Individual psychological therapy in acute inpatient settings: Service user and

psychologist perspectives

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

The role of the acute inpatient ward is to manage mental health crisis and promote recovery. Recent government initiatives have called for greater provision of psychological services in inpatient acute wards. However, there is little research into the experiences of engaging in individual psychological therapy in this setting.

Part 1 is a review of the literature evaluating the therapeutic alliance in psychological therapy for psychosis. It focuses on the measurement, predictors and outcomes associated with the alliance. A total of 21 studies were reviewed and findings were collated using a vote counting method. Eight studies examined the relationship between alliance and outcomes, and 18 examined the predictors of the alliance. The majority of studies used standardised measures of the alliance rated from both client and therapist perspectives. There was a lack of consistent findings between studies examining the predictors and outcomes associated with the alliance.

Part 2 is a qualitative study exploring service users' and psychologists' experiences of engaging in individual psychological therapy on an inpatient acute ward. It focuses on the process of forming a therapeutic relationship, and challenges to delivering psychological therapy. Semi-structured interviews were conducted with eight service users and the six psychologists they worked with. Accounts were analysed using thematic analysis. For service users and psychologists, building a trusting, collaborative and human relationship was vital to the therapeutic work within the wider system on the ward.

Part 3 is a reflective discussion of the process of conducting the research reported in Part 2. It considers three areas: the subject of self-reflexivity, the process of interviewing service users and psychologists, and several clinical issues concerning the development of therapeutic relationships in the inpatient setting.

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Part 1: Literature Review

The therapeutic alliance in the psychological treatment of psychosis: A review

of measurement, outcomes and predictors

Abstract

Aim: This review aimed to critically evaluate research investigating the therapeutic alliance in the psychological treatment of psychosis. It examined the measurement of the alliance, the relationship between alliance and outcomes, and key predictors of the alliance in the psychological treatment of psychosis.

Method: Studies were identified through a systematic search of PsycINFO, PubMed and a citation search on Web of Science. The review used a vote counting method (Hedges & Olkin, 1980) to collate and assess the evidence across studies.

Results: Twenty-one studies were reviewed: eight examined the relationship between alliance and outcomes, and 18 examined predictors of the alliance. The majority of studies used the WAI or CALPAS rated from both client and therapist perspectives. A broad array of psychological functioning and adherence outcome measures were used; there were no consistent associations between alliance and outcomes across studies. The most frequently studied predictor variables were symptoms, insight, and cognitive and global functioning; the most consistent finding was that greater insight was associated with stronger client-rated alliance.

Conclusions: Most standardised therapeutic alliance measures have been established in outpatient settings and require greater assessment of their psychometric properties in severe and enduring populations and settings. There was little agreement across the studies in the type of outcome and predictor measures used to examine the association with the therapeutic alliance. Studies also varied widely in their methodological quality and rigour. These problems are likely to have contributed to the inconsistent findings. The association between insight and the alliance should be investigated in future research.

Introduction

The therapeutic alliance has been widely recognised as an integral feature of the psychotherapeutic process (Catty, 2004) and one of the strongest and most robust predictors of treatment success (Wampold, 2015). The concept of the therapeutic alliance originated in psychodynamic therapy, but its role in the therapeutic process has since been recognised across other theoretical orientations (Horvath & Symonds, 1991). The therapeutic alliance is broadly defined as the collaborative and affective relationship between the therapist and the client (Bordin, 1979). The collaborative elements include the extent of agreement about the goals of therapy and the tasks engaged in to achieve those goals; the affective element refers to the "bond" between client and therapist, including mutual trust, respect and caring.

Several meta-analytic reviews have concluded that there is substantial evidence for a link between the alliance and therapy outcomes (e.g. Horvath, 2001; Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Consistent with previous findings, the most recent meta-analytic review of 190 data sources found a moderate relationship between the alliance and therapeutic outcomes (Horvath et al., 2011). The association was found to be consistent, irrespective of how the alliance was measured, from whose perspective it was evaluated, and the type of therapy involved. However, major methodological issues have been identified in the alliance-outcome literature that have limited our understanding of the degree and mechanisms by which the alliance develops and influences therapy outcomes (Crits-Christoph, Gibbons, & Mukherjee, 2013).

Many studies examining the relationship between alliance and outcomes measure the change from baseline to treatment termination, and correlate this with a

single measure of the alliance taken at some point during treatment. Within the limitations of this correlational design, there are several interpretations that could be made about the association between alliance and outcome. One possibility is that improvement in symptoms from baseline to the point when the alliance is measured could 'cause' a positive alliance (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000). Thus, it has been suggested that to avoid this, studies should examine the relationship between the alliance and subsequent symptom change after the measurement of the alliance (Barber et al., 2000). Furthermore, the common practice of the alliance and therapy outcome data being rated by the same individual, usually the therapist, may artificially inflate the magnitude of the relation between the two (Horvath & Symonds, 1991).

The alliance in the psychological treatment of psychosis

Over the past several decades there have been advances in the understanding of psychosis, leading to the recent development of novel and effective psychological treatment approaches (Mueser, Deavers, Penn, & Cassisi, 2013). Because such treatments are relatively new, alliance-outcome reviews to date have included only a small minority of studies examining the alliance in the psychological treatment of severe and enduring mental illness (e.g. Martin et al., 2000). These studies often included smaller samples with mixed diagnoses, impeding the investigation of the alliance in particular diagnostic groups such as psychosis.

There is reason to believe that the concept of the therapeutic alliance may differ in the psychological treatment of psychosis, compared to other populations. The symptoms associated with psychosis are unlike those of other mental health disorders. For example, negative symptoms of psychosis can significantly impair social and interpersonal functioning, and persist even after successful treatment

(Wiersma, Nienhuis, Slooff, & Giel, 1998). Also, delusional understanding of the therapeutic context and poor insight into mental health symptoms is more frequent in this population, leaving the therapeutic alliance potentially more vulnerable to rupture (Wittorf et al., 2010). The setting and nature of psychotherapeutic intervention for those with psychosis is also likely to differ substantially from other populations. Treatment for psychosis is more likely to occur in inpatient settings, often with a greater focus on concurrent medical intervention (e.g. Priebe & McCabe, 2006). Thus, the findings from research with non-psychotic populations may not be generalisable to this population, highlighting the need to understand the way in which the alliance can be best measured and conceptualised in psychological treatment for psychosis.

Among several studies, the formation of a positive alliance in individuals with psychosis has been associated with a range of diverse outcomes, such as reduced positive and negative symptoms, improved self-esteem and global functioning, and greater medication compliance (Frank & Gunderson, 1990; Gehrs & Goering, 1994; Neale & Rosenheck, 1995; Olfson, Glick, & Mechanic, 1993; Solomon, Draine, & Delaney, 1995; Svensson & Hansson, 1999). However, these findings have not been consistent and there is no agreement on whether the client's or the therapist's alliance ratings are better predictors of outcomes (Frank & Gunderson, 1990; Gehrs & Goering, 1994; Hammond, 2004; Svensson & Hansson, 1999). Evidence suggests that the alliance may take much longer to form in psychotherapeutic work for psychosis (Frank & Gunderson, 1990), and those who fail to develop a positive alliance are more likely to show a deterioration in symptoms (Dunn et al., 2012). Thus, it is important to understand not only the

outcomes associated with the alliance in psychological treatment of psychosis, but also what predicts the formation of a positive alliance.

Measurement of the alliance in the psychological treatment of psychosis

Most quantitative measures of the alliance constitute self-report measures for clients and therapists, or observers. These instruments have been used to measure the therapeutic alliance in a range of psychotherapies (Horvath & Luborsky, 1993), and more recently for clients with psychosis (e.g. Goldsmith, Lewis, Dunn, & Bentall, 2015). The California Psychotherapy Alliance Scale (CALPAS; Gaston & Marmar, 1994), and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) are the two most widely used measures in psychiatric research (McCabe & Priebe, 2004). These measures were developed to assess several key conceptualisations of the alliance. For example, the CALPAS assumes the alliance is a dynamic process influenced by the client's working capacity and commitment, the therapist's understanding and involvement, and the overall agreement on goals and strategies. The WAI is based on Bordin's (1979) conceptualisation of the alliance including three key elements: the attachment between the client and therapist (bonds), the level of collaboration in the tasks of therapy (tasks), and the agreement on the overall objectives (goals).

To date, only one review has focused on the measurement of the alliance for those with severe mental illness, in particular on the relationship between patient and 'primary mental health professional' in psychiatric settings (McCabe & Priebe, 2004). This review used a broad definition of 'severe mental illness' and examined relationships in the context of psychiatric case management, pharmacological rehabilitation as well as psychotherapeutic contact. However, since this time a number of studies have emerged specifically investigating the alliance between

therapist and client in the psychological treatment of psychosis. These studies are an important addition to the literature, which have the potential to increase our understanding of the development and nature of the alliance in the psychological treatment of psychosis. Furthermore, these studies have utilised several new measures of the alliance specifically developed for this population, which have thus far not been subject to review.

McCabe and Priebe (2004) highlighted that valid assessments of the alliance should take account of the aspects of the therapeutic relationship unique to psychiatric settings and populations. For example, patients often receive several concurrent interventions, and care is provided in a range of community and hospital settings (McCabe & Priebe, 2004). In the psychotherapeutic treatment of psychosis, both symptoms and settings might be expected to impact on the validity of the alliance measures. For example, it is likely that disturbances in insight may result in the clinician and patient holding contradictory perspectives on the nature of the problem, leading to less agreement on the tasks and goals of therapy. As such, the construct of alliance defined by these measures may be less applicable in this population, and lead to stronger associations between therapist-rated, rather than patient-rated, alliance and outcomes in the treatment of psychosis. Furthermore, the predictive validity of alliance measures is likely to be influenced by the type of therapy. For example, certain therapies such as Cognitive Behavioural Therapy may make 'tasks' and 'goals' more explicit and central to the process of therapy, compared to others such as Supportive Counselling, which may emphasise the emotional bond between client and therapist. Therefore, it is important to have an understanding of the types of measures used to assess the alliance in the psychotherapeutic treatment of psychosis and their psychometric properties when

used with this population.

Aims of the review

This review aimed to examine the research to date investigating the alliance in the psychological treatment of psychosis. Specifically, the review addressed the following questions:

1. How has the therapeutic alliance been measured and rated in the psychological treatment of psychosis?

2. What is the relationship between the therapeutic alliance and main outcomes in the psychological treatment of psychosis?

3. What are the main predictors of the therapeutic alliance in the psychological treatment of psychosis?

Method

Inclusion and exclusion criteria

Studies were included for review if they met the following criteria:

1. Used a quantitative measure of the therapeutic alliance, either rated by the client, therapist, or an observer.

2. Examined the therapeutic alliance in the context of one-to-one, face-to-face psychological therapy. Studies examining the therapeutic alliance in the context of other forms of intervention, such as psychiatric case-management or group therapy, were excluded.

3. Included analysis of predictors of the therapeutic alliance, or how the therapeutic alliance related to relevant outcome variables.

4. Included participants with primary diagnoses of schizophrenia spectrum disorders. This included clients who were considered to exhibit symptoms of 'early psychosis' or clients with a long-standing diagnosis. Studies of clients

with a range of diagnoses, or clients with an alternative primary diagnosis, were excluded.

Search strategy

The main literature search was conducted using PsycINFO and PubMed databases in August 2015. The results were limited to English only, and peer-reviewed journals with no date limits set. The search included text word and thesaurus terms to ensure that the search did not miss studies that may not have been assigned key search terms. The search terms used were derived from reading previously identified published papers in the area and conducting several scoping searches.

Search on PsycINFO

The search was structured around the three main concepts for inclusion: the therapeutic alliance, psychosis and psychological therapy. Text words and thesaurus terms were chosen for each concept. This was particularly important in describing the concept of psychological therapy, which is often defined based on the therapeutic approach of each study. Scoping searches revealed that many of the relevant studies used Cognitive Behavioural Therapy (CBT) or Supportive Counselling (SC) in the treatment of psychosis. Thus, these terms were defined specifically alongside terms aiming to capture other possible psychological therapies. The following search strategy was used:

Psychological therapy: exp cognitive therapy/ exp cognitive behavior therapy/ exp psychotherapy/ exp psychology/ exp counseling OR Cognitive behav* therapy or psychotherapy* or psychological therapy or CBT or CBTp or counsel*

Therapeutic alliance: exp therapeutic alliance OR Therapeutic alliance or

therapeutic relationship or alliance or working alliance

Psychosis: exp psychosis/ exp acute psychosis/ exp schizophrenia/ exp

schizoaffective disorder/ exp auditory hallucinations/ exp

delusions/ exp hallucinations OR Psychosis or schizophrenia

or schizo* or schizo-affective or voices or delusion

Exp. indicates that the term was 'exploded' within the search to include related subject headings and descriptors. Each step of the search was conducted separately before combining all three concepts with AND.

Search on PubMed

The search within PubMed was similarly based around the central three concepts. A thesaurus search feature [Medical Subject Headings (MeSH)] hierarchically structures descriptors based on their relatedness to other concepts and level of specificity. This feature allows for terms to be 'exploded' and more specific related terms to be added to the search. Where terms were not available in the thesaurus feature, a text word search was conducted. The following search strategy was used:

Psychological therapy: MeSH cognitive therapy/ MeSH psychotherap*/ (MeSH

cognitive behav* AND therapy)/ MeSH psycholog* therap/

MeSH counsel*/ (MeSH behavior therapy, cognitive)/ MeSH

cognitive behavior therapy OR CBT or CBTp

Therapeutic alliance: alliance or therapeutic alliance or working alliance or

therapeutic relationship

Psychosis: MeSH schizophrenia/ MeSH psychosis/ MeSH voices/ MeSH delusions/

MeSH hallucinations OR schizo-affective or schizoaffective

Study selection

Figure 1 shows the study selection process. Following the database searches, all the abstracts of the identified studies were reviewed for eligibility. Studies that were considered to meet the inclusion criteria were then reviewed in full to make a final decision on their eligibility. Finally, to ensure that all papers relevant to this field had been identified, a citation search was performed in Web of Science on a key reference, Svensson and Hansson (1999). (This paper has been cited in much of the relevant literature on the subject of both predictors of the therapeutic alliance and the relationship between alliance and outcome in psychological treatment for psychosis). The papers identified by the citation search were then reviewed in full against the eligibility criteria, and those not already identified by the database searches were added to the review.

In some cases, there was uncertainty about whether studies met the inclusion criteria: these were discussed with a second researcher in order to come to a decision about eligibility. For example, in several studies the sample included participants with a secondary diagnosis of substance misuse. However, since the therapy in these studies mainly focused on the treatment of psychosis, the decision was taken to include these studies.

Appraisal of studies

The review aimed to assess the quality of reporting, design, conduct and analysis of the studies. Numerous critical appraisal tools have been developed for evaluating the quality of evidence across research studies. However, a review of critical appraisal tools designed for allied health research concluded that there is no 'gold standard' appraisal tool, nor any tool that can be applied across study types (Katrak, Bialocerkowski, Massy-Westropp, Kumar, & Grimmer, 2004). Several

Figure 1. Process of study selection


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┌─────────────────────────┐
│ Database Search         │
│ 411 PubMed              │
│ 286 PsycINFO            │
│ Total 697               │
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┌──────────────────────────────────────────────────────┐
│ First screening – Abstract                             │
│ Excluded N=629                                         │
│ 310    Not individual psychological therapy            │
│ 178    Review/theoretical/intervention                 │
│ 55     Not Psychosis                                   │
│ 52     No measure of therapeutic alliance              │
│ 40     Duplicates                                      │
│ 6      Qualitative                                     │
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┌─────────────────────────┐
│ 68 for close reading    │
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┌──────────────────────────────────────────────────────┐
│ Second screening – Full paper                          │
│ Excluded N=49                                          │
│ 21     Not individual psychological therapy            │
│ 14     Review/theoretical/intervention                 │
│ 5      Not psychosis                                   │
│ 4      No measure of therapeutic alliance              │
│ 3      No predictor or outcome variables               │
│ 2      Qualitative                                     │
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┌─────────────────────────┐
│ 19 for inclusion        │
└─────────────────────────┘
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┌──────────────────────────────────────────────────────┐
│ Web of science citation search (Svensson &             │
│ Hansson, 1999)                                         │
│ Included N=2                                           │
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┌─────────────────────────┐
│ 21 studies selected     │
│ for inclusion           │
│ 18 predictor studies    │
│ 8    outcome studies    │
└─────────────────────────┘
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appraisal tools were considered for the present review; however, none were entirely applicable to either body of studies reviewed. Therefore, several areas of consideration were selected from critical appraisal tools that were relevant to the aims of the review. This included assessing the psychometric properties of the measures of the therapeutic alliance, the selection and rating of outcomes, and the specific design considerations for predictor studies. This review used a vote counting method (Hedges & Olkin, 1980) to collate and assess the quantitative evidence across studies. This involved reporting the number of positive associations between alliance ratings and variables clustered into relevant categories across the studies. In some cases, studies included more than one measure within a certain category and may have reported more than one finding, but for the purpose of this review this was presented as a single positive vote if the study reported at least one positive association.

Results

The first section of the results provides an overview of all the studies reviewed. Section two considers how the alliance was measured across all studies. Section three reviews the studies examining the relationship between alliance and outcomes, and section four reviews the studies examining the predictors of alliance.

