SOCIAL RECOVERY THERAPY: THERAPISTS' EXPERIENCE OF HOPE WORKING WITH COMPLEX CLIENTS

Thesis submitted for the degree of
Doctor in Applied Psychology
at the University of Leicester

by

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Declaration

I declare that the contents of this thesis are my own original work and have not been submitted for any other degree or academic qualification. I also confirm that I have checked, prior to submission, that this thesis is complete.

Thesis Abstract

Social recovery therapy: therapists' experience of hope working with complex clients

by Catarina Sacadura

Section 1: Systematic Review

The subject of therapist's emotions in the context of delivering CBT has the potential of providing insights into therapy delivery intricacies and therapist wellbeing. However, it is currently still in its infancy and has mostly been theoretical. The aim of the present systematic review is to explore the findings of empirical research carried out thus far, in terms of the emotional impact of delivering CBT on the therapist. From the 2318 papers initially identified through various database searches (PsychINFO, Medline, Web of Science and Scopus) eight were included in the analysis, using PRISMA guidelines for systematic reviews. This study uses Thematic Analysis to explore the main themes (emotional impact on the therapist, training and supervision factors, therapist factors, organizational factors) and associated sub-themes identified from the data.

Section 2: Research Report

There is currently scarce research literature looking at cognitive behavioural therapists' experiences of delivering therapy. Hope is particularly relevant in the context of working with young people at risk of developing long-term disability. A qualitative study was carried out to gain an understanding of therapists' experiences of hope in the context of delivering Social Recovery Therapy (SRT) to this population. Semi-structured interviews were conducted with ten therapists and data was analysed using Interpretative Phenomenological Analysis. Five main themes and two contextual themes emerged from the narratives, painting a picture of the therapists' journey. For each main theme, associated sub-themes were identified and discussed.

This study explores the richness of therapists' emotions via their journey of delivering SRT to young people with social disability and emerging mental health problems. It highlights therapists' challenges and strategies in the maintenance of hope through this process.

Section 3: Critical Appraisal

A critical exploration of the personal and professional reflections on the research process, based on a research journal compiled throughout the process.

Acknowledgements

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Section 2 Research Report
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List of Key Abbreviations

BABCP - British Association for Cognitive and Behavioural Psychotherapies

CBT- Cognitive Behavioural Therapy

DNA – Did not attend

EMDR – Eye Movement Desensitization Reprocessing

EQUATOR - Enhancing the QUAlity and Transparency Of health Research

FA – Framework Analysis

GAP - Generalized Anxiety Disorder

IAPT- Increasing Access to Psychological Therapy (services)

ID - Intellectual disability

ICBT - Internet based Cognitive Behavioural Therapy

IPA – Interpretative Phenomenological Analysis

PRISMA – Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PRODIGY - Prevention of Long-Term Social Disability in Young People with Emerging Psychological Difficulties

PROSPERO - International prospective register of systematic reviews

PWP – Psychological Wellbeing Practitioner

SAE - Serious Adverse Event

SRQR - Standards for Reporting Qualitative Research

SRT – Social Recovery Therapy

STROBE - Strengthening The Reporting of OBservational Studies in Epidemiology

TA – Thematic Analysis

TCIT – Therapists crying in therapy

TCS-ID – Therapy Confidence Scales – Intellectual Disabilities

TECH – Therapists' Experience of Hope Working with Complex Clients

Section 1
Literature Review

Delivering CBT: emotional impact on therapists - a systematic review of literature

Literature Review Abstract

Delivering CBT: emotional impact on therapists - a systematic review of literature

Catarina Sacadura

Background: The subject of therapist's emotions in the context of delivering CBT has been relatively under-research, though it may provide insights into therapy delivery intricacies and therapist wellbeing. Literature thus far has mainly covered this subject theoretically, however, there has been a recent surge of interest in the form of empirical studies.
Purpose: The present systematic review's aim is to explore the findings of empirical research carried out thus far, in terms of the emotional impact of delivering CBT on the therapist.
Method: From the 2318 papers initially identified through though various database searches (PsychINFO, Medline, Web of Science and Scopus) eight were included in the analysis, using PRISMA guidelines for systematic reviews. Thematic Analysis was the chosen method for analyzing the data.
Results: The analysis identified a range of ways through which the delivery of CBT may impact emotionally on the therapists. Four main themes and associated sub-themes were identified: emotional impact on the therapist (associated with beneficial and with detrimental effects), therapist factors, organizational factors (associated with service features and therapy modality) and training and supervision factors (associated with training and supervised practice).
Conclusion: There is a small but growing area of empirical research looking at the emotional impact of delivering CBT on the therapist, and associated aspects. According to findings, these factors are likely to have implications in terms of the therapist's wellbeing and therapy delivery. Further research is warranted in order to enlighten the mechanisms behind these processes and ascertain the extent of the repercussions within the therapy context.

Introduction

One of the myths surrounding cognitive behavioural therapy (CBT), which was addressed by Westbrook, Kennerley and Kirk, in a publication classically used in CBT training, is "CBT is interested in thoughts, and not emotions" (Westbrook et al., 2011, pp. 35). The authors explained that CBT's efforts to modify people's thoughts do not comprise the goal, but rather represent a means to an end, as typically clients seek help with regards to their emotions and behaviours. The authors pointed out that focusing on emotions is an essential part of the therapeutic process. The emphasis on emotion in CBT is evidenced by its feature in the ubiquitous "hot cross bun"[1] as one of four central elements to formulation in CBT (Padesky & Greenberg, 1995). This depiction of emotion refers to the client only, however therapist's emotion is also likely to be a relevant construct to explore. Therapist's emotions, particularly in the context of delivering therapy, are still a nebulous area, which has not received similar attention.

Impact of therapy on the therapist's emotion: supervision

The issue of therapist's emotions with regards to the therapeutic process has been often addressed in CBT supervision literature. Padesky (1996) described "therapist focused supervision", as a process through which more experienced CBT therapists explore their own emotions and reactions during the therapy. According to the author, the focus is on the therapist's schemas, which are activated during their work with clients, and how these might interact with therapeutic process. The author called attention to the distinction between therapist's focused supervision and therapist's therapy, in a sense that the analysis of these matters relates specifically to the therapy issues under discussion in supervision, which are not explored for the therapist's sake (Padesky, 1996).

Kimerling, Zeiss and Zeiss (2000), highlighted the importance of therapists remaining alert to their own emotional experience during therapy. The authors suggested that the

[1] The hot cross bun is a CBT formulation tool, which highlights the interaction between thoughts, emotions, physical sensations and behaviours; each of these components is idiosyncratically described in equidistant circles, with bi-directional arrows between them, within a larger all-encompassing circle, resembling a hot cross bun. It is frequently used to formulate an event or maintenance cycle.

same theoretical/therapeutic framework underlying therapy should be employed to integrate this knowledge with the planning and implementation of therapy. Kimerling and colleagues (2000) also proposed that the task of attending to one's emotional responses is best addressed in a supervision setting, particularly when it comes to trainee therapists. In the context of a literature review on recommended practice of CBT supervision, Pretorius (2006) concluded that supervision presents a context for recognizing and addressing therapists' emotions and cognitions regarding therapy and supervision. Lombardo, Milne and Proctor (2009) described the importance of considering therapist's emotions in supervision, rather than just focusing on the cognitive aspects. For example, the authors talked about the fluctuating levels of perceived competence and their emotional impact on the therapist and their professional learning. Recently, Reiser and Milne (2016) conducted a survey of CBT supervision in the UK, which looked at supervision methods used by BABCP accredited supervisors and trainers, and found that these experts reported "managing emotion and affect" among a variety of established supervision methods. However, the authors did not specify which context the emotion and affect referred to (i.e. directly connected to therapy delivery or not, e.g. therapist's personal life).

Countertransference as therapist's emotional reaction in CBT

Countertransference is a concept through which therapist's emotions have been conceptualized in the context of therapy. Moorey (2014) described countertransference in CBT as a group of reactions from the therapist in relation to the client, fostered by the therapist's own transference towards client, by the response to the clients transference towards therapist, or by empathic countertransference, where the therapist's emotions emulate those of the clients. The author explained that the relationship patterns established between therapist and client, that arise from the countertransference process, fit into three categories: schema congruence, schema conflict and schema complementarity. The author (Moorey, 2014) stated that addressing these processes requires understanding how these schemas interact with the therapy process, and therefore it is sensible to focus on the therapist's own beliefs. Moorey (2014) described a variety of methods that can be used in supervision in order to support the therapist in making sense of their own cognitions and emotions, and ultimately put these to the test in terms of validity and helpfulness.

Vyskocilova and Prasko (2013) also elaborated the notion of transference and countertransference in CBT and describe these processes as intense emotional responses between therapist and client. The authors characterized countertransference as the activation, in the therapist, of negative automatic thoughts and schemas, as a response to the client. These can provide useful insights into both the therapist and client's inner worlds, and also have the potential to interfere with the therapeutic process (Vyskocilova & Prasko, 2013). The authors pointed out the importance of therapists being aware of transference and countertransference, through reflecting on their practice and discussing these matters in supervision, where typical cognitive behavioural strategies can be employed to address them.

Ellis, Schwartz and Rufino (2018) also explored the concept of countertransference from a CBT perspective. The authors view countertransference as based on therapist's emotional reactions, resulting from the interplay in therapy between the client's behaviours and the therapist's own attributions of meaning. The authors explained that this approach based on CBT principles is likely to minimize any stigma attached to these processes, making them easier to explore and approach in supervision. Therapists can then make use of the CBT framework to make sense and address countertransference issues, fueling a better understanding of both therapist and client, and potentially improving therapy outcomes (Ellis, Schwartz & Rufino, 2018).

Impact of therapy on therapist's emotions – impact on therapy

Waller (2009, 2016) developed the concept of therapist drift, a widespread phenomenon through which therapists unintentionally fail to deliver therapy at optimum levels, by drifting away form the evidence base, with inevitable implications in terms of therapy outcomes. The author posited that three main sources of therapist drift are at play: therapists' behaviours, emotions and cognitions. For the purpose of this discussion, the focus will be on the therapist's emotions. Waller (2016) described how therapists' emotional states in relation to the therapeutic process can hinder the appropriate delivery of CBT, despite having the right tools. The therapist's anxiety - for example about distressing the client, or being perceived unfavourably by the client or peers – is proposed to contribute to avoidance of evidence-based interventions such as

behavioural techniques, and over reliance on the therapeutic alliance with the client as a means to therapeutic change (Waller, 2016; Brown, 2014). Waller pointed out that anxiety is not the only therapist emotion implicated in therapist drift, as, for example, therapist's low mood and low self-esteem also seem relevant in this matter (Waller, 2016).

The present review

Service user's perspectives have increasingly and extensively been the focus of research (e.g. Berry & Hayward, 2011; Neelakantan, Hetrick & Michaleson 2018), however, attention to the therapist's perspective has only recently been growing. Literature suggests that therapists respond emotionally to the therapeutic process, and so it is important for therapists to acknowledge this phenomenon and address it appropriately. It also seems to be the case that, with some exceptions (e.g. Waller, 2009, 2016), most of these concepts have been investigated primarily at a theoretical level. The purpose of this systematic review is to explore the findings of empirical research carried out thus far, in term of the emotional impact of delivering CBT on the therapist.

Method

Literature search

This systematic review was carried out in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, and it was registered with PROSPERO International Prospective Register of Systematic Reviews.

A literature search was conducted in four databases - PsychINFO, Web of Science, Medline and Scopus - to identify suitable references. The keywords strategy included the following terms: "therapist*" OR "clinician*" OR "psychologist*" in combination with (AND) "experience*" OR "response*" OR "reaction*", in combination with (AND) "CBT". As this search retrieved an unmanageable high number of results on Medline and Scopus, the terms "therapist*", "clinician*", "psychologist*" and the terms "reaction*", "response*", "experience*" were searched within a maximum of 3 words

of proximity. The search was not restricted by publication date, but was restricted to English language and nature of publication (journal article).

Inclusion criteria

Articles included in the review met the following inclusion criteria:

1. focus on the therapist's experience of conducting CBT
2. focus on the emotional impact on the therapist or emotional experience of the therapist
3. presentation of empirical data
4. qualitative research

Exclusion criteria

Articles included in the review met the following exclusion criteria

1. review or commentary
2. exclusive focus on therapists delivering low intensity CBT for example Psychological Wellbeing Practitioners (UK)
3. quantitative research

Data extraction

The main researcher (CS) performed the data search, screening and extraction. The initial search identified 2313 results. A further five references were identified using snowball methods bringing the total to 2318. After de-duplication, 1774 results remained. At this point the main author screened all titles and abstracts and a further 1721 records were excluded, as these were clearly irrelevant (e.g. client's experience of therapy only), leaving 53 for the final selection. The full articles were then assessed for eligibility and eight were selected for the analysis. Risk of biases in selection was addressed by an independent review carried out by a second assessor (CB), who independently screened 18.87% of full text records. Substantial agreement was achieved between reviewers, 90% corresponding to Cohen's k: 0.74. Discrepancies were resolved by consensus after discussion.

Papers excluded at each stage and accompanying reasoning were recorded and reported according to Prisma guidelines (Moher et al., 2009) (Figure 1).

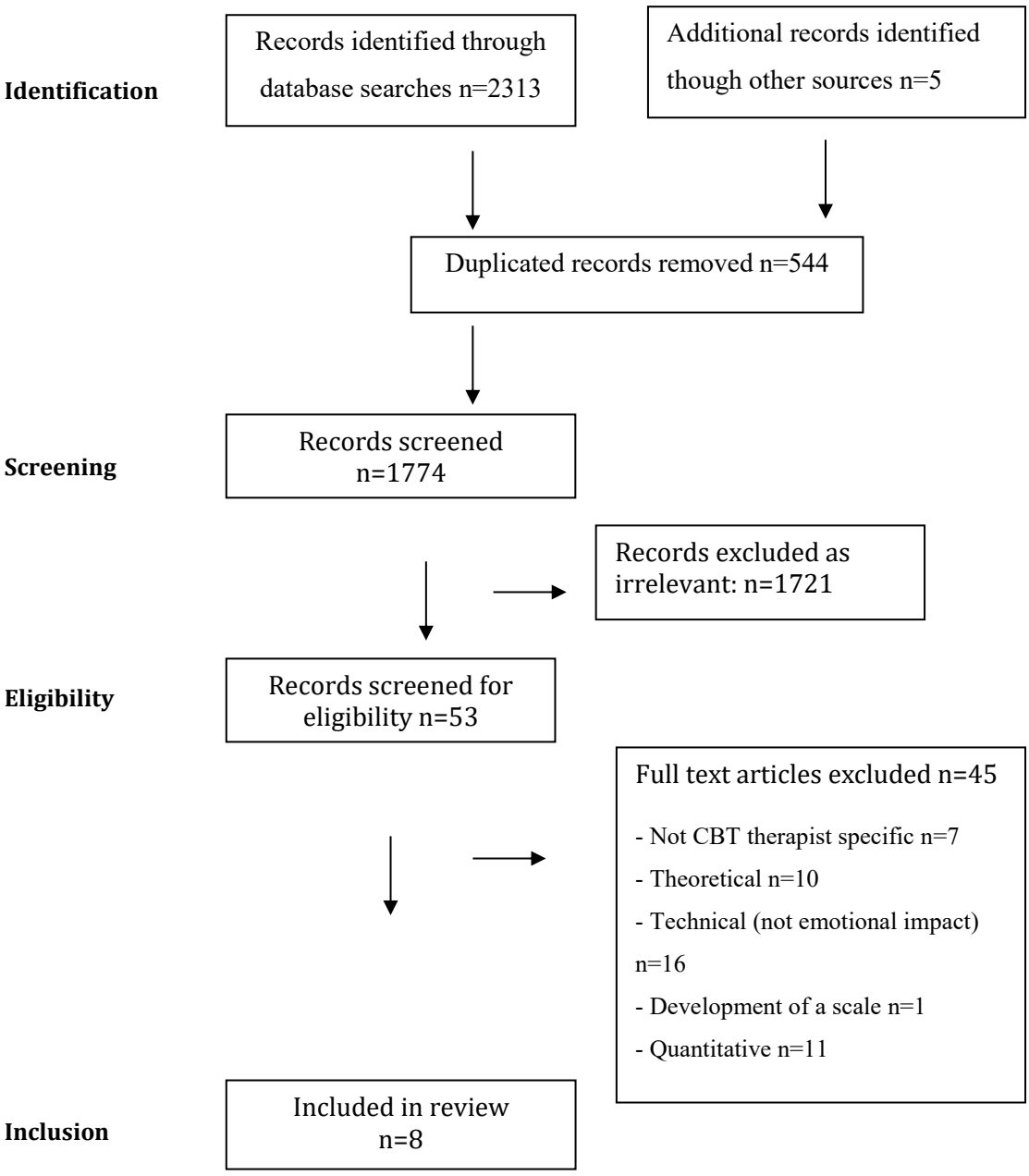


Figure 1. PRISMA flow diagram

Quality appraisal

The main researcher carried out the quality appraisal of the eight selected studies. Following the EQUATOR (Enhancing the QUAlity and Transparency of health Research) Network guidance, quality appraisal of qualitative studies was carried out using SRQR (O'Brien et al., 2014). The SRQR is a checklist comprised of 21 items, designed to improve transparency on qualitative research and support authors in optimal reporting and readers in the critical appraisal of qualitative papers (O'Brien et al., 2014). Each of the items included in the checklist is briefly described in the measure and further explained in the paper. The authors stress that, although providing information regarding important elements that should ideally be present in a qualitative research paper, the SRQR is not rigid in its application and therefore allows for flexibility in terms of order and depth in which each item is presented in a given research paper. For example, the authors state journal word limits as a possible variable that may restrict the full exploration of an item (O'Brien at al., 2014).

The results of the quality appraisal of the papers included in this study are presented in Table 1. Most papers contain elements relevant to all the items on the checklist. Although only two of the eight qualitative papers tick all of the 21 items on the SRQR checklist, the remaining papers tick between 18 and 20 items. The least endorsed SRQR items, with regards to the papers included in this study, are "conflict of interest" and "funding". As expected, the depth of the exploration of each item also varies. However, the overall quality of the papers is adequate and no records were excluded on the basis of the quality checks.

Table 1. Quality appraisal of qualitative studies - Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014)

	Lewis (2013)	Bennett-Levy et al. (2014)	Bell et al. (2015)	Bengtsson et al. (2015)	Lundkvist-Houndoumadi et al. (2016)	Millett et al. (2017)	Hassan et al. (2018)	Marwood, et al. (2018)
Title and abstract								
Title	V	V	V	V	V	V	V	V
Abstract	V	V	V	V	V	V	V	V
Introduction								
Problem formulation	V	V	V	V	V	V	V	V
Purpose or research question	V	V	V	V	V	V	V	V
Methods								
Qualitative approach and research paradigm	V	V	V	V	V	V	V	V
Researcher characteristics and reflexivity	V	V	V	X	V	V	V	X
Context	V	V	V	V	V	V	V	V
Sampling strategy	V	V	V	V	V	V	V	V
Ethical issues pertaining to human subjects	V	V	V	V	V	V	V	V
Data collection methods	V	V	V	V	V	V	V	V
Data collection instruments and technologies	V	V	V	V	V	V	V	V
Units of study	V	V	V	V	V	V	V	V
Data processing	V	V	V	V	V	V	V	V
Data analysis	V	V	V	V	V	V	V	V
Techniques to enhance trustworthiness	V	V	V	X	V	V	V	V
Results/findings								
Synthesis and interpretation	V	V	V	V	V	V	V	V
Links to empirical data	V	V	V	V	V	V	V	V
Discussion								
Integration with prior work, implications, transferability, and contribution(s) to the field	V	V	V	V	V	V	V	V
Limitations	V	V	V	V	V	V	V	V
Other								
Conflicts of interest	V	X	X	V	V	V	X	X
Funding	X	X	X	V	V	V	V	X

Analysis

Thematic analysis was the method chosen to analyse data. This is a qualitative methodology, which aims to identify, analyse and report themes within data (Braun & Clarke, 2006). Themes can be conceptualized as meaningful patterns within the dataset, which capture relevant content associated with the research topic (Braun & Clarke, 2006). Thematic analysis is characterised as a flexible methodology, which allows for a data-driven process of analysis, not guided by a specific theoretical framework (Braun & Clarke, 2006). The focus of this review, being a relatively newly studied field, lacks a strong scientific research base, and as such, is agreeable to an inductive approach to data analysis.

The process of data analysis involved the main researcher familiarising herself with the contents of the selected papers by reading and re-reading each paper. The second researcher independently read at least 20% of the included papers. After several meetings between both researchers, agreement was achieved as to the main themes and subthemes generated from the data, from the original codes - see Appendix G, page 149, for examples of early stage themes exploration- to the initially identified themes - see Appendix H, page 152, for examples of NVivo (QSR International, 2018) coding of themes - their review and final definition and naming. Following Braun and Clarke's thematic analysis guidance (2006), researchers paid attention to subjects that may be of interest in the current analysis. This facilitated coding following a data driven process.

Results

Study Characteristics

The eight records that met eligibility criteria for this systematic review are summarised in Table 2.

Table 2. Included studies - comparison table

LIST OF INCLUDED STUDIES	COUNTRY	AIM	METHODOLOGY	SAMPLING METHOD	DATA COLLECTION	POPULATION	CBT MODEL	RELEVANT FINDINGS
Lewis (2013)	UK	"understanding of primary-care therapists' perceived competence in providing cognitive behavioural therapy (CBT) to people with MUS"	Qualitative methodology (Framework Approach)	Purposive method	Semi structured interviews	Eight participants (five female, three male), age M=43.5 (S.D.= 9.04) years. Nine to twenty one years' experience in mental healthcare. Seven qualified in CBT within 3 years prior to interview, the remaining qualified in CBT ten years prior.	CBT for people with MUS (medically unexplained symptoms)	Therapists mentioned unfamiliarity with MUS, engagement issues and slow therapy progress. Therapists used more general CBT rather than specific MUS models. Range of emotional reactions to therapeutic work (anxiety, self doubt, but also positive aspects).
Bennett-Levi, et al. (2014)	Australia	"Do CBT- trained Aboriginal counsellors perceive CBT to be useful with their Aboriginal Australian clients?"	Qualitative methodology (Thematic Analysis)	Purposive method	Ten group meetings and two individual interviews	Five university-educated Aboriginal counsellors who were trained in CBT over 1 year. Participants had a minimum of of 2 years of clinical experience	Aboriginal therapists delivering CBT to Aboriginal Australians.	Participants found CBT to be useful with their aboriginal clients (improved client's wellbeing) and for themselves (improved clinical skills, therapist's wellbeing and reduced burnout). Therapists found CBT to be flexible, pragmatic, safe and containing, offering valuable techniques, self confidence promoting, with potential for low intensity interventions.
Bell et al. (2015)	UK	"what influences clinicians' use—or lack of use —of imagery in their clinical practice?"	Qualitative methodology (Interpretative Phenomenological Analysis)	Purposive method	Semi structured interview	Twelve BABCP accredited CBT therapists, nine women and three men (mean age = 43). All qualified within the previous 4 years, with post qualification experience ranging from 4 months to 3 years.	CBT unspecified and use of imagery interventions within primary care	Some participants described affinity using imagery, others found it anxiety provoking and problematic. All found imagery important, useful and appropriate training relevant. Some clinicians avoided the technique and reported personal, clinical and cultural factors.
Bengtson et al. (2015)	Sweden	"explore therapists' experiences of conducting face-to-face and Internet-based guided CBT, with special focus on how they experience their contact with the clients... "	Qualitative methodology (Thematic Analysis)	Purposive method	Semi-structured interviews	10 licensed psychotherapists, 1 licensed psychotherapist and social worker Five male six female, age M 37, and SD 5.88 All participants had at least three years of facet to face therapy and One to ten years ICBT experience (except for one who had finished two treatments when interviewed)	CBT (unspecified)	Face to face viewed as strong experience than ICBT, but also more demanding, potentially frustrating and exhausting. ICBT was perceived s more manualised and providing more work-tie control. Some participants thought that therapeutic alliance could be achieved faster and more easily in face-to-face therapy.

Lundkvist-Houndoumadi, et al., (2016)	Denmark	"parent/therapist experiences of CBT among non-responding youths with anxiety disorders… focus on parent involvement in therapy."	Qualitative methodology (Interpretative Phenomenological Analysis)	Convenience method	Semi structured interviews	Two therapists on a randomized controlled trial on a manualized CBT for youths with anxiety disorders and their parents (the Cool Kids Program)	CBT for youths with anxiety disorders and their parents	Therapists perceived family dynamics as interfering with progress and difficulties in transferring control to parents. Therapists aimed to facilitate the transfer of control to parents, but parents wished to remain "just the parents", and for therapists to take control.
Millet et al. (2017)	UK	"…exploring women's and therapists' experiences of IAPT for perinatal mental health difficulties."	Qualitative methodology (Thematic Analysis)	Purposive method	Focus groups	Two focus groups (1. twelve London-based IAPT therapists - perinatal leads; 2. mixed group of eight practitioners from services across a Northern NHS site) All therapists were female. Five psychological wellbeing practitioners (PWPs), four cognitive behavioural therapists, one psychological therapist, two clinical psychologists, and two deputy leads.	CBT for perinatal mental health difficulties	Participants highlighted the importance of perinatal-specific training, supervision and resources, and offering a more individualized treatment environment. Therapists felt deskilled, anxious and lacking confidence. They mentioned difficulties adapting the intervention to IAPT due to services constraints.
Hassan, et al., (2018)	UK	"…explore therapists' experiences of working with (…) advanced cancer patients..."	Qualitative methodology (Framework Analysis)	Convenience method	Semi structured interviews	Therapists from IAPT services in London, who had delivered CBT to patients enrolled on the CanTalk trial, predominantly female (n = 15) Therapy experience: one to eighteen years Nine therapists had experience of working with cancer patients and all had previous experience working with patients with other long-term health conditions.	CBT for advanced cancer patients	Therapists reported positive experiences. They identified flexibility, adaptability, and a consideration of individual needs as important, but the rigidity of IAPT policies and demand for services were seen as problematic. Therapists perceived training as adequate, but specified the need for specialist supervision.
Marwood et al. (2018)	UK	"… explore high-intensity therapists' experience of delivering CBT to individuals with ID [intellectual disability] within IAPT services."	Qualitative methodology (Thematic Analysis)	Purposive method	- semi-structured interviews - Therapy confidence scale-intellectual disabilities (TCS-ID)	Ten high- intensity therapists, one male and nine female. Experience of delivering CBT to at least 1 individual with ID in an IAPT service. Qualifications: professional doctorates in clinical psychology (7) or counselling psychology (1) and high-intensity diplomas (2).	CBT for people with ID	Poor confidence and stress working with this population, related to insufficient training. Importance of supervision, particularly if expert. Concerns about the rigidity of IAPT model when catering for ID population.

Themes and sub-themes

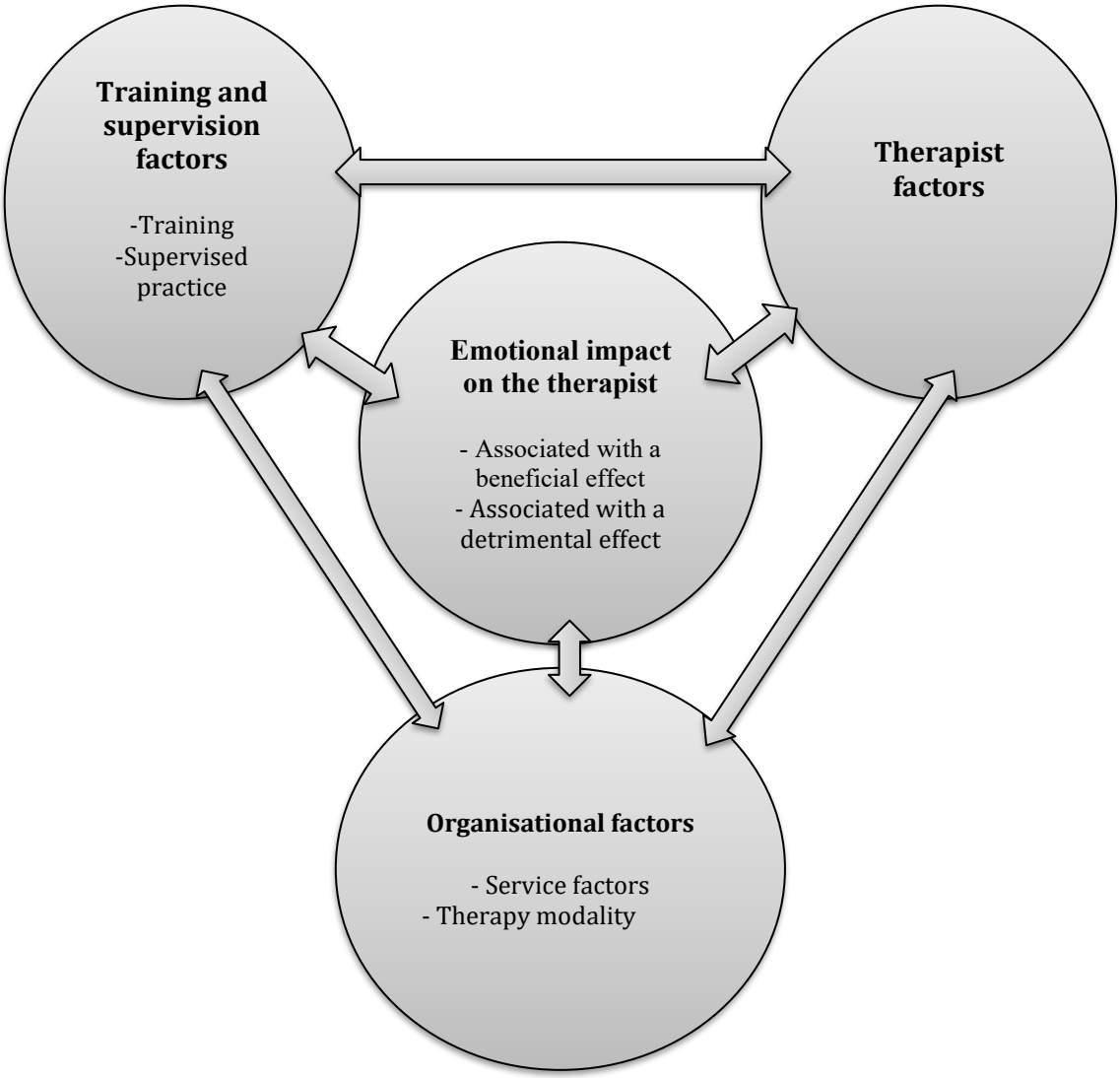


Figure 2. Themes and sub-themes

Theme

Emotional impact on the therapist

"I think that is has been both, well, fun and occasionally also very, like, demanding." **PARTICIPANT'S QUOTE** (Bengtson et al., 2015)

The selected papers included various examples of the emotional impact of delivering the therapy on the therapists. They range from enjoyment to distress, and illustrate the ubiquity of the emotional response of CBT therapists in the context of therapy:

"When it is going well and going forwards for the patients, then you become happier, and when it does not go as well or when it goes badly with, with the patient work, then you become frustrated and self-critical." **PARTICIPANT'S QUOTE** (Bengtson et al., 2015)

"It just felt a bit too much, all of it really." **PARTICIPANT'S QUOTE** (Lewis, 2013).

The emotional impact on the therapist, regarding the delivery of CBT, seemed to be contextual to a degree and mainly described in association with beneficial or detrimental bearing on both the therapist and therapy process.

Sub-theme

Emotional response associated with a beneficial effect

A portion of studies included in this analysis described therapists' emotional responses in the delivery of CBT, associated with a constructive effect on them and/or in the therapy process. Bennett-Levi and colleagues (2014) conducted a study in which Aboriginal counsellors were trained in CBT over the course of a year. They then looked at the therapists' views regarding the suitability and effectiveness of CBT for members of the Australia's Aboriginal community. The authors found that therapists had developed their knowledge skills, reduced their stress levels and become much more confident professionally:

"*I find the CBT knowledge has given the confidence to not panic. With CBT I'm becoming more confident with being able to deal with whatever walks through the door and be able to deal with it."* **PARTICIPANT'S QUOTE** (Bennett-Levi, et al., 2014)

Participants had found the intervention to be safe, structured, offering role clarity and boundaries and possibly protection from burnout. The therapists had also found CBT helpful in terms of self-practice:

"*So, yeah, it's opened up my world and I think it's actually going to make me, not only a better worker, but I'll probably . . . last longer in the industry . . . I'm finding I'm*

feeling a lot better because I'm feeling a lot safer." **PARTICIPANT'S QUOTE** (Bennett-Levi, et al., 2014)

A study by Bengtsson et al., (2015) also found that online CBT delivery, offered advantages over face-to-face in terms of acting as a possible buffer from negative emotions:

"You feel very much less burdened by (ICBT) than in regular outpatient care. It does not get as, like... heavy in the moment, as it can get when you are sitting with someone who become like that really sad or really angry or dissatisfied or—you become protected by the screen in some way." **PARTICIPANT'S QUOTE** (Begntson et al., 2015)

Bell et al. (2015) looked at recently trained CBT therapists' view of using imagery techniques in their clinical practice. The authors fond that a portion of these revealed positive experiences using the techniques, characterized by boosted confidence, trust in the technique, and an increase in its therapeutic usage:

"It feels quite natural to me, it feels like it makes sense, it feels like I understand it at a visceral level, that I can make that connection." **PARTICIPANT'S QUOTE** (Bell et al., 2015)

Positive therapist feelings were a relatively common feature in the studies, even in the context of difficult therapeutic interventions:

"It can be difficult, but ultimately as well it can be really rewarding ... There can be that moment, you know the light bulb moment, where people kind of realize 'actually this isn't as bad as I was making it, or how it has to be'." **PARTICIPANT'S QUOTE** (Lewis, 2013)

Sub-theme

Emotional response associated with detrimental effect

Lewis (2013), found that CBT therapists working with people with medically unexplained symptoms (MUS), in a primary care setting (IAPT), experienced lack of

confidence, anxiety and self-doubt in the context of unfamiliarity with MUS and treatment approaches:

"It's more difficult if you don't know what you are doing with people. A bit of anxiety, thinking 'oh, am I doing the right thing'. More self-doubts… it can sometimes feel like walking in quicksand …" **PARTICIPANT'S QUOTE** (Lewis, 2013)

Perceived inadequate knowledge and skills seems to have translated into therapist's pessimism regarding working with these clients:

"When you get the information [referral] your heart sinks a bit [laughs] . . . you feel a bit 'oh dear' if someone comes through with those sorts of conditions." **PARTICIPANT'S QUOTE** (Lewis, 2013).

Bengtsson et al. (2015) found face-to-face delivery of CBT to be associated with higher levels of frustration, exhaustion and higher perceived demands, despite being potentially more rewarding, when compared to online CBT:

"Face-to-face therapy is a, well, more, both more rewarding and more punishing in some way, it is like a strong, a stronger experience (than ICBT). When it is going well and going forwards for the patients, then you become happier, and when it does not go as well or when it goes badly with, with the patient work, then you become frustrated and self-critical. Meanwhile, in internet therapy, you might be more lukewarm all the time." **PARTICIPANT'S QUOTE** (Bengtsson et al., 2015).

When looking at the experience of therapists delivering CBT to advanced cancer patients in a primary care setting, Hassan and colleagues (2018) identified some of the therapists' concerns:

"One therapist reported that it was important to address the emotional impact of cancer on therapists as it was very emotively challenging and evocative". **AUTHORS' QUOTE** (Hassan et al., 2018)

Therapists also had anxieties regarding doing this work, prior to starting. However, the authors noted that these dissipated after starting the therapeutic work:

"A number of participants expressed anxiety about working with cancer patients, but this did not persist once they had starting working". **AUTHORS' QUOTE** (Hassan et al., 2018)

Millet and colleagues also looked at IAPT therapists' experience of delivering CBT for perinatal mental health difficulties, and found that some of these professionals felt anxious, lacking confidence and deskilled (Millet et al, 2017). The authors noted implicated factors might include services constraints and training needs:

"I have to adhere to policies. I feel I am more nervous than the actual mother" **PARTICIPANT'S QUOTE** (Millet et al., 2017)

"Therapists often just feel that they haven't got the confidence to work in that area because they see perinatal as something very specialist." **PARTICIPANT'S QUOTE** (Millet et al, 2017)

In a study on therapists experience of delivering CBT to clients with intellectual disabilities (ID) in a primary care setting (IAPT), some therapists seemed to lack confidence with regards to working with this population (Marwood et al., 2018):

"I don't feel very confident um not looking forward to working with the person particularly." **PARTICIPANT'S QUOTE** (Marwood et al., 2018).

Therapists described the emotional impact of working with the ID population in this setting as "scary" and "nightmare", and showed reluctance to work with these individuals. The authors concluded that aspects such as lack of appropriate training and supervision, and organizational factors, including the pressures of working in a high intensity primary care setting, may be related to these experiences:

"I just don't have any training and I'm very unsure of what I'm doing and I feel a bit heart sinky when I know I'm going to be working with someone with a mild learning

disability." **PARTICIPANT'S QUOTE** (Marwood et al., 2018).

