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**A qualitative study of the therapeutic alliance during  
telephone cognitive behavioural therapy: Clinicians'  
perspectives**

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## Abstract

**Background:** Telephone interventions represent a rapidly-growing method of treatment delivery, particularly in primary care. The evidence base for telephone delivery is accumulating, and studies have demonstrated high levels of client satisfaction. However, some clinicians have expressed scepticism and concerns regarding the quality of a therapeutic alliance developed via telephone. Qualitative studies have also highlighted the emergence of potentially new elements of the therapeutic alliance when treatments are delivered remotely. There is a paucity of research regarding clinicians' perspectives on these issues, which underlie the effective implementation of service delivery. Therefore, the current study investigates clinicians' perspectives and experiences of the therapeutic alliance during CBT-based telephone interventions with a view to furthering our understanding of the therapeutic alliance as a theoretical construct, and informing the development and implementation of telephone-delivered interventions.

**Methods:** Qualitative semi-structured interviews were conducted with 14 clinicians from Improving Access to Psychological Therapies (IAPT) services. Interviews were transcribed, coded and analysed using an inductive thematic analysis from a critical realist perspective.

**Results:** The thematic analysis identified four major themes: 1) *increased treatment focus*, 2) *shift in power*, 3) *reduced sense of personhood*, and 4) *adapting to the telephone*. It was also noted that participants demonstrated difficulties in discussing the therapeutic alliance per se.

**Conclusions:** Results suggest that the therapeutic alliance via the telephone may be qualitatively different from current conceptualisations and from the alliance which exists face-to-face. It is suggested that new theoretical models of distance alliance are necessary, along with corresponding clinical measures and adaptations to support clinicians.

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# CHAPTER ONE

## 1 Introduction

### 1.1 Overview

The focus of this thesis is the therapeutic alliance within the context of telephone-delivered CBT-based interventions, investigated via the perspective of practising clinicians. This introductory chapter begins with an overview of the client-therapist relationship, including theoretical models of the therapeutic alliance. The importance of this relationship in cognitive behavioural therapy (CBT) is then discussed, along with an outline of how CBT has been adapted for wide-scale delivery, including telephone CBT. Current research regarding the efficacy of telephone CBT is then critically reviewed and the disparity in the literature is highlighted, with a focus on the therapeutic alliance. Empirical evidence for the existence of a distance alliance is then discussed, and the chapter concludes with the rationale and research questions for the current study.

### 1.2 The Client-Therapist Relationship

In any therapeutic setting, there usually exists some form of relationship between the “therapist” or clinician, and the “client” or patient. According to Clarkson (2003), “relationship is the first condition of being human. It circumscribes two or more individuals and creates a bond in the space between them, which is more than the sum of the parts” (p.4). In particular, the relationship between clients and therapists has been the focus of much discussion, debate and research for many years, particularly in the field of clinical psychology. However, the therapeutic relationship remains a relatively elusive concept, and new research is continually shedding light on its constituent elements and its contribution to therapy. In the broadest sense, there are a number of important factors worth considering when discussing the client-therapist relationship.

### **1.2.1 Considerations of client-therapist relationships.**

In very general terms, the interaction between clients and therapists has been discussed through a multitude of philosophical lenses and in relation to numerous therapeutic orientations. It is beyond the scope of this project to report all of these discussions. However, it is important to acknowledge the element of social constructionism implicit in many considerations of the client-therapist relationship. Broadly speaking, social constructionism places knowledge within the process of social interchange (Gergen, 1985). According to Anderson and Goolishian (1988):

“Therapy is a linguistic event that takes place in what we call a therapeutic conversation. The therapeutic conversation is a mutual search and exploration through dialogue, a two-way exchange, a crisscrossing of ideas in which new meanings are continually evolving toward the dissolving of problems” (p. 371).

This constructionist view of the interaction which occurs in therapy highlights the client-therapist relationship as something which is co-constructed and mediated through language.

Within this school of thought, a number of writers have commented on the dynamics at play in this co-constructed relationship. Lerner and Parker (1999) highlight the power differential between client and therapist as an inevitable part of any psychotherapy, with the therapist in the position of professional authority with the responsibility to empower the client to make changes in their life. Within a social constructionist framework, therapists aim to redress this power imbalance. For example, Anderson and Goolishian (1992) advocate a *not knowing* approach to therapy to empower the client, instead of presenting the therapist as the “expert” in the relationship. In contrast, some authors have highlighted power (in terms of the influence offered through the therapist’s status and interactions) as a valuable force

in therapy (Puskar & Hess, 1986). Within cognitive behaviour therapy (CBT) specifically, whereby the therapist typically takes a more active and somewhat directive stance, a review of empirical studies described effective therapists as being ‘influential’ (Keijsers, Schaap, & Hoogduin, 2000).

Therefore, numerous stances exist when considering the client-therapist relationship, dependent upon philosophical or therapeutic orientations. Nonetheless, the vast majority of literature regarding this relationship considers it to be important in some way. This client-therapist relationship is often referred to as the *therapeutic relationship* or the *therapeutic alliance*, and rather confusingly, there are a number of definitions and views regarding its impact on therapy.

### **1.3 Theoretical Models of the Therapeutic Alliance**

Interest in the importance of the therapeutic relationship developed from the client-centred and psychodynamic traditions with which Carl Rogers and Sigmund Freud are generally credited to have founded. Freud (1912) stated that “the first aim of treatment is to attach the person of the patient to the person of the therapist” (p. 139), and discussed the client’s feelings of affection towards the therapist as “the friendly and affectionate aspects of the transference” (p. 105). Freud (1912) postulated that these elements of transference originated from positive parental relationships and formed the basis for collaboration between the client and the therapist. Similarly, Zetzel (1956) considered the therapeutic relationship to be a reflection of the positive aspects of the mother-child relationship mirrored in the client’s attachment to the therapist. Zetzel (1956) was the first to label this as the *therapeutic alliance*, although she did not define the concept specifically. Sterba (1934) termed this the *ego alliance* and discussed the importance of such alliance between both client and therapist including the client’s ability to actively partake in the process and to identify with the therapist’s working style. Later, Greenson (1965)



developed this further and coined the term *working alliance*, making the distinction between the task focus of the working alliance, and the personal bond of the therapeutic alliance.

Somewhat confusingly, these terms have often been used interchangeably, and there exists some controversy surrounding the divergent views of the alliance and the variability in its definitions. However, as outlined by Gaston (1990), the separate definitions of the client's collaboration in therapy, the working alliance and the therapeutic alliance can be considered as distinct yet interdependent elements of the alliance. The working alliance includes the skills-based aspects of the client's collaboration, focussing on the tasks of treatment, whereas the therapeutic alliance reflects the more affective elements of the client's collaboration directed toward the therapist as a person (Gaston, 1990). Later definitions of the therapeutic alliance also emphasised the therapist's role in providing the basis for this relationship via qualities such as congruence, genuineness, empathy and unconditional positive regard for the client (Rogers, 1957).

### **1.3.1 Bordin's transtheoretical model.**

In order to unite these various conceptualisations, and in response to suggestions that previous definitions were primarily a psychodynamic understanding of the therapeutic relationship, Bordin (1979) offered a pan-theoretical model of the therapeutic alliance. It is generally acknowledged that most current definitions of the therapeutic alliance are based on Bordin's (1979) transtheoretical conceptualisation (Hardy, Cahill, & Barkham, 2007). In his 1979 paper, Bordin proposed that the alliance consists of three features: a) the "agreement on goals", b) the "assignment of task or a series of tasks", and c) the "development of bonds" (p. 253). In summary, Bordin (1979) postulated that for an effective alliance to exist, the *goals* or target outcomes of therapy should be mutually agreed and valued by both client and

therapist, the *tasks* or techniques of therapy should be perceived by both as effective and relevant to the goals, and the *bonds* or affective connections between client and therapist should exist based on elements such as mutual liking and trust. Bordin (1979) also suggested that the type of bond developed between client and therapist can differ greatly, without one necessarily being stronger than the other.

Interestingly, Bordin's (1979) paper highlights the differences in the division of responsibility between therapist and client in different forms of psychotherapy, and discusses how this might influence collaboration, based on the client's own "anxieties about dependency" (p.257) and differences in preferred working styles.

Alongside this conceptualisation, Luborsky (1976) postulated a bipartite division of the client's perceived helpfulness of the therapist, and the client's experience of the process of working together. This was later developed by Hougaard (1994) who used empirical data to distinguish between *personal alliance* (the interpersonal client-therapist relationship) and *task-related alliance* (collaborative treatment planning and goal orientation) (Elvins & Green, 2008).

### **1.3.2 Working definition of the therapeutic alliance.**

For the purposes of the current study, the "therapeutic alliance" refers to Bordin's (1979) transtheoretical model, consisting of goals, tasks and bonds developed between client and therapist, as outlined above. This pan-theoretical conceptualisation is widely acknowledged as the most established model of the therapeutic alliance to date (e.g. Hardy et al., 2007), and has been corroborated by empirical studies. A meta-analytic review conducted by Martin, Garske, and Davis (2000) examined the literature relating therapeutic alliance to outcomes, and identified three common themes which appear across most theoretical definitions. These included collaboration between patient and therapist, an affective bond, and agreement on goals and tasks within treatment, in line with Bordin's triadic

conceptualisation. As such, Bordin's model of the therapeutic alliance formed the basis for the present study.

### **1.3.3 The therapeutic alliance as a non-specific factor in psychotherapy outcome.**

A number of studies investigating the effectiveness of different therapies have shown little or no difference between psychotherapies, as highlighted by Stiles, Shapiro, and Elliott (1986). This paradox of outcome equivalence, known as the *Dodo bird verdict* has given rise to suggestions that *common factors* or core features across all psychotherapies are responsible for therapeutic change. This is in contrast to *specific factors* which refer to the theory-driven techniques of therapists based on their theoretical orientation (S. F. Butler & Strupp, 1986).

Common factors have been defined in a number of ways, but commonalities in these definitions have been highlighted by Grencavage and Norcross (1990) as: an opportunity for catharsis; acquisition and practice of new behaviours; clients' positive expectancies; and importantly, the therapeutic alliance. Here, the alliance is generally acknowledged to encompass the Rogerian aspects such as warmth, empathy, acceptance and respect (S. F. Butler & Strupp, 1986). Decades of research have considered the relative contributions of these factors to psychotherapy outcome. Based on reviews of the therapy-outcome literature, Lambert and Barley (2001) estimated that 30% of improvement in psychotherapy is attributable to common factors, which include the client-therapist relationship. The authors estimated that specific therapeutic techniques and expectancy effects (the placebo effect) each account for just 15% of improvement, with the remaining 40% being attributable to factors outside of therapy (the *extratherapeutic* change). These estimates are frequently cited and have been used in support of the argument that common factors are more powerful than specific therapy ingredients (e.g. Messer & Wampold, 2002).

Similarly, Norcross (2002) reported that the therapeutic relationship accounts for approximately 12% of the total psychotherapy outcome, whereas the specific treatment method accounts for just 8%. Interestingly, this model attributes 30% of the psychotherapy outcome variance to the client's contribution (including severity of disorder). The individual therapist is estimated to contribute 7% and the remaining 40% is again attributed to unexplained variance. In this model, the common factors are assumed to be spread across the therapeutic factors relating to the client, the therapist and the therapy or treatment method (Norcross, 2002).

#### ***1.3.3.1 Empirical evidence for the relationship of alliance to psychotherapy outcome.***

Martin et al. (2000) conducted a meta-analytic review of studies relating the therapeutic alliance to therapy outcome, and revealed a moderate yet consistent relation between alliance and outcomes, despite variations in treatment type and outcome measures. The authors noted that the correlation between therapy outcome and therapeutic alliance was within the range of many other effect sizes associated with psychotherapy outcome. In addition, the alliance-outcome relation was not affected by other variables thought to influence this relationship such as the type of measure used, the time of measurement, the rater of alliance or outcome, and the treatment type provided (Martin et al., 2000). This appeared to corroborate previous research summarised in a meta-analysis by Horvath and Symonds (1991) which found a moderate yet reliable association between alliance and therapy outcome, irrespective of the type or length of therapy. Later meta-analysis of alliance-outcome associations in child and adolescent therapy also indicated similar results to the adult literature (Shirk & Karver, 2003). From their meta-analysis, Martin et al. (2000) concluded that "the direct association between the alliance and outcome identified in this empirical review is supportive of the hypothesis that the alliance may be

therapeutic in and of itself” (p. 446). That is to say, that in the presence of a positive alliance, the client will experience the relationship as therapeutic, which will directly impact outcomes, irrespective of the interventions themselves.

However, this essentially causal interpretation of a correlational analysis has received some contentious criticism (Elvins & Green, 2008). It is widely acknowledged that correlations do not necessarily signify causation, and therefore it can be argued that these findings do not indicate that positive relationships necessarily cause positive outcomes (Peck, 2010). Alternative explanations have been offered, including the role of the therapeutic alliance as a prerequisite for effective intervention, and as a variable that interacts with intervention to determine success (Gaston, 1990). For example, Greenson (1965) suggested that the therapeutic alliance allows the client and therapist to work effectively together, thereby becoming a mediator for the interventions rather than uniquely contributing to change. Similarly, Zetzel (1956) proposed that the alliance might interact with the therapist’s technical style, which can be adapted to be more explanatory or supportive. More recently, DeRubeis, Brotman, and Gibbons (2005) have argued that specific therapy techniques have been underestimated in their contribution to therapeutic change, and a positive therapeutic alliance may simply be a result of positive outcomes, rather than a causal factor, hence the association. The authors cite the literature from *sudden gains* phenomena (whereby sudden improvement in symptoms occurs during treatment) in support of their argument. For example, a study by Tang and DeRubeis (1999) demonstrated that pre-gain alliance did not predict the sudden gains, whereas post-gain alliance was reliably higher, suggesting that the positive alliance was a product of the therapeutic gains rather than the cause (DeRubeis et al., 2005).

In contrast, evidence has also been found to suggest that better alliance does precede better outcomes. Klein et al. (2003) demonstrated that early alliance, as measured in session three or four, was a significant predictor of subsequent change in symptoms of depression. In addition, the authors reported that early changes in depressive symptoms did not predict the subsequent alliance, contrary to suggestions by DeRubeis et al. (2005). These studies highlight an ongoing debate in the current literature regarding the precise contribution of the therapeutic alliance to outcomes, as opposed to more specific factors. This controversy, coupled with the lack of clarity regarding definitions and terminology, can arguably render the therapeutic alliance an obscure and elusive concept. Nonetheless, as highlighted by Norcross and Wampold (2011) in their review of the literature, “the therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment” (p. 98) and therefore cannot be ignored.

#### **1.4 The Therapeutic Relationship in Cognitive Behaviour Therapy**

Amongst all the different psychotherapies used in routine practice, cognitive behaviour therapy (CBT) is currently one of the most widely-practised therapies. This is due in part to its extensive evidence base, following a prolific increase in research studies demonstrating its clinical effectiveness across a number of mental health disorders (A. C. Butler, Chapman, Forman, & Beck, 2006). CBT is a structured, time-limited, present-focussed psychological therapy which aims to modify dysfunctional thinking and behaviour (Beck, 2011). CBT for depression draws upon Beck’s (1976) cognitive model whereby an individual’s thoughts influence his/her mood through a vicious circle of emotions, physiological symptoms and behaviours which maintain low mood. Negative cognitive schemas (long-standing patterns of thinking) are formed as a result of negative life experiences and, when re-activated by triggering events, may drive a person’s negative interpretations

(Beck, 2011). Interventions are typically aimed at breaking these unhelpful cycles and modifying dysfunctional beliefs. A number of models of CBT have been developed for use with other disorders including anxiety disorders (Clark & Beck, 2010), psychosis (Morrison, 2001), bipolar disorder (Mansell, Morrison, Reid, Lowens, & Tai, 2007) and low self-esteem (Fennell, 1997). These models have been empirically validated and their evidence base is currently increasing exponentially. In particular, A. C. Butler et al. (2006) conducted a review of the meta-analyses examining CBT and concluded that the data “support the efficacy of CBT for many disorders” (p. 17).

Within CBT, the therapeutic relationship is generally viewed as important and necessary for successful therapy. Beck (2011) states that CBT “requires a sound therapeutic alliance” (p. 7) and advocates the use of Rogerian qualities such as warmth, empathy and genuine regard. Beck (2011) also highlights that collaboration and active participation are key principles in CBT. Within this principle is the idea of teamwork, with the therapist suggesting direction for therapy sessions initially, and the client becoming more active as time goes on, for example in setting an agenda, identifying cognitive distortions or planning homework tasks. CBT aims to use *guided discovery* through Socratic questioning (Padesky, 1993) which involves helping the client to discover new cognitions or beliefs. This process is often facilitated by *collaborative empiricism*, a term used by Beck to describe the therapeutic relationship in CBT, whereby client and therapist work together to test the client’s thinking (Beck 2011). In this sense, the therapeutic alliance can be viewed within CBT as having a particular focus on collaboration and joint working.

However, CBT has received criticism in the past regarding a lack of attention to the therapeutic relationship (Leahy, 2008). The lack of empirical studies into the alliance in CBT has been highlighted by Andrusyna, Tang, DeRubeis, and Luborsky

(2001). A study by DeRubeis and Feeley (1990) suggested that there is no significant correlation between alliance and outcome in CBT, and this was replicated by Feeley, DeRubeis, and Gelfand (1999). Nonetheless, Safran and Muran (1996) have argued that rupture resolution in CBT is crucial to outcome. Their model postulates four stages including noticing the rupture, exploring the experience, exploring avoidance, and emergence of a need. This model has been supported by a number of studies detailed in a review by Safran, Muran, Samstag, and Stevens (2001). However, a later study by Aspland, Llewelyn, Hardy, Barkham, and Stiles (2008) suggested that CBT therapists tended not to discuss ruptures with clients, contradicting Safran and Muran's (1996) model. Furthermore, a study by Webb et al. (2011) investigated components of the alliance associated with symptom change in CBT, and reported that only 'task' and 'goal' components predicted outcome, with the 'bond' between client and therapist appearing to be "more of a consequence, than a cause, of symptom change" (p. 279).

A more recent model of the therapeutic relationship in CBT has been proposed by Hardy et al. (2007), who based their conceptual map on review articles relating to the client-therapist relationship. Hardy et al. (2007) suggest that there are three main stages: *establishing a relationship*, which includes expectancies, intentions, motivation and hope; *developing a relationship*, which includes openness, trust and commitment; and *maintaining a relationship*, which includes satisfaction, alliance, emotional expression and a changing view of the self. The authors state that the findings are relevant to all psychotherapies, including CBT. Nonetheless, it can be argued that further empirical support is necessary to validate these claims.

#### **1.4.1 Non-traditional methods of delivering CBT.**

Due to its extensive evidence base as mentioned previously, CBT has been adapted in a number of ways to allow delivery to the general population. This is in



response to a number of social, political and economic drivers. CBT has historically been delivered in line with traditional service models, which typically consist of face-to-face appointments during working hours, usually lasting one hour and provided on a weekly basis by psychologists or other highly-trained mental health professionals (K. Lovell & Richards, 2000). However, due to an increased demand for CBT, and the rising cost of healthcare, there has been a growing emphasis on developing cost-effective brief interventions to allow a larger number of people to access CBT (Newman, 2000). As highlighted by K. Lovell and Richards (2000), there has long been a significant disparity between the need for psychological therapy services and the available provision, often leading to lengthy waiting lists and a large unmet need in the general population, particularly in relation to those cases considered “less severe”. As a result, CBT-based interventions requiring only minimal therapist input have received considerable attention in recent years.

#### ***1.4.1.1 Guided self-help.***

This has given rise to the development of *guided self-help* interventions. Guided self-help typically involves a self-help resource accompanied by limited support from a health care professional (K. Lovell et al., 2008). The client is required to complete a standardised psychological treatment package either at home in paper format or via another media such as the internet or a computer package. The “guided” element refers to the support provided by a therapist or clinician via face-to-face contact, telephone, or email. This contact is often considerably reduced compared to typical face-to-face CBT treatments. The evidence base for guided self-help was reviewed systematically by Cuijpers, Donker, Van Straten, Li, and Andersson (2010) in their meta-analysis of outcome studies, which concluded that guided self-help can have effects comparable to face-to-face therapy and should be implemented in routine care.

In the UK, clinical care is provided by the National Health Service (NHS). The NHS receives guidance from the National Institute for Health and Clinical Excellence (NICE) - an organisation that systematically reviews the available evidence regarding the effectiveness of clinical interventions, and issues guidelines based on this evidence. As a result of a systematic review beginning in 2004, NICE published a series of clinical guidelines supporting the use of CBT for depression and anxiety disorders. As part of these guidelines, NICE advocated the use of a *stepped care* model in response to evidence that so-called “low intensity” interventions can be effective in mild to moderate depression and anxiety (Clark, 2011). The recommended interventions include the use of CBT-based group sessions, computerised CBT, or some form of guided self-help programme based on CBT techniques and facilitated by clinician input. The stepped care approach involves two principles. Firstly, the treatment offered should provide the least restrictive intervention possible whilst still likely to bring about change. Secondly, the model is self-correcting in the sense that clients can be “stepped up” or “stepped down” if the current treatment is not effective. In this way, services can make the best use of available therapist resources (Bower & Gilbody, 2005).

#### ***1.4.1.2 Improving Access to Psychological Therapies.***

In order to implement these guidelines on a wide scale and in a cost-effective manner, the UK government launched a national initiative in 2007 known as Improving Access to Psychological Therapies (IAPT). This was in response to the aforementioned political and economic drivers, along with the rationale that the cost of increased provision of psychological therapies would be outweighed by the savings in public costs such as welfare benefits and medical costs (Clark et al., 2009). This argument was put forward in the widely-cited *Depression Report* by Lord Layard (Layard, Bell, & Clarke, 2006) and academic articles such as Layard,

Clark, Knapp, and Mayraz (2007). In 2006, two IAPT demonstration sites were initially piloted and their outcomes were evaluated by Clark et al. (2009), who reported that “clinical outcomes were broadly in line with expectation” (p. 910). Following this successful pilot, the IAPT scheme is currently being rolled out across the UK, and has been positively evaluated at its midway point (Clark, 2011).

However, there exists some contention regarding these conclusions. For example, a health policy analysis by Cooper (2009) raised concerns regarding the current evidence for the success of IAPT programmes. In the absence of a randomised controlled trial (RCT) format, Cooper (2009) argued that the research methodology is not robust and overlooks the lack of double blinding. It is also noteworthy that the evaluating researchers (e.g. Clark et al., 2009) were key proponents of the IAPT initiative, introducing the potential for bias. Cooper (2009) highlights that some aspects of the IAPT scheme appear to be at odds with the NICE guidelines and evidence base, for example the number of sessions provided. Similarly, the manualised and structured approach of IAPT services has been criticised (e.g. Rizq, 2012) and debates are ongoing regarding the limitations of CBT provided in this manner versus other more traditional psychotherapies (e.g. Samuels & Veale, 2009).

Typically an IAPT service offers CBT-based psychological interventions to working-age adults suffering from anxiety and depression, using the aforementioned stepped care model. Within this framework, ‘step 2’ interventions tend to consist of guided self-help or low-intensity CBT interventions delivered by clinicians referred to as ‘Psychological Wellbeing Practitioners’ (PWPs). In keeping with the successfully piloted model and the drive to offer cost-effective easily-accessible services, PWPs often deliver these interventions via the telephone, or at the very least offer telephone delivery as an option to clients. Following the success of the

demonstration sites, telephone interventions now form part of the ‘Good practice guidance on the use of self-help materials within IAPT services’ (IAPT, 2010). More recently, the telephone has also been used to facilitate the provision of ‘high intensity’ CBT interventions provided at ‘step 3’ by CBT therapists – usually consisting of the more traditional weekly hour-long sessions.

#### ***1.4.1.3 Telephone delivery.***

This is in keeping with a growing trend towards treatments delivered via the telephone, particularly in primary-care services. Lovell (2010) highlighted how “the telephone is increasingly being used as a means to support treatment delivery . . . using its capacity to overcome many of the social, physical and economic barriers that prevent access to mental health services” (p. 275). Similarly, the evidence base for psychological interventions delivered via the telephone is relatively recent but rapidly accumulating. A meta-analytic review by Bee et al. (2008) examined studies of psychotherapy mediated by remote methods, of which 13 studies involved telephone delivery. Within this, the authors cautiously concluded that telephone interventions were effective. However, this particular meta-analysis included “any group seeking treatment for a mood disorder or functional (nonorganic) mental health problem,” (p. 3) and reviewed “any treatment incorporating a psychological intervention mediated by remote communication,” (p. 2) including telephone, internet, videoconferencing and multiple therapy modalities (Bee et al., 2008).

More specifically, Mohr, Vella, Hart, Heckman, and Simon (2008) examined the effect of telephone-administered psychotherapy on symptoms of depression. Their meta-analysis suggested that telephone-delivered psychotherapy can significantly reduce depressive symptoms, and result in lower attrition rates compared to face-to-face psychotherapy. However, this analysis included a variety of treatment orientations, including CBT, interpersonal psychotherapy, supportive

emotion-focused therapy, and emotional expression therapy. In addition, the authors included a number of studies from the health psychology literature, meaning that participants were likely to be receiving frequent contact from medical professionals and pharmacological intervention, as well as potentially experiencing physical barriers to face-to-face treatment.

