Evaluating the Effectiveness of Conversational Therapy Skills Training for Psychological Well-being Practitioners

A thesis submitted to the University of Manchester for the Degree of

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Glossary of Acronyms

CBT	Cognitive Behavioural Therapy
CCS	Counseling Competencies Scale
CNA	Could not attend (cancelled)
CPD	Continued professional development
CRQ	Counselor Response Questionnaire
CSPT	Communication skills progress test
DNA	Did not attend
EMM	Estimated marginal means
ERS	Empathy Rating Scale
FA	Framework analysis
G1	Group 1
G2	Group 2
GAD	Generalised Anxiety Disorder
GEE	Generalised Estimating Equations
GSH	Guided self-help
HSCIC	Health and Social Care Information Centre
IAPT	Increasing Access to Psychological Therapy
IRI	Interpersonal Reactivity Index
LI	Low intensity
LI-CBT	Low intensity Cognitive Behavioural Therapy
MOL	Method of Levels
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PD	Personality Disorder
PHQ	Patient Health Questionnaire
PI-E	Psychodynamic Interpersonal Empathy (Skills training)
PIT	Psychodynamic Interpersonal Therapy
PWP	Psychological Well-being Practitioner
SD	Standard deviation
SE (Std. Error)	Standard Error
SRS	Session Rating Scale
T1	Time point 1
T2	Time point 2
T3	Time point 3
TA	Thematic Analysis
TTM	Triad Training Model
UK	United Kingdom
US	United States

Thesis Abstract

Evaluating the Effectiveness of Conversational Therapy Skills Training for Psychological Well-being Practitioners

Anna Phyllis Taylor
A thesis submitted to the University of Manchester
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The aim of this thesis was to explore whether a training package based on Conversational Therapy[1] is effective in enhancing empathy within Psychological Well-Being Practitioners (PWPs). The thesis is presented as four separate papers. Paper One is a narrative review of the literature on training empathy to psychological therapists, including other factors which are considered to enhance empathy. The review highlights that as empathy is a multi-faceted concept, different approaches are required to enhance certain elements. An apparent combination of experiential learning with feedback and clinical practice combined with clinical supervision is required for empathy to be enhanced. However, further research is required into the effectiveness of empathy training for qualified psychological therapists.

Paper two is a qualitative study exploring the experiences of PWPs learning and putting into practice the skills taught within the training programme. Semi-structured interviews were conducted with fourteen PWPs. Data was analysed using a thematic analysis and themes were generated relating to PWPs experiences of the training and learning the techniques. The results suggest that learning more conversational and relational techniques supplemented PWPs current way of working. The training appeared to help increase their empathy and understanding of clients presenting difficulties. Some improvements to the job satisfaction and self-efficacy of PWPs were also apparent. Adopting the techniques did however pose some challenges, especially in relation to moving away from a PWPs current practice.

Paper three is an empirical service evaluation of the effects of the skills training on clinical outcomes. The evaluation did not find any significant results, however findings relating to a reduction in non-attendance in sessions were promising. Possible explanations and interpretations of the findings are discussed alongside suggestions for future research.

Paper four is a critical reflection of the processes involved in conducting the project. This paper provides further detail on the methodology and decision making processes which took place within the research, alongside considering the strengths, limitations, implications and suggestions for future research. This paper concludes with personal reflections on the thesis project.

[1] Referred to hereinafter as Psychodynamic Interpersonal Empathy (PI-E) skills training

Declaration

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Paper One

Can Psychological Therapists be trained to be more empathic? A review of the literature

This paper has been prepared in accordance with the author guidelines of

Clinical Psychology Review (Appendix 1)

Can Psychological Therapists be trained to be more empathic? A review of the literature

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Abstract

Empathy is often considered to be a significant predictor of outcome in therapeutic interventions. It is therefore important that ways of maximising empathy are explored. This review aims to bring together the findings of factors which can affect empathy levels in psychological therapists and whether empathy in psychological therapists can be enhanced. Methods of enhancing empathy and empathy training are discussed including the importance of; experiential learning including role-play and feedback, creative exercises, clinical practice and supervision; enhancement in communication skills plus self-reflection and mindfulness. This paper concludes that empathy is a multi-dimensional construct and therefore educational programmes for psychological therapists need to employ a combination of approaches to enhance both cognitive and affective empathy.

Key words: Empathy, Training, Therapist education, Experiential learning, Therapist Development

Highlights:

- Literature review of enhancing empathy within psychological therapists
- Most research focuses on enhancing empathy by experiential learning
- Clinical practice and supervision are necessary to supplement empathy training

Can Psychological Therapists be trained to be more empathic? A review of the literature

Introduction

Empathy has long been regarded as a central component of psychological therapy. Empathy can be described as the process whereby psychological therapists sense the personal feelings and meanings experienced by their client, and then communicate their empathic understanding effectively (Rogers, 1967). The importance of empathy within therapy has been well supported. One meta-analytic review identified that empathy accounts for 7-10% of the variance in therapeutic outcome (Bohart, Elliot, Greenberg & Watson, 2002). Empathy is also a significant predictor of clinical change when working with depression using a Cognitive Behavioural Therapy approach (CBT; Burns & Nolen-Hoeksema, 1992), with clients who rate their therapists as empathic being more likely to experience positive change (Watson, Steckley & McMullen, 2014). Empathy is therefore an important concept to understand and to cultivate within therapists.

Review rationale

Due to the importance of therapeutic empathy, there is a surprising gap in the literature for a review on how empathy can be enhanced within psychological therapists. Several reviews have studied empathy training within the broader health-professions (Hojat, 2009; Lam, Kolomitro & Alamparambil, 2011; Teding van Berkhot & Malouff, 2016) and have found training in empathy can be effective. However, it is considered the results of such reviews are not completely generalisable to psychological therapists. The present review aims to expand on a narrative review conducted by Bayne and Jangha (2016) which described ways to enhance empathy in counsellors using improvisation and creative techniques. The current review aims to broaden the scope by examining the effectiveness and content of empathy training programmes across all psychological therapists and therapists-in-training. As preliminary scoping searches revealed limited research specifically examining empathy training in therapists, a decision was also taken to also incorporate research describing communication and therapy micro-skills training. Advanced accurate empathy is a micro-skill trained in these programmes (Lang, van de Molen, Trower & Look, 1990) and although not directly measuring empathy, the ability of a therapist to be able to reflect and summarise a client's distress is hypothesised to require a level of empathic attunement. Research by Riggio, Tucker and Coffaro (1989) found social skills to be correlated with empathy and recommended

that empathy could even be best viewed as a collection of social and communication skills. Improvements in counselling communication could therefore be correlated with empathy and should also be discussed. The review also aims to explore and describe other factors which may impact empathy in psychological therapists to provide the reader with an overview of additional factors which can influence therapist empathy. Due to the broad scope of this review, a narrative approach has been employed[2]. Nevertheless, a systematic approach to searching for relevant papers was conducted.

Search strategy

Although this review does not claim to be systematic, systematic searches were conducted to identify key papers relevant to enhancing empathy in therapists. Papers were identified for inclusion via searching PsycINFO, EMBASE and MEDLINE. Search terms included Empath* to ensure all papers relating to empathy were identified combined with training and therapist related phrases. The use of truncations maximised the number of papers identified and searches were performed at the title and abstract level. A full list of search terms used can be seen in Table 1. No limits were placed on the searches. Papers were also identified via searching Google Scholar and via searching reference lists of key papers. The search yielded a total of 1552 papers which were all reviewed at title level. The most relevant papers (256) were then read at abstract level and 69 papers were then chosen to be read at full text.

Table 1. Database search terms for identifying papers relating to empathy training

Empathy related words	**Training related words**		**Therapist related words**
Empath*	Train*	Develop*	Therap*
	Educat*	Gain*	Couns*
	Learn*	Taught	Psycholog*
	Teach*	Coach*	Psychotherap*
	Increas*	Upkill*	
	Impact*	Enchanc*	

After reviewing the papers at full text, only a limited number purely investigated the training of empathy in therapists or student therapists. Most studies read at full-text assessed empathy levels in other health-care professions. Although there may be some similarities between these professions and psychological therapists, there are also many differences and therefore such papers have not been included in the review. A total of

[2] See Paper 3 – Critical Reflection page 103 for further rationale for the use of a narrative review

12 papers were selected for inclusion which related specifically to empathy training or counselling skills training in either qualified psychological therapists or therapists in training. The search results indicated and informed the use of a narrative review due to the wide variation of samples, research methodology and different research aims within the identified papers. A descriptive and qualitative approach to reviewing the papers was therefore considered the most appropriate to convey the key messages and findings identified.

In addition to the searches for papers relating to empathy training, additional literature searches were also completed to identify the research relating to internal and external factors which can impact on levels of therapist empathy. These findings will be outlined in the review prior to the main search results, to provide background to the construct of empathy and provide context for the importance of empathy training.

Therapist empathy

Defining empathy

Although most therapists would argue they understand what empathy is, it has been conceptualised and defined in over 40 different ways within psychological research (Cuff, Brown, Taylor & Howat, 2016). There is debate whether empathy is an experiential process, a personality trait or a state of being (Trusty, Ng & Watts, 2005) and empathy can also be confused with similar concepts of compassion, sympathy and validation (Thwaites & Bennett-Levy, 2007). The term therapeutic empathy may be more appropriate to describe the skills utilised by therapists within clinical sessions, to differentiate from empathy experienced by the general population in everyday scenarios (Burns & Auerbach, 1996). To be able to define and understand the process of empathy more accurately, the concept is broken down into different components. Gladstein (1983), for example, spoke of *cognitive empathy*, the ability to understand how another person might be feeling through perspective taking, and *affective empathy*, a person's ability to feel another's emotion.

In developing a concept of empathy that applies to CBT, Thwaites and Bennett-Levy (2007) described four components of empathy: empathic attunement, empathic stance or attitude, empathic communication and knowledge of empathy. They suggest that therapists may use distinct aspects of empathy during different interactions, and that therapists will hold different levels of each component, which will affect their

interactions with clients. For example, it is considered that a therapist with an empathic stance and good empathic attunement may appear warm and interested in the client, but may lack the skills to communicate their understanding of the client's experience. Alternatively, a therapist with an empathic stance and empathic knowledge but poor attunement, may understand empathy intellectually and have good intentions, but may struggle to reflect on emotions felt, both within themselves and their client. Therapists may also have different approaches to empathy, based on their therapeutic style preference and personality type. Studies by Churchill and Bayne (1998; 2001) found therapists who preferred sensing, feeling and perceiving within sessions were more likely to see empathy as a state and have a passive approach to experiencing empathy. Alternatively, therapists who engaged in more judging and thinking, used more intuition and considered empathy as an active process. Overall empathy is best considered a multi-dimensional construct with variation between therapists (Bohart & Greenberg, 1997).

How empathic are therapists?

Recent research on levels of therapeutic empathy appears to be scant. Manickam and Kapur (1985) found that experienced mental health professionals including psychiatrists and clinical psychologists scored significantly higher on empathy ratings during an interview compared to lay counsellors who had recently received a six- month training course. However, a second study by Manickham (1990) found no difference in empathy ratings in the similar sample using a different measure of empathy. A study by Hassensstab, Dziobek, Rogers, Wolf and Convit (2007) compared levels of empathy within therapists and lay persons. Therapists were found to display greater levels of cognitive empathy and were less emotionally affected by the discomfort of others but were equal to controls on measures of affective empathy and reported levels of empathic concern (Hassenstab et al., 2007). Therapists may therefore hold similar levels of affective empathy with the general population, but have greater cognitive empathy and strengths in containing empathic reactions. Although these differences may reflect personality traits of therapists, it seems likely that therapy training also enhances skills in responding to empathy.

Research has identified various individual factors associated with empathy levels within therapists. A body of research has investigated the association between

cognitive development and levels of empathy in counsellors**.** Cognitive skills such as the ability to be flexible, tolerate ambiguity and have maturity of thought are associated with empathy (Jones, 1974; Hansson, 1978; Lovell, 1999; Passons & Olson, 1969), as are levels of ethical and moral development (Bowman & Allen, 1988). Personal factors such as an avoidant attachment style and higher anxiety have also been found to reduce a therapist's ability to respond empathically (Rubino, Barker, Roth & Fearon, 2010; Trusty et al., 2005). There is also evidence that unresolved countertransference can lead to therapists being less empathic. If countertransference is unresolved then therapists are unlikely to be able to fully understand the client's experience, as they will be paying more attention to their own reactions (Giordano, Stare & Clarke, 2015). This could be one reason why personal therapy for therapists is thought to be effective in enhancing empathy. Macran and Shapiro (1998) suggest that personal therapy enhances therapists' awareness of personal difficulties that could be evoked by particular interactions and enables therapists to experience what it feels like to be a client, contributing to their empathic accuracy.

There is also likely to be variation in the individual therapist's levels of empathy over time, according to the different scenarios encountered. Interpretive phenomenological analyses have found that therapists who have shared experiences with a client, such as bereavement, can feel deeper empathic connections (Broadbent, 2013). Conversely, some scenarios (e.g. working with clients who require an interpreter) can mean therapists experience empathic communication to be 'lost in translation' (Pugh & Vetere, 2009). Therefore, empathy levels could fluctuate with different clients, depending on both personal factors within the therapist and any external factors within sessions. Therapists may also vary in their ability to be empathic with clients if they begin to suffer from burnout or empathy fatigue. Such fatigue is considered to occur when people in the helping professions have felt too much of another's distress or develop a secondary trauma from hearing harrowing stories (Figley, 2002; Stebnicki, 2007). Therapists experiencing empathy fatigue may have reduced capacity to hear and respond to distress and need to engage in self-care and adjust their practice accordingly (Stebnicki, 2007).

Methods of enhancing or training empathy

As empathy is a necessary component within therapy, it is important to consider how therapeutic empathy can be enhanced. The importance of effective therapeutic training is long-standing with Truax and Carkhuff (1967) noting little difference in therapeutic skills and empathy between novice and experienced therapists. More recently, negative correlations were found between academic grades and empathy levels of trainee therapists, suggesting that training courses were lacking focus on a key aspect of clinical performance (Ridley, Kelly & Mollen, 2011). Truax and Carkhuff (1967) suggested that training programmes were failing to bridge the gap between theory and practice, meaning students knew how they should behave empathically towards clients, but struggled to verbalise empathy in sessions. Due to empathic variance within therapists and the importance of such empathy in increasing the likelihood of positive outcome in therapy, it is imperative to identify and implement training methods which enhance therapeutic empathy. Table 2 provides a summary of studies reviewed which focus on enhancing empathy via training, education or other developmental methods.

Enhancing empathy by experiential learning

Experiential learning is different to learning via traditional cognitive and behavioural methods as it places a central focus on learning by experience (Kolb, 1984). Many programmes of psychotherapy education therefore include experiential methods and simulated practice to enhance therapeutic skills, including empathy.

Giordano, Clarke and Stare (2015) describe the process whereby counsellors specialising in working with addictions learn via continuous role-plays. The authors explain how each stage of the role-play process fits within the four stages of the learning cycle (Kolb, 1984). Giordano and colleagues (2015) suggest that in clinical workshops, two trainees are paired with an actor who plays different client scenarios for each trainee. The trainee dyad and actor then work together throughout the duration of a semester, with each role-play focusing on a new skill acquisition. During each role-play, one trainee acts as an observer and will then offer feedback on their peer's performance, by also eliciting thoughts and perspectives from both the actor and role-played counsellor. It is considered that the process of participating in a role-play is a *concrete experience. Reflective observation* occurs when participants share their thoughts and feelings experienced and reflect upon how the role-play felt. The role-play process also

Table 2

Description of research studies and findings of the 12 studies reviewed focusing on enhancing empathy by training and development

Study	Participants	Sample Size	Aims (Empathy related)	Training Method/ Skill Development	Experimental Design	Measurement Instrument	Key Findings (related to empathy)
Andersson et al. (2010)	Therapists (multiple disciplines)	13	To find out how useful therapists find Mindfulness based Role-play, especially in relation to empathy towards clients	Dialogical mindfulness role-play Experiential learning and supervision	Pilot Study Qualitative Semi-structured interviews	N/A	Empathy for a client's emotional experience was reported by most participants. Participants reported experiencing greater empathic understanding and a sense of what a client may experience in their bodies during sessions
Barak (1990)	Counselling Psychology (Israel - graduate students)	9	To evaluate the Empathy Game. To identify if levels of empathic understanding and empathic skills increase both during the game and afterwards	Empathy Game Experiential learning	Single group Pre & Post	Game scores Counsellor Response Questionnaire Empathy Rating Scale	Differences between the mean scores on the CRQ and ERS pre-to post-test were statistically significant illustrating an increase in empathy. Game scores illustrated a significant effect of 'turn' representing a linear improvement within participants during the game
Barone et al. (2005)	Psychology students (USA - graduate level)	54	To examine whether feedback on inferred thoughts and feelings of a client enhances empathic accuracy	Feedback on inferences regarding a client's thoughts and feelings	Control group Pre & Post	Observer ratings	Both the experimental and control group levels of empathic accuracy improved from pre-to post-test. The experimental group had higher levels of empathic accuracy for inferred feelings than the controls post-test
Carlson (1974)	Counsellor trainees (USA - masters level)	24	To examine if a counsellor training method of providing live feedback and instruction during clinical sessions would improve communicated empathy	Live feedback on empathic communication during counselling sessions	Three experimental conditions and a control group Pre & post	Observer ratings	Empathic responses increased in all experimental groups compared to the control group. A combination of positive feedback and instruction was considered most effective in enhancing empathic communication

Cook et al. (2008)	Counselling trainees (USA - doctoral level)	6	Aimed to explore a method of improving counsellor assessment of suicidality and empathy for clients presenting with suicide ideation	Experiential exercise Creative writing – imagining the thought processes, feelings and actions you may experience if suicidal	Qualitative descriptions of experiences (no analysis)	N/A	Participants reported a shift in their understanding of people who experiencing suicidal ideation and wish to end their life. Enhanced empathy and a reduction in being judgemental were also self-reported
DePue & Lambie (2014)	Counselling students (USA)	87	Investigating the impact of a university based practical exercise on empathy levels and counselling abilities	Live supervision received during clinical sessions	Single group Pre & post	Interpersonal Reactivity Index (IRI) Counselling Competencies Scale	Findings showed improvements on all aspects of CCS after post-test indicating the exercise was useful in enhancing counselling skills. Empathic concern was the only variable to show a significant improvement on the IRI
Giordano et al. (2015)	N/A	N/A	To describe experiential learning techniques to increase empathy in addictions counselling	Experiential learning and role-play	N/A Narrative review of experiential learning	N/A	Describes the process of using the Kolb's learning cycle and role-plays with feedback in counsellor education (non-experimental)
Kuntze et al. (2009)	Psychology students (Dutch university counselling course)	583	To investigate the use of basic and advanced counsellor communication skills (inc. advanced accurate empathy) after training	Counsellor education courses	Control group Pre & post	Counselling Skills Program Test	Improvements shown in seven basic skills and four advanced skills with a large effect size, including advanced accurate empathy. One advanced skill had a moderate effect
Nerdrum & Rønnestad (2002)	Lay and professional therapists (Norwegian - multiple disciplines)	8	To understand the trainees experience of the learning process following an empathy training programme	Empathy training programme consisting of didactic teaching on empathy, video role-play, feedback and practice	Qualitative Grounded Theory Semi-structured interviews	N/A	Trainees found it difficult and challenging to change therapeutic style. However, trainees also reported enhanced empathy, especially in relation to feeling how a client may feel

Nerdrum & Rønnestad (2004)	Lay and professional therapists (Norwegian - multiple disciplines)	a) 23 b) 8	a) To explore the impact of empathy training on levels of empathic communication b) To understand the trainees experiences of the impact of the empathy training on practice 1 year later	Empathy training programme consisting of didactic teaching on empathy, video role-play, feedback and practice	a) Two groups staggered design Pre & post b) Qualitative semi-structured interviews	a) Self-reported use of empathy b) N/A	a) A significant increase in empathic communication was found for both groups. The increase for Group 2 was less than Group 1 at the point of only Group 1 receiving the training b) Participants reported greater empathic understanding of clients and linked this to the training. Participants also reported a better understanding of self and positive effects on clients after changing therapeutic style
Payne & Gralinksi (1968)	Counselling trainees (USA)	42	To explore which type of supervisory process (counselling orientated supervision Vs technique orientated supervision) facilitated the learning of empathy	Supervisory feedback	Two experimental groups Control group Pre & post	Observer ratings using a 7 point empathy scale	Analysis of the recorded responses by participants indicated that trainees in the technique orientated supervision and control group demonstrated improvements in the learning of empathy over participants in the non-directive counselling condition
Seto et al. (2006)	Counselling trainees (USA – graduate level) + career theory students for one comparison group	14 + 34 for control	To investigate the effectiveness of the Triad Training Model (TTM) on influencing cultural empathy (alongside intolerance for ambiguity and multicultural competency)	Training programme including didactic teaching, experiential exercises, role-play and practice.	Three groups – one experimental two comparison Pre & post	IRI Intolerance of Ambiguity Scale Multicultural Counselling Inventory (MCI) Multicultural social desirability scale	No changes found in counsellor empathy measured by the IRI post TTM. The authors query whether traditional empathy measures accurately detect changes in cultural empathy. Scores on the MCI were significantly higher post training.

involves *abstract conceptualisation* when trainees comprehend the importance of using techniques learnt in the classroom. Finally, the process of *active experimentation* is thought to occur throughout the training process. One example of this would be to pause the role-play at certain moments, allowing for discussion on how the session feels which can lead to a change in skill usage or a change in the line of enquiry. This paper however, did not report the effectiveness of this approach in increasing empathy.

As touched on above, feedback on skill-use is considered an important factor in increasing empathy. A study by Barone et al. (2005) examined whether trainees who receive feedback on their initial inferences concerning a role-played client's thoughts and feelings would display a greater enhancement in empathic accuracy than a group who did not receive feedback. Both experimental and control group participants took part in an interviewing skills course. However, in the experimental group, participants were encouraged during role-plays to consider the other's experience, allowing opportunity for feedback on one's ability to infer correctly. To assess levels of empathy, participants watched a clip of a therapy session and made inferences about a client's thoughts and feelings at certain points. Trainee performance was scored by two research assistants, who had achieved an inter-rater reliability of 90%. The results indicated that participants in the experimental group achieved a greater level of empathic accuracy for feelings, but not thoughts over the control group. Empathic accuracy also increased within the experimental group for feelings, but not thoughts. Barone et al. (2005) considered that it may be more difficult to infer the cognitions of real clients as opposed to role-played clients. It may also be more difficult to infer thoughts, when not in a communication dyad. However, such findings suggest that repeated role-play exercises with feedback, could increase levels of empathic accuracy for a client's feelings.

Two studies assessed the impact of empathy training from a qualitative perspective (Nerdrum & Rønnestad, 2002; 2004). The studies explored the therapist's experiences of completing an empathy training programme, followed by a later exploration of changes within clinical practice. The training programme involved trainees receiving 56 hours of training over a four-month period. The training involved didactic teaching on the importance of empathy; videotaped role-plays; detailed feedback and real client practice. In the quantitative arm in a cross-over, staggered design, the training was found to significantly increase trainees' empathy levels (Nedrum & Rønnestad, 2004). Qualitatively, trainees highlighted the importance of

video role-plays on their learning. One participant stated, *"I think the absolute most important was the role-playing. That made me really sense it in my body."* (Nerdrum & Rønnestad, 2002. P616). This indicates that the training not only enhanced empathic communication, but also helped trainees experience a felt sense of their client's difficulties. Conversely, trainees reflected on how emotionally difficult it was to really *feel* another's distress and spoke of the difficulty in sitting with that emotion, as opposed to trying to fix it or offer a solution. Learning to be more empathic can therefore pose a challenge to therapists. The trainees reported that overcoming these challenges was essential, in order to feel comfortable in managing affective empathy (Nerdum and Rønnestad, 2002). In the follow-up study (Nedrum & Rønnestad, 2004), trainees reported changes to their practice post-training. Trainees noticed they were listening more, focusing more on their client's agendas and paying more attention to the client's feelings. Trainees also reported a greater level of patience towards clients and more respect for their autonomy. These papers show support for the implication of empathy training and provide insight from psychological therapists as to how empathy training is perceived and implemented.

Other experiential techniques aside from role-play have been utilised to enhance therapeutic empathy. The effectiveness of the Empathy Game in enhancing therapist empathy was analysed by Barak (1990). The Empathy Game consists of presenting participants with statements written to simulate client descriptions of a range of clinical problems. Participant groups are given a list of potential thoughts, feelings, causes and solutions and decided which applied most to the statement. Participants then role-played clients by reading their statements and embodying how they might behave. The aim was for the other participants to correctly identify the thoughts, feelings, cause and solution assigned to that client in stage one, from the same list of possible options. Points are then awarded for every correct inference. The Empathy Game lasted four hours, including breaks and was conducted within a lab. Participants were instructed to consider the game as a competition.

The Empathy Game was evaluated via numerous methods. Participant ratings of empathy were measured before and after via the use of the Empathy Rating Scale (ERS; Ivey, Ivey, & Simek-Downing, 1987 p, 114). Participants were also rated on levels of empathy in pre-post role play sessions with a simulated client and via completion of the Counselor Response Questionnaire (CRQ; Stokes & Lautenschlager, 1978). Empathic

accuracy was also measured within the Empathy Game, by assessing whether the participants accurately predicted more client responses over time. Barak (1990) found that participants made small improvements on the ERS and CRQ and participants became significantly better at correctly identifying client experiences throughout the game. As participants were simultaneously receiving other components of their training course throughout the duration of study and as there was no control group, it cannot be stated with certainty that any improvements in empathy were directly related to taking part in the Empathy Game. However, although it is considered that participants may score higher on the CRQ naturally over time (Stokes & Lautenschlager, 1978), positive changes on the two other measures suggest the Empathy Game could enhance therapeutic empathy by improving the therapist's ability to detect and understand how a client may be feeling more accurately (Barak, 1990).