In another study, therapists talked about the emotional impact on themselves, and also concerns about potential impact on heir clients. Therapists described working with imagery techniques as anxiety provoking for themselves and "scary" and "overwhelming" for their clients (Bell et al., 2015). Therapists referred to their perceived lack of skills, poor confidence and lack of practice as making them reluctant to use the techniques:

"Yeah, mainly I don't know what I'm doing, that's what causes the anxiety!" **PARTICIPANT'S QUOTE** (Bell et al., 2015).

Therapists also shared concerns about the potential negative emotional impact on themselves and their clients, which may have fueled hesitancy in engaging with imagery in their practice:

"You can actually get kind of pulled into their world and their image, and it's making sure that you stay quite separate, because you've got to keep yourself grounded, obviously, and make sure you're safe." **PARTICIPANT'S QUOTE** (Bell et al., 2015).

"Maybe I'm worried the client could run away with it and I wouldn't know what they are doing and I wouldn't know what to do with it." **PARTICIPANT'S QUOTE** (Bell et al., 2015).

Theme

Training and supervision factors

"Um and if we are being asked to do it, we certainly need a bit of training and a bit of support and specialist supervision." **PARTICIPANTS QUOTE** (Marwood, et al., 2018)

Several studies included in this analysis point to training and supervision factors having an impact on therapist's emotional responses to delivering CBT.

Sub-theme

Training

Bell and colleagues (2015) noted that all of the participants in their sample of primary care therapists reported anxiety or hesitation about using imagery techniques. This was attributed to several factors, including poor sense of familiarity, skill and aptitude:

"It's a technical weakness, you know, rather than an unwillingness." **PARTICIPANT'S QUOTE** (Bell et al., 2015)

"It's just kind of I don't know what I'm doing, I don't know what it is!" **PARTICIPANT'S QUOTE** (Bell et al., 2015)

Mismatches between therapist's training and service expectations regarding their competencies were mentioned by some therapists, along with implications in terms of their confidence and emotional response of delivering therapy to people with intellectual difficulties in an IAPT setting (Marwood et al., 2018):

"I'm not quite sure if things that I'm saying, how they're being understood. Um I'm not quite sure what pace the therapy should go at, if I'm too quickly, if I'm making the ideas too complex, too simple um … if the kind of goals are realistic or unrealistic… I feel quite out of my depth." **PARTICIPANT'S QUOTE** (Marwood et al., 2018)

A similar scenario emerged for some therapists working with clients with medically unexplained symptoms in a primary care setting, as they perceived inappropriate training meant they often felt uncomfortable and lacking in knowledge and confidence:

"CBT models for unexplained symptoms? I have absolutely no knowledge of that whatsoever. . . I am still struggling to be perfectly honest to consolidate all the stuff we had to learn in an incredibly short space of time." **PARTICIPANTS QUOTE** (Lewis, 2013)

"I feel generally OK about having a go . . . but I don't feel like I'm trying to work in a systematic way, it starts to feel a bit ad hoc, that feels quite uncomfortable." **PARTICIPANTS QUOTE** (Lewis, 2013)

Although lack of training was identified in the analysis as a possible factor impacting negatively on the therapists, the reverse was also true. Bennett-Levi and colleagues (2014) found that counsellors perceived their knowledge, skills and confidence to have increased after receiving CBT training:

"With CBT I'm becoming more confident with being able to deal with whatever walks through the door and be able to deal with it." **PARTICIPANT'S QUOTE** (Bennett-Levi et al., 2014)

Whilst reflecting on the strengths of the study, the authors described the type of training provided. This encompassed delivering in-depth training in CBT skills to counsellors, over one year's time:

"A year's immersion meant that the counsellors understood the strengths and weaknesses of CBT." **PARTICIPANT'S QUOTE** (Bennett-Levi et al., 2014)

Sub-theme

Supervised practice

Supervision was another factor that therapists frequently mentioned in the studies, which is likely to be connected to their emotional experience of delivering CBT. For example, when treating people with medically unexplained symptoms, therapists stated the importance not only of training, but also of specialist supervision (Lewis, 2013):

"A combination of some kind of initial theory and training, followed by some supervision, yeah. Which would be specialist supervision ... it's probably more about supervision." **PARTICIPANT'S QUOTE** (Lewis, 2013)

The issue of supervision also came up in Hassan and colleagues' study (2018) on delivering CBT to people with advanced cancer, in primary care. Therapists mentioned the importance of having a confident supervisor with specialist knowledge:

"… I think that's really important … there's something about getting that actual specialist … supervision, that, you know, by somebody who knows about the treatments and that side of things … has worked with cancer patients before and they kind of know some of the issues that they go through." **PARTICIPANT'S QUOTE** (Hassan et al., 2018)

Another study in primary care, looking at the delivery of CBT for perinatal mental health problems, also indicated therapist's need for specialist supervision:

"It's not that my supervisor isn't good but she's not, her area isn't perinatal." **PARTICIPANT'S QUOTE** (Millet, et al., 2018)

A similar scenario emerged from another study in primary care, this time within the context of CBT for learning disabilities. Some therapists described the supervision they received as unhelpful:

"To be honest, the supervision is poor for learning disabilities. There isn't anyone here that's specialist in …" **PARTICIPANT'S QUOTE** (Marwood et al., 2018)

However, the authors also mentioned that some therapists found supervision to be helpful and supportive (Marwood et al., 2018):

Theme

Therapist factors

"… despite a clinician's personal preference and ability, an upsetting experience of personal imagery appeared to have a negative impact on subsequent clinical use..." **AUTHORS QUOTE** (Bell et al., 2015)

Another cluster of factors, which also appeared to impact on the therapist's emotional experience of delivering CBT, were those related to the therapists themselves.

Therapists who portrayed themselves as being more concrete and verbal in cognitive terms, also mentioned feeling "fraudulent" and fearful with regards to using imagery techniques (Bell et al., 2015):

"That's the concrete thinker in me, I quite like to be able to experience it, even if you've not got the clinical disorders you can experientially... I always feel a bit fraudulent... how would I help someone with that if I don't really get it?" **PARTICIPANT'S QUOTE** (Bell et al., 2015)

When looking at the usage of imagery techniques by primary care therapists, Bell et al. (2015) also found that having had a distressing personal experience of imagery seemed to impact on the therapist's choice of technique:

"… despite a clinician's personal preference and ability, an upsetting experience of personal imagery appeared to have a negative impact on subsequent clinical use..." **AUTHORS QUOTE** (Bell et al., 2015)

Several papers mentioned therapist's negative expectations about therapy, which did not materialize when they engaged in the therapeutic work or when they received further training. This was the case for therapists using imagery in primary care:

"It is of note that a number of these respondents, even whilst doubting their own experience of imagery and noting high levels of apprehension, have been able to develop confidence in using imagery from additional, experiential, training (e.g., EMDR)." **AUTHORS' QUOTE** (Bell et al., 2015)

Some therapists had negative expectations about developing a sound therapeutic alliance in the context of ICBT, which dissipated once they had the experience of working with clients online (Bengtsson et al., 2015):

"A misgiving I had when I started working here, that, that how are you going to, like, get a personal relationship, uh, with patients that you never meet? (...) I have seen very, very good, fantastic alliances, even with patients over, over the internet surprisingly good." **PARTICIPANT'S QUOTE** (Bengtsson et al., 2015).

In the context of delivering CBT to advanced cancer patients, therapists reported anxious expectations with regards to the therapeutic work. For example, one therapist felt that they might be trivializing the patients' problems whilst another therapist feared that therapy could be putting more pressure on them (Hassan, et al., 2017). However, once the therapists actually experienced delivering the therapy, they mentioned feeling more confident and less anxious:

"I'm not scared anymore. It's not as scary as I thought it was." **PARTICIPANT'S QUOTE** (Hassan et al., 2017)

Theme

Organisational factors

"Nothing actually translates nicely into the IAPT model" **PARTICIANT'S QUOTE** (Millett, et al., 2017)

Sub-theme

Service factors

Finally, factors related to the service within which the therapy is delivered were mentioned in some studies as possibly influencing therapist's emotional responses. For example, therapists expressed frustration at the broadening of IAPT's remit to include services geared for specific groups, as this would mean a stretching of available resources and insufficient support to do so (Marwood et al., 2018):

"*Managing the demands of high workloads and ambitious target expectations appeared central to therapists' experiences. One therapist described IAPT as a "conveyer belt,"*

whilst another described "running on nervous energy" to manage the me demands." AUTHORS' QUOTE (Marwood et al., 2018).

Another participant pointed out that the lack of demand for therapy provision for a specific population or problem within IAPT services might signal insufficient specialized training (Marwood et al. 2018):

"Cos we don't really see that many people with a learning disability within IAPT, then obviously you might think there's not much demand for that training ... It's kind of chicken and egg isn't it- you'd want people to be trained before you encourage more referrals um so people were able to modify stuff." PARTICIPNAT'S QUOTE (Marwood et al., 2018)

A study on therapist's experiences regarding implementing CBT for perinatal mental health in IAPT services identified that some therapists felt that the lack of training and service guidelines and service limitations presented problems (Millett, et al., 2017):

"Nothing actually translates nicely into the IAPT model. So I think that to me certainly feels like that' s a real gap ... There doesn't seem to be any really helpful guidelines for IAPT work in perinatal period." AUTHORS' QUOTE (Millett, et al., 2017)

"Unfortunately there are constraints, whether it be kind of structural in terms of the buildings that we work in, or the ... rather relentless IAPT targets and the model." AUTHORS' QUOTE (Millett, et al., 2017)

Therapists talked about their concerns regarding the demands of implementing a new specific therapy approach (imagery work) within the service, and how this would bring challenges as they already struggled with time (Bell et al., 2015):

"I see six patients a day and if I was to start off with this imagery work and go through everybody and if there was quite a lot of intensive trauma behind it and if you were rooting it back to kind of autobiographical experiences, then I would imagine I would be feeling pretty sick by lunch time or emotionally drained." PARTICIPANT'S QUOTE (Bell et al., 2015)

Conversely, Bennett-Levy and colleagues (2014), found that aboriginal counsellors trained in CBT found their new therapeutic skills particularly valuable and safe with the specific service and population they worked with:

"CBT is a really safe kind of intervention, I find. And 'cause, particularly with our guys, they're so volatile, you know, with anger issues and really poor impulse control and I find it really safe." **PARTICIPANT'S QUOTE** (Bennett-Levy et al. 2014)

Sub-theme

Therapy modality

Different aspects of the therapy delivery also impacted on therapist's emotional response. For example, in a study looking at parents' and therapists' experiences of working within the context of CBT for anxiety disorders, with young people who were not responding to treatment, therapists felt frustrated and pressured regarding working with parent's as co-therapists (Lundkvist-Houndoumadi et al., 2016).

"Therapists felt frustrated when parents were unable to work more independently and when they took too much of the group's time to discuss about their child. They felt pressured by the limited time, and it was their impression that this feeling contributed to their becoming more directive than explorative when talking with parents." **AUTHORS' QUOTE** (Lundkvist-Houndoumadi et al., 2016).

A study comparing face-to-face with online CBT found that therapists experienced the latter as less emotional demanding. This finding was contextualised within the Swedish healthcare system, where significant sick leave among healthcare professionals is notorious (Bengtsson et al., 2015):

"Some participants found face-to-face therapy exhausting due to the stronger emotional experience, frustration and more administrative work. This theme might be related to a major problem in Swedish healthcare." **AUTHORS' QUOTE** (Bengtsson et al., 2015)

A manualised vs. non-manualised approach also appeared to influence the therapist's experience of delivering CBT. If on some studies deviations from a protocol caused anxiety in some therapists (Marwood, 2018; Millett et al., 2017), in others some therapists felt that having to adhere to a manual presented ethical problems, particularly with the specific client group of advance cancer patients (Hassan et al., 2018):

"… The idea of having like a sort of manualised treatment for this patient group … I'm not quite sure if I thought that at the training or subsequently, 'cos it didn't feel very patient centred" **PARTICIPANT'S QUOTE** (Hassan et al., 2018)

Discussion

The research papers included in the analysis point to a plethora of ways the delivery of CBT may impact emotionally on the therapists. Although data was categorized into themes, these are likely not rigidly delimited, but rather interact fluidly.

Some studies described a beneficial effect of this emotional impact; for example, therapists feeling confident and protected from burnout due to the nature of the therapy (Bennett-Levi et al., 2014), certain modalities of CBT delivery (online) offering a protective advantage in terms of the impact on the therapist, at least in some services (Bengtsson et al., 2015), and techniques being associated with a positive experience and more confidence in some therapists (Bell et al., 2015). In line with these findings, Daniel and colleagues (2015), indicated that CBT, when compared to other therapy approaches for eating disorders, seems to be associated with higher levels of happy/enthusiastic feelings towards clients, independently from client improvement, suggesting a therapy specific effect. Higher levels of early positive feelings from therapists towards clients have also been found to be associated with lower client resistance later on in therapy, independently from therapist's competence (Westra et al., 2012).

The studies also illustrated instances of therapist's lack of confidence, anxiety and pessimism (Lewis, 2013; Bell et al., 2015, Marwood, et al., 2018), perceived lack of skills (Millet et al, 2018), frustration and exhaustion (Bengtsson et al., 2015), and sense

of the work being challenging (Hassan et al., 2018). Westra and colleagues (2012), while pointing out the paucity of reports of negative feelings towards clients, suggested that the presence of such feelings early on in therapy may impair appropriate delivery of treatment, leading to greater subsequent resistance from the client. Resistance has been found to be implicated in undesirable consequences: e.g., hostile resistance early in therapy has been found to be associated with attrition in CBT for Panic (Schwartz et al., 2018), higher client resistance has been found to be connected to worse treatment outcome and poorer client ratings of therapist empathy in CBT for GAD (Hara et al, 2018).

Various papers revealed that therapists sometimes had concerns about the impact of some of the techniques employed with their clients (e.g. Bell et al., 2015**)**. This is consistent with findings from other research studies, which identified that a small percentage of therapists had experienced reluctance in making a client uncomfortable during exposure (McAleavy et al., 2014; Szkodny et al., 2014). This is also in line with findings from a study by Turner and colleagues (2014) which suggested that the clinician's own prospective anxiety seems to be related to concerns about using particular therapeutic techniques, such as those cognitive and behavioural techniques perceived to have greater impact on the clients. A recent research study pointed to more intense exposure leading to greater benefits in terms of fear and belief change, when compared to less intense forms of the intervention (Norberg et al., 2018). Waller and Turner (2016) have suggested that therapist's concerns about causing distress to their clients when using therapy techniques may lead to the employment of safety behaviours and avoidance on the clinician's part, in a bid to preserve one's self-identity as a positive participant in the client's life. The authors also argued that therapist's anxiety seems to be related to therapist drift away from evidence-based interventions (Waller, 2009; Waller & Turner 2016). Perhaps also in line with this notion, another study found therapist's insecure feelings to be associated with less reduction in client self reported agoraphobic avoidance during therapy in the context of personality disorders and interpersonal problems and its effect on CBT for Panic Disorder and Agoraphobia outcome; however, it was not possible for the authors to establish the direction of this association (Hoffart, et al., 2006). Schumacker and colleagues (Schumacker, Beltzer et al. 2017; Schumacker, Gauditz et al., 2014; Schumaker, Miller et al., 2015) also explored therapist's stress levels when employing exposure techniques. They found that

therapists experienced an increase in stress levels when using exposure comparable to that experienced by the clients themselves (Schumacher et al., 2014). The authors also found differences in the type of exposure, with flooding leading to therapist's significantly increased stress response but not graded exposure (Schumacher, Miller et al., 2015) and that therapists exhibited psychological habituation within exposure sessions, but not across exposure sessions (Schumacher, Beltzer et al., 2017). The authors suggested the importance of ensuring that clinical training involves regular therapist's exposure to these techniques, which may reduce therapist's anxiety and so impact on its subsequent clinical use (Schumacher, Beltzer et al., 2017). This is crucial in delivering evidence-based interventions, considering that behavioural techniques may have an edge over cognitive approaches as mechanisms for belief and behavioural change (Dimidjian, et al., 2006; Waller, 2009; Bennett-Levy, 2003), and the intensity of the exposure technique may also be associated with the therapeutic gains (Norberg et al., 2018).

A number of papers identified that therapist's pessimistic predictions about therapy did not seem to materialize, either through further training and support **(**Bell et al., 2015**)** or by engaging in the clinical work **(**Bengtsson et al., 2015; Hassan et al., 2017**)**. This may add weight to the idea that offering training and support, and exposing therapists to techniques and therapeutic approaches in practical terms may contribute to reduce such anxieties, and potentially reduce therapist drift. Understandably, the role of appropriate training and specialized supervision was widely recognized in terms of fostering confidence **(**Lewis, 2013; Bennett-Levi et al., 2014; Bell et al., 2015; Millet et al., 2018; Marwood, et al., 2018). Waller (2016), highlighted the importance of regular supervision as a way of ensuring effective clinical practice.

Therapists' factors are also implicated on how the therapy process impacts on the therapist. These include therapist's own perceived characteristics, anxiety and previous non-therapy related experience influencing the choice of techniques employed in therapy (Turner et al., 2014; Bell et al. 2015), and therapist's expectations regarding the therapeutic work (Bengtsson et al., 2015; Hassan, et al., 2017). This is congruent with findings from other research studies (e.g. Levita et al., 2016). Bell and colleagues suggested that these might highlight instances of a poor match between therapist and therapeutic approach. It is possible that training and practice may offer benefits with

regards to some of these limitations (e.g. Turner et al., 2014; Bell et al., 2015; Bengtsson et al., 2015; Hassan, et al., 2017); furthermore, Waller (2009) proposes considering the selection of therapists according to client's requirements.

Some papers included in the analysis also pointed to issues related to the services possibly influencing the impact on the therapists. For example, a few of these studies were carried out in IAPT services, and highlighted some specific features such as high workload and demanding targets (Bell et al., 2015; Millett et al., 2017; Marwood et al., 2018). High levels of problematic burnout amongst both low and high intensity therapists have been found to be very common in IAPT services (Westwood et al. 2017). IAPT professionals have been found to be vulnerable to emotional exhaustion independently of their age, sex, training, professional and client distress levels (Steel et al., 2015). The authors found that high work demands and lack of autonomy predicted high levels of emotional exhaustion, while feeling anxious about the therapeutic work, feelings of anxiety in session and stressful emotional over-involvement impacted on emotional exhaustion (Steel et al., 2015).

On the other hand, CBT was found to be particularly helpful and burnout protective in a specific service due to the potential for supporting its clients (Bennett-Levi et al., 2014). Another aspects seemingly protective of burnout was conducting therapy online, although perhaps somewhat less rewarding when compared to face-to-face (Bengtsson, 2015).

Following a manualised approach or deviating from the manual also impacted on the therapist's experience (Millett et al., 2017; Hassan et al., 2018; Marwood, 2018). Waller and colleagues (2016) discussed the issue of pros and cons of following manualised treatment protocols within the context of therapist drift, and pointed out that the beliefs and attitudes of clinicians towards the manuals may influence the implementation of evidence based protocols.

Strengths and limitations

This was the first study looking to gather evidence from empirical research studies with regards to the impact of delivering CBT on the therapist. It provides an overview of

research findings in a field that has been thus far primarily theoretical. It comprises a thorough replicable search strategy, and sound inclusion/exclusion criteria. Opting to incorporate only qualitative studies can be classed as both a strength and a limitation; as on one hand it has allowed for more rigour in synthesizing findings, due to the otherwise heterogeneity of studies, however, it also meant that only a small amount of studies were included in the analysis, potentially overlooking important research findings. Having included other research sources in the analysis, such as non-peer research and unpublished work might have contributed to a wider variety of studies, however this might have affected the quality of the research included. Overall, there seems to be a relative paucity of studies specifically focusing on the emotional impact of delivering therapy on the therapist, and so most of those included in this analysis only covered this subject partially. It may also be harder to identify such studies in literature searches, as they may be categorised under different subjects. Having adopted broader criteria, such as including dissertations and non-English references might have revealed more relevant data. The lack of a wide range of therapist's emotional responses was also evident, further highlighting the apparent absence of studies specifically delving into these, or potentially the therapist's reluctance in discussing such a personal subject (Najavits, 2000) making it a complex area to research.

Implications for research

The analysis provides some clues on avenues for future research. Looking at the emotional impact of delivering CBT on therapists is an important and under-researched area, with implication in terms of the therapist's wellbeing and therapy delivery. For example, investigating optimal clinical training to develop confidence in using therapeutic techniques may help address therapist's anxiety regarding their clinical use. Exploring therapist's positive and negative reactions towards clients may shed light over these processes, and offer insight on how to identify and address these in order to maximise therapy gains. Studying the factors implicated in fuelling and mitigating therapist burnout may offer options in terms of improving the sustainability and effectiveness of therapy approaches. The potential clinical implications of this subject are evident, and highlight the need for further research.

Conclusion

The emotional impact of delivering CBT on the therapist should not be underestimated. The papers in this review have highlighted important aspects of the therapist's emotional experience of delivering therapy and implications in terms of therapy outcome and therapist wellbeing. It is conceivable that therapists may be reluctant in sharing such experiences for fear of scrutiny (Najavits, 2000), potentially making these findings the tip of the iceberg when it comes to therapist's emotional experiences, marking the need for varied methods and approaches to studying therapist's experiences in a range of contexts.

References

Bell, T., Mackie, L., & Bennett-Levy, J. (2015).'Venturing Towards the Dark Side': The Use of Imagery Interventions by Recently Qualified Cognitive–Behavioural Therapists. *Clinical Psychology and Psychotherapy*, 22, 591–603.

Bengtsson, J., Nordin, S. & Carlbring, P. (2015). Therapists' Experiences of Conducting Cognitive Behavioural Therapy Online vis-à-vis Face-to-Face. *Cognitive Behaviour Therapy*, 44, 6, 470–479.

Bennett-Levy, J. (2003). Mechanisms of change in cognitive therapy: the case of automatic thought records and behavioural experiments. *Behavioural and Cognitive Psychotherapy*, 31, 261–277.

Bennett-Levy, J., Wilson, S., Nelson, J., Stirling, J., Ryan, K., Rotumah, D., Budden, W., & Beale, D. (2014). Can CBT Be Effective for Aboriginal Australians? Perspectives of Aboriginal Practitioners Trained in CBT. *Australian Psychologist*, 49, 1–7.

Berry, C., & Hayward, M. (2011). What Can Qualitative Research Tell Us about Service User Perspectives of CBT for Psychosis? A Synthesis of Current Evidence. *Behavioural and Cognitive Psychotherapy,* 39, 487–494.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3:2, 77-101

Brown, A., Mountford, V., & Waller, G. (2014). Clinician beliefs about what therapeutic techniques drive weight gain over the early part of outpatient cognitive behavioral therapy for anorexia nervosa. *The Cognitive Behaviour Therapist*, 7, e1-e7.

Daniel, S., I., F., Lunn, S., & Poulsen, S. (2015). Client Attachment and Therapist Feelings in the Treatment of Bulimia Nervosa. *Psychotherapy*, 52, 2, 247–257.

Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmaling, K. B., Kohlenberg, R. J., Addis, M. E., et al. (2006). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *Journal of Consulting and Clinical Psychology,* 74, 658–670.

Ellis, T., E., Schwartz, J., A., J., & Rufino, K., A., (2018). Negative Reactions of Therapists Working with Suicidal Patients: a CBT/Mindfulness Perspective on Countertransference. *International Journal of Cognitive Therapy,* 11, 80–99.

Hara, K., M., Westra, H., A., Constantino, M., J., & Antony M., M. (2018). The impact of resistance on empathy in CBT for generalized anxiety disorder. *Psychotherapy Research*, 28, 606-615.

Hassan, S., Bennett, K., & Serfaty, M. (2018). Delivering cognitive behavioural therapy to advanced cancer patients: A qualitative exploration into therapists' experiences within a UK psychological service. *Clinical Psychology & Psychotherapy*, 25, 565–574.

Hoffart, A., Hedley, L., V., Thornes, K., Larsen, S., M., & Friis, S. (2006). Therapists' Emotional Reactions to Patients as aMediator in Cognitive Behavioural Treatment of Panic Disorder with Agoraphobia. *Cognitive Behaviour Therapy*, 35, 174–182.

Kimerling. R. E., Zeiss, A., M., & Zeiss, R., A. (2000). Therapist Emotional Responses to Patients: Building a Learning-Based Language. *Cognitive and Behavioral Practice,*

7, 312-321.

Levita, L., Salas Duhne, P. G., Girling, C., & Waller, G. (2016). Facets of clinicians' anxiety and the delivery of cognitive behavioral therapy. *Behaviour Research and Therapy,* 77, 157–161.

Lewis, H. (2013). An exploratory study of primary-care therapists' perceived competence in providing cognitive behavioural therapy to people with medically unexplained symptoms. *The Cognitive Behaviour Therapist*, 6, e16, 1-10.

Lombardo, C., Milne, D., and Proctor, R. (2009). Getting to the Heart of Clinical Supervision: A Theoretical Review of the Role of Emotions in Professional Development. *Cognitive and Behavioural Psychotherapy,* 37, 207–219.

Lundkvist-Houndoumadi, I., Thastum, M. & Nielsen, K. (2016). Parents' difficulties as co-therapists in CBT among non-responding youths with anxiety disorders: Parent and therapist experiences. *Clinical Child Psychology and Psychiatry,* 21, 477– 490

Marwood, H., Chinn, D., Gannon, K. & Scior, K. (2018). The experiences of high intensity therapists delivering cognitive behavioural therapy to people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 3, 76–86.

McAleavey, A., A., Castonguay, L., G., & Goldfried, M., R. (2014). Clinical Experiences in Conducting Cognitive-Behavioral Therapy for Social Phobia. *Behavior Therapy*, 45, 21–35.

Millett, L., Taylor, B., L., Howard, L., M., Bick, D., Stanley, N., & Johnson, S. (2017). Experiences of Improving Access to Psychological Therapy Services for Perinatal Mental Health Difficulties: a Qualitative Study of Women's and Therapists' Views. *Behavioural and Cognitive Psychotherapy*, 46, 421-436.

Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses:* The PRISMA Statement. PLoS Medicine 6(7).

Moorey S. (2014). “Is it them or is it me?” Transference and countertransference in CBT In Whittington A & Grey N Eds. *How to Become a More Effective CBT Therapist: Mastering Metacompetence in Clinical Practice*. Chichester: John Wiley and sons.

Najavits, L., M. (2000). Researching Therapist Emotions and Countertransference. *Cognitive and Behavioral Practice,* 7, 322-328.

Neelakantan, L., Hetrick S., & Michaleson D. (2018). Users’ experiences of trauma-focused cognitive behavioural therapy for children and adolescents: a systematic review and metasynthesis of qualitative research. *European Child & Adolescent Psychiatry*, 1-21.

Norberg, M., M., Newins, A., R., Jiang, Y., Xu, J., Forcadell, E., Alberich, C., & Deacon, B. J., (2018). The Scarier the Better: Maximizing Exposure Therapy Outcomes for Spider Fear. *Behavioural and Cognitive Psychotherapy*, 46, 754–760.

O’Brien, B. C., Harris, I., B., Beckman, T., J., Reed, D., A., Cook, D., A., (2014). Standards for reporting qualitative research: a synthesis of recommendations. *Academic Medicine*, 89, 1245-1251.

Padesky, C. and Greenberg, D. (1995) *Clinicians Guide to Mind over Mood*. New York: Guilford Press.

Padesky, C. (1996). Developing cognitive therapist’s competency: teaching and supervision methods. In *Frontiers of Cognitive Therapy*. Paul Salkovskis (Ed.) New York: The Guilford Press.

Pretorius, W., (2006). Cognitive Behavioural Therapy Supervision: Recommended Practice. *Behavioural and Cognitive Psychotherapy*, 34, 413–420.

QSR International Pty Ltd. (2018). NVivo qualitative data analysis Software, Version 12.

Reiser, R., P., & Milne, D., L., (2016). A survey of CBT supervision in the UK: methods, satisfaction and training, as viewed by a selected sample of CBT supervision leaders. *The Cognitive Behaviour Therapist*, 9, e20, 1-14.

Schumacher, S., Betzler, F., Miller, R., Kirschbaum, C. & Ströhle, A., (2017). Habituation of Stress in Psychotherapists Performing Subsequent in Vivo Exposures - A Case Series. *Journal of Psychotherapy Integration,* 27, 2, 218–224

Schumacher, S., Gaudlitz, K., Plag, J., Miller, R., Kirschbaum, C., Fehm, L., Fydrich, T. & Ströhle, A. (2014). Who is stressed? A pilot study of salivarycortisol and alpha-amylase concentrationsin agoraphobic patients and their novicetherapists undergoing in vivo exposure. *Psychoneuroendocrinology*, 49, 280-289.

Schumacher, S., Miller, R., Fehm, L., Kirschbaum, C. Fydrich., T. & Ströhle, A., (2015). Therapists' and patients' stress responses during graduated versus flooding in vivo exposure in the treatment of specific phobia: A preliminary observational study. *Psychiatry Research*, 230, 668–675.

Schwartz, R., A., Chambless, D., L. McCarthy, K., S., Milrod, B., &. Barber, J., P. (2018). Client resistance predicts outcomes in cognitive–behavioral therapy for panic disorder. *Psychotherapy Research,* 28, 606-615.

Steel, C., Macdonald, J., Schröder, T., & Mellor-Clark, J., (2015). Exhausted but not cynical: burnout in therapists working within Improving Access to Psychological Therapy Services. *Journal of Mental Health*, 24, 33-37.

Szkodny, L., E., Newman, M., G., Goldfried, M., R. (2014). Clinical Experiences in Conducting Empirically Supported Treatments for Generalized Anxiety Disorder. *Behavior Therapy*, 45, 7–20.

Turner, H., Tatham, M., Lant, M., Mountford, V., A. & Waller, G. (2014). Clinicians' concerns about delivering cognitive-behavioural therapy for eating disorders. *Behaviour Research and Therapy.* 57, 38e42.

Waller, G., (2009). Evidence-based treatment and therapist drift. *Behaviour Research and Therapy,* 47, 119–127.

Waller, G., & Turner, H., (2016). Therapist drift redux: Why well-meaning clinicians fail to deliver evidence-based therapy, and how to get back on track. *Behaviour Research and Therapy*, 77, 129-137.

Westbrook, D., Kennerley H., & Kirk, J., (2011). *An introduction to Cognitive Behaviour Therapy – Skills and Applications*. London: Sage.

Westra, H., A., Aviram, A., Connors, L., Kertes, A., & Ahmed, M. (2012). Therapist Emotional Reactions and Client Resistance in Cognitive Behavioral Therapy. *Psychotherapy,* 49, 163–172.

Westwood, S., Morison, L., Allt, J., & Holmes, N. (2017). Predictors of emotional exhaustion, disengagement and burnout among improving access to psychological therapies (IAPT) practitioners. Journal of Mental Health, 26, 172-179.

Wolf, A., W., & Goldfried, M., R. (2014). Clinical Experiences in Using Cognitive-Behavior Therapy to Treat Panic Disorder. *Behavior Therapy,* 45, 36–46.

Vyskocilova, J., & Prasko, J., (2013). Countertransference, schema modes and ethical considerations in cognitive behavioral therapy. *Activitas Nervosa Superior Rediviva*, 55, 1–2.

Von Elm, E., Altman, D., G., Egger, M., Pocock, S. J., Gotzsche, P., C., Vandenbroucke, J., P., (2007). The strengthening of the Reposting of Observational Studies in Epidemiology (STROBE) Statement: guidelines for reporting observational studies. Lancet, 370 (9596): 1453-1457.

Section 2
Research Report

Social Recovery Therapy: Therapists' experience of hope working with complex clients

Abstract

Social Recovery Therapy: Therapists' experience of hope working with complex clients

Catarina Sacadura

Background: There is currently scarce research literature looking at cognitive behavioural therapists' experiences of delivering therapy. How therapists experience hope is particularly relevant in the context of working with young people at risk of developing long-term disability. Social recovery therapy is a novel multi-systemic intervention, based on the cognitive behavioural model of social disability and social recovery (Fowler et al., 2012), which is currently being evaluated for this population. SRT focuses particularly on fostering hope, a sense of agency and a positive sense of self.

Purpose: This study aims to gain an understanding of therapists' experiences of hope in the context of delivering SRT to young people with social disability and complex emerging mental health problems.

Methods: A semi-structured interview was developed and used to collect therapists' views on their experience of using SRT with young people at risk of developing long-term disability. Ten therapists were interviewed and their narratives were analysed using qualitative methodology (Interpretative Phenomenological Analysis).

Results: Five main themes and two contextual themes emerged from the narratives, painting a picture of the therapists' journey: 1) This is new; 2) All at sea; 2) Holding on to hope; 4) self-practice/self-reflection; 5) Campaigning; 6) Supervision is fundamental; 7) Sharing is caring. For each main theme, associated sub-themes were identified and discussed.

Conclusion: This study reveals the richness of therapists' emotions via their journey of delivering SRT to young people with social disability and emerging mental health problems. It highlights therapists' challenges and strategies in the maintenance of hope through this process.

Introduction

Traditionally, psychodynamic theory has focused on processes whereby emotions are understood to be unconsciously transferred between therapist and client during therapy (transference and counter transference); however Cognitive Behavioural Therapy (CBT) has up until recently devoted limited attention to the study of such concepts (Moorey, 2014). According to Safran and Segal (1990), there is a tendency to assume that CBT therapists will be able to use any required interventions in an optimal way, regardless of their own personal feelings. Perhaps for this reason the therapist's personal feelings became less appealing as an object of study. Safran and Segal (1990) stated that although increasingly more attention has been placed on the importance of the therapeutic relationship, the same is not true with regards to the therapist's own feelings, thoughts and responses. The authors also proposed that it cannot be assumed that cognitive behavioural therapists are somewhat insusceptible to being emotionally affected by the process of working therapeutically with someone (Safran and Segal, 1990). However, so far only a small number of recent studies have looked into cognitive behavioural therapists' experience of therapy (for example see Westra, et al., 2011; Szkodny, et al., 2014; Bengtsson, et al., 2015; Marwood, et al., 2018).

The role of hope in therapy

One concept that seems to impact on therapists and clients is hope. According to Snyder's definition, hope is "a cognitive set that is based on a reciprocally-derived sense of successful agency (goal-directed determination) and pathways (planning to meet goals)" (Snyder et al., 1991, p. 571). Hope encapsulates believing that there are pathways available to the pursuit of meaningful goals, and having the motivation to engage with them (Snyder, et al. 2018). The authors also posited that hope drives emotions and wellbeing. Snyder et al. (2018) explained that individuals perceive goal pursuit as successful when the process occurs without impediments or when barriers are effectively overcome; conversely, negative feelings emerge from unsuccessful goal attainment. Snyder et al. (2018) added that people with high levels of hope display an ability to think productively and flexibly about the future, in the knowledge that at some points they will need to deal with major life stressors, whereas those with low levels of hope are more prone to catstrophizing and rumination.

The American Psychiatric Association stated that "the concept of recovery emphasizes a person's capacity to have hope and lead a meaningful life". According to Hodgekins and Fowler (2010), service users who portray their recovery from psychosis frequently describe feelings of disempowerment and loss of hope. The authors suggested that improving self-concept, instilling hope and realistic optimism should be emphasized in treatment. Berry and Greenwood (2015) found that a positive therapeutic relationship with a key mental health professional was associated with the level of hopefulness experienced by young patients with psychosis. Moreover, Berry and Greenwood (2016) found that professionals' own optimistic expectations for patients' recovery and social inclusion were associated with the degree to which they formed hope-inspiring, positive therapeutic relationships with patients. The patient's sense of hopelessness may nevertheless also activate hopelessness in the therapist (Moorey, 2014). Whilst hopefulness and hopelessness are not automatically understood as opposite ends of the same construct, they are related; Oetttingen and Chromik (2018) characterise hopelessness as the expectation that negative outcomes will happen, and that one is powerless to change that. Hopelessness in therapists is typically addressed in the context of supervision, but little is known about how the therapists themselves experience such feelings and how they maintain their own hope. The maintenance of therapist hope is particularly interesting in the context of delivering Social Recovery Therapy to a group of clients experiencing high levels of hopelessness, as is the case with the PRODIGY trial (described further ahead).

Social Recovery Therapy

Social Recovery Therapy (SRT) is a novel intervention designed to improve social disability in the context of complex mental health problems (Fowler et al., 2009, 2012, 2017). SRT uses CBT techniques alongside assertive outreach and multisystemic principles, and requires therapists to work in a flexible way (Fowler et al., 2012). SRT entails expertise in CBT techniques to address depression, social anxiety and psychotic symptoms, as these are frequently the primary targets of the intervention. However, it is also likely to include addressing the attitudes of others, namely family members and other professionals in the multidisciplinary context and assertive case management practice (Fowler et al., 2012). SRT emphasises promoting hope and motivation as well

as the use of classic CBT techniques such as experiments and behavioural activation. In order to promote hope, sense of agency and positive beliefs about self and others in this particular group, meaningful changes need to be achieved in people's lives, in the realms of social relationships, work, education and valued social activities (Fowler et.al 2013). Consequently, therapists' work is deeply rooted in an ability to adapt to each client's needs, articulating more traditional CBT practices with approaches usually associated with case management, assertive community treatment, supported education and work and multi-systemic interventions. The structure and content of sessions varies according to how the therapist adapts the intervention to better suit the client's needs, and so SRT may present itself differently.

