforted in her experience of BDT going forward.

Participants reflected on the supportive nature of training, technical support, and clinical supervision to aid their enhanced practice of BDT overtime:

With a bit of training, it becomes second nature very quickly. [Matilda:419]

Meeting outside normal supervision to discuss technical issues that I've had and how to overcome them, those are very important. [Matilda:896-897]

I had um a pilot case who wasn't in the trial that I saw on my own and I had weekly supervision for an hour every week with a therapist to kind of share [with the supervisor] *what I was doing. And so, I felt like all of those things together really helped boost my confidence […] [Amy:447-450]*

Matilda and Amy emphasise the necessity of training and technical supervision in aiding their process of habituating to and enhancing their practice of BDT. Matilda's use of "*second nature*" portrays her mastery of using BDT, as though it has become instinctive over time and application. Their use of external support systems such as supervision and training might also portray the necessity to connect with others who might be at a level of high competence with BDT who can provide care, empathy, teaching, and reassurance for what can be experienced as an anxiety-provoking experience.

3.4.2 Safety amongst the platform's "scaffolding"

The term "*scaffolding*", coined by Laura [811], revealed itself to be a fitting metaphor symbolising the highly supportive function of the DP for the psychologists. Here, the DP was described more as a "tool" which is used by the psychologist to structure sessions and to provide clear delivery of complex psychological interventions targeting symptoms of paranoia. This was experienced as a safe experience as there was little to no room for error to be made due to the DP's reliable, systematic way of delivering interventions, being a programmed entity.

Amidst the complexities of the therapist-DP relationship, covered in "**restricted autonomy"** and "**efforts to maintain human connection"**, the current theme adds to this relational dynamic. Here, the DP offers a safe, containing, and comforting presence, which guided psychologist and client through sessions. Challenges that would commonly be experienced by the psychologists in their routine practice (before BDT) seemed to be resolved with the DP's presence. Responsibilities of session facilitation were by default shared with the DP, which was a great relief.

The DP was described as a “safety-net” due to its clear, consistent, and dependable structure:

> *I think it’s really helpful for me* [laughs] *because I tend to go off-piste. So, like, I set an agenda, and then forget a lot of it, or forget to set an agenda. Or I find something they* [clients] *said interesting, so I bin the next kind of two or three sessions I had planned and go with a new direction* [referring to routine therapy]*. So actually, to hold me on course, it’s really good there’s this structured material* [referring to BDT]*. Um, and so there’s that kind of session planning kind of perspective. [Laura:119-123]*

> *I think that message is so consistent across the sessions it helps you as a therapist to have the message straight which helps you kind of deliver it better. You don’t have to necessarily have to prep in the same way you would for a completely separate, bespoke, non-manualised session. [Laura:182-184]*

> *I guess because I’m fairly recently qualified* [laughs]. *So, it’s um, quite, reassuring to me that all the thinking for the session has already been planned out. And essentially, most of the timing for the session has already been planned out [Laura:140-143]*

Laura compares her BDT experience to her past routine therapy experience, to make sense of how she feels about BDT. She highlights her struggle of going “*off-piste*” in routine therapy, like Matilda’s experience of therapist “*drift*” highlighted in “a struggle for mastery” [*Matilda, 306*]. Perhaps as a recently qualified therapist, she seems to indicate her heightened risk of deviating from session plan, explaining the safety she feels when supported by the reliable DP, particularly as it helps improve her practice. Her identity as “*fairly recently qualified”* might indicate a sense of vulnerability, as she might be measuring her level of competence against her experience. When using the DP, she portrays a sense of stability and comfort by her description of the DP “*hold[ing]”* her and providing her with a structured course of action. Thus, the DP in BDT was experienced as a source of stability, dependability and relief from the usual anxiety and pressures she might feel when relying solely on herself in routine therapy.

Matilda previously identified herself as an experienced psychologist, especially within the field of psychosis treatment, however she also describes her personal reasons for feeling safe in BDT:

To be very, very, very honest I think it's a safe experience. [Matilda:262]

*I think it is a safe experience because as therapists we all come to a point where we think "*Oh my goodness what are we doing? Where are we going? What's happening? Did I do this right?*"* [higher-pitched tone]. *And SlowMo is actually a very well thought of intervention that works. So, it's also trusting that intervention will be very supportive in itself and there's less risk of um therapist drift. […] the session will always bring us back to the main issue that's being discussed. [Matilda:266-270]*

Matilda's expression of safety seems to have required deep reflection and vulnerability to expose, as she emphasises the level of honesty she was bringing. Matilda exposes further vulnerabilities of her tendency to self-doubt as a therapist. The process of self-questioning she describes seems continuous and might resemble a state of anxious rumination, which might symbolise the sense of anxiety and overwhelm that she and other therapists can experience about the quality of their work. The overwhelm was also noticeable in her language use "*oh my goodness"* and in her speed of speech and tone of voice during the interview which was fast and rising when she was reflecting on these questions. Matilda presents a shift in experience when she discusses BDT and expresses her sense of trust and reliance on the DP which provides a sense of reassurance and perhaps enhances confidence in her delivery.

Dana, Laura, and Frances refer to the supportive nature of the DP in aiding the delivery of complex theory and research linked to paranoia treatment in a clear and comprehensive manner:

So, it's helpful in the sense that it's, um, you know, in the context of psychosis, which can be multifaceted and complex and stuff, and pieces of work can touch on many different areas [pause]. *The benefit of this approach is it does, it does do what it says on the tin. It does target a specific area, and that brings sort of clarity in a way to the work that we're doing. So that's helpful. [Dana:145-154]*

[…] it is quite a confusing abstract concept really, um that you've got these reasoning biases and they might be, whatever. So, for somebody to really hold on to that message through each session of the course of the sessions, I think that's what good therapy should be [Laura:171-174]

> *It just talks about all the all the research that we know about um* [pause] *paranoia and people who are worried about others hurting them, and it just sort of takes all that research and explains it in a really easy to understand way [Frances:310-312]*

All three extracts highlight the complexity and overwhelming nature of treating psychosis and paranoia, considering the vast number of routes that can be taken in therapy, and complex nature of the theory and interventions behind this treatment. At the heart of each extract exists a message about the ability to share this responsibility with the DP, and the reliability of the DP in delivering complex material in a clear, effective manner, thus enhancing the quality of therapy being provided as Laura explicitly states. This level of clarity and simplicity the DP provides in delivering complex material is further emphasised by the metaphor "*it does what is says on the tin*". There exists both a sense of relief, and increased confidence in one's delivery of therapy that participants experienced working alongside the DP, portrayed in each of these extracts.

Having the DP delivering interventions also offered time and space for self-reflection, and to be in-tune with intrapsychic processes during session duration:

> *It also gives me a chance to pause* [laughs], *which I think is really helpful. Because I think often in therapy sessions, you're kind of processing and reflecting, and holding the formulation in your head, and thinking about the agenda for the session, and things like that. And with the vignettes, and with the SlowMo platform, it gives you an opportunity to pause and take a moment, and think about, kind of, where you are next going in the conversation you might have just had. [Amy:175-180]*

There is an unrelenting pressure described by Amy in which multiple aspects of the therapeutic encounter are internally examined in once space of time. Her listing of multiple responsibilities illustrates a sense of psychological strain, or overwhelm, when facilitating sessions. When the DP is delivering interventions, she seems to experience permission ("*gives me a chance*") to take time and space to address her needs and prepare herself for the direction the session is going in. This experience potentially relieves the pressure she feels, and perhaps offers a safe moment to release the psychological pressures that she describes and helps her to prepare mentally and psychologically for the rest of the session.

The feeling of confidence and reliance on the DP was a running experience for all psychologists, which is expressed by Amy:

I just think that I feel confident, it [DP] *makes me feel confident. When I go into sessions, I don't feel, I never feel "*oh gosh now I've gotta do this bit today, and I don't like this*." I never feel like that. I go into sessions feeling really confident that what we're going to do today will be helpful for my patient. And I think that's so nice because to have a therapy you really believe in makes such a difference to delivering it. [Amy:374-379]*

I feel like it enhances my therapy I don't feel like the computer does the therapy and I just sit there, and I chat with the person [client]. *I feel like it helps me to do the best therapy that I can […] [Amy:397-399]*

Amy clearly experiences the DP as enhancing her confidence as a therapist. She presents her internal dialogue before BDT sessions, emphasising that she does not experience dread before sessions but perhaps might even feel a sense of pleasure and confidence in facilitating sessions as she has the reliable support of the DP beside her. Considering Amy's internal dialogue, this extract might further describe the sense of psychological struggle, stress or anxiety Amy might experience in her routine non-BDT practise perhaps depending on the topic or intervention being discussed. The DP seems to help remove any sense of self-doubt or anxiety, providing a sense of relief, comfort, and confidence.

Further relief was described by some participants when faced with the challenging task of disagreeing with clients:

I think in those situations [when needing to correct clients] *it helped to be able to say like "well you know I'm not saying you're wrong, I'm just saying from what we've looked at, it seems to be a different answer"* [laughs]*. So, I think it helped in those instances where you want to correct somebody, you've got an easy way to do it because you've got the "program says". [Laura:525-531]*

It lets you be a lot more curious, be a lot more judgemental, but have that safety-net. So that kinda helps. [Laura:589-590]

So, if there's an explanation of something in SlowMo that the client doesn't agree with, or that they can't get on board with, we can talk about that together. Because I'm not the one who's brought that up, the SlowMo platforms brought that up. And we can think about it together and wonder about it more tentatively. Whereas in traditional therapy,

*often you're kind of making judgments about- based on the formulation and the patients presentation kind of, "*how much do I want to say here*" [Amy:211-216]*

[…] actually what the computer does is it's a kind of a neutral kind of information giver type thing. And then you discuss it and make sense of it together, so it takes that onus off you to do that part. [Amy:542-544]

Both Laura and Amy refer to the ease in managing challenging relational dynamics between themselves and their clients in BDT when disagreements might arise. The DP is described almost as being a buffer in moments of potential disagreement that might occur for client's and the material being discussed. There is a sense of freedom that Laura experiences in being able to explore her client's narrative and challenge as necessary, as she can rely on the "safety-net" and protection the DP provides from the risk of relational rupture for instance. Amy portrays a sense of ease in being able to work through these sorts of relational challenges with clients in BDT, as there are available opportunities for responsibility to be shifted onto the DP, which is the source of the material that might be triggering the client's disagreement. A sense of comfort and relief is evident for Amy, as she adopts this position of allegiance with the client, rather than their opposition, allowing a sense of harmony to occur between psychologist and client and perhaps relief for both Laura and Amy.

3.4.3 Achieving connection through the "group effect"

The "*group effect*" coined by Dana *[Dana:391],* symbolises the triadic relationship, as well as the simulation of there being a group present in BDT sessions when the DP would share video clinical vignettes. This theme aims to portray the varying and unique ways participants experienced the group effect as facilitating trust and connection between therapist and client, as well as encouraging client connection with the therapeutic process. This seemed to be greatly relieving for participants and helped them feel that they were providing a valuable therapeutic experience.

As mentioned, this theme focuses on the overall triadic relationship between psychologist, DP, and client. All participants described the importance of achieving rapport, trust and engagement when working with IeP's. Jordan makes this explicit: "*if you don't have that sort of rapport with them* [IeP's], *then really, it's very hard to do anything else […]. I think that's crucial, especially people with paranoia, because it can be difficult for them to trust other people [Jordan:33-38]."* Emphasis was placed, by all participants, on the DP's video clinical vignettes

in effectively and powerfully normalising client's experiences, thus empowering them. This experience of client empowerment overlaps with the upcoming sub-theme sharing an empowering experience". However, it has been positioned under the current sub-theme as the DP's video vignettes added to the group-effect experienced, and in turn, encouraged client's connection and trust in therapy.

The position the DP took in delivering materials and interventions in sessions (as covered in restricted autonomy) was also experienced as a positive factor of BDT, as it took the onus off psychologists to be in a dominant, all-knowing position, to an equal, cohesive position between client and psychologist. This equality emerged as an embodied experience; physical proximity with client and psychologist sitting side-by-side and watching the DP. It also occurred as an interpersonal experience of quality and connection within the therapeutic relationship.

The physical presence of the DP in the triadic relationship further provided a welcomed shift of attention away from the emotional intensity of the psychologist-client encounter for IeP's, usually exacerbated by the client's symptoms of paranoia, increased self-consciousness, and concentration issues. Consequently, the DP was a source of relief for psychologists, as they were able to comfort their clients and maintain their engagement in sessions effectively through shifting attention away from the therapist client interaction to the DP regularly. Furthermore, psychologists felt that in relieving their client of the emotional stress of the therapeutic encounter, they were proving them with an enhanced, and helpful therapeutic experience. This was noted by many participants as a pleasant and unexpected discovery whilst using BDT.

Dana and Amy share their relief of no longer needing to adopt a default power-dynamic in BDT, which they tended to adopt in routine therapy:

> *Um, and not having as a therapist to have to be talking all the time, but to have other things that kind of illuminate or illustrate all the other bases or things that the person can reflect on. In a way, I think it, it helps to sort of attenuate the risk of the psychologist just being in that sort of slightly dominant, knowing, you know, all-knowing kind of position. [Dana:244-247]*

> *It makes it, um, more collaborative, the kind of power imbalance isn't there the same way, because you're both sat there, you're both looking at the screen, you're both discussing it together. So, I feel like it's really easy to make it more collaborative which is so important for people with paranoia. [Amy:242-245]*

Dana describes a shift in his position from *"dominant" "all knowing"* to one that is more in equilibrium with the client in BDT. There is a clear sense from this extract that a pressure has been lifted from Dana as sole facilitator, bearing, and delivering materials and interventions, which in turn reduces the risk of Dana taking an un-relatable, perhaps intimidating position within the therapeutic relationship. Amy echoes a similar experience. She experiences a reduction in the power-imbalance between herself and her client. She emphasises more on the physical proximity and visible equality that is established by psychologist and client sitting next to each other, experiencing the DP equally in time and space. Amy stresses the importance of establishing and maintaining a collaborative working relationship with IeP's, and how BDT helped facilitate this. Both extract emphasis the sense of union Amy and Dana experienced with their clients, and the ease in achieving this thanks to the DP's presence.

More than half the participants described the discomfort and heightened emotional states noticeable in clients amidst the psychologist-client interaction. Participants experienced a pleasant discovery when they noticed the physical presence of the DP, and the regular requirement in BDT to shift gaze over to the DP, as relieving the client's discomfort from the human-human encounter. Adrian emphasised the welcomed regular shift in gaze over to the DP as a hugely supportive element of BDT:

> *I think the other aspect that has been very good for this chap* [IeP] *who I just saw, is that he finds this kind of* [using finger to draw an imaginary forwards and backwards line between herself and I] *sitting opposite somebody talking about stuff quite challenging. [Adrian:119-121]*
>
> *Um, and so having that sort of focal point* [DP] *breaks that kind of intensity. He doesn't get kind of so overwhelmed with those sorts of messages from the voices, so he can look at that um, and be, yeah have some respite from that kind of stuff that consumes him. [Adrian:217-221]*
>
> *[…] in being more relaxed he can take more information in [Adrian:231].*

Although Adrian does not explicitly speak about her own felt response, one can wonder the struggle and pressure of both facilitating sessions and containing her client's anxiety might bring. The ability to use and shift attention over to the DP seems to provide a period of rest and relief from the overwhelming human therapeutic encounter, which Adrian might be grateful

for and relieved by. The noticeable benefit Adrian observes from this shift in focus is that her client's lowered anxiety enhances their ability to absorb information and focus, which as she highlights can be difficult for IeP's due to their symptoms. This in turn might reassure Adrian that she is providing a helpful experience for them.

Dana has a similar experience when using BDT:

> *The flow of the session- I've noticed positive engagement the fact that it's not face to face constantly talking back and forth. I think my experience um people can find it difficult to talk for you know fifty minutes or so, particularly with issues of concentration, distraction of voices and all sort of things. I've noticed that people just engage and that sort of the switching of attention between let's do a little bit with the web app, let's do a little bit of reflection, it's worked really naturalistically. It's opened-up conversations I feel in a way that I- is better than I anticipated. [Dana:130-136]*

Dana highlights the difficulties IeP's can experience in remaining engaged in sessions due to their psychosis symptoms. He highlights the movement of gaze and attention and variety of activities from the DP as a welcome and perhaps relieving experience for him and his clients. His use of "naturalistically" emphasises the organic nature of the conversations with his clients in BDT, particularly when the DP encourages dialogue on certain topics that might otherwise be challenging to bring up.

Jordan presents relatable examples to emphasise the beneficial use of the DP as a source of respite from the challenges of the psychologist-client encounter:

> *I guess it's like you often hear people saying, if you're going to have a difficult conversation with somebody, have it when you're walking side-by-side, or have it when you're in the car, so that you're not kind of giving eye contact and you're able to talk freely. I think it's like that in a similar way. You're both focusing on the same thing but there's not that intensity of eye contact or body language in the same way as there might be- they perhaps don't feel on the spot as much. [Jordan:418-427]*

Through these relatable examples, Jordan shares strategies that might be used to survive or tolerate challenging relational encounters through physical and psychological distancing. Jordan's extract portrays the experience of using the physical presence of the platform as a distancing mechanism, to relieve the intensity of the encounter between psychologist and

client. There is still a togetherness that is experienced "*you're both focusing on the same thing*", but there is a tolerance of the social interaction. This might feel both comforting and relieving for both therapist and client, and might also feel reassuring for psychologists, that they are providing a helpful experience for their clients.