As such, these reviews appear to be fairly broad in nature and potentially less relevant to the specificity of primary-care services such as IAPT, which serve a particular working-age adult population suffering from depression and/ or anxiety, using predominantly CBT-based interventions. Therefore, in light of the emerging trend towards telephone-delivered CBT for depression and anxiety, a review of the current literature was conducted to examine research findings regarding CBT-based telephone interventions specifically relevant to IAPT services. The review aimed to answer the following question: are telephone-delivered CBT interventions effective in the treatment of anxiety and depression in working-age adults?

## **1.5 Efficacy of Telephone-Delivered CBT (T-CBT) Interventions for Anxiety and Depression in Working-Age Adults**

Details of the search strategy, selection criteria and an overview of the studies included in the review can be found in Appendix A. The results of the review, which consisted of 14 relevant studies, are presented below according to research design.

### **1.5.1 Studies comparing T-CBT to treatment as usual (TAU).**

Simon, Ludman, Tutty, Operskalski, and Von Korff (2004) conducted a large RCT, which is generally recognised as the ‘gold standard’ of research trials due to its rigour and ability to control extraneous variables (Altman & Bland, 1999). The large sample size was calculated to produce 80% power, which is generally deemed large enough to avoid false negative results (Bowers, House, Owens, & Bewick, 2013). This study demonstrated a significant advantage of T-CBT over TAU, even at six-

month follow-up, and patients were “very satisfied” with T-CBT. However, the reported NNT of 6.4 appears rather large (suggesting small effect sizes) and the patient-rated improvement and satisfaction measures are less reliable than objective measures (Krueger & Schkade, 2008).

A similar study by Ludman, Simon, Tutty, and Von Korff (2007) also compared T-CBT to TAU and found a significant treatment effect on the Hopkins Symptom Checklist (HSCL) scores, sustained at 18-month follow-up. However, despite a large sample size, effect sizes were again small (0.25-0.3) despite being a well-controlled study (although unlike Simon et al., 2004, it lacked external ratings for integrity of CBT delivery).

Another randomised trial which reported patient satisfaction and demonstrated significant treatment effects maintained at follow-up was Swinson, Fergus, Cox, and Wickwire (1995). This study only included participants with a diagnosis of panic disorder with agoraphobia, and excluded major depression, which necessarily limits the generalisability of the findings. Effect sizes were not reported and satisfaction data were participant-rated. The study is also limited by its smaller sample size (reducing its power), but it employed a delayed-treatment methodology which provided further data from within-participant measures. However, this introduces confounding variables such as time and participant history which jeopardise internal validity as no pure control group was included.

Similarly, Taylor et al. (2003) employed a delayed-treatment design within an OCD population without depression, implicating similar limitations. Assignment was non-randomised, but this was accommodated using repeated-measures *t*-tests. The authors reported ‘large’ effect sizes of 0.43 and 0.51 for pre- to post-treatment, with gains maintained at 12-week follow-ups. However, these results should be interpreted with caution as sample sizes were small, drop-out rates were relatively

high (which could imply non-acceptability of treatment), and the authors' interpretation of the effect sizes as 'large' is debatable (Cohen, 1988).

Two pilot RCTs compared T-CBT with usual care and reported positive effects of treatment. Bee et al. (2010) controlled well for bias using independent random allocation and intention-to-treat analysis which preserves these controls (Bowers et al., 2013). The authors reported 'medium-large' effect sizes on clinical outcomes (0.63-0.77) and work productivity (0.75-0.88), but clinical outcomes were not statistically significant. The study was embedded in an occupational setting, which limits generalisability, the sample was small and no follow-up data were reported. The authors also report poor uptake and 40% loss to follow-up which may be reflective of the perceived acceptability of T-CBT.

Unlike the study by Bee et al. (2010), the pilot RCT by Dwight-Johnson et al. (2011) demonstrated a statistically significant difference between groups regarding treatment response, well-defined as a 50% improvement in Hopkins Symptom Checklist (HSCL) depression scores, using appropriate intention-to-treat analysis. Follow-up data at six months and satisfaction reports also significantly favoured T-CBT. However, sample sizes were again relatively small, and the participant characteristics (e.g. 91% native Mexicans in rural USA) significantly limit the generalisability of these findings. The authors also reported that 22% of the T-CBT group received their first session face-to-face, which may have influenced outcomes by facilitating the therapeutic alliance.

Interestingly, Mohr, Carmody, Erickson, Jin, and Leader (2011) report a randomised trial with US veterans whereby no significant treatment effects were found. The authors attribute this to the possibility that veterans are refractory to psychological treatment, and also acknowledge the comparatively small sample size. Nonetheless, this was a well-controlled trial which randomised participants,

monitored therapist fidelity, controlled for pharmacological contamination and measured follow-up at an appropriate time interval.

### **1.5.2 Studies comparing T-CBT to face-to-face CBT.**

Lovell et al. (2006) conducted a randomised controlled non-inferiority trial which reportedly demonstrated equivalence of T-CBT and face-to-face CBT on clinical outcomes across all follow-ups, up to six months. The authors report a treatment effect size of 2.5 (large) and similarly high levels of satisfaction. This study was rigorously designed including randomisation, blinding, consistency of intervention, controlling for therapist effects, intention-to-treat analysis and a sample size with 80% power. However, the OCD-patient sample (excluding depression) limits the generalisability of the findings, and no true control group exists. In addition, the 10 sessions of T-CBT consisted of two face-to-face sessions which might have facilitated a therapeutic alliance, and the mean age of 32 describes a relatively young sample who might be more accepting of technological advances such as T-CBT.

A similar non-inferiority randomised trial was conducted by Mohr et al. (2012), which reported that T-CBT was equally as effective as face-to-face CBT in reducing depressive symptoms, and attrition rates were significantly lower for T-CBT. Interestingly, at six-month follow-up, the face-to-face CBT was significantly superior to T-CBT. Similar to Lovell et al. (2006), this was a well-designed trial including randomisation and masking to reduce bias, a large sample size with 90% power, controls for pharmacological and therapist effects, and appropriate intention-to-treat analysis. Unlike Lovell et al. (2006), T-CBT sessions were entirely telephone-delivered. However, no control group existed, and the primary outcome of attrition could be viewed as an insensitive dichotomous measure. In addition, the participants appear to be highly educated (65% university-educated) which limits



generalisability, and the authors have highlighted that advanced education was significantly related to lower attrition.

During the same year, another non-inferiority comparison, using observational data from IAPT services, was published by Hammond et al. (2012). The authors report 'moderate' effect sizes (0.14 and 0.10) for telephone-delivered treatment regarding anxiety and depression, and report non-inferiority of telephone versus face-to-face treatments in their stringent propensity-matching analysis. However, this interpretation of the effect sizes as 'moderate' is open to debate, as effect sizes below 0.3 are often interpreted as 'small' (Cohen, 1988). Similar to other non-inferiority studies, no true control group was included, and no follow-up data existed. Nonetheless, this study included an exceptionally large sample size (N=4106), affording power to the statistical analysis and generalisability to the results. The inclusion of a number of IAPT services, multiple clinical diagnoses and routinely-used patient-reported outcomes adds credibility to the ecological validity of this important study.

### **1.5.3 Studies with no comparison group.**

Lam, Lutz, Preece, Cayley, and Walker (2011) provide interesting but less reliable data from a pilot study reporting significant clinical improvements from T-CBT and anecdotally-reported high satisfaction. However, in the absence of a control or comparison group, these effects cannot be attributed to T-CBT specifically. In addition, satisfaction was not measured in a standardised way, drop-outs were not accounted for (despite 21% attrition), effect sizes and follow-up data were not reported, and one single clinician provided all treatment (without fidelity checks) and also rated some clinical measures herself, reducing reliability of the data.

The studies by Lovell et al. (2000) and Yeh, Taylor, Thordarson, and Corcoran (2003) provide similarly limited data reporting symptom reduction

following T-CBT in their case studies. Both papers include very small numbers of participants and no control or comparison group, meaning that only very limited conclusions can be made regarding efficacy of the intervention. Participants were also drawn from a very specific population of obsessive-compulsive spectrum disorders which limits generalisability considerably.

The final study by Bee et al. (2010) employed a qualitative methodology which highlighted the potential for patients to respond positively to T-CBT. Despite mixed views, participants reported adapting to the intervention as an acceptable therapeutic interaction. This study provides valuable insight into the acceptability of T-CBT and interestingly alludes to the notion of a therapeutic alliance perceived by recipients. However, the qualitative methodology inherently prevents any conclusions to be drawn regarding efficacy, and the authors highlight that the sample consisted of participants who were unable to access face-to-face CBT and might therefore have been more accepting of T-CBT than a wider population.

#### **1.5.4 Summary of literature review.**

Overall, the reviewed literature is indicative that T-CBT can be effective in the treatment of anxiety and depression within a working-age adult population. Where available, satisfaction data suggest high levels of patient satisfaction with treatment, and follow-up data are generally promising.

However, these studies present with substantial limitations which must be considered. With the exception of Hammond et al. (2012), sample sizes tended to be small and the generalisability of their findings is limited by the nature of the sample, often drawn from very specific geographic or diagnostic populations. Outcomes and ‘follow-up’ were defined very differently across studies and a wide range of outcome measures were used, often self-reported or clinician-rated which introduced bias. The number and format of sessions offered also varied considerably between studies,

which raises questions regarding how best to implement such interventions in clinical practice whilst retaining fidelity to the evidence base.

In addition, there is a relative paucity of well-controlled RCTs, particularly comparing T-CBT with face-to-face interventions. Trials comparing T-CBT with TAU might be more likely to elicit significant results, and are not necessarily indicative of equivalence with face-to-face CBT. This is illustrated by the long-term advantage of face-to-face CBT over T-CBT demonstrated by Mohr et al. (2012). Furthermore, it appears that the smallest effect sizes were reported from the more rigorous trials (e.g. Simon et al., 2004; Ludman et al., 2007) suggesting that these 14 studies may present an over-inflated view of T-CBT efficacy, especially if publication bias is a factor.

Another consideration includes the fact that participants will have consented to this treatment in the first instance and might therefore represent a fundamentally distinct population supposedly more receptive to telephone interventions from the outset. If so, this compromises the generalisability of the findings to a wider clinical population. In line with this view, some of the studies reported poor uptake (e.g. Bee et al., 2010) and relatively high rates of attrition (e.g. Taylor et al., 2003), which raises questions regarding the acceptability of T-CBT and the biased nature of any satisfaction reports from participants.

Nonetheless, from the current evidence included in this review, it can be concluded that T-CBT interventions have been shown to be (a) more effective than TAU in the treatment of anxiety and depression in working-age adults, with the exception of a veteran client group, who appeared not to benefit from T-CBT (Mohr et al., 2011); and (b) as effective as face-to-face CBT in the treatment of OCD, major depressive disorder, and common mental health difficulties in working-age adults (Lovell et al., 2006; Mohr et al., 2012; Hammond et al., 2012). Therefore, it can be

cautiously concluded that telephone-delivered CBT interventions, despite limitations, appear at present to offer an effective form of treatment for anxiety and depression in working-age adults. As such, the reviewed studies provide support for the implementation of telephone-delivered CBT interventions within services such as IAPT.

### **1.6. Disparity in the Telephone Literature**

Despite this trend in the literature towards generally efficacy, patient satisfaction, and some evidence of equivalence with face-to-face interventions, there appears to be considerable resistance amongst clinicians regarding the telephone as a delivery method. According to Lovell (2010), “there is significant scepticism amongst mental health professionals to deliver interventions via the phone” (p. 279). Indeed, a qualitative exploration of the views of stakeholders involved in primary care for depression by Richards et al. (2006) highlighted clinicians’ concerns, namely the lack of interpersonal communication and non-verbal cues potentially jeopardising their ability to make clinical judgements and form effective therapeutic alliances. Richards et al. (2006) reported that “mental health professionals did not like the telephone,” (p.303). Respondents in this study suggested that the use of telephone may inhibit the development of a trusting relationship due to a lack of interpersonal communication, which might compromise the therapeutic alliance in some way. Similarly, in a study by Cook and Doyle (2002), one of the key concerns amongst clinicians was the potential difficulty in establishing a strong alliance in the absence of non-verbal cues. It therefore appears that this disparity between the evidence base and clinician attitudes towards telephone interventions may implicate the concept of the therapeutic alliance.

In keeping with this idea, Haas, Benedict, and Kobos (1996) reviewed the existing literature at the time and considered the phenomenological characteristics of

telephone interventions. The authors suggested that telephone contact eliminates “non-auditory” cues, potentially limiting the clinician’s ability to interpret the client’s experience. Similarly, the potential for distraction or reverting to a more social conversation rather than a therapeutic exchange was highlighted. The paper raises questions regarding how an effective therapeutic alliance can exist “without direct experience of the other person in the encounter” (p. 159). However, more recent empirical studies have suggested that a therapeutic alliance can exist in the absence of face-to-face contact.

### **1.7 Distance Alliance**

Evidence of a *distance alliance* can be found across a number of treatment delivery methods. Day and Schneider (2002) demonstrated similarities in alliance across three different modes of CBT: video conference, audio (analogous to telephone) and face-to-face therapy. Although this was a relatively small study consisting of just 80 participants split across the three groups, the authors used the Vanderbilt Psychotherapy Process Scale, which has been shown to have good validity and reliability (Elvins & Green, 2008) and correlates well with other commonly used measures of alliance (Tichenor & Hill, 1989). Support for this idea of an alliance via videotherapy was provided by Germain, Marchand, Bouchard, Guay, and Drouin (2010), who investigated the alliance in videoconference CBT treatment for post-traumatic stress disorder (PTSD) and found that the alliance was equally strong compared to face-to-face treatment. The study only included 46 participants but employed five valid measures of alliance administered on five separate occasions and included both therapist and client ratings, providing high quality comparison data.

Online counselling interventions have also been investigated with promising results. Cook and Doyle (2002) demonstrated that online counselling produced an

alliance comparable to traditional face-to-face therapy. This was a small self-selected sample with limited generalisability, but interestingly, the authors found higher scores for the 'goal' subscale and composite alliance scores online than in the face-to-face group. The study employed the Working Alliance Inventory (WAI) which corresponds to Bordin's (1979) model of alliance and is a well-triangulated, widely-used measure with good validity and reliability (Elvins & Green, 2008). Later studies of alliance in online counselling by Leibert and Archer (2006), D'Arcy, Stiles, and Grohol (2006), and Hanley (2009) also supported this notion of a therapeutic alliance existing online, although these studies did not include a comparison group and instead compared their results to previous literature regarding face-to-face counselling. In their comparison, Leibert and Archer (2006) reported that levels of working alliance in their online study were not as strong as those observed in previous face-to-face literature, which the authors claim contradicts the findings of Cook and Doyle (2002). Nonetheless, Hanley and Reynolds (2009) reported in their review of online counselling that alliance ratings are high across existing studies, despite a dearth of research available.

Similarly, CBT delivered online has a growing evidence-base which suggests the presence of a strong alliance. Knaevelsrud and Maercker (2007) demonstrated the development of a strong therapeutic alliance in a randomised controlled trial of internet-based CBT for PTSD. The authors reported that alliance was correlated with treatment outcome. The use of the WAI and a waiting-list control group were particular strengths of this study, although the client group was very specific, limiting the generalisability of the results. More recently, Andersson et al. (2012) investigated internet-delivered CBT for depression and anxiety and reported high alliance ratings, although correlations between alliance and change scores were not significant. Whilst sample sizes across these studies were relatively small, and client

group varied, these studies nonetheless provide initial support for the notion that a distance alliance can exist in some form.

### **1.7.1 Alliance via the telephone.**

With regards to the telephone alliance literature, this body of research is also in its infancy, with a relative paucity of studies available. However, a very recent paper by Stiles-Shields, Kwasny, Cai, and Mohr (2014) analysed the alliance ratings from the aforementioned randomised controlled trial by Mohr et al. (2012). The authors examined both client and therapist ratings of alliance on the WAI, shown to be valid and reliable (Horvath & Greenberg, 1989). The analyses revealed no significant differences between alliance ratings in telephone CBT and face-to-face CBT for depression. It was also found that alliance scores predicted treatment outcomes, and this modest relationship did not vary by group. This study was a well-controlled randomised trial with a large sample size (n= 325) and all sessions in the telephone CBT group were delivered entirely via the telephone. As such, the findings provide good evidence that an alliance can exist over the telephone, of similar strength to a face-to-face CBT alliance. However, as noted by the authors, this cannot be considered a true non-inferiority analysis as no criterion for minimal clinical effectiveness exists for the WAI (Stiles-Shields et al., 2014). Similarly, the study only examined treatment for depression, limiting the generalisability to other mental health conditions, and this was measured using the Hamilton Rating Scale for Depression, which has been criticised as a weak index of depressive symptom severity (Gibbons, Clark, & Kupfer, 1993).

Nonetheless, there is supporting evidence from the telephone counselling literature that suggests a therapeutic alliance can exist via the telephone. In a study by Reese, Conoley, and Brossart (2002), clients receiving telephone counselling rated the relationship similarly to face-to-face studies measuring the same attributes.

The study employed a large sample size (n= 186) but the authors compared the results to one existing face-to-face study and used the Working Alliance Inventory Bond Scale, which only measures one aspect of the therapeutic alliance. Similarly, R. King, Bambling, Reid, and Thomas (2006) measured counselling alliance using the Therapeutic Alliance Scale which is a lesser-known measure of alliance, but was appropriate for the youth sample under investigation (Bickman et al., 2004). The authors demonstrated that self-reported alliance scores in telephone counselling were high, and interestingly these telephone alliance ratings appeared to be higher than the alliance reported for online counselling. The authors also noted that alliance did not mediate counselling outcome, and in particular the ‘bond’ element appeared to show no relation to outcome and no differences between telephone and online groups. Despite limitations regarding the naturalistic design, lack of a control group and specific youth group sample, this study does raise interesting questions regarding the contribution of the telephone alliance to outcomes.

#### ***1.7.1.1 Alliance in T-CBT.***

Telephone-delivered CBT studies report similar results regarding the presence of an alliance via the telephone. Beckner, Vella, Howard, and Mohr (2007) investigated alliance scores in telephone CBT for depression (within a health psychology setting) using the valid and reliable WAI, and the Beck Depression Inventory-II as a well-established measure of depression (Beck, Steer, & Carbin, 1988). The authors found that alliance scores were significantly higher in telephone CBT compared to the experiential treatment known as supportive emotion-focussed therapy. The authors also noted a relation between alliance and outcome in the telephone CBT group only, which they suggest is linked to the collaborative tasks and goals which form part of CBT specifically (Beckner et al., 2007). Whilst no control group existed, and it is difficult to know whether these findings would



generalise to a medically healthy population, this medium-sized randomised trial adds empirical evidence to the notion that a therapeutic alliance can exist in telephone CBT.

Similarly, studies by Applebaum et al. (2012), Brenes et al. (2012), and Mulligan et al. (2014) have demonstrated high levels of therapeutic alliance in telephone CBT across client groups such as cancer survivors, older adults and psychosis patients. Applebaum et al. (2012) reported high alliance ratings on the WAI and found that alliance scores were linked with outcomes in symptoms of depression and PTSD in cancer survivors. Brenes et al. (2012) reported high levels of both client- and therapist-rated alliance on the WAI as a secondary outcome in their efficacy study of telephone CBT for older adults. Mulligan et al. (2014) compared alliance scores on the client- and therapist-rated WAI with four previous studies and found comparable levels of alliance in their study of telephone-delivered CBT-based interventions for psychosis. In these studies, sample sizes were small, control groups did not exist, and the specialised client groups limited the generalisability of the findings. However, these studies contribute to the currently limited evidence base regarding a therapeutic alliance in telephone CBT.

Of particular note, a number of studies by Lingley-Pottie and McGrath have also demonstrated the presence of a therapeutic alliance via telephone delivery methods. Lingley-Pottie and McGrath (2006) reported very high alliance scores in paediatric telephone interventions, comparable to face-to-face alliance scores. The authors employed the previously-mentioned WAI. Despite a relatively small sample size ( $n = 64$ ), and the use of non-professional telephone coaches in the psychosocial interventions, Lingley-Pottie and McGrath (2006) claim that the alliance scores observed were similar to face-to-face scores reported previously by Horvath and Greenberg (1989), concluding that a therapeutic alliance can exist without face-to-

face contact. Similarly, Lingley-Pottie and McGrath (2008) investigated the distance alliance in paediatric cognitive-behavioural treatments via the telephone and concluded that a strong alliance does occur. Again the authors used the valid and reliable WAI, and in this study a manualised CBT treatment was offered, but again via non-professionals.

The authors also developed an open-ended questionnaire corresponding to Bordin's (1979) construct of the therapeutic alliance, and used this to investigate the distance relationship formed by adults receiving a psychosocial telephone intervention for either depression or carers' issues (Lingley-Pottie & McGrath, 2007). The results were analysed from 131 questionnaires using content analysis, and although the authors did not use standardised measures, the qualitative results revealed new aspects of clients' experiences of telephone alliance. The authors concluded that Bordin's theory may be generalisable to telephone interventions, but in addition, the paper highlighted some other important constructs emerging from clients' experiences, not encompassed by Bordin's model. These themes included *therapist attributes* such as personal traits and skills, *inapprehension* for self disclosure, and *non-stigmatisation* as a result of anonymity (Lingley-Pottie & McGrath, 2007).

These components could potentially form new elements of a 'distance' therapeutic alliance, which may differ from Bordin's original conceptualisation, and have been poorly investigated to date. Similarly, studies investigating distance alliance have tended to focus on clients' experiences (e.g. Lingley-Pottie & McGrath, 2007; Bee, Lovell, Lidbetter, Easton, & Gask, 2010) and there is a paucity of research regarding clinicians' experiences of the therapeutic alliance via the telephone.

It could therefore be hypothesised that effective alliance via the telephone may be an overlapping but non-identical construct to our current understanding of the face-to-face alliance. It is possible that it may also contribute differently both quantitatively and qualitatively to clinical outcome. Our current understanding of the therapeutic alliance via the telephone is relatively poor, and there appears to be a distinct possibility that a new model conceptualising ‘distance’ therapeutic alliance is needed. If it is the case that distance alliances are qualitatively different from face-to-face alliances, then potentially new measures of alliance will also need to be developed. This could lead to further questions regarding how to augment this type of alliance and make it more effective. Research will be necessary initially to explore the facets of this alliance in telephone therapy, and investigate any new constructs, dimensions or factors which emerge, in order to inform any new conceptualisations.

### **1.8 Rationale for the Current Research**

In summary, there appears to be some paradoxical disparity between the evidence base for telephone interventions and clinicians’ attitudes towards them, as well as some potentially new elements to the therapeutic alliance which emerge when therapy is delivered remotely. Given the recent impetus for telephone interventions, and our understanding that the therapeutic alliance can contribute significantly to clinical outcomes, it appears important to explore this conundrum in more detail. To date, client experiences have been the focus of investigation, however, the disparity appears to lie with clinicians’ perspectives. A deeper understanding of clinicians’ issues may facilitate more effective implementation of telephone interventions and allow us to explore a potentially different conceptualisation of the therapeutic alliance via ‘distance’ methods.

### **1.8.1 Research questions.**

The aim of the current study was therefore to investigate clinicians' experiences and perspectives regarding telephone interventions in more detail, with particular reference to the therapeutic alliance. As the current study was exploratory and concerned with participant perspectives, it lent itself to a qualitative methodology, which allows for an investigation into the quality and content of experiences (Willig, 2001). Therefore, the following research questions aimed to be broad enough to capture a wide range of possible outcomes, whilst acknowledging that "qualitative approaches usually entail formulating questions to be explored and developed in the research process, rather than hypotheses to be tested by or against empirical research" (Mason, 1996, p.15).

1. How do clinicians working in primary care psychological therapy services perceive and experience the therapeutic alliance with clients through telephone consultations?
2. Which aspects of telephone consultations do clinicians perceive to be helpful or hindering for building and maintaining therapeutic alliance in comparison with face-to-face consultations?
3. How might telephone consultations influence clinicians' practice and the nature of the therapeutic interventions they offer?

## **CHAPTER TWO**

### **2 Method**

#### **2.1 Overview**

This chapter begins with an outline of the study design, including the rationale for the qualitative approach and semi-structured interviews. Issues such as ontology, epistemology and trustworthiness are considered here. Section 2.3 describes the participants included in the study, and provides details of sample size, sampling technique, and inclusion and exclusion criteria. The procedure is then outlined in Section 2.4, which leads to details of the qualitative analysis in Section 2.5. Here, the rationale for thematic analysis is presented, along with how this was conducted and details of the researcher's own position and expectations. Finally, Section 2.6 addresses aspects relating to ethics within the study.

#### **2.2 Design**

##### **2.2.1 Description of the design.**

A qualitative methodology, using semi-structured interviews with individual clinicians, was employed. The researcher conducted, transcribed and analysed all interviews, which were developed through an iterative process of pilot interviews. Data from the interviews were analysed using thematic analysis (Braun & Clarke, 2006) and the researcher considered issues of epistemology and trustworthiness to render the findings more credible.

##### **2.2.2 Rationale for Qualitative Design.**

A qualitative methodology was considered appropriate due to the exploratory nature of the study and the focus on participant perspectives. According to Willig (2013), a qualitative design allows for an investigation into the quality and content of experiences. In addition, Elliott, Fischer, and Rennie (1999) stated that:

“The aim of qualitative research is to understand and represent the experiences and actions of people as they encounter, engage, and live through situations . . . the researcher attempts to develop understandings of the phenomena under study, based as much as possible on the perspective of those being studied,” (p.216).