SRT relies on a heavy behavioural component with behavioural experiments and behavioural activation at its heart (Fowler et al., 2019). Behavioural experiments are sophisticated and multi-layered; beyond testing assumptions they also seek to actively promote social recovery more widely. Through the use of behavioural experiments the therapist supports clients to leave the therapy location, in many cases the person's home, and engage in new experiences, exploring potential goals and interests according to their own values, creating opportunities for enjoyment and realisation that one can cope, promoting hope and a positive sense of self, offering scope for therapist role-modelling and rehearsal of social skills in vivo and fostering a positive therapeutic alliance through experiences of the therapist "walking alongside" the client (Fowler et al., 2019). When suitable, behavioural experiments can also be designed in ways to allow for the involvement of relevant others in order to support them in understanding and further supporting SRT. Therapists seek to capitalise on gains in the moment, for example, following the successful completion of a planed behavioural experiment, the therapist might quickly encourage the client to design an extended or different one to be conducted there and then (Fowler et al., 2019). For instance, therapist and client might collaboratively design an experiment through which they visit an animal shelter, in line with of the client's values. Assumptions to be tested might include the client's ability to communicate with staff members without making use of their usual safety behaviours. The experiment also covers leaving the house into the real world, realising that one can cope better that predicted, the feeling of enjoyment of being near rescued dogs as opposed to being at home, the sense that one has meaningful goals and can perceive pathways to pursuing them, therefore fuelling hope, role-modelling of social skills as

client also observes therapist relating to others (for example, making small talk) and the strengthening of the therapeutic alliance. After the initial experiment has been completed, therapist and client may briefly reconvene whilst on location, taking care for confidentiality to be maintained, and design another experiment through which the client may, for example, enquire about scope for volunteering at the kennels or walking the dogs. This could then lead to a behavioural activation plan. Ensuring that meaningful activities are repeated and further explored is essential in boosting activity levels. This is usually done in conjunction with behavioural experiments and can also rely on the support of the therapist during the initial stages. For example, a therapist might attend the initial martial arts class alongside the client, or volunteer at a charity shop for the client's first day of volunteer work. The later is likely to include the involvement of the shop manager, with client's agreement, in order to familiarize them with SRT and promote the therapeutic work.

According to Fowler et al. (2010) those at greater risk of developing long-term disability, including psychosis, are young people who present with comorbid complex emotional, behavioural and social problems, and also attenuated psychotic experiences. Fowler et al. (2010) explained that a decline in social ability is often evident before the development of severe mental illness, and that this pre-morbid disability becomes stable and predicts the long-term course of the disorder. The authors argued for a combined approach to complex youth mental health, based on the premise that emotional dysfunction, social disability and psychotic symptoms all need addressing (Fowler, et al., 2010; Fowler et al., 2014; Fowler et al., 2017). However, young people with complex needs do not routinely access treatment, and there seems to be major gap in recognizing and addressing the mental health problems of this group (Fowler et al., 2017). These young people may not seek support, they might struggle to engage and there might be a gap in identification and service provision for this particular group (Department of Heath, 2008; Singh, 2010; Nice, 2013a). For example, on one hand they might display sub-threshold psychotic symptoms that do not fit with criteria for a first episode of psychosis and so would not typically be offered support from an early intervention service. On the other hand, they might not be offered support by primary care services such as IAPT as they rarely fit criteria, and at the same time, they are usually not deemed severe enough for secondary care services. These are clients who mental health professionals do not usually come across in their day-to-day work in

traditional mental health services. They are complex in nature and likely to bring challenges to the therapeutic process.

SRT has emerging evidence as an effective intervention to improve social recovery in individuals at early stages of psychosis (Fowler et al, 2009), and in people with first-episode psychosis (Fowler et al, 2017). One small qualitative study looking into client's experiences of SRT during the PRODIGY trial pilot, and those receiving treatment as usual, has been recently published (Gee et al., 2016) and found that SRT was well accepted and considered beneficial by participants.

The PRODIGY trial

SRT is currently being delivered to young people with social disability in the context of complex mental health problems within the PRODIGY trial (Fowler et al., 2017). PRODIGY is a large definitive multisite Randomised Controlled Trial, taking place in Sussex, East Anglia and Greater Manchester. Within this trial, therapists deliver SRT to 16 to 25 year olds with social disability (operationalised as doing less than 30 hours a week of structured activity) and complex emerging mental health problems (such as At Risk Mental State for psychosis or depression and anxiety). The PRODIGY trial tests the clinical and cost-effectiveness of SRT compared to standard NHS treatment as usual. Eighteen SRT therapists have been involved in the delivery of the intervention and represent Clinical Psychologists and other professional groups, such as Occupational Therapists, who also have a CBT qualification.

Therapists' experience of working with young people with social disability in the context of complex mental health problems has not been researched as part of the PRODIGY trial. Furthermore, there have been no studies looking at how therapists maintain hope in the context of delivering SRT or CBT.

The present research

The present study aimed to understand more about the therapist's experience of using SRT to maintain hope in therapy. An understanding of therapist experience is useful as

it can help inform and improve the implementation of the SRT intervention and consider how delivery of the therapy can be scaffolded.

Aims of the current research

The goal of this research study was to gain an understanding of therapists' experiences of delivering SRT to young people with social disability and complex emerging mental health problems. Specifically, it aimed to look at aspects such as therapist's maintenance of hope during therapy with complex cases.

- What are the therapists' experiences of the process of SRT with young people experiencing social disability and complex emerging mental health problems?
- How do therapists maintain hope within the context of SRT with young people experiencing social disability and complex emerging mental health problems?

Method

Study design

A qualitative methodology was chosen in order to allow for a rich exploration of SRT therapist experience. In particular, IPA was selected for its focus on understanding how individuals experience a particular phenomenon by encouraging participants to share their reflections of personal experiences, seeking to understand how they make sense of them. The idea behind this approach is that people reflect on the significance of their own experiences; IPA is interested in these thoughts. This research methodology focuses on the meaning for the individuals, rather than causes or consequences of events. IPA is a bottom-up research methodology, in the sense that it is not based on a pre-existing theory from which codes are applied to the data, but rather the researcher generates codes from the data. Subsequently, themes are identified, organized and discussed. Smith, Flowers and Larkin (2009) call this a "double hermeneutic", due to the researcher's striving to carefully look at how people develop their own personal meaning regarding particular circumstances or events.

So far, the subject of therapists' personal feelings has received limited research attention within the scope of CBT. Therapists are human beings who experience complex inner worlds, and therefore are likely to interact in sophisticated ways with the therapeutic process. IPA presents itself as an ideal way to give voice to the therapists' unique experience. IPA also seems to fit agreeably with the CBT ethos, as it too looks at understanding how individuals make sense of their own experiences.

Sample

Therapists were eligible to take part in this study if they were offering SRT or had offered SRT in the PRODIGY Trial, if they have worked with at least 3 clients on this trial, and if they were willing and able to provide written informed consent. All of the therapists involved in the delivery of therapy in PRODIGY across the three research centres (Sussex, East Anglia, and Greater Manchester), who matched these criteria, were approached and invited to participate in the study via email.

All of the therapists engaged in the delivery of the intervention had specialist training in CBT skills either as part of a post-qualification training course in CBT or as part of a post-graduate Clinical Psychology training programme, or both. All Trial Therapists recruited to work on the trial have relevant experience and are trained in SRT. Smith, Flowers and Larkin (2009) suggest a sample size of between four and ten participants for a study within a Professional Doctoral project, and so ten was the current target sample size.

Procedure

Approval for this study was provided by the North West Preston NHS Research Ethics Committee (15/NW/0590, A3). The first 10 therapists who agreed to participate in the study were asked to consent and interviewed by the researcher. All therapists provided written informed consent for their participation in the study and for the interview to be audio-recorded, prior to the start of the interview. Interviews were arranged during participants' work hours at a convenient time and lasted between thirty and fifty minutes. The interviews were carried out face-to-face (n=3) or via telephone (n=7). In order to preserve anonymity of participants, pseudonyms were used in the transcripts.

Interviews were recorded using an encrypted dictaphone and transcribed verbatim by the main researcher. The researcher, who carried out the interviews, was also a therapist on the Prodigy trial and so a professional colleague of those being interviewed. The implications of such relationship are discussed under strengths and limitations, in the present chapter, and further elaborated on in the critical appraisal section (interviews).

Data collection

A semi-structured interview guide was developed in discussion with key clinicians and researchers who have been involved in the development of SRT and the current supervisor as a qualitative researcher independent of SRT and the PRODIGY trial. The schedule was devised keeping in mind the importance of offering the participants opportunities to reflect on their experiences. The participants were asked to reflect upon various experiences during therapy, including recollections of trial participants who they felt did and did not find therapy to be useful and beneficial. Participants were also invited to think about their coping strategies and how they accessed support during the therapy process with their clients. Finally, they were asked about what their thoughts were regarding training and supervision of therapists providing SRT. The consideration of personal meaning was encouraged throughout this process. As suggested by Smith and Osborn (2008), open-ended questions were employed, and prompts were used when deemed necessary by the interviewer, in order to further explore the topics examined.

Data analysis

Following an IPA methodology (Smith, Flowers & Larkin, 2009, Smith & Osborn, 2004), all interviews were read and re-read by the researcher and one other coder until they were fully immersed in the narratives. Sections that felt important were highlighted on paper with matching descriptive notes (Appendix I, page 155). This process was repeated, categorizing these sections according to their descriptions and similarities. Meetings were carried out between the two coders (CS and CB) at each step, until superordinate and subordinate themes were arrived at (Appendix J, page 159, and Appendix K, page 161). The interviews were recoded under the final theme headings then analysed in using NVivo software version 21.0 (QSR International, 2018), to facilitate checking for distinctiveness, consistency and clarity before writing an account

of the themes (Appendix L, page 163). For an in depth discussion of the data analysis process, please see Section Critical Appraisal – data analysis.

The second coder (CB) was a non-clinical member of the trial team. This person was closely involved in the identification and description of the themes.

Results

Therapists provided rich accounts of their experience. Five procedural themes emerged from the analysis, (table 1), representing therapists' experience of hope through the delivery of SRT. Additionally, two contextual themes described the scaffolds facilitating therapists' hope. These themes are clarified using illustrative quotes.

No data regarding participant's demographics is presented to preserve participant's anonymity and confidentiality, due to the very small pool they were recruited from.

Table 1. Superordinate themes and subordinate themes

Superordinate themes	**Subordinate themes**
1. This is new (journey)	1.a New philosophy of therapy 1.b Permission to be creative and flexible
2. "All at sea" (journey)	2.a Therapist frustration 2.b Hopelessness
3. Holding on to hope (journey)	3.a Finding the hook 3.b Persistence through challenges in engagement 3.c Hope from others
4. Self-practice & self-reflection (journey)	4.a Reappraising own cognitions 4.b Overcoming own avoidance 4.c Cheerleading for self and other
5. Campaigning (journey)	5.a Realization of hope 5.b Campaigning for neglected clients
6. Supervision is fundamental (contextual)	6.a A safe place 6.b Supervision is normative and restorative
7. Sharing is caring (contextual)	7.a sharing with clients 7.b sharing within the therapy process 7.c sharing among therapists

Therapist journey

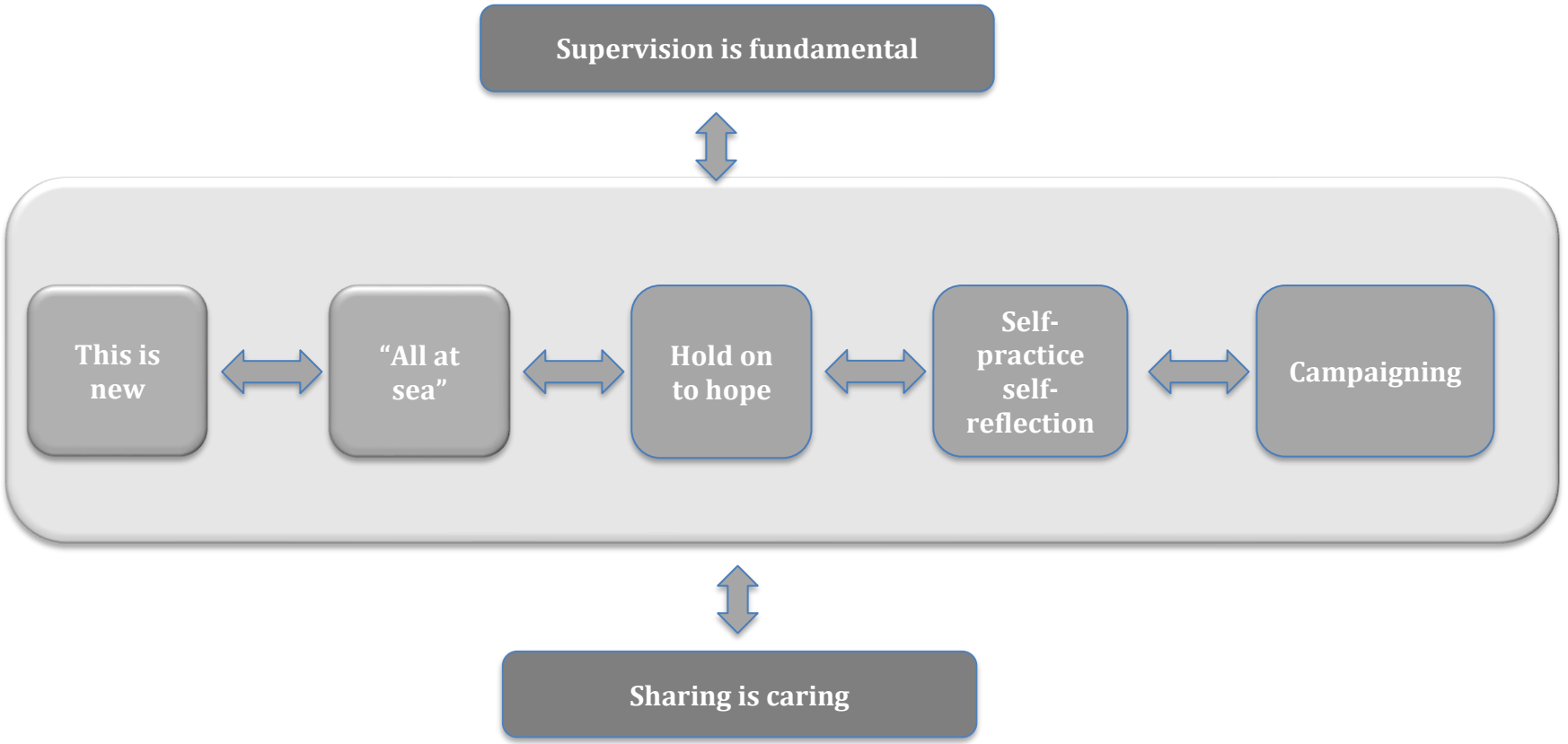


Figure 1. Therapist journey

Superordinate theme 1

This is new

"…there's a contrast between this approach and maybe other forms of, erm, CBT." Hermione

The newness of the approach emerged from the therapist's narratives in the form of a mist of hope and relative surprise at the innovative aspects of SRT.

Subordinate theme 1.a

New philosophy of therapy

The first subordinate theme emerging from the interviews was the notion of SRT representing a new therapeutic philosophy, characterised by critical differences in conceptualising and conducting therapy. Therapy focuses on engagement and collaboration processes, as well as on the systemic context, the emphasis on hands-on, out-of-the-office behavioural work and the distinctive client group:

"… it is more about understanding the philosophy, and what the differences are, and that a lot of the work takes place outside of the therapy room, and that, the collaboration might be slightly different to the collaboration that people normally have." Hermione

Therapists described an amalgamation of therapist and case manager functions:

"… it's combining the role of a care-co-ordinator and the therapist. And I, I think they are certainly merits, in doing [it]." Hector

The therapist role has been portrayed by therapists as having lost the rigidity of traditional CBT, revealing a truly enduring hands-on supportive function:

"… behavioural experiments were really important, doing stuff, being more active, getting outside the clinic room, which again I think it is not something that we traditionally tend to do because of time constraints. So getting people to be flexible in

their, the way that they work, but, making sure that you conduct behavioural experiments in a systematic CBT way...." Rachel

"... deliver that intensity and then, then trail off, ... but, ... have that space for you to be in the background. I think that's, and that's quite a different way of working, I think from other NHS therapies" Janis

Therapists described their work as being much more all-encompassing, with a strong emphasis on multi-systemic factors:

"I think what also is helpful is working with system as well, so the systemic approach, which again can be sometimes things that we don't tend to do in a traditional kind of clinical setting, we don't involve the system around the young person. And I guess what we found time and time again, with PRODIGY clients, is often the system is one of the major blocks to them moving forward in their lives." Rachel

Engagement was considered pivotal throughout therapy and the lack of it was not conceptualised as a direct obstacle to therapy, but rather an expected area of intervention. Engagement was seen as fertile ground for the development of hope:

"... the engagement part of SRT is probably ... the most important part and, and I think that I have to consciously, consider engagement every session I deliver with SRT... because if a young person isn't engaged in every session or it becomes quite didactic, for me that session becomes pretty meaningless, so my thoughts and feelings around the engagement particularly are that, that's something that makes this quite different unique, is that for every session, every part of every session I am often considering, 'Am I engaging, am I engaging this young people, young person in a genuine and meaningful way?' ... that engagement, the rapport that I, and therapeutic alliance that I have with that young person actually is probably the key ingredient and almost a springboard to the other, to the other parts and components of the intervention that we then go on to deliver." Simon

"Accepting perhaps that they won't always turn up to appointments, not discharging them or dismissing them because of that, so having a bit of a different perspective on

non-engagement, not seeing that as somebody who isn't necessarily therapeutically ready, so I think that, that can take a bit of a change of mind-set, because I think in traditional services if people don't turn up to appointments they tend to be discharged. So having, accepting and understanding the clients you are working with, and engagement is going to be an, an issue, but once you've got that engagement going then the process is likely to … move forward." Rachel

Participants talked about collaboration between client and therapist taking up different forms in SRT, requiring adaptation from the therapists to a novel way of thinking and working therapeutically. At this point of the therapist's experience, accounts start to emerge suggesting the initial hope experienced by therapists being somewhat challenged:

"… It certainly did feel at points like I was the one who was being very directive and kind of advising the person to do things." Hermione

"… I feel less like a sort of guiding therapist and more like a kind of naggy authority figure." Janis

Therapists described their experiences navigating their therapeutic work with a unique group of clients who don't normally present in services for a variety of reasons:

"These, these are the clients who would often tend not to come to therapy anyway, see, you perhaps wouldn't be working with them or you would perhaps in a team be describing as not quite ready to engage, so I think working with really hard-to-engage-people, yeah it's been, been an interesting and ultimately enlightening experience." Rachel

Engaging clients that otherwise might not receive therapy was in itself a motivation to further develop SRT:

"… it's made me realise how that is such, I guess, a big group of people to, have kind of, been thrown about by services, and I guess they've just fallen, fallen through the net, so to speak, and, I guess that's made me think kind of professionally about, I guess how,

how it would be possible to change, to change things, to change services, so that, I guess this group of people will able to access more and have more support." Miriam

"… for me that, that's a big part of why we're doing this, so trying to engage people who may not normally be, be approached to engage in psychological therapy." Hermione

Subordinate theme 1.b

Permission to be creative and flexible

Permission to be creative and flexible was welcomed by therapists as an opportunity to expand their therapeutic support of clients in ways otherwise deemed outside their usual scope. Therapists' narratives are imbued with hope stemming from a sense of freedom to carry out the essential therapeutic and multi-systemic, stripped of the habitual constraints:

"I think it's nice that it allows the freedom to, to do some of that wider work that might normally be ignored in CBT … [this] *can be incredibly valuable, both for leading to shifts in, in thinking, and also just for rapport-building."* Hector

"… as a therapist it's quite an alien concept particularly to work kind of outside the clinic, in a very kind of assertive and engaging and pragmatic manner, without relying on kind of you know the typical structures of, of just offering a clinical psychology appointment or CBT for example … It's been quite an enlightening experience, it kind of is one of those therapies where you can shake the shackles of other interventions and become a bit more flexible, a bit more free in the work that you do with young people whilst also kind of working under a specific model." Simon

Therapists referred to this newfound therapeutic freedom as a way to release themselves from the traditional constraints of their work, according to which there are explicit limitations in terms of the place of therapy, timeframes and scope:

"… All therapists, to some extent, yeah wanna get over and above for their clients, but, so sometimes the … service that they are operating from, don't allow for that. [In] *a psychological therapy service, you have to see eight clients in a room, back-to-back,*

you know, there's no chance of, of getting out, in-in-into the centre of town for a coffee with someone, because it's all go-go-go, you have to really cram it in to, you know, to put, to just so a dozen half sessions. Yeah, so I think it, it's really nice that SRT… allows therapists to, to go explore, to, al-always linking it back to a cognitive behavioural framework, but, but just to be a bit more imaginative within that." Hector

This new flexible version of the therapist's role was seen as pushing the boundaries of how they had worked prior to delivering SRT:

"… give people the permission to do things that might not be seen as in a traditional therapy …" Hermione

"… if I wasn't doing social recovery focused therapy I wouldn't have thought 'Okay yes, actually, that is something that we can do within our therapeutic work, you know, that I can come along with you and see what your experiences with this group, and support you in going along to these things.' " Zara

Superordinate theme 2

"All at sea"

"… there were times when I felt really, quite, all at sea you know and I just thought, I don't know what I'm doing here, I don't know which direction I'm going …" Zoe

Therapists also talked about the challenges they perceived using SRT with this population posed, and how this impacted on them. Their stories, at times, point to a rather intense navigation of frustration and hopelessness during the therapeutic work.

Subordinate theme 2.a

Therapist frustration

All therapists experienced frustration, at some point or another, during their journey within the SRT model. At times, therapist frustration was mentioned in connection to clients' perceived avoidance and lack of motivation:

"… there were certainly times personally where I was feeling a little frustrated, by things. It felt like we had identified quite a lot that we could work on, and, and I guess, my frustration was coming out, of the avoidance, and, and not being able to get going on working on those things." Miriam

"Frustrated, I think is the right word. Basically, it's the learning curve with these experiences it's all about managing frustration feelings basically. Because you know they can do it, you know they do have the resources and the skills, but they just, for different reasons, they just don't do it. So, it's all about frustration." Paula

This sense of frustration was often associated with questioning one's competence as a therapist. Self-questioning was a common denominator across the therapy process:

"I guess I got frustrated at …. if you work with someone, and you get, sort of a little bit of hope here and there they are almost sort of dangle a carrot. Like you, sort of, think "Oh, he's got a goal let's go for it!", and then you do a bit of work and, and that felt like it was maybe working, and then it would be dismissed, soon after then. And I think that made me feel frustrated, and also made me wonder, you know, if there were other things I could have done better to, to get more, I guess to get closer to, to what was important to him. (…) So I guess, yeah, that sort of sense of frustration and then with that worry about my own, ability, to kind of deliver the therapy and to work with this individual." Zoe

One therapist referred to a challenging experience early on in therapy, when they questioned themselves:

"I wonder if it comes, I don't know, maybe that, like you're walking uphill … There's a part of me that feels I'm, I'm missing something that and if I could just phrase it in a different way, present it in a different way it might seem more appealing or open up

something in s.., a motivation in someone so, there's a part of me that feels then de, deskilled I guess." Janis

Therapists recalled having wondered about their competence in SRT particularly in terms of matching the intervention to the particular needs of the client:

"... you do question a lot if you use the right technique, or if you are being a bit harsh on the pace of the therapy sessions, or if you are adjusting the right behavioural experiment, so you do question a lot about if you are doing the things properly." Paula

Therapists often mentioned perceived disengagement as a trigger point for their self-questioning:

"So, the cases that, you know, were challenging at the start and then we got to that point that felt great ...but then they disengaged! ... they were the cases that I found the most difficult I think because, they were the ones where you think 'Oh God, you know, I, there are other people who we got to a point where we were able to do something', and I think having that sort of challenging part and then for the person not to, you know, to stop answering your phone calls or, you know, not respond to your letters, or whatever, or not show up for appointments and just disengage, that makes you really question yourself ..." Zara

Therapists revealed that they had felt apprehension regarding having taken a more proactive role with their clients:

"... there were times he was in danger of disengaging as well, and at that point, you know, I thought 'Actually have we done too much too soon?' Because actually we did start quite quickly on getting out and doing things, and I was thinking 'Is he just going along with things, am I pushing him a bit too hard?'" Hermione

Subordinate theme 2.b

Hopelessness

In their narratives, therapists also reported having experienced hopelessness during the therapeutic process:

"… there have been times when I've thought 'This isn't going to work', you know, 'What else can I do?'. So there, there have been times when I felt kind of hopeless and, and useless as a therapist." Rachel

Another therapist described how they experienced despondency and hopelessness, particularly in the context of a therapeutic alliance that had not developed as expected:

"Yes, so if I don't have that kind of therapeutic alliance or that engagement and that has been difficult at times, or there have been times where I thought that I had engaged the young person very well and they had not engaged very well, I could feel quite despondent and, and quite hopeless…" Simon

Therapists described a phenomenon of being drawn into their clients' own negative outlook, which they found specific to this type of work:

"… I suppose the other main experience I think as a therapist … it's being kind drawn into, to the way that the clients can feel sometimes. So sometimes feeling their kind of hopelessness and stuckness, which is perhaps something that's a bit unique, or feels a bit more unique to this kind of work, than perhaps working in kind of conventional, sort of clinical, clinical work." Rachel

"…that feeling of hopelessness, can be slightly contagious I think. … it's that combination of, of sometimes some people have quite high expectations for themselves, and then are also quite critical, I think that there is a danger that, or a risk or, actually, an inevitability that the therapist will get kind of drawn into that at some point..."
Hermione

"I guess I particularly feel with this client and that kind of a bit of that, I suppose, transference of hopelessness really that they, that they feel in their life anyway, that I end up feeling a bit like that." Janis

When talking about contagious hopelessness, one therapist equated this feeling to an indicator that something in therapy process is somewhat compromised and needs addressing:

"If we are continually working hard and feeling hopeless, also that kind of contagious hopelessness, then they are they are indicators to me that things aren't going so well ..." Simon

One therapist talked about her own nihilistic thoughts that arose during therapy:

"I've had real ... moments of feeling very kind, of you know, therapeutically nihilistic about everything, and just thinking, you know, that nothing is going very well at all." Rachel

One therapist mentioned "we are all human beings", as she talks about challenging therapeutic work impacting on the therapist:

"... if you're working with people who are, aren't making much progress, we are all human beings. And actually if you're working with people, or if you have a whole case of people at one time, who are depressed, and withdrawn and, and quite negative in terms of their view on life in general, that is gonna, that is gonna rub off on you." Hermione

Super-ordinate theme 3

Holding on to hope

"… I think hope was, was a real key, and potential and optimism were kind of key things really …" Hermione

Throughout their narratives, therapists talked about their experience of holding on to hope for the clients and for themselves:

"I remember going along to those appointments and feeling like, okay, my job here in this relationship is to keep up that hope and to keep coming back and keep looking at bringing it back to values and bringing it back to what the person is doing and, and to try and not get, not feel hopeless as a therapist… Definitely, it was difficult to keep up that hope, but that keeping up hope was really important." Zara

"*I think not over-pathologising … and sending a message of hope and recovery*." Rachel

One therapist reflected on the fine line between validating client's experiences and carrying a message of hope and optimism for the future:

"I think one of the things that might be quite difficult for people is walking that line between validating someone's experience and why they're in the position that they're in, while also balancing that with sort of hope and goal setting and thinking about engaging in meaningful activity." Zara

Subordinate theme 3.a

Finding the hook

The pursuit of the client's interests, based on their own values, was frequently referred to as "finding the hook":

"And it might be not through the typical therapeutic means of engaging the young person, it might be that I just take them out and to do something novel or I, or to do something active, or to do something they enjoy or that we can enjoy together, … so we can share a positive experience. And that often then acts as a hook to further kind of positive engagement." Simon

"Because you're always thinking 'What next, where can I do next, how can I, how can I get them to bite the carrot you know, how can I find the carrot, what is the carrot?' and then - you know the, metaphysic, metaphorical carrot - erm, and 'How can I get them to be invested in this process, and be interested in something?' Rachel

"... that I think is one of the things that makes the therapy, if you can find that hook, that reason to push yourself forward..." Janis

Subordinate theme 3.b

Persistence through challenges in engagement

Therapists describe using formulation to make sense of the disengagement process, and generate avenues for intervention, as well as being persistent throughout the process:

"... he had started to disengage and, there was a process of re-engaging him and maybe, taking a few steps back, we formulated the situation and then, and then getting going again". Hermione

One of the forums where disengagement was discussed and formulated was supervision, where this process was also normalised:

"... the role of supervision there was really helpful in terms of saying well, well no because we've got an agreement in place that this is what he wants to do, and actually it seems to be working, and, it's quite normal, within this approach that people hit a bit of a wall but and you have to kind of go a round it, and we formulate and take a few steps back, and, and think about that." Hermione

"...having that space and that opportunity, to reflect on, what, what was happening and how that was making me fee, and I guess use it as an opportunity to formulate, what may have been going on for the client in terms of not engaging, ..." Miriam

Persistence, in the form of a relentless but gentle display of interest, encouragement and caring for the client, was pointed out by therapists, in their interviews, as a crucial element of their work:

"I think that one of the things that really works well was just being very available and, you know, if someone rang to cancel ... trying to negotiate that with a person, ... "You've done really well recently, let's, can we just meet for 5 minutes, I'll buy you a coffee, we'll have a little chat, and, and then you, you know, you can go back to bed if

you'd like, maybe that will feel better, you know if you just get out for a little bit in the fresh air" … It's just really good for showing that you, you kind of care, you're not going to give up on them yet, you are really rooting for them, you want to help them to make changes. I think that, I think that worked well." Hector

"And the point, the engagement issue was, the key thing is really in terms of not, not giving up." Hermione

This consistency of the care-giving role of the therapist was seen as an important part of building the therapeutic relationship and establishing trust:

"… trying to draw upon any, all engagement skills that I might have to try and get people in, in the first place, and stay in, I guess one person, thinking about who, he DNA'ed[2] *the first five sessions, I think it was, he would keep rearranging but, and not turn up, not answer his phone. So, so I guess for him just consist- consistently carrying on booking appointments, arranging and turning up, meeting up at the service even if he wasn't there, week on week, I think led to him, kind of seeing that I was reliable, and that he could trust me."* Janis

Persistence was not only characterised by "not giving up" therapeutically on the client, in the face of disengagement and hopelessness, but also showing a presence and support in between sessions as illustrated by:

"… SRT it's not just about that one week session, it's about potentially calling them in between, texting them in between, emailing in between. A week feels too long sometimes … I think that's another probably a major difference of SRT with any of type of therapy is that … with this particular client, and I think potentially some of the clients were working with, if I just saw him weekly and that was it, definitely nothing would change." Janis

This approach sometimes left therapists in unusual and potentially uncomfortable situations, and required a readiness to think on one's feet:

[2] Did Not Attend (DNA), i.e. was unexpectedly absent from the planned session.

"… turning up at her house for an appointment with someone who wasn't there, people there that you had to kind of explain why you were there, but, not sort as breaking confidentiality for the client, and you didn't really know what they knew, so that kind of left me in, in a odd situation, a few times." Zack

Keeping up this sort of perseverance in the face of disengagement and therapy difficulties was at times challenging, but as a group, therapists supported each other in maintaining this stance throughout:

"I found the process of SRT really challenging with, was someone who would make appointments but then I would show up to the house and he wouldn't answer the door, and that went on for quite a long time, in trying lots of different ways of trying to, to make it feel okay for him to come along to an appointment … to keep going to the appointments even when, you know, he's not going to answer the door, or he he's going to say after 10 minutes that actually he doesn't feel okay to have the session anymore, was again those training days and speaking to people like [therapy leads] *and all of the other therapists, for them to just go "No, you know, it, of course this is difficult, but this is about keeping that hope, keep showing up" and to have that support".* Rachel

Subordinate theme 3.c

Hope from others

Therapists emphasised the importance of holding a caseload of at least three clients at a time, in a bid to maintain their hope. The rationale is that it increases the chances that some of the clients will be making some sort of progress, therefore minimising the likelihood of developing a skewed view that one is struggling with all clients:

"I think having a number of cases is also an important thing… I think I've seen three people, at the same time, and, and normally at least one of those people would be making some form of progress. I think if you've got a caseload of, of people who are all not doing very well, they can make you feel quite hopeless, and like 'what's the point of all of this?', whereas … having a number of cases you know, you are seeing normally, there's something positive happening …" Hermione

Hope amongst therapists was not only generated by looking at positive therapy outcomes with other clients, but also by sharing positive recovery stories between therapists, often in the context of supervision:

"And again you are talking about it in supervision so, we're very, very keen, within [SRT]*, within the supervision that the offer, that we don't just focus on the negative experiences of therapy. Within our supervision actually there's a lot to be celebrated and there's a lot of hope within this intervention and that needs, for me, to be, to be replicated at every level."* Simon

Peer supervision in particular was hailed by therapist as especially facilitative of hope, as frequently other therapists in a group would be able to spot or remember signs of progress and positivity, even when the therapist themselves could not:

"I think that's also why, why supervision is so important, and why a kind of a group format supervision has been quite helpful because even if the therapists themselves are struggling to kind of see the light at the end of the tunnel, or you know so hold the hope for the person, somebody else within the group, can usually do that they, they, they maybe remember the progress that somebody made, and that, that makes it kind of feel more, more hopeful." Hermione

Super-ordinate theme 4

Self-Practice/Self-Reflection

"I guess just that, encouraging people I guess to have that space to reflect on the impact it's having on them doing the therapy and if there is anyway to minimise that or reflect on it differently…" Janis

During interviews it became apparent that therapists engaged in self-reflection and self-practice during the delivery of SRT:

"... self-reflection is really important. So, it's really important to your allow yourself the time as a social recovery therapist, to think about the work that you're doing, to reflect on your sessions, to plan for the next sessions ahead, to reflect on your engagement, to reflect on how the sessions made you feel, and therefore how you sort of interpersonally, you might also impact on the young person you are working with." Simon

"... just, just having that space and that opportunity, hmm, to reflect on, what, what was happening and how that was making me feel." Miriam

Therapists depict a process of reflection during which they not only focused on the session with their clients and how they could better support them, but also focused on themselves as interactive participants in the therapeutic process. Therapists talked about how this impacted on them and how, in turn, their thoughts and behaviours might influence the therapeutic process.