Section one: Overview of studies

Tables 1 and 2 summarise the characteristics of the 21 studies that met the criteria for the review. Eight studies examined the relationship between alliance and outcomes, and 18 examined the predictors of the alliance. Five studies included both outcome and predictor variables and are therefore reviewed in both sections three

Table 1. Characteristics of outcome studies

Study	Setting and participants	Therapy	Alliance measure	Main outcome measures
Berry et al. (2015)	Outpatient, N=135	CBTp and MI 26 sessions	WAI-Short (Client and therapist) Rated session 3	End of therapy forms Global Assessment of Functioning (GAF) Substance misuse Positive and Negative Symptom Scale (PaNSS)
Dunn et al. (2006)	Outpatient, N=29	CBTp Up to 35 sessions	CALPAS-Short (client) CALPAS-Long (therapist) Rated session 3, 9, 15 and 21	Positive and Negative Symptom Scale (PaNSS) Suitability for Short Term CT Scale to assess homework compliance
Frank & Gunderson (1990)	Inpatient and outpatient, N=143	Exploratory Insight Oriented (EIO) and Reality Adaptive Supportive (RAS) psychotherapy. 6 months-2 years	AE (therapist) Rated monthly	Length of stay in treatment Medication compliance Ratings of functioning (e.g. cognitive functioning, social functioning and role performance).
Goldsmith et al. (2015)	Inpatient and outpatient, N=308	CBTp or SC 8 sessions	CALPAS-Short (Client) Rated session 4	Number of sessions attended 18 month follow up PaNSS score
Huddy et al. (2012)	Outpatient, N=49	CRT 40 sessions	WAI-Short (client and therapist) Rated session 4	Working memory (WAIS-III) Target complaints scale Rosenberg Self-esteem Scale
Jung et al. (2014)	Outpatient, N=80	CBTp 30 sessions	STEP (Client and therapist) Rated each session	Positive and Negative Symptom Scale (PaNSS) Calgary Depression Scale for Schizophrenia Global Severity Index (GSI) Social functioning

Startup et al. (2006)	Inpatient and outpatient, N=29	CBTp Less than 12 sessions	AE (therapist) Rated every session WAI-Observer rated from two recordings	Drop out (attended less than 12 sessions)
Svensson & Hansson (1999)	Inpatient, N=28	Therapy based on CT 15-140 sessions	PSR (therapist) Scale adapted from Allen et al. (1988) (Client) Rated every 5 weeks	Hopkins Symptoms checklist Comprehensive psychopathological scale Quality of life interview Target complaints interview Global Assessment of Functioning (GAF)

Table 2. Characteristics of predictors of alliance studies

Study	Setting and participants	Therapy	Alliance measure	Predictors measured
Barrowclough et al. (2010)	Outpatient, N=116	CBTp and MI	WAI-Short (Therapist and client) Rated session 4	Social/occupational functioning (GAF) Calgary Depression Scale for Schizophrenia Substance use Inventory of drug use consequences Attitude to treatment (Readiness to Change, Drug Attitudes) Positive and Negative Symptom Scale (PaNSS)
Berry et al. (2015)	Outpatient, N=135	CBTp and MI	WAI-Short (Therapist and client) Rated session 3	Psychosis Attachment Measure (PAM)
Couture et al. (2006)	Outpatient, N=30	CBT or psychoeducation	WAI-Long (Therapist and client) Rated session 5	Positive and Negative Symptom Scale (PaNSS) Social Functioning Scale
Davis et al. (2011)	Outpatient, N=63	CBTp and SC	WAI-Short (Client) Rated monthly	Metacognition Assessment Scale (MAS) – mastery subscale
Davis & Lysaker (2004)	Outpatient, N=24	CBTp	WAI-Short (Therapist and client) Rated 3 months	Hopkins Verbal Learning Test (HVLT) Vocabulary and block design subtests of WAIS-III Attention (Conners Continuous Performance Test II)

Dunn et al. (2006)	Outpatient, N=29	CBTp	CALPAS. (Therapist and client) Rated sessions 3,9,15,21	Positive and Negative Symptom Scale (PaNSS) Suitability for short term cognitive therapy
Evans-Jones et al. (2009)	Outpatient, N=29	CBTp	WAI-Short (Therapist and client) Rated between sessions 2 - 9	Client factors: Subjective Experience of Negative Symptoms Scale (SENS), Beck Cognitive Insight Scale, Baseline Functioning Scale, Reaction to Hypothetical Contradiction Measure, The Psychotic Symptom Rating Scales (PSYRATS), Scale for the Assessment of Positive Symptoms (SAPS) Therapist factors: Therapist attractiveness, competence, and trustworthiness (CRF), Relationship Inventory (therapist empathy) Therapy factors: Presentation of a Case Formulation Checklist, CBTp Checklist
Huddy et al. (2012)	Outpatient, N=49	CRT	WAI-Short (Therapist and client) Rated session 4	Social skills (Work Behaviour Inventory) Cognitive skills (WAIS-III, California Verbal Learning test) Hospital Anxiety and Depression Scale (HADS) Positive and Negative Symptom Scale (PaNSS)
Johansen, Melle, Iversen, & Hestad (2013)	Inpatient and outpatient, N=42	Eclectic interpersonal CBT	WAI-Short (Therapist and client) Rated within first year	Personality traits (NEO-FFI) Interpersonal problems (IIP-64C) Positive and Negative Symptom Scale (PaNSS)
Johansen, Iversen, Melle, & Hestad (2013)	Inpatient and outpatient, N=42	Eclectic interpersonal CBT	WAI-Short (Therapist and client) Rated within first year	Positive and Negative Symptom Scale (PaNSS) General intellectual functioning: 4 subtests of WAIS-III Verbal memory: California Verbal Learning Test II Executive functioning: Wisconsin Card Sorting Test Attention: (CPT-II)

Jung et al. (2014)	Outpatient, N=80	CBTp	STEP (Therapist and client) Rated every session	Positive and Negative Symptom Scale (PaNSS) Calgary Depression Scale for Schizophrenia Global Severity Index (GSI) Social functioning Theory of Mind
Jung et al. (2015)	Outpatient, N=48	CBTp	HAQ (Therapist) PSB (Client) Rated session 5	Therapist empathy, genuineness, and positive regard (BQTC) Therapist competence and convincingness (QARTC) Positive and Negative Symptom Scale (PaNSS)
Kvrgic et al. (2013)	Outpatient, N=156	SC	STAR-P (Client) Rated at 3 months	Recovery Assessment Scale (RAS) Self-Stigma (Corrigan's Self-stigma in Mental Illness Scale) Birchwood Insight Scale (BIS) Positive and Negative Symptom Scale (PaNSS) Psychosis Attachment Measure (PAM) Becks Depression Inventory-II
Lysaker, Davis, Buck, Outcalt, & Ringer (2011)	Outpatient, N=40	CBTp	WAI-Short (Therapist and client) Rated monthly	Positive and Negative Symptom Scale (PaNSS) Scale to Assess Unawareness of Illness (SUMD)
Lysaker, Davis, Outcalt, Gelkopf, & Roe (2011)	Outpatient, N=40	CBTp	WAI–Short (Therapist and client) Rated monthly	Trauma Assessment for Adults (TAA) Positive and Negative Symptom Scale (PaNSS)

Svensson & Hansson (1999)	Inpatient, N=28	Therapy based on CT	PSR (Therapist) Scale adapted from Allen et al. (1988) (Client) Rated every 5 weeks	Hopkins Symptoms checklist Comprehensive psychopathological scale Quality of life interview Target complaints interview Strauss Carpenter functioning criteria Global Assessment of Functioning (GAF)
Wittorf et al. (2009)	Outpatient, N=80	CBTp and SC	TSQ (Therapist) PSQ (Client) Rated session 3	Positive and Negative Symptom Scale (PaNSS) Scale to Assess Unawareness of Illness (SUMD)
Wittorf et al. (2010)	Outpatient, N=67	CBTp and SC	TSQ (Therapist) PSQ (Client) Rated sessions 3,6,9,12	Positive and Negative Symptom Scale (PaNSS) Scale to Assess Unawareness of Illness (SUMD) Use of cognitive disputing strategies

and four (Berry et al., 2015; Dunn, Morrison, & Bentall, 2006; Huddy, Reeder, Kontis, Wykes, & Stahl, 2012; Jung, Wiesjahn, & Lincoln, 2014; Svensson & Hansson, 1999).

A total of 15 studies were conducted in outpatient settings, one was conducted in an inpatient setting. Five studies included participants from both inpatient and outpatient settings, or continued therapy from inpatient into outpatient settings. In terms of therapeutic approaches, eight studies included CBT for psychosis (CBTp) only, and seven included variations of Cognitive Therapy (CT; including CBT combined with Motivational Interviewing [MI], therapy based on CT principles, CBT or psycho-education, Cognitive Remediation Therapy [CRT], and 'eclectic interpersonal cognitive-behavioral theories'). Four studies included both CBT and SC, one focused on SC only, and one included a version of non-traditional psychotherapy.

Sample sizes ranged from 24 to 308 participants. None of the 21 studies reported power analysis as a means of determining sample size. The majority of studies (n=14) collected data from the treatment conditions of large-scale randomised control trials. As a result, several studies measuring predictors either recruited from the same treatment trials, or used the same samples in their analyses. Davis and Lysaker (2004), Lysaker, Davis, Outcalt, Gelkopf and Roe (2011) and Lysaker, Davis, Buck, Outcalt and Ringer (2011) used the same sample, and Davis et al., (2011) recruited from the same trial. Berry et al., (2015) and Barrowclough, Meier, Beardmore and Emsley (2010) recruited from another large-scale trial. Wittorf et al. (2009) and Wittorf et al. (2010) used the same sample in their studies. Similarly, Johansen, Iversen, Melle and Hestad, (2013) and Johansen, Melle, Iversen and Hestad (2013) used the same sample of consecutively admitted patients. The

remaining studies recruited from consecutively admitted patients (n=4), or opportunistically from therapists or centres offering psychological therapy (n=3).

Section two: Measurement of the alliance

The 21 studies used a combination of nine different therapeutic alliance measures (summarised in Table 3). Most studies included one alliance scale rated from different perspectives; however, three studies analysed ratings from several alliance measures (Jung, Wiesjahn, Rief, & Lincoln, 2015; Startup, Wilding, & Startup, 2006; Svensson & Hansson, 1999). In the majority of studies, both clients and therapists rated therapeutic alliance. Startup et al. (2006) included therapist and observer ratings, while Frank and Gunderson (1990) used therapist ratings only. Five studies (Davis et al., 2011; Dunn et al., 2006; Goldsmith et al., 2015; Jung et al., 2015; Kvrgic, Cavelti, Beck, Rüsch, & Vauth, 2013) only used client ratings in their analyses.

Content and background of alliance measures

The WAI and CALPAS measures were based on differing theoretical conceptualisations and developed with clients with various diagnoses mainly engaged in short-term therapy in outpatient or private practice settings (Gaston, 1991; Horvath & Greenberg, 1989). Similarly, the HAq was created to empirically test Luborsky's (1976) psychodynamic conceptualisation of the alliance. The Short Inventory for Individual Psychotherapy (STEP) (Krampen, 2002) was designed to assess therapeutic alliance, problem solving, and motivational influences in psychotherapy.

Several of the measures were developed specifically for use with severe and enduring mental illness. The Active Engagement (AE) scale is an abbreviated version of the Psychotherapy Status Report (PSR), both developed by Frank and

Table 3. Summary of therapeutic alliance measures

Therapeutic alliance measure	No. studies including measure [a]	Rater	Number of items	Example item
Working Alliance Inventory (WAI; Horvath & Greenberg, 1989)	N=12	Client (WAI-C) Therapist (WAI-T) Observer (WAI-O)	12 items (short) 32 items (long)	"We have established a good understanding of the kind of changes that would be good for me"
California Psychotherapy Alliance Scale (CALPAS; Gaston, 1991)	N=2	Client (CALPAS-C) Therapist (CALPAS-T)	CALPAS-C (12 items) CALPAS-T (24 items)	"When your therapist commented about one situation, did it bring to mind other related situations in your life?"
Psychotherapy Status Report (PSR) and Active Engagement Scale (AE) (Frank & Gunderson, 1990)	N=3	Therapist	PSR (15 items) AE (6 items)	"Patient perceives treatment as clearly in his/her interest and, despite anxiety, sticks to the therapeutic task without much interruption or denial of its unpleasantness"
Helping Alliance Questionnaire (HAq) therapeutic relationship subscale (German version) (Bassler, Potratz, & Krauthauser, 2015)	N=1	Client	6 items	"I believe that my therapist is helping me"
Short Inventory for Individual Psychotherapy & Counselling (STEP; Krampen, 2002)	N=1	Client and therapist versions	12 items	"Today I felt that I was understood by my therapist "

Psychosis Specific Bond Scale (PSB; Jung et al., 2015)	N=1	Client	8 items	"My therapist does not believe that I am crazy, even if I tell him/her about my unusual experiences"
Scale adapted from Allen et al. (1989)	N=1	Client	6 items	"I set clear treatment goals"
Bern Post Session Report – therapeutic alliance subscale (Witttorf et al., 2009)	N=2	Client (PSQ) Therapist (TSQ)	3 items	''Today I felt at ease with the therapist''
Scale to Assess the Therapeutic Relationship (German version) (STAR; McGuire-Snieckus, McCabe, Catty, Hansson, & Priebe, 2007)	N=1	Client (STAR-P)	12 items	"My clinician and I have established an understanding of the kind of changes that would be good for me"

[a] *Three studies used more than one therapeutic alliance measure; therefore total n=24*

Gunderson (1990). These scales were based on a review of clinical and research literature and trialed with patients in individual therapy with psychosis. The STAR-P was designed for use in psychiatric settings, and has been trialed in one prospective study in community mental healthcare (McGuire-Snieckus et al., 2007). The Bern Session Questionnaires emphasise the emotional bond between patient and therapist (Wittorf et al., 2009, 2010). Similarly, the Psychosis Specific Bond Scale (PSB) was designed to assess the emotional aspects of the alliance such as mutual trust, respect, and understanding.

The adapted scale from Allen et al. (1988) was designed to measure collaboration in inpatient treatment. It therefore includes items specific to this context, e.g. participation in team meetings.

Psychometric properties of alliance measures

Both the WAI and CALPAS scales have received particularly thorough scrutiny in regards to their psychometric properties compared to the other scales (Martin et al., 2000). The WAI (Horvath & Greenberg, 1989) has been shown to have high construct validity and reliability, as well as correlating with a variety of outcome indices (Horvath, 2001). Similarly, factor analytic studies have shown confirmation for the four aspects of the alliance underlying the CALPAS scale (Gaston & Marmar, 1994). The CALPAS is highly correlated with the WAI and is moderately correlated with outcomes (Martin et al., 2000). However, these studies have been conducted mainly in outpatient settings.

The HAq has less robust convergent validity compared with the WAI and CALPAS (Elvins & Green, 2008), but is moderately correlated with outcome (Martin et al., 2000). The PSR has a high level of internal consistency (Frank &

Gunderson, 1990) and is correlated with outcome in patients with severe and enduring mental illness (Elvins & Green, 2008).

Several of the alliance measures have received less robust empirical scrutiny. The STAR has not yet been used in robust outcome trials (Elvins & Green, 2008), and there is no data specific to the PSQ and TSQ alliance subscales of the Bern Post Session Report. Jung et al. (2015) showed good internal consistency for the PSB and a high positive correlation with the HAq relationship scale, indicating convergent validity. Svensson and Hansson (1999) reported acceptable internal consistency of their 6-item scale based on that developed by Allen et al. (1989).

Suitability of alliance measures

The most commonly used measure of the alliance across studies was the WAI. While this measure may have more established reliability and predictive validity within the literature, a specifically designed alliance scale (e.g. measure adapted from Allen et al., 1989) may be more sensitive to the salient features of the alliance within the psychiatric setting and therefore show greater association with predictors/outcomes. However, the relative lack of validity and reliability data for this measure is problematic.

Only one study (Startup et al., 2006) included observer ratings of alliance, which were then compared with therapist ratings on the Active Engagement (AE) scale (Frank & Gunderson, 1990) ratings. The correlations between the two measures of the therapeutic alliance were all large and highly significant, supporting the view that therapists and observers formed similar views of the state of the alliance, despite different measures.

Section three: Studies examining the relationship between the alliance and therapy outcomes

Measurement of outcome variables

All eight studies assessing therapy outcomes included more than one outcome measure, and diverse measures were used across the studies. The measures were clustered into two broad categories: psychological functioning (including symptoms, substance misuse, target complaints, cognitive functioning, self-esteem, quality of life and functioning variables) and adherence to therapy (including drop-outs, sessions attended, homework compliance and medication compliance). Appendix 1 shows how each outcome variable was clustered and by whom it was rated. Table 4 shows the frequencies of differently rated outcome variables within each cluster.

Table 4. Frequencies and raters of outcome measures across studies

Category (total measures within category)	Client	Therapist	Observer	More than one/consensus	Records
Psychological functioning (N=21)	4	3	9	5	-
Adherence (N=4)	-	-	-	2	2

Design

All studies used a longitudinal design. The majority of studies analysed the relationship between alliance and outcome using correlational and regression statistics. Startup et al. (2006) used repeated measures t-tests. Goldsmith et al. (2015) used structural equation modelling.

Six studies identified that they used correlational analysis with existing measures, and/or included additional measures, to control for potential confounding variables (Berry et al., 2015; Frank & Gunderson, 1990; Goldsmith et al., 2015; Huddy et al., 2012; Jung et al., 2014; Svensson & Hansson, 1999).

Five of the eight outcome studies applied the alliance measure early in therapy between sessions one and five (Berry et al., 2015; Dunn et al., 2006; Goldsmith et al., 2015; Huddy et al., 2012; Jung et al., 2014). While this minimised the likelihood of early symptom improvement affecting the therapeutic alliance, none of the studies examined the subsequent symptom change after the measurement of the alliance to remove the possibility of confounding the association between therapeutic alliance and outcome (Barber et al., 2000). Several studies rated the alliance later in therapy; Svensson and Hansson (1999) calculated a mean alliance score based on the ratings from every session over the first ten weeks, and Startup et al. (2006) calculated a mean alliance score based on the ratings collected every session before they dropped out (i.e. less than 12 sessions attended). Frank and Gunderson (1990) used alliance ratings collected at six months into therapy.

Association between alliance and main psychological functioning outcomes

To understand the strength of the relationship between the alliance and psychological functioning outcomes, the three most frequently used outcome measures (Positive and Negative Symptoms Scale [PaNSS], General Assessment of Functioning [GAF] and target complaints) were examined across studies. Table 5 shows the number of studies that found statistically significant associations between alliance ratings and these outcomes measures, out of the total number of studies testing the same association.

Table 5. Studies reporting significant associations between the alliance and three most common outcome measures

Alliance rating	PaNSS (Observer/therapist rated)	GAF (Therapist/observer rated)	Target Complaints (Client rated)
TA-C[a]	2/4	0/3	1/2
TA-T[b]	0/2	1/3	0/2

[a] client-rated therapeutic alliance. [b] therapist-rated therapeutic alliance.

Jung et al. (2014) found stronger early client-rated alliance was significantly associated with reduced post-treatment negative symptoms and general symptoms with small effect sizes (d = 0.29 to 0.31). Using structural equation modelling techniques, Goldsmith et al. (2015) reported that the client-rated alliance had a causal effect on symptomatic outcome, and that a poor alliance was actively detrimental: increasing the number of sessions for clients with positive alliances contributed to more effective psychological functioning outcomes, whereas increasing sessions for those with negative alliance ratings had a detrimental effect. However, because the structural equation modelling was based on correlational data, firm conclusions about causality cannot be established. Two other studies failed to find any significant findings between client-rated alliance and outcomes using PaNSS measures (Berry et al., 2015; Dunn et al., 2006).

Svensson and Hansson (1999) showed that mean therapist alliance ratings in the first 10 weeks were significantly correlated with residual change in GAF scores with a small to moderate effect size (d = 0.42), but this was not replicated in two other studies (Berry et al., 2015; Jung et al., 2014).

Huddy et al. (2012) found that client-rated alliance was significantly related to residual change in target complaints, however this was not found in Svensson and Hansson (1999). Neither study found any association between therapist-rated alliance and target complaints.

Association between alliance and adherence outcomes

Four studies included adherence outcome measures, only three of which reported the relevant statistical associations (Dunn et al., 2006; Frank & Gunderson, 1990; Startup et al., 2006). In terms of therapy attendance, Frank and Gunderson (1990) found that therapist-rated alliance at six months was moderately correlated

with length of stay in therapy (d = 0.42). Startup et al. (2006) also showed that those who dropped out of therapy had significantly poorer therapist-rated alliance scores (averaged across sessions attended) compared to those who stayed in therapy.

In terms of medication compliance, Frank and Gunderson (1990) found that in the first six months of therapy it was not significantly associated with therapist alliance ratings. However, medication compliance after six months was correlated with the alliance irrespective of baseline symptoms, medication type or dosage (d = 0.37).

Dunn et al. (2006) showed that early client and therapist ratings of the alliance (session three) were significantly associated with both client and therapist ratings of homework compliance with moderate effect sizes (d = 0.48 to 0.51).