This appears to be relevant to this particular study with regard to the topic under investigation. The therapeutic relationship represents a subjective experience on the part of the clinician and, as such, can be an elusive concept to quantify. The measures which do exist also tend to focus on the patient’s experience rather than the clinician’s (Horvath, Gaston, & Luborsky, 1993), as does the literature on telephone interventions. Therefore, a qualitative design seems appropriate to overcome these obstacles.

Similarly, the development of our understanding of the therapeutic alliance via the telephone is a relatively new area of research (as discussed previously). There appears to be a possibility that a different model conceptualising ‘distance’ therapeutic alliance is required, which in turn could lead to questions regarding new measures of alliance and how to augment this alliance to make it more effective. At this stage in the process, research is required initially to explore the different facets of this alliance in telephone therapy, and to investigate any new constructs, dimensions or factors which emerge, in order to inform any new conceptualisations. A qualitative methodology is therefore appropriate due to its capacity to reveal elements or experiences that may not have been anticipated by the researcher or identified by any previous research (Pope, van Royen, & Baker, 2002).

### **2.2.3 Rationale for individual semi-structured interviews.**

Semi-structured interviews were chosen as the method of data collection for this study. According to DiCicco-Bloom and Crabtree (2006), qualitative interviews

are useful in exploring social topics within health-care settings. The semi-structured interview is also particularly valuable due to its compatibility with many methods of data analysis (Willig, 2013). More specifically, semi-structured interviews allow for an investigation into individual experiences and perspectives on a particular subject (DiCicco-Bloom & Crabtree, 2006), which makes them appropriate in addressing the research questions for this study. The researcher considered the use of ‘focus groups’ or group interviews to elicit a wider range of experiences, but it is generally acknowledged that the public nature of this methodology can hinder a deeper understanding of the individual. This would seem particularly important given the topic under investigation which concerns personal experiences of one-to-one therapy. Similarly, due to the relatively novel nature of this research topic, individual interviews were considered more appropriate in allowing for modification of topics and questions from the ‘topic guide’ as necessary over the course of the research (Symon & Cassell, 1998).

#### **2.2.4 Ontological and epistemological considerations.**

In order to situate the research within an epistemological framework, the researcher considered her own views on these issues. Whilst previous experience with qualitative research (mostly within a commercial setting) had assumed a positivist realist approach, the researcher’s education as part of the doctorate in clinical psychology had encouraged a more critical stance, including consideration of positions such as social constructionism and social constructivism. After discussion within a qualitative research forum at the University of East Anglia, the researcher decided upon a critical realist approach for this particular study.

Critical realism assumes the principle that the world or ‘reality’ exists independently of the observer and any social constructs (Ratner, 2006). However, it also stipulates that our theories of reality are socially constructed, and our methods of

investigating this independent reality are heavily influenced by our own interests and social forces acting upon us (Pilgrim & Bentall, 1999). Therefore, it is important, from a critical realist perspective, to acknowledge one's own 'lens' through which information is received and interpreted. This is in contrast to the positivist position, which assumes that reality and experiences are readily accessible as 'truths' due to the direct correspondence between the world and our perception (Willig, 2013). In short, a critical realist approach assumes that "we can, and should, make attempts at investigating reality in itself, but do so cautiously and critically" (Pilgrim & Bentall, 1999, p. 262). This study employed a number of different techniques to adopt this cautious stance, including a reflective log and other methods of increasing trustworthiness, as discussed below.

### **2.2.5 Trustworthiness in qualitative research.**

According to Rolfe (2006), 'trustworthiness' is a concept which can incorporate qualities such as credibility, dependability, transferability and confirmability. It is generally acknowledged that these elements contribute to the standard of qualitative research, in a similar way that validity and reliability contribute to quantitative research, although some debate exists regarding these concepts. Elliott et al. (1999) developed a set of guidelines for improving quality and ensuring good practice within qualitative research studies in psychology. In order to increase trustworthiness within this study, these principles were adhered to wherever possible:

#### ***2.2.5.1 Owning one's perspective.***

In terms of owning one's perspective, the researcher has outlined her position in relation to the research in Section 2.5.4 below. The researcher also produced a reflective log to document both the rationale for research decisions, and the course of the research process itself, as well as the researcher's thoughts that accompanied this. The reflective diary was made available for audit, and excerpts were used for



reporting where appropriate. The researcher discussed her views openly with the research supervisors wherever necessary, and made attempts to explicitly acknowledge these when reporting results. This is in line with guidance by Elliott et al. (1999), who specify that the researcher should make their theoretical, methodological and personal values and assumptions transparent in order to acknowledge the role these play in interpretation.

#### ***2.2.5.2 Situating the sample.***

Basic descriptive data, within the constraints of confidentiality, are reported below in terms of age, gender, ethnicity and geographic location. Any particularly relevant details which are known to impact upon therapeutic alliance have also been highlighted, for example, the number of years' experience of the therapist has been demonstrated to affect the alliance (Ackerman & Hilsenroth, 2003). This follows guidance from Elliott et al. (1999) who advise that researchers should describe the characteristics of the participants and report any details which might directly influence the outcome of the research, in order to indicate potential relevance of the findings.

#### ***2.2.5.3 Grounding in examples.***

The current study reports direct quotes from participants, including specific examples of emergent themes where possible. Examples of the data allow readers to evaluate the fit between the participants' data and the researcher's interpretations, as well as consider alternative understandings. The examples also provide an illustration of the reported results.

#### ***2.2.5.4 Providing credibility checks.***

As a form of credibility check, all participants were provided with a copy of their transcript, and a written summary of results where requested, to allow for feedback (participant verification). The analysis was also cross-checked by Dr Paul

Fisher (secondary research supervisor) who provided feedback on the coding and themes, which was incorporated into the analysis. This is in line with Elliot et al.'s suggestion that researchers should check the credibility of their interpretations by discussing them with the original informants, cross-checking the analysis with another qualitative researcher, or using 'triangulation' e.g. with quantitative data. Further details of the credibility checks undertaken in this study are outlined in Section 2.5.3.

#### ***2.2.5.5 Coherence.***

The intention of the researcher was to coherently present a data-based 'story' including an integrated summary of findings to outline the understanding reached by the researcher. Again, this is in line with the guidance provided by Elliot et al. (1999), which suggests that data need to be integrated into a coherent narrative or framework in order to represent the researcher's understanding, which should be based in the data and should seek to reflect the nuances within it.

#### ***2.2.5.6 Accomplishing general vs. specific research tasks.***

Elliott et al.'s (1999) guidelines stipulate that researchers should identify whether they seek to achieve a general understanding of a phenomenon or provide insight into a specific instance. The former necessitates a wide enough range of informants, and the latter requires a systematic and comprehensive study and description of the case. Limitations of the generalisability of the findings should always be acknowledged. Whilst the current research aims to gain some insight into the therapeutic alliance within telephone interventions, it is made explicit that this research is limited to a specific group of clinicians undertaking specific types of telephone interventions.

### ***2.2.5.7 Resonating with readers.***

According to Elliott et al. (1999), the research should be presented to stimulate resonance and to clarify or expand upon what is already understood on the subject matter. The researcher should attempt to capture the experiences in question, and translate them into a useful contribution via clinical or theoretical implications. The current study aimed to represent the subject matter using established methods of data collection and analysis, and this report discusses the clinical implications of the research and future directions.

## **2.3 Participants**

### **2.3.1 Sample size.**

Appropriate sample size within qualitative research can be an elusive concept, but the general consensus leans towards an attempt at data saturation, where no new themes emerge from subsequent interviews (Mason, 1996). According to Francis et al. (2010), this can be achieved by specifying a minimum sample size for initial analysis, and then specifying a 'stopping criterion' defined as the number of further interviews conducted without new ideas emerging. The current study proposed an initial analysis sample of six participants. This was in line with previous qualitative research demonstrating that elements for meta-themes can be present within the first six interviews (Guest, Bunce, & Johnson, 2006). The study then employed a stopping criterion of three interviews, as suggested by Francis et al. (2010). In the interests of practicality and feasibility, it was originally proposed that the maximum sample size be capped at 12 participants, as Guest et al. (2006) concluded that 12 is a sufficient sample for interview studies analysing emergent themes, highlighted by their first 12 interviews eliciting 97% of the important codes out of a total of 60 interviews. The sample size was discussed with a qualitative research specialist as part of the 'Qualitative Research Forum' within the University

of East Anglia, and with the research supervisors. In total, this study employed a sample size of 14 participants, as recruitment was more successful than originally anticipated and the researcher was deemed to have capacity to conduct and analyse this number of interviews.

### **2.3.2 Research setting and sampling technique.**

Participants were recruited from IAPT services (as discussed previously) which offered both face-to-face and telephone interventions. The participants therefore consisted of clinicians who had experience of providing both modalities of intervention. Due to time and budget constraints, these IAPT services were situated in the local area and formed part of either Norfolk and Suffolk NHS Foundation Trust, or Cambridgeshire and Peterborough NHS Foundation Trust.

A purposive sample using maximum variation sampling (Coyne, 1997) was recruited in an attempt to explore a wide breadth of experience. Purposive sampling generally requires the researcher to actively select a sample that will be productive in answering the research questions (Marshall, 1996). In this particular study, the research questions are concerned with clinicians' experiences of telephone and face-to-face interventions, hence the nature of the sample. Within this, there were inevitable elements of 'convenience sampling' (Marshall, 1996) whereby the most accessible participants were recruited according to availability, time and budget constraints. However, wherever possible the researcher made attempts to maximise variation within the sample, in order to include a broad range of participants and help identify important common patterns that cut across variations (Patton, 1990). Within the constraints of practicality, the study attempted to achieve maximum variation within the following generic demographic factors: age, ethnicity, gender, geographical location, and also within therapist level of experience, as experience has been linked with the quality of alliance in recent literature (Horvath, 2001).

### **2.3.3 Inclusion and exclusion criteria**

The selection criteria for recruitment were purposefully broad in order to capture a wide range of perspectives. Inclusion/ exclusion criteria were as follows.

Inclusion criteria:

- Over 18 years old (no upper age limit),
- Fully-qualified clinicians (not trainees),
- Experience of minimum five cases of telephone interventions,
- Experience of minimum five cases of face-to-face interventions,
- Able to attend a one-to-one interview.

Exclusion criteria:

- Trainee clinicians,
- No experience of telephone interventions,
- No experience of face-to-face interventions,
- Unable to communicate in English.

The rationale for the above was to provide an adequate frame of reference for the discussions (at least five cases to draw upon) and to reduce the effect of therapists' level of training impacting the quality of the alliance (Horvath, 2001). For practical reasons, participants were required to be able to communicate in English in order to complete the interviews with the researcher, and to facilitate participant verification of written transcripts.

### **2.3.4 Participant characteristics.**

In total, 23 clinicians expressed an interest in the study and were screened for suitability. One person withdrew their expression of interest, one person did not meet the inclusion/ exclusion criteria (see section 2.3.3), four people did not respond to further contact and three people were screened out according to demographic

characteristics in order to achieve maximum variation sampling as mentioned above.

Key information regarding each participant is detailed in Table 1.

Table 1

*Participant Characteristics*

Participant	Gender	Age	Ethnicity	Geographic Location	Current Position and NHS Band	Years Training/ Experience	Estimated Proportion Telephone Work
P1	F	34	WB	NSFT	Psychological Therapist – 7	1/ 4	5%
P2	M	41	WB	NSFT	PWP – 5	1/ 5	80%
P3	F	45	White American	NSFT	Senior PWP – 6	2/ 5	>50%
P4	F	50	WB	NSFT	Senior PWP – 6	4/ 3	73%
P5	F	37	WB	CPFT	PWP – 5	1/ 4	40%
P6	F	23	WB	NSFT	PWP - 5	1/ 2	100%
P7	F	28	WB	NSFT	Psychological Therapist - 7	2/ 6	Not stated
P8	F	57	WB	NSFT	PWP – 5	1/ 5	80%
P9	F	27	WB	NSFT	Senior PWP – 6	1/ 5	100% excluding workshops
P10	F	54	WB	NSFT	PWP – 5	5/ 8	100%
P11	F	29	WB	CPFT	PWP – 5	1/ 5	>50%
P12	F	52	WB	NSFT	PWP – 5	3/ 6	50%
P13	M	63	WB	NSFT	PWP – 5	3/ 6	60%
P14	F	35	WB	NSFT	Senior PWP – 6	1/ 5	70-80%

*Note.* F = Female, M = Male, WB = White British, NSFT = Norfolk and Suffolk NHS Foundation Trust, CPFT = Cambridgeshire and Peterborough NHS Foundation Trust, PWP = Psychological Wellbeing Practitioner, Estimated Proportion Telephone Work = Estimated proportion of current clinical work which is conducted via telephone.

### **2.3.5 Recruitment process.**

In the first instance, Clinical Service Leads in IAPT services were contacted by the researcher via email, to outline the study and to request permission to contact staff. Where agreed, clinicians were then approached face-to-face using a PowerPoint presentation (Appendix B) to introduce potential participants to the study. This presentation took place at routine team meetings within the service (to minimise any burden on clinicians), and staff were invited to attend by their clinical team leader, who agreed to place the presentation on the agenda for the meeting. The presentation itself lasted around ten minutes. The participant information sheet (Appendix C) was provided to potential participants at this point. No mention of the therapeutic alliance was made during recruitment, in order to avoid biasing responses (but participants were fully debriefed regarding this after the interview itself) as discussed in section 2.6.2. As an incentive to participate, participants were offered £5 in Amazon vouchers upon completion of an interview, as a ‘thank you’ for their time. After the recruitment presentation, clinicians were given ‘consent to contact’ forms (Appendix D), which were returned to the researcher on the same day to allow the researcher to contact potential participants after 24 hours had elapsed, to discuss the research further and potentially arrange an interview. The participant consent form (Appendix E) was then used to take full consent on the day of the interview.

## **2.4 Procedure**

### **2.4.1 Development of the topic guide.**

The questions for the semi-structured interview were developed in line with the research questions, in order to explore clinicians' perspectives and experiences. Originally, interview questions were designed to enquire specifically about Bordin's (1979) elements of the therapeutic alliance, but after discussion with research supervisors, it was deemed more appropriate to use relatively open questions and allow for spontaneous mentions of these elements from participants. Prompts were included where necessary, to encourage fuller responses or to elicit clarification and further detail, but these were designed to be generic wherever possible. The final topic guide (see Appendix F) was based on two initial 'pilot' interviews (conducted by the researcher and included in the analysis) using a preliminary topic guide. These questions were developed through an iterative process of participant feedback, requested at the end of each interview, and consideration at the UEA Qualitative Research Forum. In keeping with the 'critical realist' perspective, the topic guide was amended as feedback emerged along this process, however, all data were included in the final analysis.

### **2.4.2 Interviews.**

Following recruitment, participants were contacted via telephone to arrange an interview at a time convenient to the participant. One face-to-face interview per participant was arranged following consent to be contacted, and formal written consent was obtained on the day of the interview, before the interview began. Demographic information was also collected at this point, using the participant demographic form (Appendix G). Participants were thanked for their attendance, reminded of the confidentiality issues concerning themselves and their clients, informed that they could terminate the interview at any point, and given the



opportunity to ask any questions. An individual semi-structured interview lasting between 40-60 minutes was then conducted by the researcher. The location was agreed according to room availability and budget constraints, but in general, interviews took place in a quiet confidential room on NHS property (such as a therapy room) at the participant's work base. The interview was recorded, with participants' consent, using a digital audio recorder. Towards the end of each interview, participants were debriefed regarding the specific topic of the discussions (the therapeutic alliance) and given an opportunity to reflect upon the interview and any issues raised. This element of the session was also audio recorded and included in the analysis, with participant consent, as it often prompted further discussions regarding the topic under investigation.

To facilitate participant verification, all participants received (via their email address provided on the participant demographic form) an electronic transcript of their interview as soon as it became available. In this email, the researcher requested that participants either confirmed the accuracy of their transcript or drew attention to inaccuracies. It was stated that if no feedback was received within two weeks, the researcher would assume that no corrections were necessary and begin the analysis process. Active confirmation of accuracy was received from three participants, no further feedback was received.

## **2.5 Qualitative Data Analysis**

### **2.5.1 Rationale for thematic analysis.**

Thematic analysis has been described by Braun and Clarke (2006) as a widely-used method which identifies, analyses and reports patterns or themes within a data set, allowing the researcher to both describe and interpret the data in relation to the research topic. Braun and Clarke (2006) argue that thematic analysis should be viewed as a valid method in its own right, due to its numerous advantages. These

include flexibility, accessibility to less-experienced researchers, accessibility of results, and its ability to summarise key features, to highlight similarities and differences across the data, and to produce analyses suited to informing policy development. For these reasons, thematic analysis appeared to be appropriate to the current study. In addition, Braun and Clarke (2006) highlight that thematic analysis can generate unanticipated insights, which appears particularly relevant to this research topic considering the paucity of previous research. It can be argued that this is in direct contrast to template analysis (King, 2004), which uses existing research and theory to construct a template through which to examine the data, producing something of a ‘self-fulfilling prophecy’ on occasions, which can be constraining. Interpretative phenomenon analysis (Koch, 1995) was also considered but deemed to be less appropriate, as an *a priori* interpretative framework based on Bordin’s (1979) conceptualisation of the therapeutic relationship did exist. With regards to epistemology, Braun and Clarke (2006) highlight that thematic analysis is “not wed to any pre-existing theoretical framework,” and “can also be a ‘contextualist’ method, sitting between the two poles of essentialism and constructionism, and characterised by theories such as critical realism” (p. 81). Therefore, it was considered appropriate that the current study employ this method of analysis.

### **2.5.2 The thematic analysis.**

Despite being frequently used in qualitative research, there is a distinct lack of published guidelines regarding thematic analysis. Braun and Clarke (2006) however, provide a useful outline of the process necessary for rigorous thematic analysis, and their paper is widely cited across the qualitative psychological literature. As such, the current study conducted a thematic analysis in line with these recommendations. Braun and Clarke (2006) note that a thematic analysis can either be data-driven using an ‘inductive’, bottom-up approach, or be theoretically-driven

using a ‘deductive’, top-down approach. The former does not try to fit into a pre-existing coding frame, whereas the latter is more driven by existing theory. Due to the aforementioned lack of existing literature regarding telephone alliance, the current study employed an inductive approach, to facilitate exploration of this relatively new area.

As recommended by Braun and Clarke (2006), the digitally-recorded interviews were transcribed verbatim by the researcher, and then re-read in conjunction with the audio recording for the sake of familiarisation and accuracy. Transcription was facilitated by the use of voice-recognition software (Dragon Naturally Speaking Speech Recognition version 12) which required the researcher to verbally repeat the audio recordings into a headset microphone and correct any inaccuracies manually. Initial codes (tags to identify content or meaning) were then generated and applied to the entire data set. The process of coding involved a number of decisions (see Appendix H for a reflective log regarding coding). The researcher decided upon a semantic-level inductive approach (Braun & Clarke, 2006) which was in keeping with the critical realist perspective and exploratory nature of the study. An initial ‘broad brush’ method was adopted to organise the data into broad topic areas, and then the researcher examined within each code to conduct more detailed coding, based on interesting perceptions, contradictions or assumptions. This employed the use of ‘topic coding’ (labelling the topic being discussed), which could be considered a form of ‘initial coding’ or ‘open coding’. This has been deemed suitable for beginner-level coders and remains open to all possible theoretical directions (Saldaña, 2012), as well as remaining in keeping with an inductive approach. All data extracts were coded and collated, and multiple codes were often applied to any given extract. This allowed the researcher to retain context by coding larger passages with multiple codes rather than assigning smaller passages a number

of individual codes (Saldaña, 2012). In total 171 codes were produced. The coding process was facilitated by the use of electronic data management software (QSR NVivo 10) which allowed the researcher to assign electronic codes and collate coded data extracts together under electronic files.

The researcher conducted the analysis process following coding by organising the existing codes in a visual ‘mind map’ to facilitate the process of considering links between codes and grouping codes together into ‘themes’, as per Braun and Clarke (2006). A process of review and refinement at the level of the coded extracts (including re-coding) allowed for clarification of the emergent themes and sub-themes. The researcher employed Patton’s (1990) dual criteria for judging categories according to ‘internal homogeneity’ and ‘external heterogeneity’, by examining coded extracts for coherence within a code and distinctiveness between codes. Themes were then reviewed and refined at the level of the coded data extracts, and a ‘thematic map’ produced. The researcher considered its validity in relation to the entire data set by re-reading the transcripts and re-coding where necessary, as suggested by Braun and Clarke (2006). For the purposes of transparency a fuller description of this thematic analysis is presented in Appendix H, and the visual representation or ‘mind map’ is presented in Appendix I. Each theme led to a detailed analysis relating to the research questions and reported in the Results chapter, with evidence of the themes from within the data to illustrate these themes.

### **2.5.3 Quality checks and reflexivity.**

Throughout this process, a number of quality checks were conducted. As discussed previously, credibility checks form an important part of ensuring trustworthiness within qualitative research. Participant verification was facilitated via email using electronic copies of personal transcripts for participants to critique. Examples of the initial coding process were shared at the qualitative research forum

at the University of East Anglia, and corrective feedback was included in the iterative process. Independent coding of approximately half an example transcript (transcript four) was conducted by Dr Paul Fisher (secondary supervisor), who coded this sample of the data separately from the existing codes and then discussed similarities and differences in order to help the researcher verify the coding process. Similarly, Dr Paul Fisher also examined an example code (the code entitled “boundaries”) at the level of the coded data extracts in order to provide validation for the coding process. Scrutiny of the analysis was undertaken by both Dr Deirdre Williams (primary research supervisor) and by Dr Paul Fisher (secondary supervisor), who provided feedback on the themes and continual supervision throughout this process. An audit trail has been made available for assessment, including iterations of the thematic analysis, a commentary of changes made, and an overview of how the conclusions were reached (see Appendices H and I), as it is important to demonstrate how interpretations were reached in order to demonstrate their validity (Mauthner & Doucet, 2003). In line with a ‘critical realist’ approach, the researcher has attempted to acknowledge her personal viewpoints and the contribution this may bring to the research process. In order to monitor and limit the researcher’s influence on the interpretation of the data, a reflective log (Mason, 1996; Willig, 2013) formed an integral part of the research, being regularly discussed in research supervision, and has also been made available for assessment. Reflective logs are generally acknowledged to enhance reflexivity and self-awareness on the part of the researcher (Smith, 2006).

#### **2.5.4 Researcher’s position.**

According to the critical realist approach underpinning the study, it is important for the researcher to acknowledge their own position and any possible biases, as well as providing the reader with information regarding the researcher’s

background, experience and assumptions, as these factors are likely to influence to the researcher's process of data analysis (Pilgrim & Bentall, 1999).

The researcher was a 29-year-old female white British trainee clinical psychologist. She conducted all the qualitative interviews, transcribed them and analysed the resulting data herself. The researcher had some experience of qualitative research from previous employment at a commercial market research organisation, whereby she undertook qualitative projects including depth interviews, focus groups, analysis and reporting of results. These projects tended to include a team of employees and concerned themselves with consumer goods and services. During her time at this organisation, the researcher completed a formal qualification in market and social research and attended a specialist training course in qualitative research. However, these projects tended to adopt a positivist, realist approach and, in the researcher's opinion, possibly a slightly less rigorous process by comparison to the nature of academic qualitative projects. Since then, during her doctorate training, the researcher has become more aware of alternative epistemological positions, and following discussions within the qualitative research forum at UEA, settled on a position of critical realism. From the researcher's viewpoint, this approach appeared to resonate most with her own understanding of these issues at the time, but also allowed for a fairly pragmatic approach to the doctoral research project in question.

Since deciding to leave market research, the researcher had worked for the NHS for four years, beginning with a PWP training post in a newly-established IAPT service. The one-year training post included specific teaching regarding telephone interventions, and the researcher used some telephone contacts in her clinical work, although the majority of interventions were delivered face-to-face. The clinical work consisted of CBT-based interventions such as behavioural activation, exposure therapy and cognitive restructuring, often using guided self-help. Prior to her

doctoral training, the researcher was relatively unfamiliar with the telephone CBT literature, other than a general overview of its effectiveness and appropriateness outlined within the IAPT training, which itself was positioned as particularly pro-telephone interventions.

The researcher's interest regarding the therapeutic alliance via the telephone was ignited during this time, following reflections on her own clinical practice. The researcher recalled feeling surprised during training, when learning that 'common factor skills' can account for as much as 30-40% of therapeutic change. This appeared to be evident within her own clinical practice. By contrast, the researcher found telephone interventions particularly challenging, and often wondered if and how the therapeutic alliance was being established via this modality. The researcher therefore had some pre-existing assumptions prior to this research, and was aware of the following expectations before beginning data collection:

- The researcher expected clinicians to express a predominantly negative attitude towards telephone interventions in general, based on her own experience and the qualitative research conducted by Richards et al. (2006).
- Similarly, the researcher expected clinicians to be concerned regarding the quality of alliance that is possible via the telephone, due to a lack of non-verbal cues, and to express a preference for face-to-face contacts.
- With regards to new elements of alliance and practice using the telephone, the researcher expected clinicians to mention factors such as anonymity, less stigma, and flexibility as suggested by Lingley-Pottie and McGrath (2007).
- The researcher also expected, from her own experience, that clinicians might be focussing more on 'task' elements of the therapeutic alliance (Bordin, 1979), and deliberately increasing their verbal communication to facilitate the development of an alliance.