Jordan shares a struggle that was overcome by the support of the digital video vignettes presented by the DP:

> *I think umm (pause) sometimes if you're not using sort of like a blended therapy, clients can kind of think you're just saying things to make them feel better. […] they don't necessarily believe you. But when they see it, like hard evidence for that, if it's written in a book or if somebody is saying on a screen or there's a video of somebody saying it I think it just feels that bit more, yeah, that bit more authentic. And they feel like "*Oh okay so you're not just saying it, actually someone else is saying it too*" um and it maybe feels more real to them. [Jordan:332-339]*

Jordan reflects on her past experiences of routine therapy to make sense of her current BDT experience. It is clear from Jordan's extract that there is a struggle in her routine therapy experience, in which she might not be believed by her clients when delivering normalising information. Though it is not clear from this extract how that feels for Jordan, one might wonder the helplessness she might feel from the client's scepticism. It seems important to Jordan to emphasise the source of where the information comes from. Being able to *see* "*hard evidence*", such as vignettes on the platform is significant. The fact that hard evidence is required, portrays the struggle to gain trust from IeP's and suggests how the vignettes serve as a type of conclusive evidence that is convincing, unchallenged and resonates with clients. This might provide a sense of ease for Jordan in achieving her clients trust and engagement when using the DP's video vignettes.

Cristina and Matilda describe the impact the presentation of vignettes, factual stories from other IeP's in video format, had on clients:

> *the examples* [vignettes] *[…] allowing people* [clients] *who don't want to bring experiences from the beginning to just open the little door for them to, to share them with you. [Cristina:72-73]*

I think it's- they [digital vignettes] *really fuel really important conversations that probably would be harder to get to without the content. [Matilda:998-999]*

Evident here is the powerful influence the DP's vignettes had on encouraging untrusting clients, to gradually open-up and engage with Cristina. Her use of the metaphor of opening the "*little door*" seems to illustrate the challenging dichotomy that exists for psychologists when relationship building with IeP's: access to client life-worlds remain closed or open. Here, perhaps trust is the key that allows the door to open. It seems that Cristina experienced the vignettes as powerful tools that allowed her clients to gradually build trust and connection with her, thus, bringing Cristina a feeling of relief and gratitude towards the DP's presence. Matilda evidently echoes a similar sentiment and expands on her unique experience of finding an ease in effectively opening-up difficult conversations with clients, thanks to the vignettes.

Amy brings up a similar moment with her client after their first BDT session:

So, in the first session I've had so many people [pause] *I mean I've had someone say that that first session that it changed their life, because they just didn't know that other people felt the same as them. [Amy:306-308]*

Amy provides evidence of the profound impact the DP's vignettes had on her client which might have been empowering for Amy to hear. It is clear the connection achieved from clients after hearing and seeing the vignettes, as well as the sense of belonging they experience. Amy and Matilda further expand on the supportive nature of the DP in engaging and empowering clients:

I think having someone, having me as a psychologist say to somebody "Lots of other people experienced this as well did you know blah blah blah", obviously not quite like that but you know- um, feels very different to actually hearing one of the vignettes, people talking about what it's like for them. And so, it can feel really normalising and that is very powerful for people [Amy:312-315]

I think it's much more powerful to hear a personal story from someone else than the therapist telling it. [Matilda:654-655]

There is an instant relatability to the visual and auditory evidence of real-life experiences shown on the DP than with the same message being portrayed by the psychologist, as Amy and Matilda voice. There is a significance in Amy's extract highlighting a comparison between

herself and the platform delivering the same message. Her identity as a psychologist seems to be portrayed as a barrier, causing a struggle to gain her client's trust in the normalising messages she was portraying. Amy seems to dismiss her usual efforts to normalise client's experiences as depicted by her use of "*blah blah blah*". This seems to imply something meaningless being said, which might symbolise the contrast she experiences between the DP's power in connecting with clients, as opposed to her own struggle to do so. This extract thus might portray the support, respite, and confidence that Amy feels when the program is able to engage her clients effectively and powerfully which Matilda evidently echoes.

3.4.4 Sharing an empowering experience

Participants felt empathy toward the hardships IeP's face personally, societally, and from mental health care experiences. At the core of this sub-theme is the sense of empowerment that participants witnessed in their clients, from BDT use. This, in turn was empowering for participants to witness, particularly as it was felt that they were providing a positive and enhanced therapeutic experience for IeP's. Over half the participants described the provision of BDT as extraordinary, or "special" experience, which was empowering for the psychologists to provide to usually hard-done-by clients.

Laura expresses her empathy for client experiences in society, and describes the provision of BDT as unique and *"special*" for her clients:

> *I think making people feel human again, 'cause I think sometimes the way that they're treated by society, or by themselves, kind of like an internalised stigma is a bit other, and a bit second class citizen. And I think people just being accepted and their experiences being accepted, um and taken seriously is really powerful. [Laura:58-62]*

> *It's something different. If they've* [clients] *had therapy before, they wouldn't have had it on the computer. Um, there's something quite nice about, um, yeah, I think especially for psychosis, you don't get like a lot of nice stuff and treats and like, and mental health teams aren't exactly showering you with gifts, you know? So, I think if somebody shows up and they've got a laptop just for you, like we're going to work on this together and this is kind of a bit different and a bit fun, it's different to any other appointment they're having at that point, so I think it feels a bit special. [Laura:207-214]*

There is a sense from Laura's second extract that offering BDT is like providing a valuable, bespoke experience. She highlights a sense of dehumanisation that these clients can experience from society in the first extract and in response, Laura strives to reverse this damage through her professional work. She organically brought up her empathy for her clients' struggles, which is emphasised by her statement "*mental health teams aren't exactly showering you with gifts*". This expression's slightly exaggerated stance might be displaying an underlying feeling of frustration or anger towards the way her clients experience routine mental health care settings. And so, for Laura, it could be interpreted that there seems to be an underlying striving and yearning to show her clients their worth and value, almost as though to provide for the deprived. She seems able to do this effectively through BDT sessions, which might bring Laura a sense of pride and value in herself when providing this special and empowering experience. This explains Laura's expression "*there is something quite nice*" about providing BDT.

Frances feels similarly:

> *It was nice to be able to give something nice. Because often in the NHS you've just got bits of paper that have been photocopied lots of times that you might be giving people. So, it's* [BDT] *really nice to give. Or you know or it's just in black and white [Frances:351-353]*

> *I think again, with something like this where you've got this really, you know, really great graphics, really fancy sort of computer kit that makes people feel sort of invested in and that they're important […] like that kind of thing that I was saying that they're worth it. 'cause you've created a whole computer program around the difficulties that they are experiencing [Frances:355-359]*

Frances describes BDT as an opportunity to provide a pleasant experience to clients, which she was otherwise lacking in routine therapy. There is an interesting portrayal by Frances in which she illustrates routine therapy materials as generic, monotonous, and monochromatic, with no individuality or creativity invested in the process. This is a clear difference to the description for BDT, a process that creates excitement, extravagance, intrigue, is progressive and which required conscientious effort in producing. This description might portray Frances' passion and praise for the BDT approach. She seems to feel able to show her clients their worth and importance and thus empower them with when providing BDT sessions. This

experience in turn might be empowering and honouring for Frances, which is shown by her statement "*it's nice to be able to give something nice".*

Along with acknowledging and empathising with the deprivation and struggles clients experience, participants also described their knowledge that IeP's might be likely to suffer from cognitive difficulties or compromised education whilst growing up. Part of the extraordinary experience of providing BDT was the opportunity granted for clients to use the DP, engage with it hands-on, master it, and understand the theoretical concepts being shared:

> *I think that's actually quite empowering for people, you know. As I said, many of the people I'm working with, you know, are people who will not always have had the experience of getting it in the same way as other people. They might have had disrupted schooling or variety of cognitive difficulties and things. Where actually, doing something that they can do, and they can- you know, you can almost see the person sort of getting a bit of a confidence boost from doing it, getting it, and sort of understanding what the things are about. [Dana:397-403]*

There might be a sense of relief that Dana experiences from witnessing his clients understanding and comprehension over the use of the DP and its materials. His mentioning this might also represent a sense of achievement he might feel as a therapist in being able to provide a helpful experience where a client's sense of self can be influenced for the better.

Amy echoes a similar sentiment:

> *I think often patients have the experience of not having a say of kind of not being kind of in charge of their own care. Of kind of not always having much decision-making power [Amy:81-83]*

> *I think part of it comes from as well like getting the person to use a computer and um, them having ownership over it. And I think as a therapist working with people with psychosis, you're always mindful of any sort of power imbalance you're always trying really hard to kind of make that as equal as possible. And I think that kind of giving that <u>person</u> access to that computer and them typing what they want, really gives the control over to them […] and helps them to feel quite invested in it. [Amy:520-526]*

I've never really asked anyone, but the sense I get from people is that that leaves them feeling quite good that they've kind of mastered something and a sense of achievement. [Amy:591-593]

Amy specifically talks about the active and physical engagement clients have with the DP in BDT, and the empowering experience this creates for them. For Amy being highly conscious and attentive to power dynamics and equalising these between herself and her client, as she portrayed in achieving connection through the "*group effect*", is highly important. There is a sense of ease that Amy seems to feel in being able to equalise the power dynamic through handing "*control*" over to the IeP, to be an agent of how they engage with the DP. Amy senses their empowerment, which might be empowering for her to witness.

Amy and Jordan share how they feel empowered or valuable as clinicians when using BDT with IeP's:

I would say that I'm always someone who wants to deliver the best possible therapy for my patients. I think that, you know, I feel really privileged to do the job I do. I work with people every day who really struggle to be around other people, who find it so hard to go out, and I just feel like they managed to get to my sessions, they managed to like meet me, and I feel like that's such a big thing for them to do. And they put so much trust in me, someone like they've never met before. And so then, being able to go along and deliver the best therapy I can, doing something that I feel will really help them […] it makes me really, really happy. [Amy:380-388]

I guess when the client seemed to find it helpful, you know, that would be a positive experience for me as well, because I'd feel like I was helping them [Jordan,183-185].

There is a clear knock-on effect from the empowering experience of using BDT with IeP's in empowering and enhancing psychologists' self-worth. Amy, through her repetition of "*really"* emphasises the enormous impact delivering BDT has on her sense of happiness. Considering she starts her extract with her striving for mastery, her yearning to provide the "*best possible therapy*" one might wonder if she feels she achieved this when using BDT. This is echoed by Jordan who emphasises this knock-on effect, whereby when her clients found BDT helpful, she in turn felt she was providing a helpful experience.

3.4.5 The evolving professional self

This theme emerged organically, and signified participants' reflections post BDT use. Over half the participants felt influenced or somewhat changed by the experience and reflected on areas they could develop on and evolve in their own routine therapeutic practice. The intention of transferring their newfound knowledge from experiencing BDT was to enhance the quality of their routine practice, and to alleviate some of the challenges of traditional therapeutic practice. Several notable points arose including feeling that BDT was adapting more to the modern world than routine therapy tools; reflecting on and enhancing one's routine practice after gaining new perspectives from BDT; and finally, a hope for future use of BDT as well as the widespread applicability of BDT. A few participants reflected on feeling unchanged by BDT.

For some, BDT had a transformative impact on one's practice:

> *It's difficult to think about how we did things before we started doing something that really made sense to us, because it seems like we erased the past a little bit. [Matilda:625-627]*

Matilda's experience of using BDT seems to have replaced her past accustomed ways of practicing therapy. She emphasises how much BDT resonated with her and so this might resemble perhaps her natural evolution of practice going forward.

The idea of fitting therapeutic practise in with the modern digital world was highlighted by Frances when describing BDT: *Fit for the modern world really [Frances:360].* She is therefore relieved by the idea of using technology to support her client's integration to modern, digital society:

> *The idea of getting out a paper diary now or recording your thoughts and feelings in that just would seem an alien concept to people anyway. But also, it's so natural for people to be on their phones that I think it helps people in terms of not fitting in, or not like they're doing something that's a bit strange or a bit weird. Like, everyone's on their phones [Frances:365-368]*

> *People aren't gonna get out their bit of paper and start writing. So, it really, you know, lends itself really well to what therapists have been trying to get people to be able to do [Frances:399-401]*

Frances' highlights how BDT potentially resolves some of the long-term challenges therapists have experienced in engaging clients in therapeutic homework tasks. Frances' concern is connected to current social norms and highlights the need for clients to be "*fitting in",* which might be something that she is actively conscious about when working with IeP's. Using materials such as "*paper diaries*" as tools for therapy seems to be a thing of the past, and perhaps even abnormal ("*alien*"). The use of technology such as phones (which SlowMo incorporated) is considered "*natural",* fitting in with the current norms. Therefore, Frances portrays the enhancement of therapeutic practice that can occur when using BDT's, and thus, might be expressing the evolution of her own practice from these perspectives gained from BDT use.

Adrian reflects on her newfound realisations:

> *[…] now that I've seen how he's* [client] *responded to the SlowMo, I think, I've been thinking more about that. Because I think it's-it's actually, it's quite an intense process isn't it, sitting opposite somebody and them sort of really intently listening to everything that you say. [Adrian:135-138]*

Integrating oneself into BDT practice influenced new realisations and reflections for participants that they might not have noticed in past practice, as Adrian describes. Witnessing the responses of her clients seems to have had a powerful impact on Adrian, perhaps encouraging her to revise and reflect on this part of her own practice which is demonstrated by her need to think more about it. She shows her own growth after BDT use which has deeply impacted her, as she portrays from her continued reflections on these newfound realisations.

Dana has had a similar process of reflection on the use of DP's:

> *I think that I would love to be able to do that even if I wasn't working in SlowMo. The sort of use of the technology to sort of you know, externalise the thought process the visualisation of bubbles which is a key metaphor, people connected massively well with that. […] So I'm just thinking, things I would definitely take if I could into my more routine clinical work there's lots of things like that. [Dana:445-452]*

What might be implied by this extract is Dana's desire to develop his "*routine*" therapy practise using technology, having witnessed the powerful way in which it engaged and connected with

clients in BDT. There is a powerful and lasting impact that BDT has left on Dana, inspiring him to reflect and enhance his own professional practise going forward.

Of all participants, there were two who felt somewhat indifferent or unchanged by their experiences of BDT, and thus expressed contrasting experiences to what has already been reflected in this segment of analysis. For instance, Adrian expressed feeling unchanged:

> [sharp inhale and sharp exhale; long pause] *I don't think my delivery of therapy has changed much at all. I think I'm still the same therapist as I am. Um, I suppose. And I'm still saying the same sorts of things and I'm still responding in the same sort of way. I think I'm just using the computer as I would another therapeutic tool. [Adrian:170-183]*

Adrian is evidently pensive at the start of her extract, perhaps demonstrating some uncertainty and tentativeness. Earlier in this sub-theme Adrian's experience of learning and reflection influenced by her BDT experience was presented. However, as shown here, she also shares feeling unchanged. This might symbolise her overall sense of uncertainty or ambivalence towards BDT use. Adrian rationalises out loud on her answer, using logic and reason "*I'm still saying the same*" "*I'm still responding […] the same*" demonstrating that any measure of change for Adrian would have been visible or tangible in some way, which she has not noticed. Reflecting on one's identity, or sense of self, after practicing a novel therapy might also be a challenging concept to comprehend. The reference to the computer as "*another therapeutic tool*" might seem like a minimisation, but for Adrian, perhaps it was felt that the platform was always just a tool, secondary to the elements and fundamental values she feels are important in her practice of therapy, observed earlier in **"moulded by one's past".**

After some time, Jordan experienced an altered view of BDT:

> *I think overtime I sort of realised that in a lot of ways, it's very similar to the therapy that I would offer anyway, because it is about having their rapport and that relationship with the client in the room, and trying to make sense out of the difficulties, and trying to think about how they can move forward. So, all the things that we were doing within therapy were similar, or the same, to what I was normally doing if I wasn't using the blended therapy [Jordan:291-295]*

She stresses the impact of time ("*overtime*") suggesting that her opinions and feelings changed as she practiced BDT. There is a resemblance that BDT has to the therapy practices Jordan

has experienced before, which might further demonstrate a sense of feeling un-impacted, or indifferent towards BDT practice.

Matilda shares a sense of hope for the future after her experience of BDT use:

> *I guess in terms of my work as a supervisor, um, that makes me feel that this intervention could be easily rolled out in the NHS to therapists, even if they weren't too experienced. So, the ones probably at greater risk of drift, because it will focus their efforts, uh, in a way that kind of feels safe for the therapist, because it can be anxiety provoking for therapists to deal with particular concerns, especially if they're not particularly, um, experienced. [Matilda:312-316]*
>
> *this is the sort of intervention that allows us to actually think "yeah, job well done". [Matilda:335-336]*

It is clear from these extracts the sense of self-assurance and self-empowerment brought about for Matilda through using the platform, demonstrated by "*job well done*". As a therapist in a position of seniority "*supervisor*", there seems to be an eagerness to share what she has experienced with others, particularly junior therapists who might be more prone to anxiety and risks of "*drift*", for which Matilda envisages BDT offering a helping-hand and respite from their stressors. This extract seems to reveal the eagerness to work towards a transformation or evolution of therapeutic practice in a systemic, widespread manner, perhaps inspired by Matilda's own inner transformation in response to feeling different and more confident as a professional when using BDT.