Section four: Studies examining the predictors of the alliance

Measurement of predictor variables

The 18 studies that examined the predictors of the alliance included a wide range of variables. These were clustered into nine categories: symptoms (including positive, negative and general symptoms); insight (including insight related to illness and cognition); cognitive; mood; functioning (including social/occupational functioning); therapist qualities; substance misuse; relational factors (including interpersonal, attachment and therapist relationship measures); and other variables (e.g. suitability for therapy, self-stigma). Appendix 2 shows how each outcome variable was clustered and by whom it was rated. While some studies made it clear that measures were rated by an observer, they did not specify whether the observer was blinded or independent to the study. Table 6 shows the frequencies of differently rated predictor variables within each category.

Table 6. Frequencies and raters of predictor measures across studies

Category (total measures within category)	Client	Therapist	Observer	More than one/consensus
Positive symptoms (N=13)	-	2	10	1
Negative symptoms (N=13)	1	2	9	1
General symptoms (N=7)	1	2	3	1
Insight (N=12)	2	1	8	1
Functioning (N=10)	2	-	7	1
Cognitive (N=9)	-	-	9	-
Other (N=7)	3	4	-	-
Relational (N=6)	5	-	1	-
Mood (N=4)	2	-	1	1
Therapist qualities (N=3)	3	-	-	-
Substance misuse (N=3)	3	-	-	-

Design

The predictor studies used both longitudinal (n=13) and cross sectional (n=5) designs. They analysed findings using mainly correlational and regression analyses. Three studies used ANOVAs to assess group differences: two differentiated groups based on mastery scores or trauma status (Davis et al., 2011; Lysaker, Davis, Outcalt, et al., 2011), whereas Wittorf et al. (2010) clustered alliance ratings into 'high' and 'low' groups and analysed group differences in the key predictor variables.

All studies of predictor variables used a symptom measure as well as collecting information on demographic variables. Several studies controlled for baseline symptoms and demographics in assessing the impact of predictor variables on the therapeutic alliance. One study also controlled for neurocognitive ability in analyses (Davis et al., 2011).

Main predictors of alliance

To understand the strength of the association between the main predictors and the alliance, the four predictor categories most frequently included across studies were examined (i.e. symptoms, insight, cognitive and global functioning). Table 7

shows the number of studies that reported positive associations between predictors in these categories and alliance ratings compared to the total number of studies testing the same association.

Table 7. Studies reporting significant associations between four most common predictor categories and alliance ratings

Predictor	TA-C[a]	TA-T[b]
Positive symptoms	3/13	1/11
Negative symptoms	2/13	4/11
General symptoms	2/6	1/5
Client-rated insight	1/2	0/1
Observer/therapist-rated insight	5/9	2/8
Cognitive	2/4	1/3
Client-rated global functioning	1/2	1/2
Observer-rated global functioning	1/4	1/5

[a] client-rated therapeutic alliance. [b] therapist-rated therapeutic alliance.

There were mixed findings relating to positive, negative and general symptom predictors of the alliance. Wittorf et al. (2009) was the only study to find that fewer positive symptoms were significantly associated with stronger therapist alliance ratings (reporting 8.3% of the variance in therapist-rated alliance was accounted for by positive symptoms). Three studies (Kvrgic et al., 2013; Lysaker, Davis, Buck, et al., 2011; Wittorf et al., 2010) found that fewer positive symptoms were associated with stronger client-rated alliance with a small effect size (d = 0.17 to 0.32). However, comparable findings were not reported in ten other studies assessing the same association.

Four studies (Barrowclough et al., 2010; Johansen, Iversen, et al., 2013; Jung et al., 2014; Wittorf et al., 2010) found that negative symptoms were associated with poorer therapist-rated alliance, with small effect sizes (d = 0.24 to 0.35). Two studies (Jung et al., 2014; Lysaker, Davis, Buck, et al., 2011) found an association between negative symptoms and poorer client-rated alliance.

Two out of six studies (Jung et al., 2014; Kvrgic et al., 2013) found correlations between client-rated alliance and general symptomology with large variation in effect sizes (d = 0.27 to 0.84). Only one out of five studies found an association between therapist-rated alliance and general symptomology (Barrowclough et al., 2010).

One study (Kvrgic et al., 2013) found that client-rated insight accounted for a significant proportion of client-rated alliance. This association between greater insight and stronger client-rated alliance was confirmed in the majority of other studies including observer or therapist-rated insight measures with effect sizes ranging from small to medium (d = 0.23 to 0.59) (Barrowclough et al., 2010; Dunn et al., 2006; Lysaker, Davis, Buck, et al., 2011; Wittorf et al., 2009, 2010). Two studies found that insight was associated with therapist-rated alliance, reporting that insight accounted for between 6% and 17% of the variance in therapist-rated alliance (Barrowclough et al., 2010; Johansen, Iversen, et al., 2013).

Two of the four studies that included cognitive predictor variables found an association with alliance ratings. Davis and Lysaker (2004) reported that poorer verbal memory performance was associated with stronger client-rated alliance, whereas better visuo-spatial reasoning was associated with stronger therapist-rated alliance. In Davis et al. (2011), clients with higher mastery scores showed stronger client-rated alliance.

Two out of six studies reported an association between functioning variables and client-rated alliance. Jung et al. (2014) reported a significant positive correlation between global functioning scores and client-rated alliance, and Svensson and Hansson (1999) found that target complaints were moderately correlated with client-rated alliance. Two out of seven studies (Couture et al., 2006; Svensson & Hansson,

1999) found that social functioning was associated with therapist-rated alliance with moderate effect sizes (d = 0.41 to 0.5).

Discussion

This review of 21 studies considered three main questions pertaining to the therapeutic alliance in the psychological treatment of psychosis: (1) how the alliance was rated and measured across studies; (2) the relationship between alliance and outcomes; and (3) the key predictors of the alliance in the psychological treatment for psychosis.

Summary of findings

The majority of the studies reviewed included psychological treatments based on CBT and CT in outpatient settings. There was a diverse range of outcome and predictor variables, which were broadly categorised in order to understand the main variables studied. Outcomes were mainly measured using psychological functioning variables rated by observers, and the most commonly studied predictors of the alliance were positive and negative symptoms rated by observers.

The relationship between alliance and outcome

In the eight studies examining the relationship between alliance and outcomes, the length of therapy ranged from eight weeks to two years, and a broad array of psychological functioning and adherence outcome measures were used. The most frequently used psychological functioning outcome measure, PaNSS, was used in half of the studies, signalling a lack of consensus in the most important outcomes of psychological treatment in this population. This is most likely due to the lack of studies in this area, and the varying therapeutic approaches included across both inpatient and outpatient settings.

One of the main findings was that greater duration and attendance in therapy was associated with stronger therapist-rated alliance, and dropout was associated with poorer therapist-rated alliance. However, contrary to prior research indicating a stronger association between therapist-rated alliance and outcomes in the treatment of psychosis (Gehrs & Goering, 1994; Neale & Rosenheck, 1995), there did not appear to be any notable advantages of either client or therapist-rated alliance in predicting the psychological functioning outcomes across the studies. Despite two studies inferring a significant association between client-rated alliance and reduced post-treatment symptomology (Goldsmith et al., 2015; Jung et al., 2014), two other studies failed to confirm this association. Therefore, the evidence for the predictive value of the alliance for treatment outcomes in this patient group is limited.

The key predictors of the alliance

The predictor variables measured across 18 studies were clustered into nine descriptive categories. The four most frequently studied predictors were symptoms, insight, cognitive and global functioning. Despite the majority of studies focusing on symptoms as the main predictor of the alliance, most of the tested associations were insignificant and there were mixed findings in relation to both client and therapist-rated alliance. However, five out of the nine studies measuring observer/therapist rated insight found that greater insight was associated with stronger client-rated alliance, with reported effect sizes ranging from small to medium. These findings appear to be consistent with previous research asserting that poor insight in psychosis is related to less participation in treatment (Kemp, David, & Hayward, 2009). However, insight was not significantly associated with therapist-rated alliance in the majority of studies. Previous research has suggested that this may be because therapists anticipate this prevalent characteristic in psychosis, and thus their

interpersonal experience is not substantially affected by it (Wittorf et al., 2009). Further research is needed to understand whether insight is significantly associated with symptoms, and whether medication compliance also plays a mediating role in the association between insight and alliance in this population. This will allow further understanding of how insight is related to both illness status and psychological adjustment to psychosis.

Measurement of the alliance

Consistent with other research investigating the alliance, the majority of studies used the WAI or CALPAS rated from both client and therapist perspectives. These measures have been shown to have a basis in theory, acceptable psychometric properties, and a moderate association with outcomes in mainly outpatient trials (Martin et al., 2000). Some of the alliance measures used were adapted or designed by study authors to better fit the population assessed. Whilst this makes the measure potentially more relevant, some of the assumptions about the reliability and validity of standardised measures cannot be applied and would require further assessment. Three studies used different types of alliance measure for different raters, reducing the likelihood that raters assessed comparable features and constructs of the alliance. Only one study included an observer-rated alliance measure, which prevented further examination of the effect of the rater on the reported associations. This also limits the overall quality of the information about the role of the alliance in psychotherapeutic treatment and should be rectified in further research.

There were also several methodological issues with regards to the measurement of the alliance. Some studies did not make it clear how measures were administered (e.g. in the presence of the therapist or not), which may particularly impact clients' responses. Also, although the majority of studies assessing the

relationship between alliance and outcome applied the measures early in therapy, three studies either averaged the alliance ratings across a longer period, or measured it much later (at six months). These studies may be particularly susceptible to the effects of symptom improvement confounding the association between therapeutic alliance and outcome.

Other methodological and design issues

None of the studies included a power analysis to determine the sample size required. As such, many studies had insufficient power to detect a small effect size, with five studies having sample sizes of less than 30. Consequently, the fact that most tested correlations were not statistically significant may be a result of the small sample sizes, with only four studies including samples of greater than 100 participants. Ten studies included in this review analysed data from just four large-scale controlled treatment trials. Seven of these studies analysed the same sample as another study included in the review. This reflects the paucity of alliance research in psychosis compared to other populations and may explain the relative lack of positive associations found.

An important strength is that most studies had outcome measures rated by clients, therapists and observers. Only one study used measures that were mainly rated by therapists (Dunn et al., 2006), and the researchers avoided inflating the magnitude of the association between alliance and outcome ratings by only reporting the associations with client-rated alliance.

Many of the studies measuring outcome sought to control for the effects of other variables when examining the association between alliance and outcome. However, there was a large range of variables assessed, often with a limited rationale for selection. Research has identified several variables that are associated with the

alliance, which may confound the relationship with outcome. For example, mood, social functioning and neurocognitive impairments have been shown to be associated with therapeutic alliance ratings (e.g. Davis & Lysaker, 2004). However, this review has shown that there is little agreement across studies of the most important variables associated with the alliance in psychological treatment for psychosis, making it difficult to assess the most relevant confounding factors. This underlines the need for more homogeneous and rigorous methodological approaches to provide the basis for greater comparison between studies and the possibility of meaningful meta-analytical review in the future.

In the 18 studies measuring the predictors of the alliance, five employed a cross-sectional design, precluding inferences about causality. Yet this was not always fully considered in the interpretation of findings, increasing the risk of premature conclusions.

Limitations of the review

This review used a vote counting method (Hedges & Olkin, 1980) to collate and assess the evidence across studies. In some cases, studies included more than one measure within a certain category and may have reported more than one finding, but for the purpose of the review this was presented as a single positive vote if the study reported at least one positive association. Therefore, this meant that mixed findings within studies were not reflected within this review. As a result, this may not have given a fully representative view of the total number of positive and negative associations across studies.

In addition, the vote counting method only took into account the relative number of similar findings across studies and did not allow for a more detailed comparison of results based on the overall quality of the studies. This method also

did not provide an estimate of the overall effect size of associations. However, the results have highlighted a lack of agreement between studies on the most important variables associated with the alliance in this population, as well as methodological issues in measuring the alliance. These concerns will be important to rectify in order to provide more comprehensive comparison in future meta-analytic review.

Recommendations for future research and clinical implications

The current findings do not suggest that alliance ratings are consistently associated with outcomes in psychological therapy for psychosis. This is most likely due to the fact that there is currently too little research and some of the existing studies are of too poor a methodological quality to provide conclusive evidence for it. This may be unsurprising given that the research into the role of the alliance in the psychological treatment of psychosis is relatively recent compared to other populations. For example, research examining the role of the alliance in the treatment of depression has overcome several methodological criticisms and inconsistencies through recursive investigation resulting in a gradual improvement in the quality of the evidence (e.g. Barber et al., 2000). This has contributed to an overall weight of evidence supporting an association between alliance and outcome in the psychological treatment of depression (Martin et al., 2000). Theory and existing research findings need to be incorporated into the design of future studies in order to potentially achieve greater consensus on the role of the alliance in the psychological treatment for psychosis.

Future research should also consider several methodological and design issues highlighted in this review to ensure greater rigour and generalisability of results. This should include conducting a power analysis to ensure that studies are sufficiently powered, and longitudinal designs to ensure temporal precedence is

achieved in measuring the predictors of the alliance. There should be greater emphasis on appropriately conceptualised and validated measures of alliance being used in this population. The research should also include the use of observer-rated measures of the alliance to allow greater understanding of the underlying constructs of the alliance pertinent to clients and therapists engaged in therapy. More homogeneous and rigourous research in this area will also allow a greater understanding of the variables that may confound the relationship between alliance and psychotherapeutic outcomes. Based on the results of this review, greater focus should also be given to the association between insight and the alliance, and its overall impact on psychotherapeutic outcomes.

The possibility that clients with poorer insight may find it more difficult to form an alliance in psychological treatment has several clinical implications. In addition to understanding insight in relation to illness status, it is likely that the cognitive appraisal of symptoms (Tait, Birchwood, & Trower, 2003), as well as family response (Patterson, Birchwood, & Cochrane, 2009), influence how well individuals will adjust to psychosis over time. Thus, psychological treatments should be tailored to the individual's responses in order to promote psychological adjustment to psychosis and engagement in therapy. Further research should explore the effectiveness of interventions adapted to patients' current emotions, appraisals and family situation in promoting the therapeutic alliance and successful psychological adjustment to psychosis.

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Part 2: Empirical Paper

Individual psychological therapy in acute inpatient settings: Service user and

psychologist perspectives

Abstract

Aims: Recent government initiatives have placed emphasis on offering greater psychological provision in inpatient acute wards; however, there is an absence of research into delivering psychological therapy. This qualitative study explored service users' and psychologists' experiences of engaging in individual psychological therapy on an inpatient acute ward. It focused on the process of forming a therapeutic alliance and the challenges to delivering psychological therapy.

Method: Eight service users and the six psychologists they worked with were recruited from four acute inpatient wards in a large psychiatric hospital. Semi-structured interviews were conducted to elicit the perspectives of the service users and the psychologists. Their accounts were analysed using thematic analysis.

Results: For service users and psychologists, building a trusting, collaborative and human relationship was vital to the therapeutic work. They also described the challenges of working together within the wider system on the ward. Psychologists emphasised the need to adapt traditional therapeutic models. Service users valued the opportunity in therapy to achieve new ways of understanding their difficulties.

Conclusions: The results suggest that developing a therapeutic alliance was important to service users and contributed to a personal sense of recovery. The findings emphasise the importance of psychologists developing practice-based evidence to demonstrate the effectiveness of adapted psychological therapy models. Targeted improvements are required to support clinicians in developing therapeutic relationships with service users in the acute inpatient setting.

Introduction

The acute inpatient ward is regarded in the UK as a key component in managing mental health crisis (Baguley, Alexander, Middleton, & Hope, 2007). Admission to an acute ward is most frequently associated with a serious psychiatric disorder exacerbated by additional problems such as risk of harm, family breakdown, treatment refusal or failure of self-care (Bowers, Chaplin, Quirk, & Lelliott, 2009). The clinical aims of treatment typically include offering crisis management, and a place of safety to stabilise symptoms and promote recovery in a time-limited fashion (Bowers et al., 2009).

Psychological provision in the acute inpatient setting

The provision of psychological input for inpatient wards remains a comparatively new development. In 2004, a study of 136 wards in England found only 13% had any dedicated psychology input at all (Bowers et al., 2006) and by March 2007, a survey revealed this had increased to 21% of 554 wards having some dedicated time from psychology staff (Healthcare Commission, 2008). In the past decade, there have been a number of policy initiatives encouraging greater provision of psychological practitioners in acute inpatient services (British Psychological Society, 2012; Clarke & Wilson, 2009). Particular emphasis has been given to offering "a wide range of effective psychological therapies" to all service users in this setting (MIND, 2011, p.45). Despite these developments, most empirical evidence supporting effective psychological therapies has focused on outpatient settings (Holmes, 2002; McGowan & Hall, 2009), thus providing little guidance on what psychological therapy should constitute in acute inpatient settings.

The role of a psychologist on an acute ward is far broader than being a therapy provider. Psychologists combine individual client work with supporting the

training and psychological thinking of the team by offering supervision, consultation and reflective practice (Nicholson & Carradice, 2002). Furthermore, on acute wards, individuals are often in a far greater state of distress than individuals in outpatient trials, receiving higher levels of medication and often receiving multiple treatment interventions alongside psychological input (McGowan & Hall, 2009). The inpatient setting is also characterised by unpredictable lengths of stay, a complex mixture of diagnostic groups and co-morbidity (Clarke & Wilson, 2009). The nature of these challenges goes some way to explaining the relative lack of evidence for psychological therapies in acute inpatient settings.

Several studies of inpatient psychological therapy have focused on individuals with discrete diagnoses of psychosis or depression, receiving structured therapeutic interventions with between three and five contacts per week (e.g. Drury, Birchwood, Cochrane, & Macmillan, 1996; Schramm et al., 2007). Such intensity of contact with discrete diagnostic groups is unrealistic in a typical acute inpatient psychology service. Given the unique demands of the inpatient setting, psychological therapy interventions are often adapted to meet the needs of the individual and the constraints of the environment (Heriot-Maitland, Vidal, Ball, & Irons, 2014). However, research has yet to address psychologists' perspectives in undertaking psychological therapy in this setting, and the adaptations they make to their therapeutic practice. Such research could provide useful information to understand psychologists' experiences and typical practice in order to plan effective psychological services in the future.

Service user perspectives

Service user experience is increasingly being recognised as an important factor in developing healthcare services. In the UK, improving the patient experience

is declared to be central to everything the National Health Service (NHS) does, and the 'Liberating the NHS: No decision about me, without me' (Department of Health, 2012) initiative is recognition of this. Service user research provides a valid method of measuring the effectiveness of services by balancing clinical outcomes alongside what individuals find acceptable according to their value systems and life histories (Walsh & Boyle, 2009).

To date, most research into service user perspectives of inpatient care has focused on their overall experiences. The findings from service user surveys have tended to be highly critical and highlighted mainly negative experiences (Quirk & Lelliott, 2001). For example, service users have reported that custodial rather than therapeutic values prevail in the acute inpatient environment, with rapid staff turnover contributing to a lack of continuity and commitment from staff (MIND, 2011; Sainsbury Centre for Mental Health, 1998). One survey reported that 82% of service users received less than 15 minutes per day of one-to-one contact with staff, which prevented them from developing therapeutic relationships and accessing vital support (S. Baker, 2000). As such, service user accounts have often supported the argument that psychological approaches should play an important role in improving the quality of care in inpatient settings (Holmes, 2002).

There is also qualitative research evidence to suggest that service users find psychosocial interventions beneficial in the inpatient setting. For example, Brown & Kandirikirira (2007) studied 64 service user accounts of recovery from long-term mental health problems. They found that the impact of various types of therapeutic input (e.g. group therapy, individual therapy and support groups) depended most strongly on the extent to which the approach was person-driven and on the strength of the relationships that were developed. Similarly, Donaghay-Spire, McGowan,

Griffiths and Barazzone (2015) found that receiving various forms of therapeutic input (e.g. individual, group and family therapy) on inpatient acute wards helped service users make sense of crisis, improved relationships and contributed to a meaningful sense of recovery.