## **2.6 Ethical Considerations**

Ethical approval was sought and granted from the Faculty of Medicine and Health Sciences Research Ethics Committee at the University of East Anglia (see Appendix J). Research governance approval was also sought and granted from the local Research and Development departments of Norfolk and Suffolk NHS Foundation Trust, and Cambridgeshire and Peterborough NHS Foundation Trust (see Appendix K and Appendix L respectively). No research activities were undertaken until full approvals had been granted.

### **2.6.1 Informed consent.**

Factual information regarding the study was provided to potential participants using the participant information sheet (Appendix C) and PowerPoint slides (Appendix B) at recruitment presentations. Participants were provided with the opportunity to discuss the research with the researcher before taking any decisions regarding participation. Potential participants were informed that participation in the study was voluntary and not a requirement of their employment in any way, and that they had the right to decline or to withdraw from the study without the need to provide a reason and without impacting their employment. Participants were able to withdraw consent for use of their data from the study up to the point at which they had reviewed their transcript as, in practical terms, it would be difficult to withdraw individual data once analysis had commenced. Written informed consent was obtained before proceeding with the interviews (using Appendix E), and only ‘expression of interest’ forms (Appendix D) were accepted on the same day as the recruitment presentation, to allow a minimum of 24 hours to elapse before obtaining formal consent.



### **2.6.2 Deception and debriefing.**

The study contained only a mild element of deception, as the Participant Information Sheet did not refer to the therapeutic alliance specifically, in order to avoid biasing responses. This was deemed necessary to elicit spontaneous mentions of the therapeutic alliance during the interviews, and to explore these responses organically. All participants were fully debriefed regarding this mild deception at the end of the interview (see Appendix F), including the rationale for deception, the exact focus of the study, and an opportunity to discuss this in more detail. Participants were also given the option to receive a written summary of the study results, and were provided with the researcher's email address to contact them with any further questions or comments.

### **2.6.3 Distress.**

It was not anticipated that the study would induce any particular distress amongst participants. However, the nature of the discussions did require participants to reflect on their clinical practice, and it was acknowledged that this may raise issues for some clinicians. Therefore, a period of time was provided at the end of each interview to allow the participant and researcher to reflect on any issues raised together. It was also suggested to clinicians that the interview was scheduled for a date and time whereby participants could receive formal or informal professional supervision shortly after the interview taking place, in order to support them with any clinical or personal issues arising from the discussions. Participants were informed at the start of the interview that if they experienced distress at any time during the interview, they could inform the researcher and the interview could be terminated at any point. However, this event did not occur over the course of this research.

#### **2.6.4 Confidentiality and disclosure.**

Participants were informed that the nature of the discussion was confidential but that disclosure of current risk to themselves or others would result in a necessary breach of confidentiality. Direct quotations from participants were used for reporting results, but no personally identifying information were included, and participants were made aware of this. Clinicians were reminded of their obligation to adhere to client confidentiality, and requested to discuss their clinical experiences in general terms only. Participants were asked explicitly to refrain from referring to specific clients during the interviews, and as such, no patient-identifiable information was included in the study. Interviews took place in appropriate confidential locations such as therapy rooms, to protect participant confidentiality.

#### **2.6.5 Data storage.**

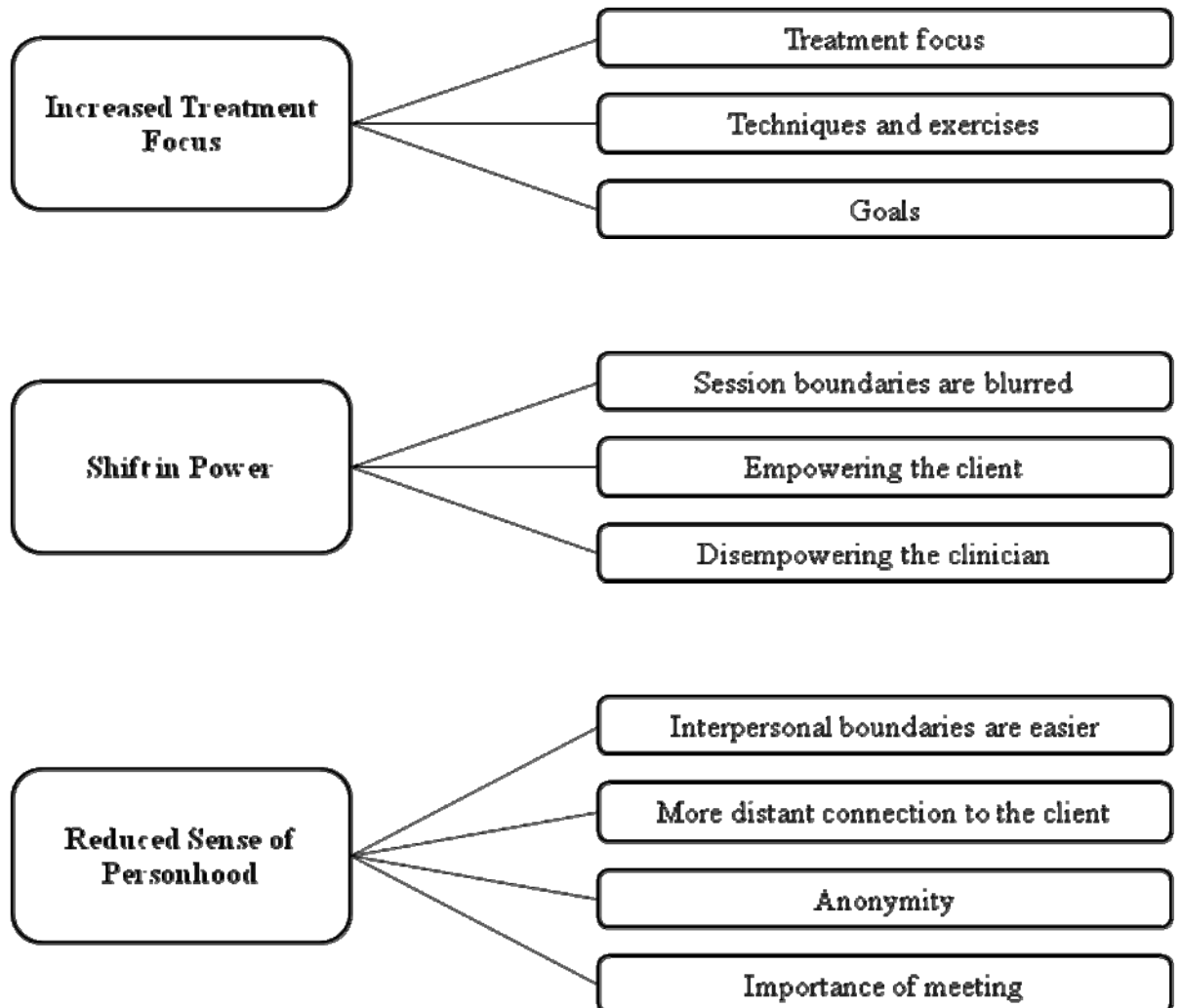
During the research process, interviews were digitally audio-recorded and transcribed verbatim, and all participants were sent copies of their transcripts for feedback purposes (participant verification). All data including paper documents, electronic documents and digital recordings were stored securely using an encrypted memory stick and locked filing cabinets. Participant data were identifiable only by a participant number, and any personal details (e.g. consent forms) were stored separately and will be destroyed after assessment of the study. Following submission of the project, data will be retained for five years in accordance with NHS protocol and the Data Protection Act (1998) to allow for critical review.

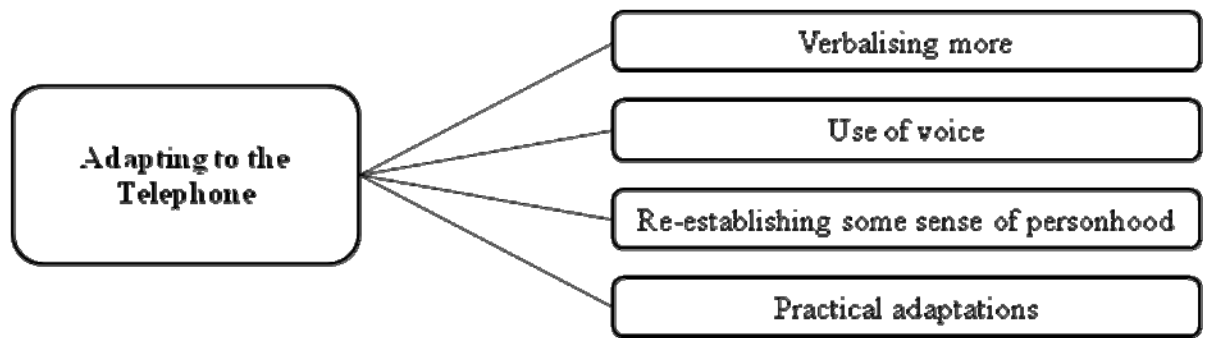
## CHAPTER THREE

### 3 Results

#### 3.1 Overview

This chapter considers the research questions in turn and presents the relevant findings in relation to each question. The thematic analysis identified four major themes. These were: 1) *increased treatment focus*, 2) *shift in power*, 3) *reduced sense of personhood*, and 4) *adapting to the telephone*. These themes and their corresponding sub-themes are detailed in Figure 1.





*Figure 1.* Themes and sub-themes from the inductive thematic analysis.

These key themes will be presented in relation to the research questions specifically. Theme one has been used to answer research question one (‘how do clinicians working in primary care psychological therapy services perceive and experience the therapeutic alliance with clients through telephone consultations?’), although it is noted that it is not possible to answer this research question fully (partly due to participants’ difficulties in discussing the topic). Research question two (‘which aspects of telephone consultations do clinicians perceive to be helpful or hindering for building and maintaining therapeutic alliance in comparison with face-to-face consultations?’) has been addressed using themes two and three, whilst research question three (‘how might telephone consultations influence clinicians’ practice and the nature of the therapeutic interventions they offer?’) is answered by the sub-themes detailed in theme four. This chapter provides direct participant quotations to illustrate and evidence the key findings and emergent themes, as well as excerpts from the researcher’s reflective log to provide insight into the analysis process.

### 3.2 Research Question One: How do Clinicians Working in Primary Care Psychological Therapy Services Perceive and Experience the Therapeutic Alliance with Clients through Telephone Consultations?

This research question has been considered using the results from theme one.

#### 3.2.1 Increased treatment focus

All 14 participants contributed to this theme. Participants reported that their work via the telephone tended to concentrate on the treatment aspect of their interventions, for example, the CBT technique or specific task at hand. This focus was reported as being more prominent in their telephone work, in comparison to face-to-face contacts. Some participants highlighted that this treatment focus meant that at times, they paid less attention to the relational aspects of the telephone sessions. Therefore, the therapeutic alliance via the telephone appeared to be more concerned with treatment focus and less concerned with the relationship aspects for many participants. This theme was supported by the inductive sub-themes detailed in Table 2.

Table 2

*'Increased Treatment Focus' Theme*

Theme:	Sub-themes:
<b>Increased treatment focus</b> (14 participants)	Treatment focus (11 participants)
	Techniques and exercises (12 participants)
	Goals (7 participants)

### *3.2.1.1 Treatment focus.*

Eleven participants contributed to this sub-theme. Participants reported that the focus of their efforts and attention tended to be on the content of the sessions, occasionally at the expense of the therapeutic relationship. Some participants attributed this to their own ways of working on the telephone. For example, Participant 7 reported “I think I’m more treatment-focused myself on the phone” (page 11, line 18) and Participant 9 noted that “I am referring back to the guided self help material a lot more than I would have done face-to-face” (page 5, lines 31-32). Other participants attributed this more to the client’s contribution, for example Participant 6 stated:

“I think people tend to just be more focused on ‘this is what is happening, this is what I want to change, how are we going to do it’, it’s much more treatment-focused, whereas I feel when it’s face-to-face it’s still got that treatment-focussed element but I feel when people become a bit more comfortable they start going more into those social niceties of having more of a general chat.” (Page 11, lines 1-4.)

In particular, participants reported that this focus on the treatment aspects of their work resulted in possibly less regard for the relational aspects of the therapeutic alliance. Participant 10 gave a description of this:

“To be honest I don’t take much heed of the relationship, I’ve been doing it, counselling and stuff, for so long, I go into my bit and I suppose if the patient doesn’t like me, they don’t like me, and that’s the bottom line, because I’m focusing on what I’ve got to do. Don’t get me wrong I’m certainly not rude or anything but I’m focusing on the work and treatment, what they’re saying, what the questions are and how I can help, and that’s pretty much it really,

it's not like a deep therapeutic relationship built up.” (Participant 10, Page 7, lines 15-20).

In this sense, participants appeared to be focussing more on the content of their telephone sessions and less on the process issues involved.

### ***3.2.1.2 Techniques and exercises.***

In relation to this, techniques and exercises emerged as central to participants' sessions. Twelve participants contributed to this sub-theme. Participants reported that they focussed their sessions on the specific task at hand, for example Participant 12 stated that “occasionally I've gone straight into the treatment and showed them the behavioural activation forms, then they've gone away to do that” (page 5, lines 21-22). Similarly, Participant 11 described an increased focus on the exercises compared to face-to-face sessions:

“Maybe just more of an emphasis on filling in worksheets and using them a bit more, I think maybe face-to-face if someone comes along and they haven't done bits, I'm maybe a bit more lenient [laughs] so maybe there's a bit more emphasis on using the record sheets and seeing that as a useful tool for them and me.” (Participant 11, page 10, lines 13-16.)

Again this focus appeared to impact the therapeutic relationship over the telephone. Participant 5 stated that “there's less emphasis on the therapeutic relationship and more emphasis on the exercises and the homework that they're going to be doing because it has to be fairly boundaried over the telephone.” (Page 3, lines 8-9). Similarly, Participant 9 implied that the use of the telephone facilitated this focus in their work, when commenting “I think it's easier to kind of not get quite so involved in the patient and focus more on the interventions.”

Overall it appeared that participants were focussing more on techniques and exercises over the telephone than in face-to-face sessions, and reportedly focusing more on these techniques than the relational aspects of the sessions.

### **3.2.1.3 Goals.**

Seven participants contributed to this sub-theme. Participants reported client goals to be a key focus of their work over the telephone, and a number of participants reported structuring their sessions around this topic. For example, Participant 2 described how “that’s what I often say to people, you know, ‘what do you want from this?’” (Page 11, line 9.)

The use of the telephone appeared to facilitate a focus on goals for some clinicians. Participant 9 stated that:

“Most sessions I’ll be asking them if they feel that this is kind of going in the direction that they want it to and do they feel it’s being helpful. And I think that’s easier to do over the phone because they might feel more able to be honest and say ‘actually no this isn’t working for me’ as opposed to face-to-face where they might feel uncomfortable saying that.” (Participant 9, page 7, lines 8-12.)

In comparison to face-to-face sessions, some participants reported an increased focus on goals, although they were unclear regarding the reasons behind this. Participant 3 highlighted this point:

“I always review the problem statement and know that that’s the first thing I always do on a telephone treatment appointment, and ‘are we on the right track using these techniques to get towards your goals?’ I don’t know why but when they come in, when I’ve got face-to-face appointments, I tend to forget about it.” (Participant 3, page 12, lines 32-35.)



This participant then elaborated to suggest that this might be a result of less focus on the personal interaction over the telephone. They commented that “I don’t know if it’s because I’m more used to the telephone work, or because I’m so concerned that I have to be paying attention to them instead of what I’m doing” (Participant 3, page 12, lines 35-37).

In summary, participants appeared to be focussing on the treatment elements of their interactions, including the techniques, exercises and goals, with less of a focus on the more relational aspects of the telephone sessions. This prominent theme from the data goes some way towards answering research question one regarding the therapeutic alliance.

### **3.2.2 Difficulties in discussing the alliance.**

In addition to the thematic analysis outlined in this chapter which forms the crux of the results, the researcher noted some key observations which should be considered here. The most striking observation was that participants appeared to have difficulty in discussing the therapeutic alliance specifically. This accounts in part for the lack of evidence to fully answer research question one. To demonstrate this lack of reflection on the therapeutic alliance, participants’ difficulties were collated in the coding process under a code entitled “difficult to answer”. Twelve of the 14 respondents contributed to this code, which included 40 extracts of coded transcripts. Some examples include:

“I don’t know, I don’t know how to answer that!” (Participant 3, page 8, lines 19-20.)

“No I think it’s a really big part of it, it is really hard to measure that though, that’s the thing but that’s the thing about therapeutic rapport anyway isn’t it, it’s just you can’t put your finger on it anyway half the time.” (Participant 5, page 12, line 33.)

“I can’t say any more than I’ve said really.” (Participant 8, page 7, line 35.)

“I don’t know really... I’ll come back to it if I think of anything else or a better way of saying it.” (Participant 9, page 5, line 14.)

“The therapeutic relationship? It’s a big... Erm... (Pause) I don’t know...”  
(Participant 10, page 7, line 36.)

“It’s hard to think about that question that you asked, about the relationship.”  
(Participant 11, page 4, line 18.)

“It’s really hard to sort of describe (laughs)...” (Participant 12, page 6, line 3.)

“I should’ve reflected on this a bit before really (laughs) I haven’t thought about it, erm...” (Participant 12, page 8, line 3.)

As discussed previously, the notion of a therapeutic alliance via the telephone was deliberately not mentioned specifically when introducing the study, in order to avoid biasing responses, and to allow exploration of the clinicians’ spontaneous responses regarding telephone work and the alliance. However, in a number of interviews, it was necessary to introduce the topic of the therapeutic relationship explicitly via the topic guide, as the concept had not been raised spontaneously by participants. The researcher noted in the reflective log that this was the case for five out of the 14 interviews, and in three of these cases the interview had already reached the halfway point before the researcher was obliged to introduce questions regarding the alliance specifically.

Excerpt from reflective log:

(Re: Transcript 3): “It was 32 minutes into the interview before the words ‘therapeutic relationship’ came up, and even then, it was me who introduced this because I felt I could not leave it any later to ask about this.”

In those cases where the alliance was mentioned by the participant spontaneously, it was noted by the researcher that many participants struggled to articulate the issues discussed or to elaborate further when prompted. The concept of the therapeutic alliance was sometimes alluded to in terms of “the rapport”, but then subsequent questions regarding this were either met with confusion or the participants responded with an answer that went somewhat off topic and seemed to indicate a difficulty in conceptualising, reflecting upon or expanding upon the concept. In addition, the therapeutic alliance appeared to be, for some participants, a topic that was not raised in supervision or discussed clinically very often. For example:

Participant: “We have talked about telephone work and how we might use it when we were starting it up, and if I wanted to raise talking about the therapeutic alliance in supervision clinical skills then I could do so...

Researcher: Is that something that’s happened?

Participant: I don’t know whether it’s on the agenda [...] But I haven’t felt the need for it.” (Participant 10, page 10, lines 1-7.)

### **3.3 Research Question Two: Which Aspects of Telephone Consultations do Clinicians Perceive to be Helpful or Hindering for Building and Maintaining Therapeutic Alliance in Comparison with Face-to-Face Consultations?**

This research question has been considered using the results from themes two and three. Emerging topics discussed by participants related to both helpful and hindering aspects of their telephone work. Therefore, a simple list of features deemed to be either “helpful” or “hindering” would not have been an accurate representation of the complex views expressed in the data. Instead, the relevant findings are presented in the overarching themes of a *shift in power* and a *reduced sense of*

*personhood*. The themes and their contributing sub-themes are detailed in Tables 3 and 4.

Table 3

*'Shift in Power' Theme*

<u>Theme:</u> <b>Shift in Power</b> (14 participants)	
<u>Sub-theme:</u>	<u>Supported by codes:</u>
<b>Session boundaries are blurred</b> (13 participants)	Valuing appointments Informality Location Noise Distractions Confidentiality Office space
<b>Empowering the client</b> (13 participants)	Telephone takes up less time for the client Focus is on them Less pressure on therapist Responsibility Convenient for client
<b>Disempowering the clinician</b> (14 participants)	(Relying on) patients verbalising more Relying on them having the materials Not being able to see their work Not always looking at the same thing Missing important things Lack of non-verbal cues Managing emotional distress is more difficult Silence & pauses Practical difficulties Everything takes longer on the phone

Table 4

*'Reduced Sense of Personhood' Theme*

<u>Theme:</u> <b>Reduced Sense of Personhood</b> (14 participants)	
Sub-theme:	Supported by codes:
<b>Interpersonal boundaries are easier</b> (11 participants)	Telephone sessions are shorter Going off topic less Less concern for client
<b>More distant connection to the client</b> (12 participants)	Less sense of client as a person Less connection to client Doubting the client Limiting
<b>Anonymity</b> (12 participants)	Disclosure Feeling comfortable Preconceptions/ judgements/ assumptions
<b>Importance of meeting</b> (10 participants)	Importance of faces in establishing a sense of the person Builds trust Recalling patients - memory

**3.3.1 Shift in power.**

All 14 participants contributed to this overarching theme. Telephone delivery appeared to create a shift in power, which effectively empowered clients but meant that the clinician was disempowered to some extent. Participants reported that when using the telephone as the primary means of conducting therapy, they were forced to relinquish some power in the relationship, as session boundaries became blurred and lack of visual clues left them feeling de-skilled. However, the therapeutic encounter

appeared to benefit from an increased focus on the client in terms of responsibility and convenience for them.

### ***3.3.1.1 Session boundaries are blurred.***

Thirteen of the 14 participants contributed to this sub-theme. These participants appeared to perceive this aspect of telephone work to be mostly hindering the therapeutic encounter. The use of the telephone made it more difficult to maintain the usual boundaries of the session, in comparison to a face-to-face appointment. This was particularly relevant to the physical boundaries of the session, concerning location, noise and confidentiality, additionally participants also reported a perceived decrease in the relative value of an appointment in clients' minds.

Thirteen participants commented on difficulties regarding location. Participants reported that the client's location during the session impacted on the session boundaries, for example Participant 6 reported "they might be somewhere completely inappropriate so it's quite hard" (page 1, line 30). Also, the clinician's location was seen as problematic, as Participant 8 remarked "you're sitting effectively in a call centre" (page 8, line 29). For many participants, there were often concerns regarding the noise levels within their office space, in relation to both their ability to conduct the session well, and the impact of background noise on the client. Participant 11 commented that:

"It's not appropriate for me, because I can't focus and concentrate, and also I don't really like people listening, I know they're not thinking anything about what I'm saying but it's a bit off-putting. And also for the person on the end of the phone, what if they hear laughter in the background or anything like that? Obviously I talk about confidentiality, well I'm in a room full of people, that all just feels a little bit uncomfortable, and if somebody's distressed on the end of the phone but there's maybe laughter going on, you know - just

office banter that sometimes crops up, then again it doesn't feel very appropriate" (Participant 11, page 10, lines 29-35).

Concerns regarding confidentiality were raised by a number of participants, and appeared to relate to aspects of the therapeutic alliance such as trust. The noise levels in some offices were also seen as a hindrance to the therapeutic encounter in terms of detracting attention from the client. In this sense, these issues appear to be a hindrance to building and maintaining the therapeutic alliance which might not occur with face-to-face appointments.

Similarly, Participant 4 noted that "there's distractions on both sides" (page 3, line 14). The location of the client when receiving the telephone call for appointments was highlighted as problematic by the majority of participants.

Distractions were a key hindrance:

"You've got children who keep crying in the background, keep asking for their attention, and sometimes they go off and have to go sort something out [...] And also I've had people getting parcels arranged to be delivered in the middle of the session, and things like they've had power cuts and they've disappeared, so it's just things like that that you just wouldn't get [face-to-face]." (Participant 6, page 2, lines 24-29.)

"They might be out shopping and think that they can do a telephone assessment or appointments where they're in the supermarket, and you know that they're not paying attention and they're not in a position where they can talk about things, where they would be able to if they were on their own somewhere private, that can be really difficult." (Participant 9, page 6, lines 26-29.)

In this sense, participants reported that the physical boundaries of the session had become blurred and they reported less control regarding intrusions to therapy.

Difficulties with clients' location also seemed to link to the issue of clients possibly valuing telephone appointments less than face-to-face appointments, which was raised as a hindrance by nine out of the fourteen participants. Participant 12 noted this in relation to non-attendance:

“We get a lot of DNA phone appointments, a lot of cancellations for phone appointments, loads of them. There's something about them feeling it's not as important as if it's face-to-face, yeah. And it's very easy to rearrange it, that probably comes into it.” (Page 7, lines 21-23.)

Participant 4 remarked that sometimes “you'll call someone and they'll say ‘oh I'm in the middle of something else at the moment’ – they don't seem to prioritise a telephone call as highly as they prioritise a face-to-face appointment” (page 2, lines 8-10). Participant 6 also noted the informality of sessions being via the telephone when “ people start to treat it a little bit less like a formal session, so some of those boundaries are then gone [...] rather than realising actually no it's still an appointment” (page 8, lines 21-24). This participant then elaborated further to highlight how this might be a hindrance for the therapeutic alliance, particularly in terms of the ‘task’ element:

“Things like preparing for a session, I think if people physically have to come and face you and say ‘oh I haven't done that, I haven't looked at it, I've lost it’ I think they find that a little bit more difficult to do, whereas when it's on the phone I think people find it quite reasonable to have not prepared for the session in the same way, and that can make it really difficult.” (Participant 6, page 8, lines 35-38.)

In relation to a possible shift in power, this de-valuing of appointments seemed to manifest itself in the relational aspect of the alliance also:



“You don’t phone up your GP and demand they see you sooner kind of thing, whereas I think when it’s on the phone there’s that thinking that it’s just a phone call, you can fit it in whenever so I’ve found that people have felt more comfortable just contacting me and asking that, so I don’t know if it’s a new element to the relationship but it does seem that, I think they treat the sessions a little bit differently in a way.” (Participant 6, page 12, line 39 – page 13, line 3.)