3.5 Summary of themes

Overall, the themes portray qualities of struggle psychologists experienced and resulting efforts made when adapting to BDT, a novel way of practicing therapy with IeP's. Past professional and training experiences significantly shaped psychologists' attitudes and reactions to BDT at the start. Adapting to the plethora of demands of managing the triadic relationship at the start of BDT use triggered anxiety, stress, self-doubt, and overwhelm, as psychologists strived to master the delivery of BDT. Psychologists experienced varying challenges when working with a DP, which was a novel experience. At the same time, psychologists faced their responsibility of caring for and being attentive to clients whilst facilitating BDT sessions. These components led to the experience of overwhelm, frustration,

and anxiety. Differences were noticed in participants who had past experiences of DHI use, who approached BDT with openness and confidence, and managed the challenges faced with greater ease than others. The themes reflect a gradual transformative process. Over time and application of BDT, psychologists developed confidence that they provided a helpful and empowering therapeutic experience for their clients. All participants felt that using BDT helped improve and enhance therapy delivery. In various ways, the DP relieved psychologists from the plethora of pressures and stressors of session planning and delivery, which could be shared with the DP. BDT was therefore experienced as a safe, comforting, confidence-boosting experience for psychologists. Notably, many experienced managing and maintaining a positive therapeutic relationship with IeP's in BDT with ease, mainly as the DP provided a supportive buffer when challenging interpersonal dynamics could occur.

Chapter 4: Discussion

4.1 Overview

This chapter aims to contextualise participants' insider perspective presented in chapter 3 by linking existing studies and published literature in the research base and highlighting uncovered novel findings.

The chapter will begin with a section summarising the research findings and linking them with existing literature, and I will highlight the novel findings discovered through the present study. A section will follow stating the clinical implications of the findings, with emphasis on implications for the counselling psychology field. Limitations of the design and analytic strategy will then be considered. The quality and validity of the research project will follow, and future avenues for research will be identified. Lastly, I will present a final reflexivity segment.

BDT use was experienced as a process of managing struggles and stressors of adapting to change, habituation, achieving new realisations, and achieving growth after change. This process was experienced as a transition from self-doubt, questioning one's competence, anxiety, stress, overwhelm, to eventual safety, confidence, mastery and growth. These ideas will thread through the first section of this chapter.

4.2 Moulded by one's past

This theme emerged organically during interviews and portrays how participants made meaning of their experiences of BDT with IeP's, particularly at the start. Unique qualities of experiencing were located according to each participant's past professional experiences, their pre-established philosophies and methods behind individualised routine practice, and the cultural lens through which they viewed their profession and thus expectations of self. All these qualities influenced how BDT was experienced.

Participants with past experiences of using DHI's or targeted interventions highlighted the confidence and resilience this equipped them with to manage BDT. This was highlighted by participants such as Cristina, Dana and Frances who had considerable experience with delivering targeted interventions, and for Cristina, an added history of using digital technologies. For Laura, her work in research teams and her awareness of the esteemed

developers behind SlowMo was enough reassurance to perceive BDT as trustworthy. The demographic table (table 2.1) seems to demonstrate that these participants tended to have a longer history of professional experience and met BDT use with a greater degree of initial openness and ease of adaptation than other participants (Laura being the exception). The existing evidence base support these findings. Studies examining therapist attitudes towards stand-alone DHI's and internet interventions for instance show a link between therapist personal experience with technology and media-supported therapy elements, and more likely positive evaluations of both treatment formats (Becker & Jensen-Doss, 2013; Gun, Titov & Andrews, 2011; Kivi et al. 2015; Vigerland, et al. 2014; Wangberg, Gammon, & Spitznogle, 2007).

Participants who were sceptical of BDT experienced greater stress and anxiety when anticipating and initially using BDT. These perceptions and feelings were related to their past professional practices, the dissonance between their established ethos and personalised methods of practice, and their perceptions of BDT. Existing studies posit that when adapting to novel therapeutic approaches, there might be a need to avoid using techniques the therapists are accustomed to using, which might raise resistance particularly if they involve ways of working that are antithetical to those the therapist is already used to applying (ten Napel-Schutz et al., 2017). Although strong feelings of resistance were not expressed by the participants, it was evident that established ways of practicing created a sense of dissonance and anxiety when using BDT, particularly if this was a novel experience for them.

Lovejoy et al., (2009) discuss the process of adopting clinical innovations using the Diffusion of Innovations Theory Framework (DIT; Rogers, 2003). The authors suggested that adopters of clinical innovations are influenced by the comparative advantage of the innovation over traditional methods, and the compatibility of the innovations with their own personal values and social norms (Lovejoy et al., 2009; Rogers, 2003). Having favourable attitudes toward change were seen to be associated with increased adoption of innovation (Aarons, & Sawitzky, 2006; Rogers, 1995). These results match the findings of this study and further explain the different attitudes psychologists held towards BDT, depending on their established therapeutic ethos and personalised practice styles. Similarly, existing studies have shown that a lack of congruence between a therapist's personal values and practice has been found to result in cognitive dissonance, leading to stress and less effective practice (Bitar, Bean, & Bermúdez, 2007; Vasco, Garcia-Marques, & Dryden, 1993).

Becker & Jensen-Doss, (2013) examined therapist-level barriers to the use of BDT and found that predictors of positive attitudes to BDT included greater general openness toward new treatments, greater comfort with computers, and easier access to technology at work. Results indicated that therapists with lower general openness, and those who identified as more process oriented, may have been sceptical of the benefit of BDT's. Participant Cristina mentioned that having DHI's as part of her doctoral training and being exposed to them at the inception of her professional career were highly influential to her openness, confidence, and positive experience of BDT. Studies have also demonstrated that therapists with bCBT experience reported different views on safety, flexibility and personalisation of the protocol, patient eligibility, and therapeutic relationship than therapists who lacked experience (Mol et al., 2020).

4.3 Struggles of co-facilitation with a DP

This theme explores the initial emotional and psychological struggles of using the BDT approach, as well as struggles that were faced whilst facilitating sessions with the DP. Three main areas formulated this struggle: (1) self-doubt and a pressure to competently use the DP when first using BDT, (2) a constant shifting of control over session direction with the DP, (3) the recognition that along with the responsibly of managing the delivery of the DP's interventions, psychologists held the crucial role of monitoring the IeP and providing person-centred care, through adjusting sessions according to their needs. This required human qualities of empathy, congruence, compassion, and flexibility, which the DP did not possess.

4.3.1 A struggle for mastery

At the start of BDT use, participants experienced psychological states of anxiety, hypervigilance and overwhelm in response to a plethora of responsibilities BDT brought with it. Participants simultaneously strived and struggled to master the use of the DP, whilst also fulfilling their duty to remain conscientious of their client in the room. Participants were uncertain at the start of how their clients might react to the DP, and therefore experienced an added source of anticipatory anxiety. This was similarly found by Mol et al. (2020) where participants highlighted higher workload and time-consuming nature of BDT at the start as hindering its uptake for depression treatment.

Anxiety seemed to be further triggered by self-doubt in one's ability to effectively facilitate the use of the DP, particularly if this was a new experience. Past studies chime well with this

finding, as a barrier to BDT use has commonly been noted as professionals' ability to manage technical issues and a lack of support to manage these (Becker & Jensen-Doss, 2013; Mol et al., 2020; Titzler, et al., 2018).

Most psychologists seemed to hold high standards and expectations of their practice, and thus, strived to provide good quality therapy for IeP's. This was a further facet of their struggle for mastery, which seemed to exist before BDT, and was carried over into their BDT experiences. These high standards of practice seemed to perpetuate their initial anxiety levels when using BDT, particularly as their competence was challenged when facing BDT as a new experience. Participants also seemed highly sensitive at the start toward client reactions in BDT sessions, alert to any signs of paranoia or discomfort that might arise. Participants also did not want to project their own anxieties around BDT delivery onto their clients. These struggles and self-doubt led to compensatory behaviours of rigorous pre-session preparation, and at times a need to compartmentalise anxiety, to present a professional and competent version of themselves, thus, protecting the IeP from their own anxiety.

Similarly, Chadwick et al., (1996) reveal therapist challenges when delivering therapy for delusions and voices which chime with this study's findings. The authors highlight the tendency for therapists to be overwhelmed by their own thoughts and feelings about the client, one's competency, or both, and the strong sense of responsibility therapists can experience over their clients as part of these challenges. Chadwick (2006) later suggested that therapists can feel anxious in the early stages of therapeutic work, which can result from implicit assumptions and beliefs therapists hold about how therapy *should* progress.

Similarities were found between the study findings and Chadwick's (2006) person-based cognitive therapy for distressing psychosis model. Chadwick highlights the concept of therapist anti-collaborative modes of *(1) "Failure" (2) "Risk to self" (3) "Risk to client" and "(4) "Organisational beliefs"* (p.22), which he claims to threaten relationship building and drives therapist anxiety. Each mode is made up of therapist beliefs, feelings, and behaviours, and many of the modes described by Chadwick resonate with psychologists' experiences covered in "**A Struggle for Mastery**" and in "**Safety amongst the platform's scaffolding**", which will be discussed further on in this segment. Within the current sub-theme, the beliefs under the "*failure*" and "*risk to client"* modes (Chadwick, 2006) were prevalent for all participants in various ways, resulting in feelings of anxiety, helplessness, caution, and a need to work hard when first using BDT.

Interestingly, for a minority of participants, particularly Cristina, Dana and Adrian, the struggle for mastery during their use of BDT was not a key experience, nor a prominent theme in their interviews. If any struggle was mentioned, it was usually portrayed as easily managed and not triggering any overt shifts in affect or causing intrapsychic struggle. Complementary assertions for this were emphasised by Cristina and Dana, who reflected the inner strength and resilience they brought to their BDT experience due to long-standing professional experiences, and past experiences of delivering targeted interventions in research trials and/or using stand-alone DHI's in the past. Thus, the overlap between "**moulded by one's past"** and "**a struggle for mastery"** is evident, with the former impacting or exacerbating the latter.

4.3.2 Restricted autonomy

This theme portrays the frustration and helplessness that participants experienced in response to feeling restricted in making autonomous decisions in BDT, due to their responsibility to follow the DP's targeted intervention for paranoia. This seemed to affect participants on an intrapsychic level, causing an internal dissonance between their duty to follow the structured program competently, and a desire to stray away from the DP's target, and meet their client's complex and fluctuating needs using pre-existing clinical knowledge and expertise. Keeping in mind the high standards of practice and expectations-of-self purported in a struggle for mastery, the sense of struggle and potentially overwhelm at managing this internal divide is comprehensible.

There emerged an anticipatory fear, therefore, of dissonance within the therapeutic alliance between psychologist and client, and example incidents of this were described by participants. For some participants, working with the DP was source of anxiety and overwhelm, as technology malfunctions could occur, and could lead to the termination of sessions. This further restricted psychologists from feeling able to use their expertise to autonomously facilitate sessions without the DP. This mainly triggered feelings of frustration and helplessness for psychologists, thus being a facet of the overall struggle of co-facilitating sessions with a DP.

Several studies examining common barriers to BDT application similarly found that issues of autonomy, regarding decisions about when and how to stick to the treatment protocol, and varied ways in which practitioners would interpret the treatment protocol, formed part of these barriers (Kenter et al., 2015; Mol et al., 2020). Furthermore, studies examining professionals' perspectives of BDT found that technical problems resulted in anger and frustration and distracted the therapy process. Further, therapists demanded more autonomy around how to

use BDT and more customizability of the online modules (Titzler et al., 2018; van der Vaart et al., 2014).

Although autonomy was challenged due to fulfilling the requirements of the DP's targeted intervention, participants did in response feel an added sense of responsibility to adapt sessions to their clients as best as they could, whilst keeping to the targeted intervention. This fits again with their existing ethos of striving to provide a good therapeutic experience for IeP's. Overtime it seemed participants felt that they could use the DP flexibly, shown by "**the calm after the storm".** However, participants were clear in that there were moments when they recognised, they had the expertise to manage different aspects of their client's difficulties, which can be complex and multi-faceted, which had to be held back due to needing to fulfil the DP's interventions, creating a sense of inner struggle and helplessness.

4.3.3 Efforts to maintain human connection

Amidst the DP-psychologist co-facilitative relationship, all participants experienced themselves as holding the responsibility to use the DP's materials and interventions and adapt these to their client in individualised ways, according to the client needs. Most participants felt the need to put extra efforts in making the BDT sessions adaptable and accessible for their clients, particularly if they struggled to resonate with the DP materials or struggled with using technology. Although participants highlighted these responsibilities as an expected part of their duties, the efforts made to adapt sessions partly seemed to fulfil a compensatory behaviour for the dissonance that could occur between psychologist and client when the DP's interventions did not resonate with clients.

Evident in this theme were psychologists' abilities to use human qualities they naturally possess, such as flexibility, adaptability, the ability to emotionally attune oneself with another, empathy, and compassion to build rapport and maintain client connection. All qualities which the DP did not possess. Similar ideas are posited within the evidence base whereby developing and tailoring digital interventions to the client have been found to be of relevance to people with psychosis or bipolar disorder who might have less experience using technology and might also have a degree of cognitive impairment (Aref-Adeb, et al., 2019; Young & Geyer, 2015). Psychologists consequently experienced their roles as key to manage and contain clients and compassionately adapt sessions to their needs, which compliments the specialist ethical

guidance (Anthony & Goss, 2009; Nagel & Anthony, 2009) and competencies (Hill & Roth, 2014) that are required for DHI's.

There were similarities between participant accounts with the concept of mentalisation. Mentalising involves an awareness of mental states in oneself or in other people and enables us to imagine what other people might be thinking or feeling (Bateman & Fonagy, 2016). This process of mentalisation seemed to be utilised by participants to assess the client's emotional states and thus adapt sessions accordingly. For instance, Jordan emphasised on her process of remaining vigilant to her client's responses to the DP materials, and accordingly adapted session length, speed, repetition and provided reassurance to alleviate any struggle they were experiencing. These mentalisation skills seemed to resonate through all participant accounts, and further emphasised the important role the psychologist had in BDT.

This is further demonstrated by the evidence base where the human-therapist has been found to add the emotional reactions that the program cannot provide, such as understanding, and empathy (Suler, 2016). The findings under this sub-theme add a depth of understanding that complement systemic reviews, which have found that offering of some form of therapist support during online treatment increases its effectiveness and is associated with higher levels of completion (Andersson & Cuijpers, 2009; Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014; Cuijpers, Donker, van Straten, Li, & Andersson, 2010; Fairburn & Patel, 2017; Newman, Szkodny, Llera, & Przeworski, 2011; Richards, & Richardson, 2012; Spek et al., 2007; van der Vaart et al., 2014; Wilhelmsen et al. 2013).

As mentioned earlier, participants found the structure of the DP's modules restrictive, and as a result, participants worried about the negative impact this would have on the therapeutic relationship and the dissonance this might create between client and psychologist. Psychologists in these circumstances felt able to be autonomous in how they managed this issue by assessing the needs of their client and adapting the program's interventions to their needs, or by bringing in elements of their own knowledge and expertise to the session over time.

4.4 Achieving respite and enhanced practice

This theme portrays the most prominent experience for all participants, which relates to beneficial and supportive experiences of BDT use. Participants felt relieved and empowered by the presence of the DP, as it provided an opportunity to share the multitude of

responsibilities over session planning and delivery, hence providing psychologists respite from their multitude of duties, and in a sense, allowed opportunities for their own stress regulation. Furthermore, in response to sharing responsibilities, and to the DP's standardised and reliable nature of delivering interventions, psychologists noticed greater self-assurance that they were providing good quality therapy each time they met a client. Further, there was a lesser chance of error in the delivery of complex interventions through the DP, which was greatly relieving. The use and presence of the DP also seemed to have a positive impact on the therapeutic alliance between psychologist and IeP and seemed to empower IeP's.

Many of the benefits highlighted by participants overlap with "**a struggle for mastery"** in that the struggles that participants would experience in routine therapy delivery, were somewhat rectified using BDT. Consequently, participants shared organically their growth as psychologists after having experienced the use of BDT with IeP's. Existing studies examined in section 1.5 of this thesis portrayed participant opinions that BDT's might not be suitable for patients suffering from chronic or severe mental health presentations (Mol et al., 2020; Schuster, et al., 2018; Titzler, et al., 2018; Topooco et al., 2017). The findings within this superordinate theme greatly challenge these findings, portraying instead that BDT was found to be both beneficial and empowering for IeP's, and greatly supportive of the psychologist using the approach.

The sub-themes alluding to personal growth, namely "**the calm after the storm"** and "**the evolving professional self",** arose organically, and were somewhat serendipitous findings (Turner, Barlow, & Ilbery, 2002) as these reflections were not prompted by the interview questions.

4.4.1 The calm after the storm

The calm after the storm reflects psychologists' process of overcoming the initial experience of a 'storm' of internal anxiety and pressures when first adapting to BDT use ("**a struggle for mastery"**), to eventually achieving a sense of calm and confidence with BDT use after regular application. Their experiences seemed to resonate with a process of habituation (Westbrook, Kennerley, & Kirk, 2011) whereby exposure to BDT use over time, led to the psychologists' anxiety responses fading away, and to their experience of mastery over BDT use. This has been echoed in past BDT research, which found the regular use of BDT led to therapists feeling ready and willing to use it in future (Titzler, et al., 2018). Participants experienced an added process of new realisations over time as they practised BDT, including noticing a shift in one's

initial beliefs and presumptions about BDT. Interestingly a minority of participants expressed their calm and control over their anxiety around the use of the DP and attributed this to their length of experience as a clinician or their past use of DHI's.

Supervision and training were mentioned as very important parts of the psychologists' experiences and were seen to be a valuable part of one's process of building confidence and being able to regulate one's anxiety around the use of the DP. Matilda who identified herself as a very experienced clinician, and who is a supervisor herself, emphasised the need for ongoing training as crucial for clinicians to build their confidence with the DP: "*I think training was very very important. I feel that we would need more training to address our anxieties. [Matilda:847-848]*".

The emphasis for sufficient training to support and optimise delivery of BDT's is echoed by findings in other studies (Brown et al., 2013; Kenter et al., 2015; Mol et al., 2020; ten Napel-Schutz et al., 2017; Whitfield & Williams, 2004). Kenter et al., (2015) further emphasise that to disseminate BDT, and increase chances of its effectiveness in routine care, there is a necessity to create manuals, treatment protocols, and to train clinicians in mastering the skills required to deliver new interventions. Furthermore, ongoing technical support is also recommended (Wandersman, Chien, & Katz, 2012).