Other research has explored creative experiential methods for enhancing empathic understanding. Cook et al. (2008) described an exercise in which doctoral students created a plan for a fictitious suicide attempt. Students were asked to include the method and location of their suicide; what they would wear; who they would like to find them; and how they imagined the person finding them might feel. For every specific given, students were asked to explain why. The second part of the exercise involved students considering that their plan had been foiled by a counsellor and how they would sabotage their counsellor's subsequent attempts to intervene. This study did not use any measures of empathy, but students reported after the exercise that they had a much deeper understanding of why someone may wish to end their life, suggesting an improvement in empathic understanding. It is important to consider the ethics of this study and that the use of such an emotive exercise may not be appropriate within therapist education, without stringent safety measures being in place. This topic is also niche and such experiences may not generalise to other scenarios as much as other training methods discussed. Nonetheless, it does highlight that putting psychological therapists in touch with how a client may be feeling is a potential way to increase therapeutic empathy.

Experiential methods used within clinical supervision have also been found to enhance empathy (Andersson, King & Lloyd, 2010). In dialogical mindfulness-based role-plays, therapists take it in turns to play themselves and their client; supervisors then guide the therapist towards dialogical mindfulness, the ability to be mindfully aware of

the phenomenological experience of everyone in the dialogue. Therapists taking part in a qualitative evaluation reported experiencing enhanced empathy towards their client's emotional experiences and greater clarity in how it may feel being a client (Andersson et al., 2010).

Enhancing empathy by clinical practice

In addition to learning empathy in a simulated, classroom environment, Carlson (1974) reports that the effectiveness of practical training exercises partially relies on opportunities to put skills into practice in real therapeutic settings. Studies by Carlson (1974) and DePue and Lambie (2014) investigated the impact of live feedback and supervision during clinical sessions on empathy levels. Carlson (1974) adopted social learning theory methods and tested the effect of providing 24 counsellors-in-training with feedback via audio equipment. Trainees were divided into four groups and received live training during six counselling sessions in a three-week period. Group one received positive reinforcement feedback of 'excellent response' only. Group two received a mixture of feedback and instruction, whereas group three received no feedback. The control group continued with counselling sessions as normal without equipment or feedback. The results suggested that the most effective way to increase empathic responses in counsellors was to use a combination of positive feedback and instruction, although these conclusions are tempered by the lack of a pre-training empathy measure.

DePue and Lambie (2014) investigated the effects of a training exercise during which trainee counsellors held clinical sessions with live supervision from their supervisor for a period of 100 hours over a 16-week period. Eighty-seven masters level counselling students and 21 clinical supervisors took park in this study within a US University. Whist in clinical sessions, counselling students could hear guidance and supervision from their supervisors using ear-pieces. Students also received feedback from one another directly after sessions. Pre-post empathy measures were scored via the administration of the Interpersonal Reactivity Index (IRI; Davis, 1980), which measures four components of empathy: perspective taking, fantasy, emotional concern and personal distress. The first two subscales measure cognitive empathy, whilst the latter measure affective empathy. Improvement in counselling skill competencies were assessed via completion of the Counseling Competencies Scale (CCS; Swank, Lambie

& Witta, 2012). The study found that counsellor skills increased on all subscales of the CCS, but scores only increased significantly on the emotional concern subscale of the IRI. The authors wondered whether a reason for this might be that Master's level counselling students may already hold a reasonable level of perspective taking. It was also considered that components of the empathy scale were likely to generate social desirability effects within students resulting in high initial pre-test scores. The increase in emotional concern, however, could reflect an improvement in the trainee's ability to be emotionally present with clients. This suggests affective empathy can increase after working with real clients, highlighting the importance of trainee therapists having opportunities to work with real people with real problems throughout their training alongside receiving feedback and supervision (DePue & Lambie, 2014).

As outlined above, supervision is considered an important part of the process in enhancing therapeutic empathy alongside therapeutic skills (Stulmaker, Letora & Garza, 2015). Supervision is the process of experienced clinicians supporting less-experienced therapists to enhance their skills, alongside aiming to protect the welfare of clients (Bernard & Goodyear, 2008). If supervision can enhance empathy, is it important to consider which supervisory styles are most effective at doing this. Payne and Gralinksi (1968) examined types of supervisory style and discovered that supervisors who provide supervision on specific techniques enhanced supervisees' empathy levels more so than supervisors using non-directive counselling techniques. This is likely to be due to the developmental needs of trainee therapists. At the start of training, therapists may benefit from more instruction and guidance to reduce uncertainty and anxiety within the session. If a trainee feels anxious, they are less likely to be attending to the emotional cues within a client and therefore less able to be empathically attuned (Stulmaker et al., 2015). Being able to engage at an emotional level and feel what a client is feeling, can be challenging for new therapists. Trainee therapists are trying to hold the new skills learnt in mind and manage their own anxieties whilst simultaneously attempting to attend to their client. The importance of a safe space to share experiences in regular clinical supervision, over and above any specific training, is therefore considered essential if therapists are to be empathic (Bernard & Goodyear, 2014; Ladany & Friedlander, 1995).

Enhancing the communication of empathy

Although 'being good at communication skills is not the same as being good at helping' (Egan, 2007, p136), general counselling skills such as reflection, summarising and asking questions, as well as advanced skills like interpretation and confrontation, are often regarded as important aspects of empathic behaviour (Lang et al., 1990). In addition, being able to provide accurate reflections of a client's difficulties and to ask relevant questions requires a certain level of empathy. Although the focus of communication skills training is not to train empathy explicitly, such courses will enhance a therapist's ability to communicate empathy to their clients as counselling communication skills and empathy are correlated (Barkham & Shapiro, 1986; Elliot, Bohart, Watson & Greenberg, 2011a; Gallagher & Hargie, 1992). Studies investigating the effects of counselling communication skills training are therefore important.

A study by Kuntze, van de Molen and Born (2009) evaluated the effectiveness of a micro-skills communication programme for counsellors in the Netherlands. Counselling micro-skills are often considered the foundation of any therapeutic intervention and teaching micro-skills is the dominant method of enhancing counsellor skills (Ridley et al., 2011). Kuntze et al. (2009), studied the improvement of basic and advanced counselling skills (Lang et al. 1990) in 538 psychology students at different stages of training, who had either received no counselling skills training, basic counselling skills, or advanced counselling skills. The structure of the training involved the cumulative microtraining (CMT) method developed by Lang and van de Molen (1992). During CMT trainees are firstly taught about the theory behind a particular counselling skill. Trainees then have opportunities to see the skill being used poorly and then adequately before having opportunity to role-play the skill and receive feedback. In the final step trainees are encouraged to generate key learning points which are then carried over into learning the next counselling skill (Kuntze et al., 2009).

The level of counselling skill competency was assessed using the counselling communication skills progress test (CSPT) in a video form (Kuntze, van de Molen & Born, 2007). The CSPT requires the participant to watch video clips of clients talking. The video is then paused and participants are prompted to write down how they would respond verbally to the client if in a therapeutic session with them. Participant responses are then scored by trained raters. Kuntze et al. (2009) found that the counselling skills

training significantly increased the use of all basic and advanced counselling communication skills over the course of the two training courses. Although not assessing empathy levels directly, therapist and counsellor core skills such as the ability to provide reflection and validation of a person's feelings are likely to be linked to the therapist's ability to be attuned to what the client is sharing and experiencing. As being empathic relates to someone's ability to feel and understand another, it is likely that enhancing core therapeutic skills will improve the ability of therapists to be empathically attuned (DePue & Lambie, 2014; Elliot et al., 2011a).

Developing cultural empathy

In addition to general empathy skills, as populations become more diverse, it is essential that psychological therapists have skills and empathy to work with individuals from different cultures (Ridley & Lingle, 1996). Cross-cultural empathy is defined as 'a general skill or attitude that bridges the cultural gap between therapist and client' (Dyche & Zayas, 2001). It is thought that greater differences between therapists and clients leads to less understanding (Pederson, 2000a) and many therapists may not gain enough experience during their training to work with multi-cultural differences effectively (Sue, Arredondo & McDavis, 1992). It is therefore important to consider how multi-cultural empathy can be enhanced.

Pederson developed a specific method for enhancing multi-cultural counselling skills called the Triad Training Model (TTM; Pederson, 2000b). The model aims to train counsellors to articulate problems from the client's perspective; recognise resistance in specific terms; and practice recovery skills to overcome ruptures. TTM does this by engaging students in role-plays with a slightly different nature to the role-plays described previously (Giordano et al., 2015). TTM role-plays involve three simultaneous conversations. In addition to the standard conversation between the therapist and the client, the internal dialogues of the client are verbalised by a third person who voices the client's negative thoughts relating to the counsellor and their understanding. This process facilitates understanding of thoughts experienced by the client which may be difficult to share with a counsellor. The counsellor is then able to respond to such concerns aloud, helping them to foster a sense that the client is understood and thereby reduce the risk of ruptures in the therapeutic alliance (Seto, Young, Becker & Kiselica, 2006).

Seto and colleagues (2006), reviewed the efficacy of TTM in enhancing cultural empathy with 14 counselling students. All students were asked to complete the IRI at the start of term, immediately prior to TTM and one week afterwards. Two comparison groups, consisting of students completing a general counselling course or Career Theory course, were used as controls. In this study, students in the TTM group received six weeks of preparation, practice and reflection time before completing a TTM role-play front of a classroom audience. Although the study found no differences in empathy between the TTM and comparison groups, the IRI may not be sensitive to specific changes in cultural empathy (Seto et al., 2006). It may also be possible that no effects were found due to the relatively small sample size. The TTM did, however, increase counsellors multi-cultural counselling skills compared to control groups. As demonstrated previously, counselling communication skills can be correlated with levels of empathy and although the TTM may not show significant increases in experienced empathy within counsellors-in-training, it may lead to a higher level of received empathy by clients, via effective communication.

Enhancing empathy by self-reflection

Enhancing self-awareness in therapy via self-practice of psychotherapeutic techniques could also enhance empathy skills. Practicing techniques from CBT and Compassion Focused Therapy, for example, have been found to enhance empathic attunement (Bennett-Levy, Lee, Travers, Pohlman & Hamernik, 2003; Gale, Schröder & Gilbert, 2015). There has also been a considerable amount of interest into the effects of mindfulness on therapist empathy. Mindfulness can be defined as the ability to have a non-judgemental awareness of emotions, thoughts and experiences within the present moment (Block-Lerner, Adair, Plumb, Rhatigan & Orsillo, 2007). There have been numerous studies investigating the impact of mindfulness and compassion meditation on empathy, which have been reviewed elsewhere (Bibeau, Dionne & Leblanc, 2016; Block-Lerner et al., 2007). Block-Lerner et al. (2007) theorise that all components of mindfulness, such as being non-judgemental, increasing attention and being in the present moment can improve skills in empathy and empathic responding. An experimental study has demonstrated a correlation between mindfulness and empathic concern and perspective taking on the IRI (Block-Lerner, Orsillo & Plumb, 2004). Training in mindfulness-based stress reduction has also been associated with enhanced empathy within medical students (Shapiro, Schwartz & Bonner,1998). Mindfulness can

be linked to the idea of empathic attunement (Thwaites & Bennett-Levy, 2007): by focusing more on the present moment and noticing things around them. Therapists who practice mindfulness may therefore be fine-tuning their skills in noticing cues and subtle changes in emotion and behaviour within their clients.

Discussion

The current review aimed to describe the different ways in which empathy can be enhanced within psychological therapists. The review describes the content and effectiveness of empathy training and the role of experiential learning, clinical practice and supervision in enhancing empathy. The review also considers personal and environmental factors which can create variance in levels of empathy both between and within therapists.

The review demonstrates that there are many ways which appear to be effective in increasing empathy. Role-plays, with an emphasis on video role-plays with feedback are a common method for enhancing empathy (Barone et al., 2005; Nerdrum & Rønnestad, 2002; Seto et al., 2006). Role-plays facilitate practice at detecting how the client feels (empathic attunement) and allow skill development in empathic communication. Creative ways of enhancing empathy such as games and experiential practice of 'putting yourself in the shoes of a client' also may be effective (Barak, 1990; Cook et al., 2007). Such methods are powerful and memorable for trainees and could foster improvements in all aspects of empathy depending on the design of the game or exercise. It is also important that learning to be more empathic is not done in isolation from clinical practice. Simulated exercises and games are effective, but it is more difficult to be empathic within a real clinical environment. It is therefore important that trainees have access to high quality supervision, which can also involve the use of session feedback and experiential exercises (Andersson et al., 2010; Carlson, 1974; De Pue & Lambie, 2014). It is therefore evidence that empathy training needs to attempt to improve skills in empathic knowledge, attunement, attitude and communication, covering both affective and cognitive empathy to be effective (Barak, 1990). In their meta-analytic review of empathy training across a broader population, Teding van Berkhout and Malouff (2016) discovered that all empathy training included a focus on cognitive empathy. This is important as it could demonstrate that cognitive empathy is

considered easier to train as opposed to affective empathy which may be a more automatic process, facilitated via clinical practice and supervision.

The findings within the current review as to how empathy can be enhanced are in keeping with research into empathy training within the wider health profession arena. Reviews into enhancing empathy across a wider population also support the use of experiential learning, role-play, modelling and interpersonal communication as found in this review (Hojat, 2009; Lam et al., 2011). This provides support for the findings in the current review and suggests such methods of enhancing empathy are robust and work across all populations. Research into enhancing empathy within medical professions also pays attention to skills such as picking up on cues, body language and how to reciprocate and mirror these with patients (Matthews, Suchman, & Branch, 1993). These interpersonal skills were not explicitly discussed in the empathy training of psychological therapists, but are skills widely used by psychological therapists and are a component of the micro-skills taught within counsellor education programmes (Ridley et al., 2011). There is also support for the Cook et al. (2007) paper which encouraged trainees to reflect on suicidality, as reflective writing pieces have been found to help increase empathy within medical students (DasGupta & Charon, 2004). Additionally, creative experiential techniques to simulate the lived experience of hearing voices or living with diabetes, have also demonstrated significant improvements in empathy within other health professionals (Dearing & Steadman, 2009; Whitley, 2012). Therefore, such approaches, with safety measures in place, are a thought-provoking and interesting way to increase therapist insight.

Several studies discussed the importance of role-play and practice in enhancing empathy and clinical skills. Simulated role-plays play a big role in empathy training programmes within a classroom. Although referring to medical education, Wear and Varley (2008) argue that simulated encounters are too artificial for empathic skills to be assessed. It is hard for trainees to really experience what it is like to be with a client during a simulated role-play as they are not truly responsible for the person in front of them. It is argued that, without feeling responsibility, a genuine empathic connection is less likely to be established. It is therefore recommended that simulated role-plays are not used in isolation and should be combined with feedback, reflective practice plus discussions around challenging cases and decision making (Teherani, Hauer & Sullivan, 2008).

To support the utility of the Empathy Game in enhancing empathy, a review of simulation games in education found that games within training to be associated with higher levels of empathy (Bredemeier & Greenblat, 1981). Games increase interest, motivation, creativity and are more memorable for the participants. Swank (2008; 2012) recommends that games should be regularly used in counselling education. However, to ensure the effectiveness of the game, educators need to consider that the game has a clear focus; will target key learning objectives; be appropriate and appealing; maintain engagement and encompass a variety of learning styles so it appeals to the entire audience.

A criticism of empathy and communication skills training is that during role-play and simulated practice, trainee therapists are mainly learning how to respond empathically in the moment, as opposed to learning how to develop a deep empathic connection (Nerdrum & Rønnestad, 2004). Empathy requires a genuine interest in the life of another, which also needs to be expressed with authenticity (Bohart & Greenberg, 1997). It is also considered that training programmes that focus on communication skills may lead therapists to feel they are required to speak more in sessions (Ridley et al. 2011), which could mean therapists pay less attention to the feelings within the room. Ridley and colleagues (2011) suggest that training programmes need to include a combination of counselling micro-skills and focus on cognition and affect. The qualitative studies by Nerdrum and Rønnestad (2002; 2004) however, did discover that a communication skills training programme did lead to more silence within sessions and embodied empathy within trainees. Nevertheless, more research needs to be undertaken to assess how affective empathy in therapists can be developed and measured alongside cognitive empathy.

Unfortunately, most of the studies identified assessed empathy training within therapists-in-training so the most effective ways to enhance empathy in qualified therapists cannot be inferred. It is also noted that no study compared the empathy of students to the levels of empathy within psychological therapists, making it difficult to conclude whether the training provides students with levels of empathy comparable to experienced clinicians (Kuntze et al., 2007). Although studying the effects of empathy training within a trainee therapist population has face validity and is important for the future development of training programmes, it would also be interesting to see what interventions could enhance empathy within qualified therapists.

A large proportion of the studies discussed had relatively small sample sizes (Barak, 1990; De Pue & Lambie, 2014; Seto et al., 2006). This is likely to limit the power of the studies and may mean the results are not a true reflection of what would occur within a larger population. It is promising however, that changes in empathy levels were found even with small sample sizes and it could be anticipated that with bigger sample sizes results may be more conclusive. Within some of the studies (Barak, 1990; De Pue & Lambie, 2014) participants were from the same cohort of a training course within the same institution, which limits the generalisability of the results. Although most studies did involve control groups, these too were small sample sizes and often involved students enrolled within a similar counselling course.

Across the studies reviewed, there is a lack of longitudinal designs. Except for the qualitative study by Nerdrum and Rønnestad (2004), most research discussed does not demonstrate whether any enhancements in levels of empathy are maintained over time. It subsequently cannot be concluded whether such empathy training methods lead to enduring improvements in therapeutic empathy. However, a study which evaluated the impact of empathy communication training in Social Work students, found that empathy levels after an 18-month follow up were not only maintained, but increased (Nerdrum, 1997). This has positive implications for empathy training in therapists and may suggest that it is a combination of training programmes and continued clinical experience that enhances therapeutic empathy over time.

When reviewing the methods of training used and their effectiveness, it is important to consider the effectiveness of individual counsellors and therapists. Research suggests that therapists vary in their effectiveness and levels of empathy (Wampold, 2001) and variation across methods is often less than that between therapists in research studies (Rønnestad & Skovholt, 2003). A single method of enhancing empathy may not the most effective for every therapist or counsellor and therefore education programmes should aim to include a mixture of all approaches to empathy training discussed. Empathy is also considered the most difficult therapeutic skill to learn (Nerdrum, 1997) so time will be needed for skills to be embedded and put into practice.

Another important consideration is whether enhancing empathy in therapists can be done without considering the personal development of the therapist (Thwaites &

Bennet-Levy, 2007). It is possible that therapists need to be able to develop their own ability to tolerate emotion and learn to be able to separate 'their stuff' from a 'client's stuff' in order to achieve full empathy. It may be that empathy training should take place alongside reflective practice or even personal therapy to maximise its effectiveness (Macran & Shapiro, 1998), which could be an important research question for future research into the enhancing of therapeutic empathy to consider.

Implications

Empathy is considered an essential component of the therapeutic process, improving therapeutic relationships between therapists and clients and enhancing the effectiveness of therapy (DePue & Lambie, 2014). Yet despite the overwhelming amount of literature on the importance of empathy in therapy, it is surprising how little research is conducted into training therapists in empathy. This contrasts with the considerable amount of research into empathy training for other medical and health care professions. This poses a conundrum as to why empathy, an important variable in therapeutic change, has been a relatively neglected focus of research. Are therapists considered to be naturally empathic? Are psychological therapy training programmes assuming that they select the most empathic individuals to complete the courses? Or are the current methods for measuring empathy deemed incapable of assessing the right components? The likelihood is that many of the research studies investigating the impact of training in psychological therapies in general will be assessing empathy indirectly to some extent (Pascual-Leone, Wolfe & O'Connor, 2012). However, if empathy is not mentioned in the title or abstract of such articles, then identifying this literature for the purposes of systematic study is an extremely difficult task. This highlights the main limitation of the current review, as it is likely that many methods of enhancing empathy have been excluded due to the studies not making explicit reference to this. Empathy will also be embedded within the wider literature on enhancing therapeutic relationships and alliance. This could mean a number of additional studies associated with the enhancement of empathy have been involuntarily omitted from this review due to their lack of visibility during performed searches.

To improve the clinical value and validity of the empathy training literature, more research into empathy training for psychological therapists needs to be conducted, with a bigger focus on studying qualified therapists, as opposed to trainees or students.

Research also needs to adopt more experimental methods with better control groups so any improvements in empathy can be reliably attributed to the training method (Kuntze et al., 2009). Sample sizes also need to be larger, with training being completed across multiple sites and therapeutic disciplines and models to enhance generalisability. Finally, more attention needs to be paid to separating empathy out from other outcomes in psychotherapeutic skills training.

Conclusion

Empathy is a complex concept with multiple components and therefore it cannot be concluded one way of enhancing empathy is more superior. Due to the multi-components of empathy, programmes responsible for all psychological therapists should aim to include a variety of training methods to target each component of empathy and to cater for the different learning styles and variation between trainees to maximise effectiveness.

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Paper Two

Evaluating Psychodynamic Interpersonal Empathy skills training for Psychological Well-being Practitioners: A qualitative perspective

This paper has been prepared in accordance with the author guidelines of Clinical Psychology and Psychotherapy[3] (Appendix 2)

[3] For consistency throughout the thesis, references are formatted in line with Paper One

Evaluating Psychodynamic Interpersonal Empathy skills training for Psychological Well-being Practitioners: A qualitative perspective

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Abstract

The present study aimed to examine the experiences of Psychological Well-being Practitioners (PWPs) who attended a 3-day training programme in Psychodynamic Interpersonal Empathy skills training (PI-E). The PI-E training package was designed to offer PWPs additional skills in attending to the therapeutic relationship and engaging in empathic communication as an adjunct to low-intensity Cognitive Behavioural Therapy (LI-CBT). Fourteen practitioners from an Increasing Access to Psychological Therapies (IAPT) service were interviewed about their experiences of learning and using the PI-E skills in practice. A qualitative thematic analysis identified four over-arching themes: the power of practice; adopting a new approach; empathic understanding and making a difference. Although PWPs evidently have personal preferences for therapeutic style, this study demonstrated that providing PWPs with additional tools to manage the complexities and challenges within their role is perceived as valuable by practitioners and could have positive clinical implications.

Key Practitioner Message:

- PI-E training is perceived as helpful but PWPs require additional support post-training to consolidate skills
- Some PWPs adopted the techniques but integrating PI-E with LI-CBT approaches posed some challenges
- PI-E skills can enhance self-efficacy and job-satisfaction
- PI-E techniques facilitate empathic understanding of client problems, alongside enhancing PWPs' self-awareness

Key words: Empathy training, Psychodynamic Interpersonal Therapy, Psychological Well-being Practitioners, IAPT, Qualitative research

Evaluating Psychodynamic Interpersonal Empathy skills training for Psychological Well-being Practitioners: A qualitative perspective

Introduction

With the conception of the Increasing Access to Psychological Therapies programme (IAPT; Department of Health, 2008), a novel therapeutic role was established within the English National Health Service (NHS), that of the Low-intensity Therapist or Psychological Well-being Practitioner (PWP). PWPs are trained to deliver low-intensity Cognitive Behavioural Therapy (LI-CBT) and guided-self-help (GSH). PWPs see large numbers of people, with a wide variety of presenting problems, whilst receiving less training than other psychological therapists (Thwaites et al., 2015). Although the IAPT initiative has been successful in improving people's access to evidence-based therapies, targets relating to recovery rates and attendance are often not met (Dormon, 2015; Health and Social Care Information Centre, 2016). PWPs can become highly skilled in delivering GSH, however there is variation in the effectiveness within the low-intensity workforce. Green, Barkham, Kellet and Saxon (2014) found that greater levels of confidence, knowledge and resilience were correlated with the effectiveness of individual PWPs.

Working as a psychological therapist can be difficult, with many clinicians experiencing low job satisfaction and burnout (Lim, Kim, Kim Yang & Lee, 2010). Burnout can be described as feeling hopeless, ineffective or like your work makes little difference (Stamm, 2010). Burnout usually has a gradual onset and is associated with a high workload. PWPs generally hold the highest caseloads within services, offering high-volume, low-intensity interventions in a target-driven environment (Rizq, 2012). IAPT staff have been found to experience high levels of emotional exhaustion and low levels of personal accomplishment, which are associated with burnout (Steel, Macdonald, Schröder & Mellor-Clark, 2015). The prevalence of burnout is higher in PWPs (68.6%) than High-Intensity CBT therapists (50%; Westwood, Morrison, Allt & Holmes, 2017). Higher odds of burnout were associated with the length of time working as a PWP, more client contact and more data inputting. Past research has found burnout is associated with therapist beliefs relating to a strong allegiance or over-reliance on one therapeutic model and where therapists believe themselves to be the agent of change (McLean & Wade, 2003). This may have important implications for the well-being of PWPs, who generally are limited to LI-CBT interventions. Westwood and colleagues

(2017) suggest that enhanced supervision and strategies to manage workload may be a useful way of tackling burnout within PWPs.

PWPs offer GSH approaches that typically rely on CBT-based treatment manuals and protocols. In a study exploring PWPs' experiences of using GSH, PWPs valued such interventions as they can be effective and offer a feeling of control (Levy, Holtumm, Dooley & Ononaiye, 2016). However, PWPs also reported difficulties in using GSH, especially in relation to working with complexity and clients with limited motivation to use materials. PWPs also struggle to use GSH with clients who do not fit into a clear diagnostic category or people presenting with difficulties caused by social exclusion and poverty (Binnie, 2015). Binnie (2015) reported that, as frontline staff, PWPs are often asked to assess large numbers of people, who can have difficult presentations and complex lives. The mixed experience of manualised interventions by PWPs supports previous research into the experience of offering manualised psychological therapies (Najavits et al., 2004). CBT therapists and Clinical Psychologists have reported that manualised approaches can enhance their practice of evidence-based interventions (Addis & Krakow, 2000; Najavits, Weiss, Shaw & Dierberger, 2000). However, there is also concern that manuals could dehumanise therapists by being too technical and rigid, rather than focusing on the therapeutic relationship (Addis & Krakow, 2000). A study investigating the use of a psychodynamic-based manual found a negative, adverse effect on therapeutic relationships (Henry, Strupp, Butler, Schacht & Binder, 1993). Such research suggests that, although helpful in delivering standardised interventions, manuals may focus less on developing the conversation and relationship in therapy, with negative consequences.