Subordinate theme 4.a

Reappraising own cognitions

Therapists described how they engaged in a process of reappraising their own negative cognitions regarding the therapeutic process, a typical cognitive strategy employed in standard CBT:

"...it's kind of just reminding yourself ... of your wins, and, and not just getting too bogged down in, in... in, in thinking about, the problem that you are encountering or having encountered." Hector

"I guess it's trying to see every case on a case-by-case basis, not on a kind of, like a wave picking up momentum, I suppose, where it gradually becomes, overwhelms you, and this sense of failure and panic and stuckness, just ma-makes you kind of paralyse as a therapist." Rachel

Therapists talked about how they generated alternative more helpful thoughts regarding the therapy process:

"But actually you're gonna get as far as you're gonna get, and if you can keep that person engaged then they're coming back and you'll, you'll be helping them to learn things about their situation and helping them to make even those first tiny steps forward, that's still really important … As well, and that every little step forward is a step in the right direction, and then that things won't stop at the end of this … not that by the end of the nineth month you know, you're gonna have everything sorted out, but you're gonna be on the path to getting there." Hermione

"My, my job is to deliver something to a reasonably good standard, the best that I can do. And then whether the person does really well or whether that person does not do very well at all, I don't take responsibility for that. … I'm excited for the person when it goes well for them rather then be excited from me as an expert therapist. And that also gives me a way out when it doesn't go well." Zack

"… there's a chance that, you know, the person might remember some stuff from your sessions … there might be some take home message that might make, you know, things slightly better even if it's just like 'If you go out you feel better'. And you know, by giving the person a good experience of services … maybe we'll give them a good experience of being more likely to seek help and, and stick with it in the future. …" Hector

Regaining perspective and being able to see the bigger picture was featured in the therapists' narratives:

"And, and even if it might feel like quite a small thing, the client themselves might, think of it as quite a small thing, in-in-in terms of kind of the bigger picture, often those kind of smaller steps are the hardest ones to take, the sort of first steps." Hermione

"I guess what we can hope is that those are memories now, those are things that are with kind of within his, his kind of cognitive make up, he can draw down on them and pull them out as things that he has done, he's achieved, and perhaps go back to them or, or, or move forward with them then." Rachel

One of the characteristics of SRT is that it adopts a more directive and assertive approach, one with which CBT therapists are perhaps unfamiliar. As such, this was also the focus of reflecting and reappraisal:

"[Clients have] *been very ambivalent about whether they want to change or not, and that that's actually okay, and that you can work with that ambivalence but you might have to be a bit more directive, and that it might not feel as collaborative as other forms of psychological therapy. But that that's okay, and you can have a collaboration in terms of asking permission from the person, to let the person know that, that "Actually there might be times where it might feel like I'm, I'm being quite directive. If it's something that you really don't want to do…", having a sort of conversation with the person about them finding a way to say if they are really, really don't want to do it, 'coz under no circumstances should you force somebody to do something they don't want to do… what I often will do at the beginning is say that actually "At times I might be quite strongly encouraging you to do something, and if you really don't want to do something, then that's absolutely fine" and we find a way of somebody letting me know that… that is agreed at the start. So you, you kind of got the collaboration through the permission of the person for you to be quite directive, and that, that, that can be collaborative too, if that makes sense."* Hermione

"…I feel like he needs that help to get there, so I guess, like bikes and stabilisers, like I'm the stabilisers right now and then, once he's going, we can take them off." Janis

This new take on collaboration was not only adhered to by the therapists, it was hailed as truly worthwhile and ultimately incorporated in their general therapeutic practice:

"I have really enjoyed, having quite a flexible approach and a quite, a kind of, proactive approach with people, especially those people who … aren't really giving that much, and so, kind of being proactive on their behalf and helping them to, take that on themselves and change their behaviour, has been, has been quite rewarding, I would say." Zoe

Subordinate theme 4.b

Overcoming own avoidance

Therapists also discussed how the early and continued emphasis on behavioural approaches in SRT illuminated and challenged their own historical reticence to work in this way, and how they put their own beliefs to the test:

"I think I knew that being behavioural with people, especially with certain clients, was a good thing and to be aimed for in CBT therapy. And yet, I think that there was, in terms of my emotions, a sort of avoidance of that. … you can give yourself reasons not to me very active with people, like "I don't have a long enough session", or "I'm not sure where we could go, you know, from here, or where we are conducting therapy", or "We will do that next week", or "The client isn't sure about this, so, so let's not do it yet". And I think that there's, there are emotional things that, that get in the way of being quite active with the clients, at times, in, in therapy. And, and that can build up over time. So I think and by, the, the focus really with SRT, you know, is, sort of, to go against that and to get active with people right away. And therefore, I guess it's, kind of, by doing behavioural experiments for me as a therapist, you know, kind of, overcoming my avoidance and challenging my cognitions that things might go wrong, or that without a very detailed formulation people might not see a benefit of, of an experiment and actually behavioural work is, is really important. And my work here kind of showed, showed me that but I knew it theoretically, but I perhaps wasn't always, using that knowledge practically in my clinical work." Zoe

"I think sometimes we have a bit of a tendency to hang on a bit too long before getting out and doing that behavioural work. Cause that can be quite daunting for therapists, I think at times we-we kind of like to cover all the angles, and, and you know no one likes a failed behavioural experiment. But, but, but then on the other hand, I, I think we, you know, I-I think not getting out can sometimes hamper therapy, so hinder therapy, to the same degree." Hector

Subordinate theme 4.c

Cheerleading for self and others

Finally, therapists showed a distinctive preference towards focusing on and verbalising the positive and hopeful aspects within therapy. A deliberately positive choice of

language and focus on achievements aims to reinforce client efforts and instil hope in both client and therapist:

"… I think it's good to be excited for clients… I suppose these are positives, all positive emotions, you know, I think, I think you can kind of, share them with clients,… when you're excited by the fact that someone's been out for the first time in a few months, it's just kind of letting them know that, you know, and "You've done a bloody great job!" You know, and "I am really pleased you've done that, that's fantastic, you know, it's an incredible achievement and, let's, let's use that, let's take that forward, and let's let', let's build on this"." Hector

"… I think in terms of, of kind of making sense of their and managing that sort of maybe sense of disappointment or that sense that you should be doing more, finding what the small element of progress that you have achieved is and keeping that in mind and reminding yourself of that, but also reminding the client of that." Hermione

One therapist described the significance of focusing on the positive aspects, and how it can influence the wider system and change people's perceptions regarding hope, including the therapists':

"I much rather think about what, what goes well and, and the positivity of therapy and the hopefulness actually, because it does breed hopefulness as well; its not just contagious hopelessness that we get from these clients. We get this kind of contagious hopefulness as well, that actually when things are going well, that hopefulness really helps us to make sense of the work that we are doing with that young person, it makes us, I think, do a better job at our next sessions and think about what we doing. But most important, I think, if then influences the wider system social recovery therapies through supervision." Simon

Super-ordinate theme 5

Campaigning

"I think I've sort of embraced it, I think not just in SRT, it I think I caught principles in SRT that can, sort of, can be very useful in CBT generally, for various populations." Simon

Participants' enthusiasm for SRT was noticeable in their narratives. It became apparent that the very experience of providing this therapy validated the need for such an intervention, in a sort of lived experience of the process.

Subordinate theme 5.a

Realization of hope

Participants talked about how they come to the realisation that SRT breeds hope beyond what was thought possible and leads to meaningful change:

"I think for other young people who've got a real paucity of... self really, of knowing who they are, what they're about, what their values are or what's meaningful to them, it can be a much harder, a much harder kind of process, but ultimately it can be probably, probably one of the most rewarding processes when you can really see, you know, having almost this light-bulb moments with people where they perhaps look at things in a different way or see themselves in different way or see that the world is full of opportunities rather than threat." Rachel

"The changes that we see with clients, for someone who had a very low functioning level, suddenly it's, it's out there, it's working, so it's, it's about seeing the changes and actually ... things happening with the clients and they are increasing their functioning, they are getting better so that's, that's what it's all about." Paula

Therapists exalted the gains that their clients made during the time they worked together, and how ultimately that reminds them of why they do what they do:

"... he didn't know what difference therapy could make ... he was one of those cases that I kind of reflected on and think 'This is why I do what I do'. And you know,

sometimes people make small gains, but sometimes people make huge gains and what a difference, you know, it can make to someone's life. I think that's so powerful." Zoe

"I think sometimes, you know, working with somebody who's, who's very distressed and motivated to change and then does something that they have never done before and feel thrilled about it, is a really lovely experience as a therapist!" Hermione

There is a sense of therapists having changed their way of working therapeutically in general after observing the potential of SRT:

"I think it's a really nice way of working with clients and… I think we've had quite a tough group to work with in this trial but I would say generally this approach could be widened out as well to, to work with people who maybe don't have such a low level of functioning. I think, you know, just getting out of the therapy room and doing more in the community is a really nice way of working and I think can bring about change quicker even in those who my have a slightly higher level of, kind of time use to begin with. I guess that's one thing I've taken from that, I guess, it's changed the way have worked with other client groups as well, who aren't in this trial." Miriam

Subordinate theme 5.b

Campaigning for neglected clients

Therapists frequently referred to the notion that the intervention is effectively targeting clients who have typically not been helped by services:

"… just knowing that everybody has some really tricky clients, and, and that's part of the reason that we're doing the trial, is because this is the group that has been neglected by services, that has fallen through the cracks, which is why, you know, it's doubly important to, to try and validate and evaluate, an intervention, to, to help them." Hector

"And I think maybe in other settings, more standard clinical, clinical settings that weren't research settings, that person - because of capacity issues within the team or

service, might, because they'd, they'd cancelled so many sessions - they might then be told that actually they couldn't have the intervention any more." Hermione

"… in this client group, I think, people have been stuck and you know either in the services and stuck or out of services and stuck for a long time." Janis

Therapists' accounts were imbued with a sense of professional responsibility towards this group of ultimately neglected clients, who had been let down, through a variety of reasons, by the available mental health services:

"I guess it's made me realise, how that is such, I guess, a big group of people to, have kind of, been thrown about by services, and I guess they've just fallen, fallen through the net, so to speak, and, I guess that's made me think kind of professionally about, I guess how, how it would be possible to change, to change things to change services, so that, I guess this group of people will able to access more and have more support." Miriam

"… I find it quite important to remember I guess the underpinning philosophy of, of, of this whole approach and trials that actually is one of the things is, I found can engage people who otherwise wouldn't be, even offered psychological therapy because of that, that ambivalence." Hermione

One therapist explained how he feelt excited about the prospect of working on a new and helpful intervention:

"… we might be working on an intervention here that's really useful for people going forward in the future, and so I guess there's, there's some… it's pleasing, it feels a bit exciting that you are working on something that might, might benefit people that, that perhaps isn't so available at the moment." Zack

Super-ordinate theme 6

Supervision is fundamental (contextual)

"I guess supervision was essential, because of the range of clients and problems and the flexibility of the model, it was really important to have regular supervision and touch base and to just check in that I was, you know, kind of doing the right things and going in the right direction, and to have sort of guidance, reassurance I suppose." Zoe

Supervision was acknowledged, by all therapists, as an integral part of their navigation through social recovery therapy.

Subordinate theme 6.a

A safe place

Supervision was used as a forum to reflect on therapists' emotions in a safe way, and ensuring their own personal wellbeing was maintained throughout what could often constitute a challenging process:

"I guess it was helpful in terms of reflecting on how I was feeling at the time to ensure that wasn't going to impact on the therapeutic relationship." Miriam

"I think, definitely again the regular contact with other therapists I think is vital for managing difficult feelings that might come up." Janis

"I think managing my own feelings, supervision and having peer support as well has been really important for that. So, I guess, having lots of informal discussions in our office, particularly if we're feeling quite frustrated by things or overwhelmed by risk issues that we were having to deal with, so the peer support as well as provision has been really helpful for that." Miriam

Participants talked about supervision as a safe place for learning and reflection that needs to be available and prioritised by both supervisors and therapists:

"I think the importance of consistent and regular supervision. I think we all sort of assume that, but then in practice it doesn't, it doesn't absolutely happen. Supervision is really important to me, and so I think it needs to be, absolutely, you know that's fundamental. I think it's very difficult for someone to deliver good SRT without having good supervision on a regular basis." Zoe

"That it's [supervision] *regular, that it's prioritised as important, so that people don't, sometimes people fill their diaries up and supervision is one of the things that gets sort of lock off because seeing people is more important, or, I don't know, doing a care plan or whatever. So I think it really, the prioritisation really needs then, to be there for supervision."* Zack

Therapists talked about supervision taking place formally in its planned time and place, but also in an *ad hoc* format, within a shared mentality of whole team mutual support:

"... it's been nice working as part of team, so I think the team approach to [SRT] *has been really important, knowing that you can pick up the phone to, to, to* [team members] *is, you know, very useful, or knowing that you can pick up the phone to any of the other social recovery therapists, or your immediate team, is a really useful process"* Simon

The mode of supervision was also a point of discussion, with therapists advocating that a mix of formal and informal, individual, group and peer format, including recording and rating sessions and writing up case reports, all have their place within the SRT model of team work:

"I think peer support is important, so maybe having, peer-supervision as well as clinical supervision." Miriam

"I think supervision ... can be conducted in a variety of different modalities, so not just kind of face-to-face but over the phone ... taping sessions, a-and, and I think even writing up, I think it has been interesting recently writing up vignettes for therapy just, just again cause it helps, I think, really cement in a therapist's mind the journey that they've been through." Rachel

"I think the peer supervision is really helpful, but the, having individual supervision with the head of therapy it's also crucial, because it's kind of, creates the, the right pace for you to share you thoughts, your emotions… it's more specific, and it's more, I think it's slightly on a different level of the peer supervision. So, one thing is more like in a clinical discussion situation when you can share, you know, you can see with other cases that there are a lot of similarities, the other thing is when you've got your own safe place and you can actually talk about what you feel and how you feel about the case and you have a kind of a more individual support that, I think, makes a difference in good way." Paula

A therapist equated operating within the SRT model to working with team cases; although clients always have their individual therapists, the whole therapeutic team will be acquainted with these via supervision and other modes of sharing, and all contribute towards the therapy:

"I think supervision is, is key, and I think actually a group supervision format with other therapists who are doing the same thing, is really important, and that's kind of how we've done things locally. Because even though you might be the person seeing, you might be the therapist seeing the client, everybody in the group generally knows a little bit about all of the clients that have come through. So you kind of feel like they're, they're almost like, team cases, if you like." Hermione

Subordinate theme 6.b

Supervision is normative and restorative

Throughout their narratives, therapists described how useful they found the various roles of supervision, particularly in terms of its normative and restorative functions and how this was instrumental in supporting hope:

"… I think it [supervision] *takes on a number of different roles. There are, there are I think the technical aspects … the intricacies of a particular behavioural experiment … discussing sometimes how the system is, sort of playing out within the system that's kind of contributing to that, what that means for the individual therapist, you know, there*

might be something that comes up within the family family sessions, or, or any session really that presses particular buttons to the therapist … but, right up to quite sort of general themes about hopefulness or hopelessness." Hermione

Some therapists revealed how they benefitted from supervision in a technical way, by obtaining practical support, boosting their creativity and expertise:

"One of the things that I really, really liked about SRT was that sort of creative element of it. And I always really enjoyed talking to other therapists doing the same therapy about what they had tried that might be a little different, you know like just where they were meeting people, where, what kind of things they were, they were trying out with them …" Zara

"… it's all about the support, the strategies …. discuss this case with someone who has got more experience than I had, reflecting about a potential plan Bs and Cs regarding therapeutic techniques, be a bit creative, … it's all about the support provided by supervision, basically." Paula

"I think I used supervision a lot throughout to try and think about other angles, that I could go in, you know, to, to try and be flexible and try different things." Zoe

Therapists pointed out a role of supervision in normalising both the progress in therapy and how the therapeutic process might be affecting the therapist:

"I think, definitely again the regular contact with other therapists I think is vital for managing difficult feelings that might come up. Also for helping you think about different avenues for a case and, the feeling stuck with it, where you might go with it, to normalise views that you might have about hopelessness or the bits not going well." Janis

"… so thinking about what other people had experienced, seeing, that, you know, your, you experiences are not, you know, are not unique, that other, other therapists experience the same difficulties and challenges, and obstacles to their work… Rachel"

Therapists talked about a much-needed sense of validation; this notion that all therapists were going through similar challenges, so 'it wasn't just me':

"… I think that gave me a bit more confidence that it wasn't just me. … So I think [the other therapists] *give me confidence that I really was being flexible and trying a range of things and giving him of the opportunity to engage as far as possible."* Zoe

Finally, supervision also supported therapists in finding the professional boundaries within SRT work and ensuring that work is sustainable:

"I mean they get into your headspace, these clients, that's what I found. So managing that, that's why I think supervision's so important. Definitely and being able to say "It's time to stop thinking about them now". Worry time I found was quite helpful." Rachel

"So we have our weekly meeting sessions, which is, they are always very, very helpful, and, and then have, make sure that, you know, you don't take it personally, it's about learning your own way to make sure that you are professional and don't take things into your own personal bubble." Paula

"So, I think peer supervision, meeting with other therapist regularly is really important is vital to make sure that you don't go mental on your own!" Janis

Super-ordinate theme 7

Sharing is caring

"… you can often be in, in this parallel kind of journey with your clients and, and, and it can be hard sometimes to separate yourself from kind of what they're experiencing, going through …" Rachel

The narratives are imbued with a sense of togetherness amongst all of those involved in the therapeutic process. Therapists talked about feeling connected to the therapy, clients

and other team members via a sense of empathy, dedication, meaningful connections and shared experiences. This process was made explicit by various kinds of sharing.

Subordinate theme 7.a

Sharing with clients

First and foremost therapists talked about how SRT was defined by 'walking alongside the client'. This is a process during which therapists effectively share themselves with the client in a sense of literally accompanying them to where required in therapy, deeply understanding the clients' inner worlds and developing meaningful connections:

"... it was a real gradual process and it was ... walking alongside her with everything that she was doing and then she had to be brave and she had to be courageous, and curious, and that's, that was what I was tying to instil in her, both that courage and that sense of curiosity." Simon

Developing and showing a deep understanding and respect for the client and their personal experiences, and using that in a sort of advocating way, was mentioned by the therapists at different points in the interviews:

"I think just helping somebody to understand, what, what's keeping them in this situation, how they've got there and informing people around them, be that their families or the people who, people at college, or employers, or, or whoever, on what keeps things stuck, can actually be quite a powerful thing in and of itself." Hermione

"... when someone has very different outlook or views to you, it's hard to, and that's something I think I'm always working on is how not to place your, your own values and your own viewpoints onto someone else, and view their life through your lens as it were, and taking what they're saying, as much as you can, at face value and, and, you know, with all the other information you can ...". Janis

Within the context of deeply understanding the client's inner worlds, therapists talked about using their own sense of frustration and hopelessness as a gateway to understanding the client's perspective and feelings:

"... I think at times it made me feel frustrated, and sort of hopeless, and, and as I say, stuck, but I think you can also use those feelings as a way of kind of getting in and kind of getting in, or climbing inside someone's head and understand what things feel like for them". Rachel

Establishing meaningful connections with clients was brought up by all of the therapists:

"I think part of the reason it worked with him was because what we did felt really enjoyable for me too. Actually I really, I enjoyed doing it and I enjoyed seeing him, I enjoyed thinking what we're going to go to next, what were going to do, and I think there's a real reciprocity in that therapeutic relationship in those moments for some people." Rachel

"... the initial process was all, seeing them at their convenience, being okay with the environment, which was a bit chaotic with parents walking around, it was engaging the participant, but it was engaging mum and dad as well, it was trying to really create a sense of, of working together, and optimism." Zack

"I tried to sort to be engaging, and have chats with him, and find out what he was interested in, and all of those things. And I think, actually it turned out that were interested in quite a lot of the same things, we like the same TV shows and read similar books and, and that was quite easy actually, that we had those things in common. I think the combination of both getting along with him and feeling, you know, that we connected, and the fact that he did really well in therapy, and worked really hard and made really positive gains, just made me feel great." Zoe

From looking at the narratives it became apparent that therapists and clients both shared a sense of excitement, in therapy, regarding each step further in recovery:

"So just feeling really excited for them that they were going to take this forward and I think it's really nice feeling all excited together in the therapy room." Janis

"I think you definitely get, get that sort of trans-transference I suppose, with clients and you can often feel, very, yeah, very sort of stuck and hopeless like they do, but equally well, you know, when things do start to go well, I think you really get, you really do feel their hope and, and their, their sort of positivity that things can change." Rachel

"Excited for them, really excited for them, like they really, you know they had so much, I think with lots of the people that we work with they have so much potential and that's what can make it so exciting ... to see them be able to, start to, I guess make the changes that they wanted to do, meet people, follow through their passions ... So just feeling really excited for them that they were going to take this forward and I think it's really nice feeling all excited together in the therapy room." Janis

Subordinate theme 7b

Sharing within the therapy process

Therapists described their work as a process through which they shared some of themselves with therapy itself, in a sense that they talked about being emotionally invested, carrying clients in their mind, and a sense of responsibility for the recovery process:

"I think also taking the time to reflect on my you know, how I am as a therapist and that, you know, what stance you bring to different relationships, and, how personally you take things as well, just as a sort of a lesson on perhaps not quite getting so caught up and invested and putting so much pressure on yourself to make it work ..." Janis

"So I feel, it feels that you were very emotionally invested, with clients in this work, from, you know, from, from being, you know, invested in their negative emotions to be invested in their positive emotions." Rachel

"... I think at times trying not to kind of take clients home with me, cause I found that literally, not literally take them home, but you know, mentally take them home with me, would be quite hard. I think sometimes the risk with working with these client groups is that you can do all the work, and it's a really big temptation, and that can make them a little bit hard to get out of your headspace sometimes." Rachel

"I think that fits in with what I mentioned about, sort of the responsibility that I felt, because I guess I felt responsibility for the relationship as well as for the therapy working itself." Zara

One therapist mentioned finding it useful to remind themselves of their role and how that might impact on their sense of responsibility in the process:

"My job is try and deliver something, even if that is, involves a personal bit of me in terms of building rapport or whatever. My, my job is to deliver something to a reasonably good standard, the best that I can do. And then whether the person does really well or whether that person does not do very well at all, I don't take responsibility for that." Zack

Subordinate theme 7.c

Sharing among therapists

Throughout interviews therapists talked about another sort of sharing, one that took place amongst therapists in terms of sharing their experiences, thoughts and feelings:

"... because your peers are doing it ... so they're gonna be experiencing the same, the same processes that you're feeling, ... the processes between what's happening with you and the client, the processes of what's happening, you know, outside the therapy room, the, the doubt ... the sort of negativity, but also the, the ... positivity and the possibility of change, which I think, you know, unless you're doing the therapy you kind of can't really understand. So I think it's a really important, really important aspect of it." Rachel

"I think if I hadn't been as open, I would, I would've found it much more challenging, because it was through that process in supervision, just saying " I'm finding this really, really difficult", and also with my colleagues saying "I'm finding this really, really difficult", that I was able to makes sense of it and feel that it was okay as well." Zara

"I guess feelings and thoughts … I've tended not to keep them to myself, so I think, I think, again kind of sharing them with my, with my peers really. Sharing them kind of with, with, with each other was really important, getting a sense of, of thinking that other people are feeling and thinking the way I do …" Rachel

One particular therapist talked about his own humbling experience of having a sense of not doing very well in therapy, and despite finding it difficult to talk about what he perceived as a personal failure, he found the group invaluable in sharing this experience and the impact that it was having on him:

"Me, I'm not normally very good at naming kind of failure or things I have not been very good at, so that was quite a difficult process for me as a therapist, myself and a good learning point actually. But I remember … the group supervision session that we had where I talked about feelings of despondency and, and sense of failure, and actually was a really enriching experience to have with my colleagues, who, you know, we forensically kind of went through what I done, how I tried to re-engage in contact. And, and they all gave me the impression that they couldn't think of anything that I could have done differently, or they would have done differently themselves. Which was quite a normalising experience for me. And also to be able to say that, actually, this is just a really tough group to work with some of the time, and so there are going to be some that won't engage whether they have the best therapist in the world or not." Simon

Finally, therapists described the importance of offloading, finding ways to debrief, be it through formal or informal supervision, or ad hoc chats to colleagues. It seems that what is important regarding this aspect is to be able to vent fairly soon within the team; this was done in a debriefing way, not always seeking advice, but mostly allowing therapists an outlet for certain challenges of the therapeutic work:

"… share, share all these frustrations and emotionally I was coping with it but at the same time the supervision give, gives you some different approaches, but it, the main thing with the supervision was, basically share this emotional burden of not engaging with clients, the clients not engaging with the therapy." Paula

"...that kind of contact when you come back from sessions, I think, quite useful. Or, you know, if you had a difficult session to be able to, sort of phone someone up, or come back to the office, and, and see them, and then "oh, this has happened", and to just be able to kind of debrief, quite soon afterwards, if it is something, you know, that has been quite difficult." Hermione

"At my site we were fortunate in so far as there are a number of therapists who work across trials, we share an office base, and, and then so there is a level of indirect peer supervision there as well. I think if I, if I hadn't had that, the work would have been quite ... isolating and anxiety provoking really (...)" Zoe

"I mean the other thing this client was like over an hour drive away, so you'd have all that time on the way there, to think about the appointment and all of that time on the way back to think about the appointment, so it was, without anybody else to bounce off the appointment with, and I think that's, I think, I in the end would make sure that I'd always call someone afterwards, because I'd, would often be feeling in a really low state after having been to see him, so speaking to someone afterwards, either the, the trial manager or another therapists was really important because, again is a space to reflect and, talk about what you'd, how the session had gone and I guess, yeah, that ability to not let it affect you so much." Janis

Discussion

Therapist journey

The aim of this study was to gain an understanding of therapists' experiences of hope while delivering SRT to young adults at high risk of long-term social disability due to emerging mental health problems. Through the detailed analysis of ten therapist's interviews using Interpretative Phenomenological Analysis, seven superordinate themes were identified (table 1), which seem to illustrate the process that therapists go through when they engage in the social recovery therapy journey with their clients (figure 1).

The first superordinate theme emerging from the analysis refers to the novelty of the intervention and its reflection on the therapist's part (this is new). Therapists celebrated their increased autonomy to deliver therapy creatively without many of the usual restrictions of standard psychological interventions. The new philosophy of work brought along new opportunities to support a population not usually represented in mental health services, which emphasised engagement throughout the therapy process, a specific focus on the system surrounding the client, and a heavy behavioural component. This translated into a strong sense of hope regarding SRT, as described by the therapists throughout their stories. Collaboration between client and therapist is a fundamental tenet of CBT, and while this aspect is vital and employed in SRT, it requires adaptations due to the assertive outreach nature of SRT (Fowler, 2012). Understandably, the investment of adopting a new philosophy of thinking and working, associated with the various distinctive aspects of SRT seems to have fuelled a sense of unease about the novel aspects of the intervention. If on one hand therapists welcomed the new approach, they also felt somewhat out of their comfort zone as they entered unchartered territory.

After the initial optimism and enthusiasm, therapists experienced first-hand the intricacies of working therapeutically with this client group (All at sea). Working towards meaningful goals is an essential part of the CBT work, and certainly pivotal in terms of social recovery (Fowler et al, 2012). However, client stuckness characterised by a lack of motivation and sense of purpose, and ambivalence about therapy, became apparent. This difficulty in shifting, even subtly, the client's outlook on how they might start or take forward their recovery process, frequently impacted on the therapy course and on the therapists themselves. A particular form of assertive outreach engagement is a pivotal aspect of social SRT, however this impacted on what collaboration would look like, frequently leading to therapist uncertainty about their role. In a context where therapy was often challenging, at times frustration was experienced and self-questioning was common, it was understandable that therapist, at some points, struggled to maintain hope. The concept of contagious hopelessness was described as sense of hopelessness born from the client's own nihilistic perspective somehow having an infecting quality and leading to a feeling of hopelessness on the therapists themselves, which was at times difficult to manage. This concept has similarities with what Moorey calls "empathic countertransference", defined by the therapist's cognitive and or emotional

response mirroring that of the patient's experience, a process mediated by empathy (Moorey, 2014).

In a context of challenging therapeutic work with a complex population typically exhibiting a bleak view of themselves and future prospects, therapists defined holding on to hope as an imperative, essential to establishing a milieu in which therapeutic techniques could be employed to the client's benefit (Hold on to hope). At the heart of SRT is a quest to tackle avoidance, and so, it is in essence a "doing" therapy, where the cognitive elements are mostly incorporated in the taking up of meaningful activities (Fowler et al, 2013). Finding the hook represents identifying the activity, goal or ideal, in line with their values, which prompts the client into behavioural changes that are likely to enable recovery. As such, it is idiosyncratic, and not necessarily easily identified by the client early on. It often led to a complex process of self-discovery facilitated by therapists. SRT therapists are experienced in CBT and so are proactive and skilled in problem solving approaches. When presented with impasse they typically resorted to making sense of what was happening before selecting ways to intervene, and so, addressed the issue of disengagement by generating a formulation of the problem. There are interesting similarities between these experiences and Snyder's hope theory (Snyder, 1994), in a sense that therapists exhibited the flexibility, perseverance and engagement in various alternatives to deal with barriers during goal pursuit, in maintaining their own hope. In the same way that engagement is paramount in SRT, so is persistence from the therapist's part, an unrelenting display of care and genuine interest for the clients and their recovery. Participants emphasised this aspect in the building of a therapeutic relationship based on trust and reliability. Finally, therapists were able to fuel their own sense of hope by looking at the success stories of other clients in their caseload and other therapists' reports of positive outcomes.

Therapists seemed to have engaged in a spontaneous and unstructured process of self-practice and self-reflection (Thwaite, Bennet-Levi, Davis & Chaddock, 2014), through which they used reflection and CBT tools to address their hopelessness. Therapists reappraised their own unhelpful cognitions about themselves and the therapy progress, and took part in sort of meta-behavioural experiments, during which they tested out their own beliefs about this technique and how they, themselves, would cope. Unhelpful thoughts imbued with hopelessness and self-doubt were addressed by generating

alternative, more helpful thoughts, and seeking new perspectives. For example, therapists practiced looking at the bigger picture and focusing on the positives, adapted initial expectations about the therapy process and developed a new approach to collaboration. According to Taylor, Feldman, Saunders and Ilardi (2000), modifying unhelpful cognitions in this way is likely to lead to the identification of future pathways, strengthen the sense of agency, and consequently boost hope.

Avoidance is at the heart of the maintenance of social disability (Fowler et al, 2013), and in order to address it, therapists need to enthusiastically encourage clients who are typically resistant to change. This is congruent with hope interventions, through which goal specific self-talk is targeted, i.e., energising self-messages are generated in the context of goal pursuit (Cheavens & Guter, 2018). One of the main SRT skills resides in the ability to develop an appropriate therapeutic relationship, based on collaboration and trust, which promotes assertively supporting clients to work towards their values through structured activity (Fowler et al, 2013). Collaboration was achieved through the mutual agreement and explicit permission for the therapist to endorse a more directive stance, as necessary to propel change. 'Real world' behavioural experiments were generated in the context of adherence to the model, which implies a strong behavioural component from early on. During their narratives, therapists mentioned apprehensions regarding the potential of the implications of such behavioural experiments on clients and themselves. Waller (2009) talks about this phenomenon, and describes therapist's reluctance regarding using behavioural experiments as a safety-behaviour. By recognising and tackling their own avoidance, therapists effectively realised the benefits of the technique at an early stage in therapy, and changed their regular clinical practice, tackling potential therapist drift.

Even though the therapists' journey, as depicted by therapists through their interviews, does not seem to follow a strictly linear path, involving movement across the various stages, the narratives reveal a sense of moving from the role of SRT therapist to the role of campaigner for the model. Participants talked enthusiastically about the realisation that SRT drives effective change by modifying people's perspectives on what they can cope with and achieve, changing their whole outlook on life. It moves beyond the idea of presence versus absence of pathology, into the realm of values and a journey towards the ideal self (Fowler et al, 2013). Also, in contrast with many of the clients' destructive

previous experiences, therapists observed how it allows, at the very least, a glimpse on how enjoyable and free life can be. Participants became ambassadors for SRT, changing the way they conduct therapy accordingly.

Crucially, both supervision and various levels of sharing scaffold each and every aspect of the process, supporting and holding the therapist and facilitating progression through the stages.

Supervision was acknowledged by therapists as critical in supporting them both at a normative and a restorative level (for a description of supervision tasks see Proctor, 1987). Regular formal and informal supervision allowed therapists to boost and refine their interventions repertoire, whilst adding a creative edge to their work. Different supervision formats were considered important in their own right: individual, group, peer, but also less orthodox setups such as email, ad-hoc conversations and phone calls, case discussion and case write-up were considered invaluable. Significantly, the unique challenges presented by working with this client group dictated the need for supervision interactions to be positive and hopeful in nature, creating an atmosphere of normalisation, validation, support and optimism.

The narratives provide a rich view on the very therapist' essence: caring. How much of the therapists' own world is involved in therapy at a personal level seems to have materialized in the various means of sharing emerging from the interviews. Sharing with clients is illustrated by aspects such as their "walking alongside" throughout therapy or from the sharing of common interests and development of meaningful relationships characterized by a deep understanding of client's inner lives, in a context where even emotions are, to a degree, also shared. The degree of involvement with the therapy process emerged from the therapists' investment in the therapeutic process, their empathy and how much clients inhabited their minds. Finally, the very process of being able to open oneself and share experiences, successes but also doubts and fears enabled therapists to feel part of a wider supportive structure that formed a cohesive whole, where individual therapists were truly cared for.

It is interesting to note that through various processes, therapists seem to have strived and succeeded to develop and maintain hope throughout therapy, despite the challenges

they faced. It is possible that amongst other factors, this could be the result of a combination of competent adherence to the model, which strives to improve client's self-concept by instilling hope and optimism (Hodgekins and Fowler, 2019), and also their own resilience as a group and mutual support. Therapists tackled disengagement, a major source of hopelessness, by formulating, problem solving and perseverance. They nourished their own hope by using CBT techniques on themselves, sharing and obtaining support from their peers. They fully submerged themselves in the therapy process, at times to their own detriment, and invested wholeheartedly in a supportive, genuine and meaningful therapeutic relationship, characterized by optimism and hope. Following this line of thought, it is possible that this has contributed to foster a positive therapeutic relationship, which may have fuelled hopefulness in the client (Berry & Greenwood, 2015). Hopefulness has been linked to social inclusion, engagement in vocational activities and personal recovery (Slade, 2009). It is conceivable to think that observing steps towards recovery in their own clients might have created a feedback loop through which therapists fuel their own sense of hope.

The therapists' journey is a process that appears to be cyclical and not necessarily linear, in that therapists may cycle back and forth between stages and also go through the process anew with each client. This journey also seems to parallel the clients' with respect to the waxing and waning of "stuckness", hopefulness and progression and coping. Therapists do not operate mechanically, and inevitably interact at many levels with the therapeutic process. They described a variety of experiences and emotions throughout the various stages, and activated a series of resources in order to maintain hope, offering clues on how to maximize both therapy quality and therapist wellbeing.

Strengths and limitations of the study

This study has contributed to the growing, but yet in it's infancy, body of knowledge, which looks at the personal standpoint of the therapist. Specifically, it looked at the experiences of therapists using SRT with a population of young people with emerging mental health problems. The purpose was to learn about how therapists approach issues such as hope, as this in particular is likely to inform with regards to training and supervision within the context of SRT either in future studies or at a stage of therapy dissemination throughout the NHS, should the evidence base accumulate in its favour.

One of the strengths of this study was giving voice to a subject underrepresented in research, yet important in terms of therapist's wellbeing and therapy delivery. Therapists' narratives not only alert to the importance of self-practice/self-reflection and supervision, but also to the significance of developing meaningful relationships with the people around them: clients and team members. These relationships based on trust and sharing, fostered hope and contributed to the therapist's resilience.

It is possible that the conclusions of this study refer to this particular population and therapeutic approach, and therefore may not be transferable. As there is a paucity of studies looking into therapists' experiences of delivering therapy, particularly in terms of managing hope, we might not exclude the possibility, however, that the processes observed in this study might be, to a degree, common to applying CBT in general. Further similar studies may generate opportunities for such comparisons.

The fact that the researcher was also one of the therapists working on the PRODIGY trial, alongside the other therapists interviewed in the study may have brought limitations as well as advantages. On one hand, it may have facilitated the conversations due to familiarity and a sense of communal experiences. On the other hand, it could have led to less expanded descriptions of one's experiences for the same reason, and potentially to therapists being less forthcoming in their narratives. A proportion of the interviews was conducted by phone (seven out of ten) which may have changed communication dynamics as non-verbal communication was not possible. More studies in the area are needed to clarify these issues.

Conclusion

Therapists start from a hopeful sense of SRT giving them the tools and permission to work creatively and flexibly with clients who may not access or be offered a service traditionally (This is new). Therapists then appear to develop a sense of being drawn into the client's experience of being stuck, partaking in the experience of confusion and hopelessness ("all at sea"), but ultimately re-establishing their own sense of hope and hope for the client (holding on to hope), and self-applying CBT techniques (self practice-self-reflection) in which they recognise and work with their own appraisals and

also their potential reticence to engage in behavioural work outside the clinic, before re-connecting with the power of SRT and a sense of wanting to advocate for the model (campaigning). This is not a strictly linear process, with movements between stages. Supervision and sharing were identified as contextual superordinate themes (supervision is fundamental and sharing is caring), enabling the therapists' journey. Therapists coped with the therapeutic challenges and maintained hope through self-reflection, self-practice of CBT techniques, formulating disengagement and perseverance, and through a process of sharing with others.

References

American Psychiatric Association. (2005). Use of the Concept of Recovery: position statement. Arlington, Va,

Bengtsson, J., Nordin, S. & Carlbring, P. (2015). Therapists' Experiences of Conducting Cognitive Therapy Online vis-a-vis Face-to-Face. Cognitive Behaviour Therapy, 6, 470–479.

Berry, C., Greenwood, K., (2015). Hope-inspiring therapeutic relationships, professional expectations and social inclusion for young people with psychosis. *Schizophrenia Research,* 168, 153–160.

Berry, C.; Greenwood, K. (2016). The relevance of professionals' attachment style, expectations and job attitudes for therapeutic relationships with young people who experience psychosis. *European Psychiatry*, 34, 1–8.

Cheavens, J., S. & Guter, M., M. (2018). Hope therapy. In M. W. Gallagher & S. J. Lopez (Eds.) *The Oxford handbook of hope* (pp. 133-142). Oxford: University Press.

Department of Health (2008). *Children and young people in mind: the final report of the National CAMHS review*. London: Department of Health and Department for Children, Schools and Families.

Fowler, D., French, P., Banerjee, Barton, G., Berry, C., Byrne, R., Clarke, T., Fraser, R., Gee, B., Greenwood, K., Notley, C., Parker, .S., Shepstone, L., Wilson, J., Yung, A. R., Hodgekins, J. (2017). Prevention and treatment of long-term social disability amongst young people with emerging severe mental illness with social recovery therapy (The PRODIGY Trial): study protocol for a randomised controlled trial. *Trials*.