4.4.2 Safety amongst the platform's "scaffolding"

All eight participants expressed their gratitude for the DP's presence, which they could use as a support system when needed. This theme highlighted how the DP acted as a stable and protective mechanism which eased psychologists' anxieties, lifted responsibilities, and stressors of facilitating sessions. Working with IeP's and delivering psychological interventions for IeP's were highlighted as being complex and multifaceted, which at times could be difficult to articulate in clear and concise manner to clients, as well as handling the responsibility of managing other client needs in routine therapy. Therefore, the DP's delivery of complex material in a clear and consistent manner was emphasised as greatly supportive and added to the security that participants felt in delivering interventions each session supported by the DP. This lifted a psychological pressure and anxiety from the psychologists. Most psychologists described themselves feeling like "better therapists" when using the clear and reliable structure of interventions by the DP.

The sense of safety manifested in multiple ways for various participants. One was the sense of cohesion and enhanced therapeutic relationship between psychologist and client that was facilitated by the DP. Psychologists such as Amy and Laura felt protected when referring to the DP as a support system to discussion points being made if a difference of opinion occurred with clients. Suler (2016) compares the digital system to the analytic neutrality that psychoanalytic clinicians use to encourage transference reactions, thus making the computer program the perfect 'blank screen' for the client's projections. This seemed to protect the alliance between psychologist and client, and perhaps reduced the potential for client-therapist rupture.

Studies have described how therapists can experience challenges such as a lack of trust that IeP's develop for their therapists in response to the previous oppression clients may have faced by mental health systems (Bassman, 2000; Deegan, 1997). Lawlor et al., (2015) found that some therapists reported feelings of self-doubt or incompetence when clients became paranoid about them, and experienced anxiety or vigilance about eliciting paranoia or negative responses in clients during sessions. Furthermore, there is a tendency for clients with psychosis to hold a different view of their problems and abilities than their therapists, which in turn might result in a client–therapist relationship that is fragile and riddled with potentials for rupture (Hasson-Ohayon, Kravetz & Lysaker, 2017; Amador & Johanson, 2000; Themistocleous et al., 2009). This also supports the potential struggle that can emerge for the participants when practicing with IeP's, such as a fear of the potential for rupture when faced with the task of modifying thought distortions for instance in CBT. In BDT, the DP would act as the necessary safety-net to manage and reduce this fear.

It has been suggested that IeP's might feel more comfortable at first in engaging with an entity that they know is not human, as well as those with co-morbidity such as being on the autistic spectrum, who might even be relieved by the consistency, predictability, and lack of emotional reactivity of the DP (Berry et al., 2018). A similar parallel process seemed to occur for psychologists in this study as a common emergent theme was the sense of safety that was encouraged by the consistency and familiarity the DP brought to each session.

Finally, the structure and predictability of the DP was also seen to reduce "therapist drift", a phenomenon whereby therapists end up not adhering to their treatment manual or protocol which has been highlighted as an obstacle to effective CBT (Waller, 2009). The evidence base shares many such findings in which DP's have commonly been found to mediate the potential for "therapist drift" (Bengtsson et al., 2015, Månsson et al., 2013; Mol et al., 2020; van der

Vaart, et al., 2014). For the psychologists, the DP's session planning and reliable structure seemed to enhance their self-assurance, as they emphasised the enriched focus and clarity of the target of each session. The DP also released them of the pressure of planning and monitoring session agendas, which seemed to provide great relief. The elements of focus and clarity of message were alluded to by all psychologists as necessary conditions for "good therapy". Thus, the value of themselves as therapists to some extent rested on these values of practise being met in BDT.

4.4.3 Achieving connection through the "group effect"

This was highly prevalent theme and one of the novel findings from the data. It focuses on the highly supportive presence of the DP, which facilitated client engagement, trust, and a sense of cohesion between therapist and client which was a great relief for participants. This theme also focused on the triadic relationship, and how the presence of DP with psychologist and client was conducive to building a strong therapeutic relationship. As Kingdon and Turkington (2004) suggest, the first step in the use of any psychological treatment with people experiencing psychosis is the development of trust and collaboration, and this seemed to be established with some ease in BDT.

The DP was described as having a powerful and enticing qualities due to its ability to deliver therapeutic material, such as clinical vignettes, through visual and auditory means. Participants highlighted the mistrust that IeP's can experience, and the typical power-imbalance that can occur between therapist and client, where therapists can be seen as all-knowing, and perhaps assumed not to experience psychological vulnerability. As Yalom and Leszcz (2008) state, some clients can be inordinately sensitive to feeling controlled or manipulated by the therapist, and find themselves in the paradoxical position of applying to the therapist for help, whilst being unable to accept help because all statements by the therapist are viewed through spectacles of distrust. Similarly, in routine therapy (before BDT), participants faced the challenge of gaining client trust when providing normalising information or offering self-disclosure of personal vulnerabilities. Often, psychologists' efforts would be dismissed in one-to-one therapy leading to helplessness.

Conversely, there was a noticeable ease in gaining their clients trust and engagement in the therapeutic process, and in them as therapists in BDT, when these normalising messages could be shared via the video clinical vignettes on the DP, creating almost a simulation of there being a group in the room, without the presence of other individuals. This idea is like the

concept of universality within real-life group work (Yalom & Leszcz, 2008). The idea that group members can hear other members disclose concerns akin to their own, allows the disconfirmation of a client's feelings of uniqueness in the world and provides a source of relief within group psychotherapy (Yalom & Leszcz, 2008). The same was felt to be achieved though sharing examples on the screen in BDT, providing relief for the therapist from this usually challenging venture.

The visual representation of ideas that might otherwise be challenging for a human therapist to portray is shared by other studies. Studies for instance have found that the ability for digital tools to visually represent hidden or abstract experiences, such as behavioural activity, emotional states, and cognitive appraisals have been thought to encourage a shift in how emotional and physical states are conceptualised, as they are visible, knowable, and thus manageable for service-users (Bucci et al.,2019a; Morrison, 2015). Researchers, such as Cavanagh and Millings (2013) have considered similar ideas, but within the context of the relationship between client and digital tool. Factors such as the responsivity to the data entered in a digital app, the tailored responses, consistency of advice, and the use of illustrative characters have been considered to enhance the relationship the individual forms with the digital tool being used. The psychologists in the present study however seemed to emphasise a more cohesive bond between themselves and their clients, forming in response to the believable and alluring materials presented by the DP.

Lawlor et al. (2015) propose that paranoia about the therapist can occur both within and between therapy sessions, and includes symptomatic and schematic paranoid beliefs, which can threaten the therapeutic relationship. This seemed to link with the participants process during BDT sessions. Participants seemed vigilant towards the IeP's emotional states during sessions and became highly aware of the discomfort IeP's experienced from the human-human relational encounter. Available evidence postulates that for people vulnerable to psychosis, minor stressors trigger negative affect, which in turn increases likelihood of psychotic experience (Ellett, Freeman, & Garety, 2008; Lincoln, Hartmann, Köther, & Moritz, 2015; Lincoln, Sundag, Schlier, & Karow, 2018; Myin-Germeys, & van Os, 2007) and negative affect seems to precede increases in paranoia (Kramer et al., 2014; Silva, Maguire, McSherry, & Newman-Taylor, 2021). An organically emergent theme within participants accounts was their gratitude towards the physical presence of the DP and the regular shift in focus that was required from the therapist-client encounter to the DP, which brough immediate relief from the discomfort of the therapist-client encounter. This seemed to resemble a natural emotion regulation mechanism that occurred in BDT, particularly as participants felt this eased client

discomfort of being the centre of attention in therapy, and allowed them to tolerate sessions more, as well as enhanced their engagement and attention. Silva et al., (2021) found improved emotion regulation alongside reduced negative affect and paranoia for their participants in their study assessing the impact of emotion regulation skills practice on affect and paranoia. Thus, the DP's physical presence within the triad was useful tool providing respite from the discomfort of the therapeutic encounter. This in turn provided a relief for psychologists, in that they felt they were offering a helpful experience for their clients particularly if their clients were visibly comfortable and engaged.

Furthermore, the consistent transition from human-to-human dialogue, to focusing on the DP supported client's experiencing symptoms of paranoia. IeP's are known to experience struggles with attention and in responsiveness due to distractions originating in their psychotic symptoms and other causes of cognitive deficit (Kingdon, & Turkington, 2004). Participants such as Dana highlighted this *"people can find it difficult to talk for you know 50 minutes or so, particularly with issues of concentration, distraction of voices and all sort of things. […] the switching of attention between let's do a little bit with the web app, let's do a little bit of reflection […] It's opened-up conversations I feel in a way that I- is better than I anticipated." [Dana:130-136].* This is supported by Kingdon and Turkington (2004) who propose that a brief period of relaxed conversation about nonclinical issues, or a pause in the therapeutic session, is needed to retain and enhance engagement, particularly for clients distracted by voices, dwelling on paranoid beliefs or cognitively impaired.

Finally, participants expressed their increased feeling of collaboration and equality with the participants as they were relinquished of the responsibility to lead session planning and structure, or to be in an "all knowing" position, as the DP was delivering interventions such as psychoeducation. Session material delivered by the DP also eased the facilitation of discussing challenging topics related to symptoms of paranoia and seemed to offer a pathway for these discussions to organically occur between therapist and client. This relieved the pressure participants would feel when working with IeP's due to the potential for relational rupture or mistrust from clients. As Chadwick (2006) explains, therapists can enter anti-collaborative modes due to common 'risk to client' beliefs that can arise. This idea resembles the sense of caution and anxiety that seemed to be expressed by participants in non-blended routine therapy, when they were in the role of initiating challenging topics to do with paranoia. The results of the study are consistent with Chadwick's (2006) concept of "Radical Collaboration". This is a mode of therapy in which therapists are free of anti-collaborative assumptions about how therapy should progress, and what should be achieved. Radical collaboration is

characterised by several attributes including active listening, supported discovery, and clear open discussion of issues (Chadwick, 2006). It creates a context within which exploration and change can be facilitated in a person-centered way. Participants seemed to feel a sense of comradery with their clients, as well as the permission to pursue challenging topics related to symptoms of paranoia in a safe and naturalistic way, when these were facilitated and brought up by the DP.

4.4.4 Sharing an empowering experience

This theme emerged as a further novel finding. Over half the participants felt empowered in being able to share a novel, enhanced and extraordinary therapeutic experience with IeP's, which fit in with the modern, digital world. Psychologists seemed to feel that the BDT experience symbolised the value and worth psychologists saw in their clients and experienced the provision of BDT as empowering their clients. Participants emphasised on the time and effort that had gone into preparing this bespoke and unique form of therapy for IeP's. This in turn helped participants feel that they were providing an enhanced therapeutic experience for their clients, which IeP's deserved. This was in turn empowering, honouring, and assuring for psychologists, particularly when they witnessed clients being engaged, and taking an active stance in using the technology. Interestingly, one of the driving factors for this theme arising came from psychologists' desire to compensate for the hardships experience by IeP's from their adverse life experiences, societal stigma, and hardships of the mental health systems. The provision of BDT was seen as a type of respite that psychologists could offer IeP's and potentially something enjoyable, which they were not able to gain from other aspects of their treatment.

A further empowering experience for psychologists and clients was witnessing their client's agency over using the DP and active engagement with it. Participants noticed the 'confidence boost' clients experienced when mastering the use of the technology, which was viewed as empowering clients. Similar findings have been echoed by van der Vaart et al., (2014) who found that therapists using BDT reported advantages for patients including empowered self-management skills and self-efficacy when using BDT for depression treatment. Watching this occurring during BDT sessions seemed to be greatly reassuring for psychologists that sessions were of interest to their clients, and there was an ability to empower their clients through offering the use of the DP. This in turn seemed to enhance one's confidence and a sense of comfort that what was being provided was of value to their clients.

4.4.5 The evolving professional self

The final sub-theme arose organically within interviews and these reflections emerged typically toward the end of interviews. Although participants presented opposing views, all participants reflected inward to understand how the experience of BDT might have impacted or perhaps transformed them in some way, and in reflecting on this, considered the future of their practice post-BDT. Thus, these findings gave rise to the idea that no matter the length of experience, psychologists' personal and professional development continuously evolve and change, or remain unchanged, depending on their lived professional experiences, such as the use of BDT. Matilda for instance, identified herself as the most experienced psychologist, according to the demographic questionnaire (table 2.1), however, she acknowledged a personally significant sense of professional growth, potentially transformative to her way of practicing therapy, from her use of BDT. "**The calm after the storm"** overlaps with the current theme, as psychologists had to become accustomed to, and habituate to their use of BDT, to then realise any lasting impact this experience might have had on them.

The findings chime with van der Vaart et al.'s study, (2014) which found that after using the BDT approach for depression, therapists felt ready and willing to use it in the future. These findings resonate with half the psychologists who spoke about their intrigue to take what they learnt from BDT and to develop their own routine practice with IeP's. The findings of the current study provide greater phenomenological depth to this idea. Participants reflected on surprising insights that were learnt about working with IeP's, particularly around the positive impact the regular shifting of attention from DP back to the therapist-human interaction had on regulating their attention, emotions, and engagement in sessions, and on helping them tolerate the discomfort that could arise with the duration of sessions. These insights were inspiring for most participants and caused them to reflect on how they might facilitate sessions post-BDT to enhance the therapeutic experience being provided to clients. Most participants felt changed by the experience and viewed the prospect of including digital mediums in their routine practice as plausible and perhaps part of their new norm, such as Matilda and Frances.

Participants who felt unchanged by their BDT experience also went through the same reflective process of looking inward during interviews to assess if any part of their belief system or values behind their practice of therapy had altered in any way. Although these participants found BDT useful, they did not experience any form of transformation, but instead seemed to feel further grounded in their usual way of practicing therapy, particularly as it was felt that the way they practiced in BDT was similar or the same to their routine practice.

Participants further shared their delight with the idea that BDT resembled progress within the field of psychology which is 'fit for the modern world', and there was a clear interest in the dissemination of the results of the study and their voices to inspire widespread development of digital therapeutics. Within this, participants shared their insights into the beneficial features of having BDT in national services, such as the NHS, where clinicians are usually managing high caseloads and undergoing matching levels of pressure and for training and enhancing confidence in newly qualified therapists' ability to deliver therapy competently.

Laura for instance envisioned during her interview the support BDT would give to time-strained and stressed clinicians in busy services: "*I could definitely see if people have like back-to-back caseloads and that kind of thing, if you're really um, familiar with what comes in each session […] you don't have to necessarily have to prep in the same way you would for a completely separate bespoke non-manualised session. [Laura:146-151]."* The benefit of achieving respite from multiple responsibilities of session planning was clearly seen to be a reason for widespread dissemination of BDT for IeP's. Similarly, studies have proposed the worktime control that therapists experience in the practice of online CBT (Bengtsson et al., 2015) which, as proposed by Nijp, Beckers, Geurts, Tucker, & Kompier (2012), can work as a first step to support therapists experiencing stress, burnout, depression, anxiety, and increased need for sick leave. These highlight some important implications of the findings in the current study, which seemed to portray psychologists' experiences of a sense of respite with the help of the DP, and thus a release of some of the stressors and anxieties of facilitating therapy sessions for IeP's.

4.5 Clinical implications

It is important to consider what these findings might portray for CoP's who find themselves in positions where they are required to use BDT's, particularly if NICE recommended. As Woolfe (2016) suggests, CoP's find themselves in a world focused on performance, outputs, and the culture of organisations such as the NHS focusing on evidence-based practise. Thus, it is inevitable that CoP's will find themselves engaging with conflicting viewpoints and worldviews as treatments develop, and as society advances.

CoP's seek to encourage democratic, non-hierarchical client-therapist relationships (Hanley & Amos, 2017), hence, queries arise around how CoP's might manage or mediate the potential challenges of taking on board therapeutic practices that might require a slight alteration to this

philosophy or practice. A BDT, such as SlowMo, is a targeted intervention for IeP's, and arguably might conflict with Counselling Psychology's strong emphasis on humanism, and a search for understanding of the individual's unique experience, rather than demanding universal truths (Rafalin, 2010). Nevertheless, CoP's hold a professional duty to be open to and consider different perspectives in clinical practice, and change their practice as needed to account for new developments or changing contexts, as demonstrated by The British Psychological Society's (BPS) '*Good Practice Guidelines*' (BPS, 2017) and The Health Care Professions Council (HCPC) '*Standards of Proficiency*' (HCPC, 2015). The positive impact that BDT had on psychologists' practice hope to provide in-depth insights and recommendations to manage and surpass barriers for BDT use, as well as provide reassurance and expectations of BDT practice for clinicians who are sceptical of, or interested in, adopting such approaches.

The study demonstrated the level of psychological pressure and stress that can be experienced when adapting to a novel model of therapy with IeP's. Consequently, the appropriate use of supervision is warranted, where clinical, relational, and importantly, technical matters to do with the use of the DP can be openly discussed and reflected upon. Supervision of psychotherapists, especially in the early years of practice, is known to be crucial for professional development and to ensure optimal patient outcomes (Bambling, King, Raue, Schweitzer, & Lambert, 2006), which was demonstrated in "**the calm after the storm"**. Dynamics that occur within the triadic relationship, such as managing the dissonance between client and DP whilst facilitating DP interventions are critical to consider in supervision for BDT's.