Therapeutic alliances can be formed when offering manualised and computerised CBT within IAPT services (Barazzone, Cavanagh & Richards, 2012). However, as co-morbid personality disorder presentations can reduce the effectiveness of CBT approaches (Menning & Heimberg, 2000), it is important to consider how therapists using manualised-based approaches can be supported to respond to interpersonal challenges within therapy. One option would be further training in approaches that focus more on the relationship, such as psychodynamic techniques. Psychodynamic training aims to facilitate therapists to develop and build deeper and more connected relationships with their clients, identify patterns and to understand and respond to difficult feelings arising in the relationship (Hill et al., 2015). In a qualitative

study, Pascual-Leone, Wolfe and O'Connor (2012) found that psychodynamic skills such as facilitating client insight, exploring non-verbal cues and making use of silences could easily adopted. Teaching psychodynamic and interpersonal approaches to doctoral students has led to students noticing that they became more interested in the session dynamics and deeper meanings for their clients, as opposed to focusing on surface symptoms (Hill et al., 2015). Such training has also led to trainees reporting enhanced empathic connections and stronger working alliance with their clients (Hill, Sullivan, Knox & Shlosser, 2007). The ability to notice and describe new things in therapy (so-called perceptual acuity) is also thought to be enhanced in some trainees who are taught psychodynamic techniques (Pascual-Leone, Rodriguez-Rubio & Metler, 2013). Psychodynamic training has also facilitated therapists to appreciate the role of the client in the therapeutic process, understanding that clients are their own experts and that therapists do not hold all the answers or responsibility. Although training in such approaches can be challenging and increase feelings of doubt in self-efficacy initially (Hill et al., 2007; Pascual-Leone et al., 2012), therapists subsequently feel more effective, confident and better suited to their role (Hill et al., 2015; Pascual-Leone et al., 2013). Alongside enhancing someone's skills as a therapist, training in psychodynamic interventions may also enhance personal development (Rogers, 1961). Training can enhance self-awareness, acceptance of self and others and empathic attunement (Pascual-Leone et al., 2012). As PWPs receive minimal formal training in therapeutic interventions, offering training in basic psychodynamic skills may therefore enhance their personal and professional development.

Psychodynamic Interpersonal Therapy (PIT), originally known as The Conversational Model, was developed by Robert Hobson in the 1970s (Hobson, 1985). Compared to other psychodynamic based approaches, PIT is considered relatively easy to learn (Moss, Margison & Godbert, 1991; Shaw, Margison, Guthrie & Tomenson, 2001). The main aim of PIT is to address difficulties in interpersonal relationships, making it somewhat different to the symptom-focused approach within CBT (Guthrie, 1999). PIT has been adopted as a time-limited therapy within NHS psychological services and has a strong evidence base (Guthrie & Moghavemi, 2013; Paley et al., 2008). PIT has also been adopted by counsellors within primary care (Guthrie et al., 2004; Mackay, West, Moorey, Guthrie & Margison, 2001). More recently, the basic competencies of PIT have been taught to groups of PWPs within the North West of

England. Psychodynamic Interpersonal Empathy skills training (PI-E; Guthrie, Hughes & Brown, Submitted) aims to teach PWPs how to understand and communicate more empathically with their clients, enabling them to work more effectively with complexity and challenging relational issues that arise within sessions. PI-E is expected to be used as an adjunct to PWPs existing LI-CBT interventions. As PI-E is a new training package, it is important that experiences of learning and using such interventions are explored.

Aims

The aim of this study was to understand and explore PWPs' experiences of training in PI-E techniques and implementing these techniques. The project also sought to explore any clinical and personal implications for the PWPs in using PI-E as an adjunct to their traditional LI-CBT practice. The present investigation was part of a larger study evaluating the impact and clinical utility of PI-E training by analysing measures of engagement such as attendance rates and session rating scales (Paper Three). The overarching aim of these studies is to evaluate the potential benefits of PI-E and implications for the future training of PWPs.

The PI-E training aims to teach attendees 'level one' competencies in PIT (Barkham, Guthrie, Hardy & Margison, 2016). These competencies include: using statements rather than questions, picking up on cues, staying with the feelings, a negotiating language and understanding hypotheses. Practitioners are therefore essentially trained to pick up on cues relating to a client's feeling state and then make tentative statements that seek to put their understanding of how the client may be feeling, into words. The overall aim of the training is to enhance practitioners' skills in attending to the therapeutic relationship and enhance components of empathy such as empathic attunement and empathic communication (Thwaites & Bennett-Levy, 2007). The training takes place over three consecutive days, during which time the participants have numerous opportunities to practice using the techniques with expert feedback. The training is facilitated by three (two per day) experienced PIT clinicians.

Method

Design

A qualitative approach was selected to allow the personal experiences of PWPs learning and implementing the PI-E techniques to be captured. Data were collected via semi-structured interviews and analysed using thematic analysis (Braun & Clark, 2006). The study aimed to use an inductive approach to allow the identification of themes from the data, as opposed to searching for evidence to support an existing theory. However, the study was exploring responses to a training package aimed at enhancing empathy.

Interview questions (Appendix 3) were developed by looking at a past qualitative research paper into the experiences of therapists learning PIT (Mackay et al., 2001) and by considering what information would best answer the research aim of understanding the experiences of PWPs learning PI-E techniques. A mind-map was developed and used as an aide-memoire for the principal researcher during the interviews (Appendix 4).

This study was granted ethical approval by the University of Manchester Ethics Committee (Appendix 5).

Recruitment and data collection

Recruitment for the present study was opportunistic, based on approaching staff within a Greater Manchester non-NHS IAPT service whose managers had requested PI-E training for staff. Participants were invited to take part in the study approximately six months after completing the PI-E training course to allow PWPs to have opportunity to use and reflect upon the techniques. If people expressed interest in participating, a mutually convenient date and time for the interview was arranged. Thirteen interviews were conducted at the participants' office-base and one interview took place in a clinic room. Prior to commencing the interviews, participants reviewed a participant information sheet (Appendix 6) and completed a consent form (Appendix 7). Participants were also asked to complete a demographic questionnaire (Appendix 8). Interviews lasted on average 51 minutes (range = 33-65) and were digitally-recorded.

Participants

Fourteen practitioners who had participated in the PI-E training agreed to participate in the qualitative study. Participants were mostly female (N=13), had a mean age of 34.14 (range = 28-56) and had been qualified for 4.6 years on average (range = 1-8). Participants saw between 5-30 clients per week depending on their working hours and job role. Nine participants worked as PWPs and five participants were clinical supervisors or operational managers. All but one participant worked with clients within the service at Step 2 of the IAPT stepped care pathway. The supervisor participants had received previous foundation training in either relational or psychodynamic approaches. Numerous PWPs also disclosed that they had been trained in Method of Levels (MOL) therapy. The specific demographic details for individual participants are withheld to protect their anonymity.

Analysis

All interviews were conducted and transcribed by the first author and analysed following the Braun and Clark (2006) six-step approach to thematic analysis (TA). Analysis was supported via the use of QSR International's *NVivo 11* Software. Following transcription, each interview was read several times and any initial ideas or notable content were recorded to allow familiarisation with the data (see Appendix 9 for a sample interview transcript). In the next stage, codes were generated to describe the content within the transcripts. The codes were listed and organised into overarching categories as part of data management. Codes were then reviewed and put into mind maps to examine potential links and to develop preliminary themes across the whole sample. In step four, the generated themes were reviewed, renamed and re-categorised on numerous occasions to ensure they reflected the data. In the penultimate step, themes and sub-themes were clearly defined and named. The final stage involved selecting key extracts from the transcripts to tell a clear narrative and producing the report[4].

Reflexivity

Anna Taylor is a white British female and Trainee Clinical Psychologist from Greater Manchester[5]. Prior to gaining a place on the Clinical Psychology Doctorate at the

[4] See Critical Reflection Paper (Page 108) for further details of the analysis
[5] See Critical Reflection Paper (page 109) for additional personal reflections, trustworthy and reflexivity statement

University of Manchester she worked as a PWP for five years. AT was invested in this project due to having awareness of the challenges faced by PWPs working with complexity and difficult emotions. As a PWP, AT had often felt unskilled when working with high levels of distress and had felt she benefited considerably from having the opportunity to access clinical supervision which involved discussion around processes and counter-transference. AT therefore felt it to be important, for PWPs to be given the opportunity to expand their skillset and feel better equipped to deal with difficult situations arising in the clinic room. However, AT had also received training in the basic competencies of PIT (similar to PI-E) during the first year of her doctorate and could therefore also understand the challenges in moving from a more cognitive to a relational stance and therefore considered herself to be as open to the potential challenges of adopting the PI-E techniques as much as the benefits.

Although AT could be considered an insider in this project due to her prior experiences, AT was aware of her position and used supervision and reflection throughout the project to try and minimise the risk of conceptual blindness (Coar & Sim, 2006). AT used skills transferred from clinical practice such as being non-assuming and non-judgemental in attempt to reduce the likelihood of her own experiences and values being placed upon those of the PWPs. However, it is important to recognise that due to AT's past experiences, she would be unable to entirely separate her experiences from the accounts told by the PWPs and prior to the interviews it was anticipated that most participants would have experienced a mixture of emotions and hold different viewpoints on the use of PI-E techniques. In this research project is it considered that the insider perspective is helpful and AT's experience and commonality with the participants facilitated a greater depth and understanding of the experience of working as a low-intensity practitioner and adapting clinical practice.

It is also noteworthy that the first cohort of PWPs trained had met AT before being interviewed as she attended part of their training course. It is therefore important to consider any potential impact this greater familiarity with half of the participants had on the interview process. The participants had also met authors Richard Brown, Else Guthrie and Rebecca Hughes, who can also be considered insiders as they were the facilitators on the PI-E training course. However, these authors did not play an active role in interview process or qualitative analysis. The TA was supervised by Adam

Danquah, who was not involved in the PI-E training but works as a Clinical Psychologist, utilising psychodynamic approaches within the NHS.

Results

Four themes were identified during the TA. A list of themes and subthemes is presented in Table 3. Themes and sub-themes are discussed in turn and illustrated with quotes from the transcripts. Participants have been given pseudonyms to protect their anonymity.

Table 3. Themes and Sub-themes

Themes	Sub-themes
The power of practice	The reality of role-play
	Keeping it fresh in mind
Adopting a new approach	Weaving the two together
	I work at Step 2
Empathic Understanding	Deeper connections
	Self-awareness
Making a difference	Dealing with complexity
	Psychological well-being of practitioners

The power of practice

This first theme describes what the PWPs perceived as important in helping them to learn and adopt the PI-E techniques taught in the training programme. It was evident that having the opportunity to practice the techniques in training and subsequently back in their service facilitated an enhanced understanding and confidence in using the techniques. These experiences are described in the sub-themes ‘Reality of role-play’ and ‘Keeping it fresh in mind’.

Reality of Role-Play

The use of role-plays (including video recorded role plays) with feedback within small groups was a predominant feature of the PI-E training. The PI-E facilitators had encouraged PWPs to 'bring' a client they were stuck with to role-play. This was described as a '*really powerful' (Zoe)* experience and allowed the PWPs to role-play a *'real life situation'* in a *'semi-real environment'* (Sam). Being the client helped PWPs to empathise more with how it might feel for a client to attend therapy:

'When you play the client, you feel more vulnerable and sometimes it's good to be reminded of that… I think it gets you on the same page and, improves the therapeutic relationship as you can be… really with that person, in their issue' (Louise)

Role-playing their client also facilitated participants' understanding of the utility of the techniques and why they might use such approaches in practice:

'it improves your empathy as to what it might feel like to be on the end of lots of questions or how it might be different to be on the end of, kind of statements and thinking about feelings… when you could see… positive benefits to it, that's helpful' (Ruth)

PWPs also described feelings of apprehension and anxiety during the experience of role plays:

'it was scary in the beginning… feeling like someone, like you know, pushing me into a pool and starting to swim. I don't like it' (Alice)

However, video role-play practice was generally experienced as an effective way to learn new skills, offering an opportunity to reflect on the usage of the skills taught, check skills were being used appropriately and gain constructive feedback. The video role-plays also enhanced confidence, as PWPs generally noticed an improvement in skill use over time:

'my second one compared to my first was so much better and there was so much more that I brought to it… and I was really pleased with the fact I'd kind of, taken everything from those days' (Sam)

The consensus was that the training had an appropriate balance of theory and practice and the PWPs welcomed the many opportunities to practice the techniques. The PWPs felt the practice was effective enough to allow the techniques to come naturally in sessions:

'It was nice, because it was effortless if you know what I mean? It wasn't something that I needed to spend like hours and hours on be able to learn and practice' (Lena)

However, a few participants felt that the '*practicing until you get it almost' (Katy)* was too much and would have preferred more theory to increase their understanding of why they were being encouraged to use more relational techniques.

Keeping it fresh in mind

This subtheme relates to the PWPs' experience of continued learning and how further opportunity to practice and discuss techniques was important. The PI-E course was set up to try and offer continued development by supporting the clinical supervisors of the PWPs to provide supervision around PI-E techniques. There was some variance in the experiences of continued PI-E supervision. Some people spoke of accessing continued PIT focused supervision and having the opportunity to further role-play skills:

'we use role-plays, PIT role-plays in supervision sessions sometimes… and we can request it specifically. We can come in and say we want to do a PIT role-play… and everybody goes for it…' (Lena)

For those in supervision groups that discussed PI-E techniques[6], this was considered a helpful experience, especially in understanding how to proceed with the techniques:

'I use it as a place to pull it together and then maybe from that I'll be able to formulate an understanding hypothesis that I can offer in the next session or when the opportunity is right…' (Rebecca)

Alternatively, others experienced supervision to be the '*main thing that is lacking' (Sandra)* and expressed a preference for more specialist PI-E supervision:

'maybe focusing more on the actual… PIT-skills, so there was more input on that… From supervisions' (Sofia)

PWPs also spoke of how it can be difficult to have time to reflect on the usage of skills when out in practice. Therefore, the busy role of a PWP may make it harder to pause and think about which key moments in sessions may be useful to take to supervision:

'… in such high volume working, you often don't get the chance to think 'what went wrong?', you just have to see everyone back to back.' (Sandra)

PWPs felt that the training focused more on initial sessions and assessments. The PWPs felt able to use the techniques to gather information but then often described feeling

[6] In addition to supervision focusing on PI-E skills, PWPs would traditionally have access to generic PWP supervision. The PWP supervision model is made up of both caseload management supervision and skills based supervision. Caseload management involves discussions about the number of people being seen, number of sessions had and recovery rates. Skill based supervision can be delivered in a group and involves case discussion and skill development to enhance skills in LI-CBT interventions. The PWP supervision model is described in detail by Richards, Chellingsworth, Hope, Turpin and Whyte (2010).

stuck, thinking '*ok I got there, now what?' (Sofia).* This experience meant the PWPs then relied upon their previous approaches to try to intervene with people's presenting problems. Several PWPs, including Megan, therefore suggested it would be beneficial to have a follow-up training day:

'Just thinking if there is potential in the future to have a follow on or something' (Megan)

It was hoped that such a follow-up would be an opportunity to troubleshoot and build upon techniques by discussing experiences with experts in PIT approaches.

Adopting a new approach

This theme and subsequent sub-themes ('Weaving the two together' and 'I work at Step 2') describe the positive and negative valences of the PWPs using PI-E techniques as an adjunct to their usual way of working. Although some PWPs had been adopting the PI-E techniques, it was evident that there remained an allegiance to existing approaches.

Weaving the two together

Many participants acknowledged that the PI-E training wasn't trying to teach them a new type of therapy, but aimed to develop and enhance the skills they already had:

'the point of the training was to enhance our skills, rather than kind of give us a whole new skill set. So, it felt as though it did help to think about what we do…, and how we can just hone that with some of the skills we learnt from the PIT training' (Heather)

A proportion of the PWPs found the experience of learning PI-E techniques quite validating as they felt encouraged to realise they already had therapeutic skills.

'…it doesn't just completely wipe of kind of what you already know or what you've done. It actually adds to that, but also highlights where you are actually doing those things really well' (Sam).

However, others faced challenges in implementing techniques such as 'using statements' due to how different this is from the PWP's traditional way of working. Sandra described this as '*being drawn back to my old habits'.* It was also noticed that PWPs sometimes had trouble in '*weaving them all together' (Rebecca)* and often were '*moving a little bit abruptly' (Ruth)* between PI-E skills and LI-CBT interventions.

The group of participants who appeared to use the techniques the least were those who tended to use Method of Levels (MOL)[7] as their main therapeutic approach instead of LI-CBT. This was because MOL and PI-E techniques were experienced to be incompatible:

'I was happy to learn about PIT but when I tried to put it in practice … it was a like a clash between PIT and MOL as they are completely different styles' (Alice)

However, many participants described seeing PI-E as an overall approach and framework to building relationships, which can supplement LI-CBT approaches. Rebecca spoke of how she found it difficult to understand why interpersonal techniques and CBT based approaches should ever be separated:

'I just think you can't do one without the other… I don't understand the idea of divorcing the two' (Rebecca)

I work at Step 2

Some PWPs viewed PIT techniques as a high-intensity therapy and therefore felt that such approaches were not appropriate for use at Step 2. Sessions are limited to 30 minutes and PWPs expressed concerns about using the techniques to open '*Pandora's box' (Lena)* and being unable to contain subsequent distress:

'my concern might actually be that… whether it would be opening something that actually can't be-, I want to say kind of put back together again in the time space that we've got and actually would it be more detrimental to sit with that? (Fran)

Although there was recognition that helping clients to process difficult emotions was helpful and PWPs reported using the 'staying with the feelings' technique, there was also a sense that this at times could be emotionally draining for PWPs due to the high volume of people they see.

'it's hard because when you are… seeing six people back to back and you are getting to those feelings over and over again, it can seem quite exhausting by the end of the day' (Sofia)

PWPs therefore felt they needed to remain mindful that their role is at Step 2:

'What point do you stop and recognise we are still low-intensity? … I suppose it's still recognising within your boundaries and what you are doing.' (Heather)

[7] Method of Levels (MOL) is a cognitive psychotherapeutic approach which is based on Perceptual Control Theory. MOL can be used trans-diagnostically and aims to help clients resolve conflicts by helping to bring their attention to higher levels of perception or 'background thoughts' to allow reorganisation of thoughts to take place (Mansell, Carey & Tai; 2012).

In contrast, some PWPs felt the training gave them permission to use techniques they may have had a natural inclination towards using, but had often felt involved them stepping out of role:

'Now I've had the training, it's more acceptable to use statements. Whereas before the training, it's not the way… you are supposed to work…' (Alex)

Nevertheless, there were certain scenarios which evoked reluctance to use some of the techniques, such as when assessing risk or drug and alcohol consumption. PWPs felt that more direct questions were needed to gather such information as opposed to the use of statements.

Overall there was an allegiance to the PWP way of working which they didn't want to move away from:

'…it was easier to almost tickle about with the edges of what you were doing without losing, you know without completely straying away from what we do. Because that was our… bread and butter' (Louise).

Empathic understanding

This theme explores the concept of greater empathic understanding, which was present throughout the interviews. This understanding was threefold, with PWPs talking about how the experience of learning PI-E had enhanced their understanding of their clients' difficulties, their ability to facilitate their clients' understanding, as well as their own understanding and acceptance of their feelings in relation to others. These processes are discussed in the subthemes 'Deeper connections' and 'Self-awareness'.

Deeper connections

As discussed in previous themes, it was a learning curve for PWPs to adopt more conversational techniques. However, after practice, PWPs who used the techniques acknowledged that this did at times, lead to more progress. Phrases such as '*deeper'* and '*faster'* were often used in relation to achieving greater levels of understanding more quickly using PI-E techniques than the traditional PWP assessment techniques:

'you can address things quicker, because sometimes with more complex clients it feels like … you need to go back and explore it a bit more and sometimes it takes two sessions or three before you really understand what's happening, when with PIT you can just tune in for ten minutes and get it.' (Lena)

The PWPs who used the techniques and achieved a greater understanding spoke of a deeper connection, with experiences of embodied empathy:

'actually feeling that difficulty or that sensitivity for them… it's a bit more real in the room… and it just feels a bit more shared rather than them just telling you how it is' (Alex)

It was felt that understanding the client and their experiences helped the PWPs use a more client-centred approach as opposed to off-the-shelf interventions for specific presenting problems:

'it's about stopping to realise what they are going through, at a deeper level. So that helps me connect with them as well… I guess it makes it more of working with the person rather than working with the problem' (Sofia)

There was a felt sense that using the techniques, especially 'understanding hypotheses', also helped clients to feel more understood by their practitioner which was considered beneficial:

'hopefully they engage so they come back having felt understood… I suppose you've got that relationship so that they can… them feeling listened to is vitally important… and with that you could get mood improvement with it…' (Fran)

In addition to enhancing PWPs' understanding of the client, it was also felt that the techniques helped the client to develop a greater understanding of their own problem. A proportion of the PWPs spoke of how they felt the techniques also helped to give clients a voice, facilitating verbalisation of the unsaid:

'and they've not necessarily said that, but just reflecting that that's how it is… sort of helps understanding and people are like 'Oh my god, yeah!', so I think it's more picking up on the unsaid…'(Megan)

This was felt to be an important learning outcome, as previously when using LI-CBT, PWPs would worry about making assumptions or predictions. However, it was recognised that vocalising these via hypotheses and giving the client the opportunity to challenge, was helpful:

'With the CBT approach I always felt that… there was almost an expectation of not suggesting anything… or not leading in anyway and with PIT, using the understanding hypotheses… they can now say it's completely wrong and I find this useful that I can be wrong… with pure CBT I would probably be wondering, is it this? And I would be more assuming than being able to check straight away whether it is that or not' (Lena)

This enhanced and shared understanding facilitated PWPs to focus in on the main issues to be addressed in sessions.

Self-Awareness

In addition to being more in tune with how a client feels, the PWPs also reported being more aware of their own feelings after completing the PI-E training. This included noticing how they felt in a session with someone, and that this could prevent them from reacting to the client in a potentially unhelpful way:

'If I am in a situation and I do feel myself kind of getting very anxious or overwhelmed… or quite frustrated and angry, it would be a reference point for me to just stay with that feeling… I really want to, you know, push this person away… but actually I know I can hold that… and that can be a way to somewhere different' (Rebecca)

Some PWPs found it difficult to bring such feelings into the room, but showed a self-awareness in acknowledging it was something they struggled with. Louise spoke of difficulties verbalising some picked up cues because of fears about damaging the working alliance:

'when you feel a bit irritated, I find that quite difficult to bring into the room because it is difficult to say… that's my personal challenge I suppose… I think that's because I worry about the therapeutic relationship…' (Louise)

However, there did seem to be a shift in PWPs discussing feelings and possible countertransference in supervision following the training:

'I've tried to introduce concepts around transference and countertransference and it takes a while, but now we talk about that in a way we never used to' (Ruth)

There was therefore a sense that the service held a *'shared language around feelings' (Rebecca)* since the PI-E training, which was important for the PWPs to be able to continue working with and contain difficult emotions.

Making a difference

The final theme follows on from the prior theme. 'Empathic Understanding', along with using the techniques, were thought to facilitate 'making a difference' to clients and the PWPs themselves. There was a sense that the techniques added to the therapy 'toolkit' and gave them alternatives to try when feeling stuck. This appeared to contribute to improved self-efficacy within the PWPs. There also seemed to be a sense that learning techniques had an impact on PWPs' job satisfaction and well-being. These experiences are described in more depth in the sub-themes *'Working with complexity'* and *'Psychological Well-being of Practitioners'.*

Working with complexity

The PWPs work in a part of Greater Manchester that serves a diverse and quite deprived client population. The PWPs described not feeling equipped to work with such complexity using a manualised LI-CBT approach alone:

'especially for our area… we see a lot of complexity. If you see a standard Step 2, IAPT textbook client I think you'd see one a year and you'd wonder what was going on if you'd seen one coz they just don't exist' (Katy)

Supervisors who were interviewed spoke of how PWPs face difficult situations when trying to use LI-CBT interventions, which can be frustrating:

'Somebody yesterday was talking about a person who complained of really bad anxiety at night but could not think of a single thought… PWPs face that a lot, 'I don't know'' (Ruth)

It was felt that the techniques offer a *'bit of flexibility' (Sandra)* in dealing with complexity and were considered an alternative way to explore what might be going on for a person struggling to engage in a session:

'*It felt less intrusive doing it this way rather than being ask the question, why? Why are you anxious… so just noticing and picking up on cues and do it in a more open and I think acceptable kind of way' (Lena)*

Sam described experiencing a '*eureka moment which came out from using the skills'* which describes a greater sense of clarity in how to help people. This enhanced ability to deal with complexity appeared to help the PWPs reflect on their skills and helped them to feel more competent and confident in their role:

'it's another skill so you're not limited for patients, which I think makes you- I don't know if it's a better therapist or, like I said it's more options which I suppose, yeah it does! You are more able to provide something more to the patients to enhance… their therapy for them' (Alex)

This greater sense of self-efficacy is also likely to contribute to a greater sense of job satisfaction and well-being within PWPs.