One area of research that has yet to be explored in qualitative research is service users' experiences of engaging in individual psychological therapy on inpatient acute wards. This is important to address since government guidelines aim to increase the provision of psychological therapy in these settings (British Psychological Society, 2012). In particular, it is crucial to understand service users' perceptions of this work in the context of the acute symptomology, high levels of medication and multiple treatment interventions that are often experienced in this setting (McGowan & Hall, 2009). This would also explore service users' views about the impact of individual psychological therapy on their overall recovery, and developing a therapeutic relationship.

The therapeutic relationship

The therapeutic relationship has consistently been shown to be an important element of psychological therapy (Roth & Fonagy, 2004) and a robust predictor of outcome, independent of the type of therapy offered (Martin et al., 2000). Bordin (1979) proposed a pan-theoretical definition of the therapeutic relationship consisting of three key components: goals (the client's hopes for therapy), tasks (the activities agreed upon for therapy), and bond (the trust and confidence built between the client and therapist). The therapeutic relationship is viewed as a collaborative effort, which makes it possible for the client to accept and follow through in the constituent processes of psychological therapy (Horvath & Symonds, 1991). However, the large majority of studies investigating the therapeutic alliance have focused on outpatient

settings (Horvath & Luborsky, 1993) and it is unclear whether this research is generalisable to the inpatient setting.

There are numerous factors that may adversely affect the formation of the therapeutic relationship in an inpatient environment. The inpatient setting necessitates the service user forming multiple relationships with care providers outside of meetings with the therapist (Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008). As service users are often held in acute inpatient units involuntarily, they are more likely to experience relationships with professionals in this environment as coercive and non-therapeutic (Gilburt, Rose, & Slade, 2008). Acute illness and unpredictable lengths of stay mean that psychological therapy sessions can be sporadic and unstructured, limiting the opportunity for a therapeutic alliance to form in a consistent way. Furthermore, there is evidence that the therapeutic relationship can take more time to establish and is more vulnerable to rupture in therapeutic work for some diagnostic groups, such as psychosis (Wittorf et al., 2010). It is therefore unclear whether it is possible to achieve a therapeutic relationship in psychological therapy in the acute inpatient environment, or whether the relationship may differ in key ways to that described in outpatient psychological therapy.

Rationale and aims of the present study

The acute inpatient environment poses potential challenges to delivering one-to-one psychological therapy (McGowan & Hall, 2009). However, there is an absence of research on the nature of these challenges and how psychologists attempt to overcome them. Furthermore, there is little research on service users' experiences of engaging in psychological therapy in this setting, and in particular, their experiences of developing a therapeutic relationship with their psychologist. The

present study aimed to explore service users' and psychologists' experiences of engaging in individual psychological therapy in inpatient acute wards. It focused on the impact the inpatient setting had on developing a therapeutic relationship, and the adaptations that were made in delivering the psychological therapy.

A qualitative approach was chosen because it enables an in-depth understanding of complex social and psychological experiences, including individual beliefs and interpretations of events (Barker, Pistrang, & Elliott, 2016). Semi-structured interviews were conducted in order to capture detailed accounts of participants' experiences.

The study addressed three main research questions:

(1) What were service users' and psychologists' experiences of engaging in individual psychological therapy in the inpatient acute setting?

(2) What impact did the acute inpatient setting have on developing a therapeutic relationship?

(3) What adaptations, if any, did psychologists make to overcome the challenges of delivering psychological therapy in the acute inpatient setting?

Method

Setting

The research took place at a large psychiatric hospital in London. The hospital had five adult acute inpatient units (two female and three male wards), which each provided 15-20 inpatient beds for service users aged 18 years or older with acute and serious mental health problems. A multi-disciplinary team on each ward provided intensive psychiatric treatment and risk management. The average stay for service users was approximately five weeks. Each ward was provided with two days of dedicated input from a qualified psychologist, which included one-to-

one psychological therapy sessions with service users. There were also several assistant and trainee psychologists who worked across several wards.

Ethical approval

Ethical approval was obtained from an NHS Research Ethics Committee via Proportionate Review sub-committee (Appendix 3) and locally from the NHS trust research and development department responsible for the hospital.

Recruitment

Service users

Service user participants were recruited from four (two male and two female) of the five acute inpatient wards. Criteria for inclusion were:

1. Service users who had received, or were currently receiving, direct psychological input on the ward. Direct psychological input was defined as at least three formal one-to-one psychological treatment sessions provided by a qualified or assistant psychologist.

2. Service users who had declined or dropped out of one-to-one psychological input were also eligible. In this case, there was no minimum number of sessions required.

3. Able to understand written and spoken English well enough to give consent and participate in an interview.

4. Deemed well enough to participate by a member of the clinical care team, and without the presence of a significant learning disability or developmental disorder that would impair their ability to participate in an interview.

Psychologists working on the respective inpatient wards were asked to identify eligible service users at any stage of therapy (e.g., service users who had declined or

dropped out, completed or were currently receiving therapy). Service users who met the inclusion criteria were invited to participate in the order in which they were identified.   Recruitment ceased when little new information emerged from the service user interviews and a rich data set had been obtained describing service users' experiences (Strauss & Corbin, 1998).

Eligible service user participants were initially approached by a member of the inpatient unit's care team (usually the ward psychologist) and informed about the study. Those who expressed an interest in the study were then approached by the researcher, and given written information about the study (Appendix 4). This provided details about the nature and purpose of the study, as well as highlighting that it was part of an independent research project that would have no bearing on their care at the inpatient unit. Interviews were arranged at a time that was convenient for the service user. Signed consent forms (Appendix 5) were obtained on the day of the interviews.

Psychologists

The psychologists and assistant psychologists who had worked, or were currently working, with the service user participants were invited to provide their perspective of the psychological intervention. They were given written information about the study (Appendix 6) and recruited after the respective service users had been interviewed.

Participant characteristics

Service users

Fourteen service users met the criteria for inclusion and eight consented to take part in the study. Of the six who declined, two stated they found it difficult to trust professionals in the ward context and feared what might be done with their data.

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Three others declined to take part without giving reasons, and one had significant symptoms that meant it was not possible for him to engage with the interview.

There were three female and five male service user participants who ranged in age from 21 to 55, with a mean age of 39 years. Six were White British, and two were Asian British. Their length of stay on the ward ranged from four to 48 weeks (mean of 20.6 weeks), and the duration of therapy ranged from three to 31 sessions (mean of 14.25 sessions). At the time of interview, the therapy had come to an end for four of the eight service users, and three of these had been recently discharged from the ward. Five of the service users reported receiving psychological input in the past, either from previous admissions to the ward, or in other services. Three service users had a primary diagnosis of personality disorder and two of psychosis. The three other participants had primary diagnoses of anxiety, depression and autism spectrum disorder respectively. In the interests of preserving confidentiality, details of the characteristics for individual service users are not reported.

Psychologists

All six psychologists who worked with the service user participants agreed to participate; two psychologists were interviewed about their work with more than one service user participant. Three were clinical psychologists, two were assistant psychologists and one was a counselling psychologist. The qualified psychologists had between one and six years' post-qualification experience. For two of them, their role on the acute ward was their first post as qualified psychologists after training. The assistant psychologists had pre-qualification experience of one and two years respectively.

For all six psychologists, the length of time working on the acute inpatient wards ranged from two months to two years (although several psychologists had prior

experience of working on other wards in the hospital). They reported working with between six and 70 service users in individual psychological therapy during their time on the wards. The most common therapeutic approach was CBT, although all of the psychologists reported using more than one therapeutic approach in their work. In the interests of preserving confidentiality, details of the characteristics for individual psychologists are not reported.

Interviews

All of the interviews took place at the psychiatric hospital in a quiet interview room. All interviews were audio-recorded and transcribed verbatim (four by the researcher, seven by volunteer research assistants, and three by a professional transcription service).

Service user interview

A semi-structured interview was developed for the purposes of exploring the service users' experience of undertaking a direct psychological intervention in the ward context (Appendix 7). The questions explored how the service user had come to meet with the psychologist, their experiences of the meetings, and the perceived outcomes of the meetings. In addition to this, questioning domains were developed around the three central components of the therapeutic alliance proposed by Bordin (1979) (i.e. task, bond, and goals). Theory can provide a useful organising framework in qualitative research for guiding the development of key questioning domains, and the interpretation of data, without distorting the overall meaning of the data (Sandelowski, 1993). These questions were intended to explore the aspects of the therapeutic relationship that were potentially pertinent to service users in their experience of psychological therapy.

The interview was adapted to the setting and intended to be easily understandable, without psychological jargon. It was conducted flexibly with attention paid to allowing the individual's meanings and personal experience to be explored. Open and non-directive questions were asked as much as possible in order to limit the interviewer's influence on the participants' answers. At times, more directive questions and follow-up prompts were required in order to clarify meanings and to elicit detailed descriptions (Britten, 2006). If service users described predominantly positive accounts, attempts were made to discuss unhelpful or contradictory experiences in order to broaden and confirm the patterns presented (Creswell, 2012).

The service user interviews lasted between 25 and 121 minutes. At the end of the interview, service user participants were given a £10 supermarket gift voucher to thank them for their time. They were also encouraged to speak to an allocated inpatient unit staff member if any upsetting issues had arisen during the interview.

Psychologist interview

The psychologist interview (Appendix 8) mirrored many of the questioning domains of the service user interview. Additionally, the psychologist interview explored possible challenges to delivering therapeutic input in the inpatient setting, and any adaptations psychologists made to overcome them.

The interviews with therapists were conducted as soon as possible after those with service users in order to minimise any discrepancies in memory of the intervention. The interviews were conducted flexibly, with a focus on asking open-ended questions. The language in the interview with psychologists was adapted to account for their familiarity with psychological constructs and therapies. Prompts

were also used to elicit detailed descriptions of psychologists' individual experiences and meanings. The interviews with psychologists lasted between 53 and 81 minutes.

Analysis

Braun and Clarke's (2006) method of thematic analysis was used to identify central ideas across the data set. Thematic analysis can be applied flexibly to complex data, as it remains largely without theoretical preconception (e.g. Howitt & Cramer, 2005). The analysis followed six phases outlined by Braun and Clarke (2006): First, the researcher fully familiarised herself with the transcripts by reading them several times. Second, the researcher began to develop codes to define elements of the data relevant to the research questions. Third, the codes were grouped to develop initial themes for each interview. Fourth, the themes were combined across interviews to produce a tentative thematic map. Fifth, the themes were checked and verified by a supervising researcher and further developed into overarching categories by comparing them across the data set. The themes not supported by rich evidence were dropped. Sixth, quotations were selected from the transcripts to illustrate how each theme related to the data. Appendix 9 shows an example of the second and third stages of analysis, and Appendix 10 shows an example of the sixth stage of analysis. The process of developing the final set of themes was informed by the frequency of material across the data set, as well as how central the ideas were to an individual's account.

The service user and psychologist transcripts were approached and analysed separately in order to gain a rich understanding of their separate perspectives of the psychological therapy and alliance. In addition, this helped to clarify the separate descriptions of the ward environment, and the adaptations that psychologists made to their work.

Credibility checks

The established criteria for qualitative research were carefully considered to ensure the study was conducted in a systematic and rigourous manner (Barker & Pistrang, 2005; Mays & Pope, 2000). All of the interpretations and generated themes were grounded in the data, which was achieved by the researcher paying close attention to the verbatim accounts of participants during the coding and development of initial themes. In order to provide triangulation in line with recommended guidelines (Elliott, Fischer, & Rennie, 1999), a research supervisor expert in qualitative research reviewed the analysis at several stages to ensure that there was a consensus on the coding and the process was reasoned and logical.

Researcher perspective

My interest in therapeutic approaches in severe and enduring mental health settings developed while working in a forensic mental health hospital prior to clinical psychology training. I observed that psychologists had a 'dual role' of both providing treatment to relieve psychological distress, and contributing to risk assessment and custodial decisions. This contributed to offenders distrusting psychologists' motives in therapy as they perceived that talking to a psychologist may lead to increases in medication or increased lengths of stay, rather than therapeutic support. This led to difficulty engaging individuals in therapy and hindered the development of strong therapeutic relationships. The importance of the therapeutic relationship was later confirmed in my own clinical practice and highlighted in my reading about 'common factors' theories (e.g. Wampold, 2015). In approaching my research, I was interested in whether it was possible to develop a therapeutic relationship in an inpatient acute ward characterised by involuntary stays for service users in crisis. It is likely that this interest influenced my approach to the interviews and reading of the data (Harper &

Thompson, 2011), for example anticipating the mention of the relationship in interviews and focusing on this during the reading of transcripts. However, I attempted to reflect on and 'bracket' my own beliefs and assumptions (Ahern, 1999; Fischer, 2009), which was facilitated by working closely with my thesis supervisors during all stages of the research process. It was also important for me to reflect that my growing clinical experience and training enhanced my understanding of the clinical issues associated with developing therapeutic relationships in inpatient settings. This enabled me to make further interpretive insights during the course of the research (Fischer, 2009).

Results

A brief contextual overview is first provided in order to orient the reader to the participants' accounts. The themes from the psychologists' accounts are then presented, followed by those of the service users. The psychologist themes are presented first because they shed light on the demands and challenges of delivering therapy in the acute ward setting, which sets a context for the service users' experiences of receiving psychological therapy in this setting.

For all themes, supporting quotations are provided. The participant identification number indicates the source of the quotations. Service users are denoted by 'SU' (e.g. SU1), and psychologists by 'P' (e.g. P1). The participant number given to psychologists corresponds to the service users they worked with (e.g. P1 worked with SU1 in therapy). A psychologist who worked with two service users was given a participant number that corresponded to both service users they worked with (e.g. P2/3 worked with SU2 and SU3 in therapy).

Contextual overview

The psychology team in this London-based psychiatric hospital represented a relatively new and growing addition to the acute wards. The qualified psychologists were employed on the acute wards for two days a week, and three also fulfilled roles elsewhere in NHS, research, or private sectors. As psychology input was a relatively new addition, there was an ongoing process of negotiation within the team about achieving the most effective psychological input on the wards. Therefore, the roles and responsibilities of psychologists on the wards often varied.

All the psychologists received referrals from multiple sources on the ward. Most frequently this involved requests from other staff members working on the ward, accompanied by a discussion involving the multi-disciplinary team. For the assistant psychologists, referrals were screened by a supervising qualified psychologist to ensure they were appropriate for their level of experience.

None of the service users reported seeking out therapy directly on the ward; rather the psychologist or a ward team member had approached them in the first instance. Some service users stated that they were not aware that individual therapy was available before a member of the team offered it.

Themes from psychologists' accounts

The analysis of psychologists' accounts generated eight themes, which were grouped into three categories (Table 1). The categories reflect the psychologists' experiences of adapting the therapeutic approach, creating a therapeutic relationship, and working within a system. All psychologists reported facing challenges in delivering psychological therapy and making significant adaptions to their practice in several areas.

Table 1. Psychologist themes

Category	Themes	Subthemes
1. Adapting the therapeutic approach	1.1 Traditional models "don't fit"	Adapting to symptoms and distress Restrictions of the ward environment "Will I be able to do things differently?"
	1.2 Flexibility and "recalibrating"	Inability to plan therapy "Recalibrating" to the service user and setting Feeling like "a juggling octopus"
	1.3 "Fire-fighting"	Focusing on risk and symptoms Reacting to crisis on the ward
2. Creating a therapeutic relationship	2.1 Being human	"Standing with them" "Sharing humanity" Attending to behavioural cues A new experience of relating
	2.2 Dependency	Preparing for the end at the beginning Psychologist availability on the ward Creating a "short-term" feeling

3. Working in a system	3.1 Advocacy and finding a shared view of the problem	Deciding "who is my client" "Becoming an advocate" Difficulty achieving a shared understanding
	3.2 Consistency in an inconsistent environment	Inconsistent care from staff Therapy as "one small component" Greater psychological provision
	3.3 Multiple relationships	Respecting the medical approach "Trying to keep everyone happy" Balancing roles of therapist and team member Psychologists as "too soft"

Category 1. Adapting the therapeutic approach

All six psychologists reported needing to adapt traditional therapeutic models and techniques to work with service users on the ward. The themes in this category reflect the factors that led psychologists to adapt their practice, and the experience of attempting to do so.

Theme 1.1 Traditional models "don't fit"

All of the psychologists felt they needed to adapt the traditional therapeutic models they had been trained in due to the limitations of the ward environment and the severity of service users' symptoms. Even for common mental health presentations such as anxiety or depression, they considered that the recommended approaches were "not going to cut it" (P4) and could even risk making symptoms worse.

"I find the type of anxiety you're dealing with when people have become an inpatient for anxiety is so, so severe that that kind of doing some breathing or mindfulness is really, really hard for people, and actually it tends, I find it makes them more anxious."(P8)

The level of insight, memory and general functioning expected by traditional therapeutic models was perceived as unrealistic for most service users experiencing acute distress and side effects of medication. Psychologists described the importance of consistently assessing the service user's capacity for a psychological intervention, and drawing on multiple psychological models and techniques to understand and "work with what [they] had" (P1).

"Most of the time on the ward it's pointless asking people to do much analysis of their thoughts, ordering their thoughts, thinking about what other people think, because they are too distressed. It might look like they're doing it, but they won't." (P6/7)

Restrictions of the ward environment meant that traditional therapeutic approaches were either not possible or needed to be significantly adapted. For

example, it was difficult to implement therapies such as behavioural activation or graded exposure, which encouraged service users to seek out new activities and experiences to overcome anxiety or achieve personal goals.

"…if you're like going to challenge beliefs or like the anxiety work…and you can't go out, and you can't encounter necessarily the things, the scenarios that people… that you're discussing in therapy. You can't directly challenge that." (P1)

This necessitated psychologists making significant changes to the recommended therapeutic models in order to accommodate both the inpatient setting and the service user's symptomology. In doing so, psychologists sometimes felt uncertain about their ability to adapt the therapeutic models, and the impact this had on the effectiveness of the work.

"…all the NICE guidelines say that CBT works for psychosis and was developed for outpatient trials anyway so I always have that in the back of my mind: what am I doing, is that evidence based practice?" (P2/3).

"'We need to do things differently…will I be able to do things differently?' You know, it's just this doubt in thinking, am I going to be good enough to work and manage that situation." (P5)

Theme 1.2 Flexibility and "recalibrating"

Psychologists needed to be flexible in their practice in a number of ways to account for the inpatient setting. For example, the unpredictable nature of service users' symptoms, staffing levels, space availability, and discharge plans made it difficult to plan and consistently provide the therapeutic work. They conducted sessions at unplanned times and settings, with the constant threat of service users being on leave or unexpectedly discharged from the ward.

"The ward setting. Yes, just a total lack of space and privacy, you know, and sometimes not only that but…but he quite liked when he met with me sitting in front of the toilet door playing cards on the ground." (P8)

"So basically, you start seeing, assessing a patient, see them once, then they're discharged because they are well enough to go home in the community because they are pushed for beds. That's it. You don't get to say goodbye, hello." (P5)

The focus of sessions also needed to be "recalibrated" (P6/7) according to the changing picture within therapy and on the ward. Psychologists discussed instances of having to adapt to the service user's mental state and to events on the ward, such as unexpected changes in treatment decisions and breakdowns of relationships between service users and ward team members.