The need for knowledge and training in the delivery of DHI's, like BDT, is seen to be crucial in building the confidence and trust required in their implementation (Bucci et al., 2019b). However, many clinical training programs do not provide training on internet-based therapies (Alleman, 2002; Lovejoy et al., 2009; Mallen, Vogel, & Rochlen, 2005). As Anthony and Nagel, (2010) suggest, it is important for the practitioner to assess what levels of post-graduate trainings are required to be effective and ethical online, and what their responsibility is in gaining Continuing Professional Development (CPD). These recommendations are highly supported by the HCPC Standards of Proficiency (HCPC, 2015) and by scholars highly versed in the field of digital and online therapies (Anthony, 2015; Hanley, 2017a; Nagel & Anthony, 2009), in that, if a practitioner wishes to move outside of their scope of practice, they are to undertake necessary training and experience before moving into a new area of practice to work lawfully, safely, and effectively. The implications of my research are akin to past research, in that there is an emphasis on enabling therapists to experience BDT through workshops, its inclusion in the curriculum of universities and/or training institutes, and through providing free

educational test accounts to therapists to promote its usage (Titzler et al., 2018). It is strongly suggested that these recommendations apply to the practice of BDT, considering the struggles that were expressed by participants, particularly in the beginning stages of using the DP. Recommendations also suggested are psychologists' encouragement to shadow the work of other colleagues, attending regular training, watching video demonstrations, group, or peer supervision (Hanley, 2017b).

The findings demonstrated that BDT did not negatively impact the therapeutic relationship, but rather, facilitated client engagement, a tolerance of the therapist-client interaction, and encouraged a sense of equality between therapist and clients. Considering the quality of the therapeutic relationship is an important core principle in most, if not all therapeutic approaches, these findings offer revolutionary implications for other existing therapeutic modalities, outside of pure CBT, for interventions to be digitised and delivered consistent with a BDT model. Examples of such interventions include the potential use of digital avatars in the facilitation of Gestalt 'chair work' (Perls, 1969; Kellogg, Garcia & Torres, 2021) for instance, which is commonly integrated with approaches like internal family systems (Schwartz & Sweezy, 2019) and Schema therapy (Pugh & Rae, 2019; Young, Klosko, & Weishaar, 2003) in treating various mental health concerns such as eating disorders.

The findings revealed the sense of safety, security, and work time control the DP's modular structure provided for therapists when facilitating sessions, as well as the powerful impact the visual and interactive digital features had on engaging their clients and gaining their trust. These findings are encouraging for non-digital, mainly paper-based, modular therapeutic approaches to consider the digitising of their modular treatments into interactive DP's, so as to be delivered in a BDT format. Examples of these non-digitised modular interventions include the "Feeling Safe Programme" (Freeman et al., 2021) for persistent persecutory delusions, or the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) (Schmidt & Treasure, 2014).

There are crucial implications for the utilisation of this approach for highly busy clinicians working in national services with heavy caseloads and for newly qualified or trainee psychologists in relieving the pressures of session planning and assisting with enhancing one's knowledge and application of complex CBTp principles in practice with IeP's. As highlighted earlier, these implications might allow for clinicians' greater work time control (Nijp, et al.'s, 2012) to potentially support therapists experiencing stress, burnout, depression, anxiety, and increased need for sick leave.

As BDT's become more promising and practitioner uptake increases, guidance and national policy developers need to follow suit. Competencies help mental health practitioners navigate issues of ethics and laws (Lustgarten, & Elhai, 2018). Past research has found that a barrier to the use of BDT is the absence of guidance regarding when and how to implement it (Wentzel et al., 2016). Currently, various clinical guidelines exist for online, remote working (BPS, n.d.; BPS, 2021; Digital Health Skills, n.d; HCPC, 2021; NHSX, 2021), many of which arose in response to the Covid-19 pandemic. The findings of this study necessitate the enhancement of such guidelines to include blended working, and the competencies required to do so. Findings from the study highlighted the need for regular training, supervision, particularly for novice BDT practitioners, as well as the need for flexible working when using a targeted DP.

4.6 Limitations

This research contributes valuable knowledge on the subjective lived experience that psychologists have had of using BDT with IeP's that has been less represented in the current evidence base.

An important consideration for this study is establishing too narrow and homogenous a participant sample, thus challenging transferability to other areas or groups (Pringle, Drummond, McLafferty, & Hendry, 2011). The study only focused on one BDT intervention for paranoia, SlowMo, and participants shared experiences from using SlowMo within the context of a RCT. Furthermore, the IeP's would have been screened via an eligibility criteria process and would have had some openness and acceptance toward using BDT. These factors might limit transferability of findings to psychologists working in routine practice settings in the 'real world' where therapists might hold radically different views towards BDT's, and they might be working with IeP's who also hold different views of BDT, and might be presenting with increased severity of symptoms compared to those who participated int eh RCT. Furthermore, the sample of participants were involved in the trial for the effectiveness of SlowMo, and so it is questionable if participants already carried a biased viewpoint or a vested interested in this intervention being effective, compared to how non-trial psychologists might feel, further limiting transferability.

The sample was reasonably homogeneous, however, due to the female dominance within the sample, there might be a limitation to the transferability of findings to male psychologists for instance. Alongside this, the entire sample consisted of clinical psychologists who have had

further specialist training in CBTp. Therefore, transferability could be further limited to psychologists who might adopt other methods of practice such as those adopting Schema Therapy, Psychodynamic, or Humanistic models of practise as their core model within their clinical work. The research base has presented substantial evidence that psychotherapists' attitudes and acceptance of DHI'S in mental health can be highly influenced by their preferred theoretical orientation of practice (Baumeister et al., 2020; Schröder et al., 2017; Vigerland et al., 2014; Wangberg et al., 2007). This study was also carried out within the UK, which is considered a 'frontrunner' within the field of DHI's (Topooco, et al., 2017). These socio-cultural factors, although not highlighted by participants in their interviews, could have interplayed with participants' positive attitudes towards BDT's, which might not occur in countries less digitally advanced where DHI's are not commonly used or known about.

CoP's emphasise the reflective practitioner model and carry with them the ethos and philosophy of humanistic psychology, of empathic engagement with clients concerned with health rather than pathology These values are claimed to set CoP apart from other practices such as clinical psychology (Woolfe, 2016). Thus, the findings provide crucial insight for all professionals within the helping professions to learn from, however, it is questionable whether a CoP would have provided perhaps a different quality of experiencing. As mentioned, BDT for paranoia is a novel approach to treating paranoia developed in the UK, and so accessibility to varying professional backgrounds was extremely limited, leading to the sample that was approached.

As is depicted by the demographic questionnaire results (table 2.1) all eight participants identified as either White British or White from any other background. Therefore, the findings might be limited to a westernised experience of BDT, and thus the transferability of findings is limited to clinician of various other cultural backgrounds or from Black, Asian, and Minority Ethnic (BAME) backgrounds. It was also of personal interest to me throughout interviews and analysis that there was no direct or clear reference to cultural differences by participants, for instance, using BDT with clients from BAME communities. As a British Asian, I realised my own peaked interest in the cultural implications of using BDT's, and what this form of therapy might be like for BAME psychologists and for BAME clients who might bring the addition of their cultural experiences to their therapeutic work, and how this is managed using a targeted DP. I realise that there could have been an inclusion of questions in my interview schedule exploring race and culture in the BDT experience, which would have encouraged a wider and inclusive nature of psychologist experiences. I recall thinking of this aspect of experience when creating the interview schedule for the study, but I omitted mentioning race to allow organic

reflections by the participants. This was to assess the parts of their experiences that were important for them to mention, rather than influencing them to discuss race, which might have not been an emergent or crucial part of their experience and could have overshadowed what they wanted to bring to their interviews.

4.7 Quality Assurance

Quality criteria are ways to ensure and demonstrate that qualitative work is high quality and therefore has validity (Frost & Kinmond, 2011). Yardley (2000; 2017) present four principles for assessing the quality of qualitative research, which this study aimed to comply with.

The first principle, sensitivity to context, urges the importance of showing sensitivity to the data, by not imposing pre-conceived categories, and instead by carefully considering the meanings generated by the participants (Yardley, 2017). The chosen method of data collection was non-leading and flexible, thus enhancing the focus on the participant. Furthermore, reflexivity ensures that the research process is scrutinized throughout. Thus, I continuously reviewed my own role in the research to inhibit impositions of meaning I was making to promote validity (Willig, 2013). Smith et al., (2009) emphasise the immersive and disciplined attention that is required for unfolding the accounts participants provide. Therefore, verbatim extracts from participants' material and participant quotes were present within the analysis, to anchor the context and ensure the argument being made was supported.

The second principle, commitment, and rigour, can be demonstrated by in-depth engagement with the topic, including the data collection process and in undertaking a detailed, in-depth analysis (Yardley, 2017). Recruitment was carefully targeted to gain unique and rich interview material. The analysis was interpretative, rather than a simple description. Participant quotes were presented in the findings chapter, showcasing rigour. I used research supervision to ensure that the analysis maintained a balance between idiography, and my own meaningful interpretations. Furthermore, as mentioned, I carefully adopted Smith et al.'s (2009) step-by-step analytical strategy proposed for IPA, a trail of which has been demonstrated in the appendices. As Smith et al., (2009) and Osborn and Smith (1998) suggest external audit should be used to add credibility of the accounts being made. This was fulfilled in my study through the support of my research supervisor auditing an anonymised draft section of first transcript I had analysed and created emergent themes for and auditing the preliminary version of the master table of themes I had created.

The third principle, transparency and coherence refer to the reader's ability to clearly ascertain how the interpretation was derived from the data (Yardley, 2017), and how clearly the stages of the research process are described in the write-up of the study (Smith et al., 2009). In line with this, a detailed account of my methods has been provided. Reflexivity segments as well as the inclusion of transcript extracts in the findings chapter aimed to fulfil transparency and coherence.

Finally, impact & importance refer to the requirement for research to generate knowledge that is useful, whether in terms of practical utility, generating hypotheses, or even changing how we think about the world (Yardley, 2017). It is hoped that this study will enrich the understanding of BDT use with IeP's and contribute towards a deeper understanding. This was demonstrated in the implications for practice section earlier in this chapter.

4.8 Future Research

Although the current research adds a crucial phenomenological understanding of psychologist's experiences of using BDT's for the specific population of IeP's, at present a dearth still exists in the different areas of knowledge that we need on BDT's to ensure we are practising BDT ethically. As mentioned within the limitations segment, the transferability of findings was limited due to the narrow homogenous sampling. The purpose for future research would be to add to the further gaps within the research base.

Cultural implications in the use of BDT's are greatly warranted. The current research findings did not fulfil this area, particularly as there was no prompting question around this and this subject did not arise organically by participants. Qualitative research adopting a social constructionist epistemology can explore discourses of race using thematic analysis (TA). A TA method and constructionist theoretical underpinning would allow for the assumption that experience and meaning are socially constructed instead of inherent within the individual. Therefore, the focus is on the way sociocultural and structural contexts allow the individual participants' stories to emerge about a phenomenon (Braun & Clarke, 2006; Burr, 2015). Thus, this approach would be very suited to understanding how therapists and clients have experienced the use of BDT's, and if this allows the emergence of discussions around culture in sessions for instance.

As mentioned, my study assessed psychologists who were involved in a RCT for the effectiveness of SlowMo, thus they were greatly focusing on their experiences in the context

of a research trial. To ensure ecological validity of findings and transferability of findings to 'real life' settings, future studies could focus on psychologists' experiences of using BDT in NHS settings with IeP referrals from the community.

Further to the clinical implications mentioned earlier in this chapter, BDT studies would greatly benefit from expanding further into various therapeutic modalities and for various populations, apart from CBT and psychosis treatment. We would gain important knowledge from trialling the use of Gestalt or Schema Therapy chair work via digital avatars for instance, which could be delivered as a BDT. Furthermore, studies could also seek to understand the results of digitising established and applied non-digital modular approaches such as the MANTRA model (Schmidt & Treasure, 2014) or the Feeling Safe Programme (Freeman et al., 2021), to ascertain if these approaches enhance treatment effects and adherence when delivered as a BDT.

There was a clear expression of psychologist's great efforts and thus struggles experienced to master one's practice and to provide the 'best therapy possible' for IeP's. These struggles emerged for various unique reasons such as the complexity of working with multiple facets of psychosis, and the need to deliver clarity and focus within session structure following the CBTp model. To support psychologist better, to prevent possibilities of burnout, and to ensure ethical practise, it would be of great interest to understand therapists' experiences of working with IeP's as research on this seemed to be limited. Chadwick's (2006) anti-collaborative modes provide important understandings to this area, and it might be of importance to support this literature further with more in-depth research into the phenomenon of anti-collaborative modes as these experiences seemed to organically emerge within my participants interviews and played a huge role in how they viewed BDT for IeP's. Further studies could also carry out a correlational analysis to assess the relationship between BDT use for IeP's and levels of psychological stress or burnout. Keeping my study's findings in mind, particularly "**achieving respite and enhanced practice"**, the prediction for this analysis might be that the use of BDT leads to lower experiences of stress and burnout.

4.9 Personal Reflexivity

The theme of "growth after change" was significant for me personally through this research journey. I recall starting the journey holding an initial scepticism towards BDT, due to my past professional experiences and core humanistic values. I noticed my transition overtime, eventually building an intrigue and reassurance towards BDT use, so much so that I find myself

debating and defending digital therapeutics nowadays with fellow (mainly sceptical) colleagues. I was conscious throughout this research of my own identity and lived experience as a trainee CoP working with IeP's, and worked towards not allowing my preconceptions, particularly at the start, to impede my ability to empathise with participant accounts, as highlighted in the methodology chapter.

I was conscious about interviewing participants who were likely to identify as researchers as well as psychologists. Their way of formulating answers to the research questions offered me important insight into their own lifeworld's, their ontological and epistemological viewpoints, and their reality, which might be to explore and express personal viewpoints and experience through a more positivistic, empirical, and objective lens. This was at times evident during interviews when it appeared there was a tentativeness when participants shared personal, subjective experiences of BDT delivery, particularly those that triggered vulnerability. To manage this, I would use prompting questions that would use more emotive language such as "*how did you feel about that*" to encourage subjective experience to emerge. I would also remind participants it is their personal experience I was interested in, and there was no right or wrong answer, which seemed to help participants share deeper subjective experiences.

I resonated with the common struggles that participants felt when working with IeP's. The struggle for mastery, imposter syndrome (as Matilda mentioned) were experiences that I related to. It made me reflect on my own anxiety, and struggles as a therapist, and how potentially, the drive behind these feelings is a deep yearning to be of value to another in the journey of healing. I was pleasantly surprised and inspired by findings such as the great benefits of the triadic relationship for IeP's in aiding with the regulation of stress and paranoia in sessions. As a TCoP interested in the field of psychosis, this learning is something I will hold onto. My aim, in my future work is to allow for more flexible thinking around BDT's amongst professionals and colleagues, to diminish what sometimes feels like a taboo when discussing digital therapies.

The experiences shared by participants were deeply insightful, and only strengthened the purpose for this research to be done; to allow important reflective space for psychologists trying new approaches and to emphasise the need to know about the practitioners experiencing so that we all may learn and grow from these. I was surprised by the dearth of literature in the research base in terms of psychologist experiences of BDT, considering the importance placed on being well-trained, practicing competently and ethically and being a reflective practitioner is well documented within professional standards and literature. Therefore, the efforts of this

research were to concentrate on the lived experiences of psychologists rather than clients consciously, to focus on understanding the perspectives of this group.

I believe this study was able to provide a platform for psychologists to present their lived experiences of practising a novel therapeutic intervention for paranoia. My hope is like many of my participants, in that I hope the voices of participants can provide critical knowledge about the application and dynamics of the BDT approach, and to reassure others who might be sceptical, even fearful of the digital and therapeutic worlds joining, just as I have been reassured. On a personal level, I feel privileged to have had the opportunity to interview these psychologists who have been a minority group to experience this currently unique intervention in the UK, and I feel honoured to be able to share these insights to others within the field.

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Appendices

Appendix A: Participant Recruitment Presentation

Introduction

Hello, my name is Varsha Punjabi, and I am a second-year trainee counselling psychologist at City University of London. Thank you for allowing me the time to present my doctoral research proposal to you all. As you might be aware, I am here to inform you about this research topic, and I am also here with the purpose of recruiting practitioner psychologist participants who meet inclusion criteria for this study.

I would be very grateful to hear any feedback you might have at the end of the presentation. I will read out my interview schedule to you so you may familiarise yourself with the nature of the questions. If you have any questions to ask, please do so at the end and I will try my best to answer them. If I cannot provide an answer today, I will be sure to look into the query and return to you as soon as possible.

Research Presentation

As we know, there has been a great clinical need for a more effective and accessible psychological interventions for paranoia. The way in which the NHS is attempting to tackle this issue is by introducing the integration of digital technologies into psychological interventions, also known as ‘blended therapy’.

What we notice so far is that the body of literature for blended therapies in general is largely made up of quantitative studies and there is a dearth of qualitative literature. There seems to also exist a dearth of qualitative research into understanding the unique experiences of the psychologists involved in delivering this type of therapy for clients experiencing paranoia, also known as “a fear of harm from others”. In line with this, my doctoral research aims to provide important knowledge for this methodological gap in the literature by using a qualitative research design to understand the experiences and themes that come up for the psychologists that have used this therapy with individuals experiencing paranoia. By doing so, I hope to enable clinicians to gain greater insight into this novel approach for working with paranoia.

As a brief overview of the methodology, I am proposing to use; this will be an Interpretive Phenomenological Analysis (IPA), using semi-structured interviews. The purpose of an IPA

study is the detailed examination of the individual's lived experience, and how individuals make sense of that experience. IPA is seen as most appropriate for this research, as it is concerned with trying to understand the subjective experiences of participants, how they make sense of their experiences, and their perception of a particular phenomenon. In this case, the phenomenon is psychologist's experiences of using of blended therapy for clients experiencing paranoia.