Fowler, D., French, P., Hodgekins, J.; Lower, R.; Turner, R.; Burton, S.; Wilson, J. (2012). CBT to address and prevent social disability in early and emerging Psychosis. In C. Steel (Ed.) *CBT for Schizophrenia: Evidence-Based Interventions and Future Directions* (pp. 143-167*)*. Charlie Waller Institute for Evidence-Based Psychological Treatment, University of Reading.

Fowler, D., Hodgekins, J., Arena, K. et al., Turner, R., Lower, R., Wheeler, K., Corlett, E., Reilly, T. & Wilson, J. (2010). Early detection and psychosocial intervention for young people who are at risk of developing long term socially disabling severe mental illness: should we give equal priority to functional recovery and complex emotional dysfunction as to psychotic symptoms? *Clinical Neuropsychiatry*, 7, 63 – 71**.**

Fowler, D., Hodgekins, J., Berry, C., Clarke, T, Palmier-Claus, J., Sacadura, C., Graham, A., Lowen, C., Steele, A., Pugh, K., Fraser, S., Fitzsimmons, M. & French, P. (in press). Social recovery therapy: a treatment manual. Psychosis.

Fowler, D., Hodgekins, J., French, P., Marshall, M., Freemantle, N., McCrone, P., Everard, L., Lavis, A., Jones, P.B., Amos, T., Singh, S., Sharma, V., Birchwood, .M (2018). Social recovery therapy in combination with early intervention services for enhancement of social recovery in patients with first-episode psychosis (SUPEREDEN3): a single-blind, randomised controlled trial. *Lancet Psychiatry*, 5: 41–50.

Fowler, D., Hodgekins, J., Painter, M., Reilly, M., Crane, C., Macmillan, I., Mugford, M., Croudace, T., & Jones, P. B., (2009). Cognitive behaviour therapy for improving social recovery in psychosis: a report from the ISREP MRC Trial Platform study (Improving Social Recovery in Early Psychosis), *Psychological Medicine*, 39, 1627–1636.

Gee, B., Notley, C., Byrne, R., Clarke, T., Hodgekins, J., French, P., and Fowler, D., (2016). Young people's experiences of social recovery cognitive behavioural therapy and treatment as usual in the PRODIGY trial. *Early Intervention in Psychiatry*, 12(5): 879-885.

Hodgekins, J., Fowler, D. (2010). CBT and Recovery From Psychosis in the ISREP Trial: Mediating Effects of Hope and Positive Beliefs on Activity. *Psychiatric services*, 61, 321-324.

Marwood, H., Chinn, D., Gannon, K., Scior, K. (2018). The experiences of high intensity therapists delivering cognitive behavioural therapy to people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 31, 76-86.

Moorey, S. (2014). 'Is it them or is it me'? Transference and Countertransference in CBT. In N. Grey & A. Whittington (Eds.), *How to Become a More Effective CBT Therapist* (pp. 132-145). Chichester :Wiley-Blackwell.

National Institute for Health and Care Excellence (Nice) (2013a). Psychosis and schizophrenia in children and young people: Recognition and management NICE CG155. London: NICE.

Oetttingen, G. & Chromik, M. P. (2018). How hope influences goal directed behaviour. In M. W. Gallagher & S. J. Lopez (Eds.) *The Oxford handbook of hope* (pp. 69-79). Oxford: University Press.

Proctor, B. (1987). Supervision: a co-operative exercise in accountability. In M. Marken and M. Payne (Eds.). Enabling and Ensuring: supervision in Practice (pp. 21-34). National Youth Bureau and the Council for Education and Training in Youth and Community work: Leicester.

QSR International Pty Ltd. (2018). NVivo qualitative data analysis Software, Version 12.

Safran, J and Segal, Z, (1990). *Interpersonal Processes in Cognitive Therapy*. New York: Basic Books Inc.

Schumacher, S., Gaudlitz, K., Plag, J, Miller, R., Kirschbaum, C., Fehm, L., Fydrich, T., Ströhle, A. (2014). Who is stressed? A pilot study of salivary cortisol and alpha-amylase concentrations in agoraphobic patients and their novice therapists undergoing in vivo exposure. *Psychoneuroendocrinology*, 49, 280-289.

Singh, S.P., Paul M., Ford, T., Kramer, T., Weaver, T., McLaren, S., Hovish, K., Islam, Z., Belling, R., White, S. (2010). Process, outcome and experience of transition from child to adult mental health care: multi-perspective study. *British Journal of Psychiatry*, 197, 305-312.

Slade, M., (2009). *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals*. Cambridge: University Press.

Smith, J., Flowers, P. & Larkin M. (2009). *Interpretative Phenomenological Analysis*. London: Sage.

Smith, J.A. & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), Qualitative Psychology. A Practical Guide to Research Methods (pp. 51–80). London: Sage.

Snyder, C. R. (1994). The psychology of hope: You can get there from here. New York, NY, US: Free Press.

Snyder, C. R., Irving, L. M., & Anderson, J. R. (1991). Hope and health. In C. R. Snyder & R. Donelson (Eds.), *Handbook of social and clinical psychology: The health perspective* (pp. 285-305). Elmsford, NY: Pergamon Press.

Snyder, C. R., Rand, K. L., & Sigmon, D. R. (2018). Hope theory: A member of the positive psychology family. In M. W. Gallagher & S. J. Lopez (Eds.) *The Oxford handbook of hope* (pp. 27-43). Oxford: University Press.

Szkodny, L., Newman, M., & Goldfried, M. (2014). Clinical Experiences in Conducting Empirically Supported Treatments for Generalized Anxiety Disorder. *Behavior Therapy*, 45, 7–20.

Taylor, J., Feldman, D., B., Saunders, R., S., Ilardi, S., S., (2000). Hope theory and cognitive-behavioural therapies. In C. R. Snyder (Eds.), *Handbook of hope* (pp. 109-122). Academic Press.

Thwaite, R., Bennett-Levi, J., Davis, M. L., & Chaddock, A. (2014). Using self-practice and self-reflection (SP/SR) to enhance CBT competence and metacompetence. In N. Grey & A Whittington (Eds.), *How to Become a More Effective CBT Therapist* (pp. 241-254). Chichester, John Wiley and sons, ltd.

Westra, H. A., Aviram, A., Connors, L., Kertes, A. & Ahmed, M. (2011). Therapist Emotional Reactions and client Resistance in Cognitive Behavioural. *Therapy. Psychotherapy*, 2, 163-172.

Section 3
Critical Appraisal

Critical Appraisal

The following critical appraisal comprises a collection of reflections on my research journey, regularly compiled in a notebook along the way. These include thoughts on my own experience, as well as take home messages to myself, which I am sure will be helpful in my research career.

Introduction: the research idea

Supporting clients suffering from mental health problems to take control of their lives, resume meaningful activities and pursue goals has been an enduring interest of mine. Whilst in primary care this is a mostly tangible outcome, in other contexts it can be much more challenging. The impairment and long term disability maintained by some psychological problems is simultaneously evident and puzzling. From a clinical point of view, on one hand one can understand how circumstances snowball into severity and chronicity yet interventions designed to address this process are scarce and struggle to succeed. This seems to be the case for some people suffering with disorders such as psychosis, but also with severe depression and anxiety; these can be extremely debilitating and there can sometimes also be a trajectory into more severe mental illness. In these cases social disability is pervasive. The loss of employment, interruption of education, withdrawal from social aspects of life and meaningful activities are signs of a lifelong struggle that clinicians, such as myself, recognise in so many of their clients.

Some years ago I was fortunate enough to join a fascinating project designed to address such issues, the PRODIGY Trial. The acronym PRODIGY loosely stands for Prevention of Long-Term Social Disability in Young People with Emerging Psychological Difficulties. The principles behind this study rest on the concept, supported by research, that serious and complex mental health problems often begin in adolescence or young adulthood. For some young people who experience psychological difficulties it may be difficult to carry on living the life they want to live: it is not uncommon for them to have problems going to school or college, finding a job or taking part in social activities. This could lead to long-term social disability and seriously

affect their future prospects of life. However, the lack of appropriate services for young people with severe and complex mental health problems, particularly those at risk of social disability, has been highlighted by recent reports. The PRODIGY study, which was then in full motion, aimed to evaluate a new psychological intervention specifically designed to address the needs of this group: Social Recovery Therapy (SRT). "Social recovery" is a term used to describe when someone is living the life they want to despite having experienced psychological difficulties. The study aimed to test whether the intervention helps with social recovery and mental health problems, and will also evaluate the cost-effectiveness of the intervention. The intervention is based on a model developed by experts, closely supervised, and it is tailor-made to suit client's individual needs. However, the group targeted by this intervention is one which has not typically been seen in services. Delivering a new intervention to a new population brings promise and hope as well as new challenges.

I have been working as a research trial therapist in this trial, and as such I came face to face with these challenges and witnessed my colleagues' occasional struggles with these too. I have been in a privileged position where I have had access to therapist's unique experiences of delivering SRT to this particular population, which were shared in group supervision, team meetings and other similar settings. Soon we came to realise, collectively as therapists that the emotions stirred up by working on this trial were, to a degree, communal to us all. At this point I started wondering whether it would be helpful to explore these at a deeper level, particularly in relation to the processes of maintenance of hope both for clinician and for the client. Fostering hope in clients is an essential mechanism within SRT, however, challenges around the delivery of the therapy to this population mean this is not a straightforward undertaking. Knowledge emerging from such a study could offer insights into helpful and unhelpful processes generated in therapy, and inform appropriate training, supervision and support for therapists. This is where the idea for developing this research topic came from.

Research proposal

Writing up the proposal was an opportunity to explore the area I was planning to research. This process involved learning through literature and also by talking to my supervisor, colleagues, researchers and relevant members of staff within my research

team. If on one side I expanded my knowledge and understanding of the subject by reading from a variety of sources, which allowed me to decide on the focus of my study, on the other hand it was mostly through different conversations I had with experienced people that it became clearer how to shape, structure and verbally populate the proposal document. Developing the research materials was another set of tasks I completed at this point. Whilst I am very used to working with materials such as participant's information sheets and consent forms, I am less accustomed to preparing these. This was again a very useful learning experience. I particularly found thought-provoking having in mind the participant's point of view, and balance the need to offer the necessary information for someone to decide they could give informed consent for their participation in the study, but not so much that could potentially bias the interview answers. The interviews to be used with the study participants were also developed at this stage. I found it very helpful to trial these with members of the research team who did not meet inclusion criteria to take part in the study. One of the most interesting aspects I learned at this point was how I felt during the interview process as the interviewer. The research required me to be a neutral subject while asking the questions and prompting participants for further information when required. However, the nature of the materials discussed meant that I also had strong opinions and often emotions, which could not be shared in that context. I realised two main things then: 1) I needed to remain neutral so as not to influence answers in anyway, for which I developed my version of "poker-face" at a visual and verbal level; 2) this neutral, almost detached stance, felt very alien to me as I am naturally friendly and chatty. In a way, I feared I was coming across as dismissive, distant and verging on almost rude, considering the subjects explored were sensitive and required a degree of self-disclosure form the participants' part, which I certainly did not want to compromise in any way. For these reasons I also decided to include a small sentence in the introduction to the interview, before the start, which I dully repeated to every one of my interviewees, where I explained my impartial and non-communicative almost aloof stance. Working with a knowledgeable and friendly team, as well as a supportive supervisor, was certainly a bonus I was fortunate to benefit from. Throughout the whole research study I frequently, whenever appropriately, made use of these resources, which made the process feel accessible and in its majority enjoyable.

Obtaining ethical approval

The following step encompassed obtaining ethical approval for the empirical study. I had predicted this would be one of the hardest tasks of my research work, as ethical approval has a sort of reputation for being laborious and time consuming, not to mention frustrating. In my previous dealings with ethics applications I had found the process to be a complex one. That was certainly not my current experience. Completing the ethics application for my research study was relatively straightforward as I was lucky enough to be able to submit this as a substantial amendment to the main randomised controlled trial (PRODIGY). Once I had filled in the appropriate forms and collected the relevant documents, I was ready to submit my application, which felt like a surprisingly manageable task. I was not naïve to think that this was a matter of luck. Working in a research based environment, which is very supportive of its members, allowed me to access appropriate and timely advice. A mere few weeks after the form was submitted I received the good news that it had indeed been approved and so I was officially allowed to move on to the next step of the project: the interviews.

Interviews

After a brief period recruiting participants for the study, I was ready to embark in the next phase: the interviews. The recruitment process entailed contacting eligible fellow research therapists on the trial about the study via email, enclosing information sheet and consent form. Potential participants were very receptive to the project and the proposed quota was quickly achieved, with interviews booked within the following few weeks. Although I was initially somewhat apprehensive regarding these, they turned out to be relatively uncomplicated to carry out. The interviews were also extremely interesting as they allowed me into the un-edited inner world of my fellow research therapists, through the candid and sincere narratives of their own experience. All of the interviewees were very understanding of my neutrality, and being researchers themselves, would have for sure been aware of this even without the added instructions. However, this meant I became much more comfortable during the interview process.

I was acutely aware of the fact that I knew all of the interviewees professionally, and that this could have implications on some levels. For example, it could be that because we have a sort of shared language and experience, having worked on the same trial, that

they might not feel the need to explain their views with enough detail, as it could be understood that I would know what they would be talking about. This could restrict the richness of the data. On the other hand, for the same reasons they might be reluctant about disclosing more personal information about how they felt during the therapy process. I hope that my reassurance regarding the anonymity of the interviews and my non-judgemental stance will have been enough to address these concerns. Having said this, it may well have been the fact that there was a shared professional experience that allowed for the interviewees to answer the questions freely and trustingly, safe in the knowledge that I was "one of them". After the interviews were completed, and I made sure to relay to the participants that I had stopped recording, and the process had been completed, I allowed brief minutes for any debriefing from the participant's part, without deliberately inviting it. At this point, the majority of the interviewees decided to disclose that they had found it very useful to have the time to reflect on the process of delivering SRT, which, in a way, really validated the research purpose to me and offered some reassurance regarding the richness and representativeness of the content discussed.

Data analysis

Before analysis could begin, all of the interviews had to be transcribed verbatim. After exploring and trying out several software programmes, with the hope of having the task of putting around 8 hours of interview time into words significantly simplified, I realised that none of these would adequately transcribe - and in fact some seemed to complicate the process further - and so I made the then daunting decision of doing it myself. In what seemed to become a trend in my research project, transcribing the interviews myself turned out to be really useful and much quicker than I had initially expected. As a beneficial side effect, I can now type faster than most people I know, which I am sure will be an advantage at some point! The transcribing really marked the first stage of immersing myself in the data, which is a pivotal part of the interpretative phenomenological analysis. Despite having conducted the interviews myself, I quickly realised there was so much that was said that had not registered in my mind at the time. There were so many different avenues for interpretation of the material, and it was necessary to try and explore these fully before attempting to make sense of it. Listening, writing and then reading and re-reading the interviews allowed for a deeper

understanding of the narratives, which paved the way for the initial coding. What followed was a series of coding attempts, defining and redefining provisional themes and subthemes, eventually leading to getting closer to making sense of the interviewees' experiences. This was by far the most complex part of the study, during which I often felt frustrated and at points even defeated. Having successfully (hopefully!) completed this process, I certainly take a few learning points for the future, when I am sure I will use this research approach again. Amongst these are: teasing out themes and sub-themes is a task that requires time and cannot be done in one go. It requires reflection, discussion, and then time to process one's thoughts. It takes the energy and nerve to rid oneself of previous attempts to analyse the material and start again. It takes the courage to know that a good night sleep and a few days not thinking about it will bring more clarity than persevering when data feels like an endless maze. It also requires trust in that the process is sensible and will lead to the desired outcome: data becomes more manageable and clarity becomes more and more apparent.

The writing-up process

Once again, against my preconceptions of what this stage in the research process would be like, the writing up of the results of the study still felt, to a great extent, part of the analysis. Through putting the results into words, ideas take shape and frequently assume a somewhat different form than initially expected. By defining and describing the themes and the subthemes, similarities and distinctions become more evident. This was the stage where the main elements of the analysis were refined and polished: redundant subthemes were collapsed or absorbed into others, a clearer picture of the story behind the narratives materialized. I found the writing up one of the most enjoyable parts of the research project. It allowed me to fully explain the rationale supporting the ‘therapist’s journey’ with all the richness I had observed and made sense of. I experienced, nevertheless, two main difficulties with this task, one practical in nature, and another more conceptual. The practical struggle was around identifying a block of time that allowed me to focus, absorb, digest and interpret the data. As this research work was conducted alongside my job, during which I worked in other research projects and provided therapy to a variety of clients, it was not easy to identify uninterrupted time to do so. I am also a mother of two relatively young children, and so home time typically has not belonged to me for as many years as my children have been alive. Setting and

enforcing new boundaries to ensure some quiet thinking/working time outside work certainly added new pressures to the already challenging task of parenting. Finally, the very precious time that I had allocated to my own needs such as exercise and relaxation was inevitably shrunken and at times completely put on hold. If on one had this allowed for working time, on the other hand insufficient respite probably impairs productivity. I am yet to achieve the appropriate balance.

The difficulty I experienced at a conceptual level when writing up was about the need to confine the report of the findings and subsequent discussion to a set word limit. My initial approach to the work was to freely produce a written account of all of the significant aspects I had encountered. This inevitably led to a document, which was far too large for submission. I had then to undertake the ungrateful job of ruthlessly trimming parts, some times whole sections of the work, in order to keep to the rules, whilst ensuring adequate description and discussion of the main findings. In hindsight, the initial document was probably too expansive to allow for a comprehensive reading and as such would probably not constitute a good piece of research work. I understand the importance of the research succinctness, and the process has equipped me with a better sense of how to produce academic work.

Dissemination

I have had discussions with my supervisor regarding the plan to publish both the IPA study and the systematic review. We have looked at possible journals where it might be appropriate to attempt publishing (the main one being *Cognitive and Behavioural Psychotherapy*), and I am now in the process of restructuring the two papers into a suitable publishable format. Some of the findings form both the IPA study and the systematic review have also been discussed as part of larger presentations on Social Recovery Therapy at SPRIG events (Sussex Psychosis Research Interest Group) and in the context of teaching on the Post Graduate Certificate in Enhanced CBT (Oxford Cognitive Therapy Centre). The results of the IPA study are also due to be presented to the whole SRT team in March, when we will meet next. The results of the PRODIGY trial will also be known at that point and suitable conferences to present all findings will also be discussed then.

Conclusion

This research project undoubtedly represented a complex and multi-layered learning experience. I significantly expanded my knowledge in this particular area through reading, discussing and researching. The choice of methodology was a very fortunate one in many ways. It allowed for an exploration and interpretational process, which I believe was adequate for the study subject. Interestingly, it presented itself as a good fit within the nature of cognitive behavioural therapy: both approaches seek to appreciate the inner worlds of those involved by seeking to make sense of how they understand their own experiences. I also learnt a fair amount in terms of research methodology and procedures, particularly with respect to interpretative phenomenological analysis and of the practicalities it entails at every stage of the research process. With regards to this particular aspect, I also came to realise that research requires much more from the researcher than hard work and learning; it demands an enthusiastic, yet calm approach, a comfortableness to question oneself and one's decisions along the way, but also a confidence that one has engaged in a process that will yield fruits in its own time, a determined stance characterised by perseverance and relentless, but also the ability to walk away, temporarily, knowing that thoughts and ideas need time to brew and grow. I felt wholeheartedly supported by my supervisor and my wonderful team throughout this process, and I realise how fortunate I have been, as it is not always easy to navigate the ups and downs of such an endeavour.

I also learned that embarking in a project like this requires one's ability to look after oneself. Sleep, exercise, socializing and rest are as essential as the work itself, in order to maintain good health, mental and physical, and retain productivity. I strived to sustain this balance throughout these last two year, but I realise that I could have done better in terms of home life/work balance, and so I will make sure I will try and redeem myself to my family and especially my children, from my habitual and resented absences of the last couple of years.

I had initially predicted that the findings from the present study were also likely to resonate with my own experience of delivering SRT, but I realised I was in fact delighted to have had privileged access to the inner worlds of my colleagues and the opportunity to acknowledge the various shared elements in our experience. I was

humbled by their honesty and frank disclosure. I hope that it will help normalise not just their own experience, but that of all therapists, in viewing themselves as complex human beings delivering therapy as opposed to callous machines, and in that sense, contribute towards supporting them in their work.

Appendices

Appendix A
(mandatory)

Student's statement of epistemological position

Student's statement of epistemological position

The student's epistemological position is based on the convergence of three philosophical approaches: phenomenology, hermeneutic and idiograpy. The student/researcher is also a clinical psychologist, whose main therapeutic approach is cognitive behaviour therapy (CBT). CBT aims to understand the human mind mainly by studying the dynamics of the interactions between thoughts, emotions, physiological sensations and behaviours. Whilst general assumptions are developed, which can be broadly applicable to all, CBT focuses on the individual's experience and specifically the meanings attributed to that very experience, which is idiosyncratic. In fact, according to the cognitive behavioural model, individuals emotional responses and behavioural are heavily influenced by the meaning they attribute to the events in their lives (Westbrook et al., 2011). Whilst a common sense model might suggest that people are directly affected by events or situations, the CBT perspective argues that this is a simplistic and unrealistic view, as if this premise were correct, people would respond emotionally and behaviourally in the same way to similar life events. This is, of course, not the case. According to Beck, the founder of CBT, it is the meaning ascribed to an event or situation that defines how that individual feels and behaves as a response (Beck, 1985). CBT therapists frequently take on the task of examining, exploring and interpreting how their clients idiosyncratically make sense of their own experience.

This epistemological stance has inevitably influenced the choice of research methodology employed in this study. IPA is a qualitative research approach grounded on phenomenology, hermeneutics and idiography (Smith et al, 2009). Its main focus is seeking to understand how individuals experience a particular phenomenon through interpreting how they make sense of it (Smith et al. 2009). On one hand, the phenomenological methodology invites explicit reflexivity on what the individual experiences in their consciousness. For example, Husserl, a philosopher who was the main founder the school of phenomenology, highlights the detailed and organized analysis of the contents of consciousness, the significance of examining lived experience. On the other hand, this approach relies on the researcher's interpretation of the object of study. Heidegger, a ground-breaking philosopher in the area of hermeneutics (1962/1927), argues that the process of making sense of the description of

someone's own experience, implies interpretative efforts. Smith et al. (2019) explain the process of double hermeneutics in IPA, in a sense that the researcher seeks to make sense of the experience described by the individual, which in turn represents that person's meaning making efforts regarding the phenomenon being studied. Idiography has also been an influence on IPA. It attends to the particular and therefore demands attention to detail and meticulous analysis in specific contexts, looking at the perspective of certain individuals, examining specific cases of lived experience (Smith et al., 2009).

This study locates its epistemological stance within all of these epistemological approaches: phenomenology, hermeneutics and idiography. Considering these notions, IPA emerges as an ideal methodological approach to tackle the research questions this study proposes to explore, as these are intimately intertwined with the meaning making endeavour by the researcher, of the specific experience of the interviewee: "What are the therapists' experiences of the process of SRT with young people experiencing social disability and complex emerging mental health problems?" and "How do therapists maintain hope within the context of SRT with young people experiencing social disability and complex emerging mental health problems?". IPA stands as an appropriate and effective methodology to give voice to the therapists' unique experience of challenges and efforts in maintaining and fostering hope in the context of working with complex clients.

References

Beck, A., T., (1985). Cognitive therapy. In H. I., Kaplan & B., J., Sadock (Eds.), *Comprehensive textbook of psychiatry* (4th ed., Vol 2). Baltimore: Williams and Wilkins.

Heiddeger, M. (1962/1927). *Being and Time*. Oxford: Blakwell.

Husserl, E. (1927). Phenomenology, for *Encyclopaedia Britannica* (R. Palmer, Trans. and revised).

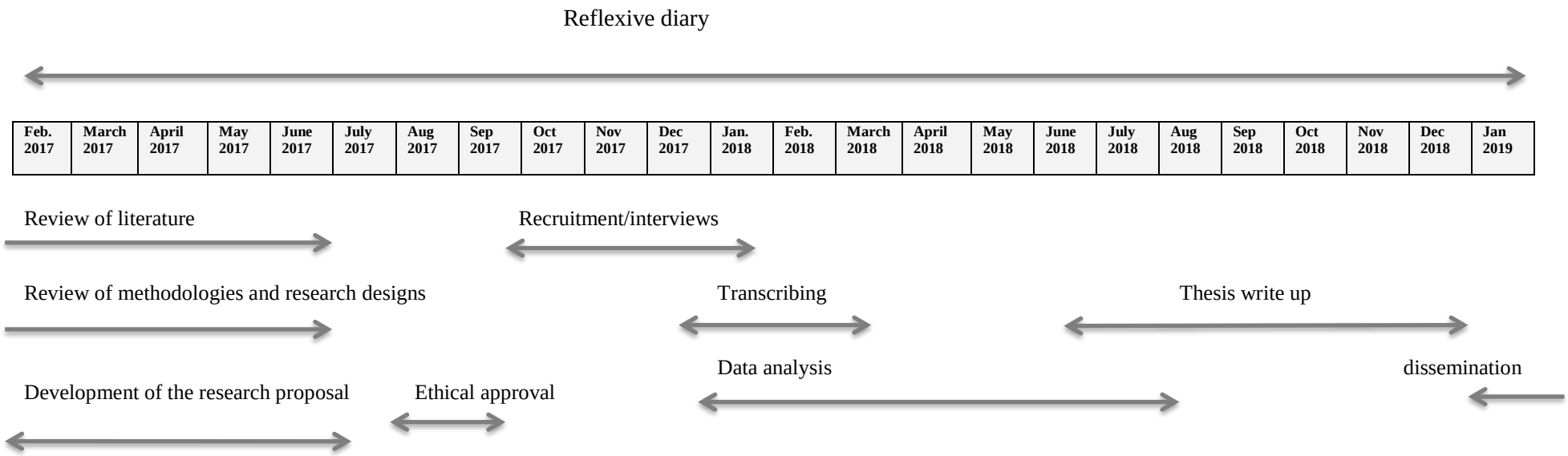
Smith, J., Flowers, P. & Larkin M. (2009). *Interpretative Phenomenological Analysis*. London: Sage.

Westbrook, D., Kennerly, H. Kirk, J. (2011). *An introduction to cognitive behavioural therapy*. London: Sage.

Appendix B
(mandatory)

Chronology of the research process

Chronology of the research process



Appendix C
(mandatory)

Guidelines to authors for journal targeted for literature review

Behavioural and Cognitive Psychotherapy Instructions for contributors

(from website https://www.cambridge.org/core/journals/behavioural-and-cognitive-psychotherapy)

Editorial Statement

Behavioural and Cognitive Psychotherapy is an international multidisciplinary journal for the publication of original research of an experimental, or clinical nature that contributes to the theory, practice and evaluation of cognitive and behavioural therapies. As such the scope of the journal is very broad, and articles relevant to most areas of human behaviour and human experience which would be of interest to members of the helping and teaching professions will be considered for publication.

As an applied science the concepts, methodology and techniques of behavioural psychotherapy continue to change. The journal seeks both to reflect and to influence those changes. While the emphasis is placed on empirical research, articles concerned with important theoretical and methodological issues as well as evaluative reviews of the behavioural literature are also published. In addition, given the emphasis of behaviour therapy on the experimental investigation of the single case, the journal from time to time publishes case studies using single case experimental designs. For the majority of designs this should include a baseline period with repeated measures; in all instances the nature of the quantitative data and the intervention must be clearly specified. Other types of case report can be submitted for the Brief Clinical Reports section.

Articles should concern original material that is neither published nor under consideration for publication elsewhere. This applies also to articles in languages other than English.

Sections of the Journal

Main

Reports of original research employing experimental or correlational methods and using within or between subject designs. Review or discussion articles that are based on empirical data and that have important new theoretical, conceptual or applied implications.

Accelerated Publication

The accelerated publication section is intended to accommodate a small number of important papers. Such papers will include major new findings for which rapid dissemination would be of considerable benefit and impact. For example: reports of the results of important new clinical trials; innovative experimental results with major implications for theory or practice; other work of unusually high calibre. If submitting a manuscript to this section you must specify in your cover letter why it should be considered as Accelerated.

Empirically Grounded Clinical Interventions

This section is intended for reviews of the present status of treatment approaches for specific psychological problems. It is intended that such articles will draw upon a combination of treatment trials, experimental evidence and other research, and be firmly founded in phenomenology. It should take account of, but also go beyond, treatment outcome data.

Brief Clinical Reports

Material suitable for this section includes unusual case reports and accounts of potentially important techniques, phenomena or observations; for example, descriptions of previously unreported techniques, outlines of available treatment manuals, descriptions of innovative variations of existing procedures, details of self-help or training packages, and accounts of the application of existing techniques in novel settings. The BCR section is intended to extend the scope of the clinical section. Submissions to this section should be **no longer than 1800 words** and should include **no more than six references, one table or figure**, and an **extended report** that contains fuller details. There are no restrictions on the size or format of the extended report as it will be published online only. It may, for instance, be a treatment manual, a fully detailed case report, or a therapy transcript. If a submission is accepted for publication as a Brief Clinical Report, the author(s) must be prepared to send the fuller document to those requesting

it, free of charge or at a price agreed with the editor to reflect the cost of materials involved. The extended document will also be mounted on the journal's website as a PDF format (the document will not be copyedited).

Study Protocols

Protocols of proposed and ongoing trials in behavioural and cognitive therapies will be considered. Your study must be registered and have ethical approval, and proof of this will be required. The abstract should be **structured** under the following four headings; **Background, Aims, Method, Discussion.**

Please use the *Standard Protocol Items: Recommendations for Interventional Trail* (SPIRIT) checklist for protocols of randomised controlled trials (see the reporting standards section below). Manuscripts should be **under 2000 words** at the point of first submission, and include no more than **15 references**, and no more than **three tables/figures in total**. A PDF with additional, unlimited text, figures and tables may be included designated for online only publication.

Reporting Standards

Behavioural and Cognitive Psychotherapy supports standardised reporting practices, consult the following table to ensure your submission meets the reporting standards for your manuscript type. Please include the relevant supporting information (such as diagrams and checklists) with your submission files. See http://www.equator-network.org/reporting-guidelines/ for more information on manuscript types not described below.

The journal also encourages clarity in describing interventions sufficient to allow their replication through the use of the Template for Intervention Description and Replication Checklist (TIDieR).

Randomised Controlled Trial	CONSORT	http://www.consort-statement.org/
Systematic reviews and Meta-Analysis	PRISMA	http://www.prisma-statement.org/
Study Protocols	SPIRIT	http://www.spirit-statement.org/

Preparing Your Manuscript

Articles must be under 5,000 words at the point of submission, excluding references, tables and figures (please see separate instructions for Brief Clinical Reports and Study Protocols). Manuscripts describing more than one study may exceed this limit but please make this clear to the editorial office in your cover letter.

Authors who want a blind review should indicate this at the point of submission of their article, omitting details of authorship and other identifying information from the main manuscript. Authors who do not omit this information will be assumed as submitting a non-blinded manuscript. Submission for blind review is encouraged.

All submissions should be submitted via this portal: http://mc.manuscriptcentral.com/babcp

Style

APA style should be followed throughout. http://www.apastyle.org/

Abbreviations where used must be standard. The Systeme International (SI) should be used for all units. Probability values and power statistics should be given with statistical values and degrees of freedom (e.g. $t(34) = 2.39$, $p<.001$), but such information may be included in tables rather than in the main text. Spelling must be consistent within an article, using either British spelling (*The Shorter Oxford English Dictionary*), or American (*Webster's New World College Dictionary*). However, spelling in the list of references must be literal to each publication.

In-text references

In-text references should be cited as follows: "...Given the critical role of the prefrontal cortex (PFC) in working memory (Cohen et al., 1997; Goldman-Rakic, 1987; Perlstein et al., 2003a, 2003b)..." with multiple references in alphabetical order. Another example: "...Cohen et al. (1994, 1997), Braver et al. (1997), and Jonides and Smith (1997) demonstrated..."

References cited in the text with two authors should list both names. References cited in the text with three, four, or five authors, list all authors at first mention; with subsequent citations include only the first author's last name followed by et al. References cited in the text with six or more authors should list the first author et al. throughout. In the reference section, for works with up to seven authors, list all authors. For eight authors or more, list the first six, then ellipses followed by the last author's name.

Details of style not specified here may be determined by reference to the *Publication Manual of the American Psychological Association*.
Manuscripts Should Conform to the Following Scheme

1. Title Page
The title should phrase concisely the major issues. Author(s) to be given with departmental affiliations and addresses, grouped appropriately. A running head of no more than 40 characters should be indicated and carried through the document as a header. This should be uploaded as a separate file.

2. Main Manuscript
a. Abstract. Unless a Study Protocol (see separate guidelines), a 250 word abstract should be structured under the following five headings: Background, Aims, Method, Results, and Conclusions. Include up to six key words that describes the article.
b. Main Text. Following APA guidelines, this should contain the sections *Introduction* (including overview and theoretical background), *Method* (participants, design and data analyses), *Results* (described in detail with summary figures and tables), *Discussion* (including conclusions and limitations).
c. Required Sections
Acknowledgements
You may acknowledge individuals or organizations that provided advice, support (non-financial). Formal financial support and funding should be listed in the following section.
Ethical statements
All papers should include a statement indicating that authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the APA http://www.apa.org/ethics/code/. Authors should also confirm if ethical approval was needed, by which organisation, and provide the relevant reference number. If no ethical approval was needed, the authors should state why.
Conflict of Interest
Please provide details of all known financial, professional and personal relationships with the potential to bias the work. Where no known conflicts of interest exist, please include the following statement: "(Authors names) have no conflict of interest with respect to this publication".
Where conflict of interest, ethical statements and acknowledgements would compromise blind review, these may be anonymized from the main manuscript, but should be included in full on the separate title page which is not seen by reviewers. During the review process within the main text it is acceptable to replace identifiable information by using XXXXXX or similar.
Financial Support
Please provide details of the sources of financial support for all authors, including grant numbers. For example, "This work was supported by the Medical research Council (grant number XXXXXXX)". Multiple grant numbers should be separated by a comma and space, and where research was funded by more than one agency the different agencies should be separated by a semi-colon, with "and" before the final funder. Grants held by different authors should be identified as belonging to individual authors by the authors' initials. For example, "This work was supported by the Wellcome Trust (A.B., grant numbers XXXX, YYYY), (C.D., grant number ZZZZ); the Natural Environment Research Council (E.F., grant number FFFF); and the National Institutes of Health (A.B., grant number GGGG), (E.F., grant number HHHH)". Where no specific funding has been provided for research, please provide the following statement: "This research received no specific grant from any funding agency, commercial or not-for-profit sectors."
d. References. References should be consistent with the *Publication Manual of the American Psychological Association (6th Edition)*.
If a DOI has been assigned to an article that you are citing, you should include this after the page numbers for the article. If no DOI has been assigned and you are accessing the periodical online, use the URL of the website from which you are retrieving the periodical.

Examples of the APA reference style are as follows:
Online/Electronic Journal Article (with DOI):
Kaltenthaler, E., Parry, G. & Beverley, C. (2004). Computerized cognitive behaviour therapy: a systematic review. *Behavioural and Cognitive Psychotherapy, 32*, 31–55. doi:10.1017/S135246580400102X.
Book:
Tharp, R. G. and Wetzel, R. J. (1969). *Behaviour Modification in the Natural Environment.* New York: Academic Press.
Book Chapter:
Roskies, E. and Lazarus, R.S. (1980). Coping theory and the teaching of coping skills. In P. O. Davidson and S. M. Davidson (Eds.), *Behavioural Medicine: Changing health lifestyles* (pp. 38-69). New York: Brunner/Mazel.
Manual, Diagnostic Scheme, etc.:
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
Authors are encouraged to make use of referencing software packages (e.g. Endnote, Mendeley, Reference Manager etc.) to assist with formatting - extensions for APA formatting are easily accessible. However, you are also reminded to check citations and reference lists in detail and not to rely on software packages to format references correctly.
Detailed guidelines on the APA citation and referencing style can be obtained online from sources including the via the Writing Center of the University of Wisconsin–Madison.
e. Footnotes. The first, and preferably only, footnote will appear at the foot of the first page of each article, and subsequently may acknowledge previous unpublished presentation (e.g. dissertation, meeting paper), financial support, scholarly or technical assistance, or a change in affliction.