However, this informality was highlighted as a possible helpful aspect of telephone work by a small minority of participants. In particular, Participant 9 commented that “it’s just a bit more relaxed and people are more like themselves” (page 8, line 10). This seemed to impact positively upon the ‘bond’ aspect of the therapeutic alliance in the sense that “it’s easier to share jokes or laugh with each other than it might be face-to-face, because it’s kind of more formal face-to-face and over the phone, because it’s in their environment, their life, it feels a bit more relaxed” (page 8, lines 12-14). This idea of “their environment, their life” represents a possible shift in power towards the client, which will be discussed further as part of the subsequent sub-theme.

### ***3.3.1.2 Empowering the client.***

Thirteen of the 14 participants contributed to this sub-theme. The use of the telephone was seen as shifting the focus onto the client, which effectively empowered the client in a number of ways. Telephone work was perceived as more convenient for the client, affording them more control over the appointments, as well as placing increased responsibility on the client to undertake the work and less dependency on the clinician as a result of not meeting. Participants reported that this client empowerment was mostly helpful for the therapeutic encounter.

Nine participants commented on the convenience factors for clients using the telephone. Participant 9 stated that clients “can slot it into their daily routine, they don’t have to travel anywhere, they don’t have to make any big effort.” (Page 3, lines 10-11). Participant 8 also highlighted the benefits for clients who are employed full-time: “they can nip out to their car at lunchtime, they don’t have to leave work to come and do it, it can stay private.” (Page 8, lines 15-16). Likewise, the time saved by telephone appointments seemed important, as Participant 1 noted “it probably takes up significantly more of their time actually to come to face-to-face appointments” (page 6, lines 33-34). This convenience aspect of telephone appointments appeared to have a positive impact on the therapeutic alliance between clients and participants:

“I think because you’re coming into their life rather than them coming into a clinic or somewhere to see you face-to-face, [...] it does feel more like they’re integrating that into their life, and so in a way it can be a kind of... That connection is built that way.” (Participant 9, page 5, lines 8-11.)

Similarly, seven participants contributed to the idea that the focus is therefore more on the client via the telephone. Participant 1 commented that “phone work is a positive thing, because I think on the whole it’s about the patient not the therapist” (page 9, lines 15-16). This appeared to be empowering for the client, which was deemed to be helpful for the therapeutic relationship:

“Telephone for me feels a little bit more like you’re giving them more ownership. I think that’s what the PWP role is about, it is about gearing someone up to be their own therapist, [...] so for me it feels more like I’m empowering them to take away what we’re discussing to make changes, rather than them sort of coming in and feeling reliant upon me and that sort of relationship.” (Participant 11, page 6, lines 6-11.)

This appeared to be linked to the notion of responsibility and the telephone “putting the onus on to them” (Participant 10, page 6, line 42). Participant 11 noted that the telephone “feels a little bit more like it’s just giving that person a bit more responsibility” (page 6, lines 15-16). In terms of the therapeutic alliance, this was largely perceived to be helpful due to a reduced reliance on the clinician:

“I actually feel now that meeting someone face-to-face sets them up to have a dependency on you, in some way. And I think the phone is much more freeing for a patient, I think it frees them from that dependency, they don’t meet me, I’m not a face. I actually think that it fits perfectly for what we’re doing with people.” (Participant 14, page 6, lines 18-22.)

Participants reported that this had a positive knock-on effect for them as a clinician, as they could feel “less under pressure or on the spot as a therapist” because “when you’re face-to-face with somebody [...] there’s a bit more pressure on you to actually run the session” (Participant 7, page 2, lines 7-10). This might relate to the alliance in terms of helping the collaborative nature of the work. This shift in power was perceived to be quite containing for both clients and participants, as Participant 11 highlighted: “there’s something about the phone that allows me to feel that I’m just sticking to what I’m trained to do, and that feels very safe for me and for them” (page 7, lines 31-33). However, empowering the client did appear to come at a cost to participants, as highlighted by Participant 9:

“I think it’s about the kind of power balance and I don’t think it should be, but I think in face-to-face it’s so much easier to slip into this role of you being the clinician, the authority on the subject, and having the answers and helping someone to feel better, whereas over the phone I think it’s more of an equal partnership. And I think when you first think about having to do telephone work, it’s almost like giving up that power in the relationship [...] I

just think about everyone's reaction when we were told we were going to be doing more telephone work and it was all negative." (Participant 9, page 9, lines 26-31.)

The results therefore suggest that whilst the telephone can help empower the client, it may also force the clinician to relinquish some aspects of power within the relationship. The impact upon participants and the subsequent therapeutic alliance will be discussed further within the following sub-theme.

### ***3.3.1.3 Disempowering the clinician.***

All 14 participants contributed to this sub-theme in some form. The telephone modality restricted participants' abilities to build and maintain a therapeutic alliance in some ways, and rendered participants almost powerless in some situations. Participants perceived that practical difficulties and a lack of non-verbal cues reduced their opportunities to use their clinical skills effectively, and produced an increased reliance on the client to be organised and to verbalise everything over the telephone. Participants reported this aspect of telephone contact to be unhelpful for their therapeutic work.

Participant 8 reported that the telephone "can be in some respects de-skilling" (page 9, line 23). For example, thirteen participants made reference to the lack of non-verbal cues. This included aspects such as lack of body language, lack of eye contact, and lack of gestures. Participant 1 implied that this was important for the therapeutic relationship by stating "I personally prefer face to face, because you've got [...] all of the non-verbal stuff and rapport building, I think it's helpful for that" (page 3, lines 35-37). This lack of non-verbal cues appeared to affect participants' power to communicate things to the client, as described by Participant 13: "leaning forward for example, eye contact, just gently nodding, smiling... Those non-verbal signals that we all do, unconsciously, particularly if we're a good therapist" (page 8,

lines 2-3). It also affected participants' power to gather information, as described by participant 5 who noted "you're not able to read their, you know, their 80% of non-verbal cues or whatever it is, so you've got none of that that's kind of helping you understand the situation" (page 4, lines 37-38).

In this respect, clinicians reported fears that they might be missing important things over the telephone. Participant 7 explained that "in my mind it's just like, what can I not see? It could be nothing that I'm missing but you don't know" (page 5, lines 14-15). In particular, participants expressed concerns regarding detecting and managing emotional distress over the telephone, which related to the concept of the therapeutic alliance, either in terms of rapport, or in terms of mutual understanding and the expression of listening and empathy. Participant 5 described this as:

"You haven't got that, you can't see what they're feeling and you haven't got that kind of, making them feel safe or making them feel as though they can speak to you or... It's a hard thing to describe really." (Page 3, lines 11-13.)

This appeared to be in direct contrast to their experience of face-to-face appointments where participants felt more empowered:

"When I compare it to face-to-face working where maybe you're working through with someone and they are with you and you are able to kind of take some time about it and you're able to see if they're upset and you may be able to react to that, then you kind of feel like you're side by side with them, you're supporting them more." (Participant 5, Page 3, lines 32-35.)

Participant 1 agreed that "if you're in session obviously you can tell before they cry, they look like they're going to cry anyway, and you can just manage that maybe a little bit easier." (Page 8, lines 25-27.)

In particular, silence and pauses seemed to cause difficulties over the telephone and reduce the power of the clinician. Eleven participants made mention of

silences and pauses. Participants reported that silences from the client could be confusing, unsettling, or leave the clinician open to misinterpreting the client:

“You can’t see them, so you can’t be sure sometimes whether somebody’s emotionally distressed or not. So if they go quiet, it could be that they’re emotionally distressed, it could be that they’re thinking, it could be that they’re texting somebody on their phone (laughs), I mean I don’t know, it’s really hard to tell sometimes.” (Participant 4, page 3, lines 30-33.)

“You do have lots of questions flying round in your head when you’re sitting waiting... And it can be quite, I wouldn’t say anxious-making, but it can be a bit kind of “hmm what’s going on here? I wonder what this is about then.” I would say it’s slightly harder to deal with, because you can’t see it.”

(Participant 8, page 6, lines 10-13.)

Similarly, the use of the telephone seemed to reduce participants’ power to use silences therapeutically:

“When somebody starts crying on the phone, it always feels a bit like you can’t do anything, it’s a little bit powerless. I know you can’t do that much face-to-face, but you can just kind of give that look of you’re understanding and perhaps not having to say something sometimes, whereas on the phone you can’t do that silence bit where you just kind of allow them to collect themselves a little bit more, because you can, but then it becomes a little bit strange, and I don’t think that helps them when it just seems a little bit like you’re ignoring them over the phone, so you’ve kind of lost that power of just actually not saying anything at all.” (Participant 6, page 5, lines 33-39.)

These difficulties were deemed to have a negative impact on the therapeutic relationship overall, as Participant 6 described it “can ruin that rapport a little bit

because they're then feeling that you're not really understanding things quite so correctly" (page 7, lines 6-7).

Another way in which participants appeared to be disempowered related to the practical aspect of being physically unable to see the task at hand. For example, participants reported that they relied on clients to verbalise their homework tasks:

"It's obviously harder to pick up what people are actually doing in terms of homework, it's harder to go over the details of cognitive restructuring or behavioural activation, you know – 'so read out those things that you've put down' - it's quite clunky, and also there may be bits that they've written next to it that you're not going to pick up and they might not exactly say everything. So that can be a bit unwieldy, whereas obviously face-to-face you've got it in front of you, you can be scanning it as they're telling you things, and maybe you're ahead of the game or you can put it into context a bit easier." (Participant 2, page 7, lines 3-9.)

Similarly, participants reported that telephone work seemed to hinder their ability to collaborate with the client and to ensure client understanding:

"Sometimes it's quite difficult to explain it, you have to make sure you've got your copy that they've got, I haven't quite worked out sometimes how to deliver it or how to interact [...] Whereas if you've got somebody face-to-face, you've got the booklet there, you can sit next to each other and say 'okay so this is the graph that you're going to do' and you're sharing it, you're both engaged in the same thing and you know they're looking at it, they're understanding it, you can check that easier I think." (Participant 10, page 5, lines 6-21".

This appeared to relate to the therapeutic alliance in terms of the 'task' element and collaboration being more difficult. Eleven participants commented on this inability to

be looking at the same thing as the client, although it was not deemed to be a problem by everyone. Participant 14 remarked that “for me it really feels like there’s no difference than if you were in the same room” (page 6, lines 9-10). However, the majority of participants reported a reliance on the client having the materials in front of them, and this seemed to reduce the power of the clinician:

“You can’t guarantee they’ve got that booklet in front of them, you might have sent it but they might have lost it, or they might be somewhere completely inappropriate so it’s quite hard to try and explain things sometimes and I just think it’d be so much easier if I could just do this in person.” (Participant 6, page 1, lines 28-31.)

The practical difficulties of telephone work also appeared to hinder the participants’ therapeutic contact with clients. Participants commented on issues such as poor mobile phone signal, clients being hard of hearing, or difficulties with postage. Participants appeared to be disempowered by these difficulties when building a rapport:

“People don’t quite realise how much you can’t hear them and I just think you lose quite a lot of that valuable information through it sometimes, and that can be quite frustrating as well when you can tell they’re talking about something, it’s quite upsetting, you’re having to say ‘I’m really sorry I can’t hear that, could you repeat it’, and it might have been quite a big thing for them to share that in the first place, then to make them have to say it again because you didn’t even hear it isn’t always the nicest thing to have to tell someone.” (Participant 6, page 8, lines 7-13.)

As a result of practical difficulties, relying on clients to verbalise everything, and not having shared materials in front of them, many participants reported that the telephone can prolong the tasks involved in their work. For example, the minimum



data set questionnaires (the routine outcome measures such as PHQ9 and GAD7 used in IAPT) reportedly became “very laborious doing it over the phone rather than someone handing you the questionnaire” (Participant 5, page 5, line 17). This appeared to impact participants’ abilities to focus on the ‘bond’ elements of the alliance:

“A lot of the time is taken up with them describing what’s on their homework, so even more practicalities, so you’re getting less of the kind of feelings stuff and a bit more of the ‘what have you done?’” (Participant 5, page 4, lines 27-29.)

These difficulties therefore appeared to impact upon both the power elements of the relationship and also the ‘bond’ aspects of the therapeutic alliance, as discussed further in the subsequent theme.

### **3.3.2 Reduced sense of personhood.**

All 14 participants contributed to this theme. Some elements of ‘personhood’ appeared to be lost via the telephone, both for the apparently “faceless” clinician and the more anonymous client. This appeared to produce both benefits and disadvantages for the therapeutic alliance, in terms of interpersonal boundaries and anonymity facilitating disclosure. However, the connection between client and clinician appeared to be more distant, and participants emphasised the importance of meeting each other to establish a therapeutic relationship.

#### ***3.3.2.1 Interpersonal boundaries are easier.***

Eleven of the 14 participants contributed to this sub-theme. The use of the telephone appeared to make it easier to maintain appropriate interpersonal boundaries between the client and the clinician, in comparison with face-to-face appointments. Participants reported that it was easier to time-manage over the telephone, clients appeared to veer off topic less, and participants felt less burdened

in terms of concern for the client. Participants perceived this aspect of telephone appointments to be mostly helpful to their therapeutic work.

One aspect of this appeared to relate to participants ending the appointment and feeling it was easier to keep to time. Eight participants commented that telephone sessions tended to be shorter than face-to-face appointments. This appeared to be linked to the idea that interpersonal boundaries might be easier over the telephone:

“I’m very conscious of time over the phone, and I will be much more boundaried about that, whereas face-to-face I find time boundaries really difficult to manage. [...] I think because I haven’t got a person in front of me, I find it much easier to say ‘if we run out of time I will stop us, if we need to move it on’ - I will say that over the phone, but I wouldn’t say that to someone face-to-face, which is ridiculous, saying that out loud now I know that’s ridiculous.” (Participant 14, page 4, lines 19-24.)

The impact of distance on the relational aspect of the appointment appeared to be a benefit for some participants. Participant 8 implied that in telephone interventions there is less of a personal relationship, which brings its own benefits:

“I think over the phone it’s easier to boundary people, in person you’ve got all of the body language, you’re making a personal relationship with someone, people often want to talk a bit more when you’re face-to-face, and it is harder to boundary someone face-to-face, I think generally people feel that, because it can feel rude, or ruder.” (Participant 8, page 1, lines 18-21.)

In turn, participants reported that clients tended to veer off topic less in telephone sessions than in face-to-face sessions, which appeared to benefit mainly the ‘task’ element of the therapeutic alliance:

“People don’t seem to necessarily want to talk about the other bits and bobs that are going on for them, they just seem to be much more boundaried on the phone, I don’t know why that is, but face-to-face it just feels like people come in and it’s a bit of an offloading, and I don’t quite know why that is, I don’t know what makes people want to offload more when it’s face-to-face as opposed to the phone, but it just feels I can just stick much more easily to what we actually need to be focusing on.” (Participant 11, page 2, lines 16-21.)

Participant 6 also noted that the telephone seemed to facilitate interpersonal boundaries by reducing the ‘personhood’ aspect of the clinician and limiting curiosity from clients:

“I find when you’re on the telephone people ask you less personal questions, because I think when you meet somebody face-to-face you meet up and I think it starts to confuse the boundaries a little bit, whereas on the telephone I think they just see you as that person they talk to and they have less interest in you. Whereas when I was doing a lot more face-to-face I did have to have those awkward conversations to try and ask why are you interested in all this about me?’ and trying to clarify that it’s not about me, it’s about them.

Whereas I haven’t really experienced that on the phone before.” (Participant 6, page 3, lines 23-29.)

The reduced sense of personhood via the telephone appeared to help participants maintain the boundaries imposed by the service in terms of offering the client telephone appointments rather than face-to-face appointments:

“There’s a bit of me, if I’m entirely honest, that thinks ‘well you might well prefer face-to-face but this is what’s on offer’, and [...] you do get people who say ‘well I’d rather see someone face-to-face’ and [...] I might feel a bit like

‘well tough basically, this is what you can have, and it’s a free NHS-funded service, and this is what’s available’.” (Participant 4, page 11, lines 24-28.)

Participant 6 described this as “losing some of that concern” for the client (page 12, line 1), and this seemed to facilitate interpersonal boundaries in terms of participants keeping clinical work separate from their own time:

“I go home and have less sleepless nights thinking about people and worrying about them, so in that way it’s great, but at the same time part of me is feeling really guilty that you’re not, because you feel that those people are in a similar sort of position to the people you’d seen before but you haven’t quite grasped that in the same way.” (Participant 6, page 10, lines 4-7.)

Therefore, whilst generally helpful for participants, this distance and reduced sense of personhood also appeared to concern some participants in terms of a reduced connection to the client, as evidenced in the following sub-theme.

### ***3.3.2.2 More distant connection to the client.***

Twelve participants contributed to this sub-theme. The element of distance over the telephone appeared to limit participants’ connection to the client, reducing their sense of the client as a person. Participants felt the telephone was more clinical, less personal and introduced some element of doubt into the relationship. Participants appeared to find this aspect of telephone work to be both helpful and hindering to the therapeutic encounter.

For example, ten participants commented on the sense of distance between them and the client introduced by the telephone. Participant 10 described this as: “you can sort of feel less, I suppose the word is less involved, it’s a little bit more clinical I suppose” (page 2, lines 6-7). This appeared to negatively impact the therapeutic alliance in terms of the ‘bond’:

“I think it makes me more distant actually, [...] adding the telephone into that almost makes you be less compassionate I think, because you haven’t got that person in front of you, you know, they’re at the end of the phone they’re not in front of you, you don’t have to be maybe as... It’s not empathic - none of us would be like that - but I think it’s distancing, it’s not as nurturing in a way.” (Participant 5, page 3, lines 15-21.)

However, some participants felt that this distance could be helpful in terms of allowing for a focus on the ‘task’ elements of the therapeutic alliance. Participant 9 commented that “it’s easier to not get quite so involved in the patient and focus more on the interventions” (page 2, lines 3-4).

This appeared to be linked to this notion of reduced ‘personhood’ as a number of participants reported having less sense of the client as a person over the telephone. Participant 1 described how “you’ve got to almost just maybe take a minute before, just think ‘right, who am I calling? What’s their issue?’ You know, whereas if they’re with you face-to-face, you kind of ground that a bit quicker maybe” (page 9, lines 33-35). Again this appeared to affect the ‘bond’ element of the alliance and seemed to hinder some participants in forming and maintaining a therapeutic relationship:

“I do find that sometimes you kind of pitch it wrong at the start of the call sometimes, and then you’re like ‘oh no they didn’t like that’, and you then kind of catch up on yourself again, but I do find it makes the start of the phone call a little bit awkward because you’re not quite sure who you’re talking to, which is not the nicest thing at all, I hate that.” (Participant 6, page 5, lines 19-22.)

In particular, six participants commented on the fact that they sometimes doubted the client over the telephone, possibly reflecting this more distant connection to the client and a possible element of reduced trust.

“It sort of makes me wonder, like when you’re reviewing it and they’re explaining it, it makes me wonder how, with my cynical hat on, they could be saying the right things like ‘yeah I did this this and this’ but maybe if you’d been there, if you’d seen each other face-to-face, you might have picked up on something.” (Participant 7, page 5, lines 35-38.)

This more distant connection to the client also appeared to impact upon the participants’ sense of personhood, as Participant 12 described “it feels a bit like having to be a robot” (page 11, lines 32-33). Two other participants compared their telephone work to “conveyor belts” (Participant 5 and Participant 8), which appeared to reflect the lack of personhood and connection to the client in some cases. However, this distance between client and clinician also presented some benefits to the therapeutic alliance, as discussed in the following sub-theme.

### ***3.3.2.3 Anonymity.***

Twelve of the fourteen participants contributed to this sub-theme. The telephone appeared to reduce the sense of personhood by introducing an element of anonymity for both client and clinician, which in turn appeared to benefit the distance alliance in a number of ways. Anonymity was perceived as facilitating disclosure for some clients, enabling both parties to feel more comfortable, and reducing the impact of preconceptions, judgements or assumptions. Participants reported on the whole that anonymity was generally helpful for the therapeutic alliance.

Anonymity appeared to enable disclosure for some clients. Participant 13 explained that “if someone is going to disclose something that they find difficult,

they might find it easier if they're not looking at you" (page 7, lines 17-18). In particular, the idea of the clinician having a reduced sense of personhood in relation to the client seemed to play an important part:

"For some people it's just nice to have that person on the phone that they can't see when they're sharing some of those things. Quite a lot of people have said that they haven't opened up about things previously, and I think it's almost like you just talk to this faceless person that you don't feel judged by as such, and it can make some people feel more comfortable, although I suppose it could do the opposite for some others as well." (Participant 6, page 2, lines 34-38.)

Five participants described themselves as being "faceless" clinicians or a "disembodied voice". This was reported to have benefits for participants as well as their clients, as Participant 14 explained: "The anonymity? I love it, because when we did used to see people all the time, you'd bump into people, you'd not know what to say [...] Over the phone you don't have that problem" (page 7, lines 24-27). In terms of the therapeutic alliance, this appeared to liberate both clients and participants: "You don't have to worry about the impact that might have if you see them again or you don't worry what they think because it's not somebody you ever even know who that is" (Participant 6, page 3, lines 10-12). However, not all participants viewed this anonymity as helpful for the therapeutic alliance. Participant 13 stated "I don't think they necessarily kind of see you as a person as much, they don't necessarily open up as much as they might face-to-face" (page 3, lines 19-21). Participant 8 noted that "it varies, some people will tell you something because they can't see you, other people will wait until they've met you to decide whether they're going to trust you to tell you something" (page 4, lines 28-30).

In relation to this reduced sense of personhood and the anonymity of telephone work, seven participants commented on the lack of initial judgements or assumptions over the telephone. Participants reported that this was both helpful and hindering:

“Some of the visual things about people actually make you have preconceptions about what their difficulties might be, and that might be a negative thing, it might be a positive thing. So if somebody came into my room who was really large, I might have a preconception that some of their difficulties were related to their size, and actually I might be wrong. But on the other hand that might be really useful to know that, because I might be right but because I can’t see them, I don’t know that.” (Participant 4, page 7, lines 35-40.)

In particular, some participants noted a positive impact of this lack of visual judgements on the therapeutic relationship. In this case, the anonymity afforded to participants via the telephone appeared to be helpful:

“I find when I’m doing face-to-face work a lot of people have difficulty with my age because I am quite young, [...] but what is nice on the phone is that you can’t really judge somebody’s age by their voice so that hasn’t been such a barrier in building that rapport, I find it a little bit easier to move forward without age being a problem.” (Participant 6, page 3, lines 16-23.)

However, a number of participants commented on the importance of reducing this general anonymity in order to build trust and help the client feel comfortable. This is discussed further in the subsequent sub-theme.

#### ***3.3.2.4 Importance of meeting.***

Ten participants contributed to this sub-theme and reported that it was common practice for them to meet clients for at least one face-to-face session (early



on in the course of treatment) to supplement their telephone work. The majority of these participants commented on how helpful this aspect of their current telephone delivery could be to the therapeutic relationship. The importance of faces in establishing a sense of the person (for both clients and clinicians) was highlighted, and meeting each other reportedly helped build trust and improve participants' memory of clients. Only four participants reported that they usually conduct their telephone work without ever meeting the client.

The importance of meeting the client was linked to establishing a greater sense of personhood, both for the client and the clinician. Participants reported that they found the face-to-face appointment reassuring and felt it benefitted the therapeutic relationship in terms of the 'bond' element:

“As long as I have the additional face-to-face so that we can both get to know each other, build up some kind of rapport and trust, and get more of a full picture, then I'm more than happy to do it by telephone now.” (Participant 12, page 1, lines 34-36.)

For the client, the initial face-to-face appointment appeared to aid engagement:

“Some people I've seen face-to-face and then had telephone contact, and actually they tend to speak a lot more and relaxed almost, but whether that's because they've seen me... I suppose that's often how it feels - the next time I speak to them they're usually actually more engaged. It feels, well, my thought is that they've checked me out.” (Participant 2, page 11, lines 24-27.)

This appeared to be due to a greater sense of personhood regarding the clinician, as explained by Participant 8: “Well it must be about what they feel about you as a person, you're a disembodied voice aren't you, whereas meeting you face-to-face you are actually a real human being” (page 7, lines 30-31). In turn, this appeared to benefit the therapeutic alliance: “Maybe the relationship or the rapport, for me that

first appointment face-to-face is really important, I think they perhaps need to know who they're speaking to, they need to put a face to the name.” (Participant 11, page 3, lines 20-22.)

This idea of the importance of faces was mentioned by ten participants in total. Meeting each other in order to see someone's face and establish a sense of that person appeared to be helpful in building the therapeutic alliance.

“Because I've seen them face-to-face, it's easier because they know, they have a picture of me in their head don't they – ‘I know XXX, he's an older guy, he's nice to me, he smiles’ [...] So when you phone them, they go ‘oh yeah it's XXX yeah, I quite liked him, he was quite nice, he had some good ideas’ you know, so you're halfway home aren't you.” (Participant 13, page 5, lines 19-24.)

Without seeing the client's face, participants reported that the therapeutic relationship could feel more distant: “it just feels like it's not as tangible [...] Their face isn't in front of you - it kind of goes back to that - the person isn't there, it's just a voice.... Even though it is a person” (Participant 5, page 8, lines 11-13).