Interviews will last approximately 60 to 90 minutes, and participants will be assured that they may withdraw from the study at any time. After the interviews, participants will be provided a "debrief" sheet, containing more information about the study. The study population will consist of qualified psychologists who have been trained in the use and delivery of SlowMo, and who self-identify as having experienced the use and delivery of SlowMo blended therapy with clients experiencing paranoia, also known as the "SlowMo" program. I have copies of consent forms and information sheets containing greater information on how the research will be carried out and any ethical considerations, that will be passed round to all of you today.

The identity of participants will be kept confidential and written informed consent will be obtained prior to participation. Confidentiality will be maintained by anonymising any identifying information. All transcripts and audio recordings will be anonymised, encrypted, and securely stored on a laptop device and destroyed once the research requirements have been fulfilled. The interviews will be recorded using a Dictaphone. The recordings will later be transcribed for analysis. The recordings and transcriptions will be kept on a password-protected file on a laptop hard-drive, and the recordings deleted from the Dictaphone as soon as they have been uploaded to the laptop. Interviews will be held on site at City, University of London, or in each participant's respective NHS setting depending on what is most accessible and convenient for the participant. Interviews can also take place via Skype, if the destination of the participant or researcher is too far for either party to travel to.

Thank you for your time. I'm happy to take any questions or feedback you may have.

- **End of presentation.**

Appendix B: Consent Form

Title of Study: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF PSYCHOLOGISTS' EXPERIENCES OF DELIVERING BLENDED THERAPY FOR PARANOIA

Please initial box

1	I confirm that I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.	
	I understand this will involve:	
	• be interviewed by the researcher	
	• allow the interview to be audiotaped	
	• make myself available for a further interview should that be required	

2	This information will be held by City as data controller and processed for the following purpose(s): Public Task: The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees. I understand that the following Special category data (demographic details) will be collected and retained as part of this research study: Ethnicity; Number of years' experience as a practicing psychologist; Length of time using blended therapy for paranoia. City considers the processing of special category personal data will fall under: Article 9(2)(g) of the GDPR as the processing of special category data has to be for the public interest in order to receive research ethics approval and occurs on the basis of law that is, inter alia, proportionate to the aim pursued and protects the rights of data subjects and also under Article 9(2)(a) of the GDPR as the provision of these personal data is completely voluntary.	
3	I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
4	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.	
5	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties	

	and obligations under the General Data Protection Regulation (GDPR).	
6.	I agree to the arrangements for data storage, archiving, sharing.	
7	I agree to the use of anonymised quotes in publication.	
8	I agree to take part in the above study.	

_____ _____ _____

Name of Participant Signature Date

_____ _____ _____

Name of Researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix C: Participant Information Sheet

Title of study: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF PSYCHOLOGIST' EXPERIENCES OF DELIVERING BLENDED THERAPY FOR PARANOIA

Name of principal investigators:

Varsha Punjabi (Trainee Counselling Psychologist)

Alison McGourty (Research Supervisor)

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

There is a great clinical need for a more effective and accessible psychological intervention for paranoia. The NHS is attempting to tackle these issues by introducing the use of technology in, and/or as a part of therapy. An innovative digital intervention named "SlowMo" has been created (currently under trial within the NHS), which targets a reasoning style referred to as "fast thinking", associated with paranoia. The incorporation of such digital technologies into psychological interventions presents unique opportunities for improving outcomes and reducing costs. SlowMo is being trialled as the first blended digital therapy to target fears of harm from others, through an inclusive design approach called blended therapy. In other research, concerns have been voiced by Psychologists, suggesting use of technology in therapeutic encounters may lead to a negative impact on rapport and treatment outcomes. It is important to understand the general experiences and themes that may come up for the handful of Psychologists that are currently trialling SlowMo within a blended therapy approach with patients in the NHS. It would also be crucial to understand their experiences of using this approach with culturally diverse individuals. The aim of this study is to develop an understanding of the subjective experiences of Psychologists using a blended therapy approach, for clients with paranoia. This study will answer the methodological gap in the literature that currently exists and will enable clinicians to gain better insight into this new promising approach for working with paranoia. This study is being undertaken as part of a

Professional Doctorate in Counselling Psychology with City University, London. This study will begin in September 2018 and is due to be finalized by September 2020.

We will be collecting the following Special Category Data from all participants who have given consent to participate. The purpose of providing these Special Category Data is because it will form part of the themes we will be constructing in the final data analysis. Please note, the provision of your personal data is voluntary, and so you have the right to opt out from providing any of these details:

Ethnicity;

Number of years' experience as a practicing psychologist;

Length of time using a blended therapy treatment approach for paranoia.

Why have I been invited?

Approximately 10 psychologists who have been trained and have experience of using the SlowMo programme as part of a blended therapy approach for clients experiencing paranoia will be invited to participate. It was necessary to recruit a group of practitioners working within the same orientation, as we are seeking to find any similarities or differences between the psychologists' experiences of using this style of therapy. Both male and female Psychologists will be approached, and participants will also not be excluded on the basis of age. Participants will be recruited from three NHS settings in London, Sussex and Oxford, where the SlowMo trials are conducted.

Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate in part, or all of the project. You can opt out of answering any questions that you do not feel comfortable with answering. You can withdraw at any stage of the project without being penalised or disadvantaged in any way if you feel uncomfortable or distressed. It is up to you to decide whether, or not, to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. Please note that once the data has been anonymised and published, participants will no longer be able to withdraw their data.

What will happen if I take part?

- You will be invited to participate in a one-to-one interview with the researcher. The duration of the interview is approximately 60 minutes.
- The research study is due to end in September 2020.
- You will meet the interviewer twice; once for a pre-interview meeting where any questions can be answered before you are asked for consent, and the second time for the interview.
- The duration of each meeting is approximately 60 minutes each.
- You will be asked a list of semi-structured interview questions. These will be open questions, to gain an understanding of your subjective experiences.
- Research method: Interpretive Phenomenological Analysis to understand your subjective experience of using a blended therapy approach for paranoia.
- In a private pre-booked room, either in your respective NHS service (if deemed appropriate and approved of by service managers), or in a pre-booked room at City University, London.

Expenses and Payments

- Travel expenses will be reimbursed with cash. Please ensure that you bring a receipt of your travel cost with you on the day.

What do I have to do?

- You will be asked to sign a consent form once you are satisfied that you understand the study and its rationale.
- You will be asked to arrange an interview date with the researcher after we have received your consent to participate. No preparation is required on the participant's side for this interview.

What are the possible disadvantages and risks of taking part?

It is possible that you may feel some emotional upset when revisiting your experience of working with some of your clients, and the meaning that this has for you, or in hearing the experiences of others. At all stages, you are reminded that your participation is voluntary and you can withdraw your consent at any time.

Your identity will be anonymized, and any material deemed as sensitive material relating to your clinical work with clients will be anonymized. You will be asked to reflect on your therapeutic relationship with your clients, whilst using blended therapy with them. There is a possibility in future if this research is published to the public, that your past clients with whom you carried out the SlowMo therapy trial may gain access to the published research.

What are the possible benefits of taking part?

- Contribution to trial run of SlowMo therapy for paranoia. If this trial is successful, SlowMo it will be made available in the NHS.
- Results will help inform if any changes are required to be made to this therapeutic approach before the trial is complete.

What will happen when the research study stops?

You remain free to withdraw at any point by notifying me, either in person or using the contact details below. Should this situation arise, all contributions made in the interview will be erased from the recordings and transcripts. Withdrawn participants' data will not be analysed and will not be published.

If you do not withdraw, these interviews will have been recorded using a Dictaphone. The recordings will later be transcribed for analysis. The recordings and transcriptions will be kept on a password-protected file on a laptop hard-drive. The recordings will be deleted from the Dictaphone as soon as they have been uploaded to the laptop. After analysis is complete, the recordings and transcripts will be destroyed from the laptop.

Will my taking part in the study be kept confidential?

All information disclosed by you will be treated as private and confidential. Access to raw data will be restricted to the researcher and research supervisor. All recordings/transcripts will be encrypted, stored securely and notebooks will be kept in a locked drawer to which the researcher only has access. Confidentiality will only be broken in the following circumstances: should the researcher feel there is a risk of serious harm either to you or others or where the researcher is legally compelled to do so. In terms of anonymity, this research aims to comply with BPS ethical guidelines, and all participants will be consenting adults whose anonymity will be guaranteed. As such all names and identifying information will be changed to preserve confidentiality and you will be able to choose how you wish to be represented.

Only the researcher will have access to the participants' recruitment details and these will be kept in locked drawers and not disclosed to anyone. Any future use of personal information will only be with the participant's signed consent. There will be no sharing of data with other universities or researchers.

If any future use of your personal information is required, we will ask for your consent again by contacting you by telephone or sending you a letter, and asking to arrange a meeting to discuss the reasons for requiring your information, before we ask for your official consent.

What should I do if I want to take part?

You will need to attend a meeting with the researcher where you can ask any questions you may have before giving consent. You will then be required to sign a consent form if you agree to participate. You will then need to organize an interview date that works well for you. The interview will last approximately 60 minutes.

What will happen to results of the research study?

The findings of the study will be written up for a Doctorate in Counselling Psychology but may also be disseminated more widely through journal publications and academic conferences. Future publications may include the BPS journal and the Counselling Psychology Quarterly Review. It is important to make you aware that in both the report and the future publications, some direct quotes from your interviews may be used. However, all personal details will be changed and so it will not be possible for readers to identify you. If you would like a copy of the research findings, once the study has been completed, you can contact me directly at any point thereafter and I will ensure that you receive it by post.

What will happen if I do not want to carry on with the study?

You are free to withdraw from the study without an explanation or penalty at any time. You can contact the researcher on the telephone number stated below, or send an email letting them know.

Who has reviewed the study?

This study has been approved by City, University of London Research Ethics Committee.

Further information and contact details

Researcher: Varsha Punjabi

Email: ***[REDACTED]***

Phone: ***[REDACTED]***

Principal investigator: Alison McGourty

Email: ***[REDACTED]***

Data Protection Privacy Notice: What are my rights under the data protection legislation?

City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

Further, City considers the processing of special category personal data will fall under Article 9(2)(g) of the GDPR as the processing of special category data has to be for the public interest in order to receive research ethics approval and occurs on the basis of law that is, inter alia, proportionate to the aim pursued and protects the rights of data subjects.

The rights you have under the data protection legislation are listed below, but not all of the rights will be apply to the personal data collected in each research project.

- right to be informed
- right of access
- right to rectification
- right to erasure
- right to restrict processing
- right to object to data processing
- right to data portability
- right to object
- rights in relation to automated decision making and profiling

For more information, please visit www.city.ac.uk/about/city-information/legal

What if I have concerns about how my personal data will be used after I have participated in the research?

In the first instance you should raise any concerns with the research team, but if you are dissatisfied with the response, you may contact the Information Compliance Team at ***[REDACTED]*** or phone ***[REDACTED]***, who will liaise with City's Data Protection Officer [redacted] to answer your query.

If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at www.ico.org.uk

What if there is a problem?

If the research is undertaken in the UK if you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone ***[REDACTED].*** You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF PSYCHOLOGISTS' EXPERIENCES OF DELIVERING BLENDED THERAPY FOR PARANOIA

……

You could also write to the Secretary at:

[REDACTED]
Research Integrity Manager
Research & Enterprise
City, University of London
Northampton Square
London
EC1V 0HB
Email: ***[REDACTED]***

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

Appendix D: Demographic Questionnaire

We will be collecting the following demographic information (Special Category Data) from all participants who have given consent to participate. The purpose of providing this demographic data is because it will form part of the themes, we will be constructing in the final data analysis. Please note, the provision of your personal data is voluntary, and so you have the right to opt out from providing any of these details:

Ethnicity:

Number of years' experience as a practicing psychologist:

Length of time using blended therapy for paranoia:

Appendix E: Interview Schedule

1) What motivated you to participate in this study?

2) What is your idea of psychological therapy?

(Possible prompts: what do you think are important components to have in therapy?)

3) What do you personally feel is important in therapy, when working with clients experiencing paranoia?

4) How has your experience been of using blended therapy for clients experiencing paranoia?

(Possible prompts: (a)Can you tell me more about either the positive and the negative aspects that you have mentioned? Why is it negative, why is it positive? (b) Have you noticed any helpful elements of using blended therapy? (c) Have you noticed any unhelpful elements of using blended therapy? (d) If you were to change this therapy in any way, how would you change it?) (e) how did you feel whilst using it?

5) How has your experience of the therapeutic relationship been when using blended therapy for clients experiencing paranoia?

(Possible prompts: why do you feel this way? What makes you feel this way? Can you give me an example?)

6) When in the process of delivering blended therapy session, how have you felt your clients have experienced this therapy?

(Possible prompts: did you make any adaptations for any clients? did you feel this therapy suited some clients more than others; can you tell me more?)

7) Is there anything you think I've missed?

Appendix F: Debrief Sheet

Title of study: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF PSYCHOLOGISTS' EXPERIENCES OF DELIVERING BLENDED THERAPY FOR PARANOIA

Thank you for taking part in this research project. The information you have provided contributing to this interpretative phenomenological analysis "IPA" interview schedule will be analysed using thematic analysis techniques. IPA was used as it is concerned with trying to understand the subjective experiences of participants, and how they make sense of their experiences. I sought to do this through asking open questions so you could recount your experiences in detail, so that I could gain a fuller and richer understanding of your experience. In the case of this research, I am trying to investigate psychologists' subjective experiences, so it is essential to use a method that allows for this.

Considering blended therapy as a new therapeutic approach in the UK for paranoia, there are approximately 10 therapists within the UK that are currently accessing it, and there is a dearth of research on the therapists' experiences of using this approach for paranoia. I therefore was seeking therapist's experiences to inform the use and efficacy of this therapeutic approach further. This research was looking into understanding if the use of blended therapy has any impact on the therapeutic relationship with clients, and if there were any further relevant themes in psychologists' experiences of using of this type of therapy, with clients experiencing paranoia. Blended therapeutic approaches could soon be more widely available within the NHS, and so the present research hopes to provide clinicians such as Psychologists, with better insight into this phenomenon.

You remain free to withdraw at any point by notifying me, either in person or using the contact details below, stating the Participant ID number given at the top of this form. Your contribution will thereafter be erased from the recordings and transcripts. Withdrawn participants' data will not be analysed and will not be published.

If your participation in this research has evoked concerns or queries about any aspect of your participation, please do not hesitate to raise them with me. Should you wish to you can arrange a meeting with me where your concerns can be discussed in confidence and

assistance will be provided to find you further support as necessary. To find a Counselling Psychologist or therapist go to the BPS website (www.bps.org.uk) and click on “Find a Psychologist” or visit the British Association for Counselling and Psychotherapy website (www.bacp.co.uk) and click on “Find a Therapist”. If you wish to contact me or my research supervisor in relation to this research, please find contact details below.

We hope you found the study interesting. If you have any other questions, please do not hesitate to contact us at the following:

Researcher: Varsha Punjabi

Email: *[REDACTED]*

Research Supervisor: Dr Alison McGourty.

Email: *[REDACTED]*

Appendix G: Ethical approval

Dear Varsha

Reference: ETH1819-0589

Project title: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF PSYCHOLOGISTS' EXPERIENCES OF DELIVERING BLENDED THERAPY FOR PARANOIA

Start date: 21 Jan 2019

End date: 30 Sep 2020

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology low risk review. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

The approval was given with the following conditions:

- ...
- ...
- ...

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;

- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology low risk review, I do hope that the project meets with success.