"…sometimes that [focus of the session] completely goes to pot when there has been a real crisis in the ward and you have to spend time trying to contain that."(P2/3)

"…it's like being a car engineer, you know, like test running a car because you're constantly   having to recalibrate things and think, well, when she's feeling like that I can't really do that." (P6/7)

This set of complex challenges required psychologists to be highly flexible in their work, while remaining person-centred and attuned to the needs of each service user as much as possible.

"It's like being an octopus, a juggling octopus. That's one of the reasons why it's so intense, you know. More than just the content of what they're doing, the actual logistics, the therapeutic logistics…. And there's the deeply disturbing content of what these people have experienced and what they feel…"(P6/7)

Theme 1.3 "Fire-fighting"

The rapidly changing situation on the ward meant that psychologists often felt they were "fire-fighting" (P5) in the therapeutic work by focusing on managing the most risky behaviours and prominent symptoms, rather than getting to the root of the problem.

"The strategies and the coping mechanisms, it's not quite…you know, it's fire-fighting. It's not getting to that core of what I should be because I only have a limited amount of sessions." (P5)

They also felt under pressure from other professionals to react to unexpected crises or urgent referrals on the ward, and therefore to suspend their established individual therapeutic work. This emphasis on dealing with crises on the ward further impacted their ability to conduct regular and planned sessions.

"…you need to see this person quickly, they're going to be discharged or something like that so, I mean, I might be doing assessments, start writing a report, doing this thing that will take up loads of time, and then not having enough time to see people." *(P8)*

Category 2. Creating a therapeutic relationship

Forming a therapeutic relationship was highlighted as a vital part of the therapeutic work. The themes in this category reflect how psychologists attempted to create such a relationship, why it was perceived as particularly important in the inpatient setting, and the challenges of dependency on the relationship.

Theme 2.1 Being human

An important priority for psychologists was offering service users the opportunity to tell their story, and to feel listened to and understood, in order to normalise distress and provide a genuine sense of "standing with them" (P6/7).

"…be compassionate and listening attentively and very much use verbal and nonverbal communication and just trying to, I suppose, just sit with them in terms of when they are very distressed." *(P2/3)*

Psychologists also felt it was important to "share a humanity" (P1) with service users by attuning to their pace and emotional state and treating them as "an equal" (P1). In the inpatient environment dominated by a medical view of mental health and diagnosis, several psychologists felt it was particularly important to provide a humanising and supportive experience for individuals.

"I can share that humanity with them that they're not a label, or an illness, or a bad thing that's happened, or any of those things, they are just a person, and I'm a person too." *(P1)*

In contrast to the formality and "rigid question structures" (P2/3) of ward rounds, psychologists aimed to be sensitive to service users' non-verbal and behavioural cues, and adjust their interpersonal style to allow them to feel more supported to talk openly.

"…it was easier for him to have an activity rather than having, kind of sitting across from me, you know, in a room, and had more, I think it was just a decrease of intensity of that interaction with him and maybe made it a bit more tolerable and a bit easier" (P8)

Psychologists noted that many service users had long histories of attachment and relationship difficulties, and developed risky coping strategies such as self-harm or substance abuse. They therefore felt it was important to provide service users with the experience of a therapeutic relationship where it was possible to make mistakes and repair relationships when things went wrong, in order to develop new ways of coping and relating to others in the future.

"…give them the experience that things can go badly and then they can be repaired, you know. These people have just been through so much stuff that's never been repaired and no one's ever helped them pick up the pieces before." P(6/7)

Theme 2.2 Dependency

The advantages of developing a positive therapeutic relationship were balanced against the potential consequences of dependency and difficulty ending therapy. When making decisions about offering individual therapy, psychologists considered whether there was provision to continue therapy after discharge from the ward.

"…it's almost unethical, I think, to see them lots and lots and lots and lots, and then they suddenly fall of a cliff. So we're quite careful about stuff like that, how we manage the issue of dependence." (P6/7)

Psychologists tried to carefully balance maintaining the therapeutic relationship alongside personal and professional boundaries. They were concerned that their availability on the ward outside of therapy could increase the likelihood that service users relied on the therapeutic relationship with the psychologist for support, rather than communicating with other professionals on the ward.

"…you [the psychologist] go to the ward and all the patients you're seeing every session are there. And you don't want to, say, be unkind or unhelpful, so that's quite

difficult to manage if they come up and want to have a chat with you and you've already met with them for an hour." (P2/3)

Psychologists also tried to mitigate against dependency by openly discussing the uncertainty about the number of sessions with service users, and their options after discharge. One psychologist felt that with one particular service user, the busy ward environment and unpredictable session times actually helped to prevent dependency in the relationship.

"…for me and him, that ward environment was quite good to maintain that 'I'm seeing you short-term' type feeling." (P4)

Category 3. Working in a system

Service users and psychologists existed within a system of multiple professionals on the inpatient ward, and within a wider NHS mental health system. This category reflects the particular challenges and complexities that working in this system created for psychologists delivering individual therapy.

Theme 3.1 Advocacy and finding a shared view of the problem

Psychologists were asked by the ward team to offer therapy to service users who might not be aware of the referral, or encountered contrasting views between the team and the service user about the nature of the 'problem'. They found themselves deliberating about whether to focus their attention on the needs of the ward team, or the needs of the service user, or both.

"I felt that I was wondering is the client my client or is the ward my client, you know, is it the ward with the people with the problem that needs to be resolved, or is my client the one that has some issue that they want to talk about?"(P8)

There was a sense of balancing dual responsibilities: on the one hand, working with service users in therapy to understand and overcome difficulties; and on the other hand, supporting the staff team to understand the service users' perspective, and develop consistent ways of working together. Several psychologists

described how some service users provoked polarised or fearful reactions from staff, which became important to address both in therapy and with staff on the ward.

"…'Cause he did split team a bit because of his past and the team isn't very comfortable with working with him. So a bigger part of my role is managing that relationship with staff." (P2/3)

Psychologists developed various strategies to support a shared understanding, such as offering consultation with staff, taking up an advocacy role for service users in team meetings, and helping service users find ways to articulate their views.

"…you [the psychologist] become an advocate for them [the service user] as well, in terms of offering support, if they are having difficulties with medication or they can't seem to talk to other staff… You develop that relationship and you end up sort of offering additional support in addition to just psychology sessions." (P2/3)

"I would champion him at ward rounds, or we'd prep for ward round. We'd go over what he was going to say, and we would debrief after" (P1)

There were often mixed results in achieving a shared understanding within the team. Psychologists described facing confusion, scepticism and opposition when their suggestions conflicted with other professionals' usual practice, or the accepted understanding of the service user's 'problem'. In turn, this meant care remained inconsistent on the ward, and threatened the possible effectiveness of individual therapeutic work.

"We write the care plans and can we get the them to actually do it? No we can't. The people who will do it, will do it, and the people who won't, won't even read the care plan to do it." (P6/7)

Theme 3.2 Consistency in an inconsistent environment

Psychologists described how service users sometimes received inconsistent care on the ward due to differences in shift patterns, training discipline, and attentiveness of staff. This environment was felt to make it difficult for service users to develop trust in staff and a sense of safety that was important to their recovery on the ward.

"I think it can be really hard in this environment to trust what the staff are telling you when often it's so inconsistent just by the way it works…The smallest thing, you know, not getting a one-to-one when you're supposed to have a one-to-one from a nurse, different people being on shift from who you were expecting…" (P6/7)

Psychological therapy was only "one small component" (P1) of service users' experience on the ward. Therefore, even though the therapeutic work might be consistent, the context of inconsistency in the ward environment was perceived as inevitably influencing service users' experiences, and threatened to undermine the effectiveness of the therapeutic work.

"When you're [the psychologist] saying [to the service user] 'you're worth exactly the same'…and then they get dismissed accidentally because someone has to do whatever else…it just goes straight down." (P1)

Greater provision of psychologists on the wards was viewed as essential, in order to see clients more frequently and offer more consistency. For only one psychologist, it was possible to continue to offer therapy after service users were discharged from the ward, and thus to support their transition into the community.

Theme 3.3 Multiple relationships

Psychologists described the multi-disciplinary teams on the wards as hierarchically structured, with psychiatrists taking the lead in treatment decisions and overall care of service users. Psychologists felt responsible for maintaining cohesive team relationships under the direction of the psychiatrist, while also presenting alternative approaches informed by their psychological understanding of the service user and their needs. In the ward round setting, psychologists sometimes felt they needed to find the right balance between respecting the psychiatrist's clinical approach, and offering their input when it was most helpful.

"…it's like I'm stepping into the consultant's ward round, he has his questions he needs to answer and then I wait until a certain point where SU8 seems like he's uncomfortable or things aren't going well and then I try to kind of step in to help a little bit." (P8)

In one team, the psychiatrist defined the contributions he felt were required from the psychologist, and limited the amount of individual therapy work.

"the psychiatrist very rarely refers to me for psychological therapy on the ward. He's more referring to me for assessment, diagnosis opinions." (P4)

In other teams, psychologists tried to balance the treatment goals of psychiatrists and other team members (such as medication compliance) alongside the objectives of the therapeutic work. This meant that psychologists felt they constantly walked a "tightrope" (P6/7) in keeping in mind multiple perspectives in planning and delivering the therapeutic work to achieve a mutually beneficial outcome.

"…sometimes the staff's goals aren't necessary the same as the clients' are but I managed that in terms of balancing it again, trying to keep everyone happy." (P2/3)

This became particularly tricky when service users directly disagreed with the views of other professionals in the team. Psychologists attempted to empathise with service users' views, whilst maintaining a professional stance and role as a team member.

"…you [the psychologist] have to tread a professional line between empathising and not saying, yes they're all shit, aren't they? Which is what patients sometimes say." (P6/7)

The team's perception of the psychologist's work and their relationships with service users could also be experienced as problematic. Psychologists felt they were perceived by some team members as "too soft" (P2/3), and easily influenced by service users.

"If you manage to create something really positive but that isn't replicated outside, very often there's the perception that you've been hoodwinked somehow by a manipulative patient." (P6/7).

They therefore felt under pressure to explain and defend their therapeutic work and interpersonal relationships with service users in order to maintain positive relationships with the team.

Themes from service user accounts

The analysis of service user accounts generated seven themes, which were grouped into three categories (Table 2). The categories reflected service users' emphasis on connecting with their psychologist and making sense of their problems. Service users also reflected on the role the psychologist played in co-ordinating their care in therapy, and in the wider system on the ward. Although accounts of the therapies varied widely, all of the service users interviewed reported a positive overall experience of working with the psychologists.

Category 1. Connecting with the psychologist

The themes in this category reflect service users' experiences of opening up and building a relationship with the psychologist on the ward. Service users emphasised the importance of feeling cared for, listened to, and understood, as well as developing mutual respect in order to work together in a collaborative way.

Theme 1.1 Someone who listens and is "there just for me"

All service users described their psychologist allowing them time to open up and listening carefully to what they had to say. They knew the psychologist had listened and understood by the ways they responded (e.g. remembering what they had said, and making helpful comments).

"I'd make a certain comment and then her reply, you knew she'd understood what you'd said, by the way she replied; so I knew she was getting it." (SU5)

Psychologists were also viewed as non-judgemental and focused on the issues pertinent to service users' explanations. Service users felt psychologists did not use technical terms and were "on my wavelength" (SU6).

"…talking to her did feel like you aren't talking to somebody who might be judging you or whatever – you are as relaxed as when talking to a friend." (SU3)

Table 2. Service user themes

Category	Themes	Subthemes
1. Connecting with the psychologist	1.1 Someone who listens and is "there just for me"	Knowing the psychologist "was getting it" Being prepared and asking relevant questions A "safe space" to open up Finding "the right person at the right time"
	1.2 Respecting each other	Importance of shared goals Respecting boundaries Acceptance, "warts and all" Not feeling "bamboozled"
	1.3 The psychologist as "the rudder of the boat"	"Steering the conversation" "Bringing things out of me" "Minimising the pain"
2. Making sense of the problem	2.1 "Dealing with the underlying problem"	Understanding "the Sudoku of the mind" Linking it all together Normalising and self-acceptance
	2.2 Hope as a "rare commodity"	A new understanding: "The last little pieces of jigsaw" Possibility of relapse: "Things come and go in waves"

| 3. Co-ordination of care | 3.1 Consistency and flexibility | Co-ordinating therapy
A "wish" for more sessions
Continuity of therapist |
| | 3.2 "Taking my side" | Mismatched treatment goals
Psychologist providing a voice for the service user
"We couldn't really focus on the issue" |

Service users emphasised how psychologists were prepared for the sessions, showing an awareness of the service user's history and asking relevant questions. They felt this demonstrated a genuine care and interest that they did not experience with other staff; in contrast, they described other ward staff reading or taking notes when they met with them, or asking questions that seemed repetitive or irrelevant.

"…you come in and see so many people but they always ask me the same questions. But she didn't, she asked me different ones." (SU6)

"There's some people, who like just literally listen to you while they're writing and I realised that they are not listening to what you are doing, they are just note taking and I don't tend to open up to people like that." (SU4)

This helped service users develop a sense of trust and confidence in the psychologist, and feel that that the psychologist was there "just for me" (SU3). This was a novel experience for some service users who felt unable to talk to others on the ward due to feeling paranoid, or other staff not having enough time.

"…the staff or something…like, they're sort of looking after everyone they don't have time, and then…and so if you're just meeting with [the psychologist], then it's just you and him." (SU8)

Opening up in therapy produced a sense of relief, as though "a weight lifted off your shoulders" (SU6). However, for two service users, the process of opening up was more challenging, as they believed it might trigger a relapse or worsening of their symptoms. For these service users, it was particularly important to consider whether it was the right time to open up with their psychologist.

"…if I open up to the things I'm bottling up then there is a danger that I might go back to self-harm for relief, or drinking. So it has to be at the right place at the right time with the right person." (SU1)

Theme 1.2 Respecting each other

Psychologists were viewed as taking a collaborative approach to therapy by demonstrating an interest and willingness to respond to service users' needs and goals for therapy.

"…you have to work together, you have to work together in psychology to resolve conflicts as mine are." (SU2)

For some, this required a process of learning and negotiation in which service users and psychologists found ways to agree on the most important goals and ways to work together in therapy. Two service users described instances in the early stages of therapy when they felt unsure of how to work with the psychologist, or felt the psychologist did not ask them about their main concerns.

"I do feel they should ask what the person wants to get out of it…so you are giving that person a chance to say what is on their mind as well." (SU5)

Service users felt that they could be open and honest with their psychologist in therapy and choose what they were comfortable to talk about. Even when they chose not to share information, they felt the psychologist respected their boundaries and remained focused on helping them.

"…she was approaching it, but she knew it was a delicate issue…so she wasn't harassing me about it or wanting to know what happened, she just said 'you don't have to tell me what happened but here are some skills to use.'" (SU7)

Even when they exposed their perceived flaws, service users felt that psychologists responded with compassion and acceptance. This helped service users feel their psychologist was trustworthy, respectful and working with them to bring about helpful insights.

"…you are opening yourself up, you are emotionally naked. And how the person reacts, what they say, their body language – because in a way, I was I'm sure…looking for approval that it was okay. You know, look at me, warts and all. And they don't turn away." (SU3)

The experience of working with the psychologist was described as qualitatively different to working with other staff. For example, one service user described their psychiatrist as taking less time to understand their goals or explain treatment processes and decisions. In turn, the service user seemed unable to trust that the psychiatrist was working in his best interests.

"…she [the psychologist] seemed sort of different from the psychiatrists who were, all seemed to have these grand schemes and treatment plans and were bamboozling me with kind of little charts, and saying you know, we have got to get through this stage." (SU4)

Theme 1.3 The psychologist as "the rudder of the boat"

As one service user described it, the psychologist was "the rudder of the boat" (SU2) in therapy due to their unique skill and ability to steer the conversation effectively, and move at the service user's pace. Psychologists were perceived as navigating the conversation so that "the sessions just flowed" (SU6), while allowing service users to feel in control.

"…her guidance, her rudder of the boat, steering… she steers the conversation. And it ends up being about me and it brings stuff out." (SU2)

By focusing on the most important topics, and picking up on unspoken thoughts and emotions, psychologists helped service users open up and discover "the real me inside" (SU2).

"…she has this knack the way that she asks something…or whether it's just that I'm ready to talk, I don't know. But that she has this way of making me say things I didn't realise." (SU4)

"…she brought it all out of me, the real me inside. I mean, I had so many feelings and thoughts and she brought them all out." (SU2)

Psychologists were also seen as sensitive and skilful in the way they anticipated service users' emotional responses and helped service users recognise them in advance. In doing so, they gave service users greater control over choosing the best time to discuss distressing topics and ways to manage their emotions.

"…that's where the skill of the psychologist comes in, is they bring it out in a way where they minimise…I'm not saying they take it away…but they minimise the pain" (SU3)

Service users noticed that despite changes in their mood and situation each week, psychologists seemed to know how to thoughtfully respond to them each time.

"…to me that is mind boggling. How do you [psychologists] know, how do you know what to say? When to say it, and it's not just the words, it's the choice of words, it's the tone of voice, it's the speed, when you say it." (SU3)

The psychologists' skill seemed so unique and special to some service users, they developed a profound trust and belief in their ability to help them tackle their most difficult issues. The confidence service users had in psychologists' skill was demonstrated by the way they described them as "wise" (SU2), "skilled" (SU4), and as though they "walked on water" (SU3).

"If she [the psychologist] can make me feel better about myself, then she can make me feel better about everything, do you know what I mean?" (SU6)

Category 2. Making sense of the problem

All service users valued the opportunity in therapy to achieve a new way of understanding their difficulties. The themes in this category reflect the service users' experience of understanding the "underlying problem", and developing a "rare" and valued hope.

Theme 2.1 "Dealing with the underlying problem"

Service users felt that medication and confinement on the ward were not "dealing with the underlying problem" (SU3). They felt that other professionals did not take enough time to understand them, and they were unable to explore their deep-rooted issues until psychologists became involved in their care. Interventions by other professionals were more likely to be perceived as coercive or unhelpful.

"…[other professionals] just kind of kept pushing papers around the table and just you know, why don't we try this drug and we will try this anti-depressant or we will try that. Really, they are just missing the whole Sudoku of the mind." (SU4)

"The doctor doesn't really know me, they sit with me for, what - a little bit of time once a week, so they don't really know me." (SU6

For most service users it was a novel experience to have a psychologist link together their past experiences and show how they could help explain their current problems in a simple and memorable way.

"I told him stuff I did when I was younger like he would draw diagrams… like he drew a diagram of why that happened, the reason and stuff." (SU8)

This reduced the confusion and shame they felt about the chronicity of their symptoms and their unsuccessful attempts to manage their difficulties in the past. Making sense of the problem made it seem more manageable and controllable.

"…[the psychologist] said okay, the reason it's happening with you is, this, then this thing led to that. You see, so okay, maybe if this didn't happen, this would not have happened. Which means that maybe, I am not so messed up, I'm not such a jinx."(SU3)

Building a new personal meaning and understanding of themselves with the psychologist was a normalising experience for service users. They felt less isolated and blamed for their past struggles, and able to achieve a new self-acceptance.

"It makes you feel that you are not an idiot, it makes you, it shows you that actually there are reasons behind why you feel how you do. And easily explained reasons why you do it."(SU6)

Theme 2.2 Hope as a "rare commodity"

The overall experience of developing a therapeutic relationship and shared understanding with a psychologist offered all service users a new hope for the future. This was particularly valued by service users who felt that hope had been a "rare commodity" (SU3) in their lives.