Similarly, seven participants commented on difficulties recalling clients with whom they had telephone appointments. In particular, those cases where the participant and client had never met appeared to be the most difficult to remember:

“One thing I do notice is when I have supervision and when I go through my caseload, I find it really hard to recall who people are, and I think I'd find that easier if I knew what they looked like, [...] I've not got a face to place to them at all, so I find that more difficult to sort of remember what we've been doing together without that face to remind me of who they are.” (Participant 4, page 3, lines 20-28.)

The importance of having met someone in order to keep a sense of that person in their memory was highlighted by a number of participants:

“Having a face, for me, it triggers it off. So when we have case supervision, case management supervision, there’s a list of names, I’ve struggled, I can’t remember anything about that person. But then maybe I start reading a sentence and then I can visually, I see them sitting in front of me, and think ‘oh that’s the person who was that’, and then it all sort of clicks in, which I think is harder over the phone. It happens, it still happens, but it’s a bit more difficult.” (Participant 2, page 4, lines 6-11.)

Therefore, although telephone work did appear to introduce an element of reduced personhood, participants also appeared to be adapting to this by using an initial face-to-face appointment to help build the therapeutic alliance. Other ways in which participants adapted to telephone work are discussed in the following research question.

### **3.4 Research Question Three: How Might Telephone Consultations Influence Clinicians’ Practice and the Nature of the Therapeutic Interventions They Offer?**

This research question has been considered using the results from theme four. Firstly, the data regarding interventions offered is reported for information, followed by details of theme four: *adapting to the telephone*.

#### **3.4.1 Interventions offered.**

Overall, 12 participants stated that the interventions they offered via the telephone were the same as those offered face-to-face. A large number of participants referred specifically to the ‘seven PWP interventions’ which consisted of behavioural activation, cognitive restructuring, medication support, exposure therapy, problem solving, managing panic, and sleep hygiene. Participants reported that “there’s

nothing I wouldn't do over the telephone that I would do face-to-face" (Participant 4, page 1, lines 21-22) and "all of the interventions that we should be doing face-to-face I've just switched to telephone" (Participant 11, page 1, lines 33-34).

However, one participant noted that the telephone might restrict the ease with which they might change interventions mid-treatment, in response to the client's needs:

"The flexibility in terms of changing clinical direction, in terms of switching interventions, it kind of feels like I would be more willing to do that face-to-face than I would do telephone, because I'd have more time. So if someone's not getting behavioural activation or it's maybe not working for them, I mean I wouldn't just carry on regardless, but I maybe wouldn't have discovered that as quickly as I would do face-to-face." (Participant 5, page 9, lines 11-15.)

Similarly, Participant 9 noted that although clinicians seem to be offering "the same basic interventions," the use of the telephone has "changed how we deliver them maybe" (page 1, line 26). This theme of adapting to the telephone modality was raised by a number of participants.

### **3.4.2 Adapting to the telephone.**

In total, all 14 participants contributed to this theme. Participants reported a number of adaptations to their clinical practice in order to overcome the barriers imposed by telephone working. Some of these adaptations appeared to be strategies to re-establish some sense of personhood, others were attempts at regaining some power in the therapeutic interaction. Participants highlighted new ways of working including verbalising everything, making more use of voices, and using practical adaptations such as email.

Participant 4 noted that “working with people face-to-face is a slightly different skill to working with them over the telephone” (page 13, lines 25-26). This appeared to induce anxiety for some participants initially:

“It’s a new concept, a way of working to get your head around, so there is that bit, and I was wondering will it de-skill me, will it mean that I can’t use the skills that I’ve gained? [...] I was wondering will it feel like a call centre, will people like it, will people get on with it? Will it work? So it’s concerns for me personally and then concerns for patients.” (Participant 11, page 6, lines 19-23.)

However, nine participants reported warming to telephone work following positive experiences of using the telephone. Participant 7 commented that “I had some sort of reservations about it really but my experience on the whole was surprisingly positive, yeah it worked ok” (page 1, lines 26-28). Some participants also reported that they felt the alliance over the telephone could be “good enough” to do the work:

“I was quite sceptical about the effect it could have, but I’m starting to realise that no, actually you can still do quite a lot of work over the telephone.

Because I was worried that it would be hard to build that rapport, but actually I’ve not found that’s overly difficult.” (Participant 6, page 4, lines 11-13.)

In particular, Participant 9 suggested that the alliance might be qualitatively different rather than weaker: “having done lots of telephone work, I do think that actually the alliance can be just as strong, just in different ways” (page 4, lines 32-33). However, this participant was unable to expand further on this point. Participants reported achieving this strong alliance in a number of ways, using a number of adaptations to their clinical practice. These are detailed in Table 5.

Table 5

*'Adapting to the Telephone' Theme*

Theme:	Sub-themes:
<b>Adapting to the telephone</b> (14 participants)	Verbalising more (10 participants) Use of voice (11 participants) Re-establishing some sense of personhood (7 participants) Practical adaptations (14 participants)

**3.4.2.1 Verbalising more.**

Ten participants mentioned that they might be using more verbal elements of communication. Participants reported verbalising their expressions of empathy: “you have to say it out loud, you know, the empathy” (Participant 5, page 8, line 4) whilst also informing clients explicitly of their actions on the other end of the telephone:

“You just talk a lot more, because I’m trying to explain everything that I’m doing as well because in the past it’d be quite obvious that I’m taking notes and that’s why there might be a bit of a pause, whereas now you’re having to say all these things as well just to keep reassuring people I’m here.”

(Participant 6, page 6, lines 21-24.)

Participants also appeared to be verbalising their listening skills: “doing that active listening, summarising, feeding back, making empathic statements [...] you do it a little bit more because if you’re face-to-face you can show some of the non-verbals” (Participant 7, page 8, lines 29-33). In addition, explaining things to clients and checking their understanding appeared to become a more verbal process:

“I think [I’m] checking with them a lot more than I might face-to-face, making sure they understand what I’m trying to say, because it can be very

easy I think to just say ‘yeah that’s fine’ so I’m having to pay attention to how they sound in order to check with them that we’re on the same page.”

(Participant 9, page 7, lines 5-8.)

#### ***3.4.2.2 Use of voice.***

This element of tone of voice and how the client sounds appeared to be a key focus for participants using the telephone. Participants also reported making more use of their own voice in telephone interactions. Eleven participants made mention of using voices differently to face-to-face contacts. Participants reported that “it’s quite a skilful way of working because you have to tune in to other bits, like silences for example or listening to tone of voice and how that changes” (Participant 11, page 4, lines 15-16). Similarly, participants appeared to be focussing more on the content of clients’ speech: “you really concentrate on what people say, because before you’ve got so many other cues that you’re not really focusing so much just on that” (Participant 6, page 6, lines 28-29).

In return, participants appeared to be adapting the use of their own voice to enhance communication via the telephone:

“Simple things like changing your tone of voice, I think I’ve become far more elaborate in my tone of voice whereas before I don’t think I really gave it that much thought, [...] I don’t think I’d have been quite so elaborate in my speech, I’ve become a bit more theatrical I suppose.” (Participant 6, page 12, lines 5-10.)

#### ***3.4.2.3 Re-establishing some sense of personhood.***

Participants reported a number of adaptations to their clinical work which appeared to be in response to the aforementioned reduced sense of personhood. Seven participants contributed to this sub-theme. For example, four participants described noting down small details such as an upcoming event or a personal hobby,

which they could later remember to ask the client “and then I think at least they feel valued, they’re not just another number” and “there’s something in there that makes them feel like a person” (Participant 12, page 6, lines 20 and 30). Others mentioned an increased use of humour because “it can sound very flat and very clinical over the phone and I think it’s important that it doesn’t sound like that” (Participant 8, page 6, lines 33-34). Participant 14 noted a deliberate effort to regain some sense of personhood over the telephone using names:

“Establishing really early on what the person would like to be called, and using their name throughout the session, I think that feels really nice for somebody,[...] I think that immediately breeds familiarity for you both, and I always repeat my name, [...] It’s all things that we do, unconsciously, we just have to perhaps be a bit more conscious of them on the phone”. (Participant 14, page 8, lines 25-34.)

#### ***3.4.2.4 Practical adaptations.***

Lastly, all participants reported a number of practical adaptations as a result of using the telephone which impacted on their practice. Four participants mentioned the augmentative use of email, both to provide clients with materials and to view client’s homework tasks: “Sometimes people email me, perhaps a thought record or something, people will email me bits and I’ll have a little look at it before the appointment” (Participant 11, page 9, lines 22-24). The difficulties posed by the minimum data set questionnaires (routine outcome measures) were reportedly overcome by providing clients with multiple copies at their initial face-to-face appointment and asking them to be completed in advance of the telephone appointments, so “then you just kind of whizz through it” (Participant 11, page 9, line 11). Similarly, participants appeared to overcome the lack of shared materials by using post:



“So say I’m doing cognitive restructuring – ‘what’s the thought?’ – and I’ll fill it in – ‘let’s find the evidence for and against’ - so I just start asking them and I write it down and I’ll send them those copies along with some more blank ones, because that seems to be a better way than to try and go ‘now imagine this bit of paper with this on it’ – that just doesn’t work, does it.”

(Participant 3, page 3, lines 5-9.)

Some participants also reported typing up their session notes during the telephone appointments: “You can write what they’re saying while they’re saying it on the computer so you can get ahead of yourself, I’m adapting to it by making it easier for me really” (Participant 10, page 9, lines 36-38). In this sense, via these adaptations, participants appeared to be attempting to regain some sense of power in their clinical work, however small that might be.

## CHAPTER FOUR

### 4 Discussion

#### 4.1 Overview

This chapter summarises the results in relation to research questions one to three in turn, then consider these findings in the context of the existing literature and theory. A critical appraisal of the study is then presented, followed by implications for clinical practice and suggestions for future research.

##### 4.1.1 Overview of the results.

*4.1.1.1 Research question one: how do clinicians working in primary care psychological therapy services perceive and experience the therapeutic alliance with clients through telephone consultations?*

There were two key elements relating to this research question specifically. Firstly, a prominent theme emerged regarding clinicians' focus on the treatment or technique elements of their work rather than the relational aspects of their interactions with clients. Secondly, of note was the observation that participants demonstrated difficulties in discussing the therapeutic alliance per se.

*4.1.1.2 Research question two: which aspects of telephone consultations do clinicians perceive to be helpful or hindering for building and maintaining therapeutic alliance in comparison with face-to-face consultations?*

Two overarching themes emerged from the analysis to answer this research question. Participants described an overall shift in power, effectively empowering clients but disempowering clinicians to some extent, including sub-themes such as session boundaries being blurred. Participants also described a reduced sense of personhood, with underlying sub-themes of anonymity, interpersonal boundaries being easier, a more distant connection, and the importance of meeting. Participants

emphasised different aspects of all these elements as being helpful and hindering in various ways.

***4.1.1.3 Research question three: how might telephone consultations influence clinicians' practice and the nature of the therapeutic interventions they offer?***

Again there were two key findings in relation to this research question. Firstly, the vast majority of participants reported that they are offering the same therapeutic interventions via the telephone as they would do face-to-face. However, a prominent theme emerged regarding clinicians adapting their practice to the telephone. This included sub-themes of verbalising more, use of voice, re-establishing some sense of personhood, and practical adaptations such as the use of email.

**4.2 Discussion of Study Findings in Relation to Literature and Theory**

The above research findings will be discussed in relation to specific models of the therapeutic alliance and in terms of the wider debates regarding the importance and influence of the therapeutic alliance.

**4.2.1 Difficulties discussing the therapeutic alliance.**

One interpretation of the difficulties in discussing the therapeutic alliance might be that a relatively weaker alliance exists for telephone interventions and that it is a less powerful or salient feature of the intervention. That is to say, that the use of the telephone might weaken the presence of the therapeutic alliance, resulting in clinicians having less to discuss. However, this interpretation is not supported by the existing literature as this suggests that a strong alliance can exist over the telephone (e.g. Reese et al., 2002; King et al., 2006; Lingley-Pottie and McGrath 2006, 2007, 2008; Beckner et al., 2007; Applebaum et al., 2012; Brenes et al., 2012, Mulligan et

al., 2014). A recent RCT also confirmed no difference between alliance scores face-to-face and over the telephone (Stiles-Shields et al., 2014).

Moreover, it cannot be assumed that participants' lack of ability to reflect upon the alliance necessarily equates to a lack of alliance per se. This observation may simply reflect a relatively low level of consideration given to the alliance by some clinicians in these services. It could be argued that this supports the notion that CBT interventions pay less attention to the therapeutic relationship than other psychotherapies (e.g. Leahy, 2008). However, another interpretation is that this observation is simply a reflection of the high-volume low-intensity nature of this specific role (i.e. the PWP role) where clinicians are afforded very little time to reflect upon the therapeutic alliance and it may not always be a priority for supervision, which tends to focus on case management due to high-volume caseloads. Similarly, this difficulty in discussing the therapeutic alliance may reflect a different issue entirely, relating to how IAPT clinicians may view themselves in terms of "therapists" and whether they view low-intensity work as "therapy". Within the interviews, some participants referred to their work as "therapy" and some made a conscious point of stating that PWP work is actually not therapy. It could be argued that this would have a direct impact on clinicians' views of the therapeutic alliance and its relative importance. Alternatively, this observation may simply be a reflection of the intangible nature of the therapeutic alliance as something which is difficult to verbalise, and may even be operating at a subconscious level. With case management supervision in mind, this may not have been something which participants had necessarily discussed in depth before.

#### **4.2.2 Increased treatment focus and reduced sense of personhood.**

Interestingly, it was reported that participants focussed more on the treatment or technique aspects of their therapeutic encounters, rather than the relational

elements. This finding could be understood by reference to Bordin's (1979) transtheoretical model which outlines the components of the alliance as the 'agreement on goals', the 'tasks', and the 'bond'. It could be argued that clinicians were focussing more on 'tasks' and 'goals' than on the 'bond' aspect of the alliance over the telephone. This finding may identify a possible difference between the face-to-face alliance and the telephone alliance. For example, if we assume that alliance is not reduced in telephone therapy (e.g. Stiles-Shields et al., 2014), it is possible that the alliance is *qualitatively* different, with an increased emphasis on tasks and a reduced emphasis on bond. That is to say, that this finding might reflect differences in the relative presence of each element of the alliance, as described by Bordin (1979), over the telephone.

Clearly, qualitative studies cannot quantify variables such as these, but if it is hypothesised that the bond elements of the alliance are relatively reduced, this could be subjected to quantitative testing in future research. The possibility that telephone alliance may consist primarily of tasks and goals is an interesting avenue to consider. It could be argued that the "reduced sense of personhood" as a key finding in this study supports this notion. For example, it may be the case that this reduced personhood is reflective of a reduced 'bond' element in the alliance via the telephone. In support of this idea is the aforementioned study by R. King et al. (2006). King and colleagues investigated the 'bond' element of both telephone and online counselling and hypothesised that the 'bond' would be higher in telephone contact. However, the authors noted the absence of a difference between the two groups and the absence of evidence that 'bond' (measured using the Therapeutic Alliance Scale) contributed significantly to outcome. This could suggest a relatively reduced role of the bond component of alliance via the telephone.

It could be argued that the findings involving treatment focus and a reduced sense of personhood are simply a reflection of the focus on collaboration as a key part of the therapeutic alliance in CBT generally. It may be the case that by their very nature, CBT alliances are more task-focussed and less bond-focussed. Indeed, Webb et al. (2011) have suggested that tasks and goals may be more important in CBT than in other psychotherapies, and the bond element may simply be consequential. Webb et al. (2011) examined the different components of the alliance in relation to depressive symptom change in CBT. Again, Webb et al. (2011)'s study demonstrated evidence that therapist-client agreement on tasks and goals contributed significantly to outcomes, whereas the bond element did not. In this sense, the present study findings may be in keeping with this line of argument. Alternatively, it could be argued that these findings are simply a product of the questions asked of participants, although this critique would apply to all qualitative research of this nature. Whilst treatment focus was an inductive theme that emerged from participants' own reports, it can also be argued that in the absence of a formal discourse analysis, participants' prominent talk of task and treatment and less discussion around bond does not necessarily imply less bond overall, although these observations are noteworthy nonetheless.

If the current findings were to be reflective of an increased task element and reduced bond element of the alliance via telephone, this could be considered in light of the available efficacy data. The literature review described in chapter one highlights that telephone CBT appears to be effective in a population relevant to IAPT settings. If telephone CBT is effective despite a possibly reduced bond, then it could be argued that the focus on tasks and goals is in fact compensating in some way for this deficit. The literature regarding the overall strength of the alliance present during telephone contact appears to support this idea (e.g. Reese et al., 2002;

Lingley-Pottie & McGrath, 2008; Stiles-Shields et al., 2014). For example, if telephone contact has a reduced element of bond, but still demonstrates high alliance scores overall, then perhaps the other elements of the alliance (i.e. task and goals) are contributing to the alliance more, leading to overall equivalence in alliance and outcome data, when compared to face-to-face therapy.

#### **4.2.3 Shift in power.**

In line with the possibility that the alliance may be qualitatively different, the present study identified a shift in power between the therapist and the client as a result of using the telephone. It appeared that clinicians were in some ways relinquishing some power in the therapeutic relationship, whereas clients were empowered by many aspects of telephone working. This relates to Bordin's (1979) model of alliance in the sense that it is not currently accounted for by the existing conceptualisation. The present literature on therapeutic alliance does not consider empowerment of the client as a significant contributor to therapeutic outcome, and conceptualisations of therapeutic alliance do not include issues of power explicitly, although it can be argued that power is included implicitly in terms of agreement on tasks and goals, and in terms of collaboration. The results of this study highlight that the shift in power towards empowering the client and disempowering the clinician was salient and significant for participants. However, the current research in this area does not indicate whether this suggested shift in power contributes positively or negatively to therapeutic effectiveness and outcome.

The present findings regarding power are in line with the ideas expressed by Haas et al. (1996) in their review of the risks and benefits regarding telephone therapy. The authors suggested that "telephone therapy balances the interpersonal power and control over the interaction" (p. 157). It can be further argued that the reduced sense of personhood discussed previously may be linked to this sense of

empowerment for clients, as interpersonal boundaries were found to become easier over the telephone, and clients benefitted from an increased sense of anonymity. This finding regarding anonymity concurs with and expands upon previous literature such as Lingley-Pottie and McGrath (2007) who noted clients' "inapprehension for self-disclosure" (p. 363) as a result of visual anonymity, and highlighted that this component is lacking from Bordin's theory of alliance. Similarly, Haas et al. (1996) suggested that telephone conversations allow anonymity, and went on to suggest that this was an advantage for both client and therapist as "the patient can construct an ideal view of the therapist that is unhampered by the therapist's actual appearance" (p. 157). This appears to relate to the finding in the current study whereby a lack of initial judgements or assumptions over the telephone contributed to the sub-theme of anonymity. However, the present study noted that this was considered both helpful and hindering to clinicians.

The concept of telephone work empowering clients is also supported by Day and Schneider (2002)'s study, which compared face-to-face, video and audio (similar to telephone) treatment. The authors noted that, unexpectedly, client participation (as measured by the Vanderbilt Psychotherapy Process Scale) was significantly higher when client and therapist were not face-to-face. This resonates with the findings in the current study, whereby participants reported an increased onus on the client to take responsibility, and less dependence on the clinician via the telephone. Indeed, Day and Schneider (2002) speculate that clients may take more responsibility for the interaction in distance modes, in an attempt to overcome the barriers imposed by technology. The current study would appear to provide tentative support for this suggestion, at least from clinicians' anecdotal perspectives.

Bordin, in his 1979 paper, makes brief reference to this "division of responsibility between therapist and patient as a feature of collaboration" (p. 257) but



does not elaborate further on this concept. Similarly, Hardy et al. (2007) in their model of the therapeutic relationship in CBT discuss a *collaborative framework* in terms of establishing a relationship, but responsibility and empowerment are not addressed specifically. It can be argued that a new model of distance alliance and any corresponding measures might need to incorporate these notions, particularly if these concepts can be demonstrated empirically to be linked to alliance and outcomes.

#### **4.2.4 Contributions to outcome.**

It has already been discussed that alliance might be contributing to outcomes in a qualitatively different way via the telephone, in terms of relative emphasis on task, goals and bond. The factors identified as important for participants, including power, responsibility and anonymity, might be compensating for any reduced bond in the alliance via the telephone and contributing to the equivalence in outcomes compared to face-to-face therapy. Alternatively, these elements could be considered as factors outside of the alliance, which might be contributing to outcome more than expected. It might be the case that, in telephone-delivered CBT interventions, the concept of alliance as currently postulated by Bordin (1979) needs to be broadened to include these additional elements, as empowerment, responsibility and anonymity might play a prominent role in contributing to outcomes. Therapeutic alliance as measured quantitatively has been shown to be relatively high in telephone interventions (e.g. Beckner et al., 2007; Stiles-Shields et al., 2014), yet very little is known regarding how these alliance ratings contribute to outcome in comparison to the apparently robust relationship between alliance and outcome in face-to-face treatments (e.g. Martin et al., 2000).

Andersson et al. (2012), in their study of internet-delivered CBT (ICBT) suggested that even if alliance ratings are high or equivalent to face-to-face therapy,

the alliance itself is probably less important than in traditional face-to-face therapy. Their results showed no significant correlation between alliance measured on the WAI and outcome scores. This suggests that alliance may not play a key role in outcomes in ICBT, and it is possible that the same may be true in telephone therapy. In support of this idea is the study by R. King et al. (2006) investigating telephone and online counselling. The authors noted that alliance was not a mediating variable in outcome, either in the telephone or the online conditions. If alliance is less influential on outcomes in telephone therapy than face-to-face therapy, and yet outcomes are still equivalent (e.g. Lovell et al, 2006; Mohr et al., 2012; Hammond et al., 2012), it is possible that some of the elements described in the present study, such as empowerment and anonymity might contribute to the improvements shown by clients receiving telephone CBT.

This pertains to the relative contributions to outcome considered by authors such as Lambert and Barley (2001) and Norcross (2002). If 30% of improvement in psychotherapy is attributable to common factors, which include the client-therapist relationship (Lambert & Barley, 2001), then it could be argued that elements such as empowerment and anonymity form part of these common factors in distance therapy. Clients do positively connote these elements, as suggested by studies of therapy via videoconferencing by Simpson, Deans, and Brebner (2001) and Simpson, Bell, Knox, and Mitchell (2005), where participants reported an enhanced sense of control and reported that distance therapy felt less personal than face-to-face sessions, which provided some benefits. Norcross (2002) has estimated that the therapeutic relationship accounts for approximately 12% of the total psychotherapy outcome, and 30% is attributable to the client's contribution. It may be the case that via the telephone, where there appears to be a shift in power from clinicians to clients and a

reduced sense of personhood, the client's contribution to outcome may be increased and the relative impact of the therapy relationship may be decreased.

#### **4.2.5 Mechanisms of change.**

Although substantial quantitative research is required to examine which elements of the relationship and alliance contribute to therapy outcomes, this study suggests that factors such as power and anonymity are worthy of investigation. Power within psychotherapy is a topic which has received some attention, particularly within the social constructionist literature. Guilfoyle (2003) argues that power is a common factor shared by all psychotherapies, which in turn supports the idea of power contributing to outcome. In Hardy et al. (2007)'s consideration of the therapeutic alliance, the authors cite social influence theory (Turner, 1991), stipulating that client resistance can be unhelpful to the relationship. According to Beutler, Moleiro, and Talebi (2002), therapy is most effective if clinicians can avoid stimulating client resistance by moderating their directiveness. This might go some way to explaining the possible contribution of the shift in power highlighted by the current study's participants. Empowering the client and disempowering the clinician via the telephone may lead to reduced resistance in therapy, which in turn could contribute to outcomes.

Alternatively, the observed shift in power which potentially occurs in telephone therapy might contribute to the efficacy of telephone interventions via another mechanism. Powerlessness has been linked to psychological distress across a number of mental health difficulties (Proctor, 2002). For example, Gilbert (1992) outlines depression as a response to powerlessness. In contrast, mutuality within the therapy relationship has been postulated as a positive aspect of therapy (Proctor, 2002). The inequality of power between a therapist and a client has been described as oppressive (e.g. Masson, 1989) and some have argued that the aim of therapy should

be to redress this power balance (e.g. Bannister, 1983). Proctor (2002) describes how “the effect on the client of the therapist’s power is also documented and is argued to be anti-therapeutic” (p. 16). In this sense, the shift in power towards empowering the client via the telephone might be a contributor to efficacy if it reduces clients’ sense of powerlessness and equalises the power in the therapy relationship.

Similarly, new elements to the client-therapist relationship such as anonymity might impact upon outcome in a number of ways. The present study found that anonymity appeared to enable disclosure for some clients, and the “faceless” nature of the interaction was perceived as somewhat liberating for both clients and clinicians. This corresponds to previous studies of distance alliance such as Cook and Doyle (2002), and Day and Schneider (2002) which reported that clients benefitted from the ability to express themselves openly. Lingley-Pottie and McGrath (2007) have suggested that this element of feeling comfortable may enhance the therapeutic relationship. It could be argued that this might in turn enhance outcomes. Alternatively, the perceived sense of anonymity might reduce any fear of rejection in the client-therapist encounter (Lingley-Pottie & McGrath, 2007), and in light of the key findings in the present study, this might encourage client contribution to therapy, redressing the power balance and contributing to outcomes directly.