Kind regards

[redacted]

Psychology low risk review

City, University of London

Appendix H: Example coding and development of emergent themes for "Amy"

Coding key:

D: Descriptive comments

L: Linguistic comments

C: Conceptual comments

DX: De-contextualisation

Transcript	Coding	Emergent Themes
R: Mhmm A: …um and you know so it kind of allows a pause, allows a shift in attention in a different way to to that of traditional therapy and I feel like that means that, the kind of, I don't know, the focus or the pressure is taken off that person. It's in a- it's a different way of taking the pressure off. It's a bit like, it's- it's not the same, but it's a bit like you have a break in the session and like, I don't know, go for a walk with the patient and talk about something completely different. What that offers is kind of a pause in a different way to	DX: pause: interrupt action or speech briefly C: feeling less overwhelmed by the therapeutic interaction through the switching of attention to the computer away from client-therapist. C: shift in focus to cope with the intensity of the interaction. D: focus of attention/pressure moving away from client L: difficulty in articulating– sense of uncertainty L: use of 'person' to refer to client/patient – humanising the client C: BDT alleviates pressure off clients which in turn alleviates pressure off therapist? Comforting/relieving for therapist? D: reduction in the intensity of the therapy. L: difficulty in articulating point- sense of uncertainty? Self-doubt? L: now using 'patient' when describing traditional therapy –	*Feeling comforted by the presence of the computer in shifting attention and enhancing collaboration/connection* *Relief when managing the pressures of therapy through taking breaks*

SlowMo, but it's it's different to just kind of stopping in the session. And the other thing I think is that because of the vignettes, I'm a bit obsessed with the vignettes (*laughs*). Because of the vignettes you get a chance to deliberately focus on somebody else's experience. The <u>patient</u> isn't, you're not asking the <u>patient</u> to talk about their experience in relation to that necessarily <u>straight away</u>. What you're asking is you know, um "what do you think's happening for Nadia here? what do you- how do you think she's feeling?" You know, and rather than it being about them they can then relate to that person. And also, often then <u>people</u> will say "Oh yeah I have had the experience…" and it feels like it comes out in a a much easier way rather than you asking an open question of what's	resembles the more pressured clinical nature of traditional therapy as opposed to the more 'humanising' comforting nature of BDT? C: therapy tends to be experienced as pressured- there is a need for a coping mechanism in the form of a break/escape the pressure of therapeutic encounter. D: a need to avoid or distract to cope herself and to help the other to cope. L: repetition – strong emphasis on the vignettes. L: laugh – discomfort? Managing the discomfort of being repetitive. D: emphasising the importance of the vignettes in her experience DX: deliberate: purposefully; with intent C: feeling relieved by the program presence? C: experiencing a gentle/easier approach to difficult topics with clients through the use of vignettes. D: by using vignettes Amy is not feeling the pressure to ask difficult/sensitive questions too quickly. In traditional therapy asking clients about their experiences might feeling challenging for Amy? As though it is pre-mature/too quickly done. D: process of exploration rather than forcing the client to think about their own experience straight away. DX: straight away- immediately	*Feeling comforted by the presence of the computer in shifting attention and enhancing collaboration/connection* *Experiencing an ease with approaching difficult topics through using digital vignettes*

happening for you with the situation. I don't know. **R:** I guess on those two points; taking the pressure off the clients, and the clients' relating to the vignettes- I've understood about how you feel that may have helped the client. I wonder what that's done for you, in your experience? **A:** <u>It also gives me a chance to pause</u> (*laughs*). Which I think is really helpful because I think often in therapy sessions, you're kind of processing and reflecting and holding the formulation in your head and thinking about the agenda for the session and things like that. And with the with the vignettes, and with the SlowMo platform, it gives you an <u>opportunity</u> to <u>pause</u> and take a moment and think about kind of where you are next going in the	C: Feeling supported/ relieved by the program's vignettes to engage in (gentle?) exploratory discussion. D: clients feeling able to connect to the vignette. C: An ease for Amy in gaining the client's connection with therapy through the use of digital vignettes. D: Less challenge to ask difficult questions in therapy. C: BDT helps by-pass the challenges of developing connection with the therapist. L: I don't know – uncertainty/self-doubt? L: laugh- discomfort? L: I think – in a process of discovery whilst in the interview D: feeling supported by the program. A sense of liberty? C: Gaining a sense of relief from the pressures of therapy delivery, which in turn improves practice of therapy? C: Overwhelming responsibility as a therapist/ struggle for mastery. DX: in your head: feeling of carrying a heavy load internally. D: opportunity, chance, choice for therapist to take a break- sense of relief / liberty? C: Welcoming a moment of coping/ recuperating/ reflecting on ones practice D: important to have a sense of direction and planning. Constant reflection on one's practice.	*Experiencing security in taking an exploratory stance with clients* *Experiencing an ease with approaching difficult topics through using digital vignettes* *Relief when managing the pressures of therapy through taking breaks* *Welcoming the liberty to recuperate and reflect on one's practice*

conversation you might have just had.	Responsibility of the therapist in BDT	

Appendix I: Using Emergent Themes to Create Cluster Themes for "Laura"

Cluster theme ***(Super-ordinate theme for Laura)***	***Emergent Themes***	***Example transcript extracts***
The self as knowledgeable from experience	*The self as experienced*	I work in a research team. So I have kind of been around a lot of different research, um trials and studies.
	Laura's autonomy and openness to providing other forms of psychological therapy	I tend to hang things off of that but I'm not completely, cause of my training, I'm not completely um wedded to that being my only form of psychological therapy.
Laura's need for evidence of credibility to build trust in new models of therapy delivery	*Laura's need for direct exposure to the program to relate to it and build trust through time*	I think it was when I actually got my hands on the training program and I could look through and could go "Ahh OK this I see what see what they're doing here."
	Laura's need for credible evidence as reassurance for the efficacy of blended digital therapy	so um, and the evidence base is there more importantly. I would want to know like who designed it where it had come from that kind of quality level
Laura's pressure to influence positive change for her clients	*The self as holding the power to create change for clients*	we need to understand what is happening in people's minds, how they're thinking about things to understand how we might be able to influence how they feel
	Laura's duty and determination to provide a useful experience for her clients	I think there needs to be a better treatment for psychosis… And anything I can do to advance the treatment
	Laura's pressure to fulfil the duties of her role of facilitating the efficient delivery of the program	I have to keep an eye on not chatting too much in between points, and kind of hurrying people along if we're spending too long on something.

"they're getting a therapist who's a human…It's got that personal touch" ***Laura's valuable human presence alongside the computer***	*The importance of Laura's human contact to encourage her client's connection to the therapy*	how you talk around it…how you explain what you're doing and how you set up your laptop in the first session… It's this joint discovery kind of thing.
	Laura's duty to help clients manage their challenges with using technology	we had to print it out which he had to fill by hand, which I think he found more accessible.
	Laura's fulfilling experiences of building rapport with mistrusting clients	I think also think a big part of that is the relational aspect and kind of having initially someone who starts off as a stranger who people begin to build a relationship with and trust.
	Experiencing fulfilment from establishing an authentic relationship with her clients	I think people realise that its interactive that they're getting a therapist who's a human.
	Recognising the value of her presence alongside the program to establish a connection with clients	I think especially in IAPT because it was like "here's your log on off you go". Um, you know you kind of work through the material by yourself, rather than having somebody alongside you going through it at exactly the same time that you are….it seemed like a step-on from what I've read before because it's got that personal touch because you go through it in the moment with the patient with you- um with the therapist with you.

Laura's self-doubt as a newly qualified clinician	*Laura's self-doubt due to being newly qualified*	I guess because I'm fairly recently qualified it's um, quite, reassuring to me that all the thinking for the session has already been planned out
"I need this session to be good for you" **Laura's struggles to master the many demands of being a good therapist**	*A struggle for mastery*	being a good therapist for me involves a lot of different things, but what I was referring to there was about having the theory really clear in your mind about why you're asking people to engage with this particular piece of information or do this particular behavioural experiment. So having the theory and the rationale behind your treatment really clearly in your head, and then also being able to communicate that really, really clearly.
	Feeling overwhelmed by the multiple responsibilities to be a competent therapist	So for somebody to really hold on to that message through each session of the course of the sessions, I think that's what good therapy should be
	Laura's discomfort with appearing intrusive to her clients in the therapeutic encounter	I know that I've had um previous patients who find it a little bit, um, I don't think intimidating is the right word, but um, just a lot you know, to, to be face to face with somebody. Talking directly about them, all the questions are, you know "*what's you and your experienc*e", and it feels quite like vulnerable I guess, especially for people with a high-level of paranoia.
	Striving to be a competent therapist through thorough preparation	I think also, it gave me the chance to rehearse. Especially on my training case I would go through the computer session for that session, so I had it fresh in my mind exactly what the case study was going to say, exactly the kind of points and how. And that let me have an idea in the room about timing, but I felt I was kind of better as a therapist (*laughs*) because I had that rehearsal time.

	Laura's need to engage in dialogue with colleagues to gain reassurance and confidence in using a new therapeutic model	I really like that there is this space to talk around the computer parts as well I think that's really important. Um so I think whether or not, say I got given a program to use with somebody tomorrow I think whether or not they told me to I'd want to talk around it in the way I have with this blended therapy.
"if somebody shows up and they've got a laptop just for you…I think it feels a bit special" **Experiencing the self as valued when providing an extraordinary experience to clients**	*Feeling honoured by the opportunity to provide an extraordinary experience where her clients feel valued*	people feeling engaged in it, because it's something different. If they've had therapy before they wouldn't have had it on the computer. Um, there's something quite nice about…So I think if somebody shows up and they've got a lap top just for you like we're going to work on this together and this is kind of a bit different and a bit fun, it's different to any other appointment they're having at that point, so I think it feels a bit special
	Laura's pride as a therapist in offering a unique and meaningful intervention	Which is just nice to give to people who don't have very much often, uh just a nice experience. That they feel that they've been thought about and this thing has been designed for them.
	Feeling sympathetic towards the challenges of living with psychosis in society	I think especially for psychosis, you don't get like a lot of nice stuff and treats and like, and mental health teams aren't exactly showering you with gifts you know?
	Laura's determination to empower and rehumanise her clients	the normalising that of course if you've had bad experience or you're very anxious of course you're going to feel this way. I think making people feel human again,
"so there's that fresh new dilemma that I've never had before, "how to fill the time when the therapy is loading"":	*Feeling overwhelmed by the uncontrollable issues that occur with technology*	The kind of frustration when the page isn't loading. Or you don't know how you're going to get the internet in a team base you've just travelled an hour to get to. And um, that kind of stuff can kind of bring you kind of crashing down to earth. I really want to show this thing and it's not loading.

Feeling uncontained by the unpredictability of technological failures	*Laura's worries related to technology defects effecting the future delivery of blended digital therapy in public services*	I guess it made me a little worried…I wonder how this generalises out into NHS technology where things are a lot slower. I've tried to log onto an NHS machine and it took me 20 minutes, (*laughs*) so that kind of worries me. (*laughs*).
	Self-doubt when frustrations arise from unpredictable technological difficulties	Um so there's that fresh new dilemma that I've never had before, "how to fill the time when the therapy is loading".
	Laura's empathy towards the anxiety experienced by individuals with paranoia	you've got all these factors that make anxiety worst, but essentially what its coming from is the belief that you're under threat and you've got to protect yourself. Um so people are in this constant state of high alert, which is exhausting basically (*laughs*) so yeah,
	Laura's empathy towards her clients struggles to use technology	my second case that I worked with by myself, um, he also didn't feel comfortable using the mobile phone he just felt low in confidence with his spelling and his kind of literacy. So he felt like he wouldn't be able to fill in a thought diary on a phone because it would be that extra level of using a keyboard
"Less of a recipe…more of a set of directions"	*Experiencing enjoyment in the delivery of blended digital therapy*	So I had one case, which I was going to say I enjoyed, I've enjoyed them all (*laughs*). It's a very enjoyable kind of way of <u>doing</u> therapy.
Laura's appeal for the use of technology in therapy due to her autonomy over the use of the computer as a tool	*Laura's autonomy over the use of the computer*	I think because the material is all there and there's enough space for you to talk <u>around it</u>. You can do the adaptation around the material. So you don't have to automatically move onto the next page you can spend some time talking and then move on.
	Laura's encouragement in response to the agency she has within sessions	that seemed like something <u>nice</u> and something that you could integrate your own therapy skills with.

	Feeling liberated in her ability to take ownership in delivering therapy due to the program's flexibility	you can kind of freely explore and create the boundaries of that and you can explore and kind of think about things within that.
"I could see how the sessions built together. I could see how they sit together" **Laura's security due to the harmony within the triadic relationship and the therapeutic frame**	*Developing security in blended digital therapy response to witnessing the harmonious working relationship between herself and the computer*	I could see how the sessions built together. I could see how they sit together. I can see where a therapist could jump in at that point and make sure the person has taken the message home from here. So you could see space where you could be involved but you could see where the program is doing the setting up of the concepts for you. Um so I thought that seemed like something nice and something that you could integrate your own therapy skills with.
Laura's development of trust and confidence in blended digital therapy through time	*Laura's surprising discoveries which challenged her assumptions during her delivery of blended digital therapy*	people can feel quite paranoid about technology…I was really interested that actually that wasn't the problem people had…neither of them showed any suspicion about it. No one seemed to be concerned about the laptop being in the room.
	Laura's established trust in blended digital therapy as a method of therapy delivery for her future practice for selective presenting issues	I definitely would be up for doing blended therapy for this problem or for any other problem in theory. Because I just think it's a really nice way of working with somebody for a small kind of concrete problem, or a one maintenance factor.
Laura's attentiveness to her client's reactions for self-reassurance	*Laura's ambivalence towards the impact of blended digital therapy on clients due to their unpredictable responses*	Yeah, maybe this is a function of the actual patients that I've had cause I've had conversations with other therapists who felt like their patients just hasn't got it. But then strangely they've had, they've arrived to the next session and then suddenly it's just clicked (*laughs*). So, so I don't know, I don't know what that is but I'd like to think that the message is just really clear (*pause)* the clarity of the message is such that eventually they'll be like "Oh OK" (*laughs*). So yeah, I think that's why

	Gaining reassurance through remaining alert and attentive to her clients developing responses	So I think people, you kind of see them not being quite sure when you first start up the computer, like whether it's going to be relevant to them. But…they begin to see that actually it is personalised…So and then you see this kind of increase in engagement in people who are quite interested in what's coming up next.
"it's easier to sit alongside somebody and "look at this"" **Laura's ease in softening the intensity of the therapeutic encounter through shifting attention to the computer**	*Feeling relief in shifting attention to the program to bring comfort within the therapeutic encounter*	with this you can kind of shift the focus a bit, and we can talk about you know "what did Nadia say there?" and "how did she find that?" and "do you, do you also get that?" So it's a bit softened. We're together on this looking at something else and we can relate it back to you. So I think for people who find that face to face thing a bit intense there's a way for people to soften that
"It lets you be a lot more curious, be a lot more judgemental, but have that safety-net": Laura's experience of safety in adopting a non-expert stance next to the computer		
	Laura's safety in adopting a non-expert position amongst the presence of the program	you get to be more equal, um, you get to kind of take the more of the non-expert stance and be there for that person and their experiences, rather than be there for that but then to also bring the theory in.
	Laura's security in the collaborative agreement with her clients to be inclusive of the program	But that seemed to work for people because we both know this thing, we're both doing this
	Experiencing security through using the program as a safety-net when experiencing dissonance with clients	if they would be saying something that was kind of off theory, I'd kind of go "I wonder what the SlowMo program would say about that?" "I wonder if it would actually say that you would need to slow down in those instances". And kind of use it in a way that, it's not me saying it, it's the program (*laughs*). It lets you be a lot more curious, be a lot more judgemental, but have that safety-net. So that kinda helps.

"it's already done a lot of that thinking for you" **Laura's self-assurance as a therapist when supported by the scaffolding of the program**	*Feeling confident in achieving client engagement due to the increased agency the computer offers to clients in therapy*	the fact that this SlowMo program will give you a video, a sound bite, a forum that people can click on, it's so much more engaging than you having to find a way to bring that to life for somebody, or reading out a vignette in your own voice.
	Experiencing ease in building a relationship of equality with her clients	you've got that alongside feeling, um and they feel like they're sharing something with you because you're both sitting there and you're both going through it together.
	Laura's developing confidence in self when assisted by the program due to its consistency & clarity of message	that message is so consistent across the sessions it helps you as a therapist to have the message straight which helps you kind of deliver it better.
	Feeling hopeful in gaining her clients engagement due to the clarity and consistency of the program	I think it's just because the whole thing is very normalising, you see these three case studies all the way through you can kind of use them as "oh isn't that interesting that you've got the same thing as them"
	Laura's security in using the program to provide an accessible and engaging intervention to her clients	the case studies are really nice. It's really um engaging as the way it's set up and the way it's written. So it just seemed to me that it wasn't patronising people that it wasn't way over peoples' heads', but it was still actually delivering something meaningful. And I think I'm quite aware of, having worked with people with psychosis for a while people can get patronised by things that are intended to help.
	Feeling secure due to the scaffolding of the program	I tend to go off-piste, so actually to hold me on course it's really good there's this structured material um, and so there's that kind of session planning kind of perspective.
	Experiencing relief due to the computers assistance in reducing her responsibilities	You don't have to necessarily have to prep in the same way you would for a completely separate bespoke non-manualised session.