"…what [the psychologist] and that did, they gave me hope. And for people like myself, situations I have been in, hope is not something we have and it's a rare commodity." (SU3)

Service users described how different aspects of working with the psychologist had offered them hope for the future. For example, some service users felt that a new way of understanding their difficulties was especially profound, and improved their overall confidence and outlook for the future.

"The last little pieces just slotted in and…I'm kind of better now, I feel much stronger emotionally now than I have maybe for 30 years." (SU4)

Other service users valued the techniques and strategies that they had been taught in order to manage their particular symptoms. This offered a new hope that they could be more in control of their reactions and could continue to benefit from psychological therapy in the future.

"I'm hoping within time, it will get me in my brain to think 'hey up, I'm not right now, perhaps I should be doing this, should be doing that.'" (SU5)

Most service users balanced this new hope alongside the uncertainty of the future and a real possibility of relapse when they moved beyond the structure of the ward. Despite this, they felt that they had made personally relevant gains, which needed to be cautiously acknowledged and measured. Service users began to re-evaluate the way they felt about themselves and expressed a considered hope and optimism for the future.

"To be able to say this is what is working for me is an improvement. That does not necessarily mean that you know, two days later I may not try and hang myself, because things come and go in waves. But it's the frequency of the waves, the intensity of the waves, you know, the progress has to be measured carefully." (SU3)

Category 3. Co-ordination of care

At any one time, service users often received several types of treatment intervention from different professionals in the ward team. The themes in this category reflect service users' need for both flexibility and consistency from psychologists in therapy, as well as a co-ordinated approach to their overall care on the ward.

Theme 3.1 Consistency and flexibility

Some service users felt that it was important for them to have an organised time for psychological therapy in the inpatient context to avoid missing sessions. Such consistency and structure allowed them to develop trust and a sense of safety in the therapeutic relationship.

"…she will tell me that 'I will see you at that time' as she realised that was what I needed. So, you know, that gave me faith. That gave me trust. Which led to this feeling of safety, which was very important to me." (SU3)

However, for others, flexibility in the timing of sessions, and even having unplanned sessions when required, were also helpful. One service user recognised that the symptoms he experienced meant he needed the psychologist to recognise when was the best time for therapy, and to offer reminders.

"…if you're confused, you might have a voice inside your head, or feel suicidal, don't know what's going on. You really need someone to organise your life for you, and say 'look, come in, now is the time, you've got an hour to see the psychologist, sit down, have a cup of tea, and do psychology.'" (SU2)

Service users also felt they required flexibility in the length and frequency of sessions to make therapeutic gains. Some felt that the gap of one week between sessions was too long for them to be able to reliably build upon their progress from the previous week, while others felt that an hour per week was not enough to discuss their issues in sufficient depth.

"…sometimes you just think 'I've just got into something and then I have to wait another week'. You know what I mean? Sometimes, you wish you could have a bit more." (SU6)

Some psychologists continued to offer sessions after service users had been discharged from the ward, although this was not possible for others. Service users felt that this continuity while transitioning back into the community was important in order to honestly discuss their concerns and to prevent relapse.

"…she knows so much about me, yeah. If I had been given someone else just for those few weeks, although I didn't know then it would have been only for a few weeks, it would have been difficult to starting up totally afresh again." (SU6)

The prospect of ending therapy was particularly difficult for one service user who feared they would not be able to achieve an open and trusting relationship with another psychologist in the future.

"I'm not scared of dying, but losing [the psychologist] is the biggest shock you know, because I developed that trust with her." (SU3)

Theme 3.2 "Taking my side"

Some service users felt that other members of the ward team did not fully understand their individual needs, or recognise the underlying issues contributing to their difficulties. This resulted in a perceived mismatch between the treatments emphasised by the ward team, and those valued by the service user.

"…the doctor is not keen on making sure I see [the psychologist], but it should be the priority. The priority is medication, and eating properly. There doesn't seem to be many… they make sure I eat properly and take medication, but they should say I should see the psychology session." (SU2)

One service user felt coerced by his psychiatrist when he disagreed with their treatment decision and valued the psychologist's intervention to help resolve the situation.

"So she [the psychologist] fought for me, for example, they wanted to give me ECT. And for a variety of reasons from the past, I was not going to take it. And the psychiatrist was adamant." (SU3)

As a result, service users emphasised the importance of the psychologist advocating on their behalf with different members of the ward team. They felt this input was invaluable in providing an accurate and consistent understanding of their needs across the ward team, and ensuring that their voice was heard in making important treatment decisions.

"She always used to meet up with me in the ward round and took my side." (SU1)

Conflicting treatment approaches within the team sometimes impacted on the psychological therapy sessions. One service user felt he needed to use the therapy sessions to discuss his frustration with other professionals and find ways to communicate his perspective: consequently, focusing on his longstanding difficulties took a back seat.

"…the immediate was dealt with, but the long term, underlying problem wasn't. So it kept getting delayed and then people saying 'well he's got 30 sessions'. But how do you explain to them that, you know, we couldn't really focus on the issue?" (SU3)

Discussion

This study explored the experiences of engaging in individual psychological therapy in the acute inpatient setting, from the perspectives of service users and psychologists. There were many parallels between the service user and psychologist accounts. Firstly, despite challenges, both service users and psychologists emphasised the importance of developing a therapeutic relationship. For service users, this was central to feeling respected and working collaboratively with the psychologist, which they felt was not always achieved with other professionals. Similarly, psychologists felt that sharing a sense of humanity with service users was important in an inpatient setting dominated by a biomedical approach. Secondly, both service users and psychologists described challenges of working together within the wider system on the ward. Service users particularly valued the psychologists' willingness to advocate on their behalf; psychologists highlighted the experience of walking a "tightrope" in balancing multiple roles and relationships within the team. In addition, the two sets of accounts included several distinctive themes. Psychologists described significantly adapting traditional therapeutic models in therapy, while also remaining flexible to the unpredictability of events on the ward and service users' distress. Although the service user accounts of therapy varied,

most service users felt they were better able to understand their underlying problems and achieved a valuable new hope for the future.

Developing a therapeutic relationship

Both service users and psychologists described how the therapeutic relationship was particularly important to the process of psychological therapy in the acute inpatient setting. Service users described the therapeutic relationship as characterised by feeling listened to and understood by their psychologist; this, plus the psychologist's acceptance of them helped them to develop trust and to open up about their personal thoughts and feelings. These findings are broadly consistent with existing explanations of the therapeutic relationship in psychological therapy delivered in outpatient settings, often for more common mental health problems such as depression (see Horvath & Luborsky, 1993). This finding is particularly striking given the nature of the acute inpatient context where psychologists faced significant challenges in delivering traditional models of psychological therapy (McGowan & Hall, 2009). In addition, psychologists were unable to predict the frequency or duration of therapy due to changes in service users' symptomology, levels of medication and discharge planning. These difficulties may go some way to explaining why there is currently a lack of evidence in the literature for the important role of the therapeutic relationship in the psychological treatment of severe and enduring mental health problems, particularly in inpatient settings. In this study, psychologists explained that by remaining flexible to the environment and the individual needs of service users, they were able to develop strong bonds with service users characterised by a sense of trust and respect central to the overall aims of the therapeutic work. Further research is needed to explore the role of the therapeutic alliance in the psychological treatment of severe and enduring mental

health problems in inpatient settings, and it's possible association with therapy outcomes.

Service users particularly valued the relationship with the psychologist because of the contrast to relationships with other staff. For example, service users described that other staff appeared too busy, inattentive and less collaborative compared to their experience of the psychologist. Similarly, psychologists described that "sharing humanity" with service users was especially important in a setting dominated by a biomedical approach to care. Similar ideas have been expressed in user-led research demonstrating that basic human qualities such as kindness, empathy and respect are most valued in developing effective relationships with inpatient staff (Gilburt et al., 2008). Independent reviews into inpatient care have consistently emphasised the need to improve the overall quality of therapeutic relationships in the acute inpatient environment (MIND, 2011). However, the systemic challenges to achieving this within the current mental health care system are also apparent. Research has indicated that nurses are often inadvertently encouraged to focus on risk and ward management tasks on the ward, at the expense of one-to-one time with service users, making them appear inaccessible (Bee et al., 2008; Stenhouse, 2011). Similarly, psychiatrists have reported that the immense time pressure they face in providing care undermines their ability to meet the individual needs of service users alongside managing major risk and clinical decision making (Green & Bloch, 2001). These issues underline the importance of developing systems to support multidisciplinary team members in delivering psychologically informed and recovery-based approaches to care (Holmes, 2002).

Psychologists highlighted the possibility of dependency within the therapeutic relationship as particularly significant in the inpatient setting and

recognised that ending therapy at the same time as discharge from the ward was potentially de-stabilising for service users. Research has shown that issues of dependency are relevant in many forms of psychological therapy (Weiss, 2002). In particular, dependency has been highlighted in the psychological treatment of personality disorders, where relational dysfunction can occur around fears of abandonment and social isolation (Gunderson, 2008). In addition, service users on acute wards are more likely to have experienced family breakdown and impoverished social networks (Bowers et al., 2009). Thus, although dependency is a common issue in therapy, the diagnostic profile of service users in the acute inpatient setting, combined with a potential lack of social support upon discharge, may particularly heighten the issue in the inpatient context.

Individual therapy in the inpatient environment

One of the central challenges in delivering psychological therapy was the need to adapt traditional therapeutic models to "fit" the acute inpatient setting. Psychologists felt that the level of functioning and insight required by traditional therapies was not realistic for service users experiencing acute distress and the effects of medication. Psychologists also adapted the therapy to the unpredictable lengths of stay and restricted ward environment. This offers a particularly important insight into the process of delivering psychological therapy on inpatient acute wards, which has been poorly reflected in the literature so far (McGowan & Hall, 2009). Further research is required to develop evidence for the effectiveness of adapted therapeutic approaches and guidelines for clinical practice.

Despite the psychologists' inability to implement NICE recommended therapeutic models, service users felt they helped them to understand their "underlying problems", and achieve a tentative hope of successfully managing their

symptoms in the future. These outcomes are consistent with the current literature on key recovery processes in acute mental health care. For example, systematic review evidence has shown that experiencing a connection with others, and the promotion of hope and empowerment, are common features of recovery from mental health crises (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Similarly, developing a sense of control over mental health symptoms has been recognised as fundamental to regaining self-respect and self-esteem in recovery (Baker, Sanderson, Challen, & Price, 2014). This underlines an important challenge for psychologists to evidence the recovery outcomes promoted by individual psychological therapy in acute inpatient settings (Durrant, Clarke, Tolland, & Wilson, 2007).

Both service users and psychologists described attempting to find a balance between consistency and flexibility in therapy, as well as in the wider team to provide a co-ordinated approach to care for service users on the ward. The importance of this process has been supported by research showing that a ward atmosphere that strikes an appropriate balance between structure and responsiveness is associated with improved service user satisfaction and reduced readmission rates (Middelboe, Schjødt, Byrsting, & Gjerris, 2001). However, the accounts from service users and psychologists highlighted that there were also significant obstacles to achieving this, which inevitably impacted on the psychological therapy. In some instances, psychologists described responding to the priorities of the team in dealing with events on the ward, which impacted on their ability to offer consistent therapy sessions. Psychologists also felt they were perceived by other professionals as "too soft" or "easily manipulated" due to their interpersonal approach and positive rapport with service users. This seemed to exacerbate differences between professionals on the ward and decrease the likelihood of providing a consistent therapeutic approach

within the team. Thus, the complexity of roles and relationships in the inpatient environment may impact on psychologists' ability to provide consistent and effective psychological therapy. This is an area which warrants further research to understand the way in which other clinicians perceive the role of psychologists and individual psychological therapy in this setting. This will be important for the future planning of inpatient psychological services to maximise cooperation and co-ordination of care for service users.

Limitations of the study

Several methodological issues need to be considered when interpreting the findings. The study had a small sample size, with few black or minority ethnic participants, and all were recruited from a single London-based psychiatric hospital. The participants represented a subset of service users who were willing to discuss their experiences, and were well enough to participate in a one-to-one interview with the researcher. Given that the interviews required a certain level of verbal ability and comprehension, service users with poor verbal skills and impaired intellectual functioning were excluded. Thus, the service user participants in this study are not representative of the acute inpatient population, and consequently the overall generalisability of the findings is limited.

A second, important issue is that the service users' accounts were uniformly positive, despite the researcher's efforts to encourage and capture negative views. This might be due in part to the recruitment procedure, whereby psychologists identified potential participants: they may have been more inclined to approach service users who stayed in therapy, developed a therapeutic alliance, and had more positive experiences of therapy. Another possibility is that the interactions service users had with psychologists starkly contrasted to their other interactions on the

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ward, making it more likely that service users idealised their psychologist and were more likely to report positively on their experiences. The researcher sharing a professional background with the psychologists may also have influenced service users to report more positively on their experiences of therapy.

It is notable that no service users who had dropped out of, or declined, psychological therapy were recruited. It is likely that these individuals would have had less favourable experiences of therapy, and may not have developed a meaningful therapeutic relationship with their psychologist. Without such views, it is difficult to understand the relative importance of the experiences described by the service users in this study, and their possible relation to staying in therapy and reporting subjectively positive outcomes. Therefore, the findings represent a limited range of experiences of psychological therapy in acute inpatient settings. Despite this, however, the findings may demonstrate what is possible to achieve with some service users under optimal circumstances in therapy, rather than what is typical.

Some service users were able to engage with the interview and reflect on their experiences more than others, which meant the richness of the accounts varied across participants. This was mainly due to the fact that service user participants experienced varying levels of symptomology, medication, and lengths of time since admission at the time of interview. As a result, the findings in this study drew on the accounts of some service users more than others, due to the level of information and detail provided.

The study also had a small sample of six psychologist participants from various training backgrounds and levels of experience in a relatively new psychological service. Also, most of the psychologists reflected on their psychological work with just one service user in the study. Thus, the findings may

not be generalisable to a broader range of psychologists working in acute inpatient settings.

Research implications

The findings of this study suggest that service users can develop a meaningful therapeutic relationship and experience personally beneficial outcomes from psychological therapy in acute inpatient settings. However, further research should focus on better understanding the effectiveness of adapted therapeutic approaches in this setting, as well as using quantitative measures to assess the therapeutic alliance and outcomes. This will help to provide crucial evidence for the effectiveness of psychological interventions and guide clinical practice in the future.

The conditions of the acute inpatient ward are not conducive to conducting Randomised Controlled Trials (RCTs), which are considered the 'gold standard' of evidence in mental health care (Slade & Priebe, 2001). Therefore, psychologists must use alternative approaches to develop evidence of the psychological work that is effective in this setting, for example practice-based evidence using quasi-experimental designs (Anthony, Rogers, & Farkas, 2003). However, there is currently little consensus about the most appropriate outcome measures of the effectiveness of psychological therapy on inpatient units. While this study found that service users described personally beneficial experiences of therapy, more standardised methods of assessing outcomes are required in order to provide evidence for the effectiveness of psychological approaches. Meaningful benefits of short-term psychological work have been demonstrated using self-esteem questionnaire measures pertinent to specific types of psychological intervention (Durrant et al., 2007). However, questionnaire measures may place inappropriate cognitive and emotional demands on service users and fail to incorporate their

subjective experience (Walsh & Boyle, 2009). The most appropriate measures should be developed in consultation with service users alongside qualitative research exploring their experiences in this setting. For example, the findings of this study suggest that service users value making sense of their underlying problems to achieve a sense of control over their symptoms and hope for the future. In addition, psychologists perceived that dependency may be an important issue in the inpatient setting and should be considered when choosing and developing measures related to the therapeutic relationship.

Clinical implications

Given the brevity of stay and nature of mental health disturbance on most inpatient wards, it would not be realistic or appropriate to recommend psychological therapies for all service users. However, the service users' accounts point to the importance of developing therapeutic relationships not only with psychologists, but with all clinical staff in this setting. Therefore, an important role for psychologists is to promote the development of therapeutic relationships with all staff on the wards in line with a recovery-orientated approach (Leamy et al., 2011). Clinical psychologists have the knowledge and expertise to train and support clinical staff to improve the overall quality of care on acute wards. This approach should emphasise "being human" in interactions with service users, allowing staff to see the person rather than the label, and taking account of the subjective personal experiences (Holmes, 2002). However, this will require a significant change to the current culture, management and training in inpatient mental health services (Baguley et al., 2007). To accomplish this necessitates committed action from government, research and management sectors, but if successful, the positive impact on service users' experience and recovery would be significant.

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Part 3: Critical Appraisal

Introduction

In this critical appraisal, I will reflect on the role I took in conducting the research presented in Part 2 of this thesis. The first section outlines the role of self-reflexivity in qualitative research and considers the ways in which my preconceptions may have shaped and influenced the research. In the second section, I consider the methodological and ethical considerations that were made in interviewing both service users and psychologists in the acute inpatient setting. In doing so, I highlight the ways in which I attempted to overcome the challenges I faced in interviewing participants and analysing the data, and developed my skills as a clinical researcher. Finally, the third section considers some broader conceptual and clinical issues relevant to the development of therapeutic relationships in the inpatient setting. In particular, I discuss the importance of developing a 'human' approach and promoting personal autonomy in inpatient settings.

Self-reflexivity

Qualitative research is concerned with investigating individual descriptions of complex social and psychological experiences (Barker et al., 2016). The process of analysis involves examining the meaning and interpretation that are given to participants' experiences (Willig, 2008). However, the position and role of the researcher in conducting the analysis means that their own individual experiences and perspectives are also inevitably involved in shaping the findings (Tufford & Newman, 2010). Reflexivity allows the researcher to consider the ways in which their values, experiences, interests, beliefs and social identity have shaped the research (Willig, 2008). This provides an important context in which the meaning derived from the research can be understood and evaluated (Elliott et al., 1999).

I first became familiar with the psychological treatment approaches to severe and enduring mental health problems while working in a medium-secure forensic mental health hospital prior to clinical psychology training. The role of forensic mental health services has been described as facilitating a therapeutic environment for mentally ill offenders, protecting society, managing risk and maintaining security (Kennedy, 2002). Despite the provision of psychological services in the forensic inpatient setting in which I worked, the majority of offenders distrusted psychologists and were reluctant to engage in psychotherapeutic treatment. They worried that discussing their background or personal feelings with a psychologist might heighten professionals' concerns about risk, and increase their levels of medication or length of stay. These concerns were reflected in the conflicting roles that psychologists held as both providing treatment to relieve psychological distress, and contributing to expert risk assessment, medication decisions, and reports for the Ministry of Justice (Maruna, 2011). From a psychological perspective, I understood the importance of developing a strong therapeutic relationship for effective psychotherapeutic treatment (Horvath & Luborsky, 1993). I perceived that for many psychologists, these 'dual roles' consistently undermined their attempts to develop strong therapeutic relationships on the wards, which in turn made it less likely that service users would engage in psychological treatment. This experience meant that I approached the research project assuming that the 'dual role' of psychologists in the care of involuntary service users presented a significant barrier to developing a strong therapeutic relationship in psychological treatment (Crewe, 2009).