3. Tables and Figures
Manuscripts should not usually include more than five tables and/or figures. They should be supplied as *separate files*, but have their intended position within the paper clearly indicated in the manuscript. They should be constructed so as to be intelligible without reference to the text.
Figures. Tints and shading in figures may be used, but colour should be avoided unless essential. Although colour is possible in the online version, when designing a figure please ensure that any line variation/distinction demonstrated by colour can still be noted when in black and white. Colour figures are free of charge for online published articles but if authors wish figures to be published in colour in the print version the cost is £200. Numbered figure captions should be provided. All artwork should be submitted as separate TIFF format files.
The minimum resolution for submission of electronic artwork is:

- Halftone Images (Black and White Photographs only): 300 dpi (dots per inch).
- LineTone (Black and White Photographs plus Line Drawings in the same figure): 600 dpi.
- Bitmap (Line Drawings only): 1200 dpi

Please follow this link for full guidance on artwork.
Tables should be provided in editable Word format. They should be numbered and given explanatory titles.
4. Appendices. If any, are intended for inclusion in the printed version of the manuscript and should be kept to a minimum. Please consider the use of supplementary information instead.
5. Supplementary Information – Online only
Where unpublished material e.g. behaviour rating scales or therapy manuals are referred to in an article, copies should be submitted as an additional document (where copyright allows) to facilitate review.
Supplementary files can be used to convey supporting or extra information to your study, however, the main manuscript should be able to 'stand-alone' as these documents are not published in the printed issues.

Supporting documents are reviewed but not copyedited on acceptance of the article. They can therefore be submitted in PDF format, and include figures and tables within the text. There is no word limit for supporting online information.

Suggested Reviewers

During the submission process, you will be asked to indicate your preferred and non-preferred reviewers, and the reasons for your choices.

Preferred reviewers:

- Should not have a conflict of interest (such as a recent or current close working relationship, or from the same institution)
- At least half of the list should be international to yourself
- Please consider early career researchers as well as field leaders
- Please suggest both niche experts and those with wider knowledge of the subject

Non-preferred reviewers:

- May have personal or subjective bias to your work which disregards the scientific merit
- May have seen or commented on the submitted manuscript, or prior versions.

Ethical Standards

Behavioural and Cognitive Psychotherapy is committed to actively investigating any cases of suspected misconduct, even in the event of the manuscript being withdrawn. All manuscripts are screened for plagiarism before being accepted for publication. All editors and reviewers are asked to disclose any conflict of interest when they are assigned a manuscript. If deemed necessary, alternative or additional opinions will be sought in order to maintain the balance of fair and thorough peer review.

The journal is a member of COPE.

Retractions

Behavioural and Cognitive Psychotherapy follows the COPE guidelines on retractions.

Transfer Of Files For Submission To the Cognitive Behavioural Therapist

Editors for *Behavioural and Cognitive Psychotherapy* (BCP) can choose to recommend submission of a manuscript not suitable for *BCP* to *the Cognitive Behavioural Therapist (tCBT)*, thus effectively submitting to both journals sequentially. This allows the automatic transfer of the manuscript files, including, as appropriate, transmission of reviewers' comments (at the discretion of the handling Editor) where this seems likely to facilitate manuscript handling. Selection of a manuscript to be transferred to *tCBT* is at the Editor's discretion, and is then subject to the peer-review process of that journal. No guarantee of suitability for *tCBT* or acceptance is made. Those papers not passed on to *tCBT* by a *BCP* Editor can be submitted by the author via the usual channels.

Open Access

Upon acceptance of your paper, you may choose to publish your article via Gold Open Access (following payment of an Article Processing Charge). Current APC rates for *Behavioural and Cognitive Psychotherapy* can be found here.

Please note: APC collection is managed by Rightslink, who will contact authors who have elected to publish via Open Access.

Green Open Access is also supported by Cambridge Open and full details can be found on the journal copyright form.

Note: Open Access publication under a CC-BY licence may be required when funding has been received from some funding bodies. If this applies to your paper make sure to let us know during the submission process, and complete the appropriate Open Access copyright form. You can also indicate through the ScholarOne system that your paper should deposited in PubMed Central if accepted, which may also be required by funders.

Proofs And Copyright

Proofs of accepted articles will be sent electronically to authors for the correction of printers' errors; authors' alterations may be charged. Authors submitting a manuscript do so on the understanding that if it is accepted for publication exclusive copyright of the paper shall be assigned to the Association. The publishers will not put any limitation on the personal freedom of the author to use material contained in the paper in other works.

Author Language Services

Cambridge University Press recommends that authors have their manuscripts checked by an English language native speaker before submission; this will ensure that submissions are judged at peer review exclusively on academic merit. We list a number of third-party services specialising in language editing and / or translation, and suggest that authors contact as appropriate. Use of any of these services is voluntary, and at the author's own expense.

Appendix D
(mandatory)

Patient information sheet and consent form

Participant Information Sheet

Social Recovery Therapy: Therapists' experience of coping and hope working with complex clients

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

Why is this research being done?

Therapists' experience of delivering therapy is an area which has so far been relatively overlooked in terms of scientific research. However it has the potential of offering important clues in terms of training, supervision and support of therapists using the intervention.

This study aims to look at therapists' experience of working with a particular group of clients who do not usually present in traditional mental health services.

What's involved in taking part in this research?

Participation in the study involves a single interview with the researcher. During this interview the researcher will focus on your experience of working with clients using Social Recovery Therapy, mainly in terms of coping and maintenance of hope. This is likely to last between 30 minutes to 1 hour. The interview will be carried out face-to-face in a convenient NHS or educational institution location or by telephone or Skype. The interview will be audio-recorded with your consent. The interviews will be transcribed verbatim by the researcher, and themes will be identified via qualitative process of research (interpretative phenomenological analysis). Participants will not be matched to their interview responses in anyway nor to themes. In this sense, the information provided by you (your data) will remain confidential.

Are there any advantages and disadvantages of participation in this research?

It is not expected that the interview will cause any distress to the participants. However, in the unlikely event that you experience distress during the interview, the researcher will stop the interview, discuss the issue with you and, if needed, direct you to sources of support.

There may be no immediate benefits to taking part in this research. However, it is hoped that you will have a positive experience in participating in an interview in which you can reflect on experience of delivering Social Recovery Therapy with different clients. We believe that the findings will be useful to future projects or services in which therapists deliver social recovery focused therapy to clients.

Is my participation voluntary?

Yes, it is up to you to decide whether or not you want to take part. If you do decide to take part you will be given this information sheet to keep and will also be asked to sign a consent form. Even if you decide to take part, you can change your mind at any time without having to give a reason. It will not be possible to remove your data from the study after April 2018, when the data will be analysed.

How would my participation be kept confidential?

Your participation will remain confidential. Names or other identifying materials will not be included in the transcript of your interviews, nor in any further publication of this work. Recording will be done digitally in audio and kept in a Sussex Partnership NHS Trust encrypted memory stick in a locked NHS cabinet and in a secure computer file, for 10 years after the close of the trial unless otherwise advised by the Sponsor.

Should you disclose any information that suggests any client or you yourself are at possible risk of any harm, this information would need to be passed on to your line manager to ensure that you and all clients are kept safe. The researcher would discuss the best way of passing on this information with you during or after the interview.

Who has reviewed this research?

The PRODIGY Trial has been approved by the Preston Research Ethics Committee (15/NW/0590). This amendment and its sub-protocol have been reviewed by the Health Research Authority.

Will this research be published?

The present research study will be presented as part of the Dissertation for the Doctorate in Clinical Psychology, University of Leicester. It is expected to be submitted before January 2019. The researcher plans to publish it as a research paper in a scientific journal.

Who is organising and paying for this research?

This research is being organised by [redacted], employed by [redacted], as part of an educational qualification at the University of Leicestershire. This research is being done as an amendment to the PRODIGY Trial, which is paid for by the National Institute of Health Research (NIHR) and sponsored by [redacted].

Who can be contacted about this research?

[redacted]

What if there is a problem or concern about this research study?

If you have a concern about any aspect of this study, you should ask to speak to the Researchers, using the contact information above, who will do their best to answer your questions using the information above.

If you remain unhappy and wish to complain formally, please contact:

[redacted]
email: [redacted]

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against [redacted] but you may have to pay your legal costs.

CONSENT FORM

Title of Project: **Social Recovery Therapy: Therapists' experience of coping and hope working with complex clients**
Name of Researcher: **Catarina Sacadura**

Please initial box

1. I confirm that I have read and understand the information sheet dated 16.08.17 (V1) for the above study. I have had the opportunity to consider the information, ask questions and have any questions answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, up until the point of data analysis. ☐

3. I am willing to take part in the interview for this study and for the interview to be audio-recorded. ☐

4. I understand that my data will be anonymous and will be stored separately from my personal information. ☐

5. I understand that all identifying information will be removed from interview transcripts and any quotes used in any reports or publications will not be identifiable. ☐

6. I agree to agree to take part in the above research study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix E
(mandatory)

Ethics Committee correspondence

Sussex Partnership NHS
NHS Foundation Trust

26th September 2017

Research and Development
Sussex Education Centre
Mill View Hospital
Nevill Avenue
Hove BN3 7HZ

www.sussexpartnership.nhs.uk

Sussex Partnership NHS Foundation Trust
Arun House
16 Liverpool Gardens
Worthing,
West Sussex
BN11 1RY

Dear

Study title: PRODIGY: Prevention of long term social disability amongst young people with emerging psychological difficulties: a definitive randomised controlled trial of social recovery cognitive behavioural therapy.
R&D Ref: IRAS 185153
REC reference: 15/NW/0590
Amendment number: 3
Amendment date: 22 August 2017

Further to the initial study approval letter on 28th August 2015, a substantial amendment (3) has been received for review.

I am pleased to confirm that Sussex Partnership is able to accommodate the amendment and therefore confirm continued capacity and capability at approved Sussex Partnership Sites.

The final list of substantial amendment documents reviewed is as follows:

Document	Version	Date
Interview schedules or topic guides for participants [Tech]	1	16 August 2017
	1	27 July 2017
Participant consent form [Tech]	1	16 August 2017
	1	27 July 2017
Participant information sheet (PIS) [Tech]	1	16 August 2017
	1	27 July 2017
Research protocol or project proposal [Tech sub protocol]	1	16 August 2017

	3	27 July 2017

Conditions of approval

The approval covers the period stated in the Research Ethics Committee (REC) application and will be extended in line with any amendments agreed by the REC. Research must commence within 12 months of the issue date of this letter. Any delay beyond this may require a new review of the project resources.

Please alert the Research and Development Office if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.

Please ensure that you comply fully with the Department of Health Research Governance Framework, in particular that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.

Please ensure that all information regarding patients or staff remains secure and strictly confidential at all times. Ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice, Data Protection Act and Human Rights Act. Unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Amendments

Project amendment details dated after the issue of this approval letter should be emailed to the Research and Development Office for formal approval.

NIHR Adoption

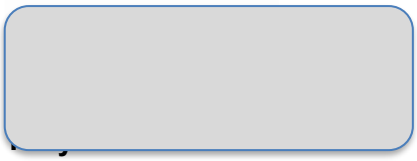
This project has been adopted by the NIHR and as Principal Investigator for this site you are responsible for ensuring accrual numbers are submitted to the co-ordinating centre for study. If you need any support to manage this please contact me.

ICH-GCP Monitoring

The Trust has a duty to ensure that all research is conducted in accordance with the Research Governance Framework and to ICH-GCP standards. In order to ensure compliance the Trust undertakes random audits. If your project is selected you will be given 4 weeks notice to prepare all documentation for inspection. The trust undertakes annual monitoring of all research studies, please respond to any requests for information. Failure to do this will result in the suspension of research governance approval.

I wish you luck with your project and would be grateful if you could inform me when the project is complete or due to be closed on this site.

Yours sincerely,



Lead Research Governance Officer

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
PRODIGY (Definitive RCT): Version 1

1. Is your project research?

(●) Yes ( ) No

2. Select one category from the list below:

( ) Clinical trial of an investigational medicinal product
( ) Clinical investigation or other study of a medical device
( ) Combined trial of an investigational medicinal product and an investigational medical device
(●) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
( ) Basic science study involving procedures with human participants
( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
( ) Study involving qualitative methods only
( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
( ) Study limited to working with data (specific project only)
( ) Research tissue bank
( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Will the study involve the use of any medical device without a CE Mark, or a CE marked device which has been modified or will be used outside its intended purposes?

( ) Yes (●) No

2b. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation? ( ) Yes (●) No

b) Will you be taking new human tissue samples (or other human biological samples)? ( ) Yes (●) No

c) Will you be using existing human tissue samples (or other human biological samples)? ( ) Yes (●) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

- [x] England
- [ ] Scotland
- [ ] Wales
- [ ] Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- (•) England
- ( ) Scotland
- ( ) Wales
- ( ) Northern Ireland
- ( ) This study does not involve the NHS

4. Which applications do you require?

IMPORTANT: If your project is taking place in the NHS and is led from England select 'IRAS Form'. If your project is led from Northern Ireland, Scotland or Wales select 'NHS/HSC Research and Development Offices' and/or relevant Research Ethics Committee applications, as appropriate.

- [ ] IRAS Form
- [x] NHS/HSC Research and Development offices
- [ ] Social Care Research Ethics Committee
- [x] Research Ethics Committee
- [ ] Confidentiality Advisory Group (CAG)
- [ ] National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D Offices in Northern Ireland, Scotland and Wales the CI must create NHS/HSC Site Specific Information forms, for each site, in addition to the study wide forms, and transfer them to the PIs or local collaborators.

For participating NHS organisations in England different arrangements apply for the provision of site specific information. Refer to IRAS Help for more information.

5. Will any research sites in this study be NHS organisations?

(•) Yes ( ) No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or a Diagnostic Evidence Co-operative in all study sites?

Please see information button for further details.

( ) Yes (•) No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

(•) Yes ( ) No

The NIHR Clinical Research Network provides researchers with the practical support they need to make clinical studies happen in the NHS e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.

6. Do you plan to include any participants who are children?

( ) Yes (•) No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

( ) Yes (•) No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

(•) Yes ( ) No

9. Is the study or any part of it being undertaken as an educational project?

( ) Yes (•) No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

( ) Yes (•) No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

( ) Yes (•) No

NOTICE OF SUBSTANTIAL AMENDMENT

Please use this form to notify the main REC of substantial amendments to all research other than clinical trials of investigational medicinal products (CTIMPs).
The form should be completed by the Chief Investigator using language comprehensible to a lay person.

Details of Chief Investigator:

	Title Forename/Initials Surname
Work Address	[redacted]
	Pevensey 2
	University of Sussex, Falmer
PostCode	BN1 9QH
Email	
Telephone	[redacted]
Fax	

For guidance on this section of the form refer to the guidance

Full title of study:	PRODIGY: Prevention of long term social disability amongst young people with emerging psychological difficulties: a definitive randomised controlled trial of social recovery cognitive behavioural therapy.
Lead sponsor:	Sussex Partnership NHS Foundation Trust
Name of REC:	North West - Preston
REC reference number:	15/NW/0590

International Standard Randomised Controlled Trial Number (ISRCTN):	ISRCTN47998710
ClinicalTrials.gov Identifier (NCT number):	

Additional reference number(s):

Ref.Number Description	Reference Number

Name of lead R&D office:	Sussex Partnership NHS Foundation Trust
Date study commenced:	01/09/2015
Protocol reference (if applicable), current version and date:	
Amendment number and date:	Amendment 3.0 22.08.2017

Type of amendment

(a) Amendment to information previously given in IRAS

◉ Yes ○ No

If yes, please refer to relevant sections of IRAS in the "summary of changes" below.

Changes relating to part one of the amendment (school functioning):

(b) Amendment to the protocol

◉ Yes ○ No

If yes, please submit either the revised protocol with a new version number and date, highlighting changes in bold, or a document listing the changes and giving both the previous and revised text.

Revised protocol enclosed with changes highlighted in bold.

(c) Amendment to the information sheet(s) and consent form(s) for participants, or to any other supporting documentation for the study

◉ Yes ○ No

If yes, please submit all revised documents with new version numbers and dates, highlighting new text in bold.

Additional Participant Information Sheet and Consent Form which are additional to but do not replace originals.

Is this a modified version of an amendment previously notified and not approved?

○ Yes ◉ No

Summary of changes

Briefly summarise the main changes proposed in this amendment. Explain the purpose of the changes and their significance for the study.
If this is a modified amendment, please explain how the modifications address the concerns raised previously by the ethics committee.
If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained.

Two main changes are proposed. The first is the addition of a sub-protocol (TECH PRODIGY Sub-Protocol V1 16.08.2017) encapsulating a sub-project focused on interviewing PRODIGY therapists regarding their experiences of delivering the trial intervention (Social Recovery Therapy). The second change (School Functioning) involves the addition of two brief secondary outcome measures, administered once, which capture aspects of premorbid school

Both changes have been reviewed by all members of the PRODIGY Trial Management Group (TMG) who represent national and international leaders in youth mental health, psychological intervention development, and trials. It is the opinion of the TMG that the proposed changes will add to the scientific value of the research and all members are in support of these proposed changes. The proposed amendment will not alter the scientific quality of the research and

will be used in sub-analyses with no changes to planned primary and secondary research questions or analyses. The Norwich Clinical Trials Unit are also aware and in support of the planned changes. The changes are outlined in more detail below.

1. Additional sub-protocol (TECH Version 1 Date).

This additional sub-protocol represents an additional sub-project which involves only NHS staff. We are aware that a staff-only study does not require full REC review. We have included it here as this sub-project will be an amendment of the PRODIGY study, which required full REC/R&D review, and because the NHS staff participants will be drawn from the therapists working on the PRODIGY trial. However, we confirm that this additional sub-project constitutes no change to the overarching PRODIGY trial protocol or change to the involvement of PRODIGY patient participants or any patient participant study documentation. For clarity, we thus present this sub-project as a sub-protocol rather than including within the PRODIGY trial protocol.

This proposed sub-project aims to capture therapist perspectives of delivering the trial intervention (Social Recovery Therapy; SRT) to young people with mental health problems and social disability. SRT is a novel intervention delivered to a novel group of young people who do not commonly present at or receive a service from standard NHS services; thus capturing the therapist experience of delivering this intervention is of great interest. This sub-project will form part of an educational qualification for one of the current PRODIGY trial therapists.

As stated, no changes have been made to the PRODIGY protocol with respect to this proposed sub-project. Rather, an additional sub-protocol (TECH Version 1, 16.08.17) is enclosed. A TECH Therapist Participant Information Sheet (Version 1, Date 16.08.17) and TECH Therapist Consent Form (Version 1, Date 16.08.17) for therapist participants are also enclosed. Finally, the semi-structured interview schedule (Version 1, Date 16.08.17) is also enclosed.

2. Substantial amendment to the PRODIGY Trial Protocol (Version 3.0 Date)

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r[illegible]

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[illegible]

A[illegible]
1. [illegible]
2. PR[illegible]
3. PROD[illegible]/07/17

Any other relevant information

Applicants may indicate any specific issues relating to the amendment, on which the opinion of a reviewing body is sought.

Part one of the amendment (TECH) represents a sub-protocol which involves a new sub-project involving only NHS staff therapists employed to work on the PRODIGY study. This part of the amendment makes no changes to the PRODIGY protocol proper.

List of enclosed documents

Document	*Version*	*Date*
TECH PRODIGY Sub-Protocol	1.0	16/08/2017
TECH Therapist Participant Information Sheet	1.0	16/08/2017
TECH Therapist Consent Form	1.0	16/08/2017
TECH Semi-structured Interview Schedule	1.0	16/08/2017
P	3.0	27/07/2017
	1.0	27/07/2017
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Declaration by Chief Investigator

1. *I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.*
2. *I consider that it would be reasonable for the proposed amendment to be implemented.*

This section was signed electronically on 31/08/2017 10:59.

Job Title/Post: Professor of Clinical Psychology

Organisation: University of Sussex

Email:

Declaration by the sponsor's representative

I confirm the sponsor's support for this substantial amendment.

This section was signed electronically by on 31/08/2017 11:00.

Job Title/Post:	Lead Governance Officer
Organisation:	Sussex Partnership NHS FT
Email:	

Appendix F

Interview Schedule

Interview Schedule

Introduction:

Thank you for agreeing to participate in this study.

I am going to ask you about your experiences as a therapist using Social Recovery Therapy. I'll call it SRT from now on. There are no right or wrong answers. I am just interested in your thoughts and experiences. I have some questions to ask you to help guide our discussion but I am really interested in anything you feel is important even if I don't ask you specific questions about it.

1. What has been your experience of using SRT with this population?

Prompts: What has been the experience in terms of therapeutic relationship?
How has this impacted on you as a therapist, for example in terms of your feelings and thoughts?
How has the experience of negotiating goals/discussing values/implementing change been?

2. Thinking about a specific client you have worked with using SRT, for whom you feel therapy did not go well, can you describe the stages in the process of the therapy with this client and how you felt as therapist at these points?

Prompts: Before starting therapy (reading referral)
First session (building therapeutic rapport, establishing therapeutic relationship, negotiating goals and contract etc)
Immediately after a therapy session
Discussing client in supervision
Planning actions/change
Reviewing goals/ progress
End of therapy

3. How do you make sense of the experience of feeling like SRT did not go well with this client?

Prompts: What made you feel positive about it?
What was challenging about it?
What knowledge has supported you in making sense of your experience?
In which contexts have you reflected on your experience in this way (e.g. supervision, colleagues, literature, self practice/self reflection) and how helpful was it?

4. Thinking about a specific client you have worked with using SRT for whom you think SRT worked well, can you describe the stages in the process of the therapy with this client and how you felt as therapist at these points?

Prompts: Before starting therapy (reading referral)

First session (building therapeutic rapport, establishing therapeutic relationship, negotiating goals and contract etc)
Immediately after a therapy session
Discussing client in supervision
Planning actions/change
Reviewing goals/ progress
End of therapy

5. How do you make sense of the experience of feeling that SRT went well with this client?

   Prompts: What made you feel positive about it?
   What was challenging about it?
   What knowledge has supported you in making sense of your experience?
   In which contexts have you reflected on your experience in this way (e.g. supervision, colleagues, literature, self practice/self reflection) and how helpful was it?

6. How have you managed your experience of using SRT with this population?

   Prompts: How did you manage the therapeutic relationship? (e.g. develop, maintain, etc.)
   How did you manage your feelings and thoughts?
   How did you manage the negotiation of goals/discussion of values/implementation of change?
   What was helpful in dealing with the positives?
   What has been helpful in dealing with the challenging aspects?
   Did you have strategies to deal with this?
   How did you develop these strategies?

7. What kinds of things useful for training therapists to use SRT?

   Prompts: What if SRT was delivered by professionals with different professional backgrounds? With different levels of experience? With clients with different presentations? In different types of services?

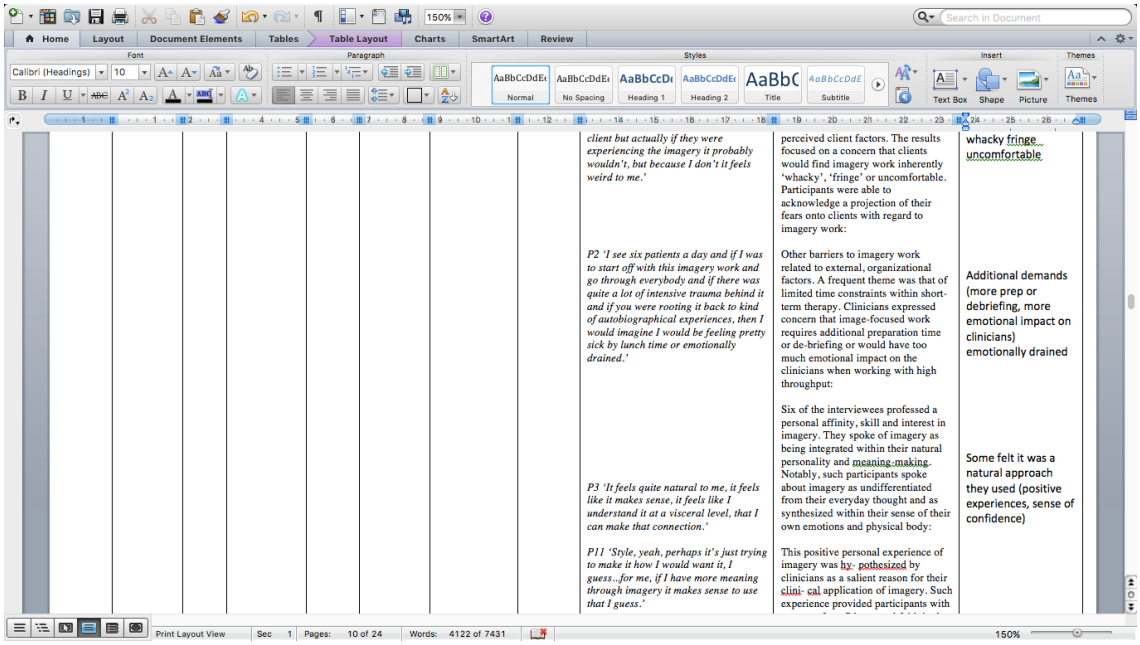
8. What kinds of things would be useful and important for supervision and support for therapists using SRT?

9. Is there anything else about your experience of using SRT that you feel is important and that we haven't talked about yet?

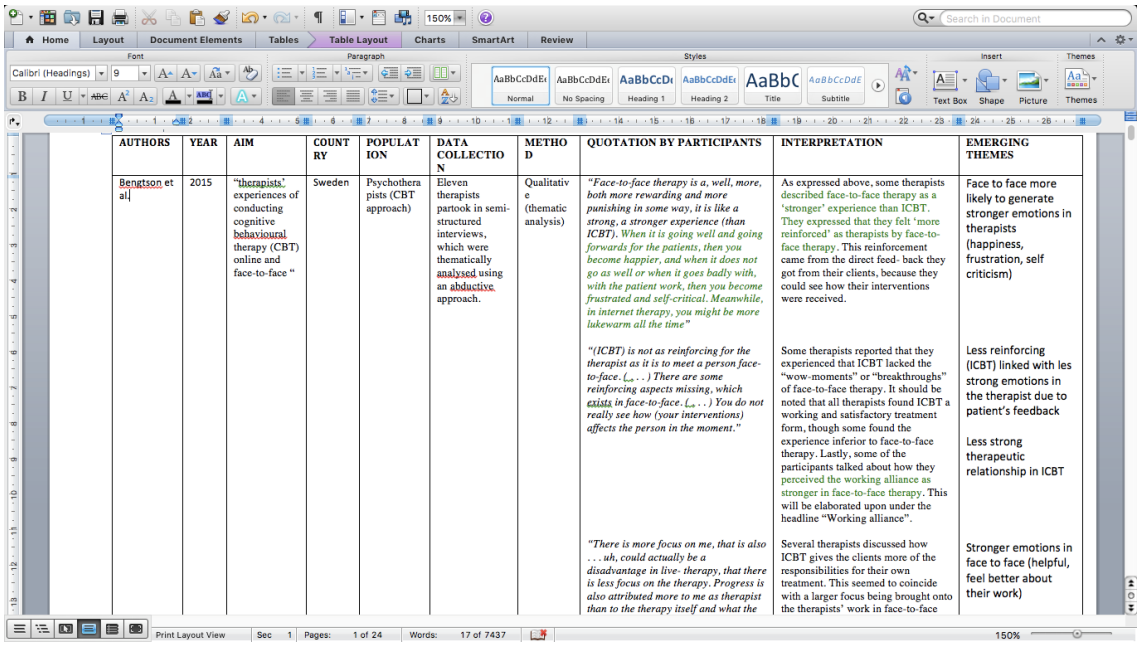
Generic prompts likely to be used throughout the interview: Can you tell me more about that? What did that mean to you? What words come to your mind when you think of this? What do you think about this? How did this make you feel?

Appendix G

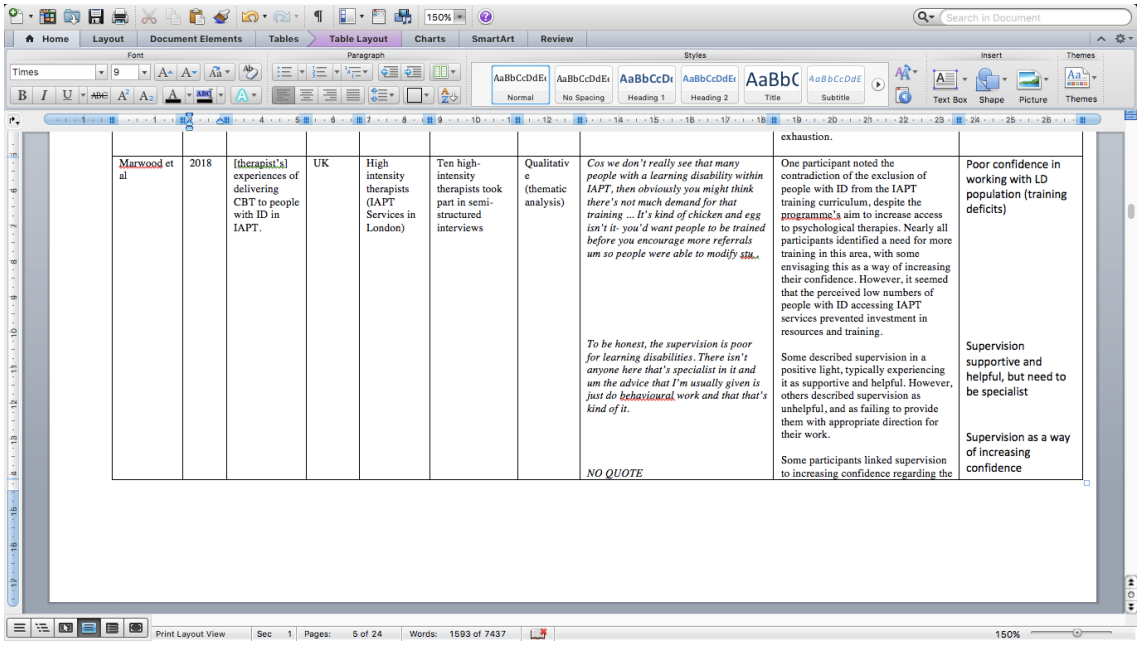
Literature Review: Screenshot of early stage themes exploration (example)



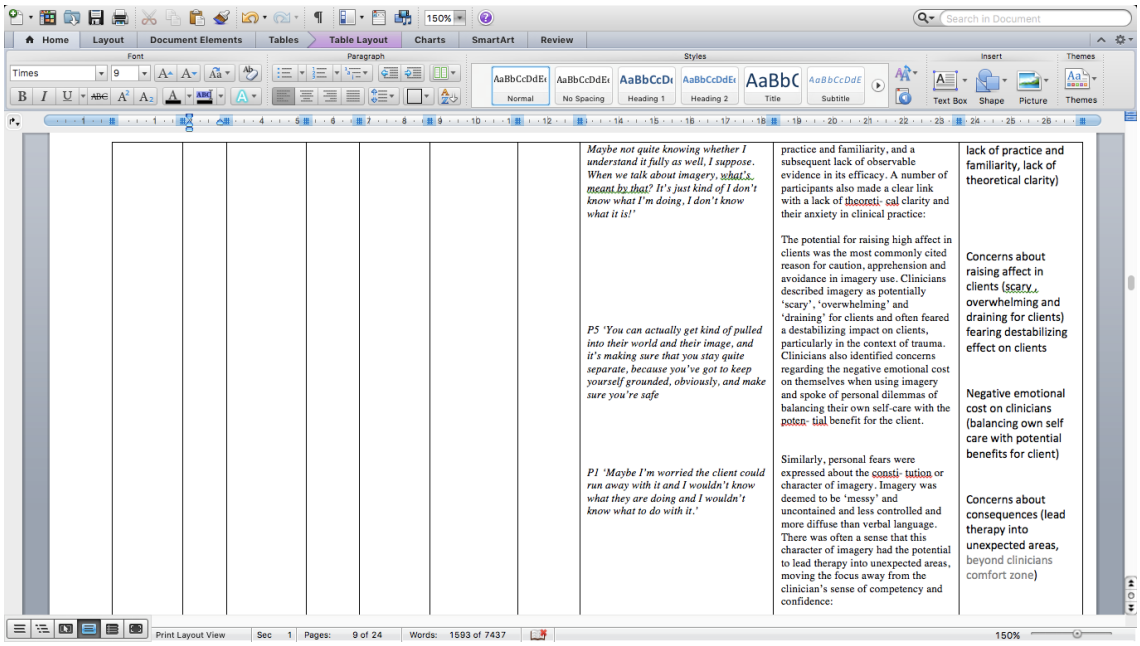
client but actually if they were experiencing the imagery it probably wouldn't, but because I don't it feels weird to me.'	perceived client factors. The results focused on a concern that clients would find imagery work inherently 'whacky', 'fringe' or uncomfortable. Participants were able to acknowledge a projection of their fears onto clients with regard to imagery work:	whacky fringe uncomfortable
P2 'I see six patients a day and if I was to start off with this imagery work and go through everybody and if there was quite a lot of intensive trauma behind it and if you were rooting it back to kind of autobiographical experiences, then I would imagine I would be feeling pretty sick by lunch time or emotionally drained.'	Other barriers to imagery work related to external, organizational factors. A frequent theme was that of limited time constraints within short-term therapy. Clinicians expressed concern that image-focused work requires additional preparation time or de-briefing or would have too much emotional impact on the clinicians when working with high throughput:	Additional demands (more prep or debriefing, more emotional impact on clinicians) emotionally drained
P3 'It feels quite natural to me, it feels like it makes sense, it feels like I understand it at a visceral level, that I can make that connection.'	Six of the interviewees professed a personal affinity, skill and interest in imagery. They spoke of imagery as being integrated within their natural personality and meaning-making. Notably, such participants spoke about imagery as undifferentiated from their everyday thought and as synthesized within their sense of their own emotions and physical body:	Some felt it was a natural approach they used (positive experiences, sense of confidence)
P11 'Style, yeah, perhaps it's just trying to make it how I would want it, I guess...for me, if I have more meaning through imagery it makes sense to use that I guess.'	This positive personal experience of imagery was hy- pothesized by clinicians as a salient reason for their clini- cal application of imagery. Such experience provided participants with	



AUTHORS	YEAR	AIM	COUNTRY	POPULATION	DATA COLLECTION	METHOD	QUOTATION BY PARTICIPANTS	INTERPRETATION	EMERGING THEMES
Bengtson et al.	2015	"therapists' experiences of conducting cognitive behavioural therapy (CBT) online and face-to-face "	Sweden	Psychotherapists (CBT approach)	Eleven therapists partook in semi-structured interviews, which were thematically analysed using an abductive approach.	Qualitative (thematic analysis)	*"Face-to-face therapy is a, well, more, both more rewarding and more punishing in some way, it is like a strong, a stronger experience (than ICBT). When it is going well and going forwards for the patients, then you become happier, and when it does not go as well or when it goes badly with, with the patient work, then you become frustrated and self-critical. Meanwhile, in internet therapy, you might be more lukewarm all the time"*	As expressed above, some therapists described face-to-face therapy as a 'stronger' experience than ICBT. They expressed that they felt 'more reinforced' as therapists by face-to-face therapy. This reinforcement came from the direct feed- back they got from their clients, because they could see how their interventions were received.	Face to face more likely to generate stronger emotions in therapists (happiness, frustration, self criticism)
							"(ICBT) is not as reinforcing for the therapist as it is to meet a person face-to-face. (...) There are some reinforcing aspects missing, which exists in face-to-face. (...) You do not really see how (your interventions) affects the person in the moment."	Some therapists reported that they experienced that ICBT lacked the "wow-moments" or "breakthroughs" of face-to-face therapy. It should be noted that all therapists found ICBT a working and satisfactory treatment form, though some found the experience inferior to face-to-face therapy. Lastly, some of the participants talked about how they perceived the working alliance as stronger in face-to-face therapy. This will be elaborated upon under the headline "Working alliance".	Less reinforcing (ICBT) linked with les strong emotions in the therapist due to patient's feedback Less strong therapeutic relationship in ICBT
							"There is more focus on me, that is also . . . uh, could actually be a disadvantage in live- therapy, that there is less focus on the therapy. Progress is also attributed more to me as therapist than to the therapy itself and what the	Several therapists discussed how ICBT gives the clients more of the responsibilities for their own treatment. This seemed to coincide with a larger focus being brought onto the therapists' work in face-to-face	Stronger emotions in face to face (helpful, feel better about their work)