Psychological Well-being of Practitioners

Similarly, to dealing with complexity described above, some PWPs spoke of how the training helped them deal with interpersonal challenges they could face in sessions, which had positive implications for how they feel within their role. Fran described how using the techniques had allowed her at times to feel more '*on a par'* with her clients when in some previous scenarios, she may have experienced the following:

'You'd feel like that, hopelessness, worthlessness within the job role… if you've not got a voice and you feel that voice has been taken away from you then actually, you kind of question what is the point in being in that job role and being in that situation' (Fran)

This helped Fran to recognise *'actually you are still a person'* and the techniques can help increase the PWPs voice and control in challenging scenarios with clients. Being able to feel less stuck and manage difficult situations in more effective ways therefore leads to a better job satisfaction:

'In terms of job satisfaction, I guess if you… just always felt stuck as if nothing was moving, then you might think 'maybe I'm not doing my job right'… if you felt as though something was happening and quite meaningful… you might get a sense of 'actually that was really good' or you know, 'I enjoy my job' (Heather)

There was also a sense that the PI-E techniques generated a more relaxed way of working which was described as *'quite refreshing'* by Heather. PWPs appeared less pressured to know the answers and shifted from a more 'doing' to a 'being' place. There was also a sense it was more acceptable to be struggling with someone in sessions and take this to supervision. In the same vein, PWPs noticed a reduction in self-criticism including; *'I'm not as… dismissive in myself' (Alex)*. Two of the main reasons for a reduced pressure on the PWPs, the reduction in session planning and collaborative responsibility, were articulated by Sandra:

'definitely less sort of stress because instead of preparing or thinking what I was actually… going to say and do with this person… takes the pressure off and actually you are just very present with someone and… your mind is not thinking 'where am I going with this?'… you don't know where it's going and that's okay because you are working together to figure it out…' (Sandra)

Finally, improving PWPs' well-being, job satisfaction and reducing stress via techniques such as PI-E, could be important in reducing instances of becoming *'really burnt out' (Katy)*:

'We've got targets, we've got to see so many people in a clinic so it's easy to kind of fall into that thing of 'okay this person has to come in, go through his, okay next person', whereas this is actually making a connection with people, so that makes it more validating' (Sofia)

Discussion

This research project set out to explore the potential benefits and implications of training PWPs in PI-E, an empathy training package based on basic PIT competencies. Overall, the results suggest that training PWPs in PI-E can be beneficial to their clinical and professional development as therapeutic practitioners. In the first theme, it is

demonstrated that PWPs found the PI-E package to be an effective training course. It facilitated skill enhancement and reflection via the use of role-play and repeated practice. It was also a valued experience for PWPs to role-play being one of their clients with whom they were struggling to work, as this brought the training and purpose of the techniques to life. This was described as a powerful experience that helped put them in touch with a client's possible experience of the techniques, as well as being reminded of how difficult it is for clients to attend therapeutic sessions.

Although the training was considered effective at helping the PWPs to learn the skills initially, there appeared to be difficulty in maintaining the interventions once out in practice. Participants expressed a desire for an additional training day or follow-up to help further embed the techniques and to have an opportunity to reflect on their use of skills with experienced PIT clinicians. Secondly, although supervision arrangements had been made and supervisors had also received the training, there appeared to be a lack of consistency in how often the PWPs had access to supervision that discussed PI-E interventions or facilitated role-plays. This could reflect the variance in the PWPs' adaptation of the techniques but could also reflect the supervisors' felt level of expertise. Most supervisors received the training at the same time as their colleagues and may therefore found it '*difficult to come from a place of knowing' (Ruth).* Supervision is a vital and necessary component of continued professional development (CPD) and has been shown to be important in supporting practitioners to implement new skills (Bernard & Goodyear, 2014; Ladany & Friedlander, 1995)**.** Supervision is also crucial in helping novice therapists deal with and respond to critical incidents and ruptures in the therapeutic relationship (Howard, Inman & Altman, 2006); additional supervision may therefore have helped reduce PWPs' apprehensions about opening *'pandora's box'* or picking up on certain cues.

The second theme explored PWPs' experiences of putting the techniques into practice. Several PWPs embraced the techniques and chose to use them to supplement, rather than replace, their existing skillset. There was, however, variance in people's confidence and felt ability to use the techniques. It was evident that PWPs struggled at times in integrating the learnt techniques with the LI-CBT interventions. There was a sense that PWPs used the techniques to help them get to a certain place with their clients in terms of information gathering and understanding and would then switch to using guided self-help approaches. PWPs could therefore benefit from more support in

making a fluid transition in sessions between PI-E techniques and LI-CBT interventions in addition to the more focused PI-E supervision outlined above.

There was also variation in how much the techniques were used and adopted by individual practitioners. From the analysis, it was apparent that a strong allegiance to a therapeutic approach led to less adoption of the interventions. Having a strong allegiance to an approach is known to be an important factor in the successful outcome of therapy (Messer & Wampold, 2002). However, over-reliance on one model can also put therapists at risk of burn-out (McLean & Wade, 2003). In a target driven environment such as IAPT, practitioners are aware of their individual recovery rates (Rizq, 2012). This could potentially generate levels of uncertainty and anxiety to move away from an intervention you feel works. As high-lighted in previous research, although learning psychodynamic approaches can lead to enhanced self-efficacy as a therapist, initially therapists can feel more uncertain and aware of the limits to their skills (Hill et al., 2007; Pascual-Leone et al., 2012) which could create a difficulty for PWPs, especially if they felt specialist PI-E supervision was lacking.

Some PWPs also struggled with understanding that PI-E techniques were not the same as PIT as a standalone (i.e., high-intensity) therapy, but aimed to supplement existing ways of working. It is considered that working as a PWP gives you a unique identity in psychological therapies. There are mixed messages around their identity (Watts, 2016) as research into IAPT often refers to the training of thousands of 'therapists' (Clark, 2011), whereas the PWP best practice guidance states "PWPs can be seen more as 'coaches' or facilitators of treatment rather than therapists" and states they do not offer therapy (PWP Training Review, 2015). This could potentially leave PWPs feeling inexperienced to work with complexity, but equally not wanting to step out of role and engage in 'high intensity drift', which is discouraged within IAPT culture (Waller, 2009; Waller & Turner, 2016). Relational techniques based on psychodynamic approaches are considered harder to learn and more challenging to adopt than CBT-based interventions (Hill et al., 2015; Najavits et al., 2004), so PWPs will inevitably need time to practice using the techniques in a supported environment. The practitioners who adopted the PI-E techniques more fluidly tended to be those who were more experienced and had already felt they had been using some of the techniques intuitively.

Despite the variance, apprehension and perceived difficulties in adopting the techniques, those using PI-E interventions noticed a difference in their practice and ability to build deeper connections to clients, as described in the third and fourth themes. The PWPs experienced the techniques as enhancing their ability to deal with complexity and the differing presentations of people they are work with. It was acknowledged that manualised LI-CBT interventions work really well for 'step 2 clients', but the reality is that many people referred into services have much more complex needs (Binnie, 2015). The techniques helped PWPs build more empathic and understanding relationships with their clients, which then facilitated knowledge of how to intervene. This allowed practitioners to feel like more competent and effective practitioners. Subsequently, some PWPs also reported improvements in their job satisfaction and well-being. PWPs reported that the PI-E techniques allowed them to 'just be with the person', as opposed to large amounts of session planning and thinking about the problem. It was felt this reduced the pressure upon them and allowed them to enjoy building relationships with their clients. PWPs also reflected that they had recognised it wasn't up to them to do all the work in sessions and there was in fact a shared responsibility with the client to work together. This is an important discovery due to recent evidence that PWPs are experiencing high rates of burnout and occupational stress (Westwood et al., 2017).

Finally, the PWPs observed development of their self-awareness and ability to be more in tune with their own feelings within sessions. Self-awareness, alongside positive well-being and emotional receptiveness, is considered at least as important as specific therapeutic skills in effective therapists (Jennings & Skovholt, 1999). This self-development facilitated improvements in sessions, such as PWPs not responding to countertransference, and helped establish a new common language around feelings. It also became more acceptable to be open and honest in supervision regarding feelings. When working with such a high-volume of people, it can be difficult to have time for self-reflection. Nevertheless, self-reflection and discussion of feelings in the room are also important in reducing emotional burnout and exhaustion and also to reduce the risk of therapeutic ruptures not being addressed (Safran & Muran, 2000). Although it was acknowledged that working more with feelings and recognising these could be exhausting, it was generally seen as a good thing, with PWPs recognising that getting to a difficult emotion was usually a signal that something important was happening in the

session. PWPs also expressed an enhanced ability to *'pick up on the unsaid'.* This demonstrates that PWPs could take on board and utilise some of the central components of psychodynamic-interpersonal working (Barkham et al., 2016).

Limitations

Participants were recruited from the same non-NHS service, which can be considered a limitation as this service may have a different culture to other IAPT services. PWPs had also been encouraged to attend PI-E training as part of a service initiative. The findings may therefore have been different if participants had been PWPs from different services and had chosen to attend the training. A small number of the PWPs in the sample were not using LI-CBT as their predominant model. This was not predicted prior to the study and it was thought that the research would be exploring the implication of using PI-E as an adjunct to LI-CBT. Therefore, this sample composition was not as expected. However, MOL practitioners stated that if they had been still using LI-CBT, then they would have welcomed the additional skills.

Another possible limitation is that the PWPs were aware they were being interviewed as part of a doctoral research project and the first cohort of PWPs had met the interviewer at the training. This increases the risk of social desirability bias and participants sharing more positive views of the training. An attempt was made to mitigate this in the recruitment process by being explicit that the research was interested in all their experiences, good and bad. The researcher was also mindful to pay as much attention to negative valences in relation to the techniques in attempts to negate bias.

Although thematic analysis is a flexible approach and accessible for those inexperienced in qualitative research[8] (Braun & Clark, 2006), adopting this approach might have limited the explanatory power and exploration of the PWPs deeper experience. It is therefore important to consider that a possible limitation of this study is that the themes generated may to some extent be more reductionist in nature than if an alternative method of qualitative analysis had been utilised.

Implications

This qualitative evaluation has indicated some implications for the delivery of PI-E training for PWPs. Firstly, it is important that PWPs are given the opportunity to expand

[8] See Critical Reflection paper page 106 for further discussion on the use of thematic analysis

their skills to work relationally as this has potential benefits for clients and practitioners. Secondly, training needs to continue to be experiential and include practice and video role-plays wherever possible as video role-play is an effective tool in enhancing self-reflection and skill acquisition. It is also important that, following the training, PWPs are supported within services to have continued access to supervision and CPD on PI-E skills and working interpersonally.

The TA also identified that not all PWPs fully understood that PI-E was being taught as an adjunct and not an entirely new approach. Such skills are not necessarily a therapy, but a way to engage in a meaningful conversation with somebody that helps get to the core of the problem. The PI-E training could be more explicit that PWPs should still be using LI-CBT interventions as their core approach and that the use of questions is still an appropriate, and integral part of CBT approaches. This could alleviate the discomfort PWPs felt when they perceived being asked to entirely change their practice, which is not the case with PI-E. Such skills are also not just specific to therapists and this may need to be made more explicit in the training.

Conclusion

This is the first study exploring the experiences of PWPs learning work relationally, alongside LI-CBT interventions. The results suggest that PWPs implemented the techniques to varying degrees. Although PWPs who embraced PI-E found integration challenging at times, they regarded it as beneficial overall in terms of their clinical capability, their job satisfaction and their ability to build deep meaningful relationships with clients. It is therefore recommended that more PWPs have opportunities to access PI-E training and further research be conducted to assess the wider implications.

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Paper Three

Evaluating the effectiveness of Psychodynamic Interpersonal Empathy skills training for Psychological Well-being Practitioners

This paper has been prepared in accordance with the author guidelines of Clinical Psychology and Psychotherapy[9]
(Appendix 2)

[9] For consistency throughout the thesis, references are formatted in line with Paper One

Evaluating the effectiveness of Psychodynamic Interpersonal Empathy skills training for Psychological Well-being Practitioners

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Abstract

This study aimed to evaluate the impact of a skills training package in Psychodynamic Interpersonal-Empathy (PI-E) for Psychological Well-being Practitioners (PWPs). Nineteen PWPs attended a 3-day training course in a staggered design, which focused on enhancing their skills in engagement and empathic communication by teaching level one Psychodynamic Interpersonal Therapy competencies (Barkham, Guthrie, Hardy & Margison, 2016). The impact of the training was evaluated by examining pre-post training rates of drop-out and non-attendance, alongside a measure of the working alliance across 2,546 clients over a year period. A near significant reduction in DNA rates were found post-training, but it was not possible to attribute this to the training explicitly. Further research exploring the impact of PI-E training is therefore warranted. Possible explanations for findings alongside limitations and implications of the current study are discussed.

Key words: Empathy, Training, Psychological Well-Being Practitioners, Engagement, Non-attendance

Key Practitioner Message:

- IAPT services need to enhance engagement and reduce drop-out rates
- Additional training for Psychological Well-being Practitioners is important
- PI-E skills training shows promise
- Further experimental research into PI-E is warranted

Evaluating the effectiveness of Psychodynamic Interpersonal Empathy skills training for Psychological Well-being Practitioners

Introduction

With the introduction of the Increasing Accessing to Psychological Therapies (IAPT) programme in 2008, the face of the psychological therapies workforce in the UK changed (Binnie, 2015). To tackle waiting times and improve access to evidence-based Cognitive-Behavioural Therapy (CBT) interventions, a minimum of 3,600 low-intensity (LI) therapists have been trained (Clark, 2011; Levy, Holtumm, Dooley & Ononaiye, 2016). Low-intensity therapists, more commonly known as Psychological Wellbeing Practitioners (PWPs), offer CBT interventions in the form of guided self-help (GSH). The National Institute for Health and Care Excellence (NICE) recommends the use of GSH and CBT for a variety of common mental health presentations, most noticeably anxiety disorders and depression (NICE, 2009; 2011). IAPT follows the stepped care model (Clark et al., 2009), which organises therapeutic intervention into levels of intensity to match the severity of presenting symptoms (NICE, 2011). Within stepped care, people initially access shorter and less intensive interventions, but can be 'stepped-up' to access more in-depth therapy if required (Delgadillo et al., 2014). Within IAPT services, LI-CBT is offered at Step 2 of the stepped care model, with traditional CBT offered at Step 3.

IAPT services are closely monitored and are required to regularly report progress on key performance indicators such as drop-out and recovery rates. Recovery within IAPT services is defined as going from above clinical caseness on measures of depression and anxiety to below (Gyani, Shafran, Layard & Clark, 2013). The national target is that IAPT services achieve recovery rates of at least 50%. In the most recent annual report, the Health and Social Care Information Centre (HSCIC; 2016) reported that recovery rates for 2015-2016 were falling short of this target at 46.3%. Due to how recovery is measured, published recovery rates exclude people who do not complete treatment. Therefore, realistic recovery rates, accounting for everyone referred, may be much lower (Atkinson, 2014) and there may be a risk of IAPT services over-estimating their effectiveness (Clark et al., 2009). The HSCIC (2016) reports that of the 953,522 who entered treatment last year, only 537,131 completed treatment, equating to a drop-out rate of 43.67%.

Overall, the IAPT programme has clearly been successful in providing greater numbers of people with access to evidence-based interventions, many of whom have benefitted (Dormon, 2015); nevertheless, the available data suggest that there needs to be greater exploration of ways to enhance the effectiveness of IAPT services both to improve recovery rates and reduce drop-out rates. Therapy drop-out is a frequent occurrence within psychological therapies (Bados, Balaguer & Saldaña, 2007). A meta-analysis conducted by Wierzbicki and Pekarik (1993) found that, depending on the definition of drop-out, between 35-48% of people terminated their therapy prematurely, a figure that is consistent with the recent estimates from the IAPT programme. Within LI-CBT, drop-out rates have found to be significantly associated with poor outcomes (Delgadillo et al., 2014). The reasons for people to drop-out of therapy can vary. People who drop-out may not be responding to treatment, experiencing a worsening of symptoms or lacking in motivation (Bados et al., 2007; Schindler, Hiller & Witthöft, 2013). Therapist factors may also increase drop-out rates. Bados and colleagues (2007) found that dissatisfaction with therapist was one of the biggest predictors of drop-out within CBT. Barrett et al. (2008) also found that problems within the therapeutic relationship and inadequate resolution of alliance ruptures were causes of premature termination of therapy. Drop-out is more common during the initial stages of therapy, which may be due to people not finding the therapeutic approach helpful, or the therapeutic relationship not being effectively established (Bados et al., 2007). As many people drop-out before finishing a course of therapy, many people are therefore not receiving the minimum effective dose of intervention required to make a positive recovery (Barrett et al., 2008). Consistent with this, Gyani and colleagues (2013) found that, within IAPT services, a higher number of sessions attended was a factor in predicting recovery. One way to enhance recovery in IAPT services, may therefore be to focus on reducing drop-out rates by enhancing engagement and quality of therapeutic relationships.

The therapeutic relationship and working alliance between a therapist and client is an important factor in predicting therapeutic outcome (Horvarth, Del Re, Flückiger & Symonds, 2011). It is also evident that strong therapeutic relationships are required for successful CBT interventions (Bohart, Elliot, Greenberg & Watson, 2002; Raue & Goldfried, 1994). Previous literature on the therapeutic alliance within CBT suggested that relationships are built via technical interventions such as adherence to goals and

symptom reduction, with less focus on interpersonal factors within the relationship (Andrusyna, Tang, DeRubeis & Luborsky, 2001; Safran & Wallner, 1991). However, the therapeutic alliance can also be improved by assimilating techniques from CBT with relational approaches, such as brief Psychodynamic therapy (Goldman, Hilsenroth, Owen & Gold, 2013). A study by Watson and Geller (2005) explored the working alliance in CBT and Process-Experiential Therapy (also known as Emotion-Focused Therapy), a type of psychotherapy that focuses on enhancing awareness and acceptance of emotions (Greenberg, 2004). Watson and Geller's findings supported the premise that, regardless of the specific techniques used by the therapist, their ability to be empathic, congruent and accepting of their clients was related to a better therapeutic relationship and enhanced negotiation of the focus of therapy. Watson and Geller (2004) also found that adherence to techniques was not enough for a successful therapeutic outcome, leading to the conclusion that it is important for all therapeutic interventions to be delivered in a flexible way that makes sense to the client and fits with their personal goals. This could have important implications for PWPs who generally work using a manualised GSH approach to CBT. Studies into the effectiveness of LI-CBT have found considerable variation in PWPs (Firth, Barkham, Kellett & Saxon, 2015; Green, Barkham, Kellett & Saxon, 2014). Indeed, PWPs who are more clinically effective can achieve almost double the change per intervention session.

As the IAPT programme has developed, there is an awareness that CBT does not work for everyone and there needs to be some choice and flexibility in therapies offered. Step 3 clinicians have been trained in other therapeutic modalities such as Interpersonal Therapy, Dynamic Interpersonal Therapy, Behavioural Couples Therapy and Counselling for Depression (Clark, 2011; Hill, 2010; Lemma, Target & Fonargy, 2010). PWPs, in contrast, typically have few opportunities to access additional training due to concerns regarding 'therapeutic drift' and practitioners working outside the remit of Step 2 (Telford & Wilson, 2010; Waller, 2009). Research has indicated that CBT treatments for problems such as panic disorder may be less effective for people who have a co-morbid Personality Disorder (PD) or difficulties with interpersonal relationships (Menning & Heimberg, 2000; Telch, Kamphuis & Schmidt, 2011). One in 20 people in the UK are considered to have a PD, with many people being undetected or undiagnosed for many years (Coid, Yang, Tyrer, Roberts & Ullrich, 2006; Mental

Health Foundation, 2017). It is therefore highly likely that PWPs will be attempting to offer LI-CBT to some people with undiagnosed PD, due to the high volumes of people they work with. It is therefore considered that additional skills in managing some of the challenges of working with people with a PD or similar complex presentations, may be necessary if PWPs are able to work effectively with the wide range of issues they encounter.

A training package designed to enhance the empathic skills of PWPs (Psychodynamic Interpersonal-Empathy skills training, PI-E; Guthrie, Hughes & Brown, Submitted) has recently been developed. This training package is based on Psychodynamic Interpersonal Therapy (PIT), a conversational therapy that enables therapists to understand and work alongside their clients as they develop a better awareness of their emotional difficulties (Barkham et al., 2016)**.** As a stand-alone intervention, PIT has one of the best evidence bases of brief psychodynamic therapies (Guthrie & Moghavemi, 2013); in addition, level one PIT skills can be taught to non-specialists to enhance their delivery of other psychological therapies. Initial anecdotal feedback regarding PI-E has been positive but the impact of training PWPs in PI-E is yet to be evaluated.

Aims and hypotheses

The aim of the current study was to evaluate whether teaching level one competencies of PIT to PWPs using the PI-E training package has any impact on outcomes related to the therapeutic relationship. PI-E skills training focuses on teaching level one competencies in PIT (Barkham et al., 2016). The competencies taught within the training package include: 'using statements rather than questions', 'picking up on cues', 'using a negotiating language', 'understanding hypotheses' and 'staying with feelings'[10].

This study is part of a larger research project, which has also sought to investigate the experience of the PWPs learning and implementing PI-E (Paper Two). It is hypothesised that if PI-E does increase the communication of empathy within PWPs, then there may be a reduction in early session attrition rates and non-session attendance. It is also hypothesised that clients may rate the therapeutic alliance more strongly when PI-E techniques are being utilised.

[10] Please refer to Paper Two (Page 52) for further details on the PI-E training

Method

Design

This project is a pragmatic and naturalistic service evaluation of the impact of training PWPs in PI-E. Nineteen employees of an IAPT service completed a 3-day training course in PI-E. Cohort A trained in September 2015 and Cohort B trained in January 2016. Attendees within each training course consisted of a mixture of PWPs, clinical supervisors and operational managers. All but one supervisor delivered low-intensity interventions as a part of their role. PWPs trained with their clinical supervisor wherever possible and supervisors were offered additional input in how to support the PWPs in the delivery of PI-E interventions following completion of the training.

In the 3x2 repeated measures design data were collected from both cohorts over three periods of four months. Neither group had received the training at time point 1 (T1), Cohort A but not Cohort B had received the training at time point 2 (T2) and both groups had received the training at time point 3 (T3). Table 4 demonstrates the design and the periods of data collection. The training was delivered in a staggered fashion so that the second group trained acted as a natural control group at T2. The dependent variables evaluated were the drop-out rates for clients dropping out of treatment after either session one or session two, rates of non-attendance and a measure of working alliance. Non-attendance was measured in the form of did not attend (DNA), could not attend (CNA) and combined DNA/CNA rates.

Table 4. Study design

	Time point 1 (25/05/15 – 24/09/15)	**Time point 2** **(**25/09/15 – 28/01/16)	**Time point 3** (29/01/16 – 24/05/16)
Group one	Not trained in PI-E	Trained in PI-E	Trained in PI-E
Group Two	Not trained in PI-E	Not trained in PI-E	Trained in PI-E

Participants

Clinical outcome data were collected from 2,546 clients accessing an IAPT service between May 2015 and May 2016. All clients who attended at least one session with a PWP were included. Clients had a mean age of 38.29 years (SD = 14.28 years, range =

16-100 years). The sample was made up of 61.1% females. In terms of ethnicity, 50.9% of clients identified themselves as Caucasian, 0.9% as Asian, 0.9% as Black African or Caribbean, 1% as dual heritage and 3.3% as other ethnicity. Ethnicity was not recorded for 43.9% of the sample.

All PWPs and their supervisors worked within the same IAPT service within Greater Manchester, which is a non-NHS social enterprise. The service in which the PWPs worked had requested the PI-E training for their PWP workforce. Recruitment for the service evaluation was therefore not necessary as all PWPs were taking part in the training as part of their contract of employment. Of the 19 practitioners trained, 14 worked as PWPs or Gateway Workers (3 male, 11 female) and five as supervisors or managers (100% female). Additional demographic details were not asked of everyone taking part in the training, although the 14 PWPs who participated in the qualitative arm of the study[11], had a mean age of 34.14 years (range 28-56 years), an average of 4.6 years qualified experience (range 1-8) and saw between 5-30 clients per week depending on their job role and number of working hours. Some PWPs disclosed they had received training in additional models or techniques such as Method of Levels[12] or Mindfulness which they adopted into their practice. The supervisors had also completed previous training in more relational approaches such as a foundation in psychodynamic psychotherapy or Cognitive-Analytic Therapy.

Measures

The Session Rating Scale (SRS V.3.0; Miller, Duncan & Johnson, 2000; Appendix 10) is a brief 4-item measure to assess the 'working alliance' between a therapist and a client. The measure asks the client to rate the quality of the relationship, focus on goals and topics, the approach or method and their overall experience of the session. The maximum score is 40, which would indicate a strong working alliance. The SRS was introduced by the service in 2015 as eliciting client feedback has been related to positive outcome and engagement (Reese, Norsworthy & Rowlands, 2009). The SRS is reliable, valid and relatively quick to administer compared to other measures of therapeutic alliance (Duncan et al., 2003). The SRS is also recognised as part of the IAPT minimum

[11] Refer to Paper Two (Page 54)

[12] Method of Levels (MOL) is a cognitive psychotherapeutic approach which is based on Perceptual Control Theory. MOL can be used trans-diagnostically and aims to help clients resolve conflicts by helping to bring their attention to higher levels of perception or 'background thoughts' to allow reorganisation of thoughts to take place (Mansell, Carey & Tai; 2012).

data for Children and Young People's IAPT Services (Law & Wolpert, 2014). SRS scores from session one were used in this evaluation to identify whether the PI-E techniques had an impact on the development of the working alliance in the first session.

The Patient Health Questionnaire Depression measure (PHQ-9; Kroenke, Spitzer & William 2001) and the Generalised Anxiety Disorder scale (GAD-7; Spitzer, Kroenke, Williams & Lowe, 2006) are also usually completed each session (Appendices 11 and 12). These measures are part of the IAPT minimum data set and are used to measure recovery and reliable change. These measures were used as covariates to assess whether initial severity of client difficulties was a confounding factor.

Power calculation

Assuming on average each PWP would see 40 clients (i.e., cluster size of n=40) and an estimated Intra Cluster Correlation of 0.08, the study required PWPs to work with 560 patients in total (280 per group, equating to 14 PWPs in total and 7 per cohort) to achieve 80% power and to have the ability to identify a medium effect size.