Appendix J: Master table of themes with example quotes

Superordinate	Sub-theme	Present in over half sample? Y/N	Example quotes [line numbers]
Moulded by one's past		**Yes: 8/8**	"I definitely had all those worries beforehand, but um, having been part of a similar study [past research trial] I was also quite excited to be delivering it as well." [Frances:421-423] "I think umm, we often sort of get all excited about different tools and techniques, um but when you don't have a-a basic kind of connection or an empathy- and I think this is particularly key for people with psychotic disorders [pause] If you don't have that kind of rapport, it's very, very difficult to move forward with anybody. [Adrian:33-40] "when I'm working with people in psychological therapy, I spend quite a lot of time focusing on that relationship and really trying to build rapport and um empathy and, for people's experience." [Adrian:48-50] "Maybe there's a difference between me and someone that has never (pause). For example, with [fellow trial therapist] we had conversations about it […] you know I could feel I could feel the difference between the anxiety around technology, uh one and the other." [Cristina:254-259] "Well in terms of SlowMo itself I do think that um I think we're very experienced therapists, so that probably helps" [Matilda:602-603] "it's not something that I've ever done before and initially I think I was quite sort of sceptical of it 'cause I was thinking "it's very structured is this really gonna fit for people? Are they gonna feel like we are not taking their experience seriously" like we're just trying to almost kind of say "oh well just try this and you'll feel better" [Jordan:234-237] "You know, I've obviously had quite a lot of experience about engaging people where engagement has been difficult for quite short periods of targeted work […] I sort of had quite a lot of experience of building these sorts of positive relationships and engagement, so I think in a way that's experiences I brought into this. [Dana:476-481]

			"I think my expectations of what a blended therapy would be I would have been quite cautious of it for all sorts of reasons. Reasons both relating to my own practise, and the idea of bringing technology into therapy session." [Amy:649-651] I knew it was going to look nice, sound good and actually have a sound theory behind it. [Laura:398-399] I work in a research team. So I have kind of been around a lot of different research, um trials and studies. I think there needs to be a better treatment for psychosis… And anything I can do to advance the treatment
Struggles of co-facilitation with a digital platform	**A struggle for mastery**	**Yes 5/8 (Minus Adrian, Dana & Cristina)**	"…it's something that can happen sometimes can't it in therapy sort of drifting away from what your original target was because of the things that people present with" [**Frances:218-220**] "I kind of felt a there was a bit more of a set up to do here and I don't want them to be walking in and me trying to make it work I really wanted it to be set up." [**Frances:410-412**] "I think it's very very easy to drift, especially if its um, with some issues that can be confusing even for the therapist and can lead to these kind of questioning "*am I doing the right thing or not?*". And sometimes, not going through the path that perhaps we should go through. […] So I think, and not just as a therapist but as a supervisor, and having supervised many people doing therapy, there is definite risk there, and I guess the more complex the issues are the more chances for therapist drift there are." [**Matilda:282-287]** "When it came to start doing the therapy [*BDT*] I thought "*Oh my goodness will I be able to do this" (laughs*) it's complicated. and I was actually a bit stressed about it, I can't say that I wasn't, I was a bit stressed about it." [**Matilda:368-371**] "So, you know, making sure that they feel kind of comfortable and safe and able to kind of talk to you. I think if you don't have that sort of rapport with them, then really, it's very hard to do anything else. Um, I think you have to kind of have that foundation initially um, to, for everything else to kind of ripple off that and build off that really. I think that's crucial especially people with paranoia because it can be difficult for them to trust other people" [**Jordan:33-38**] "I think in some ways I found it difficult because it introduced another element into the room in terms of you know making sure that that was working correctly" [**Jordan:77-79**] "I would say that I'm always someone who wants to deliver the best possible therapy for my patients. I think that you know I feel really privileged to do the job I do. I work with people every day

			who really struggle to be around other people who find it so hard to go out and I just feel like they managed to get to my sessions they managed to like meet me, and I feel like that's such a big thing for them to do, and they put so much trust in me someone like they've never met really before. And so then being able to go along and deliver the best therapy I can, doing something that I feel will really help them […] it makes me really really happy." [**Amy:380-388**] "[…] it is quite a confusing abstract concept really, um, that you've got these reasoning biases and they might be whatever. So for somebody to really hold on to that message through each session of the course of the sessions, I think that's what good therapy should be [**Laura:171-174**]
	Restricted autonomy	**Yes: 8/8**	"Um, even like in the case with this guy [*Frances's client*] it might have been really helpful maybe if I would have worked individually, I would have gone down a voices track rather than this, but that's what he signed up to do" **[Frances:252-254]** "But um (*pause*), yeah you could sometimes think "*oh this is, this module isn't saying enough it's not quite fitting*" yeah and then I think you could feel a bit frustrated **[Frances:517-519]** "And so we very much try and be normalising this is you know "It's not as simple as this we get it" etc etc. Um but I think sometimes just having a simple message on a computer makes it seem like we're not understanding the complexity around things." [**Adrian:155-159**] "And so umm, I think for him [*client*] his relationship to his illness and his hopefulness for therapy is, I think it's far more complex than the 8-session blended therapy, to use your term. [**Adrian:288-295**] So probably, and this is not based on data because I don't have the data, but like, people that are not from, not very young people (*laughs*). I just don't want to say old people, might not have been the greatest candidates for the use of the phone. […] sometimes I found myself going through the basics of a smartphone (*laughs*). So how to open it and how to work with the app blah blah rather than doing the therapy itself. So, I think that was that was kind of a challenge. [**Cristina:79-93**] "Effectively if you don't have the computer working you can't have the session. Cause the session is in the computer, the vignettes are in the computer the writing down then appears on the phone but starts off with the computer. So all of that is in the computer." [**Matilda:425-427**] "if they weren't finding it very helpful then it sometimes meant the sessions could be more tricky because you sort of feel like "oh well this is what we're talking about today but you're not getting it" (*giggles*)" [**Jordan:522-524**]

			"The flipside of it is is the potential for flexibility and for when when the web app isn't as applicable how do you then adapt that that that's the sort of that's the other side of the coin" [**Dana:175-176**] "My observation is that that I've, I've found it possible to sort of uh, use the central tenets of the SlowMo and use it as a springboard to look into other aspects of the persons difficulties um (*pause*) and you know that's been mostly OK, but I guess there are just sometimes where the specific targeted, the specific targeted interventions the person's sort of rapid thinking style is not really applicable." [**Dana:183-187**] "I think that one of the things that sometimes could make it easier is as a therapist would be if um (*pause*) if kind of the way the sessions were was a bit more flexible" [**Amy:624-626**] "The kind of frustration when the page isn't loading. Or you don't know how you're going to get the internet in a team base you've just travelled an hour to get to. And um, that kind of stuff can kind of bring you kind of crashing down to earth. I really want to show this thing and it's not loading." [**Laura:438-444**] "Um so there's that fresh new dilemma that I've never had before, "*how to fill the time when the therapy is loading*". [**Laura:445-446**]
	Efforts to maintain human connection	**Yes: 8/8**	So, it's umm, yeah, can feel a bit less (pause) flexible, but then like I said you're trying to be as flexible as you can when you're delivering it cause you're always trying to make it work for them and individualising it so. [**Frances:590-592**] the chap that I'm working with at the moment […] I worked with him for uh "Oh Gosh!" I think we had maybe 25 sessions or something. Um, and I think part of the reas- And he's responding really well to the SlowMo. And I think part of the reason is that he knows I know what what's going on for him. [**Adrian:76-81**] You know, you never know; you might have the best preparation, um beforehand, and really carefully thought through what you want to cover in session. And then when someone brings something to you, umm, that you know, you haven't thought about, or is new, or whatever. So, trying to be adaptable, and adapting to whatever people bring to you. [**Adrian:429-436**] Uh, we had some, or I had some people that have paranoid thoughts about their voices only. […] but not from other people so we had to adapt examples to those, but it was quite easy because the techniques were also applicable to paranoia coming from voices, and then the other adaptation was of course people who couldn't use the phone at all. We used flashcards so the same content that was on the phone they just have on a notebook [**Cristina:161-167]**

			But as I mentioned there is flexibility there you don't have to stick to 50 minutes so the programme can be followed and there's flexibility that allows for other things to be discussed in the session for example if the client says "can we talk about this?" Of course. [**Matilda:318-321**] I guess obviously I had to make adaptions in terms of whether if the client wanted me to type or they wanted to type or them to take control or me to take control. So those kinds of things you needed to be so mindful of each time and change depending on the client. [**Jordan:481-484**] I think you know without um you know, being too self-aggrandising, I've had a fair bit of experience of delivering kind of targeted interventions on trials and sort of have always advocated and sort of I think I think this has been the case in things I've worked with, you must have a flexibility of approach no intervention is going to work if you're very rigid. **[Dana:179-182]** I think obviously like there are times when you are talking about things that aren't on the platform, or you're making it unique to that individual you're not just kind of going through each screen and talking about it. **[Amy:252-254]** I could see how the sessions built together. I could see how they sit together. I can see where a therapist could jump in at that point and make sure the person has taken the message home from here. **[Laura:290-293]**
Achieving respite and enhanced practice	**The calm after the storm**	**Yes, 6/8 (Minus Adrian & Frances)**	it's important to talk about and for therapists to be aware of it and to be aware of the fact that actually it's, um, even though it might not be straight forward to use at first because it's a new thing actually it's perfectly doable, it's perfectly OK. And actually if anything it makes the work of a psychologist easier. **[Matilda:48-51]** I sort of found my rhythm […] I think I found that initially I was busy writing and pressing things on the computer and I felt I wasn't with them enough. So I tried to kind of minimise that a bit and that made it easier. [**Jordan:113-119**] I initially was a bit worried before I did the therapy, I was worried before I did the therapy, I was worried that it might be a bit clunky. […] In the sense that you know you've got sort of content to go through the web app content and then you've got the natural flow of the conversation […] And I worried that it might feel that you know we're going to stop what we're doing here and now let's just tune into the web app. [**Dana:115-122**] we've got really high levels of completion of this therapy really um really significantly good actually. […] Um, so I think that there is a sense that people kind of get it and they get over the hurdle of the

			technology quite readily for most people, but I think more so with the web app than the phone. **[Dana:377-381]** for me it's been really surprising because I was a bit worried at first that "gosh am I gonna get all of this done in this session". "Am I gonna get it all done in an hour" and actually sometimes I don't, and that's okay. [Amy:113-115] I also thought that people might be quite worried about the technology but that hasn't really been a problem. […] delivering the blended therapy has definitely challenged my assumptions and my expectations. [Amy:139-140] You, I, you can have, you shouldn't have, but you have like (pause) at the beginning like ideas of this person is going to be a good candidate […] but with SlowMo it was like you-you never know, someone could be like "ooo he's going to have difficulties" and after a week of using the app they were like "oh this is great I've managed to-" and the other way round yeah. I don't know. [Cristina:213-218] Yeah, I think we could have one thing that we could have done better was to have a guide for the phone. I think we did it afterwards but from the beginning just giving people like an easy guide or step guide on how to use the phone itself how to unlock it and how to get to the app like that. [Cristina:98-101] Um (laughs) my first thought I have to say, was, because I've never worked with people with paranoia before using blended therapy […] and I was a little bit like, "oh I wonder how people will take the technology element". 'Cause people can feel quite paranoid about technology. Um, and I was really interested that actually that wasn't the problem people had. [Laura:374-380]
	Safety amongst the platform's scaffolding	**Yes 8/8**	it can be really helpful if they're kind of, if someone's got lost in a bit of a tangent […] I supposed he [the client] could get tied in his thinking quite a lot so it's quite useful to have that tool of "let's just come back to this we're going to cover the content of this and see how it fits with you". And so I think it can be really useful to have that sort of extra tool in the room to bring you both back if you gone off on a tangent somewhere about something else so. [**Frances:207-213]** Draws you back in yeahh. Keeps you focused; I think. **[Frances:218]** I have the framework of SlowMo to kind of guide the *gennerralll* theme of the session. [**Adrian:440-441]** the person brings the personal examples. You know you have the material there. You know what you have to do. But at the same time, just because it's there, you will have more time to adapt it to the person **[Cristina:53-55]**

			knowing that all the intervention bits all the components of the intervention that I would have used if I wasn't using SlowMo are there, but they're structured in very seamless very very, in a way that makes sense for people and it's all kind of there in a plate for you to use so it's made simple for everyone. **[Matilda:357-360]** I suppose if you weren't using that technology then you're kind of relying on your memory to remember, unless you've known about having this conversation in advance, and then you would perhaps bring something with you into the session. […] it was useful to have that on the screen and to be able to go back and replay them as well, that was very useful, because sometimes I found that clients couldn't take in what they were hearing and what they were seeing at the same time, so to be able to go back and replay it a couple of times was useful. [**Jordan:364-371]** I guess yeah, the clarity is as a therapist it's clear to me what I'm trying to facilitate what I'm trying to focus on what I'm trying to sort of yeah facilitate through these sessions. **[Dana:171-173]** I think it's nice because as a therapist often you want to be really collaborative with somebody but if you're giving information all the time and they might not agree or they you you need to be slightly tentative. what's good in SlowMo is that the computer gives the information and you can discuss it together so it's it's it kind of takes some of that difficulty away as well I guess. [**Amy:193-197]** I think that message is so consistent across the sessions it helps you as a therapist to have the message straight which helps you kind of deliver it better. **[Laura:182-183]** Yeah um- yeah I guess I hadn't really realised until talking to you that actually it did give you the freedom to kind of be- 'cause I think we're always taught to be kind of curious and open and the whole point of therapy is to kind of have this guided discovery that you're hopefully leading in some way because of your theoretical knowledge. But this lets you have that extra freedom to be even more curious even more open and to act as if you're learning alongside […] um the patient. **[Laura:607-614]**
	Achieving connection through the "group effect"	**Yes 8/8**	There are other people who feel like this you're not alone, here look, listen, there's three of them! […] you can hear them speaking. I think that sort of thing is really helpful, yeah, for you to be able to prove it, yeah. [**Frances:336-338**] Um where it's really been able to break that intense- that intensity I think by going "OK well why don't we hear about you know what's happened to this person, or why don't we look at the computer now." And so I think he has found that useful as a sort of, I don't know, I guess a break

			from the intensity but still kind of you know learning from the materials. Um, so I I found it being, yeah really helpful for him. **[Adrian:140-144]** it's been kind of, I guess humbling for me to see that, you know even though I've been trying to be normalising to provide those messages, but that sometimes because it's coming from me, it might not have the same resonance as coming from a a service user, if you like **[Adrian:393-396]** giving examples from other people um helped a lot. Umm even if they were um you know coming from a technological platform or technology platform, we explained that this was based on like real people experiences so it felt um, yeah like people were accepting this (short pause) […] listening from other people and not me saying "oh there are people saying that they experience blah blah blah" it was coming from someone saying it you know with a little illustration and I think that helped as I said that helps for them to open up [**Cristina:136-143**] […] I've seen leaps in that sense when I presented the video clip and they went "*yeah that's exactly how I feel that's amazing! oh can I find out more about that?*!" (*enthusiastic tone*) and this genuine interest for what we we're discussing in the context that we're discussing and almost being thankful that that person is there taking time to show you this and to guide you through this. And with SlowMo you just have that, already, in a package. You don't have to go look for something that fits with a person's experience it's already there. [**Matilda:703-709**] it's given us sort of a different focus cause I think sometimes people can struggle when you're just talking to them and you're using sort of eye contact a lot and it can feel a bit more intense. […] I think sometimes people find it easier to open up when they're not feeling under that pressure. [Jordan:73-77] I think sometimes they can be a bit sceptical that you might be just saying it you know just to make them feel better or something. Whereas I think when they have another format where they're seeing it, it's not just you saying it, but they're looking at it or their hearing it as well it just adds that bit more umph to it I think, a bit more yeah just makes it a bit more real [**Jordan:349-354]** the flow of the session I've noticed positive engagement the fact that it's not face to face constantly talking back and forth I think my experience um people can find it difficult to talk for you know 50 minutes or so particularly with issues of concentration, distraction of voices and all sort of things. I've noticed that people just engage and that sort of the switching of attention between let's do a little bit with the web app let's do a little bit of reflection it's worked really naturalistically. It's opened-up conversations I feel in a way that I- is better than I anticipated. [**Dana:130-136**]

			There is also another component which means that you know for part of the session both my attention and the clients attention will be on that on the screen, and we'll be discussing things that we've heard together so it feels in a way sometimes um it allows you to be really collaborative. **[Amy:101-105]** I know that I've had um previous patients who find it a little bit, um, I don't think intimidating is the right word, but um, just a lot you know, to, to be face to face with somebody. Talking directly about them, all the questions are, you know what's you and your experience, and it feels quite like vulnerable I guess, especially for people with a high-level of paranoia. **[Laura:231-235]**
	Sharing an empowering experience	**Yes 5/8 (Minus Adrian, Cristina, Jordan)**	using a tool like that can then be really helpful for people and it does speak with them because then they're like "oh wow not only do other people think like this or have these experiences somebody's gone to the trouble of making something all about it" so I think that can be really for some people that can be really validating I think **[Frances:115-120]** I think there's nothing better to improve someone's relationship than them feeling truly understood and them feeling that the therapist is truly making an effort to kind of make them feel comfortable and um (pause) I guess you know the word is really understood **[Matilda:692-694]** my experience with the laptop in sessions is almost overwhelmingly positive um. […] I think there's a sense of people engaging and thinking of actually doing something and you know the start when someone sets up their profile and puts their name then chooses the colour and creates you know, there's a sense of action and being an agent in the session so which I think is quite nice and it happens early. **[Dana:290-295]** I think part of it comes from as well like getting the person to use a computer and um, them having ownership over it. And I think as a therapist working with people with psychosis you're always mindful of any sort of power imbalance you're always trying really hard to kind of make that as equal as possible. And I think that kind of giving that person access to that computer and them typing what they want, really gives the control over to them […] and helps them to feel quite invested in it. **[Amy:520-526]** Which is just nice to give to people who don't have very much often, uh just a nice experience. That they feel that they've been thought about and this thing has been designed for them. So yeah, I think it's cool. **[Laura:431-433]**
	The evolving professional self	**Yes 7/8 (Minus Cristina)**	you know like with CBT you're often trying to get people "you know in that moment what did you think, in that moment what did you feel?" and people aren't gonna get out their bit of paper and start writing. So, it really you know lends itself really well to what therapists have been trying to get

			people to be able to do. It's much more accessible for them now potentially to do that, so I think that's really useful. [**Frances:397-402]** when I'm working psychologically with people it's really those two things [*rapport and collaboration*] that are key. I think the techniques and the tools that we have are useful, but I think it's those things that really make a difference. If you don't have those things, the best tools and techniques and jazzy apps and stuff are just not going to do it. **[Adrian:63-67]** So to be very honest it makes me think that with more with other disorders having these sort of personal experiences in a nutshell that we can use here and there in therapy would be just perfect to have. **[Matilda:543-546]** I think it's quite important that that we actually find out what the therapists experiences are because I think there might be perhaps apprehension from umm therapists from psychologists in general about using blended therapy. Uh there's usually kind of a bit of resistance to doing things differently […] to kind of um dissipate this idea that it's a tough therapy to do, because I don't think it is. **[Matilda:25-35]** I suppose that you know I think it is a useful tool and it's important to have an open mind to using a kind of blending therapy, but thinking about maybe making that potentially a bit more flexible **[Jordan:502-504]** think the SlowMo as it stands delivering the content it's not you know, you could envisage it being disseminated quite widely and wouldn't necessarily need people with huge, huge experience **[Dana:219-221]** varying the focus of attention within within the session seems quite helpful to me in a way which obviously wasn't my experience before. [**Dana:453-454]** it really really helps, it really helps, it's really good, I really like it. I'm going to be sad when it finishes, yeah, I'll be sad. [**Amy:665-666]** I personally didn't have this, but I could definitely **see** if people have like back-to-back caseloads and that kind of thing, if you're really um, familiar with what comes in each session […] you don't have to necessarily have to prep in the same way you would for a completely separate bespoke non-manualised session. **[Laura:146-151]** I think it's something I'd definitely use in the future and I'd encourage other therapists to have a go at the very least because it is like it's a really interesting way of working. **[Laura:803-805]**