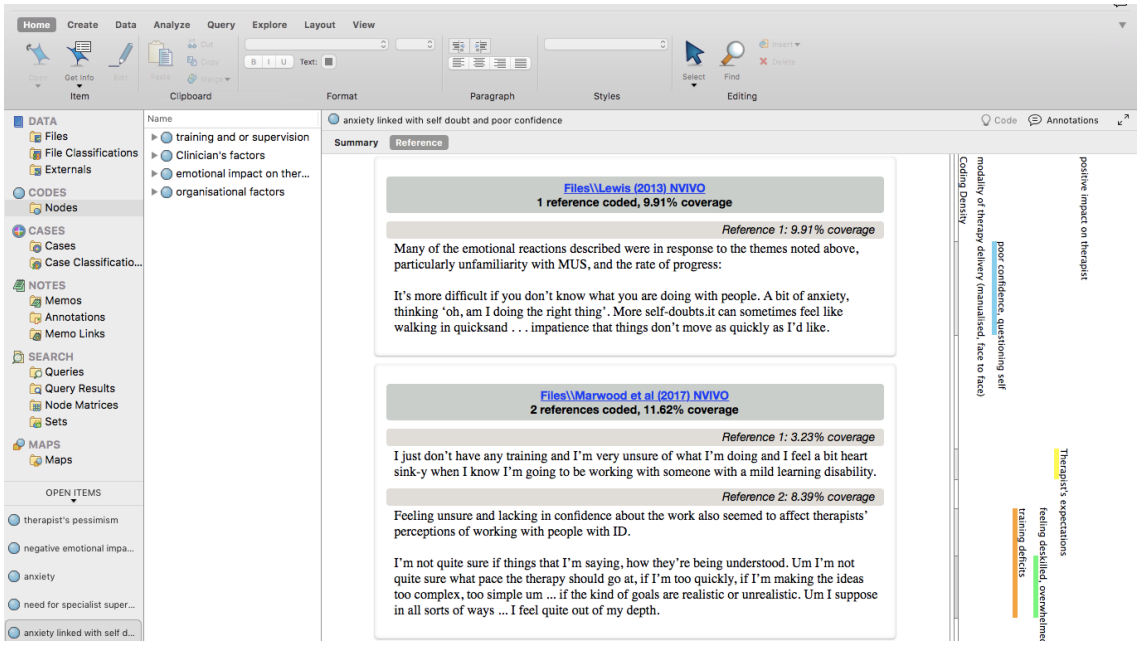
								exhaustion.	
Marwood et al	2018	[therapist's] experiences of delivering CBT to people with ID in IAPT.	UK	High intensity therapists (IAPT Services in London)	Ten high-intensity therapists took part in semi-structured interviews	Qualitative (thematic analysis)	*Cos we don't really see that many people with a learning disability within IAPT; then obviously you might think there's not much demand for that training ... It's kind of chicken and egg isn't it- you'd want people to be trained before you encourage more referrals um so people were able to modify stu..* *To be honest, the supervision is poor for learning disabilities. There isn't anyone here that's specialist in it and um the advice that I'm usually given is just do behavioural work and that that's kind of it.* *NO QUOTE*	One participant noted the contradiction of the exclusion of people with ID from the IAPT training curriculum, despite the programme's aim to increase access to psychological therapies. Nearly all participants identified a need for more training in this area, with some envisaging this as a way of increasing their confidence. However, it seemed that the perceived low numbers of people with ID accessing IAPT services prevented investment in resources and training. Some described supervision in a positive light, typically experiencing it as supportive and helpful. However, others described supervision as unhelpful, and as failing to provide them with appropriate direction for their work. Some participants linked supervision to increasing confidence regarding the	Poor confidence in working with LD population (training deficits) Supervision supportive and helpful, but need to be specialist Supervision as a way of increasing confidence



							Maybe not quite knowing whether I understand it fully as well, I suppose. When we talk about imagery, what's meant by that? It's just kind of I don't know what I'm doing, I don't know what it is!' *P5 'You can actually get kind of pulled into their world and their image, and it's making sure that you stay quite separate, because you've got to keep yourself grounded, obviously, and make sure you're safe* *P1 'Maybe I'm worried the client could run away with it and I wouldn't know what they are doing and I wouldn't know what to do with it.'*	practice and familiarity, and a subsequent lack of observable evidence in its efficacy. A number of participants also made a clear link with a lack of theoreti- cal clarity and their anxiety in clinical practice: The potential for raising high affect in clients was the most commonly cited reason for caution, apprehension and avoidance in imagery use. Clinicians described imagery as potentially 'scary', 'overwhelming' and 'draining' for clients and often feared a destabilizing impact on clients, particularly in the context of trauma. Clinicians also identified concerns regarding the negative emotional cost on themselves when using imagery and spoke of personal dilemmas of balancing their own self-care with the poten- tial benefit for the client. Similarly, personal fears were expressed about the consti- tution or character of imagery. Imagery was deemed to be 'messy' and uncontained and less controlled and more diffuse than verbal language. There was often a sense that this character of imagery had the potential to lead therapy into unexpected areas, moving the focus away from the clinician's sense of competency and confidence:	lack of practice and familiarity, lack of theoretical clarity) Concerns about raising affect in clients (scary, overwhelming and draining for clients) fearing destabilizing effect on clients Negative emotional cost on clinicians (balancing own self care with potential benefits for client) Concerns about consequences (lead therapy into unexpected areas, beyond clinicians comfort zone)

Appendix H

Literature Review: Screenshot of NVivo with codes (example)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emotional impact on ther...
organisational factors
anxiety linked with self doubt and poor confidence
Code
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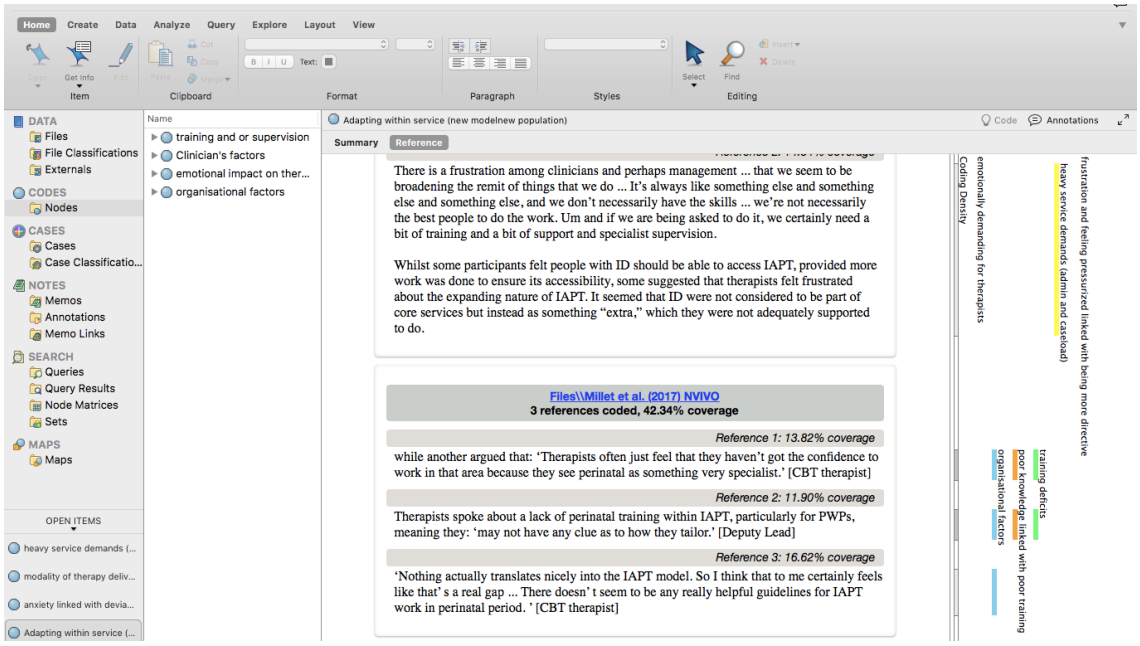
Reference
Files\\Lewis (2013) NVIVO
1 reference coded, 9.91% coverage
Reference 1: 9.91% coverage
Many of the emotional reactions described were in response to the themes noted above, particularly unfamiliarity with MUS, and the rate of progress:
It's more difficult if you don't know what you are doing with people. A bit of anxiety, thinking 'oh, am I doing the right thing'. More self-doubts.it can sometimes feel like walking in quicksand . . . impatience that things don't move as quickly as I'd like.
Files\\Marwood et al (2017) NVIVO
2 references coded, 11.62% coverage
Reference 1: 3.23% coverage
I just don't have any training and I'm very unsure of what I'm doing and I feel a bit heart sink-y when I know I'm going to be working with someone with a mild learning disability.
Reference 2: 8.39% coverage
Feeling unsure and lacking in confidence about the work also seemed to affect therapists' perceptions of working with people with ID.
I'm not quite sure if things that I'm saying, how they're being understood. Um I'm not quite sure what pace the therapy should go at, if I'm too quickly, if I'm making the ideas too complex, too simple um ... if the kind of goals are realistic or unrealistic. Um I suppose in all sorts of ways ... I feel quite out of my depth.
Coding Density
positive impact on therapist
modality of therapy delivery (manualised, face to face)
poor confidence, questioning self
Therapist's expectations
feeling deskilled, overwhelmed
training deficits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modality of therapy deliv...
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Adapting within service (...
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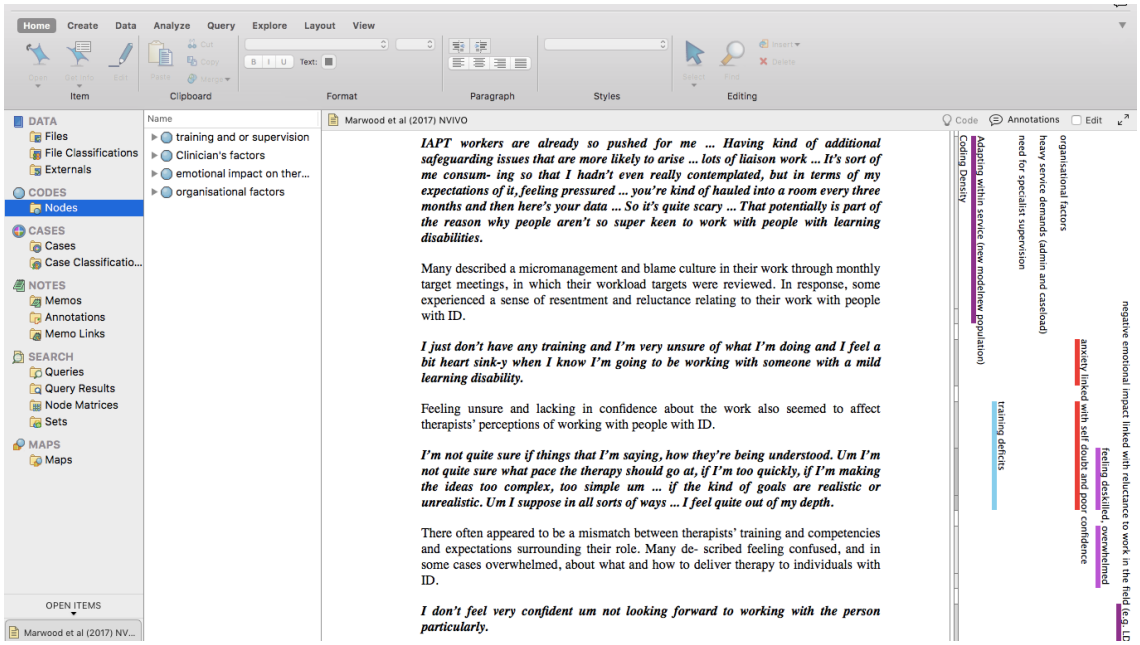
training and or supervision
Clinician's factors
emotional impact on ther...
organisational factors
Adapting within service (new model\new population)
Code
Annotations
Summary
Reference
There is a frustration among clinicians and perhaps management ... that we seem to be broadening the remit of things that we do ... It's always like something else and something else and something else, and we don't necessarily have the skills ... we're not necessarily the best people to do the work. Um and if we are being asked to do it, we certainly need a bit of training and a bit of support and specialist supervision.
Whilst some participants felt people with ID should be able to access IAPT, provided more work was done to ensure its accessibility, some suggested that therapists felt frustrated about the expanding nature of IAPT. It seemed that ID were not considered to be part of core services but instead as something "extra," which they were not adequately supported to do.
Files\\Millet et al. (2017) NVIVO
3 references coded, 42.34% coverage
Reference 1: 13.82% coverage
while another argued that: 'Therapists often just feel that they haven't got the confidence to work in that area because they see perinatal as something very specialist.' [CBT therapist]
Reference 2: 11.90% coverage
Therapists spoke about a lack of perinatal training within IAPT, particularly for PWPs, meaning they: 'may not have any clue as to how they tailor.' [Deputy Lead]
Reference 3: 16.62% coverage
'Nothing actually translates nicely into the IAPT model. So I think that to me certainly feels like that' s a real gap ... There doesn' t seem to be any really helpful guidelines for IAPT work in perinatal period. ' [CBT therapist]
Coding Density
frustration and feeling pressurized linked with being more directive
heavy service demands (admin and caseload)
emotionally demanding for therapists
training deficits
poor knowledge linked with poor training
organisational factors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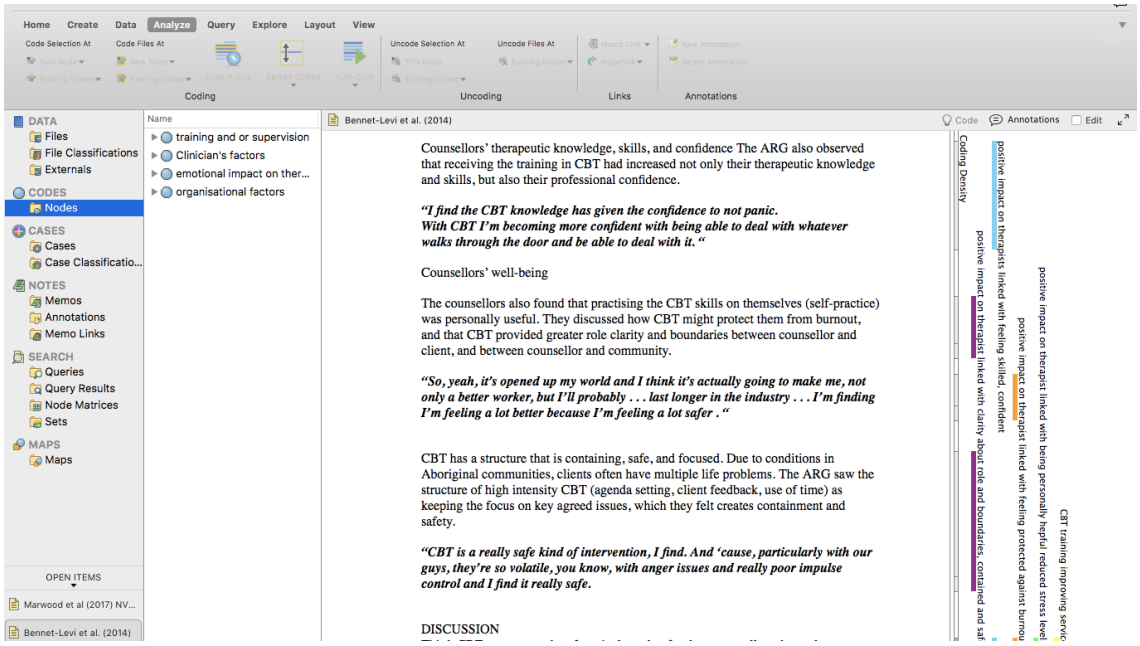
IAPT workers are already so pushed for me ... Having kind of additional safeguarding issues that are more likely to arise ... lots of liaison work ... It's sort of me consum- ing so that I hadn't even really contemplated, but in terms of my expectations of it, feeling pressured ... you're kind of hauled into a room every three months and then here's your data ... So it's quite scary ... That potentially is part of the reason why people aren't so super keen to work with people with learning disabilities.
Many described a micromanagement and blame culture in their work through monthly target meetings, in which their workload targets were reviewed. In response, some experienced a sense of resentment and reluctance relating to their work with people with ID.
I just don't have any training and I'm very unsure of what I'm doing and I feel a bit heart sink-y when I know I'm going to be working with someone with a mild learning disability.
Feeling unsure and lacking in confidence about the work also seemed to affect therapists' perceptions of working with people with ID.
I'm not quite sure if things that I'm saying, how they're being understood. Um I'm not quite sure what pace the therapy should go at, if I'm too quickly, if I'm making the ideas too complex, too simple um ... if the kind of goals are realistic or unrealistic. Um I suppose in all sorts of ways ... I feel quite out of my depth.
There often appeared to be a mismatch between therapists' training and competencies and expectations surrounding their role. Many de- scribed feeling confused, and in some cases overwhelmed, about what and how to deliver therapy to individuals with ID.
I don't feel very confident um not looking forward to working with the person particularly.
Coding Density
Adapting within service (new model/new population)
training deficits
anxiety linked with self doubt and poor confidence
feeling deskilled, overwhelmed
negative emotional impact linked with reluctance to work in the field (e.g. LD
need for specialist supervision
heavy service demands (admin and caseload)
organisational factors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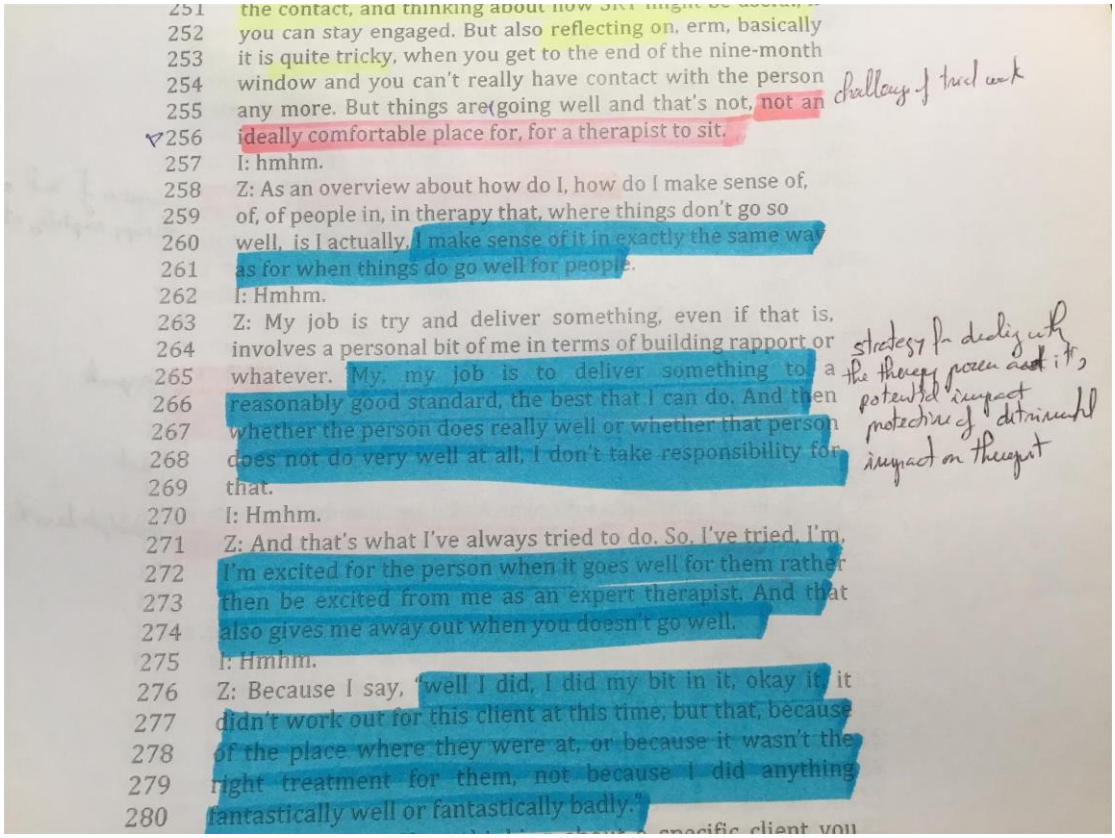
Counsellors' therapeutic knowledge, skills, and confidence The ARG also observed that receiving the training in CBT had increased not only their therapeutic knowledge and skills, but also their professional confidence.
"I find the CBT knowledge has given the confidence to not panic. With CBT I'm becoming more confident with being able to deal with whatever walks through the door and be able to deal with it."
Counsellors' well-being
The counsellors also found that practising the CBT skills on themselves (self-practice) was personally useful. They discussed how CBT might protect them from burnout, and that CBT provided greater role clarity and boundaries between counsellor and client, and between counsellor and community.
"So, yeah, it's opened up my world and I think it's actually going to make me, not only a better worker, but I'll probably . . . last longer in the industry . . . I'm finding I'm feeling a lot better because I'm feeling a lot safer ."
CBT has a structure that is containing, safe, and focused. Due to conditions in Aboriginal communities, clients often have multiple life problems. The ARG saw the structure of high intensity CBT (agenda setting, client feedback, use of time) as keeping the focus on key agreed issues, which they felt creates containment and safety.
"CBT is a really safe kind of intervention, I find. And 'cause, particularly with our guys, they're so volatile, you know, with anger issues and really poor impulse control and I find it really safe.
DISCUSSION
Coding Density
positive impact on therapists linked with feeling skilled, confident
positive impact on therapist linked with clarity about role and boundaries, contained and saf
positive impact on therapist linked with being personally helpful reduced stress level
positive impact on therapist linked with feeling protected against burnou
CBT training improving servic

Appendix I

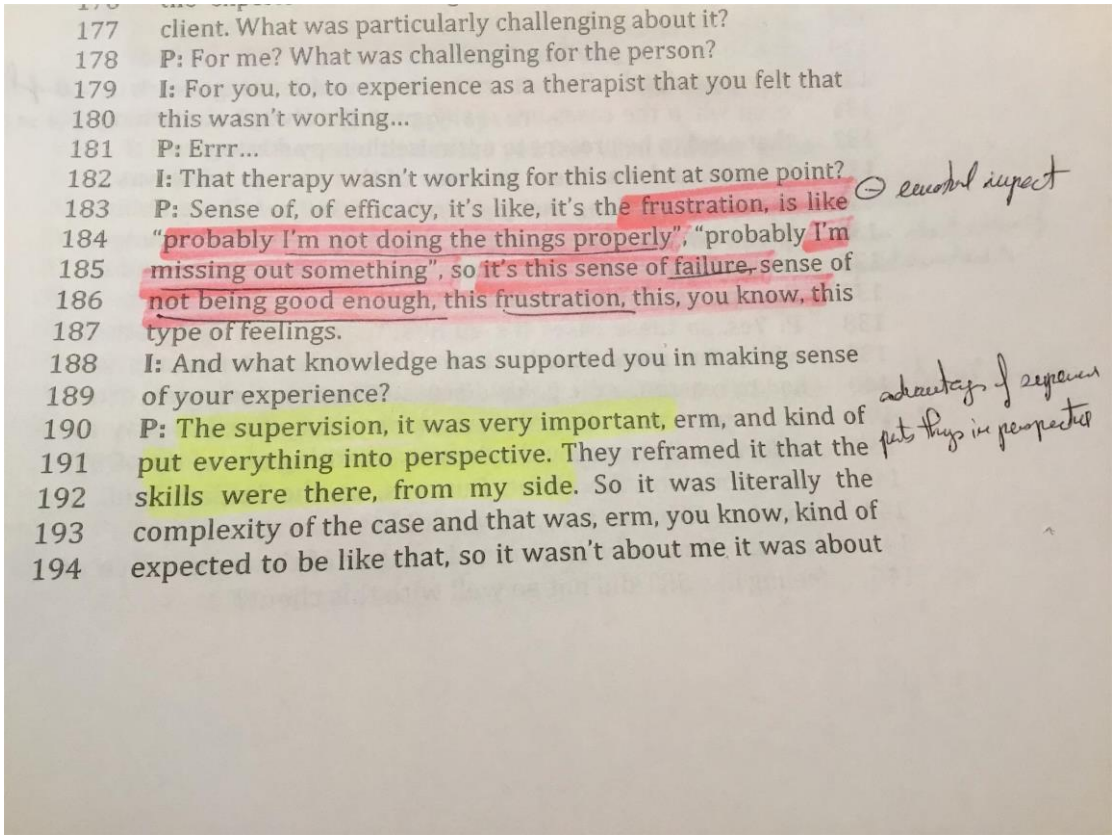
Research Report: Photo of initial stage coding examples



the contact, and thinking about how SKT might be ...
you can stay engaged. But also reflecting on, erm, basically
it is quite tricky, when you get to the end of the nine-month
window and you can't really have contact with the person
any more. But things are going well and that's not, not an
ideally comfortable place for, for a therapist to sit.
I: hmhm.
Z: As an overview about how do I, how do I make sense of,
of, of people in, in therapy that, where things don't go so
well, is I actually, I make sense of it in exactly the same way
as for when things do go well for people.
I: Hmhm.
Z: My job is try and deliver something, even if that is,
involves a personal bit of me in terms of building rapport or
whatever. My, my job is to deliver something to a
reasonably good standard, the best that I can do. And then
whether the person does really well or whether that person
does not do very well at all, I don't take responsibility for
that.
I: Hmhm.
Z: And that's what I've always tried to do. So, I've tried, I'm,
I'm excited for the person when it goes well for them rather
then be excited from me as an expert therapist. And that
also gives me away out when you doesn't go well.
I: Hmhm.
Z: Because I say, "well I did, I did my bit in it, okay it, it
didn't work out for this client at this time, but that, because
of the place where they were at, or because it wasn't the
right treatment for them, not because I did anything
fantastically well or fantastically badly."
specific client you

challenge of hard work

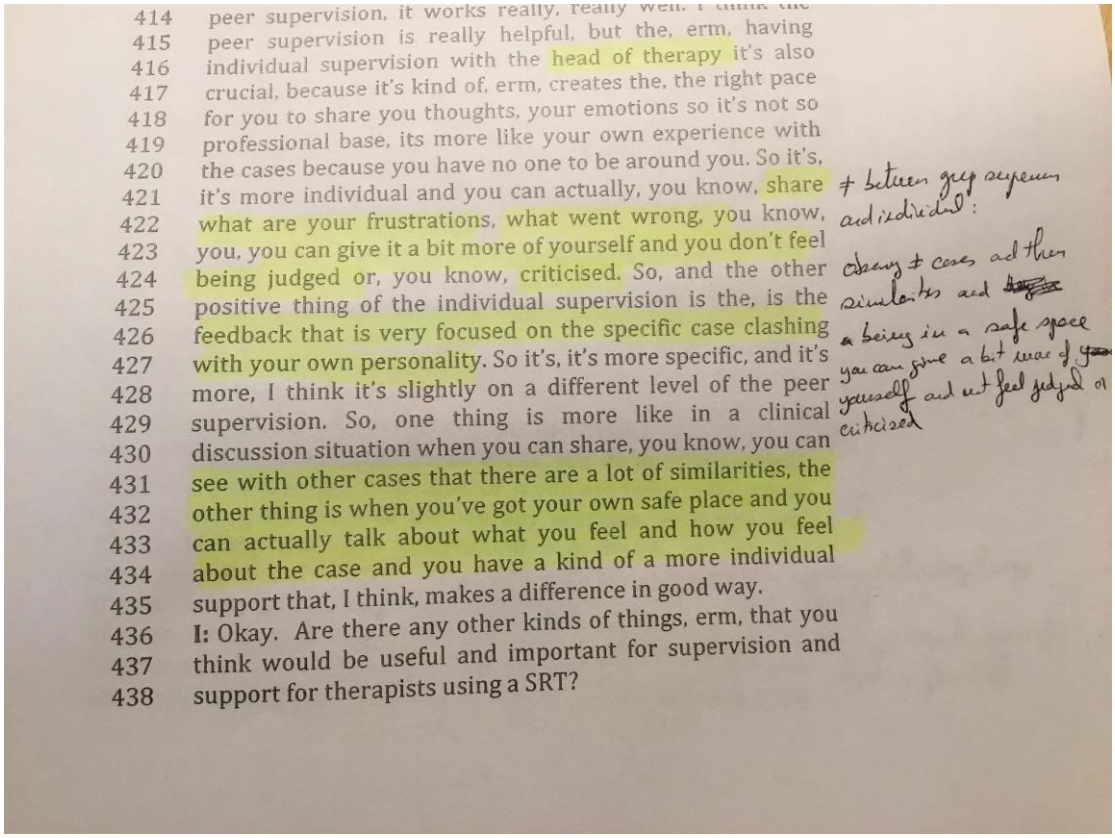
strategy for dealing with the therapy process and it's potential impact protective of distressed impact on therapist



client. What was particularly challenging about it?
P: For me? What was challenging for the person?
I: For you, to, to experience as a therapist that you felt that
this wasn't working...
P: Errr...
I: That therapy wasn't working for this client at some point?
P: Sense of, of efficacy, it's like, it's the frustration, is like
"probably I'm not doing the things properly", "probably I'm
missing out something", so it's this sense of failure, sense of
not being good enough, this frustration, this, you know, this
type of feelings.
I: And what knowledge has supported you in making sense
of your experience?
P: The supervision, it was very important, erm, and kind of
put everything into perspective. They reframed it that the
skills were there, from my side. So it was literally the
complexity of the case and that was, erm, you know, kind of
expected to be like that, so it wasn't about me it was about

⊖ emotional impact

advantage of supervision puts things in perspective

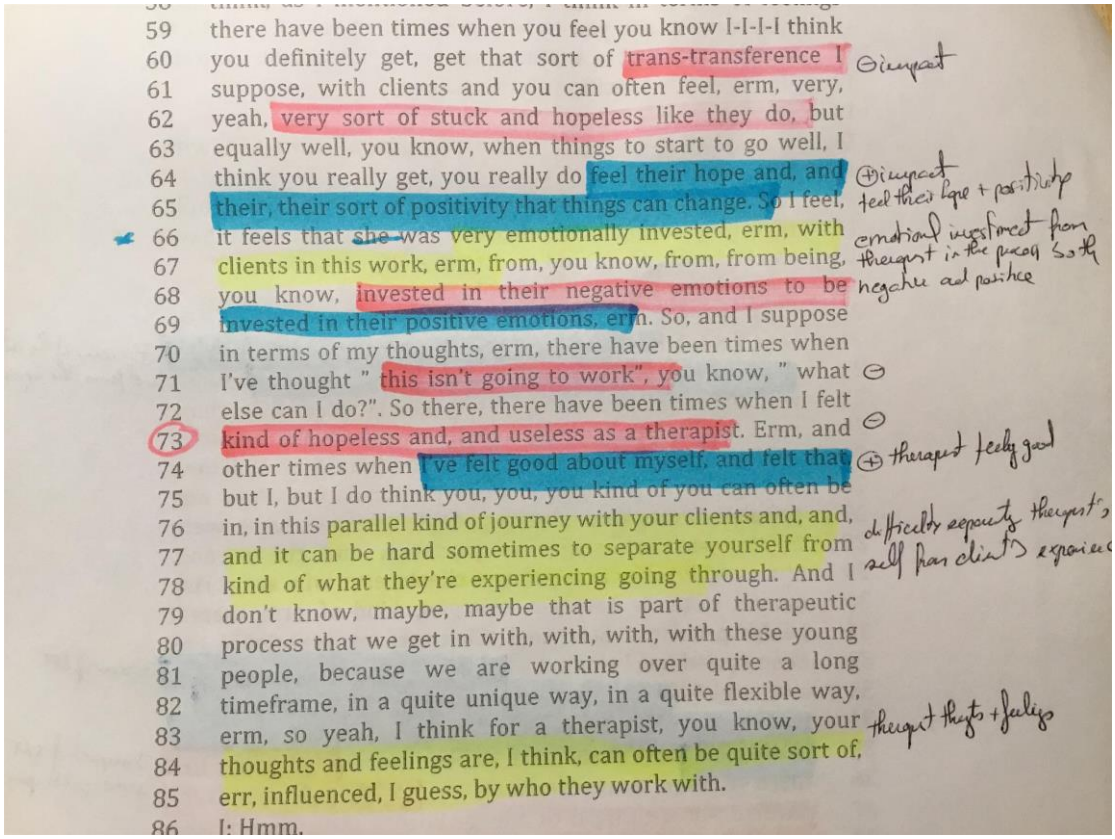


peer supervision, it works really, really well. I think the peer supervision is really helpful, but the, erm, having individual supervision with the head of therapy it's also crucial, because it's kind of, erm, creates the, the right pace for you to share you thoughts, your emotions so it's not so professional base, its more like your own experience with the cases because you have no one to be around you. So it's, it's more individual and you can actually, you know, share what are your frustrations, what went wrong, you know, you, you can give it a bit more of yourself and you don't feel being judged or, you know, criticised. So, and the other positive thing of the individual supervision is the, is the feedback that is very focused on the specific case clashing with your own personality. So it's, it's more specific, and it's more, I think it's slightly on a different level of the peer supervision. So, one thing is more like in a clinical discussion situation when you can share, you know, you can see with other cases that there are a lot of similarities, the other thing is when you've got your own safe place and you can actually talk about what you feel and how you feel about the case and you have a kind of a more individual support that, I think, makes a difference in good way.

I: Okay. Are there any other kinds of things, erm, that you think would be useful and important for supervision and support for therapists using a SRT?

+ between grp supervision and individual:

observing + cases and their similarities and ~~[illegible]~~ a being in a safe space you can give a bit more of ~~you~~ yourself and not feel judged or criticised



there have been times when you feel you know I-I-I-I think you definitely get, get that sort of trans-transference I suppose, with clients and you can often feel, erm, very, yeah, very sort of stuck and hopeless like they do, but equally well, you know, when things to start to go well, I think you really get, you really do feel their hope and, and their, their sort of positivity that things can change. So I feel, it feels that she was very emotionally invested, erm, with clients in this work, erm, from, you know, from, from being, you know, invested in their negative emotions to be invested in their positive emotions, erm. So, and I suppose in terms of my thoughts, erm, there have been times when I've thought " this isn't going to work", you know, " what else can I do?". So there, there have been times when I felt kind of hopeless and, and useless as a therapist. Erm, and other times when I've felt good about myself, and felt that but I, but I do think you, you, you kind of you can often be in, in this parallel kind of journey with your clients and, and, and it can be hard sometimes to separate yourself from kind of what they're experiencing going through. And I don't know, maybe, maybe that is part of therapeutic process that we get in with, with, with, with these young people, because we are working over quite a long timeframe, in a quite unique way, in a quite flexible way, erm, so yeah, I think for a therapist, you know, your thoughts and feelings are, I think, can often be quite sort of, err, influenced, I guess, by who they work with.

I: Hmm.