#### **4.2.6 Explaining the disparity in the literature.**

The results of this study contribute to our currently limited understanding of clinicians’ perspectives of these issues and also elucidate some of the possible factors underpinning initial scepticism and resistance to telephone working amongst clinicians (e.g. Lovell, 2010). The shift in power reported in the present study describes a disempowerment of the clinician in a number of ways, as they relinquish some power in the therapy relationship. Whilst this might be perceived as beneficial for clients, and may help to explain the efficacy data and client satisfaction

associated with telephone CBT (e.g. Simon et al., 2004), it may not be particularly attractive for clinicians. Participants reported less control over the boundaries of the session, less opportunity to use their clinical skills effectively, and an increased reliance upon the client, in comparison with face-to-face contacts. With these factors in mind, it seems understandable that clinicians might be reluctant to deliver interventions via the telephone. These findings correspond to the brief mention of these issues in the study by Richards et al. (2006), who reported that “patients and primary care staff acknowledged benefits from the telephone in terms of the security, control and distance it gave patients. However, this was precisely why many mental health professionals did not like the telephone” (p. 303).

Similarly, the reduced sense of personhood described by many participants in this study may also contribute to clinicians’ reluctance to use the telephone. Clinicians reported less sense of the client as a person, less connection to the client and difficulties in recalling clients they had never met before. In terms of job satisfaction, it might be logical to assume that many clinicians enter such a role in order to gain a sense of helping others. It might therefore follow that the reduced personhood of the telephone encounters also reduces this sense of reward. Indeed, a small number of participants in the present study alluded to this idea, but the sub-theme was not prominent enough to report. Alternatively, the reduced sense of personhood reported by clinicians may actually exacerbate their perceived disempowerment in terms of feeling de-skilled, in line with suggestions made by Richards et al. (2006), who reported that “mental health workers in particular felt that the very impersonality of telephone contact might compromise the exercise of their special skills” (p. 302).

#### **4.2.7 Adapting to the telephone.**

Nonetheless, the current study found that nine participants reported warming to telephone work following positive experiences of using the telephone. This positivity towards telephone working was both surprising to the researcher, and in contrast to previous studies such as Richards et al. (2006). This finding may be a reflection of the fact that a therapeutic alliance can exist without face-to-face contact (as suggested by Lingley-Pottie and McGrath, 2006), despite clinicians' initial fears. However, it may also be testament to the multiple ways in which clinicians appear to be adapting their practice to accommodate the limitations imposed by the telephone. Participants reported verbalising more, using their voices differently, focussing on what clients said and tone of voice, as well as numerous practical adaptations to overcome logistical issues. In particular, participants reported adaptations which related to re-establishing some sense of personhood. This may begin to explain how studies such as Stiles-Shields et al. (2014) found similar levels of therapeutic alliance in telephone CBT compared to face-to-face CBT.

Alternatively, the levels of positivity expressed by participants in the current study could be attributed to the unexpectedly high number of participants who routinely met with clients face-to-face early on in their telephone treatment. Ten participants reported that this was common practice, and meeting was consistently reported as beneficial for the therapeutic relationship. This is in keeping with a sub-theme reported by Richards et al. (2006), who found that "respondents recognized that an initial or occasional face-to-face contact could help with the therapeutic alliance" (p. 301). The use of this one-off face-to-face encounter appears to be a key way in which clinicians are attempting to overcome the apparent reduced sense of personhood via the telephone, and is almost certainly a contributor to the presence of an alliance in these telephone interventions.

### **4.3 Critical Appraisal of the Current Study**

The above findings and any subsequent clinical or research implications must be considered in light of a number of limitations imposed by the current methodology and by the generalisability of the results.

#### **4.3.1 Qualitative methodology.**

Along with other qualitative research, the present study is relatively small in scale and cannot make claims to significance based on the statistical relationship of the sample to the population (Willig, 2013). The current study is therefore limited in the sense that it applies to a specific group of clinicians (PWPs and High Intensity Therapists in IAPT services in the East of England) undertaking specific types of telephone interventions (low-intensity CBT-based guided self-help interventions). However, the study does shed some light on the processes occurring in these particular settings, with theoretical insights having a relevance beyond this.

#### **4.3.2 Sampling.**

Firstly, the study sample size of 14 participants can be viewed as a strength of the research. This number went above and beyond the originally anticipated cap of 12 participants, which suggests that data saturation may have been more likely to occur and the sample size was large enough to allow key themes to be present (Guest et al., 2006). The sample itself only included clinicians and not clients from IAPT services. Whilst this was appropriate in addressing the relative paucity of research investigating clinicians' perspectives, it also limits any conclusions that can be drawn regarding the clients in this process. Any mention of the client in this study is effectively "second-hand" opinion and reflects only the perception of clinicians, which may not be a true reflection of client experiences. Nonetheless, it would have been impossible to artificially remove the role of the client from a study regarding client-therapist relationships.

The sample can be viewed as adding external validity to the research, as participants were drawn from currently functioning services and described experiences from current everyday practice. As a result, the study did not exclude clinicians who met clients face-to-face as part of their telephone treatment, as this represents the reality of present service delivery. Similarly, the sample included both PWPs and High Intensity Therapists as both types of clinician are reportedly delivering telephone interventions in current IAPT services. However, it could be argued that this compromises the homogeneity of the sample. If some participants had met with clients, this is likely to have impacted upon the therapeutic alliance in terms of being more akin to face-to-face alliance. Therefore a “purer” sense of distance alliance could have been gained from using stricter inclusion and exclusion criteria, although this would have limited the ecological validity of the research. Similarly, the exclusion of High Intensity Therapists would have provided a more homogenous sample but at the expense of the ecological validity and range of views captured by the study.

The inclusion of High Intensity Therapists also helped to overcome another limitation of the sample. It could be argued that the PWPs included in this sample were not delivering CBT therapy as such, and therefore the present study does not fit with the existing evidence-base regarding telephone CBT using a more traditional format. Similarly, as alluded to in the current findings, some PWPs may not view themselves as “therapists”, making them seem an odd choice to investigate telephone therapy. However, the High Intensity Therapists included in the sample did report offering more “traditional” CBT via the telephone. It was also apparent that many PWPs did consider themselves to be therapists and were using traditional CBT techniques, albeit in a low-intensity format.



One limitation of the sample is the self-selected nature of participants. Clinicians with strong views or those who felt particularly positive about telephone work may have been more likely to volunteer for this project, and therefore this study may under-represent clinicians with more moderate views or those who feel generally more discontentment towards telephone working. This may be due to feelings of apathy towards the topic, or clinicians possibly fearing reprimand if they were to discuss more negative aspects of their work. Similarly, it may have been assumed that the researcher held positive views of telephone work in order to wish to investigate it further, leading to demand characteristics. The researcher took steps to assure clinicians of the confidentiality of their interviews and the impartiality of the researcher, but nonetheless these factors may have influenced the research. This was noted by the researcher in the reflective log:

Excerpt from reflective log:

(Re: Transcript 3): “I am starting to think that perhaps the nature of my study attracts a certain type of clinician – someone who has good things to say about telephone work and wants to share these views, perhaps as an advocate against the “bad press” that telephone work receives. Alternatively it could be a form of response bias whereby people think I am looking for positivity, although I have been careful to appear as neutral as possible regarding telephone work.”

The pragmatic convenience sampling is another limitation of the study. Time and budget constraints limited the extent to which the researcher could employ true maximum variation sampling (Coyne, 1997). As a result, the sample is not ethnically diverse and consists of only two men in a sample of 14 participants. In addition, the sample appeared to consist predominantly of clinicians with around four to six years’

experience and only included two High Intensity Therapists. As a result, the perceptions and experiences of much less or much more experienced clinicians may be under-represented, which may be important as therapist experience has been linked with the quality of alliance in recent literature (Horvath, 2001). However, the study did include a good range of ages and recruited clinicians from a number of different IAPT services which is likely to have broadened the range of perceptions and experiences included in the research.

#### **4.3.3 Data collection.**

Due to budget constraints, all interviews took place on NHS property at the participants' location of work. Whilst this naturalistic setting will have aided ecological validity, it may also have influenced participants' responses. Participants may have felt less able to be open and honest regarding their views of their current work, particularly if they feared being overheard. The interviews were all conducted in confidential settings in rooms usually used for therapy purposes, but nonetheless, the proximity of other colleagues at the time of the interview may have been inhibiting for some participants. An increased budget might have allowed for travel and room hire at a more neutral location, which might have facilitated more open responses.

The iterative process of developing the topic guide and incorporating respondent feedback was in keeping with a critical realist perspective. The decision not to mention the therapeutic alliance when introducing the study appears appropriate to avoid demand characteristics and allow an exploration of participants' spontaneous responses. However, the difficulties in discussing the therapeutic alliance amongst some participants were not anticipated and as a result, the researcher adapted the topic guide to introduce this concept sooner and to debrief participants before the end of the interview. Whilst these changes were appropriate in

order to help answer the research questions, they will undoubtedly have impacted the responses gathered from later interviews compared to earlier interviews. As a result, views of later participants (regarding the therapeutic alliance) may be better represented than those interviewed earlier on in the process. Nonetheless, the larger-than-anticipated sample size is likely to have compensated for this, and Guest et al. (2006) suggest that overarching themes can be present within as few as six interviews.

The process of the interviews themselves provided some epistemological dilemmas for the researcher. Despite adopting a critical realist perspective, the interviews appeared to be affected by social constructionist concepts. For example, the identity of the researcher posed an obvious limitation for the research process. Participants were aware, via the recruitment information and informal discussions, that the researcher had previously worked as a PWP and was currently a Trainee Clinical Psychologist. The researcher noted in the reflective log that this appeared to be impacting the interviews:

Excerpt from reflective log:

(Re: Transcript 1): “I was also aware that a lot of what she referred to were familiar concepts for me due to my clinical training – agenda setting, summarising, empathy, formulation, the structure of CBT – and I wonder if I should have asked her to elaborate further on these points rather than assuming I knew what she meant. Also I wonder how much of this she was discussing because she was aware of my own position as a trainee clinical psychologist and maybe felt the need to discuss these clinical aspects specifically.”

As a result, the researcher attempted to limit this influence by remaining inquisitive and not expressing any personal viewpoints. However, the critical realist perspective is unlikely to have accounted for such influences in the social interaction of the interview.

#### **4.3.4 Data analysis.**

Similarly, the critical realist approach to data analysis appeared to pose some limitations during the analysis process. As discussed previously, the researcher held some pre-existing views regarding telephone therapy based on their previous experience. In keeping with a critical realist perspective, these were outlined at the beginning of the study and the researcher kept extensive reflective logs to acknowledge and ‘own their perspective’, as outlined by Elliott et al. (1999). Similarly, appropriate quality checks and transparency in the analysis process provided the study with good levels of rigour and trustworthiness. However, the personal experience of the researcher is likely to have impacted upon the analysis process a great deal, perhaps more than a critical realist perspective can account for. It could be argued that it would have been more appropriate for someone more detached from these processes to have investigated these issues. For example, the researcher reflected on her own position regarding power in the therapeutic relationship and noted the following:

Excerpt from reflective log:

Having thought about power in relation to the therapeutic alliance throughout the analysis process, I realised that my own views on power have changed over time.

Whilst working as a PWP, I remember learning that the therapeutic alliance itself accounted for a proportion of client change, and this seemed to somehow emphasise

that what *we* did as clinicians was important. I think I was very influenced by the medical model and a feeling that I needed to ‘fix’ things for the so-called ‘patients’ coming through the door. In this way, I suppose I felt that the ‘power’, or at least the responsibility, lay quite heavily with me as a clinician. Since training to be a clinical psychologist, I would like to think that these views have softened somewhat, and I am now more appreciative of the importance of empowering clients, and the self-agency of the client as a powerful factor in change. I would hope that my clinical practice now seeks to minimise the power differentials often observed within therapy, something which I am sure I had not reflected upon until I began my doctoral training. These views, both past and present, will have inevitably influenced my analysis process.

The critical realist approach assumes that we can access knowledge via questioning, albeit through our own personal lens (Pilgrim & Bentall, 1999). The present inductive thematic analysis was in keeping with this perspective and highly appropriate given the exploratory nature of the study and the paucity of existing literature regarding distance alliance to guide any a priori themes. However, the assumption that participants would be able to discuss the therapeutic alliance directly appeared to limit the available evidence to answer research question one. The therapeutic alliance was perhaps a concept too intangible to ask about directly, as acknowledged in the reflective log:

Excerpt from reflective log:

(Re: Transcript 7): “This participant and many others seemed to struggle to conceptualise new elements of their work and in particular, new elements of the

alliance itself. This might reflect a lack of new elements themselves or, more likely in my view, the intangible nature of it and possibly the subconscious level at which it is happening [...] There are 2 questions here really – 1) are there any new elements? And 2) have you noticed them? If the answer to 2) is no, we will not be able to know the answer to 1).”

A more social constructionist approach such as a discourse analysis to investigate how clinicians discuss the telephone alliance may have revealed some interesting insights that were perhaps not captured in the semantic thematic analysis.

Alternatively, more emphasis on the therapeutic alliance early on in the interviews may have produced more data with which to fully answer research question one.

It could be argued that the research questions themselves were somewhat limiting. Given the relative infancy of this area of research, the research questions could have been broader. The data appear to be somewhat constrained by the research questions, and the inductive findings do not necessarily correspond easily to these questions, particularly the concept of helpful and hindering aspects.

Participants’ difficulties in discussing the therapeutic alliance rendered the questions difficult to answer and challenged the researcher’s critical realist perspective.

Nonetheless, the findings resulting from the thematic analysis are relevant to the area under investigation and provide some key insights into the processes occurring during telephone contacts, as well as challenging the existing conceptualisations of therapeutic alliance.

#### **4.4 Implications for Clinical Practice**

The insights provided by this exploratory study point towards a number of ways in which the effective development and implementation of telephone-delivered CBT interventions could be maximised.

#### **4.4.1 Practical changes.**

Firstly, if clinicians feel disempowered when using the telephone, and this explains some aspects of clinician resistance to telephone-delivery, then it might be beneficial to empower clinicians wherever possible in order to reduce any resistance to this way of working. For example, if session boundaries are more difficult to maintain via the telephone, then strategies to overcome this could be considered. Noise levels could be reduced by providing clinicians with more appropriate office space, particularly if open plan offices are the norm. Alternatively, the use of headphones might be appropriate to remove background noise. The value of the appointments could be emphasised to clients using an information leaflet where possible, highlighting the importance of finding somewhere private and respecting the timings of scheduled appointments.

Secondly, if there is a reduced sense of personhood via the telephone, which may contribute to a reduced ‘bond’ in the alliance, then it seems important to consider ways to increase this connection between client and clinician, particularly as alliance has been linked to outcomes (Martin et al., 2000). One key method of achieving this involves the use of an initial face-to-face contact before telephone treatment commences, which participants in this study reported to be hugely helpful in establishing a sense of the person, building trust and aiding recall for clients later in treatment. Indeed, Richards et al. (2006) advocate the use of an initial face-to-face appointment for telephone interventions in their protocol for collaborative care in the UK, but it appears that this is not standard practice at present. The importance of clients and clinicians meeting face-to-face should not be underestimated in terms of building a therapeutic alliance. Similarly, any adaptations that reinstate some of the visual cues available to clinicians should be considered, for example the use of video links such as “skype”. This is particularly relevant as the evidence-base for alliance

via videoconferencing is growing (e.g. Germain et al., 2010), although obvious limitations regarding resources and confidentiality would need careful consideration.

Thirdly, if clinicians are already taking strides to adapt their clinical practice to overcome the barriers imposed by telephone-working, then these adaptations should be facilitated wherever possible. Increased provision of a “no reply” email address, electronic versions of guided self-help materials and increased administrative support to facilitate postage could all be beneficial to clinicians’ practice.

#### **4.4.2 Training and supervision.**

In addition, the provision of specific training regarding the use of telephone would seem to be a logical recommendation. If some clinicians have developed adaptations to telephone-working, then these could be shared nationally, taught to novice therapists and supported through a structured training programme, rather than individuals needing to discover these strategies for themselves. Training from specialists in telephone therapy such as Relate UK could also increase clinicians’ skills in adapting to the telephone and might help in overcoming any initial scepticism or resistance to telephone-working.

Lastly, if clinicians have demonstrated difficulties in discussing the therapeutic alliance, then it is possible that this area of clinical practice might benefit from further consideration in clinical supervision. An increased emphasis on the issues surrounding the therapeutic alliance via the telephone might alert both clinicians and supervisors to areas where improvements could be made. It appears that group supervision or case management supervision often have a fixed agenda, and it might be the case that the therapeutic alliance needs a greater presence on these agendas. Given the wealth of evidence linking alliance to outcomes, and given that the distance alliance appears to be qualitatively different to previous



conceptualisations, an increased awareness and dialogue surrounding these issues is likely to benefit both clinicians and clients.

#### **4.5 Implications for Further Research**

The present study is a small-scale exploratory project and there are numerous ways in which it could be improved, extended or developed. These include increasing the sample size, using quantitative methods to quantify some of the elements discussed, or using tighter exclusion criteria to investigate more specific aspects of the telephone alliance, for example, those interactions where client and clinician have never met. Nonetheless, the current study provides some insights which pave the way for further investigation and suggest that further research is needed in this area.

The possibility that the therapeutic alliance over the telephone might be qualitatively different from face-to-face alliance despite being just as strong (e.g. Stiles-Shields et al., 2014) has significant implications for future research. If distance alliance differs from current conceptualisations such as the widely accepted model by Bordin (1979), then new models of the alliance via distance modalities are required. These could be developed using a qualitative methodology such as grounded theory technique (e.g. Glaser & Strauss, 2009) and empirically validated using quantitative methodologies. In relation to this, new measures of the therapeutic alliance which correspond to these new models of distance alliance would need to be developed. At the very least, ways of measuring these new elements such as anonymity and power would need to be incorporated into any considerations of distance alliance in future research.

Similarly, if telephone alliance, as conceptualised by Bordin (1979), appears to be more task-focussed and less bond-focussed, then quantitative investigations could clarify the extent to which this is the case. Very little is known about the

relative presence of these elements in distance alliance or their contributions to clinical outcomes. Studies such as Webb et al. (2011) investigating the individual contribution of these elements of the alliance could be replicated using telephone CBT to explore this further and to determine the impact on outcomes.

The present study provides some insight into clinicians' perspectives of telephone alliance, but it is not clear whether these views are shared by clients. Further investigation into the client's perspective regarding this possible shift in power and reduced sense of personhood would be beneficial to clarify the processes underlying telephone interactions. With regards to clients, further research appears to be necessary to establish who might benefit the most from telephone-delivered CBT, as suggested by Brenes, Ingram, and Danhauer (2011). Similarly, the role of the therapeutic alliance as a mediator in the outcome of telephone CBT requires further empirical investigation, to establish the importance of the factors discussed here.

With regards to the elements of power discussed in the present study, there appears to be a relative paucity of research surrounding these issues in relation to CBT interventions. Proctor (2002) claims that "cognitive behaviour therapy (CBT) fails to analyse or problematise the position of the therapist as expert" (p. 137) and that "very little attention is paid to the issue of power in most literature on CBT" (p. 82). It does appear that current considerations of the therapeutic alliance and outcomes in CBT do not consider the role of power, and therefore investigations into the structures of power within therapeutic relationships and contributions to change outcomes might be beneficial in shedding some light on this topic.

It is also worth noting that, with the current literature in mind, there appears to be a lack of evidence regarding the therapeutic alliance within the role of PWPs specifically, regardless of the modality of service delivery. This has implications for the present study in terms of situating the research. For example, it is possible that

the present findings are more reflective of the alliance via low-intensity interventions in general, rather than pertaining specifically to telephone delivery. Without existing literature to contextualise these findings, it is difficult to comment on this with any certainty. Therefore, further research regarding the therapeutic alliance within low-intensity interventions, such as those provided by IAPT services, would contribute greatly to our understanding of these issues.

#### **4.6 Conclusions**

The aim of this study was to investigate clinicians' perceptions and experiences of the therapeutic alliance in telephone CBT interventions. Telephone-delivered CBT has been shown to be effective (e.g. Hammond et al., 2012; Mohr et al., 2012), but the mechanisms of change contributing to these effects are largely unknown. The therapeutic alliance is widely cited as an important factor in psychotherapy outcome, with a robust but modest correlation with outcome (e.g. Martin et al., 2000). However, research has questioned the contribution of the different components of the alliance to outcome in CBT compared to other psychotherapy orientations (Webb et al., 2011). In addition, the role of the alliance in telephone-delivered CBT is not well investigated. However, high alliance ratings have been demonstrated in various forms of telephone therapy (e.g. Reese et al., 2002; King et al., 2006; Beckner et al., 2007; Stiles-Shields et al., 2014). The current study suggested that the therapeutic alliance via the telephone may be qualitatively different compared to both current conceptualisations (e.g. Bordin, 1979) in terms of new elements of the alliance (such as empowerment and anonymity), and in comparison to face-to-face alliance in terms of being more task-focussed and less bond-focussed. As a result, it is suggested that new theoretical models of distance alliance might be necessary, along with corresponding clinical measures. Further

investigation into the relative presence and contribution of these elements in relation to clinical outcomes is also warranted.

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## **Appendix A**

### **Details of Literature Review**

#### **Search Strategy**

A literature search was conducted using electronic databases (PsycINFO; Medline; EMBASE; CINAHL; Web of Science; Science Direct). Initial exploratory searches using broad truncated search terms such as ‘tele\*’ produced unmanageably large results (e.g. 1949 articles) due to the prevalence of ‘telehealth’ or ‘teletherapy’ involving non-CBT interventions. In order to narrow the search appropriately, the search term ‘telephon\*’ was employed originally to search titles and abstracts, but after yielding similarly unmanageable results (due to the prevalence of recruitment or follow-ups conducted via telephone) it was decided that search terms would be applied to titles only, in order to produce a more focussed search. The search terms were entered as follows:

1. ‘Telephon\*’
2. ‘CBT’
3. ‘Cognitive behav\* therap\*’
4. ‘Cognitive therap\*’
5. ‘Behav\* therap\*’
6. 2 OR 3 OR 4 OR 5
7. 1 AND 6

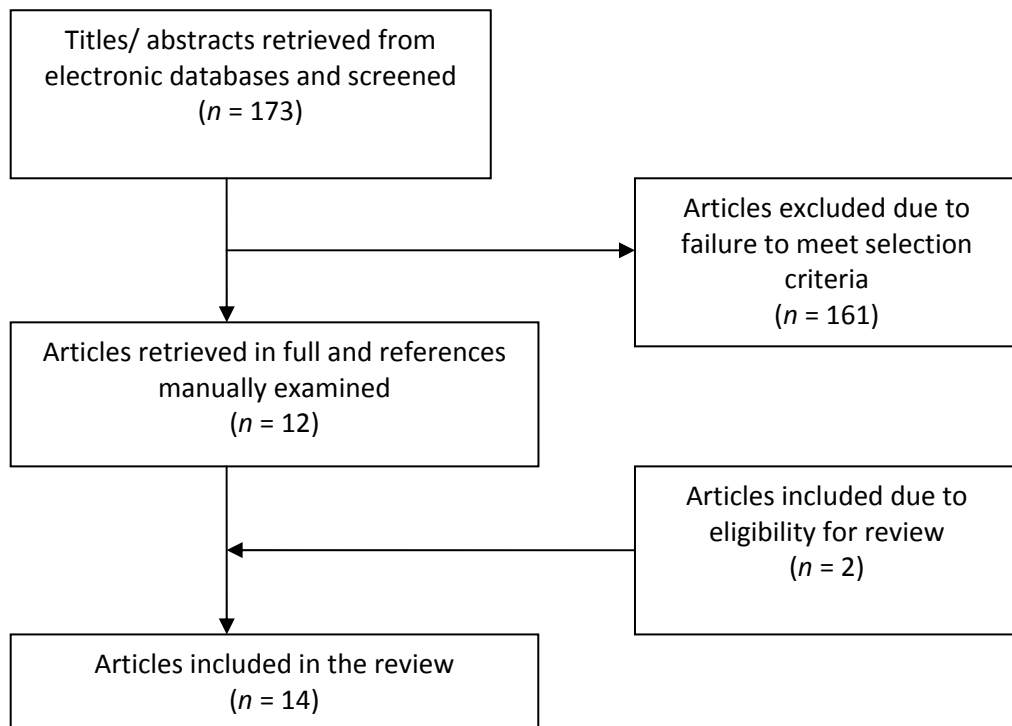
Search limits were applied to include only peer-reviewed journals and articles in the English language. Further articles were identified using manual reference examination of relevant published studies, but reviews, conference abstracts and unpublished theses were excluded. Key authors in the field such as Karina Lovell and David Richards were also contacted for articles ‘in press’, and their websites were searched for relevant studies. From this initial pool, titles and abstracts were screened to assess their eligibility for inclusion.

#### **Selection Criteria**

The following inclusion and exclusion criteria were applied to focus the review on a population relevant to primary-care services such as IAPT and to exclude confounding variables:

1. Participants must be working-age adults (i.e., aged between 18-65 years).
2. Participants must have clinically-significant symptoms of depression and/ or anxiety.
3. Health psychology literature was excluded (e.g. chronic pain, multiple sclerosis etc.)
4. Traumatic brain injury literature was excluded.
5. The study must include a telephone-delivered CBT-based intervention.
6. Internet-based treatments were excluded.

The initial search produced a pool of 173 articles, and the above screening process produced a final pool of 14 studies for inclusion in the review. The below CONSORT diagram depicts the flow of articles through the search procedure.



*Figure 1.* Summary of selection procedure.

### **Evaluation of Literature**

Following the selection process, studies were evaluated using the below criteria:

1. Sampling – What were the participant characteristics? How large was the sample? What are the implications for the generalisability of the findings?
2. Research design – Was there a control group? What was the intervention compared with? How rigorously did the study control for potentially confounding variables?
3. Efficacy – How was outcome defined and measured? Were effect sizes reported and how large were they? Were any follow-up data included in the study?