Ethical considerations

Advice was sought from the University of Manchester Ethics Committee. It was deemed that this study did not require ethical approval as the data used in this evaluation were collected as part of routine data collection for the IAPT minimum data set. No additional sensitive or identifiable data were collected as part of this evaluation. Permission to evaluate PI-E within the service was gained from the Board of Directors (Appendix 13).

Data analysis

Data were analysed using SPSS version 23 (IMB Corp., 2015). Aggregated cluster analyses (Campbell & Walters, 2014), were performed to take into account the variation in therapist effectiveness (Firth et al., 2015; Green et al., 2014) and to investigate the effects of the training at the individual PWP level. These analyses were performed by calculating the mean drop-out, CNA/DNA and DNA rate, alongside initial SRS scores for each PWP at each time point. Means were then weighted to account for the number of people seen by each PWP, resulting in a total of 18 clusters. To explore the hypotheses that rates of drop-out, DNA and CNA/DNA would reduce and SRS scores

would increase post-training, initial paired samples *t*-tests were conducted to compare pre-post training outcomes at the cluster level. These analyses were to identify if there was any change from the four months prior to PWPs receiving the training to the four months directly after. Data included in these analyses were therefore taken from T1 and T2 for Cohort A and T2 and T3 for Cohort B. To analyse the effect of PI-E training on the outcome variables, generalised estimating equations (GEE; Hanley, Negassa, Edwardes & Forrester, 2003) analyses were performed to assess the main effects of group, time point and any group*time point interaction[13]. It was hypothesised that rates of drop-out, attendance (DNA and CNA/DNA) and scores on the SRS would be equal at T1 (neither group trained) would show improvement at T2 for Cohort A (trained), but not Cohort B (not trained), with both groups achieving an equal improvement at T3 (both groups trained).

Results

Drop-out rates

Table 5 indicates that there was a decrease in dropout rates for the combined groups following the training, although the paired *t*-test found this decrease to be non-significant, $t(17) = 0.68$, $p=0.508$. Figure 1a shows a greater difference in drop-out rate between groups at T2, however in the GEE analysis conducted on estimated marginal means (EMM; Table 6 shows EMM for all variables), no significant differences were found between group (Wald Chi-Square =0.03, $p=0.859$), time point (Wald Chi-Square = 4.01, $p=0.135$) or for the group*time point interaction (Wald Chi-Square = 0.18, $p=0.912$) Figures 1b-4b highlight EMM with +/- 1 standard error for all variables.

Table 5: Aggregated cluster means for pre-post training outcomes

	Pre-training	**Post-training**
Measure	**Mean** (SD) n=	**Mean** (SD) n=
Drop-out rate (%)	**21.43** (9.38) n= 18	**19.95** (9.12) n= 18
DNA/CNA rate (%)	**15.95** (5.42) n= 18	**14.57** (5.12) n= 18
DNA rate (%)	**9.52** (3.56) n= 18	**8.21** (3.12) n= 18
SRS total score	**37.82** (1.26) n= 14	**37.58** (1.02) n= 14

[13] See Critical Reflection paper (page 112) for further details

Non-attendance

The difference in aggregated mean DNA/CNA rate pre-post training (Table 5) was not statistically significant, $t(17) = 1.12$, $p=0.279$. GEE analyses also found no significant differences between group (Wald Chi-Square = 0.02, $p=0.963$) or time point (Wald Chi-Square = 1.41, $p=0.495$). Figure 2a indicates an interaction was occurring between group and time, however this was not significant (Wald Chi-Square = 1.04, $p=0.593$).

Table 6: Estimated marginal means (EMM) for groups at each time point

		Time point 1	Time point 2	Time point 3
Measure	Cohort	**EMM** (Std. Error, [95% CI])	**EMM** (Std. Error, [95% CI])	**EMM** (Std. Error, [95% CI])
Drop-out rate (%)	A	**22.71** (4.17, [14.53, 30.89])	**20.33** (3.11, [14.24, 26.42])	**18.79** (2.44, [14.00, 23.57])
	B	**23.52** (2.97, [17.69, 29.35])	**21.76** (2.50, [16.85, 26.66])	**18.49** (2.84, [12.93, 24.05])
DNA/CNA rate (%)	A	**16.68** (1.58, [13.59, 19.78])	**14.53** (1.71, [11.17, 17.89])	**15.19** (1.95, [11.36, 19.02])
	B	**16.10** (2.27, [11.66, 20.54])	**15.99** (2.01, [12.05, 19.93])	**14.61** (1.54, [11.60, 17.63])
DNA rate (%)	A	**9.77** (1.20, [7.42, 12.11])	**8.12** (1.04, [6.08, 10.16])	**7.27** (0.94, [5.43, 9.11])
	B	**10.08** (1.91, [6.34, 13.81])	**9.68** (1.09, [7.56, 11.81])	**8.73** (0.87, [7.02, 10.43])
SRS total	A	**37.63** (0.71, [36.23, 39.02])	**36.76** (0.53, [35.73, 37.79])	**36.36** (1.23, [33.94, 38.78])
	B	**36.61** (0.84, [34.96, 38.26])	**37.72** (0.31, [37.11, 38.32])	**37.77** (0.18, [37.41, 38.13])

Figure 1a. Percentage Drop-Out rates

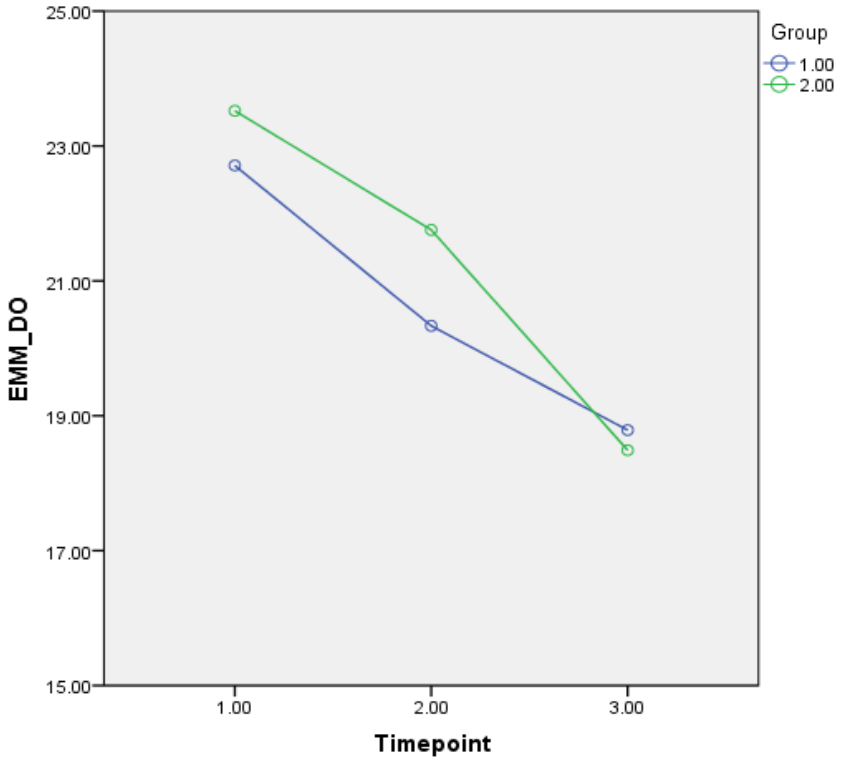


Figure 1b Drop-Out EMM

With +/- 1 Std.Error

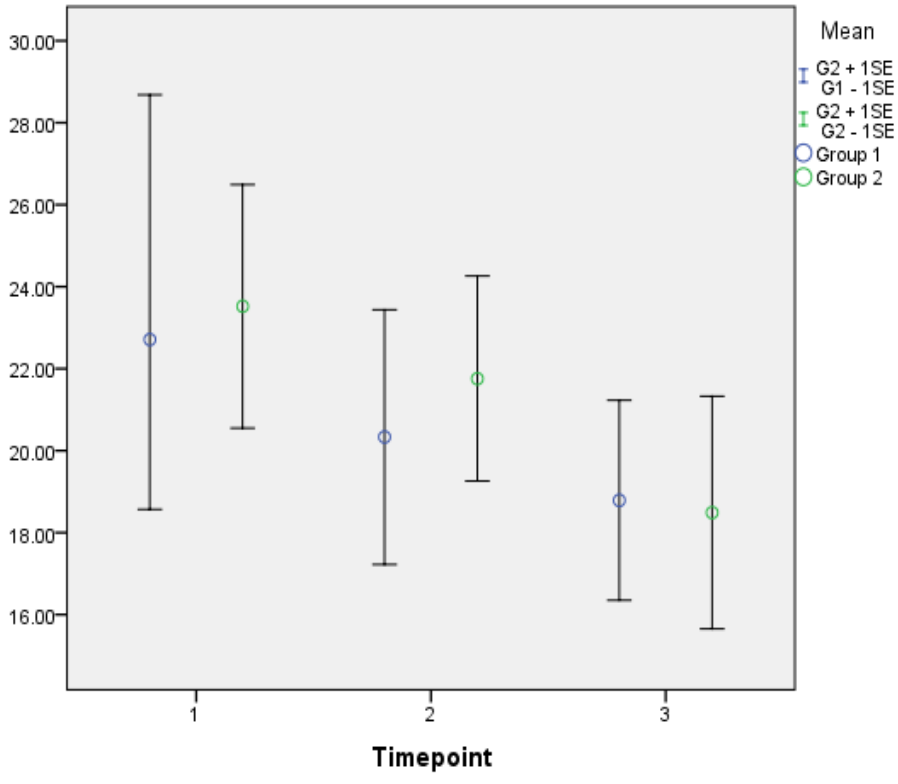


Figure 2a. Percentage DNA/CNA rate

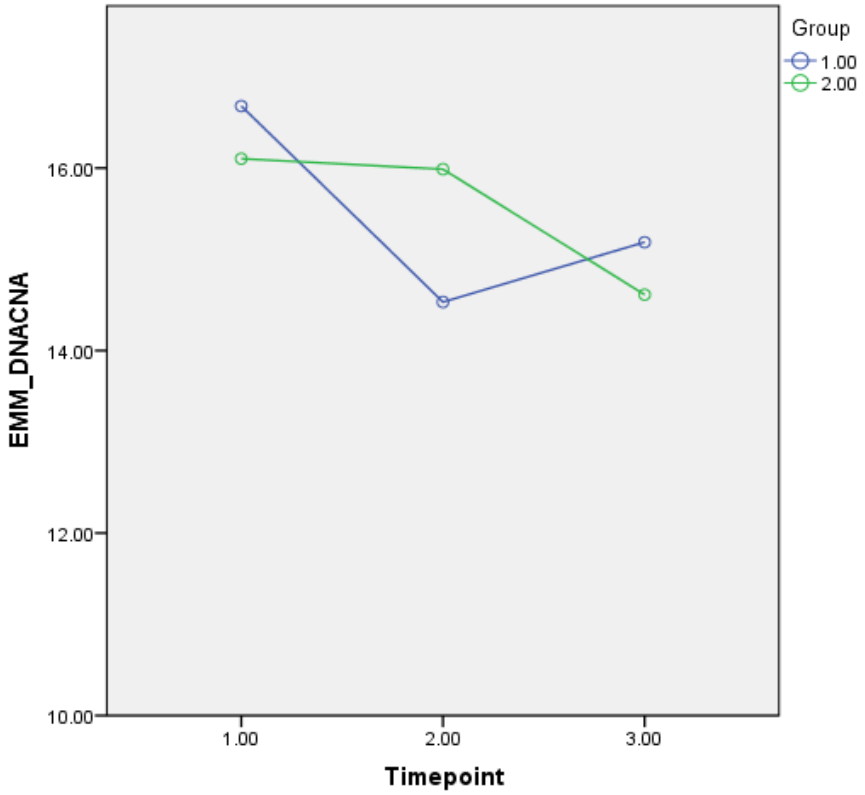


Figure 2b DNA/CNA EMM

With +/- 1 Std.Error

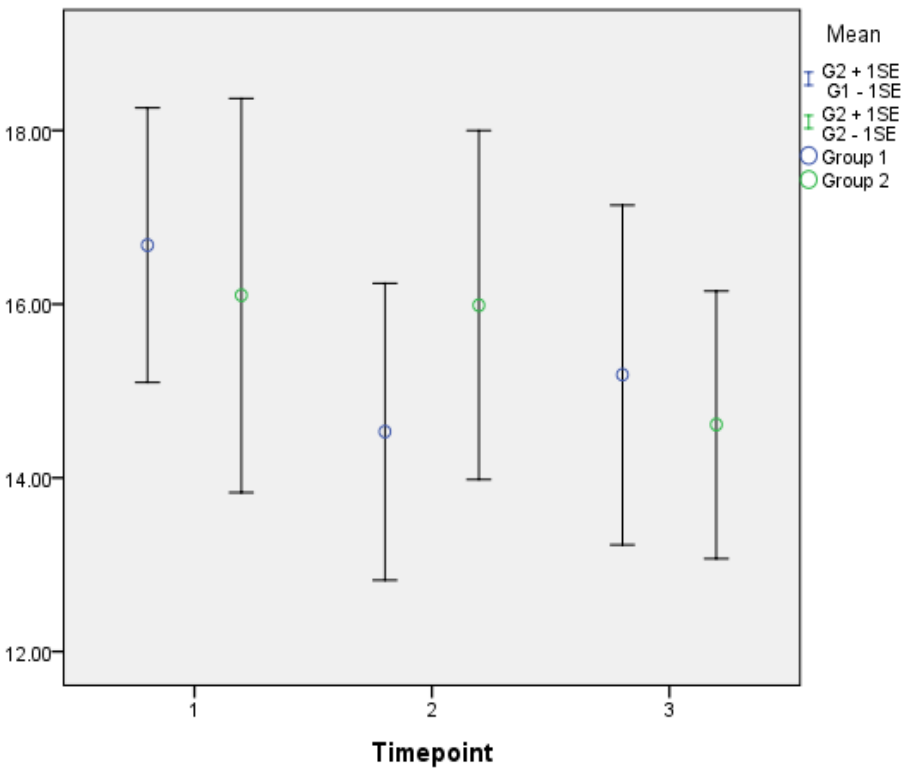


Figure 3a. Percentage DNA Rate

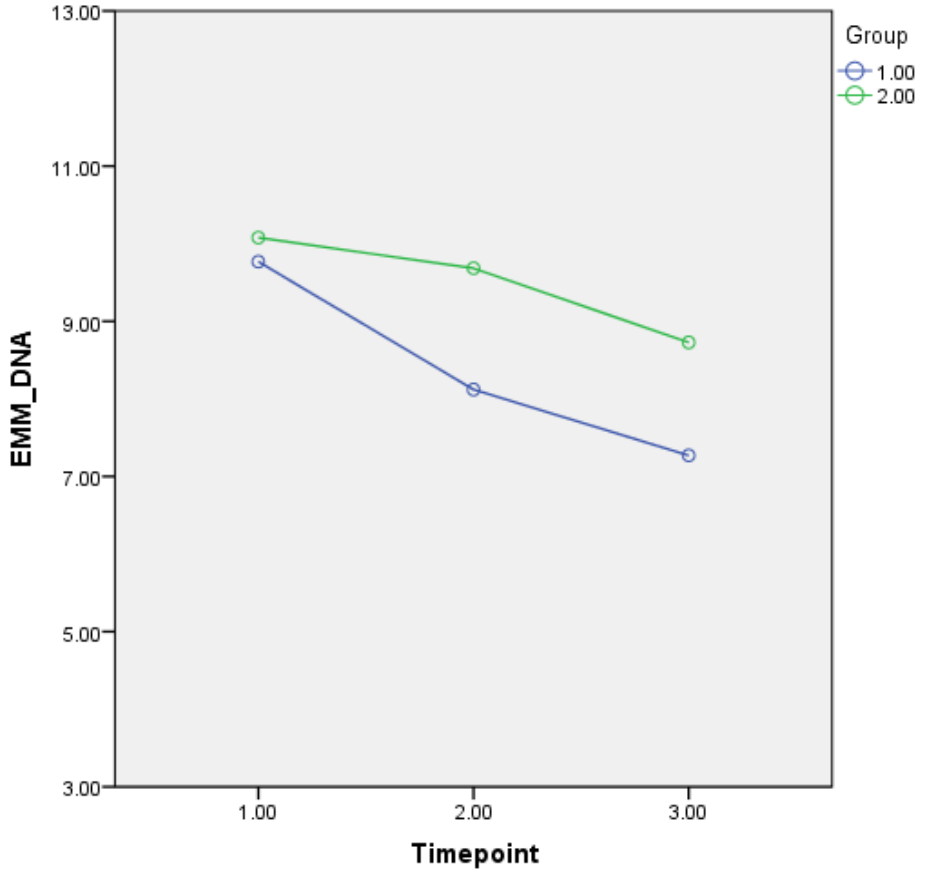


Figure 3b DNA EMM

With +/- 1 Std.Error

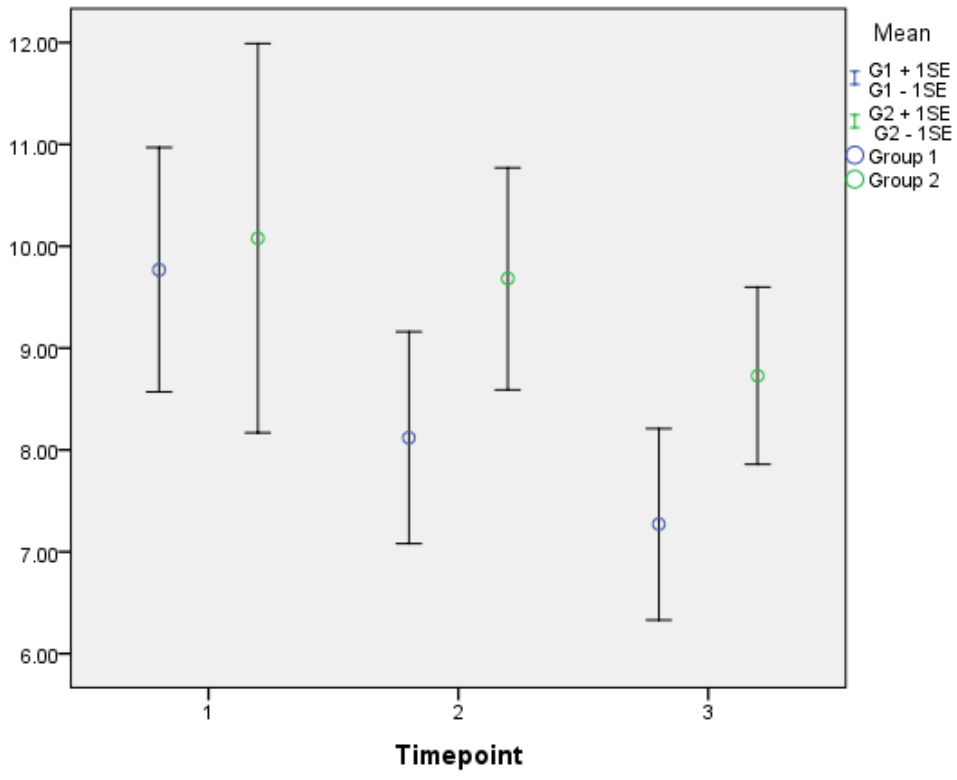


Figure 4a. Total SRS score

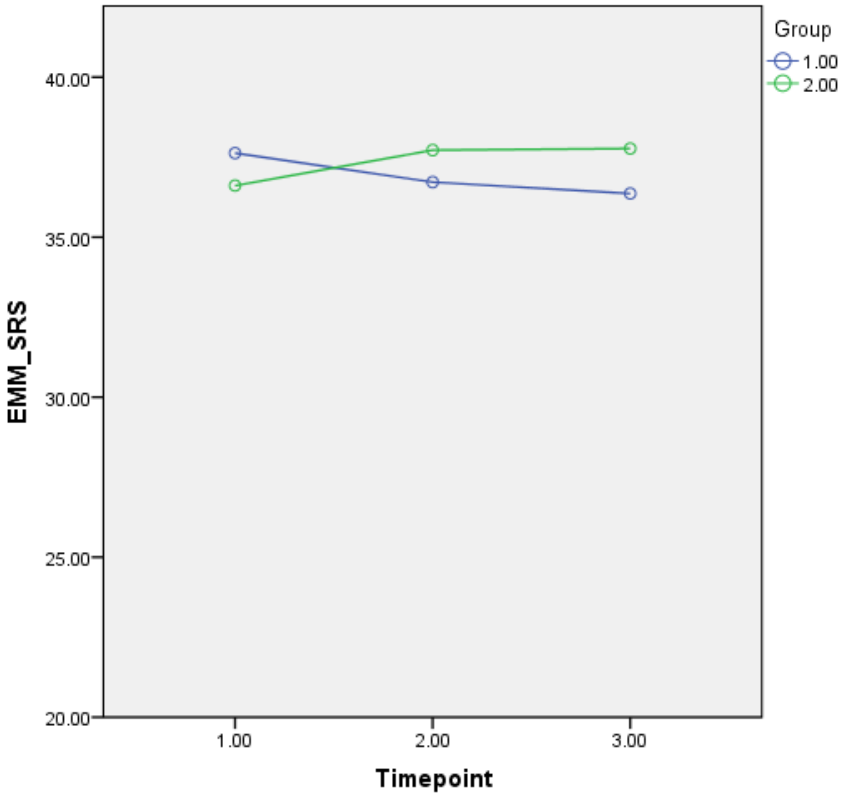
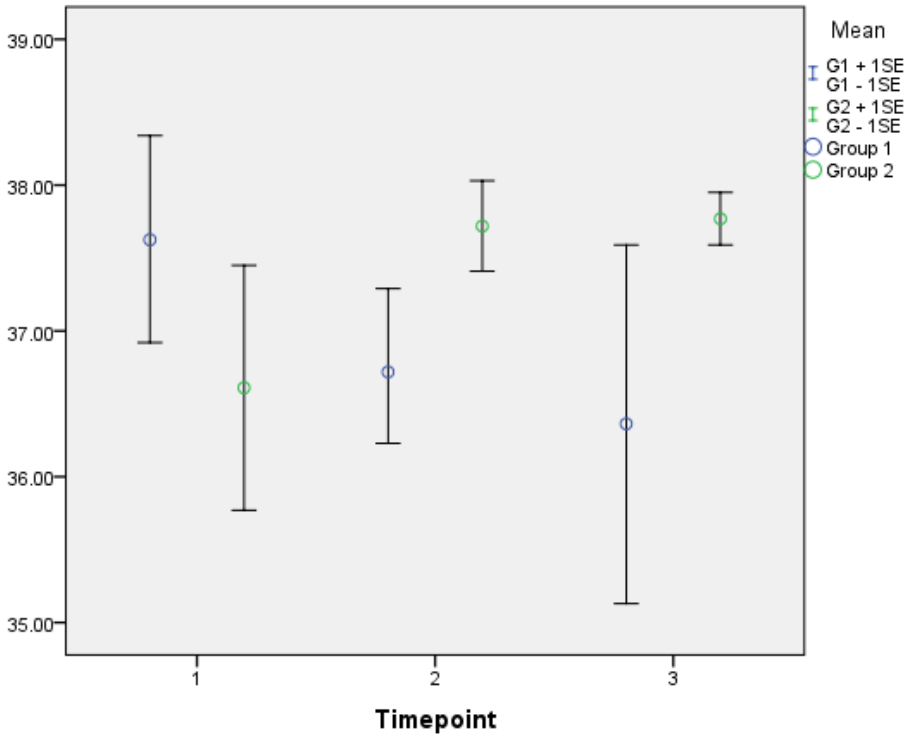


Figure 4b SRS EMM

With +/- 1 Std.Error



The paired *t*-test for DNA rates alone revealed a near significant drop in DNA rates from pre-training to post-training, $t(17) = 2.03$, $p=0.058$. GEE analyses found no significant effect of group (Wald Chi-Square = 0.57, $p= 0.449$) and although Figure 3a demonstrates that DNA rates dropped more sharply in the time points after a group had trained, the group*timepoint interaction was not significant (Wald Chi-Square = 0.566, $p = 0.754$). The level of significance for effect of time point (Wald Chi-Square = 4.79, $p = 0.091$), when controlling for PHQ9 and GAD7 increased to $p =0.068$ (Wald Chi-Square = 5.38). When age and gender were added into the GEE model as covariates, the main effect of time point was significant, Wald Chi-Square = 7.45, $p = 0.024$. Post hoc tests showed DNA rate at T3 to be significantly lower than at T1 (Wald Chi-Square = 7.68, $p = 0.006$).

Working alliance

SRS scores were obtained from only 343 out of 2203 clients seen. The number of PWP clusters were also reduced as not all PWPs had administered the SRS. There was also less SRS data at T1 compared to T2 and T3. With the scores obtained, there was minimal difference in the pre-post training means of initial SRS score (Table 5; $t(13) = 0.66$, $p= 0.520$). GEE analyses also found no statistical differences in SRS score between group (Wald Chi-Square = 0.40, $p = 0.527$), time point (Wald Chi-Square = 0.06, $p = 0.963$) or within the group*timepoint interaction (Figure, 4a Wald Chi-Square = 4.41, $p = 0.110$).

Discussion

This study aimed to investigate the effectiveness of PI-E training for PWPs in enhancing the therapeutic relationship with clients by measuring indicators of engagement, including drop-out rates, CNA/DNA rates and ratings of the working alliance. Training PWPs in techniques taken from a Psychodynamic based therapy may be considered contentious to some, due to concerns about therapeutic drift (Telford & Wilson, 2010; Waller, 2009). However, the consistent failure of IAPT services to enhance attendance rates suggests that it is important to explore ways of enhancing engagement.

As this evaluation of PI-E is novel, there is no previous research to compare outcomes with. It is therefore important to consider the possible reasons for the minimal findings. Analyses suggest that there was a near significant drop in DNA rates from pre-

training to post-training, and the reduction in combined CNA/DNA and drop-out for both groups appears sharper in the time immediately after PI-E (Figures 1a & 2a), suggesting some effect of the training. Although it cannot be claimed that PI-E itself is responsible for this apparent reduction in DNA rates, it shows sufficient promise to suggest that further research on the effectiveness of the training is warranted.