⊖ impact

⊕ impact feel their hope + positivity

emotional investment from therapist in the process both negative and positive

⊖

⊖

⊕ therapist feeling good

difficulty separating therapist's self from client's experience

therapist thoughts + feelings

will try to get on his own? I don't know. Erm,
I: Hmm.
R: So I-I guess ch..., what will change in the longer term for him, I'm not sure. So, I guess, I guess from me that feels like a bit of a therapeutic kind of failure in that, what, what have we really achieved. But, I guess it's about trying to be a bit more objective, about what we can achieve some clients in the space and time that we've got, with a lifetime, difficulties, erm, yeah.
I: In, in terms of h-how it feel for you, erm, how, how do you make sense of it, what does it mean to you?
R: Wha-what does what mean to me then?
I: The sense of how therapy went
R: for him?
I: and how it impacted on you as a therapist?
R: I think it, I-I think it, it was a difficult, because it was my first case, so it didn't make me go into the, sort of, rest of therapy feeling positive, erm, I think it lowered my, erm, it lowered my expectations of what was possible, erm, I think at times it made me feel frustrated, and sort of hopeless, and, and as I say, stuck, erm, but I think you can also use those feelings as a way of kind of getting in and kind of getting in, or climbing inside someone's head and understand what things feel like for them
(mobile txt sound)
I: Sorry our mobiles decided to...

felt like therapeutic failure

being objective about what is accomplished in therapy in the context of difficulties

lowered expectations frustration, hopelessness stuck

these feelings may be an important part of the process

I: Hmm, and how did you address that?
P: Hmm, again it was hard, hmm, and rethink about the case, erm, trying to find answers why the person is not coming, why it's not engaging, so it was very centred on myself, and on my skills instead of trying to put things into perspective.
I: Hmm, can you tell me a little bit more about that?
P: So, basically the main thing is what I've could done that, erm, could change the course of the engagement, erm, it was something that I did, did I miss anything, did I, so it's all about my own failure, about my own skills a not so much about, erm, the client and that was the bit of the struggle with the, you know where I think it didn't went good, it was because of the high DNA rates and not engaging with the therapy. And basically the way I was reading this process was because I were not, I was not doing the right thing, instead of put things into perspective.
I: Hmm, and how did that make you feel what did that mean to you?
P: It made me feel frustrated and erm, the way to cope with it was basically it meant that I think it was not the therapy, it's not the protocol, it was about myself. So, it did made feel obviously upset sometimes. But it was all about managing erm, high levels of frustration.
I: Hmm, and how did you would address that?
P: Supervision meetings erm, share the clinical case, and, and revise carefully every single session.
I: Hmm, what was the impact in terms of the therapeutic

looks at own skills and therapist when engagement issues

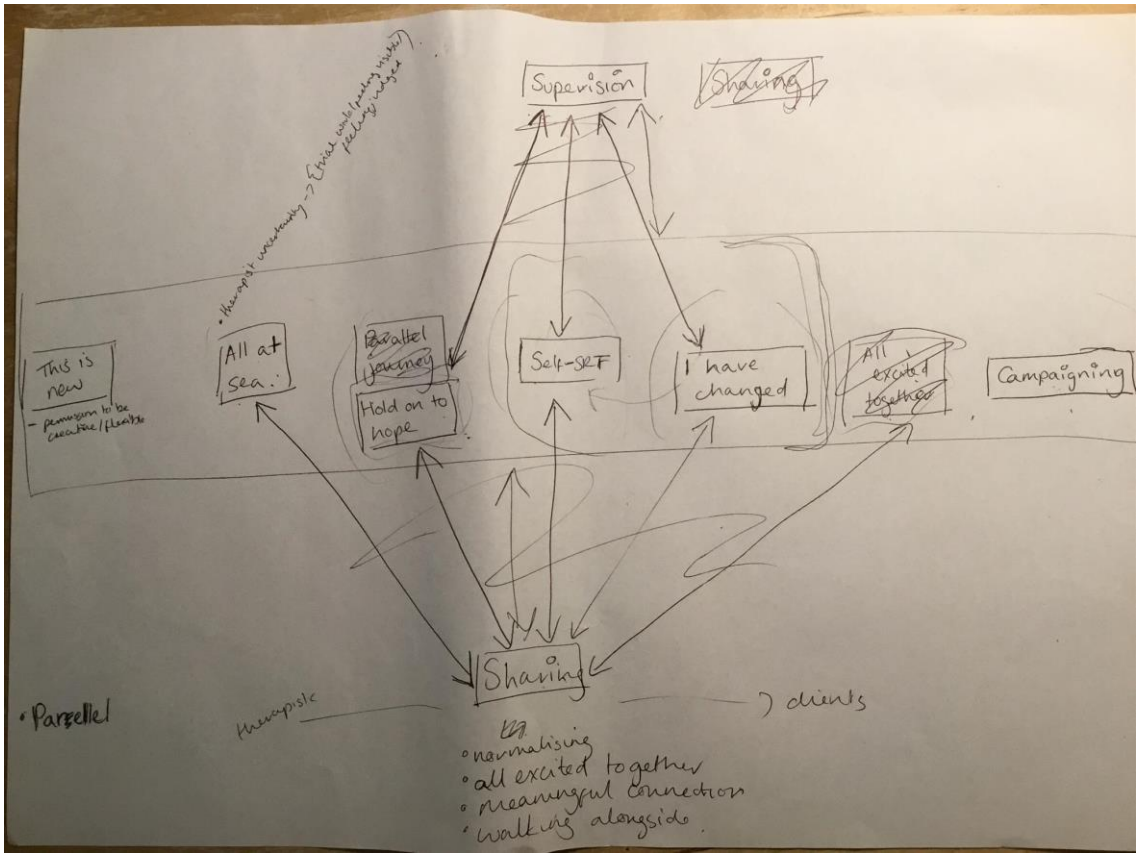
difficulty putting things in perspective when facing challenging cases "I was not doing the right thing"

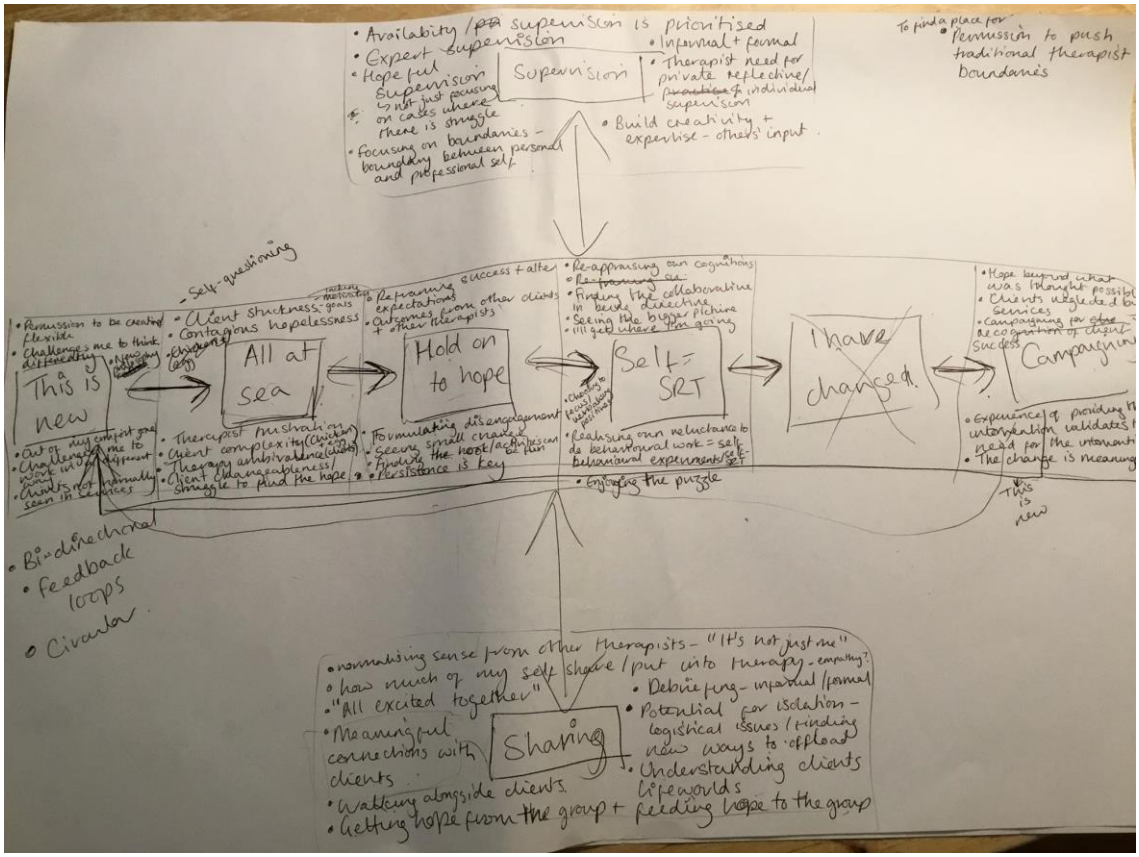
frustration it was about myself upset sometimes

share clinical case in supervision

Appendix J

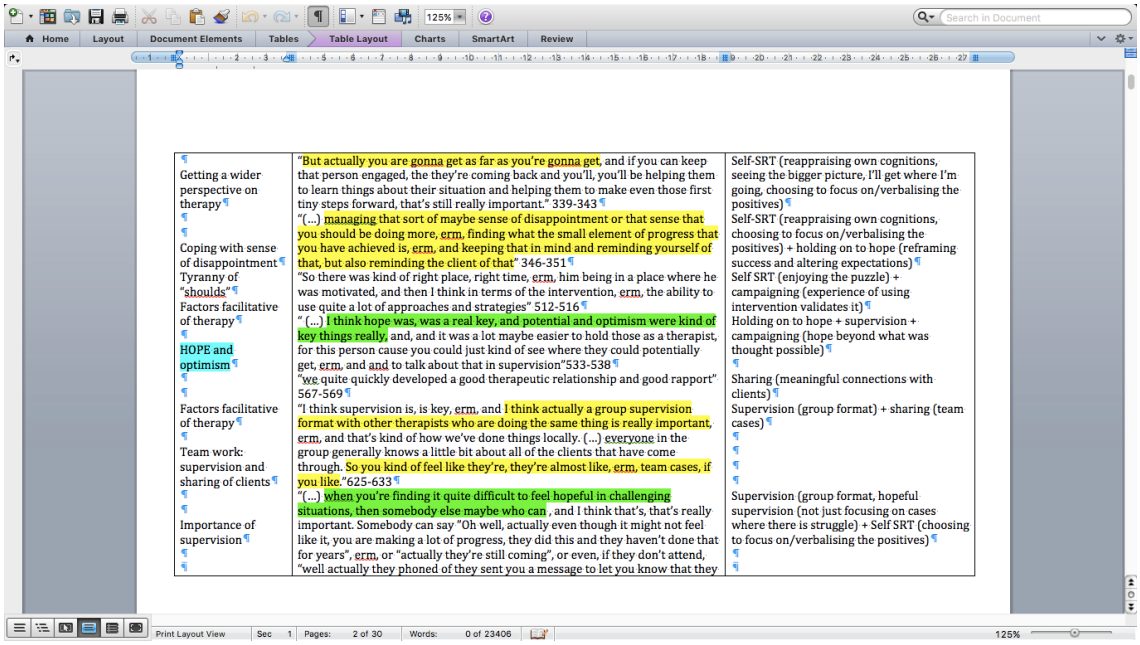
Research Report: Photo of initial coding diagrams (example)


Supervision
Sharing
This is new
All at sea
Hold on to hope
Self-SRT
I have changed
Campaigning
Sharing
clients
normalising
all excited together
meaningful connection
walking alongside

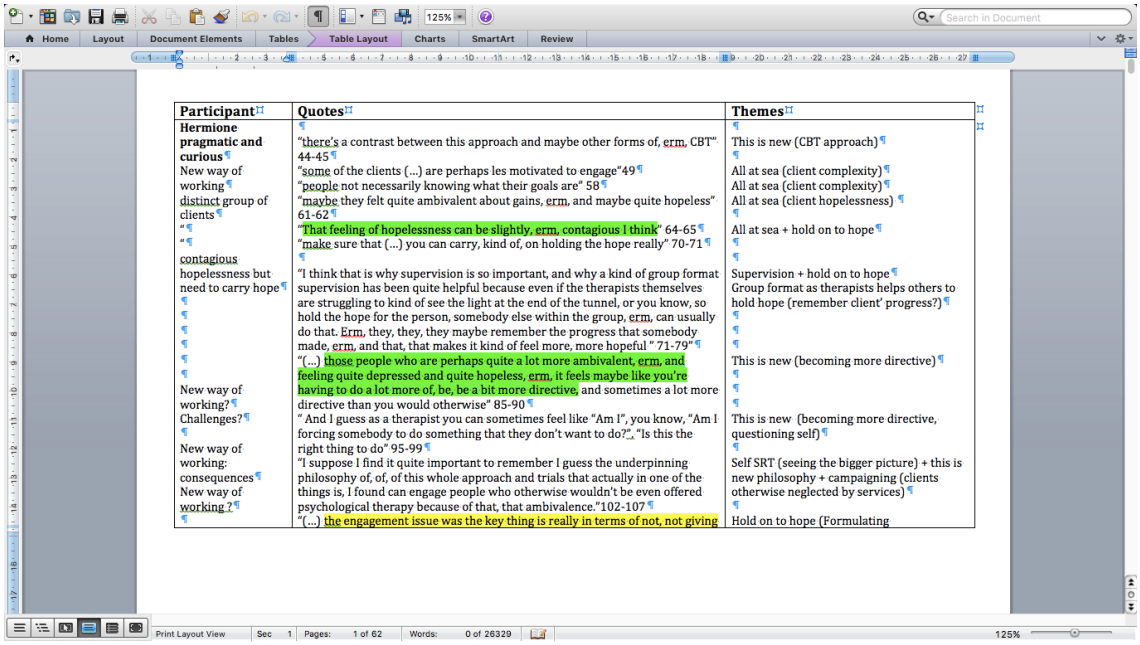

Supervision
This is new
All at sea
Hold on to hope
Self-SRT
I have changed
Campaigning
Sharing
normalising sense from other therapists
"All excited together"
Meaningful connections with clients
Watching alongside clients
Getting hope from the group + feeding hope to the group

Appendix K

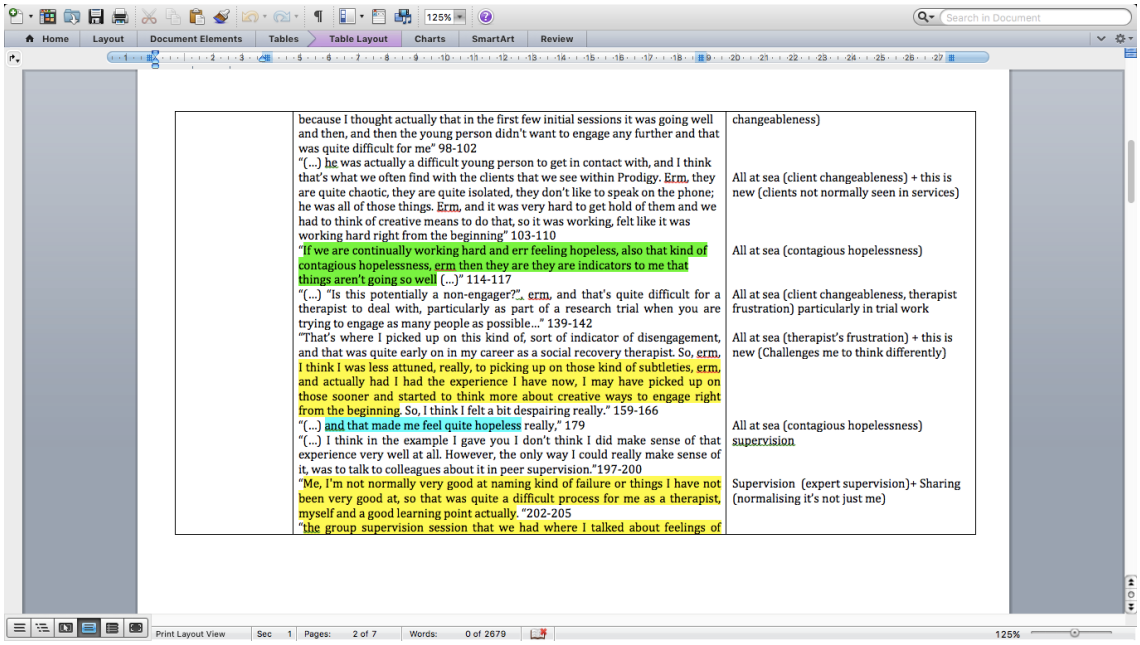
Research Report: Screenshot of emerging themes (example)



¶ Getting a wider perspective on therapy¶ ¶ ¶ Coping with sense of disappointment¶ Tyranny of "shoulds"¶ Factors facilitative of therapy¶ ¶ HOPE and optimism¶ ¶ ¶ Factors facilitative of therapy¶ ¶ Team work: supervision and sharing of clients¶ ¶ ¶ Importance of supervision¶ ¶ ¶	"But actually you are gonna get as far as you're gonna get, and if you can keep that person engaged, the they're coming back and you'll, you'll be helping them to learn things about their situation and helping them to make even those first tiny steps forward, that's still really important." 339-343¶ "(…) managing that sort of maybe sense of disappointment or that sense that you should be doing more, erm, finding what the small element of progress that you have achieved is, erm, and keeping that in mind and reminding yourself of that, but also reminding the client of that" 346-351¶ "So there was kind of right place, right time, erm, him being in a place where he was motivated, and then I think in terms of the intervention, erm, the ability to use quite a lot of approaches and strategies" 512-516¶ " (…) I think hope was, was a real key, and potential and optimism were kind of key things really, and, and it was a lot maybe easier to hold those as a therapist, for this person cause you could just kind of see where they could potentially get, erm, and and to talk about that in supervision"533-538¶ "we quite quickly developed a good therapeutic relationship and good rapport" 567-569¶ "I think supervision is, is key, erm, and I think actually a group supervision format with other therapists who are doing the same thing is really important, erm, and that's kind of how we've done things locally. (…) everyone in the group generally knows a little bit about all of the clients that have come through. So you kind of feel like they're, they're almost like, erm, team cases, if you like."625-633¶ "(…) when you're finding it quite difficult to feel hopeful in challenging situations, then somebody else maybe who can , and I think that's, that's really important. Somebody can say "Oh well, actually even though it might not feel like it, you are making a lot of progress, they did this and they haven't done that for years", erm, or "actually they're still coming", or even, if they don't attend, "well actually they phoned of they sent you a message to let you know that they	Self-SRT (reappraising own cognitions, seeing the bigger picture, I'll get where I'm going, choosing to focus on/verbalising the positives)¶ Self-SRT (reappraising own cognitions, choosing to focus on/verbalising the positives) + holding on to hope (reframing success and altering expectations)¶ Self SRT (enjoying the puzzle) + campaigning (experience of using intervention validates it)¶ Holding on to hope + supervision + campaigning (hope beyond what was thought possible)¶ ¶ Sharing (meaningful connections with clients)¶ Supervision (group format) + sharing (team cases)¶ ¶ ¶ ¶ ¶ Supervision (group format, hopeful supervision (not just focusing on cases where there is struggle) + Self SRT (choosing to focus on/verbalising the positives)¶ ¶ ¶



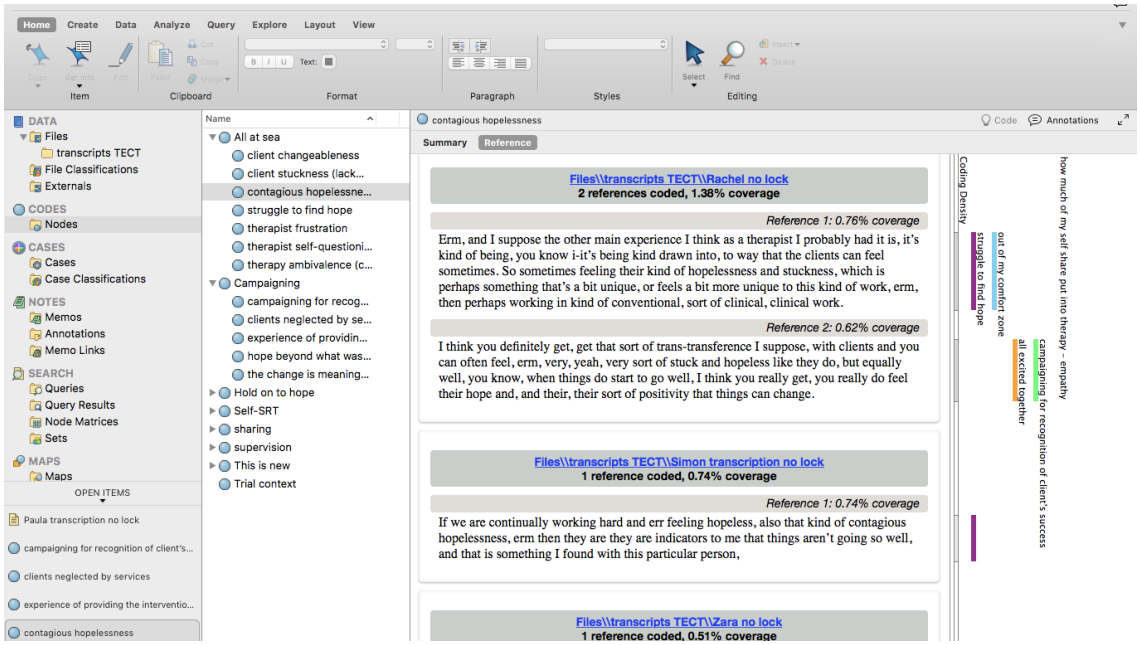
Participant	Quotes	Themes
Hermione pragmatic and curious¶ New way of working¶ distinct group of clients¶ "¶ "¶ contagious hopelessness but need to carry hope¶ ¶ ¶ ¶ ¶ ¶ ¶ New way of working?¶ Challenges?¶ ¶ New way of working: consequences¶ New way of working ?¶ ¶	¶ "there's a contrast between this approach and maybe other forms of, erm, CBT" 44-45¶ "some of the clients (…) are perhaps les motivated to engage"49¶ "people not necessarily knowing what their goals are" 58¶ "maybe they felt quite ambivalent about gains, erm, and maybe quite hopeless" 61-62¶ "That feeling of hopelessness can be slightly, erm, contagious I think" 64-65¶ "make sure that (…) you can carry, kind of, on holding the hope really" 70-71¶ ¶ "I think that is why supervision is so important, and why a kind of group format supervision has been quite helpful because even if the therapists themselves are struggling to kind of see the light at the end of the tunnel, or you know, so hold the hope for the person, somebody else within the group, erm, can usually do that. Erm, they, they, they maybe remember the progress that somebody made, erm, and that, that makes it kind of feel more, more hopeful " 71-79"¶ "(…) those people who are perhaps quite a lot more ambivalent, erm, and feeling quite depressed and quite hopeless, erm, it feels maybe like you're having to do a lot more of, be, be a bit more directive, and sometimes a lot more directive than you would otherwise" 85-90¶ " And I guess as a therapist you can sometimes feel like "Am I", you know, "Am I forcing somebody to do something that they don't want to do?", "Is this the right thing to do" 95-99¶ "I suppose I find it quite important to remember I guess the underpinning philosophy of, of, of this whole approach and trials that actually in one of the things is, I found can engage people who otherwise wouldn't be even offered psychological therapy because of that, that ambivalence."102-107¶ "(…) the engagement issue was the key thing is really in terms of not, not giving	¶ This is new (CBT approach)¶ ¶ All at sea (client complexity)¶ All at sea (client complexity)¶ All at sea (client hopelessness) ¶ ¶ All at sea + hold on to hope¶ ¶ ¶ Supervision + hold on to hope¶ Group format as therapists helps others to hold hope (remember client' progress?)¶ ¶ ¶ ¶ This is new (becoming more directive)¶ ¶ ¶ This is new (becoming more directive, questioning self)¶ ¶ Self SRT (seeing the bigger picture) + this is new philosophy + campaigning (clients otherwise neglected by services)¶ ¶ Hold on to hope (Formulating



	because I thought actually that in the first few initial sessions it was going well and then, and then the young person didn't want to engage any further and that was quite difficult for me" 98-102	changeableness)
	"(…) he was actually a difficult young person to get in contact with, and I think that's what we often find with the clients that we see within Prodigy. Erm, they are quite chaotic, they are quite isolated, they don't like to speak on the phone; he was all of those things. Erm, and it was very hard to get hold of them and we had to think of creative means to do that, so it was working, felt like it was working hard right from the beginning" 103-110	All at sea (client changeableness) + this is new (clients not normally seen in services)
	"If we are continually working hard and err feeling hopeless, also that kind of contagious hopelessness, erm then they are they are indicators to me that things aren't going so well (…)" 114-117	All at sea (contagious hopelessness)
	"(…) "Is this potentially a non-engager?", erm, and that's quite difficult for a therapist to deal with, particularly as part of a research trial when you are trying to engage as many people as possible…" 139-142	All at sea (client changeableness, therapist frustration) particularly in trial work
	"That's where I picked up on this kind of, sort of indicator of disengagement, and that was quite early on in my career as a social recovery therapist. So, erm, I think I was less attuned, really, to picking up on those kind of subtleties, erm, and actually had I had the experience I have now, I may have picked up on those sooner and started to think more about creative ways to engage right from the beginning. So, I think I felt a bit despairing really." 159-166	All at sea (therapist's frustration) + this is new (Challenges me to think differently)
	"(…) and that made me feel quite hopeless really," 179	All at sea (contagious hopelessness)
	"(…) I think in the example I gave you I don't think I did make sense of that experience very well at all. However, the only way I could really make sense of it, was to talk to colleagues about it in peer supervision."197-200	supervision
	"Me, I'm not normally very good at naming kind of failure or things I have not been very good at, so that was quite a difficult process for me as a therapist, myself and a good learning point actually. "202-205	Supervision (expert supervision)+ Sharing (normalising it's not just me)
	"the group supervision session that we had where I talked about feelings of	

Appendix L

Research Report: Screenshot of NVivo with codes (example)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contagious hopelessness
Name
All at sea
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contagious hopelessne...
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hope beyond what was...
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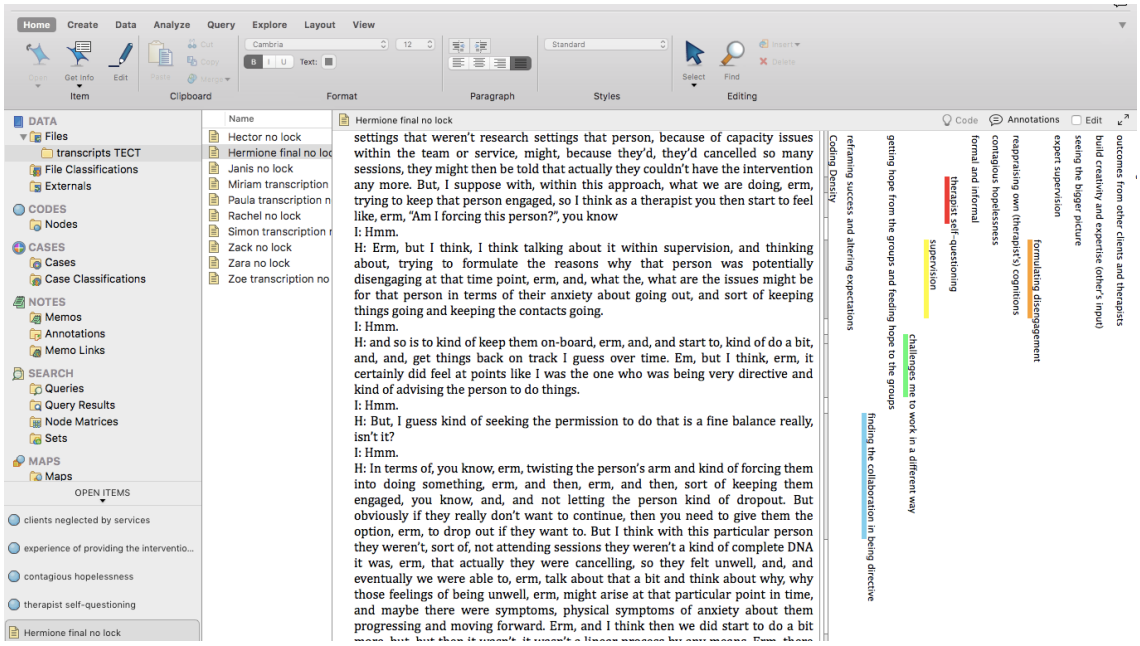
Hold on to hope
Self-SRT
sharing
supervision
This is new
Trial context
contagious hopelessness
Code
Annotations
Summary
Reference
Files\\transcripts TECT\\Rachel no lock
2 references coded, 1.38% coverage
Reference 1: 0.76% coverage
Erm, and I suppose the other main experience I think as a therapist I probably had it is, it's kind of being, you know i-it's being kind drawn into, to way that the clients can feel sometimes. So sometimes feeling their kind of hopelessness and stuckness, which is perhaps something that's a bit unique, or feels a bit more unique to this kind of work, erm, then perhaps working in kind of conventional, sort of clinical, clinical work.
Reference 2: 0.62% coverage
I think you definitely get, get that sort of trans-transference I suppose, with clients and you can often feel, erm, very, yeah, very sort of stuck and hopeless like they do, but equally well, you know, when things do start to go well, I think you really get, you really do feel their hope and, and their, their sort of positivity that things can change.
Files\\transcripts TECT\\Simon transcription no lock
1 reference coded, 0.74% coverage
Reference 1: 0.74% coverage
If we are continually working hard and err feeling hopeless, also that kind of contagious hopelessness, erm then they are they are indicators to me that things aren't going so well, and that is something I found with this particular person,
Files\\transcripts TECT\\Zara no lock
1 reference coded, 0.51% coverage
Coding Density
how much of my self share put into therapy - empathy
campaigning for recognition of client's success
all excited together
out of my comfort zone
struggle to find hope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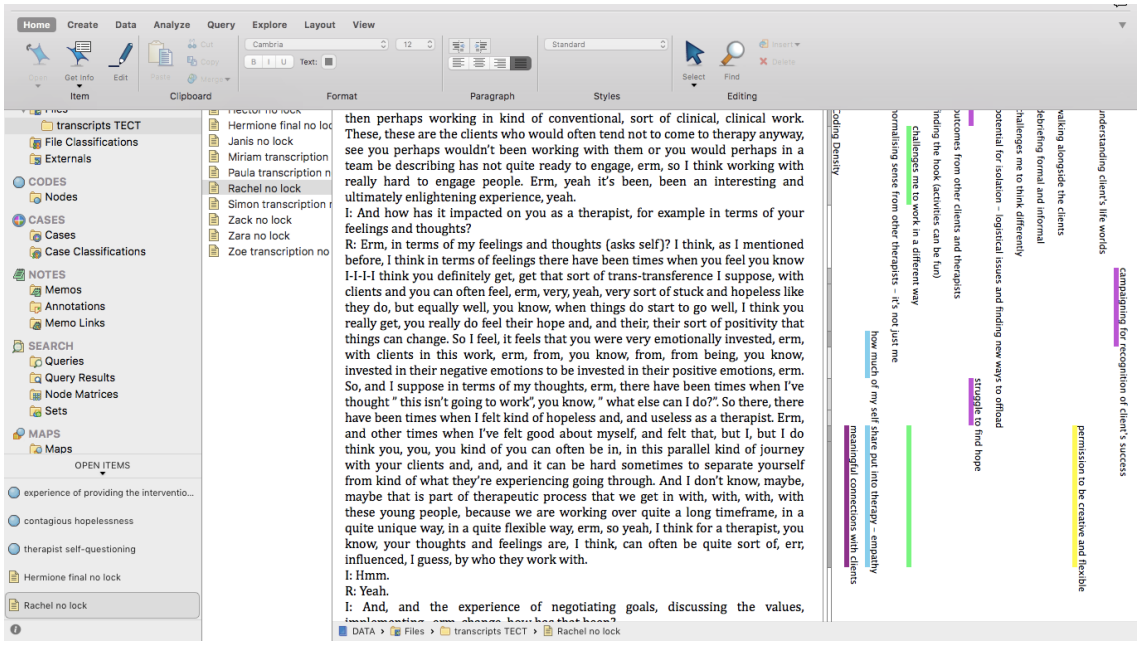
settings that weren't research settings that person, because of capacity issues within the team or service, might, because they'd, they'd cancelled so many sessions, they might then be told that actually they couldn't have the intervention any more. But, I suppose with, within this approach, what we are doing, erm, trying to keep that person engaged, so I think as a therapist you then start to feel like, erm, "Am I forcing this person?", you know
I: Hmm.
H: Erm, but I think, I think talking about it within supervision, and thinking about, trying to formulate the reasons why that person was potentially disengaging at that time point, erm, and, what the, what are the issues might be for that person in terms of their anxiety about going out, and sort of keeping things going and keeping the contacts going.
I: Hmm.
H: and so is to kind of keep them on-board, erm, and, and start to, kind of do a bit, and, and, get things back on track I guess over time. Em, but I think, erm, it certainly did feel at points like I was the one who was being very directive and kind of advising the person to do things.
I: Hmm.
H: But, I guess kind of seeking the permission to do that is a fine balance really, isn't it?
I: Hmm.
H: In terms of, you know, erm, twisting the person's arm and kind of forcing them into doing something, erm, and then, erm, and then, sort of keeping them engaged, you know, and, and not letting the person kind of dropout. But obviously if they really don't want to continue, then you need to give them the option, erm, to drop out if they want to. But I think with this particular person they weren't, sort of, not attending sessions they weren't a kind of complete DNA it was, erm, that actually they were cancelling, so they felt unwell, and, and eventually we were able to, erm, talk about that a bit and think about why, why those feelings of being unwell, erm, might arise at that particular point in time, and maybe there were symptoms, physical symptoms of anxiety about them progressing and moving forward. Erm, and I think then we did start to do a bit
Coding Density
reframing success and altering expectations
getting hope from the groups and feeding hope to the groups
finding the collaboration in being directive
challenges me to work in a different way
supervision
therapist self-questioning
formal and informal
contagious hopelessness
reappraising own (therapist's) cognitions
formulating disengagement
expert supervision
seeing the bigger picture
build creativity and expertise (other's input)
outcomes from other clients and therapists


then perhaps working in kind of conventional, sort of clinical, clinical work. These, these are the clients who would often tend not to come to therapy anyway, see you perhaps wouldn't been working with them or you would perhaps in a team be describing has not quite ready to engage, erm, so I think working with really hard to engage people. Erm, yeah it's been, been an interesting and ultimately enlightening experience, yeah.
I: And how has it impacted on you as a therapist, for example in terms of your feelings and thoughts?
R: Erm, in terms of my feelings and thoughts (asks self)? I think, as I mentioned before, I think in terms of feelings there have been times when you feel you know I-I-I-I think you definitely get, get that sort of trans-transference I suppose, with clients and you can often feel, erm, very, yeah, very sort of stuck and hopeless like they do, but equally well, you know, when things do start to go well, I think you really get, you really do feel their hope and, and their, their sort of positivity that things can change. So I feel, it feels that you were very emotionally invested, erm, with clients in this work, erm, from, you know, from, from being, you know, invested in their negative emotions to be invested in their positive emotions, erm. So, and I suppose in terms of my thoughts, erm, there have been times when I've thought " this isn't going to work", you know, " what else can I do?". So there, there have been times when I felt kind of hopeless and, and useless as a therapist. Erm, and other times when I've felt good about myself, and felt that, but I, but I do think you, you, you kind of you can often be in, in this parallel kind of journey with your clients and, and, and it can be hard sometimes to separate yourself from kind of what they're experiencing going through. And I don't know, maybe, maybe that is part of therapeutic process that we get in with, with, with, with these young people, because we are working over quite a long timeframe, in a quite unique way, in a quite flexible way, erm, so yeah, I think for a therapist, you know, your thoughts and feelings are, I think, can often be quite sort of, err, influenced, I guess, by who they work with.
I: Hmm.
R: Yeah.
I: And, and the experience of negotiating goals, discussing the values,
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Zoe transcription
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permission to be creative and flexible
struggle to find hope
how much of my self share put into therapy – empathy
meaningful connections with clients
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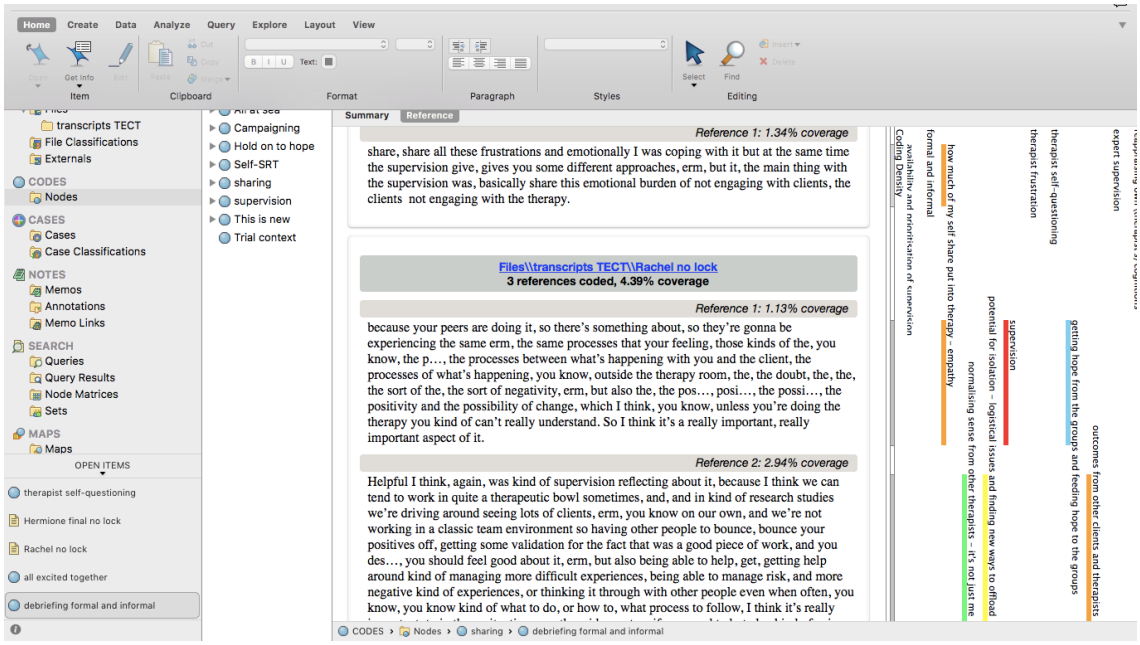
Summary
Reference
Reference 1: 1.34% coverage
share, share all these frustrations and emotionally I was coping with it but at the same time the supervision give, gives you some different approaches, erm, but it, the main thing with the supervision was, basically share this emotional burden of not engaging with clients, the clients not engaging with the therapy.
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3 references coded, 4.39% coverage
Reference 1: 1.13% coverage
because your peers are doing it, so there's something about, so they're gonna be experiencing the same erm, the same processes that your feeling, those kinds of the, you know, the p…, the processes between what's happening with you and the client, the processes of what's happening, you know, outside the therapy room, the, the doubt, the, the, the sort of the, the sort of negativity, erm, but also the, the pos…, posi…, the possi…, the positivity and the possibility of change, which I think, you know, unless you're doing the therapy you kind of can't really understand. So I think it's a really important, really important aspect of it.
Reference 2: 2.94% coverage
Helpful I think, again, was kind of supervision reflecting about it, because I think we can tend to work in quite a therapeutic bowl sometimes, and, and in kind of research studies we're driving around seeing lots of clients, erm, you know on our own, and we're not working in a classic team environment so having other people to bounce, bounce your positives off, getting some validation for the fact that was a good piece of work, and you des…, you should feel good about it, erm, but also being able to help, get, getting help around kind of managing more difficult experiences, being able to manage risk, and more negative kind of experiences, or thinking it through with other people even when often, you know, you know kind of what to do, or how to, what process to follow, I think it's really
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Campaigning
Hold on to hope
Self-SRT
sharing
supervision
This is new
Trial context
therapist self-questioning
Hermione final no lock
Rachel no lock
all excited together
debriefing formal and informal
expert supervision
therapist self-questioning
therapist frustration
getting hope from the groups and feeding hope to the groups
outcomes from other clients and therapists
supervision
potential for isolation – logistical issues and finding new ways to offload
normalising sense from other therapists – it's not just me
how much of my self share put into therapy – empathy
formal and informal
CODES › Nodes › sharing › debriefing formal and informal