In conducting the interviews, I attempted to 'bracket' my assumptions (Ahern, 1999; Fischer, 2009) about the impact of service users' voluntary or involuntary status on their perceptions of psychologists, and their ability to develop a

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therapeutic relationship. However, there was sometimes a tension between bracketing my assumptions, and using them to inform my follow-up questions (Finlay, 2002). I attempted to mitigate this by taking a curious stance in interviewing. I attempted to use reflections, summaries, and open-ended questions to stick closely to the service users' experiences of working with the psychologist while being held under mental health section.

In reviewing the transcripts, I found that neither service users' nor psychologists' accounts were consistent with my preconceptions about the difficulties posed by involuntary admission and psychologists' 'dual role' in this setting. I found that by re-reading the transcripts several times, and using quotes from the text at each stage of the analyses, I gained a more nuanced understanding of psychologists' multiple roles and relationships in this setting. Similarly, I gained insights into the valued experiences of service users, as well as their ability to develop a therapeutic relationship. Discussing tentative themes with my research supervisor enabled me to form the conceptual ideas about both the parallel and distinctive service user and psychologist experiences in the data.

Reflexivity also can be used to consider how the process of conducting the research has changed and influenced the perceptions and beliefs of the researcher (Willig, 2008). Through the process of hearing service user and psychologist experiences of developing a therapeutic relationship, and navigating the barriers of the inpatient setting, I began to consider the benefits of psychologists' multiple roles. Rather than perceiving psychologists as just therapy providers, service users viewed psychologists as taking a more integrated and co-ordinated approach to their care based on their ability to helpfully advocate for them, and bring an in-depth understanding of their personal issues to the team. In addition, psychologists

attempted to effect change within staff teams to help them creatively manage the challenges in the ward environment. Above all, demonstrating an ability to remain "human" in the interactions with staff and service users seemed to helpfully overcome power imbalances and create an environment where problems and difficulties could be discussed and overcome collaboratively. This led me to re-evaluate my views on the 'dual roles' of psychologists by perceiving their significant benefits in creating a therapeutic environment and contributing to the integrated care and recovery of service users in the ward setting.

Interviewing service users and psychologists

Interviewing service users and psychologists in an acute inpatient setting raised several important methodological and ethical issues. Service users in this setting experienced varying levels of acute and distressing mental health symptoms, and their mental state was also affected by various medications. Thus important adjustments needed to be made to account for differences between participants at the time of interview. Firstly, the semi-structured nature of the interview schedule offered flexibility that enabled areas to be explored in more or less depth, according to the individual's memory, ability and preference (Britten, 2006). The interview deliberately began with more closed questions that the service users could answer easily and then proceeded to more open-ended questions which required personal reflection and insight (Britten, 2006). This helped me put the service user at ease, build up their confidence in answering the questions, and establish a rapport (Gill, Stewart, Treasure, & Chadwick, 2008). If service users had difficulty in answering open-ended questions, I attempted to use more focused 'entry questions' (e.g. "can you tell me about a time when…?") followed by follow-up, or unfolding probes to encourage them to provide more detail and clarity in their responses (Barker et al.,

2016). At times service users' responses appeared to be incongruent, or influenced by delusional thoughts and ideas they were experiencing. I attempted to listen and acknowledge these thoughts, while also tracking the relevance of their responses to the overall research questions, and adjusting the direction of questioning when necessary (Kvale, 1996). Thus, interviews often took longer, and there was more deviation from the intended focus, than initially expected.

Using in-depth interviewing to study the therapeutic relationship had the potential to threaten the privacy and confidentiality of participants if an interviewee perceived the probes as intrusive, or as attempting to reveal details between the pair that were previously undisclosed (Forbat & Henderson, 2003). In interviewing service users and psychologists, I addressed this issue by asking service users and psychologists to refrain from discussing topics that they would expect to be kept confidential within the therapy. However, as semi-structured interviewing can sometimes explore unanticipated areas, it was important to remain aware of potential confidentiality issues throughout the interview (Brinkmann & Kvale, 2008). In order to prevent participants from feeling obliged to continue discussing a topic they did not feel comfortable with, I continually reaffirmed their willingness to pursue the direction of questioning throughout the interview (Rosenblatt, 1995). In cases where participants were concerned about protecting confidentiality or chose not to discuss issues further, we agreed to change the line of questioning. My ability to navigate the interviews, and know when (and when not) to explore topics further, developed over the course of the research process. During initial interviews I stuck more rigidly to the interview schedule and asked less open-ended follow-up questions, which arguably provided fewer opportunities for participants to offer in-depth accounts of their experiences. As my confidence in interviewing grew, however, I began to be

much more flexible in my approach, and stayed closer to what the participants were saying, inviting them to expand on the issues that had personally affected them.

Research has shown that the identity participants attribute to the interviewer plays an important role in forming the 'data' that is collected (Chew-Graham, May, & Perry, 2002). In this research, I took on the role of interviewer and researcher, but I was also a Trainee Clinical Psychologist working in a separate clinical setting. In interviewing service users, I was aware that there was a risk of portraying a therapeutic intent by the empathic stance or style of questioning which I was accustomed to in clinical practice (Brinkmann & Kvale, 2008). I attempted to mitigate this risk by adjusting my language, and disclosing my professional background to service users, while also emphasising my role in the interview as a researcher (Richards & Schwartz, 2002). I found that my clinical skills were an important advantage in maintaining an empathic, flexible and relaxed approach during the interviews, encouraging the service user to relax and reflect on their experiences (Barker et al., 2016). I believe that being independent from the clinical setting was a particular advantage, and offered the participants an opportunity to speak more freely and provide comments about issues they may have felt unable to make in the presence of staff members from the inpatient unit. However, participants may also have been influenced by the fact that I shared a professional background with the psychologists, and thus felt more inclined to give a positive account of psychological therapy. It is possible that the participants' accounts would have differed in content if a member of the ward team, or a researcher from an alternative professional background had conducted the interviews.

In interviewing the psychologists, I was aware that I was more likely to be treated as a peer, given that I had the same professional background (Chew-Graham

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et al., 2002). I noticed that psychologists tended to use psychological jargon to describe the therapeutic techniques they used and assumed that I would understand their meaning since we shared a common language and frame of reference as fellow psychologists. This presented the risk in interview that my understanding of these terms would prevent me from asking follow-up questions and influence my interpretation of the data (Chew-Graham et al., 2002). I attempted to overcome this by checking with the participants that I understood their individual meanings during the interview, instead of relying on my own assumptions and knowledge (Britten, 2006). I also reflected on these processes with my research supervisor during the interviewing and data collection.

Therapeutic relationships in the inpatient setting

It is well established in the literature that the strength of the therapeutic relationships formed in the psychiatric inpatient settings are highly correlated with service user satisfaction and recovery outcomes (Priebe & McCabe, 2006; Priebe, Richardson, Cooney, Adedeji, & McCabe, 2011). Despite this, poor relationships between staff and service users are frequently reported (Stenhouse, 2011) and many studies have reported on the barriers to developing therapeutic relationships in the inpatient setting (McCabe & Priebe, 2004; Quirk & Lelliott, 2001).

The findings of this study highlight that the most important determinants of the therapeutic relationship, whether in the context of psychological therapy or with staff on the ward, are basic personal qualities and interpersonal relationship skills (Sweeney et al., 2014). This includes the ability of staff to listen and to demonstrate warmth and empathy within their professional role. It is a major cause for concern that service users often experience and report a lack of care, humanity and compassion in their interactions with ward staff (Sweeney et al., 2014). Greater

research and discussion around these issues are urgently required if we are to adequately improve the situation, and promote therapeutic relationships in line with the best practice guidance for recovery-oriented mental health services (Le Boutillier et al., 2011).

Supporting the development of therapeutic relationships and basic human values in inpatient mental health care is likely to require individual, cultural and systemic change in mental health services (Holmes, 2002). It may be that the high levels of stress experienced by inpatient staff cause them to experience burnout, and they then lack the capacity to provide empathic support to others in this environment (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). This is particularly an area where the skills of a psychologist may be beneficial in offering intervention for staff, drawing on a broad range of cognitive-behavioural approaches. For example, educational information, cognitive restructuring, progressive muscle relaxation, social skills training and communication skills training have all been shown to reduce the effects of burnout and emotional exhaustion (Awa, Plaumann, & Walter, 2010). However, individual level interventions alone are unlikely to be successful without organisational level changes. For example, staff could be provided with services aimed at increasing social support, especially by teaching communication and social skills to supervisors, and providing mentors (Morse et al., 2012). Future research should explore and evaluate the introduction of training programs that offer skills for clinical staff to engage and interact with service users in order to enhance their therapeutic relationships.

Another important factor in determining the strength of therapeutic relationships is the loss of personal autonomy that often occurs upon entering the inpatient ward (Hughes, Hayward, & Finlay, 2009; Sweeney et al., 2014). Service

users who have been detained by compulsion, as well as those staying voluntarily, have reported a loss of autonomy in the inpatient setting (Johansson & Lundman, 2002). This is important because the power dynamics established between service users and staff in the inpatient setting risk creating interactions where service users feel disempowered and coerced. Gilburt, Rose and Slade (2008) found that perceived coercion was the main barrier to therapeutic relationships between service users and staff in the inpatient setting. Despite this, evidence has shown that staff's accounts of service users' inpatient experience pay little attention to issues of autonomy (Sweeney et al., 2014). This is problematic as it increases the likelihood that staff may unintentionally exacerbate power imbalances in interactions with service users. For example, staff may inadvertently express annoyance or ignore a patient's reports of symptoms, or requests for support. The experience of not being seen as someone worth respecting can have a negative impact on mental health and increase a service user's vulnerability (Johansson & Lundman, 2002).

Psychologists have a role in training staff and raising awareness of the interpersonal and psychological factors relevant to increasing an individual's sense of personal autonomy within the confines of the inpatient setting. For example, interactions with staff can serve to be therapeutic and strengthen autonomy by allowing service users to develop personal narratives that incorporate their experiences within mental health care (Roe & Davidson, 2005). Regular reflective practice and supervision time for staff can also enhance the effectiveness of interpersonal skills training and development (McCabe & Priebe, 2004).

The findings of the study reported in Part 2 of this thesis suggest that openly discussing the aims of treatment, as well as working collaboratively in the process of therapy, were central to developing a therapeutic relationship and making therapeutic

gains. This is consistent with evidence that providing information about treatment and care, as well as service users' ability to exercise some choice and control over clinical decision-making, is important in improving autonomy (Johansson & Lundman, 2002). However, research has shown that previous attempts to offer these elements in the absence of positive therapeutic relationships were not effective in reducing perceived coercion (Sørgaard, 2004). Furthermore, service users have been shown to view their experiences as more coercive when they had negative relationships with clinicians (Sheehan & Burns, 2011). This suggests that interventions to reduce coercion must be combined with efforts to improve therapeutic relationships in the inpatient setting. This is a promising area for future research with the potential to understand the processes by which clinicians establish and maintain positive therapeutic relationships within complex inpatient mental health care settings.

Conclusion

During the research process, I attempted to negotiate the tension between bracketing my assumptions, biases and personal experiences, and using them to inform and develop the research. I also developed my qualitative interviewing skills and became more attuned to the ethical considerations when interviewing service users and psychologists. In analysing the accounts, I was struck by the way service users particularly emphasised and valued the 'human' qualities psychologists demonstrated in individual therapy, rather than any specific therapeutic approaches or techniques. For me personally, it illuminated the way in which psychologists can negotiate multiple roles within the inpatient setting and promote the development of positive relationships.

The findings of this study have important implications for psychologists developing practice-based evidence to support the important role of psychological therapy in inpatient settings. Further research and intervention is needed to prioritise the development of positive therapeutic relationships in inpatient care. Potential areas for further exploration are the role of burnout and personal autonomy in developing therapeutic relationships. To sufficiently improve the current situation, it is clear that concerted cultural and systemic changes will be required at both the individual and organisational levels in inpatient mental health services.

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Appendix 1. Categories of outcome variables

Study	Outcome measure	Rater	Category
Berry et al. (2015)	1. End of therapy forms (e.g. challenges, strengths, symptoms) 2. GAF 3. Substance misuse 4. PaNSS	1. Therapist 2. Observer 3. Client, informant, hair sample 4. Observer	1. Psychological functioning 2. Psychological functioning 3. Psychological functioning 4. Psychological functioning
Dunn et al. (2006)	5. PaNSS 6. Scale to assess homework compliance	5. Therapist interview 6. Therapist and client	5. Psychological functioning 6. Adherence
Frank and Gunderson (1990)	7. Length of stay in treatment 8. Medication compliance 9. Ratings aggregated across several measures to assess signs and symptoms, cognitive functioning, ego functioning, social functioning and major role performance	7. Therapist, client, medical records 8. Therapist, client, medical records 9. 7 blind observers, 3 client	7. Adherence 8. Adherence 9. Psychological functioning
Goldsmith et al. (2015)	10. Number of sessions attended 11. PaNSS	10. Records 11. Blind observers	10. Adherence 11. Psychological functioning
Huddy et al. (2012)	12. Working memory (WAIS-III). 13. Target complaints scale 14. Rosenberg Self-esteem Scale	12. Observer 13. Client 14. Client	12. Psychological functioning 13. Psychological functioning 14. Psychological functioning
Jung et al. (2014)	15. PANSS 16. CDSS 17. GAF 18. Social functioning - (RFS)	15. Observer/therapist consensus 16. Observer/therapist consensus 17. Observer 18. Observer interview	15. Psychological functioning 16. Psychological functioning 17. Psychological functioning 18. Psychological functioning
Startup et al. (2006)	19. Drop out (attended less than 12 sessions)	19. Records	19. Adherence
Svensson and Hansson (1999)	20. Hopkins Symptoms checklist 21. Comprehensive psychopathological scale 22. Quality of life interview 23. Target complaints interview 24. GAF	20. Client 21. Observer interview 22. Observer interview 23. Client 24. Observer interview	20. Psychological functioning 21. Psychological functioning 22. Psychological functioning 23. Psychological functioning 24. Psychological functioning

Appendix 2. Categories of predictor variables

Study	Predictor measure	Category	Rater
Barrowclough et al. (2010)	1. Social/occupational functioning (GAF) 2. CDSS 3. Substance use 4. Inventory of drug use consequences 5. Attitude to treatment (Readiness to Change, Drug Attitudes) 6. PaNSS	1. Functioning 2. Mood 3. Substance misuse 4. Substance misuse 5. Substance misuse 6. Symptoms – P&N&G& insight	1. Researcher 2. Observer 3. Client 4. Client 5. Client 6. Researcher
Berry et al. (2015)	**7.** Psychosis Attachment Measure (PAM)	**7.** Relational	**7.** Client
Couture et al. (2006)	8. PaNSS 9. Social Functioning Scale	8. Symptoms – P&N 9. Functioning	8. Blind research staff 9. Client
Davis et al. (2011)	10. Mastery (MAS)	10. Cognitive	10. Observer
Davis and Lysaker (2004)	11. Hopkins Verbal Learning Test (HVLT) 12. Vocabulary and block design subtests of WAIS-III 13. Attention (Conners Continuous Performance Test II)	11. Cognitive 12. Cognitive 13. Cognitive	11. Observer 12. Observer 13. Observer
Dunn et al. (2006)	14. Suspicion, hostility and poor insight (PaNSS) 15. Suitability for short term cognitive therapy	14. Symptoms – P&N&G 15. Other	14. Therapist 15. Therapist
Evans jones et al. (2009)	16. Subjective Experience of Negative Symptoms (SENS) 17. Beck Cognitive Insight Scale (BCIS) 18. Baseline Functioning Scale (PAF) 19. Reaction to Hypothetical Contradiction Measure (RTHC) 20. The Psychotic Symptom Rating Scales (PSYRATS) 21. Scale for the Assessment of Positive Symptoms (SAPS) 22. CRF (therapist attractiveness, competence, and trustworthiness) 23. Relationship Inventory (RI)(therapist empathy) 24. Presentation of a Case Formulation Checklist (PCFC) 25. CBTp Checklist	16. Symptoms - N 17. Insight 18. Functioning 19. Insight 20. Symptoms –P&N 21. Symptoms - P 22. Therapist qualities 23. Relational 24. Other 25. Other	16. Client 17. Client 18. Researcher 19. Researcher 20. Researcher 21. Researcher 22. Client 23. Client 24. Therapist 25. Therapist

Huddy et al. 2012	26. Social skills (Work Behaviour Inventory)	26. Functioning	26. Observer
	27. Cognitive skills (WAIS-III, California Verbal Learning test)	27. Cognitive	27. Observer
	28. HADS	28. Mood	28. Client
	29. PaNSS	29. Symptoms –P&N& insight	29. Observer
Johansen, Melle, et al. (2013)	30. Personality traits (NEO-FFI)	30. Relational	30. Client
	31. Interpersonal problems (IIP-64C)	31. Relational	31. Client
	32. PaNSS	32. Symptoms –P&N& insight	32. Observer
Johansen, Iversen, et al. (2013)	33. PaNSS	33. Symptoms - P&N	33. Observer
	34. General intellectual functioning: 4 subtests of WAIS-III	34. Cognitive	34. Observer
	35. Verbal memory: California Verbal Learning Test II	35. Cognitive	35. Observer
	36. Executive functioning: Wisconsin Card Sorting Test	36. Cognitive	36. Observer
	37. Attention: (CPT-II)	37. Cognitive	37. Observer
Jung et al. (2014)	38. PaNSS	38. Symptoms – P&N&G& insight	38. Observer/therapist consensus
	39. CDSS	39. Mood	39. Observer/therapist consensus
	40. Social functioning - (RFS).	40. Functioning	40. Observer interview
	41. GAF	41. Functioning	41. Observer/therapist consensus
	42. Theory of Mind	42. Relational	42. Independent observer
Jung et al. (2015)	43. BQTC (therapist empathy, genuineness, positive regard)	43. Therapist qualities	43. Client
	44. QARTC (Therapist competence, convincingness)	44. Therapist qualities	44. Client
	45. PANSS.	45. Symptoms P&N&G& insight	45. Therapist interview
Kvrgic et al. (2013)	46. Recovery Assessment Scale (RAS)	46. Other	46. Client
	47. Self-Stigma (Corrigan's Self-stigma Scale)	47. Other	47. Client
	48. Birchwood Insight Scale (BIS)	48. Insight	48. Client
	49. PaNSS	49. Symptoms –P&N	49. Blind researchers
	50. Psychosis Attachment Measure (PAM)	50. Relational	50. Client
	51. BDI-II	51. Mood	51. Client

Lysaker, Davis, Buck, et al. (2011)	52. PaNSS	52. Symptoms -P&N	52. Researcher
	53. Scale to Assess Unawareness of Illness (SUMD)	53. Insight	53. Researcher
Lysaker, Davis, Outcalt, et al. (2011)	54. Trauma Assessment for Adults (TAA)	54. Other	54. Client
Svensson and Hansson (1999)	55. Hopkins Symptoms checklist	55. Symptoms -G	55. Client
	56. Comprehensive psychopathological scale	56. Symptoms -G	56. Observer interview
	57. Quality of life interview	57. Functioning	57. Observer interview
	58. Target complaints interview	58. Functioning	58. Client
	59. Strauss Carpenter functioning criteria	59. Functioning	59. Observer interview
	60. GAF	60. Functioning	60. Observer interview
Wittorf et al. (2009)	61. PaNSS	61. Symptoms – P&N&G	61. Blind observers
	62. SUMD (global insight)	62. Insight	62. Observer
Wittorf et al. (2010)	63. PaNSS	63. Symptoms –P&N	63. Blind observer
	64. SUMD (global insight)	64. Insight	64. Observer
	65. Use of cognitive disputing strategies	65. Other	65. Therapist

Appendix 3. NHS research ethics committee approval

09 July 2015

Dr Vyv Huddy
University College London
1-19 Torrington Place
London
WC1E 7HB

Dear Dr Huddy

Study title:	Service User and Staff Experiences of the Provision of Psychological Support in an Inpatient Mental Health Setting
REC reference:	15/EM/0263
IRAS project ID:	171378

Thank you for your letter of 3 July 2015, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter.   The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Assistant Tad Jones, ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮ Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

<u>Registration of Clinical Trials</u>

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact█████████████████████The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" above).