The almost significant reduction in DNA rates but not within other variables is one of interest. It is possible that although CNA is a measure of ambivalence to therapy, it could be less affected by changes in the therapeutic relationship. Clients may have a plethora of genuine reasons as to why they could not make a given appointment or choose to terminate therapy. A reduction in DNA rates however could be related more to a change in the therapeutic relationship. If clients feel more engaged in and understood, they may be less likely not to turn up and could be more likely to attend or cancel an appointment instead. It is also important to note that when attending to the therapeutic relationship more explicitly via the use of measures, potential difficulties could be explored and overcome (Reese et al., 2009), therefore the SRS may have independently been contributing to an improvement in engagement and could therefore be a confounding variable.

There was also no change observed in the SRS scores taken from clients' first appointment or drop-out rates after session one or two. In early sessions PWPs typically conduct a psycho-social assessment to find out people's presenting problems. PWPs are trained to ask multiple questions and demands to gather information could make it difficult for a therapeutic relationship to be established (Farrand & Williams, 2010). It is therefore possible that some PI-E techniques could be more difficult for PWPs to use in initial sessions. There was a sense from PWPs in the qualitative study, that using the PI-E techniques were more difficult in assessment, due to the need to ask specific questions. Although some PWPs found techniques facilitated getting to the core of a client's problem more promptly, there was also a sense that PWPs have a lot of ground to cover in their initial appointment and may have limited capacity for what they see as 'additional' techniques. It is therefore possible that measuring drop-out and the working alliance in early sessions is not capturing the full use of the PI-E techniques in later sessions. It is however, important to note that SRS scores were generally high initially and left little room for improvement. This indicates that this group of PWPs were already well equipped to establish a strong working-alliance with their clients. Many of

those trained were experienced PWPs and level of therapist experience has previously been found to be correlated to the working alliance and reduced drop-out rates (Hersoug, Hoglend, Monsen & Havik, 2001; Roth & Fonargy, 1996) The effects of the PI-E training on the therapeutic relationship could therefore potentially have greater impact in training less-experienced practitioners.

Another possible reason for lack of significant change is that it is unclear how much the PI-E techniques were being used by the PWPs following the training. As PWPs were not taking part in a research trial, they were not informed they had to use the techniques or follow certain adherence guidelines. PWPs were encouraged at the PI-E training to use the techniques as and when it felt appropriate to enhance their clinical engagement skills with clients. No quantitative assessment of PI-E use has been undertaken and therefore the use of a questionnaire to evaluate the frequency of techniques used may have been helpful in interpreting the results. The interviews with the PWPs conducted for the purposes of Paper Two[14] however, did reveal that not all the PWPs had adopted the techniques. Those who were utilising PI-E techniques, did so as an adjunct to their existing LI-CBT approach and generally tended to use the techniques more when feeling stuck rather than in every session. It could therefore be possible that the subtle changes found in the outcome variables following the training reflect this modest adoption of techniques within the service. A larger sample of PWPs who invest more wholly in the uptake of PI-E techniques could generate different results.

As learned in the qualitative arm of the research study, several PWPs use a therapeutic approach called Method of Levels (MOL) as their predominant model as opposed to LI-CBT[15]. Although MOL comes from a different school of thought and therapeutic discipline to the principles behind PI-E, MOL shares some commonalities with PI-E techniques. MOL is a transdiagnostic approach and focuses on reducing a client's internal conflict, facilitated by the therapist picking up on cues (Mansell, Carey & Tai; 2012). It is therefore possible that some of the criticisms of LI-CBT and manualised working for specific problems, were already being addressed by this service by offering a more empathically curious, patient-centred approach (McEvoy, Baker, Plant, Hylton & Mansell, 2013). Therefore, adopting PI-E techniques within a service

[14] and
[15] Please refer to Page 59 in Paper Two

that may already be using alternative ways of delivering therapy at Step 2 may have had less effect on outcomes than a service that uses more traditional LI-CBT methods. Additionally, some of the supervisors had already received training in relational approaches and may have used some techniques taught in PI-E in previous practice. This could possibly mean that this group of PWPs may not have changed their practice as much as their counterparts who work in a more conventional LI-CBT approach, limiting the effect of any changes.

The main limitation of this project is that it was non-experimental and researchers had only minimal control by introducing a staggered design. PWPs were not randomly allocated to training groups and there was no real control group of practitioners not receiving the training. Although adequate sample sizes were achieved in relation to client data, the number of PWP clusters was small. The average number of clients per cluster were also highly variable. For example, the size of clusters for drop-out data ranged from PWPs seeing between two and 110 clients within a given timepoint. This poses a difficulty as PWPs are known to vary in effectiveness (Firth et al., 2015; Green et al., 2014) and the outcomes of clients seen by one PWP will be more correlated than clients seen across all PWPs. This could limit the power of the analysis and it would be preferable for clusters to be equal size to reduce the impact of variability in the sample.

The fact that all PWPs were from the same service also poses some methodological limitations. Firstly, the generalisability of any findings are limited to within this IAPT service. Secondly, the staggered design raises the possible issue of contamination between cohorts. Cohort B trained four months after Cohort A, but may have been privy to discussions relating to the techniques and possibly taken part in clinical supervision groups which discussed the use of PI-E. Although the service attempted to separate the clinical supervision for cohorts trained, this was not always possible. Everyone within the service was also aware of the ongoing evaluation which may have influenced the results. The evaluation was an opportunistic, pragmatic and practice-based investigation of training in PI-E and has merit in understanding the effects of interventions in real practice (Cahill, Barkham & Stiles, 2010). However, the pragmatic nature of this investigation also limits replicability of the results and the ability to draw conclusions about causal relationships. Therefore, further experimental research into PI-E is required across multiple IAPT services with a larger, randomised

sample and pure control groups to establish the true effect PI-E has on clinical outcome measures.

Conclusion

Overall it is not possible to conclude that training PWPs in PI-E enhances their ability to form a stronger therapeutic relationship with their clients. There is also no conclusive evidence that PI-E training can improve engagement and reduce drop-out rates and attrition rates within an IAPT service. However, the apparent improvements in DNA rates following the PI-E training suggest that the package may have promise and that further investigation is warranted. It is therefore recommended that additional research into PI-E is conducted to further explore any potential benefits of this training package for PWPs, IAPT services and most importantly the people they seek to help.

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Paper Four

Critical Reflection

This paper is a reflective piece and not intended for publication

Critical Reflection

Overview

This paper provides an overview and critical reflection of the research presented in this thesis. Descriptions of the research methodology, plus strengths, limitations and implications are discussed in relation to the literature review, empirical papers and the overall project.

Paper One - Literature review

Topic Selection

Deciding on the topic for the review component of the research was difficult. The initial plan was to conduct a systematic review into whether empathy can be taught, focusing on studies measuring empathy pre-post training. However, initial scoping exercises revealed numerous reviews examining the effectiveness of empathy training for the medical professions, but a lack of research looking explicitly into the empathy training of psychological therapists.

As the focus of the empirical research within this project was qualitative, we then considered conducting a meta-synthesis of qualitative research on factors therapists feel facilitate and hinder empathy. I therefore conducted systematic searches within databases, reviewed titles, abstracts and full-texts of potentially relevant papers only to discover that there were not enough similar papers to conduct such a review without relying on grey literature. Due to this occurring late into the research process, it was agreed in research supervision to start the process again but complete a narrative review on how empathy can be enhanced within therapists.

Although narrative reviews can be of poorer quality and open to more bias (Aveyard, 2014), there are occasions when such reviews can be more useful. Sometimes the strengths of a systematic review in providing a detailed description of a narrow topic area can become a weakness when a broader area, with multiple types of studies, need to be explored (Collins & Fauser, 2005). In this case, to write a comprehensive review on training therapeutic empathy, it was important to broaden the scope to identify studies on factors that could facilitate therapist empathy, alongside research specifically on training. Moreover, there appears to be little research focusing on empathy training in psychotherapists. This would be problematic in conducting a systematic review to

ensure there was enough high quality literature published to answer the research question (Aveyard, 2014). It may be that empathy is 'lumped in' with the therapeutic relationship more generally, or that empathy is only a secondary focus of the research, thus not explicit in study titles or abstracts. Alternatively, there may be an assumption that therapists are naturally empathic and therefore less attention is focused on training therapists in empathy.

Aveyard and Sharp (2013) describe the concept of a *good quality literature review*, which incorporates systematic elements but is not a formal systematic review. It is considered that the present review meets this standard. Thus, a systematic search ensured that all papers specifically relating to 'empathy training' in psychological therapists were discussed, meaning that the review cannot be accused of 'cherry picking' relevant studies (Aveyard, 2014).

Search Method

Systematic searches were conducted to identify key papers relevant to enhancing empathy in therapists. Papers were identified for inclusion via searching PsycINFO, EMBASE and MEDLINE. Papers were also identified via searching Google Scholar and reference lists of key papers. Search terms included Empath* to ensure all papers relating to empathy were identified combined with training and therapist related phrases. Using truncations maximised the number of papers identified and searches were performed at the title and abstract level. A full list of search terms used can be seen in Appendix 14. No limits were placed on the searches. After reviewing the papers at full text, only a limited number purely investigated the training of empathy in therapists or therapists-in-training, many of which were quite dated (pre-1980). Such limited findings reinforced the rationale for completing a narrative review with a wider scope.

Limitations

Although the methodology of individual studies in the review were appraised, a formal quality rating tool was not used. Quality rating tools are used to assess the internal validity of research studies by evaluating their aims, methods, analysis and results whilst assessing for bias (Zeng et al. 2014). However, as there are different quality appraisal tools for each type of study design, ranging from randomised controlled trials to case series, it was impossible to select one tool to evaluate all study types discussed

in the review. Nevertheless, it was evident that many of the studies included had methodological weaknesses due to limited control groups, small sample sizes and a lack of exploration of empathy training within qualified psychological therapists.

Implications and Future Directions

A strength of this review is that it synthesises research on different aspects of therapeutic empathy and how it can be enhanced, resulting in a novel and potentially important contribution to the literature. A lot of the studies included sought to enhance the empathy of therapists-in-training and showed that empathy can be trained by a variety of methods. The review therefore provides a useful overview for clinicians and clinical educators about training novice therapists to be more empathic, and suggests that training programmes could benefit from focusing some of their curricula on methods that employ a combination of experiential and creative learning exercises with multiple opportunities for practice and feedback, alongside opportunities for practice within clinical settings supported with high quality supervision.

The review highlighted a gap in the literature and demonstrated that more studies need to be conducted in relation to the training of empathy within qualified therapists. Such studies need to have larger sample sizes and better control groups for accurate conclusions to be drawn in relation to the effectiveness of empathy training packages.

The review complements the empirical papers described below as focused on the training of empathy, and highlighted the importance of experiential role-play and clinical practice for skills in therapeutic empathy to be enhanced.

Empirical papers

As Paper one demonstrated, empathy is often not separated from other core therapeutic skills in the training of psychological therapists. This suggests there may be a gap in the market for a training package that does focus on empathy and enhancing the therapeutic relationship. The overall aim of the empirical project was to evaluate a new empathy skills training package: Psychodynamic Interpersonal Empathy skills training (PI-E; Guthrie, Hughes & Brown, submitted). The initial project proposed to evaluate the clinical impact of PI-E by comparing relevant clinical outcomes pre- and post-training. As this component of the study required data analysis but not recruitment, it was

considered important to expand the project so I could make a more significant contribution. The qualitative research project was therefore developed to create a mixed-methods research project that would enhance our understanding of PI-E and any potential benefits.

Paper Two - Qualitative paper

Rationale for thematic analysis

The research team initially considered using Framework analysis (FA; Gale, Heath, Cameron, Rashid & Redwood, 2013), an approach widely adopted in healthcare research. FA encourages analysis of individual participant experiences, therefore potentially posing a risk of breaching the confidentiality of participants who had unique job-roles or experiences within the sample. Thematic Analysis was therefore chosen as an alternative approach. Thematic analysis (TA) shares some similarities to FA and is an interpretative process of systematically searching for patterns within a data-set (Smith & Firth, 2011). Braun and Clark (2013) state TA is a flexible approach to qualitative research that works well across a range of research questions; it is also accessible for researchers who are new to qualitative research as it is relatively easy to learn. These were important considerations due to this being my first qualitative research project and the practicalities of completing the service evaluation alongside.

Recruitment

This study aimed to interview the majority of participants receiving the PI-E training. The maximum of possible participants was 19. It was impossible to know whether this would be enough to reach saturation, which is important for the validity for qualitative research (Fusch & Ness, 2015). However, Braun and Clark (2013) recommend that between 10-20 participants is enough when completing a qualitative study as part of a larger project, as applies here. Of the possible nineteen people who attended the training, two PWPs had since left the service and a further PWP was on maternity leave during recruitment; interviewing fourteen participants therefore, was considered a success.

Interviews took place approximately six months after the PI-E training. Ethical approval from the University of Manchester was gained almost five months after Cohort One had trained and recruitment could only commence subsequently. It was important

both groups were interviewed at a similar time point in relation to receiving the training. Although the gap meant that the training seemed a long time ago, it gave the PWPs an extended opportunity to implement the PI-E techniques, which was beneficial to learning about the practical value of the training. PWPs clearly remembered some experiences on the training, some six months later, which was testament to the effectiveness of the training in terms of facilitating retention of key learning points.

Experience of interviewing

As a method of data collection, interviews suit the exploration of experiences, in which people have a personal stake (Braun & Clark, 2013). Semi-structured interviews provided a structure, but were considered more flexible than structured interviews for responding to new information or different directions the participants took (Galetta, 2013).

The interview schedule was developed via discussions in research supervision and by reviewing the literature. The paper by Mackay, West, Moorey, Guthrie and Margison (2001) was influential, as this described a similar research study exploring the experience of primary care counsellors learning PIT. This paper provided a detailed method section and gave explicit topic areas covered, which were then adapted to suit the purposes of the current study. Adaptations were necessary due to the differences in the studies, as PWPs were not being asked to learn and adhere to a new therapy model as such. It was considered that the interview schedule (Appendix 3) and subsequent mind-map (Appendix 4) were appropriate to facilitate in-depth discussions about the PWPs' experiences of the PI-E techniques. However, upon reflection, asking PWPs to recall more specific examples of using the techniques with clients may have further facilitated understanding on use of techniques in practice.

Significant attempts were made to ensure that the research questions were clear, open-ended, and non-leading wherever possible (Braun & Clark, 2013). However, it was difficult at times being a novice interviewer to always adhere to these principles. In this regard, some skills developed from clinical interviewing were transferable to research interviewing, whereas other clinical skills such as reflection and commenting are less appropriate in research, as they may influence the participant's decision about what to talk about (Braun & Clark, 2013). It was therefore important during the early stages of interviewing to listen back to the interviews and reflect both alone and in supervision on

my interviewing style. I subsequently attempted to use less of the skills common in clinical practice, such as providing validation and reassurance. Research interviews are, however still conversations between people and therefore interpersonal skills and the ability to be warm and engaging are important (Fontanella, Campos & Turato, 2006; Rubin & Rubin, 1995). Reflecting upon my own experience of being interviewed within a research project, I had been aware of the importance of feeling that the researcher was interested in my views, so I could feel relaxed and provide open and honest answers. There were frequent supervisory discussions around whether to some extent, the interviewing technique should model the PI-E techniques. I was aware of times when I used statements rather than questions, picked up on cues and used a negotiating language within the interviews, whilst maintaining a balance with research interview skills.

It is important to consider the implication of meeting participants from cohort one, but not cohort two. I attended part of the first PI-E training course to develop a better understanding of the training content. This could be a limitation of this study as it may have influenced social desirability effects for participants in the first cohort as I may have been associated with the delivery of the PI-E training, unlike an independent researcher. Alternatively, my familiarity with cohort one may have facilitated rapport in interviews. Ideally, it would have been preferential to treat both groups equally, either attending both training courses, or none.

Analysis

Interviews were transcribed alongside the data collection process as this allowed opportunity for reflection on interesting concepts and my interview style. However, analysis was not commenced until familiarisation with the data had taken place, in keeping with Braun and Clark's (2006) six-step approach to TA. *NVivo* 11 software helped facilitate the efficient coding of a large quantity of data (Wong, 2008). A complete coding approach was employed as opposed to selective coding to ensure everything that might be of interest was included (Braun & Clark, 2013). This led to over 900 initial codes being generated so data-management strategies were employed to reduce the codes into fourteen overarching categories such as "initial thoughts", "changes in practice" and "difficulties or challenges"[16] to name a few. This step helped

[16] See Appendix 15 for an example

to make the process of theme identification more manageable. Analysis then became more organic with the use of hand-written mind-maps and post-it notes. Visual representations of the data facilitated observations of the links and patterns between the codes and supported the development of the themes.

Trustworthiness

To achieve trustworthiness in the methodology and findings, qualitative researchers should consider the dependability, credibility, confirmability and transferability of the research (Guba, 1981). Credibility and dependability were maximised by ensuring that codes and themes were cross-referenced across the interviews (Gale, Schröder & Gilbert, 2015) and an audit trail was established via the transcripts, reflections and research supervision minutes. Although data were only collected via the use of semi-structured interviews, triangulation was sought by interviewing participants with different job roles. It was important to understand the experiences of the PWPs, but also their clinical supervisors and operational managers in terms of understanding the wider picture. The credibility of the research is also established by the results being congruent with similar research exploring trainees' experiences of learning psychodynamic based approaches (Hill et al., 2015; Hill, Sullivan, Knox & Shlosser, 2007; Pascual-Leone, Wolfe & O'Connor, 2012; Pascual-Leone, Rodriguez-Rubio & Metler, 2013). Such studies found that learning similar approaches help improve feelings of self-efficacy, abilities to understand clients' difficulties more deeply and an awareness of the importance of sharing responsibility with clients. Such factors were also common concepts within the present research.

In considering transferability, discussions took place in research supervision around how the coding and development of themes had been approached. The themes were re-organised numerous times in this process. Initially, themes were linked to the aims of the project in terms of exploring the experiences of training, putting the techniques into practice and then the subsequent impact. However, this felt quite reductionist and may have led to important concepts being lost. Developing themes was therefore an evolving process: seven themes were initially (See Appendix 16) generated to represent the data more wholly, before being condensed into the final four themes and relevant sub-themes. The transferability could be affected by participants being from the same service; however, the sample size and length of interviews were

considered adequate in providing an in-depth narrative on the experience of learning and implementing the PI-E techniques within this context.

Reflexivity

It is important to be reflexive and turn awareness onto oneself in qualitative research to 'own' your own perspective (Elliot, Fischer & Rennie, 1999; Mcleod, 2001) and achieve confirmability (Shenton, 2004). Due to my previous experience of working as a PWP, it was particularly important to retain a reflexive stance. I had found working as a PWP challenging at times due to feeling unskilled in managing highly emotive sessions. It was also difficult to try and use CBT approaches with people who I felt were being realistic in their thinking or had suffered at the hands of difficult life events. I therefore feel that courses such as PI-E would have given me more skills in managing certain scenarios. Conversely, I could recognise potential challenges of learning PI-E as a PWP, in that facilitating more intense emotions in sessions could be exhausting due to the high volume of clients seen. It was therefore important for me to have good self-awareness during interviews and the analysis so as not to impose my views onto participants. During the interviews, I tried to remain curious about the PWPs' experience and not make assumptions. To aid this I relied on my experience as a clinician, where I remain curious about clients' meanings and understandings even if I could identify with their experience. Relevant discussions in research supervision were also helpful in remaining reflexive. Although I was unable to achieve full separation from my previous experiences, I feel that I was able ensure that the codes and themes generated accurately reflected the data.

Paper Three - Quantitative evaluation

This component of the research project was an opportunistic and pragmatic service evaluation. However, due to service practicalities and ensuring that PWPs were trained with supervisors for the purposes of continued support in implementing the techniques, we had limited control over the study design. Suggestions to improve the experimental methodology are outlined later under 'Suggestions for future research'.

Design

The evaluation had a 3x2 mixed methods design with two groups of PWPs and three timepoints. Three timepoints were established to assess the clinical outcomes pre-

training and post-training. A decision was made for each timepoint to reflect a four-month period due to there being a four-month gap between the two training courses. Data were therefore collected from four months prior to Cohort A training (May 2015) until four months after Cohort B had received the training (May 2016). The staggered design allowed for any pre-post changes in clinical outcomes to be evaluated, whilst considering the specific effect of the training as far as possible.

Data collection

Data were collected from the services patient information recording system. With data spanning an entire year, this resulted in the anonymous clinical outcome data of 2,546 clients seen by 18 PWPs. The first steps upon receiving the data were to remove the clients seen by PWPs who had not completed the PI-E training, clients who had not attended any appointments and to anonymise the PWPs. The latter was achieved by generating codes for each PWP. After doing so, these codes were then sent to an operational manager within the service and deleted from my computer. This process ensured that the identity of the PWPs remained anonymous to the research team but also provided the potential to return to the dataset if necessary due to missing data. Fortunately, this process was not required.

Dependant variables

Due to the volume of clinical data collected it was important to consider the most important variables to analyse. At conception of the project, the plan was to analyse all outcome data including scores on measures of anxiety, depression and working alliance alongside measures of engagement such as drop-out rate and rates of DNA (did not attend) and CNA (could not attend/cancellations). However, due to the service evaluation being completed alongside a time-consuming qualitative project it was deemed appropriate to reduce the number of variables to those which were most clinically relevant. The aim of the PI-E training was to enhance empathy and clinical engagement within sessions. Although research suggests the therapeutic relationship is linked to clinical outcome (Horvarth, Del Re, Flückiger & Symonds, 2011), for the purposes of this study the most important variables were therefore seen to be those relating to engagement and the therapeutic relationship. The variables were therefore reduced to: drop-out rates (after session one or two), combined CNA/DNA rate, DNA rate and scores on the Session Rating Scale (SRS V3.0; Miller, Duncan & Johnson,

2000). Drop-out rates were limited to those after session one and two as it is during the preliminary sessions where the highest drop-out rates usually occur (Bados, Balaguer & Saldaña, 2007). We also anticipated that PWPs would be more likely to employ PI-E techniques in earlier sessions during information gathering and building the relationship, before moving onto their usual interventions in subsequent sessions. The SRS had been introduced to the service shortly before the first cohort was trained. This measure was implemented to capture the working alliance and was chosen as it is quick and easy to administer (Duncan et al., 2003). This was an important consideration within an IAPT service that already requires PWPs to complete numerous outcome measures within 30-minute sessions. Unfortunately, uptake of implementation for the SRS was slow. This meant that the sample size for SRS scores were small, especially for clients seen within the first time-point. PWPs also achieved high SRS scores with their clients pre-training, reducing the room for improvement on this scale. The SRS may subsequently not be an ideal outcome measure for determining change.

Data analysis

The dataset was complex as it had clusters (PWPs), between participant variables (group) and within participant variables (timepoints). A sophisticated analysis was therefore required to reflect these design factors. Aggregated cluster analyses were performed in order to take into account within-cluster variance (which is likely to be more important than variance between clusters; Campbell & Walters, 2014) and thereby reduce the risk of Type 1 errors. Paired *t*tests were used to compare the outcome variables pre-post training and Generalised Estimating Equations (GEE; Hanley, Negassa, Edwardes & Forrester, 2003) were employed to investigate any interactions between group and timepoint.

One limitation of this approach is that it reduces the data to a much smaller number of data points (i.e., 18 clusters, one for each PWP), even though the client sample were more than ample. Due to differences in roles and working hours of the participants, there was also variation between clusters on the number of clients seen. This will also have reduced the power of the study. GEE can usually account for clustering without needing to aggregate the data; however, due to the volume of clinical data, SPSS was not sophisticated enough to perform such analyses. Preliminary analyses were performed at the individual client level using Mixed Effects Longitudinal

Models in Stata. These preliminary results provided similar statistical outcomes to the clustered analyses, indicating that the therapist level analyses were accurate and robust (Appendix 17). Any further work would focus on the individual level analysis, attempting to disentangle the effects of cluster, individuals and timepoint.

Implications of results

The results from the review and the empirical studies suggest PI-E training has some value. Although further research is necessary to support the notion that PI-E training can improve engagement and reduce DNA and drop-out rates, there is some indication that the training may have positive effects on attendance rates. Moreover, the qualitative analysis suggests that using PI-E techniques does have positive implications on the therapeutic relationship which could lead to improvement in engagement and drop-out rates.

If PI-E training is ultimately found to be effective, it could have positive implications across the board. PWPs are likely to feel effective which could have an impact on retention within the job-role, services will be more likely to meet targets and most importantly, more clients are likely to feel listened to, invested in and able to access treatment that meets their requirements. Later down the line, this could lead to a change in policy and clinical guidelines to incorporate the use of techniques focusing on relational aspects within LI-CBT.

Due to recent research suggesting that PWPs are at risk of burnout (Westwood, Morrison, Allt & Holmes, 2017), health education and services have a duty of care to their workforce to consider ways to reduce this. If PI-E can, as indicated within the qualitative study, enhance job satisfaction and a sense of self-efficacy then this could reduce feelings of being ineffective, which is associated with burnout (Stamm, 2010). Conversely, paying more attention to difficult emotions could put PWPs at risk of higher levels of emotional fatigue if they are not supported, which is another factor to consider in burnout (Craig & Sprang, 2010). This relates to a wider issue about the necessity of offering high quality clinical supervision to PWPs that allows discussion around therapeutic processes and issues such as countertransference, to supplement the caseload management supervision already received.

Implications for personal practice

Being involved in this research project has implications for my own clinical practice alongside the clinical implications for PWPs. Being part of this project helped me to refresh my knowledge of the PIT competencies taught within the ClinPsyD and sharpened my awareness of the importance of empathy and the therapeutic relationship. I believe that PIT skills can be used well as an adjunct to therapies like CBT and I have embodied some of the techniques on recent clinical placements. Such experiences have been invaluable in helping me to build strong therapeutic relationships with people. It has also been reassuring to be reminded that learning any new approach takes time and it is OK to feel stuck or even get things wrong in sessions as long as you attend to it and seek supervision. This has had positive implications on my own sense of self-efficacy and reduced the pressure I place on myself as a therapist. This project will also have implications for my future development as a clinical supervisor, when I think about how to support Trainee Clinical Psychologists to attend to their relationship with clients by using some of these skills.

Suggestions for future research

Although the service evaluation outcomes were not significant, the near-significant results for DNA rates were a promising indicator that the PI-E may have positive effects. This, coupled with the qualitative findings on the perceived benefits of PI-E training, suggests that further research on the impact of PI-E training is warranted. It would also be of clinical interest to research the experiences of clients on the receiving end of PI-E, to see if that matched the PWPs' sense of enhancements within the therapeutic relationship.

As the quantitative evaluation in this study had some methodological limitations, it is important to analyse the effects of PI-E in an experimental research trial. It is recommended that a larger study should be conducted with PWPs who use LI-CBT as their predominant model. PWPs should be recruited from multiple services and services be randomly allocated to receiving the PI-E training, versus continuing with usual practice. This would address the risk in the present study of cross-contamination between groups, in which PWPs in the first cohort may have, to some extent, shared their knowledge of the PI-E interventions prior to the second cohort being trained. It

would also be useful to introduce some measure of skill use, such as a questionnaire in attempt to quantify how often PI-E techniques are used in sessions.

Future research into the effects of PI-E may also wish to consider evaluating the impact on clinical outcome data such as recovery rates and reliable change, which are key measures within IAPT services (Gyani, Shafran, Layard & Clark, 2013). If PI-E training was found to have impacts on such measures, this would pose even greater implications for the future training of the PWP workforce.

Personal reflections

I found completing the review the most challenging aspect of the research project. I was initially disheartened by my unsuccessful attempts to complete a systematic review. However, with encouragement from supervision, I did later enjoy the freedom that a narrative review provided to include a broader range of studies on different facets of empathy. On completion, I feel this paper has a clinical and practical use for clinicians and trainers and can be used as an overall guide to factors related to enhancing empathy in therapists.

Prior to starting this project, I had no prior experience of qualitative research and was initially apprehensive about the process. Although the transcription of the interviews was at times laborious, I was surprised to find I thoroughly enjoyed this part of the project. It was a privilege to explore PWPs' experiences of learning a new approach and taking ownership of the qualitative research experience was invaluable. With guidance from supervision, I felt able to totally immerse myself in the data, leading to a deep understanding of the PWPs' experience of learning PI-E. The main difficulty I experienced was concern about doing the vast amount of information I collated in the interviews justice, and a responsibility to ensure I was accurately reflecting the PWPs' views. It was therefore difficult to condense all the information to be able to fit within a limited word count.

The service evaluation supplemented the qualitative evaluation of the PI-E training package. However, I was surprised and at times frustrated with the amount of time required to continually re-organise the data within SPSS to perform the appropriate analyses. Completing a GEE statistical analysis, which I had previously been unaware of, did cause some initial apprehension. However, I overcame the barriers and completed the analysis with advice from a statistician.

Overall the project enhanced my appreciation for mixed-methods and qualitative research in terms of the considerable effort and dedication required to complete qualitative projects, but also in relation to the benefits to clinical knowledge and understanding. Without the qualitative component, it may have been much harder to understand or attempt to explain the results found within the quantitative evaluation. I therefore believe it is important that all phenomena need to be explored using both qualitative and quantitative methods to understand the whole picture.

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Appendix 3: Interview Topic Guide

Topic Guide - Interview Schedule for PWP qualitative interviews

Overall topic	Possible Questions
Overall opinions of the PIT-PWP training	• What did you think about the training? • What do you think about the PIT model? • What were your initial thoughts on using PIT-PWP in sessions? • What are the advantages and disadvantages of using PIT-PWP in comparison to usual PWP practice? • What was your experience of the video role plays? • What were the best parts of the training? • What were the worst parts of the training? • What did you take away from the training?
Use of PIT-PWP in practice	• How has the PIT-PWP training influenced your PWP practice? • Have you been using PIT-PWP in sessions? • What PIT-PWP techniques have you used? • Which PIT-PWP techniques have you used the most/found easiest to use? • Have you had any difficulties using the PIT-PWP techniques? • How competent do you feel in the use of PIT-PWP techniques? • What have you noticed to be the benefits of using PIT-PWP techniques? • What have you noticed to be the problem with PIT-PWP techniques? • Do you expect to continue using the techniques as an adjunct to the PWP techniques
Impact on the relationship	• What impact has using PIT-PWP had on your clients? • How does PIT-PWP training affect your feelings in relation to your clients? • Have you been able to use PIT-PWP skills to manage a situation which may have been difficult to manage prior to the training? • How does PIT-PWP training affect your behaviour in relation to your clients?

Supervision	• Have you used PIT-PWP supervision to support you to use the PIT-PWP skills? • How often have you discussed PIT-PWP techniques in supervision? • Has PIT-PWP supervision differed to usual PWP supervision? • What impact (if any) has supervision in PIT-PWP facilitated interventions
Reflections on self as a therapist	• What impact has the PIT-PWP had on how you feel about yourself as a clinician? • What impact has PIT-PWP had on your working day/life? • Has PIT-PWP had an impact on how you feel about your work?
Contamination	• (Group 1) Did you discuss techniques used with your colleagues? • Did you discuss (advise/talk/share) techniques with your colleagues before they received the training? • (Group 2) Had you heard about the PIT-PWP techniques before you completed the training? • Were you ever given advice or supervision on the use of PIT-PWP techniques with a client before you completed the training?

Appendix 4: Interview schedule mind-map


Interview Map
Conversations with (other group)
Knowledge of skills prior to training
Contamination
Best parts
Worst parts
Comparison to other training
Views
Role plays
Learning points
The Training
Initial thoughts
Conversational skills
Expectations about using in practice
Advantages/ Disadvantages
Impact on working life
Feelings about role
Reflections on self as a therapist
PWP experiences of Conversational Skills Training
Use of skills in practice
Impact on practice
Benefits
Difficulties
Which techniques...
Most used
Least used
Easiest to use
Hardest to use
Feelings of competence
Continuation of use
Supervision
Frequency
Impact on use of skills
Difference to usual supervision
Impact on feelings of competence
Therapeutic relationship
Impact on clients
Feelings about clients
Behaviour towards clients
Situations handled differently

Appendix 5: Ethical Approval

Ref: ethics/16014

Research Governance, Ethics and Integrity
2nd Floor Christie Building
The University of Manchester
Oxford Road
Manchester
M13 9PL
Tel: 0161 275 2206/2674
Email: research.ethics@manchester.ac.uk

Mrs Anna Taylor c/o Dr Richard Brown

School of Psychological Sciences

Zochonis Building S20

26th February 2016

Dear Mrs Taylor and Dr Brown,

Study title: Evaluating the effectiveness of conversational therapy skills training for PWPs

Research Ethics Committee 2

I write to thank you for coming to meet the Committee on 8th February 2016. I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

This approval is effective for a period of five years. If the project continues beyond that period an application for amendment must be submitted for review. Likewise, any proposed changes to the way the research is conducted must be approved via the amendment process (see below). Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

1. Amendments
2. Breaches and adverse events

3. Notification of Progress/End of the Study

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a feedback sheet

[https://survey.manchester.ac.uk/pssweb/index.php/739975/lang-en**]**

We hope the research goes well.

Yours sincerely,

Ms. Genevieve Pridham

Secretary to University Research Ethics Committee 2

Appendix 6: Participant Information Sheet

Version :3
Date: 25/02/2016

Evaluating the Effectiveness of Conversational Skills Training for PWPs

Participant Information Sheet

You are being invited to take part in a research study as part of a Clinical Psychology Doctorate Project. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. **You are welcome to take part in the study if you would like to but you are not under any obligation to do so.**

Thank you for taking the time to read this.

Who will conduct the research?

The research is being conducted by Anna Taylor, Trainee Clinical Psychologist, and her supervisors (Dr Richard J Brown, Dr Adam Danquah, Prof Else Guthrie, Dr Rebecca Hughes) from the Section for Clinical and Health Psychology, School of Psychological Sciences, University of Manchester.

What is the purpose of the research?

The purpose of the research is to evaluate the conversational therapy skills training for Psychological Well-being Practitioners that you took part in recently. We would like to learn about PWP's experiences of the training and also of using the skills in clinical practice. The purpose of the research is **not** to evaluate your clinical practice or assess your use of the conversational therapy skills. The findings of the study could have important implications for future training of PWPs.

Why have I been chosen?

You have attended a 3 day training course on conversational therapy skills training for PWPs requested by Six Degrees Social Enterprise.

What would I be asked to do if I took part?

If you agree to take part you will be asked to complete an interview with the researcher. The interview is expected to last between 30-60 minutes. You will be asked questions about your experience of the training, your thoughts about the conversational therapy techniques and the use of these skills in your clinical practice. All interviews will be audio-recorded for the purpose of analysis.

You will also be asked to not discuss specific details about the clients or service users you have worked with in order to ensure their confidentiality.

The interviewer will come to your service so you do not need to travel.

What happens to the data collected?

After the interviews have been completed the recordings will be transcribed, to ensure anonymity. The transcripts of the interviews will then be used to complete a qualitative analysis.

How is confidentiality maintained?

Interviews will be recorded on a voice recorder. Immediately after the interview the audio file will be transferred onto a secure server or an encrypted memory pen until access to the secure server is available. Once transcribed, data will be stored using a code number to indicate when you attended the training; no personally identifying information will be stored with the transcriptions.

The audio-recordings and transcriptions will not be shared with other staff or managers at Six Degrees. Themes and results from the qualitative analysis will be disseminated but your confidentiality will be protected throughout.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw from the interview, without giving a reason and without detriment to yourself, up until the point of anonymised transcription and the start of the analysis. After this point it would be very difficult to identify your data in order to remove it from the analysis.

Will I be paid for participating in the research?

You will not be paid for participating in the research but your service has given permission for you complete an interview during work hours.

What is the duration of the research?

The interview is expected to take between 30-60 minutes.

Where will the research be conducted?

At the base of your service, or a clinical environment convenient for you.

Will the outcomes of the research be published?

The findings of the study will be written up as part of a doctoral thesis. It is also anticipated the results will be written up and submitted for publication to a Psychological journal and may be presented at conferences or other relevant meetings.

Six Degrees Social Enterprise will also be informed of the overall results of the research but the confidentiality of individual participants will be protected.

Who has reviewed the research project?

The project has been reviewed by the University of Manchester Research Ethics Committee and consent has been provided by the board of directors at Six Degrees.

What if something goes wrong?

It is not anticipated that anything will go wrong during the interviews. However if you wish to stop the interview at any point please let the researcher know and they will do so.

What if I want to make a complaint?

Minor complaints

If you have a minor complaint then you need to contact the researcher's supervisor in the first instance.

Dr Richard J Brown
Senior Lecturer in Clinical Psychology
Section for Clinical and Health Psychology
School of Psychological Sciences
University of Manchester
Manchester, M13 9PL

E-mail: richard.j.brown@manchester.ac.uk **Tel: +44(0)161 306 0400**

Formal Complaints

If you wish to make a formal complaint or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact the Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674 or 275 2046.

What Do I Do Now?

If you have any queries about the study or if you are interested in taking part then please contact the researcher via e-mail.

Anna Taylor
Trainee Clinical Psychologist
Section for Clinical and Health Psychology
School of Psychological Sciences
University of Manchester
E-mail: anna.taylor-2@postgrad.manchester.ac.uk

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [UREC reference number 16014].

Appendix 7: Consent form

MANCHESTER 1824

The University of Manchester

Version :3
Date: 25/02/2016

Evaluating the Effectiveness of Conversational Skills Training for PWPs

CONSENT FORM

If you are happy to participate please complete and sign the consent form below.

		Please initial box
1.	I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
2.	I understand that my participation in the study is voluntary and that I am free to withdraw at any time (until the point of anonymous transcription) without giving a reason and without detriment to myself	
3.	I understand that my data will remain confidential	
4.	I understand that the interviews will be audio-recorded.	
5.	I agree to the use of anonymous quotes.	

I agree to take part in the above project

Name of participant	Date	Signature
Name of researcher	Date	Signature

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [UREC reference number 16014].

Appendix 8: Participant demographic questionnaire

MANCHESTER 1824

The University of Manchester

Evaluating the Effectiveness of Conversational Skills Training for PWPs

Participant Information Questionnaire

Thank you very much for ageeing to take part in the research interview. Please take the time to to complete this short questionnaire about your demographic information.

1. **What is your gender?**
2. **How old are you?**
3. **Do you work Full-time or Part-time?**
4. **What is your current job title?**
5. **How many years have you been qualified in your current profession (e.g. PWP)?**
6. **On average how many clients do you work with each week?**
7. **Please briefly list any other therapeutic work you did prior to your current role**
8. **Please briefly list any other training in therapeutic interventions you have attended**

Thank you very much for your participation

Anna Taylor - Trainee Clinical Psychologist
Section for Clinical and Health Psychology
School of Psychological Sciences
University of Manchester
E-mail: anna.taylor-2@postgrad.manchester.ac.uk

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [UREC reference number 16014].

Appendix 9: Sample Interview Transcript

Interview with 'Lena' (Pseudonym)

I = Interviewer

P = Participant

I: So thank you very much for agreeing to participate in the interview today. You've been asked to participate because you were attending some training back in January. So first of all it might be quite nice just to get your experiences of what the training was like.

P: Mmhm… I find it- I found it very useful. Especially the practical parts and although it was probably intimidating because it was all erm videoed. Erm… yeah I found it useful and it wasn't stressful when we were doing it because the, the erm… facilitators of the training were so approachable and not judgemental at all that is it was- it was really like a pleasant experience. Yeah and considering that it was such a brief really training it- I think it is… it's almost surprising how much you actually remember from it and how much you use unconsciously of the techniques. Not so much as maybe a specific intervention, I don't maybe- I don't with patients really think oh this is the understanding hypothesis or this is that, I just really use it and it's a bit more flexible. So yeah I found the training very, very useful.

I: OK so what do you think it was about the training that kind of helped you to take on board some of the stuff so easily?

P: I think it was the practice, the role plays and I think it was erm… the handbook as well with the examples and dialogues which were transcribed. So you can- when you sometimes feel a bit stuck and you think how can I ask patient about that, what kind of phrase can I use or how can I approach this you can look at the transcript and see how that played out so I think those two parts were the most useful for me.

I: OK and what do you think it is about the video role plays that is useful in a learning process?

P: Erm…to be fair I don't usually like role plays because it's such an intense experience when you do that, that you can't really reflect on what you are

saying, what kind of questions you are asking but with this training, it was useful that we could look at it, later. So that it was good that it was recorded and we could look at ourselves and gather the feedback and talk with other people and see other people's videos as well. So maybe not the role play as such on it's own but the fact that it was recorded and then we could look at it.

I: Hmm and what was that like - the feedback after the videos?

P: It was very useful, it was useful and sometimes even watching it you would pick up on things, 'oh I shouldn't have… oh I didn't know that to say there or I should have done this, done something differently' but when you are actually doing the role play, it- it's just happening so you don't really think about it that much and in order to learn and practice the techniques in an appropriate way you need to be able to reflect on it after. So…

I: So watching it back, seeing yourself, getting feedback from others helps with that reflection and what was it like… were you asked to be the therapist a couple of times on video? What was it like doing it a number of times?

P: It was fine… and it was easier the more we'd done it so the first time we were asked to do it everyone was kind of participating something really scary but then the following day everything was fine and it was actually like I want to go and practice it.

I: And what was it like being the client or patient in the role plays and kind of being on the receiving end of those techniques?

P: Mmhmm, it was erm… probably hard to… formulate to some extent and think what- put myself in the clients shoes but then… it was, it was easy because sometimes I find that when you are asked a direct question it can be quite intimidating and then when you are, are expected to provide an answer it can block everything and you might not be able to generate anything at all and with- with the training that we had it's sometimes like a gentle statement or an observation and it can open up so much more erm… and I thought that it was- it felt less intrusive doing it this way rather than being asked the question why? Why are you anxious? What are you anxious about? So just noticing and picking up on cues and, and do it in a more open, and I think acceptable kind of

way… so yeah I didn't think about this until you asked now so that's actually quite a good thing from a client perspective yeah.

I: So why do you think that is a good thing from a client perspective?

P: Because, because experience of therapy can be quite scary. Not only are people feeling depressed or anxious but they don't know what to expect and if they have been bombarded with one question after another it's- it's even worse isn't it? and that probably can sometimes put them off from the therapy.

I: OK so what were your thoughts about all the different techniques that were talked about on the training when you first heard of them?

P: I found it difficult to start off with I found like I constantly wanted to ask questions and then I had to remind myself no, let's rephrase this let's, let's erm put it in a different way. But what I found good about it, I always felt that CBT approach is quite rigid and some- to some extent and feeling like it sometimes- it can feel like you are getting somewhere but you are not able to elicit that information because the patient or the client is not able to express what- what really is happening and with CBT approach I always felt that it was… there was almost an expectation of not suggesting anything or not double checking or not leading in anyway and with, with PIT it's you know, using the understanding hypotheses, it can say now- they can say it's completely wrong and I find this useful that I can be wrong and they said no, but if they said no then this is not what I thought it was or with pure CBT I would probably be wondering is it this? And I would be more assuming than being able to check straight away whether it is that or not.

I: OK so that sounds like by being able to assume out loud then that makes you less assuming…. All together?

P: Yeah so getting that confirmation and then you sort of see or more sense if you are going in the right direction or not.

I: Yeah and what do you think the benefit of that is?

P: Having a better understanding of what the client is going through and that the problem is really.

I: OK thank you. So you said that maybe the questions to statements was maybe difficult at first, why do you think that can be difficult making that shift?

P: I think it's habit really, so it's just the way we've been trained and we get the four W's and we ask questions and we got lots of questions in the initial assessments and sometimes there is loads of information that we never return to and some of them you don't really need to understand what's really happening yeah so I think it was just a matter of you know, habit. This is just how we always get information by asking and it was difficult to sort of slow down a little bit more and just let the client lead.

I: So what were your initial thoughts about maybe asking a few less questions in sessions or… thinking about an assessment as a PWP is very question heavy. What were your thoughts about maybe adapting that to maybe use statements instead?

P: Yeah, yeah… I think I have, I think I have done. I think I ask less questions now and sometimes and it's less uncomfortable sitting with the sort of silence when I just make a statement and I just wait and there is no pressure then to ask another question so they can answer me back and sometimes it's minutes before they say anything back and that's fine as I know they are thinking and it- it's useful in that way. So I think I have been using it and before the interview today I was thinking how I can… I was trying to think about it, to what extent I used it because I didn't really think I was using it that much erm so I looked at all the training papers that we- that we had and I looked at the interventions and the methods and I was actually looking at them and thinking ok I use that and I use all of them to be fair so, without even thinking about it. So considering it was such a brief training and the fact that it was engrained in such a solid way that we use it without thinking about it, that's probably a successful thing for the training session I think.

I: It's something that you naturally adopted without…

P: … without thinking about yeah.

I: OK going back to the questions… so different people have maybe had different views about… can you always ask statements for somethings… I'm

trying to explain this, what I'm trying to ask… erm… can you see anything that the statements might not be useful for?

P: Right ok… so I do ask questions still, probably more when I need to find out something more specific or if I want to make sure that I get it right and I reckon that it's probably more in relation to risk that I want to be a bit more specific and- and find out the solid pieces of information that I'm entirely right and I'm not sort of leaving it off… as sometimes clients- you will comment on risk and they will talk about risk but not in the way that you needed them to talk about err so there will be certain parts of, of risk assessment that I would still use the questions for.

I: OK so… what did you think… I mean you might have already of touched on this, you said the video role plays and feedback in the training was helpful… was there any other bits of the training that you thought were helpful? Or which were the other best bits for you?

P: Erm… watching the In Patient it is called isn't it?

I: In Treatment

P: In Treatment yeah, In Patient, yeah In Treatment. I've seen this before but I've never… I've seen it like years back and to be honest when I first watched it I thought it was like some form of witchcraft almost and I was thinking how can he do that? He's asking direct excu- he's leading the patient, he's getting information and this is not acceptable… but I didn't know, I was coming from a CBT perspective and then after this training I thought oh actually yeah, that's… that's quite useful so now I know where they were coming from but before when I'd seen it… and I'd actually… last week I watched a documentary it was something about err… disruptive- distressed parent and disruptive child, something like that and there was a psychodynamic therapy family therapist and she was talking to the father erm… and she was picking up on his physical cues and I was thinking now I know what you are doing (laughing)… so it's quite useful to be able to recognise what's- what's… and it's- it worked as he was tapping his knee and he was smiling and it looked like everything was fine and she just mentioned that to him 'you look like you are quite happy' and then completely broke down so yeah so… watching the video and being able to take

it apart in the training and reflect on it and see why the questions were being asked in that way and where were the cues and what could be potentially asked in a different way, yeah that was, that was very useful.

I: It kind of brought it to life a little bit seeing it… in a video.

P: Yeah, yeah.

I: What did you think… erm… maybe were the worst bits or any bits of the training that you didn't like or would have liked to have changed?

P: I don't there was any bits that I didn't like err I would probably think, I would probably like to have more… training on the transition between… finding out what we need to find out, staying with the feeling because sometimes it's what stops us from progressing, so finding this out but sometimes by finding this our you can find out so much then you feel like oh my gosh! What am I doing with it? Because it is still a step 2 intervention. Sometimes those feelings are very intense as well and you don't want to leave the client with it so probably more about how to help transition from being able to use PIT and find out loads of information and how to move to a specific intervention without feeling like it is two separate parts and it's more… more one part.

I: OK, is that something that is a bit more difficult… the kind of linking

P: Linking it…

I: Linking the two together? Does that kind of feel a bit like what do I do with…?

P: Yeah so I found out loads and I know what the problem is but then what am I doing with this? Yeah.

I: So how do you think you have gone about that?

P: So I haven't- I haven't done the… full assessment using just PIT so I'm- I'd tend to use it when I get stuck with something so I'll have- I'll have the background of everything else, I've asked lots of different questions and then if I felt like I am not going anywhere or I'm not touching on the- on the real issues around there so… erm…. I would use PIT in my clinical practice for just… brief period of time just to elicit some more information and then I can go back to CBT approach, but it still feel… like not- like it's not entirely PIT. Do you know

what I mean? It is… tuning in for some parts and then having to take the step back when I feel there is probably something that if it links directly that it could be more smooth… transition between those two. Does it make sense?

I: Yep. So what do you think would help with that then?

P: More training!

I: More training? Yeah. And what would you like that to be like?

P: Probably based on the role plays perhaps as well and- and videos, probably the same style of the training because it's worked so… so maybe yeah… maybe another different day of focusing on just on that and what to do with the information we find out what the problem is and how to… because we did cover that but it was sort of on the last day and- and there was no need to cover the intervention specifically because we know them from the CBT background but it's about that transition or maybe more working on case scenarios and seeing… how, how things were linked in relation to specific patients err problem. That might be useful as well.

I: Hmm… and what are your thoughts on maybe… although it might be difficult to link them now… what are your thoughts on how well using some of the PIT techniques do fit with the traditional CBT low intensity approach?

P: I think it does fit. I think it fits pretty well. It's just that sometimes with PIT you find out more information that you'd normally do with standard CBT questions and sometimes you can feel that it's so much information and there is a lot of very emotive content as well that it- it feels like almost sometimes… not appropriate, not appropriate to squeeze that in- back into that half an hour session or 15 minutes of intervention that we've got left so if- and unpicked it loads and we took like loads of information and we feel like we understand the client and then we have to put it back in that box erm… yeah.

I: Does that feel difficult… for you as the therapist, to kind of have that emotion?

P: I think so, yeah… I think so because I wouldn't- I wouldn't want to… well I don't know about the client's experiencing the same way but if you feel like you've… you've had like a massive breakthrough in the session and then you

think that you, you found out something very useful and it helps you to… to understand but then… it can be something that is not really low intensity therapy and you know it might be something that is getting a bit deeper and then you still have to proceed with the tools that you've got available in our service then it feels a bit like you've opened a Pandora box almost at times. Like you have so much information erm… about what is the client experience that then it might not be suitable to… but then you can always refer them on and discuss that with the client as well so that's not entirely a big issue. As if you find… that probably needed to come out if it came out again so… yeah.

I: So has that happened- how have you managed that when that has happened in the session?

P: It's… erm… it's not happened as such. It's probably more a concern that it might do erm… if I properly went into using the PIT techniques for the whole session rather than just finding out a bit- a bit more information so. I feel like I've used it more on the surface rather than going… probably for that reason, probably it's my reservations really err… I was using them just in case there was anything… anything there that needed a bit more intensive… input.

I: Hmm I suppose that is how the training was designed wasn't it as a kind of an add on, an adjunct to what you are already doing, rather than a whole new approach – so it sounds like what you are doing is… kind of complimenting the two together. What do you think erm… you talked a little bit about the understanding hypotheses and the statements, what did you think about the other techniques; staying with the feelings and the picking up on cues?

P: Staying with the feelings is definitely for me very helpful erm… especially with clients who are scattered and they talk a lot and there is a lot of narrative and there is one story after another and when I struggle to understand what the problem is, then I tend to stay with the feeling and catch something specific to hold on to at that moment and see what's – what's happening there and – and picking up on cues I think especially non-verbal ones… I find it – because I remember years back that I found it difficult to do. I would see like… a client smirk and I would always think 'ooh – what was that about?' but I was like how do I ask about it? Well now I just mentioned it and it's – it's fine and it's not a

problem so I feel more comfortable with it so yeah – I think all of them are very good to be fair.