Approved documents

The documents reviewed and approved by the Committee are:

Document	Version	Date
Covering letter on headed paper	1	27 May 2015
Covering letter on headed paper	2	03 July 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Document]	1	
Interview schedules or topic guides for participants [formal support service user]	1	

Interview schedules or topic guides for participants [Interview schedule about formal support psychological therapist]	1	29 May 2015
Interview schedules or topic guides for participants [informal support service user]	1	29 May 2015
Interview schedules or topic guides for participants [Interview schedule informal support staff member]	1	29 May 2015
IRAS Checklist XML [Checklist_03072015]		03 July 2015
Letter from sponsor [Confirmation from sponsor]	1	
Other [CV Anna Galloway]	1	01 April 2015
Other [CV for student Catherine Small]	1	02 April 2015
Participant consent form	1	01 April 2015
Participant information sheet (PIS) [Staff]	v1	01 April 2015
Participant information sheet (PIS) [Patient]	1	01 April 2015
REC Application Form [REC_Form_27052015]		27 May 2015
Referee's report or other scientific critique report	1	16 December 2014
Research protocol or project proposal	3	03 July 2015
Summary CV for Chief Investigator (CI)	1	01 April 2015
Summary CV for supervisor (student research)	1	01 April 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

<u>Reporting requirements</u>

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

<u>Feedback</u>

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

15/EM/0263	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

pp. ████████████████

Vice-Chair
Mrs Janet Mallett

Email: ███████████████████████████

Appendix 4. Service user participant information sheet

Participant Information Sheet: Version 1

Exploring the experience of talking therapies in ward environments

You are being invited to take part in a research study. This information sheet explains the purpose of the research study and what participating will involve. Please take time to read the following information and discuss it with others if you wish. If there is anything that is unclear, or if you would like more information, please ask.

What is the reason for the study and why is it important?
We would like to explore what people think about psychological therapies that are offered on inpatient wards. The information we gather may help us to find ways to make talking therapies more accessible and meaningful to individuals who are part of the ward. We hope this will give individuals more choice and variety in the services they can access.

Why have I been chosen?
You have been invited to participate in this study because you are or have been resident on the ward and may be expected to receive psychological therapy.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form to say that you have agreed to take part. If you decide to take part you are still free to change your mind at any time during the study without giving a reason. The choice to take part or not will not affect the care you receive.

What will happen if I take part?
If you agree to take part, we will arrange a time to meet with you and conduct an informal interview lasting no longer than an hour. During the interview they will ask you some broad questions about your views and experiences. Notes will be taken of your responses and the interview will be audio recorded. Once it the recording has been typed up, the recording will be destroyed.

What happens if I don't want to discuss something during the interview?
It is up to you what you talk about and you are free to refuse to discuss anything about which you do not feel comfortable.

What will happen to the results of the research study?
The researchers will listen to all the interviews, identify frequent themes and ideas, such as those that are talked about by more than one person. These themes will be written up into a report. If you would like a copy of the final research report you can contact the research team.

Will I be identified in any report?

Your name will not be identified in any report. Quotes from the interviews will be used in the write up of the results of the study to give examples of the points being made. Any information that may identify you will be deleted from the quotes. If you would not like any direct quotes from your interview to be included in a report that follows this research please let us know on the consent form.

What are the possible benefits of taking part?
The information we get from this study may help us to find ways to make talking therapies more accessible and meaningful to individuals who are part of the ward. We hope this will give individuals more choice and variety in the services they can access.

Contact for further information

act one of the chief investigators, ███

███████████████████████

Thank you for considering taking part

Appendix 5. Consent form

Experiences of Psychological Support in Inpatient Settings

I confirm that my participation in the above project has been explained to me. I have read and understood the information sheet and have had the opportunity to ask questions.

I am aware that (please initial in the boxes):

o I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐

o I am free to withdraw from the project at any time and to withdraw any data that I have supplied without giving any reason. ☐

o The interview will be recorded and all data or information used for research or publication purposes will be anonymous. ☐

In addition

o I give consent for quotes from the interview I take part in to be included in reports of the research findings. ☐

I agree to participate in the above project.

Participant's Name: …………………………………………………..

Signature: …………………………………………………………….. Date:
………………….…………..

Researcher's Name: ……………………………………………………….

Signature: ………………………………………………………………….. Date:
………………….…………..

If you would like any further information please contact
███
████████████████████████

Appendix 6. Psychologist participant information sheet

Staff Member Information Sheet: Version 1

Exploring the experience of talking therapies in ward environments

You are being invited to take part in a research study. This information sheet explains the purpose of the research study and what participating will involve. Please take time to read the following information and discuss it with others if you wish. If there is anything that is unclear, or if you would like more information, please ask.

What is the reason for the study and why is it important?
We would like to explore what people think about psychological therapies that are offered on inpatient wards. The information we gather may help us to find ways to make talking therapies more accessible and meaningful to individuals who are part of the ward. We hope this will give individuals more choice and variety in the services they can access.

Why have I been chosen?
You have been invited to participate in this study because you either deliver talking therapies as a Clinical Psychologist on the ward or work alongside them.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form to say that you have agreed to take part. If you decide to take part you are still free to change your mind at any time during the interview without giving a reason and this decision will not impact on your role.

What will happen if I take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form to say that you have agreed to take part. If you decide to take part you are still free to change your mind at any time during the study without giving a reason.

What happens if I don't want to discuss something during the interview?
It is up to you what you talk about and you are free to refuse to discuss anything about which you do not feel comfortable. If you become distressed during the interview you can talk to the researcher.

What will happen to the results of the research study?
The researchers will listen to all the interviews, identify frequent themes and ideas, such as those that are talked about by more than one person. These themes will be written up into a report. If you would like a copy of the final research report you can contact the research team.

Will I be identified in any report?

Your name will not be identified in any report. Quotes from the interviews will be used in the write up of the results of the study to give examples of the points being made. Any information that may identify you will be deleted from the quotes. If you would not like any direct quotes from your interview to be included in a report that follows this research please let us know on the consent form.

What are the possible benefits of taking part?
The information we get from this study may help us to find ways to make talking therapies more accessible and meaningful to individuals who are part of the ward. We hope this will give individuals more choice and variety in the services they can access.

Contact for further information
If you would like further information please contact one of the chief investigators, █████
████████████████████████████

Thank you for considering taking part

Appendix 7. Service user semi-structured interview schedule

Introduction

Thank you for meeting with me today. As you know, I'd like to talk with you today about your experience of working with a psychologist on the ward. My aim is to get to know how you came to meet with one of the psychologists, what it was like to meet together, what was helpful or unhelpful about it for you, and whether the meetings made a difference to you or your overall experience on the unit. I will not ask you to speak about anything confidential that was shared in the sessions. To start with, it would be really helpful if you could tell me a bit about how you came to the unit.

Background

- How long have you been on the unit?

- Have you been to this unit before?

- Can you briefly describe what led to your admission?

- How did you first find out about meeting a psychologist on the ward?

- Had you ever seen a psychologist before coming the unit?

  o What was your experience like?

- Did you have any expectations about what meeting a psychologist would be like?

  o How did you imagine it?

Description of meetings with the psychologist

- How many times have you seen the psychologist?

- Have you planned to see the psychologist further?

  o Is this what you would like to happen or not?

- What has been your overall experience of working with the psychologist?

- o Was it different from what you expected or not?

- o Was it different from other things you do on the ward or not?

- o Was it different in any way to meeting with other professionals on the unit?

- How do you and the psychologist use your time together?

  - o How was this decided?

  - o Were the meetings as you wanted them to be?

- What were the meetings like for you?

- Who decided what you talked about?

  - o Was this as you wanted it to be?

Relationship with the psychologist

- Were you able to talk openly to the psychologist about the issues that were important to you?

  - o Can you give an example of when this happened?

  - o How important was this to you?

  - o Was this different to conversations you've had with other professionals?

- Did you feel listened to and understood by the psychologist?

  - o How important was this to you?

  - o Was there anything that made this more difficult?

- Did you feel that you and your psychologist 'connected'?

  - o How important was this to you?

  - o Was there anything that made this more difficult?

- Did you feel that you and your psychologist agreed on what your main difficulties were?

- o Can you give an example of when this happened?

- o Was there anything that got in the way of doing this?

- Did you feel that you agreed on what to focus on when you met?

  - o Can you give an example of when this happened?

  - o Was there anything that got in the way of doing this?

- Did you feel that you agreed on what you wanted to achieve in sessions?

  - o Can you give an example of when this happened?

  - o Was there anything that got in the way of doing this?

The impact of meetings with the psychologist

- In what ways were the meetings with the psychologist helpful or unhelpful for you?

  - o What aspects were the most helpful/unhelpful?

  - o How important was this to you?

- Did meeting with a psychologist make a difference to you in any way?

  - o What changes did you notice?

  - o At what point did you notice this change?

  - o How important was this to you?

  - o Did this make you feel differently?

- Did the meetings make any difference to the way you understand your difficulties?

  - o What changes did you notice?

  - o At what point did you notice this change?

  - o How important was this to you?

- Did the meetings make a difference to the way you think about things?

  - o What changes did you notice?

- At what point did this change?

- How important was this to you?

- Did the meetings make a difference to how you feel about yourself?

  - What changes did you notice?

  - At what point did this change?

  - How important was this to you?

- Did the meetings lead you to act differently in any way?

  - What changes did you notice?

  - At what point did this change?

  - How important was this to you?

- Did the meetings make any difference to the way you think about your future?

  - What changes did you notice?

  - At what point did this change?

  - How important was this to you?

Conclusion

- Are there any ways in which your meetings could have been better for you?

  - What would you have liked to be different?

  - How would this have been helpful?

- Would you recommend meeting with a psychologist to other people on the unit?

  - If you were to describe what the meetings were like to others, what would you say?

Appendix 8. Psychologist semi-structured interview schedule

Introduction

Thank you for meeting with me today. As you know, I'd like to talk to you about your experience of the psychology sessions with client X on the ward. My aim is to get to know how you came to meet with client X, how the sessions were conducted, what you believe might have been beneficial about the sessions, and any barriers you might have experienced. I will not ask you to speak about anything confidential that was shared in the sessions. To start with, I'll be asking you about how clients access psychology on the ward and how you came to meet with client X.

Context of psychology on the ward

- How long have you worked on the unit?

- Approximately how many clients have your worked with on the unit during this time?

- How do psychologists usually become involved in the care of service users on the ward?

- How many sessions do you usually see clients for?

    o How is this usually decided?

- How do you usually determine the focus of the sessions with clients?

    o Does this sometimes change during sessions?

- Is there a particular therapeutic approach that you usually take?

Background to meeting service user

- How did you first come to know of client X on the ward?

- How did client X first come to be referred for psychology sessions?

- How did the team believe client X might benefit from sessions?

    o Did this fit with your ideas?

- How many sessions did you initially foresee meeting with the client for?

o   What informed this idea?

- Did you have any ideas of what the focus of the sessions might be prior to

  meeting with client X?

  o   What informed this idea?

Description of meetings with client

- How many sessions have you had with client X?

- What has been your overall experience of working with client X?

  o   How did this fit your expectations?

- How was the focus/goals of your sessions decided?

  o   Did this change during the course of sessions?

  o   How beneficial was this approach in your opinion?

- What psychological models or approaches did you draw on in working with

  client X?

  o   How did you decide on these?

  o   How beneficial do you think these were?

- Is the intervention now complete?

  o   How was this decision made?

  o   What influenced this decision?

The therapeutic relationship

- What was your experience of trying to establish a therapeutic relationship

  with client X?

  o   How important was this to the intervention?

- To what extent did you feel that you were able to achieve a therapeutic

  alliance with client X?

  o   What facilitated this process?

- o Was there anything that got in the way of doing this?
- Was there anything about the inpatient setting that made it made it easier or harder to achieve a therapeutic alliance?
  - o Did you make any changes to the way you were working as a result of this?
- Do you believe client X was able to talk openly about the issues that were affecting them the most?
  - o How important was this to the intervention?
  - o Was there anything that made this more difficult?
- Did you feel that you and client X agreed on what the main difficulties were?
  - o How important was this to the intervention?
  - o Was there anything that made this more difficult?
- Did you feel that you agreed on the focus of the sessions?
  - o How important was this to the intervention?
  - o Was there anything that made this more difficult?
- Did you feel that you agreed on what you wanted to achieve in sessions?
  - o How important was this to the intervention?
  - o Was there anything that made this more difficult?

Barriers to practice and adaptations made

- How, if at all, did the inpatient setting impact on undertaking psychology sessions with client X?
- Were there any constraints or barriers to your usual practice?
  - o In what ways do you think this impacted your sessions?
  - o How did you manage these?

- Did you need to make any adaptations to your practice or sessions with client X?

  - In what ways?

  - What impact did this have?

- In an ideal setting, would you have liked to done anything differently in working with client X?

  - How do you think this might have helped?

Impact of sessions for client X

- How helpful do you believe the sessions were for client X?

  - What aspects were most helpful?

  - Was there anything that was unhelpful?

- How do you think the sessions made a difference for client X?

  - What changes did you notice?

  - At what point did you notice these changes?

- Did the sessions make a difference to the way client X understood the difficulties they were struggling with?

  - What changes did you notice?

  - At what point did you notice these changes?

- Did the sessions make a difference to the way client X thinks about things more generally?

  - What changes did you notice?

  - At what point did you notice these changes?

- Did the sessions make a difference to the way client X feels about themself?

  - What changes did you notice?

  - At what point did you notice these changes?

- Did the sessions made a difference to the way client X acts?

  o What changes did you notice?

  o At what point did you notice these changes?

- Did the sessions make a difference to the way client X thinks about the future?

  o What changes did you notice?

  o At what point did you notice these changes?

Conclusion

- Are there any ways in which you could have improved the effectiveness of your meetings?

  o How would this be helpful?

- Are there any changes that could be made to the setting to make your sessions more productive?

  o How would this be helpful?

Appendix 9. Example of 2nd and 3rd stage of thematic analysis

Extract of interview with initial notes, codes and subthemes

Extract of interview for Psychologist 1	Initial notes	Code	Subtheme
P: So I think he was also scared for me to go because I would champion him at ward rounds, or we'd prep for ward round. We'd go over what he was going to say, and we would debrief after. Did it go the way he wanted… because you become quite powerless. I think sometimes you go from being somebody who works, not necessarily directly just before, but in your lifetime you've been a dad or a husband, an employed person, a functioning member of the community, to someone who, you know, has to almost ask if they can go to the toilet. You don't have any power over anything can make you…I think that spirals and people don't ask what they want in ward round, or say the things that they want to say. So a lot of psychologists' role, I know a lot of the trainees and a lot of the psychologists who before ward round will 'what you gonna say', will list the questions, 'lets practice', 'lets role play it' and then, you know… I: you've said a couple of things there that seem to be unique to the inpatient setting. So having to prepare for an ending when they may not even be leaving, and having to advocate for them in the team, and prepare them for ward round, things like that. I was wondering if you could tell me any more about the adaptations you have to make to therapy because you're in this setting?	Championing SU at ward round Prepping for ward round. SU powerless on the ward compared to life before the ward. Not having power over decisions or being asked what you want to say Psychologists practice role-playing with SU before ward round	Championing service users' voice Need for advocacy due to sense of powerlessness Advocate their perspective and things they want to say	Becoming an Advocate

P: definitely if you think of some of the basic interventions, so…CBT or if you're like going to challenge beliefs or like the anxiety work…and you cant go out, and you can't encounter necessarily the things that, the scenarios that people, that you're discussing in therapy. You can't directly challenge that, or behavioural activation stuff…you're quite limited in what people can do. Like if someone is super motivated to go swimming, you can't go swimming. Its got to be something that you can do on the ward. Or a lot of the values based work we did – I would say 60% of people valued freedom as number one. So then…I mean you make it work, whatever happens you make it work. I: how do you make it work? Can you say how you make it work? And especially with [service user], how you made it work. P: Well he didn't have freedom, but if someone has freedom then its like 'how do you feel free', 'how can you…' – I mean you don't say it like this, you say it a bit more animated – 'is there any times when you're not just outside that you could feel free', 'is there anything that we can bring in here, or will it be being outside, or shall we be like in the garden, and like, meditation'. Go through all the different things – what symbolises this freedom for you, and make it happen. And if it can't…because for some people it just literally means they don't want to be on the ward, then we have to choose another value to work towards.	Not able to encounter real life scenarios that you discuss in therapy Limited in exposure and behavioural activation work SUs value freedom. Need to "make it work" Finding ways to incorporate the ways in which SUs feel free/autonomous Work in line with SU values to overcome ward limitations	Adapting therapy for the limitations of the ward environment Adapting therapy based on SU values	Adapting traditional therapeutic models to the restrictions of the ward environment

Appendix 10. Example of 6th stage of thematic analysis

Example of quotes supporting two key themes:

<u>Advocacy and finding a shared view of the problem</u>
- I would champion him at ward rounds, or we'd prep for ward round. We'd go over what he was going to say, and we would debrief after (P1)
- …And I also think that you become an advocate for them as well, in terms of offering support, if they are having difficulties with medication or they cant seem to talk to other staff… You develop that relationship and you end up sort of offering additional support in addition to just psychology sessions. (P2/3)
- Clients come with a story and there'll be, kind of, a story that's repeated a million times in the ward rounds and in the run through and in the notes and, you know, it becomes the client story, which is really weird. (P4)
- A big part of the role here is very much about having to do staff consultation work informally and formally to build relationships with the team, to do formulations for the team. (P6/7)
- I think he's one good example of where I felt if there was no psychologist on the ward who could help kind of thing, I think he probably would've been discharged without a lot of this stuff happening because they would've said he seems safe, he's probably better off at home. (P8)

<u>Traditional therapeutic models don't fit</u>
- …you're quite limited in what people can do. Like if someone is super motivated to go swimming, you can't go swimming. Its got to be something that you can do on the ward. (P1)
- I find the type of anxiety you're dealing with when people have become an inpatient for anxiety is so, so severe that that kind of doing some breathing or mindfulness is really, really hard for people, and actually it tends, I find it makes them more anxious. (P8)
- …anyone acute distress is basically unable to reflect. Most of the time on the ward it's pointless asking people to much analysis of their thoughts, ordering their thoughts, thinking about what other people think, because they are too distressed. It might look like they're doing it, but they won't. (P6/7)
- So I don't use a traditional psychoanalytic method, you know, nobody's got ego strength sufficient to manage that. People are paranoid, people are highly anxious. If you just sat and didn't say anything to them they would lose it completely, it's that really. (P6/7)
- There's a big part of me that's, like, that's not going to cut it. That's really not – you're going to need a hell of a lot more than anxiety management or mindfulness to manage your situation on the ward. (P4)
- I suppose thinking about evidence base, I do try to predominantly offer CBT but it's probably not in the same form as you would find in the community because we don't have 8-12 sessions to work with someone. (P2/3)