I: So it sounds like some of the things that you maybe… thought about doing before the training but didn't because you didn't maybe know how to… or whether it was right to… do you think that the trainings maybe given you a different… outlook on…

P: Yeah, yeah, yeah as I think before I was thinking before that I wouldn't want to put the client in an uncomfortable position by picking up on something that might be difficult for them when now I think it is probably useful to acknowledge that so yeah…

I: And how have you found that clients or patients have reacted to that when you've… you've commented?

P: Quite well to be fair, so they usually- they usually tend to open up and it's usually completely different emotion to what is – to what is was shown as so it's usually covered with a smile and there is usually something there, something sad there behind the…

I: So you get to a bit of a deeper level of understanding than you would have… by not mentioning it… OK so before you actually started to use these techniques when you were kind of leaving the training, what were your kind of key learning points or what did you plan to go away and do?

P: I was planning probably… hmm… I definitely wanted to try it out and because we'd talked on the last day about different – different kind of – everybody had to bring a difficult patient, a complex patient on the – at the very end and that sort of triggered my memories about patients that I had in treatment at that time and I was thinking oh so I could do this and I could ask that and do this and I can ask that and it's about – it was really like an anticipation of going away and seeing if it worked- works... that was the most, the biggest thing for me. I just wanted to go and see if it works, and it works so that's fine.

I: So what is it that works do you think?

P: I think it's… I feel it is more acceptable for the client that it's not that intrusive and you kind of get more information in a non-direct way but not scaring anyone with difficult question. You can still get information that you need. So I think – and it's less rigid than CBT. More flexible, which is… easier than having to stick with questions and dig and… err harass almost the client almost with questions and put pressure on them.

I: Who do you think it's easier for?

P: I think it's easier for both – for both the practitioner and the client because for client it's probably more, a comfortable experience. Well maybe not comfortable, comfortable is probably not the word, the best word as it can be quite distressing as well… but maybe less intimidating. And for the practitioner it's – it's – it almost feels like more secure but it feels like you know, you know… you know your client a bit better, you know what the problem really is instead of second guessing and not being entirely sure if you are on the right side.

I: And why do you think that's helpful?

P: Sorry?

I: And why do you think that's helpful?

P: Well I think you need to understand what the problem is in order to help them… otherwise you might not be – not even be on the same page so… the client might be experiencing completely different things that you are assuming and by – by testing these techniques I've – I've definitely had a few, a few cases when I was assuming something and it was completely wrong and they said 'no – that's actually entirely wrong, this is not what I feel' and I was like 'ok that's absolutely fine' and we moved in a different direction and it was – and it was probably quicker… because I'd probably get there a few sessions later but with the… sort of the approach I can confirm it as soon as it – as it happens.

I: And why do you think that's an advantage?

P: For a low-intensity therapy? Because we only have six sessions and they are half an hour sessions. So if there is something slightly more complex and slightly more… perhaps intense in an emotional way or that patient can't

formulate and express what it is that they – that's happening, directing the patient in that way might speed the whole process up. Which then would leave more time for interventions anyway.

I: So have you noticed a difference in your sessions then… because of maybe speeding things up a little bit… in terms of what you've achieved or…

P: Yeah, yeah… I think in those cases that I did use it… erm, not always I was able to finish the – complete the err, treatment as such… sooner. But sometimes I was able to probably get more information and we could make that decision about whether it was appropriate or not or whether they wanted something else instead. When sometimes I definitely, used to spend seven, eight sessions on trying and trying and trying and it was not working and then in the last session it was that something was coming out that they – they had actually something historical that they wanted to address as well. So yeah… it's – I think it shows in treatment that you can – that you can address things quicker… Because sometimes with more complex clients it feels like sometimes you do the assessment for two or three sessions like, you do one… but then you feel like you go away and I don't feel like I have got the right picture of it and you feel like you need to go back and explore it a bit more and sometimes it takes two sessions or three before you really understand what's happening, when with PIT you can just tune in for ten minutes and get – get it.

I: OK thank you… I know you've said that you hadn't maybe realised or reflected on in practice which ones you'd been using the most or – but do you have a sense about which one you might naturally use more or which one you might feel comfortable using?

P: The… understanding hypotheses, hypotheses I definitely use the most, probably… erm… and I think tentative statements as well and just… just letting it – letting it hang for a while and just sitting with it, yeah.

I: OK thank you… and what are your thoughts about how comfortable or confident you are using these techniques at the minute?

P: Hmm. On a scale from 0-10?

I: However you want to answer it.

P: (laughs) erm… maybe about 7?

I: OK

P: Yeah, I think there is definitely space for improvement and filling in the gaps with more and I've been thinking about going for the full pack as well, of the five days. Yeah.

I: So you'd like to do a little more training in this model?

P: Yeah, yeah I think definitely.

I: What do you think it is about you as a therapist or a person that's taken to this model, why do you think you like using it?

P: I think it's because it's a bit more out of the box and more… err adapted to… to the client and more person-centred probably than just… not – I'm not thinking CBT as such, but it can be quite… formal and this approach is more responsive to what's actually happening in the session and err not even for the client themselves but also the interaction between the practitioner and the client, so I think – it's the flexible approach of it and… and it just covers all those additional bits of CB- that CBT was missing so that's why, it sort of forms a good approach all together.

I: OK and what are your thoughts about the impact of using some of these techniques on maybe things like the therapeutic relationship?

P: Oh I - especially with the picking up on the cues, I think that's definitely helpful because it can help you to approach a certain subject if you see that something is not entirely right erm or if you've noticed that the patient that there is like erm something emotional happening, the patient might be frustrated in the session? Or they might be frustrated with you because you are asking lots of questions erm bothering them or not understanding properly so it's it's a right press – a place probably to use that to address those issues there and then rather than let it go on for a number of sessions without it being spoken about.

I: OK and can you think of any – well you've talked about maybe feelings that clients can have like frustration and that, sometimes… as therapists you can experience feelings towards a client for whatever reason… have you noticed

anything about how these techniques might help you deal with some of those feelings at all?

P: My own feelings in the session?

I: Mmm

P: I don't think about this… although probably we do talk about this in supervision mostly, so I don't think I – I don't think I think about it in the session with the patient, but then in supervision… and we use role plays, PIT role plays in supervision sessions sometimes so yeah… yeah we do talk about it and we do think about how we feel and how the patient is making us feel and how that might play out as well yeah… so we do use that and that's probably alive when it's happening in the session but later on in supervision.

I: And what's that been like – if that's something that's a bit different to what you did before?

P: Err well to be fair, our supervisor is trained in one of… and my previous supervisor was trained in psychodynamic therapy and the other one is a psychiatrist and she has got an interest in PIT so they were always using it so there was a lot – a big emphasis on checking how did we feel sitting with the patient then and that would – that'd open up a bit more about the interaction so we always used to have access to it without knowing what it was (laughs).

I: OK and… I don't want to put you on the spot… it's ok if you can't think of anything but… I was just wondering if there had been any situations… with clients which might be quite difficult to manage… if you've noticed that these techniques have helped you to manage in a slightly different way…

P: Ohh that's a good question…

I: I don't know… not bringing homework or… one of those sorts of things that might be difficult sometimes

P: Yeah, yeah… (15 second pause)… I can think of one patient and it was a lady who came in and she said she was angry for no reason at all and we spent – and I think she was in treatment with me at the time when I was doing the training, so I had a few sessions and I then I done the training and then we had

a few left… so we spent a few sessions just talking about ABC-E and… standard CBT formulation and anger management techniques and it just wasn't going anywhere and then… we've spent another two sessions I think just looking at that frustration and that anger and it turned out that it wasn't anger at all…eventually… so that was like an eye opener for me then, because actually she felt sad that she was not understood by her husband and that was leading to anger, but anger was more acceptable, than feeling like she is not being looked after to her…

I: Hmm so what do you think the benefit was of…

P: Helping her understand the emotions I think that she's experiencing… that she was experiencing, because she was coming and she was saying 'I feel angry, there is no reason for me to feel angry. I don't know… I'm acting this way and there is absolutely nothing I can do to control it' and then when she actually realised that it wasn't anger, it was something else… she stopped doing it. She stopped shouting. It was not recovered by any means at that time, but at least she, she sort of had that understanding that it wasn't the primary problem, that was happening for her. So yeah that is probably one of the examples of a more complex case, that you need to go a bit deeper to get it out.

I: OK thanks for sharing that erm… have you… you've talked about supervision and how different supervisors have got experience of using a psychodynamic approach or PIT… is this… have you noticed any changes in supervision since using these techniques?

P: I don't think so… but I think they were being used before. They were being used before.

I: So are you able to talk about using this approach in supervision?

P: Yeah, yeah and we can request it specifically. We can come in and say we want to do a PIT role-play, we can – and everybody goes for it so yeah.

I: OK, so do you think that you are – do you feel supported to carry on using these techniques if you want to?

P: Definitely… yeah, by the service definitely we are supported to carry on using it… even more encouraged to use it.

I: How often do you think that this style of approach comes up in supervision?

P: Everytime, probably. Every single supervision session it comes up.

I: OK thank you… I was just wondering about… whether… what you think or if there has been any impact of sort of using these techniques on how you feel about your role as a PWP or as a therapist.

P: Well I suppose it's always, it's always a good feeling when you… when you feel you are increasing your knowledge in any shape or form and you feel like you are building up on your knowledge and you are becoming a more experienced practitioner… but I think, I think… I don't know if it – I would say that it improved my confidence in the sessions but it feels like it gave me the, the tool that was sometimes missing. So there is something that… I don't have to rely on all the time but when I get stuck in the session with the client and there is something I don't understand, I can use that and it usually works so it's… almost like a back-up plan even… if everything goes fine, it goes fine but when things become a little bit more difficult I can always try something else. So it's like another thing I can use aside from CBT.

I: And why do you think that might be helpful?

P: To… probably to make me believe more that I can help the client, in a way… if that make sense? So more sometimes if you've got – sometimes you could, you could I don't know have a session with a client and you get stuck and you feel like 'oh I can't do anything, I can't – I don't understand, I can't help them at all' and then you might start thinking I don't know that it's yo – being in the wrong place or there is nothing that can be done and almost take more responsibility on you that things are not moving forward… and when you actually focusing on the dynamic in the session and you explore the feelings that are hanging – hanging in there a bit more… it feels sometimes like it's more shared responsibility… of the process of the discovery… rather than me digging in and asking loads of questions. So yeah, I think overall it's a better

experience, I think it's more… yeah… Yeah so maybe it's not only more acceptable for the client but also for - for myself perhaps.

I: Is there any other ways in which it is helpful for you as a therapist?

P: Well definitely in supervision, if I can re-reflect on what – on how I felt and acknowledge all my frustrations perhaps from the session and be able to – to look at them as well and realise where they are coming from and why they are happening. That is definitely useful because if they make me – it makes me more aware about it when I'm working with somebody and I can… I can at least do something about it perhaps rather than just let it influence the interaction.

I: OK and has it had any other impact on sort of your working life at all?

P: I don't think so…

I: OK. So you talked a bit about how… you think some like, there have been PIT techniques talked about in supervision prior to you doing the training. Did you have any… did you have any conversations with people who had done the training in September about what the training was about and what was taught on it all?

P: Yeah, yeah. We did talk about it err and erm… most the people found it useful, most the people found it useful. I think more the CBT inclined people found it very useful because they were all saying that it sort of, patched the gaps and filled those… filled those bits that were missing. I think… yeah… yeah and it was about – I think it's about staying with the feeling as well because I think this can be scary for practitioners as well – especially if it's not a good feeling… and it hardly ever is a good one in therapy, so being able to sit with your own anxiety while you can – while you are supporting somebody, I think that was the most, the key message from it.

I: And what's that been like doing that then, if that is something that is quite nerve-wracking….?

P: It's fine now – it was… it used to be nerve-wracking, I can sit with it now.

I: So it's something that got a bit easier with practice and time?

P: Yeah and this is sometimes probably more useful if it does happen… err if we – if there is an uncomfortable feeling as at least you know you are close to something if… even if it's not comfortable… rather than drifting on the surface and not being able to… find the core of the problem.

I: OK so you say you – you heard from the other people that had done the training in September and from supervision… do you think you had used any of these techniques prior to doing the training from what you'd heard? Or did you sort of wait for the training…?

P: Do you mean did I use the techniques before? Or did I use the techniques in my clinical practice before? No I wasn't using it – I don't think. Well we were talking about it in supervision, about staying with the feeling and exploring the here and now and focusing on what is happening for the client when they are happening then… but I don't think we were – I don't think I was… hold on yeah we were yeah… there was no names of interventions mentioned but now when I think about it, we were all using it… but perhaps more after the session. When we'd done the session we came back and we would say 'oh this patient was like… I don't know, pulling funny faces and he was a bit awkward' and they would be like 'why didn't you know… ask what was happening' and then we had to go away and test it out and stuff like that and after the training we could implement it straight away… without having to take that step back and ask somebody who is more experienced and then come back to it.

I: OK so it's something that was around… and that it was touched upon… but it was … suppose it may be felt a little bit more abstract or unknown until you had the training?

P: Yeah definitely

I: That gave you permission to do that.

P: Yeah yeah! That's a good way of putting it… getting permission to do it.

I: As I suppose it does feel… I suppose some of these things are quite a bit different to what you are taught on the PWP training…

P: Definitely… yeah and you don't want to step away too much from the model just in case… it was not considered Step 2 or low intensity, stuff like that so… and I suppose there is always that if you are trying to practice something that you were not trained in. So that was always… that worry that you think you know what you are doing but you might not know. So it was definitely much more comfortable to, to test it all out after the training.

I: OK, so have you got any other… sort of thoughts or reflections on this experience or the PIT approach or… how it fits with Step 2?

P: No I don't think so… I think the key – the key thing for me was actually this week finding out that how much I actually have used it, although I wasn't consciously thinking about it. As I knew I'd done the training and I have got the booklet at home and I had it and now I have to do the techniques and I probably need to read it again… and think about it and I opened it and I was like 'oh actually I'm using it all' so I was actually surprised that it's, that it's stayed as I wasn't consciously thinking about… planning to use it… I didn't think I'm going to go into a session and I'm going to use PIT… it was just sort of naturally happening so… yeah quite surprised to be fair how well that training works without me being aware of it (laughs).

I: So what's that like? What was that like that reflection?

P: It was nice, because it was effortless, if you know what I mean? It wasn't something that I needed to spend like hours and hours on and to be able to learn and practice something and just three days of role plays and… usually with – with some of the different kinds of trainings you go on and then you use it for a while and then you forget a bit and then… you don't really know what was happening and what you are supposed to do and with that… without consciously trying to remember about those techniques and consciously trying to use them, I still did… so... that must have been a very effective training I reckon, looking back at it. If it stayed.

I: And do you think that is the video role play feedback or do you think there was something different about that training that helped?

P: I'm not too sure… erm… I think it's a combination of watching the videos and… case studies maybe and being able to – to think about how to- to… to phrase things or perhaps also doing the role play about doing it a bit more mindfully… because you don't have to – if – there were exercises that we had to do that we… well we could ask questions but probably less than normally and you had to mindfully remember about it that it was supposed to be a statement. So it makes you think twice about what it is that you are saying. So maybe that's why it stayed a bit more… and it was practiced based training so it was – it was a good balance of… of learning about the techniques and being able to test it out straight away.

I: OK any other thoughts or comments?

P: Nope.

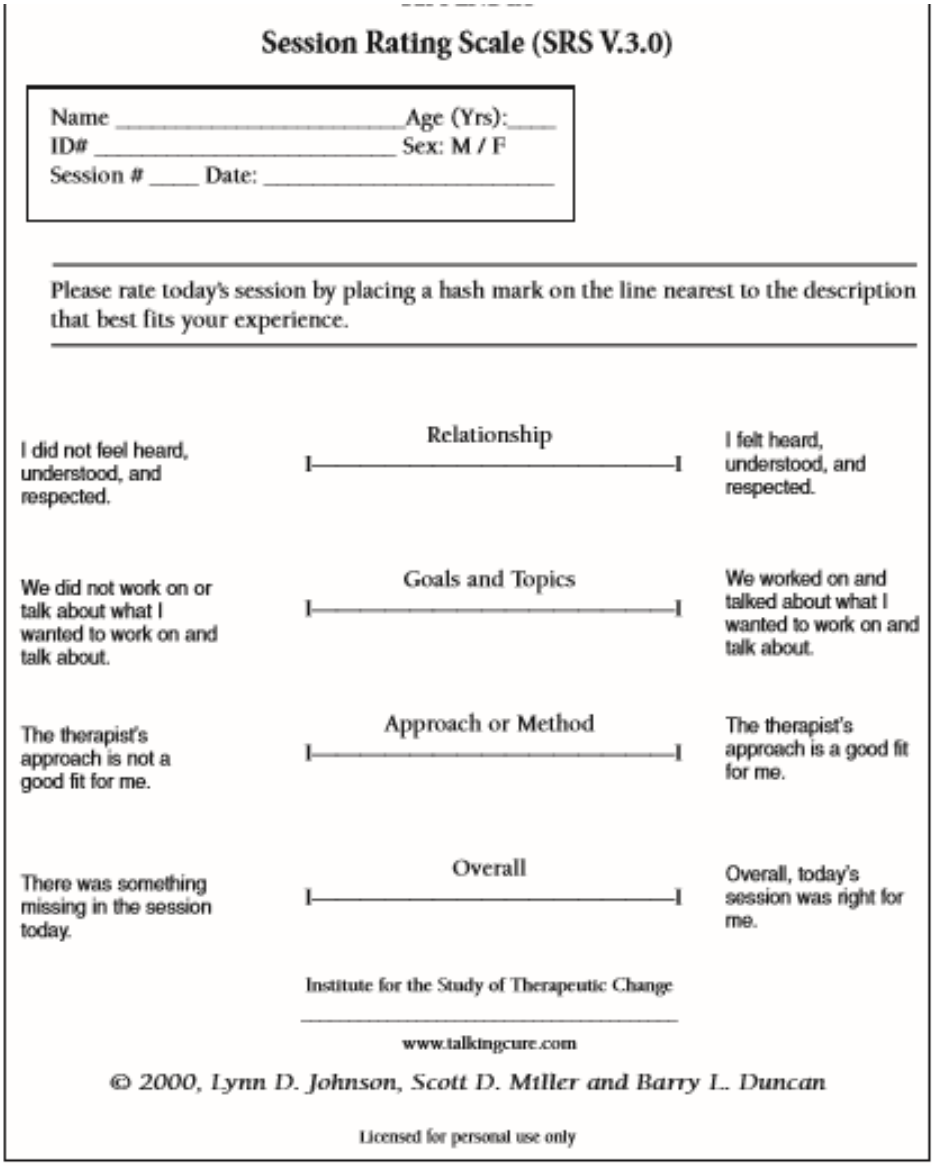
I: Nope? OK thank you very much for your time. I'll stop the interview there.

P: You are very welcome.

End of interview: 42:52.4

Appendix 10: Session Rating Scale (SRS)

(Miller, S. D., Duncan, B. L., & Johnson, L. D. (2000).



Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

I did not feel heard, understood, and respected.	Relationship	I felt heard, understood, and respected.
We did not work on or talk about what I wanted to work on and talk about.	Goals and Topics	We worked on and talked about what I wanted to work on and talk about.
The therapist's approach is not a good fit for me.	Approach or Method	The therapist's approach is a good fit for me.
There was something missing in the session today.	Overall	Overall, today's session was right for me.

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Appendix 11: Patient Health Questionnaire (PHQ9)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
⑤	⑤	⑤	⑤

Appendix 12: Generalised Anxiety Disorder scale (GAD7)

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Appendix 13: Service consent from Board of Directors

Private & Confidential

Anna Taylor

University of Manchester

Section for Clinical & Health Psychology

Zochonis Building

Brunswick Street

Manchester |

M13 9PL

27th August 2015

Dear Anna,

RE: ***** PSYCHOLOGICAL WELLBEING PRACTITIONERS TRAINING

I am writing to confirm that the **** Board met on Friday 8th May 2015 and consented to the use of the IAPT step 2 service in ***** being used as a site for the evaluation of 'Enhancing Therapeutic Skills in the Conversational Approach' developed by Dr Brown, Professor Guthrie and Dr Hughes. Approval was also given to the trainee Clinical Psychologist Anna Taylor (Nee Hardisty), who is conducting the evaluation to access the routine outcome data held on PCMIS for the purposes of the evaluation and to conduct interviews with self-selecting PWPs to explore the impact of the training.

Yours sincerely

******

Managing Director

******

Appendix 14: Search Terms

Review search terms

Empathy related words	Training related words		Therapist related words
Empath*	Train*	Develop*	Therap*
	Educat*	Gain*	Couns*
	Learn*	Taught	Psycholog*
	Teach*	Coach*	Psychotherap*
	Increas*	Upkill*	
	Impact*	Enchanc*	

Search yield

Total Yield	Abstracts reviewed	Full Texts read
1552	256	69

Appendix 15: Example of coding data management

An example list of codes organised into a category of ‘Experience of Technique’

A framework or approach rather than techniques to adhere to
Acceptable to other health professionals, easy, less diagnosing
An easier model than psychodynamic to apply
Approach helps focus in on clients actual problem
Break down barriers
Bringing more out in sessions
Can be used with whatever people bring
Can refer clients on if uncover info
Cautious with techniques, reservations
Check in with colleagues their experiences of techniques
client distress
Clients are all different - need different things
Clients need to be in touch with what talking about
Come back to things later
Competence reflections
Considers the physical aspect of feelings
Continuing using techniques
Conversation rather than techniques
Could use PIT with anybody
Cycle of change, meets people where they are at
Doesn't lead to same outcome in everyone
Easier with clients engaged and open
Easy to integrate techniques
Encouraging client feedback
Encouraging staff to be open to new techniques
Example of using it with a client
Facilitating discussion of difficult feelings
Feelings in the room helps introduce techniques to manage them
Fit it to different models
Flexibility in using techniques
General thoughts about using the techniques
Getting a 'picture' of how the person feels
Helps connect a piece of the jigsaw (Nodes)
Hypotheses based on own experiences increase credibility
Hypotheses help clients put things into words
Hypotheses help normalise feelings
'I wouldn't use it with everyone'
Importance of a coherent therapeutic approach
Intervention 'falls out' of the conversation
Knowing how far to push staying with the feelings
Linking past experiences together
Making links, shared understanding faster
Managing difficult feelings in the room

Metaphor use
Moving beyond the client surface level
Negative or difficult experiences of using the technqiues
Negotiating style helps people correct you
Negotiating style is helpful
Not entirely sure when using approach
Not solely using PIT in assessment
Not used the techniques yet
Not using it as a blended version
Not using techniques to explore barriers to e.g. homework
Not using the techniques
Noticing the unsaid
Noticing things in the moment
Occasional eureka moment
Open to new techniques
Opening up feelings
People correcting you increases understanding
People stuck less often
Picking up on cues
PIT helps understanding with difficulties e.g. homework, cbt
PIT in assessment helps understand direction of therapy
PIT is an overall style not a technique
Provides a way of handling difficult things
Putting the techniques into practice
Quick but not too quick
Refining hypothese giving - before was too much or too soon
Respecting clients lead - not coming back to it
Seeing things from other people's perspective
Sense of therapist in control - choosing which cues to mention
Sense there is a right and wrong client to use these techniques with
Sense things will come out if they needed to
Sharing feelings with a client
Simplicity of the techniques
Sometimes still need to ask questions - lot of info to collect
Sometimes used only with difficult situations
Sometimes works sometimes doesn't
SRS helpful, opens discussions
Statements rather than questions
Staying with feelings - modelling to clients
Staying with the feelings - focusing on feelings more
Staying with the feelings can help elicit thoughts and memories
Staying with the feelings now over past history
Takes time for client to be comfortable
Takes work for the techniques to fit smoothly
Techniques are powerful

Techniques as a whole
Techniques feel new
Techniques related to psychotherapy
Tentative 'floating it' style
Therapist decide which approach might work
Therapist intuition
Therapists noticing their senses in the room
Therapy situations the techniques could help in
Things come up if the clients want them to
Thinking about what the client wants
Timing of interventions
Timing of interventions, bringing things up when rapport is built
Timing, choosing when to use what, what to focus on
Too much information - what to do with it
Trying new things when the old isn't working
Unconsciously using the techniques
Understanding the benefit of faciliating the client to sit with difficult feelings
Use of hypotheses generally
Use techniques as a 'back up' plan
Use techniques less in assessment
Use with 'robust' clients
Used in a phone assessment
Used with people upset without a clear problem
Useful for clients with less awareness
Useful for realistic worries
Using cues to test people's receptiveness to approach
Using techniques in assessment, aiming for relationship
Using techniques in other roles - volunteering
Using techniques to explore barriers e.g homework
Verbalising, checking out assumptions is better than running with them
Wanting to see if techniques work
Way to check things out with patients clients
Weaving between techniques easily done
Will go off clients lead as to approach, e.g. like structure or not
Would like to formulate using this mode
Zooming out, seeing the wider picture

Appendix 16: Initial themes

The below table shows the initial themes generated before these were condensed into the final themes

Themes	Sub-themes
1. **A well-designed course**	1a. Enhancing existing skills 1b. Video role-plays 1c. Being the client
2. Giving it a go	2a. I work at step 2
3. Making a difference	3a. Dealing with complexity 3b. Increase awareness
4. More of a connection	4a. Going deeper 4b. *Feeling* their difficulty 4c. They feel more understood
5. Awareness of my own senses	5a. Pandora's box 5b. Owning stuff 5c. Shared language around feelings
6. Making a hard job more manageable	6a. Less pressure 6b. All fired up 6c. I'm kind of doing alright
7. Keeping it fresh in mind	7a. Old habits 7b. Element of supervision 7c. Follow-up please

Appendix 17: Preliminary analyses using Mixed Effects Longitudinal Methods

Preliminary analyses using Mixed Effects Longitudinal Models within Stata to look at the individual client data

Drop-out rate

Odds ratio = -0.89, p= 0.35, 95% CI (0.69-1.14)

DNA/CNA

Odds ratio = -0.09, p= 0.44, 95% CI (-3.2, 1.4)