Table 1

*Summary of Studies Included in the Review*

Study	Sample Size (n)	Participant Characteristics	Research Design	Outcome Measures	Results	Follow-up Data
1. Bee, Bower, Gilbody & Lovell (2010)	53	UK employees with mild-moderate mental health difficulties. Mean age 45 (SD 9), 51% male, 96% Caucasian; 55% university/ college education.	Pilot RCT: 12 weeks T-CBT vs. TAU.	CORE-OM, HADS, WSAS, WHO-HWPQ.	T-CBT associated with medium-large effect sizes on clinical outcomes (0.63-0.77) and work productivity (0.75-0.88).	None
2. Bee, Lovell, Lidbetter, Easton & Gask (2010)	Study A = 15 Study B = 15	Study A: Severe and long-standing mental health difficulties. 73% female, 86% white British, aged 22-66 yrs. Study B: Participants from Bee, Bower, Gilbody & Lovell (2010) see [1]. 52% female, 97% white British, aged 22-60 yrs.	Study A: Qualitative service evaluation Study B: Nested qualitative evaluation within RCT.	Qualitative themes	Mixed user satisfaction with T-CBT, but most participants adapted with relative ease.	N/A
3. Dwight-Johnson et al. (2011)	101	Latino patients from rural clinics in USA. Major depressive disorder. Mean age 40 (SD 11), 78% female, 91% native Mexicans, 9% college or higher education.	Pilot RCT: 8 sessions T-CBT vs. TAU.	PHQ-9, HSCL, 7-point Likert scale for satisfaction.	Greater proportion of T-CBT group achieved treatment response at 3 months (sig). T-CBT group more likely (sig) to report satisfaction.	At 6 m: T-CBT group sig improve-ment.



Study	Sample Size (n)	Participant Characteristics	Research Design	Outcome Measures	Results	Follow-up Data
4. Hammond et al. (2012)	4,106	Adults referred to IAPT services for low-intensity interventions. Aged 18-85, modal age range 36-45, 65% female.	Observational, non-inferiority comparison: average 4 sessions T-CBT vs. face-to-face CBT.	PHQ-9, GAD-7, WSAS, Cost per session.	Greater reduction (sig) in scores for T-CBT. Effect sizes: PHQ-9= 0.14, Gad-7= 0.10, WSAS= 0.03 Non-inferiority between T-CBT vs face-to-face. Cost per session 36.2% lower for T-CBT.	None.
5. Lam, Lutz, Preece, Cayley & Walker (2011)	39	Canadian employee assistance programme. Clinically-relevant depression symptoms. Mean age 45 (SD 9), 79% female.	Pilot study: 8 sessions T-CBT. No control/comparison.	PHQ-9, GAF, Clinician ratings of absence and performance.	Improvement (sig) in PHQ-9 and GAF scores. Reduction (sig) in performance impairment. Anecdotally-reported high satisfaction.	None.
6. Lovell et al. (2006)	72	UK OCD patients. Mean age 32 (SD 10), 59% female.	Randomised controlled non-inferiority trial: 10 sessions T-CBT vs. face-to-face CBT.	Y-BOCS, BDI, Client satisfaction questionnaire.	Clinical outcome of T-CBT equivalent to face-to-face at all time points up to 6 m. Similarly high levels of satisfaction reported.	T-CBT equivalent to face-to-face at all time points up to 6 m.
7. Lovell, Fullalove, Garvey & Brooker (2000)	4	UK OCD patients: 35-year-old male, 30-year-old female, 35-year-old female, 40-year old female.	Pilot study: 8 sessions T-CBT. No control/comparison.	Y-BOCS, BDI, WSAS.	All participants showed clinical improvement on Y-BOCS. Sig mood change in 3 participants.	At 1 m: Only one participant still in depressed range.

Study	Sample Size ( <i>n</i> )	Participant Characteristics	Research Design	Outcome Measures	Results	Follow-up Data
8. Ludman, Simon, Tutty & Korff (2007)	393	US patients beginning antidepressant treatment. Mean age 44 (SD 16), 76% female, 38% college graduates, 77% Caucasian.	Randomised trial: 8 sessions T-CBT vs. usual care.	HSCL, PHQ-9.	T-CBT group sig lower HSCL scores. Difference in HSCL scores during follow-up: effect size = 0.25-0.3 (small).	At 18 m: T-CBT group sustained benefits.
9. Mohr, Carmody, Erickson, Jin & Leader (2011)	85	US veterans with major depressive disorder. Mean age 56 (SD 11), 91% male, 79% Caucasian, mean education 14 years (SD 2.9).	Randomised trial: 16 sessions T-CBT vs. TAU.	HDRS, PHQ-9.	No significant treatment effects despite compliance.	At 6 m: no sig difference between groups.
10. Mohr et al.(2012)	325	US patients with major depressive disorder. Mean age 48 (SD 13), 78% female, 63% white, 24% African American, 14% Hispanic/ Latino, 10% mixed race, 65% university-educated.	Randomised trial: 18 sessions T-CBT vs. face-to-face CBT.	Attrition (completion vs. non-completion), HDRS, PHQ-9.	Sig fewer patients discontinued T-CBT, no sig treatment differences between groups, effect size on HDRS: $d=0.14$ , on PHQ-9: $d=-0.02$ . At 18 weeks, T-CBT was not inferior to face-to-face CBT.	At 6 m: Face-to-face group sig less depressed than T-CBT group.
11. Simon, Ludman, Tutty, Operskalski & Von Korff (2004)	600	US patients beginning antidepressant treatment for depression. Mean age 45 (SD 16), 75% female, 80% white, 39% college graduates.	RCT comparing: - 8 sessions T-CBT, - TAU, - TAU plus telephone care management.	HSCL, PHQ-9, Patient-rated improvement and satisfaction.	T-CBT sig lower HSCL scores, more patients reporting depression as “much improved” and “very satisfied” with treatment. NNT = 6.4 for 50% improvement in HSCL.	At 6 m: T-CBT group showed sig lower depression

Study	Sample Size (n)	Participant Characteristics	Research Design	Outcome Measures	Results	Follow-up Data
12. Swinson, Fergus, Cox & Wickwire (1995)	42	US patients with panic disorder with agoraphobia, living in rural areas. Mean age 41 (SD 11), 88% female.	Randomised trial: 8 sessions T-CBT vs. TAU.	FQ, STAI-T, ASI, BDI, SCL-90, Treatment satisfaction questionnaire, 2 global improvement scales.	Sig treatment x time interaction effects on several outcomes. Treatment group sig improvements and reportedly very satisfied with T-CBT.	At 3 m and 6 m: gains maintained in treatment group across all measures.
13. Taylor et al. (2003)	33	Canadian patients with OCD (without depression). Mean age 38 (SD 12), 76% female, 91% Caucasian, 94 % completed at least Grade 12 education.	2 trials: 12 weeks T-CBT, one delayed for 12 weeks and one immediate. Non-random.	Y-BOCS, Padua Inventory, Dimensional Y-BOCS.	Scores declined (sig) over treatment with effect sizes = 0.43 and 0.51 (large), vs. no change during waiting list interval.	At 12 wks: gains maintained.
14. Yeh, Taylor, Thordarson, & Corcoran (2003)	2	40-year-old female Caucasian and 33-year-old female Caucasian with obsessive-compulsive spectrum disorders.	Case reports: 12 weeks T-CBT.	Dimensional Y-BOCS, BAI, BDI.	Treatment resulted in symptom reduction for both participants.	At 3 m: one relapsed and one maintained gains.

*Note.* RCT = randomised controlled trial; TAU = treatment as usual; SD = standard deviation; T-CBT = telephone cognitive behavioural therapy; CORE-OM = Clinical Outcomes in Routine Evaluation outcome measure; HADS = Hospital Anxiety and Depression Scale; WSAS = Work and Social Adjustment Scale; WHO-HWPQ = World Health

Organisation Health and Work Performance Questionnaire; m = months; PHQ-9 = Patient Health Questionnaire-9; HSCL = Hopkins Symptom Checklist; Sig = statistically significant; GAD-7 = Generalised Anxiety Disorder-7; GAF = Global Assessment of Functioning; OCD = obsessive compulsive disorder; Y-BOCS = Yale Brown Obsessive Compulsive Disorder Scale; BDI = Beck Depression Inventory; HDRS = Hamilton Depression Rating Scale; NNT = number needed to treat; FQ = Fear Questionnaire; STAI-T = State-Trait Anxiety Inventory – trait version; ASI = Anxiety Sensitivity Index; SCL-90 = Symptom Checklist 90; BAI = Beck Anxiety Inventory.

**Appendix B**  
**Recruitment Presentation**

# A Study Investigating Telephone Interventions in Primary Care

Celine Webb  
*(Date of presentation)*

## Who is the researcher?

- Trainee Clinical Psychologist at UEA
  - Supervised by clinical lecturer, Dr Deirdre Williams
- Thesis for doctorate training course
- Previous experience as PWP in IAPT
  - Experience of telephone interventions
  - Personal topic of interest



## What is the study about?

- Telephone interventions
  - In primary care
  - Using CBT
- Clinician's experiences and perspectives
  - Not much existing research
  - Qualitative study



## Why am I invited?

- IAPT clinicians
  - Aiming for up to 12 participants
- Participation is totally voluntary, and will not affect your employment in any way
  - All discussions confidential
    - Except any disclosure of current risk
  - Can withdraw from study at any point
    - No reason needed
    - No consequences to yourself



## Who can take part?

### Inclusion



- Fully-qualified practitioners
- Experience of minimum 5 cases telephone
- Experience of minimum 5 cases face-to-face
- Working in primary care
- Able to attend a one-to-one interview

### Exclusion



- Trainees
- Unable to read or write English
- No telephone experience
- No face-to-face experience

## What will happen?

- Qualitative one-to-one interviews
  - Discussion about your experiences
  - Convenient date/time for you
  - Appropriate local NHS location
  - 40-60 minutes
- Researcher will conduct all interviews & analysis
  - Audio recorded and transcribed
  - Written transcript sent back to you
  - Data analysed by researcher
  - Summary results can be requested
  - Possible journal article publication



## What about data protection?

- All data treated as confidential
  - Except current risks if disclosed
  - Stored securely using password-encrypted memory sticks & locked cabinets
- Direct quotations will be used for reporting results
  - But no personally identifying information will be included
- Data stored for 5 years
  - In line with policy
  - Not possible to link personal info



## Are there any risks?

- The study will ask you to reflect on your clinical work
  - If distressed you can stop the interview at any time
  - Time at end of session to discuss any issues raised
- Recommend supervision available within 24hrs of discussion
  - Formal or informal
  - To discuss any issues





## What's in it for me?

- Opportunity to express your views
  - Have your voice heard
  - Clinicians' experiences re: telephone under-researched
  - Potential to influence service delivery
- £5 Amazon voucher
  - To thank you for your time
  - All travel expenses will be reimbursed



## How do I get involved?

- Complete a 'consent to be contacted form' today
  - The researcher will contact you
    - To discuss the research
    - To arrange an interview if you are still interested
    - Written consent taken on the day
- Return a written consent form via post
  - Once you have had at least 24hrs to decide
  - Stamped addressed envelopes provided
- Any questions can be discussed now
  - Researcher contact details on info sheet



Thank you & any questions



## Appendix C Participant Information Sheet

**Chief Investigator: Celine Webb**  
Trainee Clinical Psychologist  
Norwich Medical School  
University of East Anglia, Norwich NR4 7TJ  
**email:** celine.webb@uea.ac.uk  
**phone:** 07811210252



**Primary supervisor: Dr Deirdre Williams**  
Norwich Medical school  
University of East Anglia, Norwich NR4 7TJ  
**email:** Deirdre.williams@uea.ac.uk  
**phone:** 01603 593547

### Participant Information Sheet

#### A Study Investigating Telephone Interventions in Primary Care

*You have been invited to take part in a research study. Before you decide, this information sheet will explain why the research is being carried out and what it will involve for you. Please read the following information and take time to decide whether or not you wish to take part.*

#### **1. What is the purpose of the study?**

The aim of this study is to investigate clinicians' perspectives of delivering treatment using the telephone. The researcher would like to find out about clinicians' experiences, and how these might compare to face-to-face appointments. Therefore clinicians from Improving Access to Psychological Therapies (IAPT) services are being invited to participate. The study is being carried out by the researcher (Celine Webb, a trainee clinical psychologist), and a clinical lecturer, Dr Deirdre Williams, at the University of East Anglia, in part-fulfilment of an educational degree.

#### **2. Why have you been invited?**

You have been invited as you are a clinician who offers telephone interventions to patients and the researcher would be very interested to discuss this with you. The researcher is hoping to include a total of up to 12 participants in the study.

#### **3. Do you have to take part?**

No. It is up to you to decide whether or not to take part. Your participation is totally voluntary, and will not affect your employment in any way. After you have read this information, you will be asked to complete a consent form to show that you are happy to take part.

#### **4. What will happen if you take part?**

If you agree to take part in the study you will be contacted by the researcher to arrange a convenient time and place for a discussion about your experiences. The discussion will last approximately 40-60 minutes and will generally ask you to reflect on your clinical experiences and opinions. There are no right or wrong answers, and the researcher will simply be interested to hear about your experiences. A written consent form will be used on the day of the interview to record your formal consent to take part. A written copy of your interview will be sent to you for you to review and comment upon if you wish.

#### **5. Can you stop taking part if you change your mind?**

Yes. If you decide to take part in the study you can change your mind about participating and withdraw from the study. If you choose to withdraw, you do not have to provide a reason and there will be no consequences. If you do choose to withdraw, the information you have already provided will be destroyed and not

used in the research, up until the point at which you have reviewed your interview transcript. Beyond this point, it will not be possible to withdraw individual data from the analysis.

#### **6. Will your taking part in this study be anonymous and kept confidential?**

All collected data will be treated as confidential. However, the researcher will have to inform relevant individuals or services if you disclose any current risk or raise anything that would cause concern for the welfare of yourself or others, including clients. If this were to happen, the data collected from you would be withdrawn from the study and where confidentiality had been breached, the data would be destroyed. The researcher will have direct contact with you, and direct quotations from your discussions may be used for reporting results, but no personally identifying information will be included. The discussions will be audio recorded and transcribed by the researcher, and a written transcript will be sent to you for your feedback via your email or postal address. These details will be kept separate from the transcripts and will not be able to be linked in any way. All data including paper documents, electronic documents and digital recordings will be stored securely using a password-encrypted memory stick and locked cabinets where appropriate. Once the study is completed, the information will be stored in a locked drawer at the University of East Anglia for 5 years, in line with the current policy. The consent forms will be stored separately from the transcripts and destroyed on completion of the research. It will not be possible to link the consent forms to your personal transcripts.

#### **7. What will happen to the results of the research study?**

The information collected will be written into articles and potentially published in a relevant journal. You will not be identified personally in any of these articles. If you are interested in finding out about the results from the study, a summary can be requested to be sent to your email or postal address. These details will be kept separate from the transcripts and will not be able to be linked in any way. After the researcher has sent you information about what they have found, your email/postal addresses will be deleted.

#### **8. What are the possible disadvantages or risks of taking part?**

The study does require you to reflect on your own clinical practice. A period of time will be provided at the end of the session to allow discussion of any issues raised. You might also want to consider accessing clinical supervision after the interview to discuss any clinical issues. If you feel distressed during the study you may stop the discussion at any point, and the researcher will be available to discuss the study further if necessary.

#### **9. What are the possible benefits of taking part?**

It is hoped that this research will improve our understanding of telephone interventions and may help to develop better treatment delivery via the telephone. This is an opportunity for you as a clinician to discuss your experiences, and to have your voice heard. Also, the researcher is offering each participant a £5 in Amazon vouchers to thank you for your time, and any travel expenses will be reimbursed.

#### **10. Complaints**

If you have any further concerns about any aspect of the study you can contact Professor Kenneth Laidlaw, Elizabeth Fry Building, University of East Anglia, Norwich NR4 7TJ. Tel.: +44 (0) 1603 593600.

#### **11. Who is organising and funding the research?**

This research is organised by Celine Webb and Dr Deirdre Williams and is funded by the University of East Anglia Doctoral Programme in Clinical Psychology.

**12. Has this study been approved?**

Yes, this study has been approved by the Faculty of Medicine and Health Sciences Research Ethics Committee at the University of East Anglia, as well as the Research and Development departments of Norfolk and Suffolk NHS Foundation Trust, and Cambridgeshire and Peterborough NHS Foundation Trust.

**13. Further information**

If anything is not clear, or if you would like more information, please do get in touch.

*Thank you for taking time to read this information sheet, please keep this information for your records.*

**Appendix D**  
**Expression of Interest/ Consent to Contact Form**



Norfolk and Suffolk



NHS Foundation Trust

**EXPRESSION OF INTEREST:**  
**CONSENT TO CONTACT FORM**

**Title of project:** A Study Investigating Telephone Interventions in Primary Care

**Researcher contact details:** Celine Webb (celine.webb@uea.ac.uk/ telephone 07811210252)

Please initial  
box:

1. I am interested in taking part in an interview.

2. I have read and understand the Participant Information Sheet about the interview.

3. I give permission for the researcher to contact me on the telephone number below to discuss the research, what it would entail, and whether I would like to take part.

4. I understand that if I no longer wish for the researcher to contact me or change my mind about taking part, I can withdraw from the research at any time.

Name: ..... Date: .....

Signature: .....

Contact Phone Number:.....

**Appendix E**  
**Participant Consent Form**



**PARTICIPANT CONSENT FORM**

**Title of project:** *A Study Investigating Telephone Interventions in Primary Care*

**Researchers and contact details:**

Celine Webb (celine.webb@uea.ac.uk/ telephone 07811210252)

Dr Deirdre Williams (deirdre.williams@uea.ac.uk/ telephone 01603 593547)

**Please initial each box and sign/print your name at the bottom if you agree to participate.**

1. I have read the Participant Information Sheet relating to this study. I understand what my role will be in this research, and all of my questions have been answered to my satisfaction.
2. I understand that I do not have to take part in the discussion and that I can stop the discussion at any time without giving any reasons. I understand that if I decide to stop the discussion, this will not affect my employment either currently or in the future
3. I have been informed that the confidentiality of the information I provide will be safeguarded. I understand that the researcher will have to inform the relevant services if I disclose any current risk to myself or others.
4. I understand that relevant sections of my data may be quoted verbatim in the reporting of the study but no personally identifying information will be included. I give permission for these quotations to be used.
5. I understand that I am free to ask any questions at any time before and during the study, and have the contact details of the researcher should I wish to discuss any aspect of the study.
6. I give permission for the interview to be audio-recorded for the purposes of this research.
7. I understand that a written transcript from my interview will be sent to me for me to comment upon, and I have provided a postal or email address for this purpose on the participant demographic form.

8. I would like a written summary of the research findings to be sent to the address mentioned above.

9. I understand that if I withdraw my consent, it will only be possible to withdraw my individual data up until the point at which I have reviewed my interview transcript.

10. I agree to take part:

Name of Research Participant:

\_\_\_\_\_

Signature: \_\_\_\_\_ Date:

\_\_\_\_\_

Name of Researcher: Celine

Webb \_\_\_\_\_

Signature: \_\_\_\_\_ Date:

\_\_\_\_\_

*Please save a copy of this for your own records*



## Appendix F Final Topic Guide

### INTERVIEW TOPIC GUIDE

Thank you for giving me this hour of your time to talk about your experiences and views of providing interventions via the telephone. Please feel free to be open with your views because our discussion will be confidential, although I must warn you that disclosure of current risk to yourself or others will mean that I have to break confidentiality. Direct quotations from our discussion may be used for reporting results, but no personally identifying information will be included. As we will be talking about your clinical experiences today, can I just remind you to maintain client confidentiality at all times, and can I ask you to discuss your clinical experiences in general terms only - please do not refer to specific clients during our discussion. If at any time you feel distressed, please do let me know and we can stop the interview at any point. There will be some time at the end to reflect on any issues raised today. I plan to audio record today's discussion and post you a copy of your transcript for you to have a look at. Do you have any questions before we start?

#### Q1. GENERAL EXPERIENCES AND PERSPECTIVES OF TREATMENT

**a. Can I start by asking you: how much telephone work do you do, and what kinds of interventions do you deliver over the telephone?**

*Prompt for: how often they use the telephone, what proportion of their work this represents, whether this has changed over time, what the content consists of – whether more B.A./ cognitive restructuring or more guided self-help.*

**b. How do you find delivering interventions over the telephone in general?**

*Prompt for: general attitude and experiences, how well they feel it serves patients' needs and meets service needs, how they have found patients' responses to this modality, possible comparison with face-to-face interventions, preferred modality and why.*

**c. Can I continue by asking you: when you get off the phone from an appointment with someone, how does it feel?**

*Prompt for: overall impressions, perceptions of efficacy, reasons behind this, what that might be like on a day-to-day basis.*

*Generally follow-up on any points raised by the respondent regarding experience:*

- *Can you tell me some more about that?*
- *What's that like for you?*

## Q2. THE THERAPEUTIC ALLIANCE

### a. Can you tell me about your general experience of forming therapeutic relationships with patients over the telephone?

*Prompt for:*

- *What are your impressions of the relationships you form with patients over the phone?*
- *How do you work to achieve an alliance via telephone?*

### b. How does this compare with forming therapeutic relationships face-to-face with patients?

*Prompt for:*

- *Are there elements of the relationship that you focus on more when not face-to-face? What are these and why?*
- *Are you changing your clinical practice to adapt to this modality? If so, how?*

*Generally follow-up on any points raised by the respondent regarding alliance:*

- *Can you tell me some more about that?*
- *Can you explain that to me please?*

## Q3. POSITIVE AND NEGATIVE ASPECTS OF TELEPHONE TREATMENT

### a. Overall, what's good about doing clinical work over the telephone?

*Prompt for:*

- *Have there been any other productive, helpful, positive or encouraging things about using the telephone?*
- *Which aspects of telephone work help you in your relationships with patients?*
- *How does this compare with face-to-face interventions?*

### b. Overall, what's bad about doing clinical work over the telephone?

*Prompt for:*

- *Have there been any other hindering, unhelpful, negative or disappointing things about using the telephone?*
- *Which aspects of telephone work hinder you in your relationships with patients?*
- *How does this compare with face-to-face interventions?*

*Generally follow-up on any points raised by the respondent regarding experiences and the alliance:*

- *Can you tell me some more about that?*

#### Q4. NEW ELEMENTS AND NEW PRACTICE

- a. Are there any new elements to your relationships with patients via the telephone which don't exist with face-to-face clients?**

*Prompt for:*

- *What do these tend to be?*
- *What makes it this way?*

- c. Are there any new elements to your clinical work which you use as a result of telephone working?**

*Prompt for:*

- *What do these tend to be?*
- *What makes it this way?*

- a. How do you think services could help you make the most of telephone interventions?**

*Prompt for suggested solutions to overcoming any barriers mentioned earlier.*

DEBRIEFING: You may have noticed that some of today's conversation was about the idea of a therapeutic alliance via the telephone, which was not mentioned specifically when I introduced you to the study using the Participant Information Sheet and my presentation. The reason for this was to avoid biasing any responses, as I was interested to see what you had to say about telephone work and the alliance spontaneously. Much of the focus for this study is the idea of the therapeutic alliance via telephone as this is a relatively new area of research.

Do you have any questions regarding this? *Discuss as appropriate.*

#### CLOSING QUESTIONS

- **Do you have any suggestions for us, regarding the interview today?**
- **Is there anything else that you think will be important for me to understand about your experience of telephone interventions?**

Thank you very much for sharing your views and experiences with me. Your answers will be written up and then we will compare them with other people's answers to arrive at general conclusions about clinicians' experiences of telephone interventions.

Would you like to take some time to reflect upon today's conversation?

*Discuss as appropriate.*

Appendix G  
Participant Demographic Form



**PARTICIPANT DEMOGRAPHIC FORM**

**Title of project: A Study Investigating Telephone Interventions in Primary Care**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Gender:** \_\_\_\_\_

**Ethnicity:** \_\_\_\_\_

**Marital status (please circle):** Married Cohabiting Single \_\_\_\_\_

**Number of years training as a therapist:** \_\_\_\_\_

**CBT qualification held:** \_\_\_\_\_

**Number of years experience as a therapist:** \_\_\_\_\_

**Current position and NHS band:** \_\_\_\_\_

**Email address for correspondence:** \_\_\_\_\_

Many thanks for completing this form. All information provided will be treated as confidential. If you have any queries please do not hesitate to contact the researcher – Celine Webb: [celine.webb@uea.ac.uk](mailto:celine.webb@uea.ac.uk) / 07811210252.

## Appendix H

### Reflective Log Regarding Coding and Analysis

#### Reflections – Coding

**Initial decisions** - I am finding coding a challenge as the process is very new to me and appears to be very subjective. After reading some of the Coding Manual by Saldana I have decided to take an “eclectic coding” approach, combining techniques such as in vivo coding and descriptive coding to suit the research needs of the project itself, which is exploratory. This decision is based on the fact that I am using an inductive bottom-up approach so my coding needs to be rooted in the participants own words and the content, rather than guided by a priori themes or existing hypotheses. I feel as I am new to this process this reduces the room for misinterpretation and keeps the codes closer to the data rather than my own views. I decided to use multiple coding in an attempt to capture multiple meanings within one passage, and to retain context by coding a larger passage with multiple codes rather than smaller passages with individual codes.

**Revision of coding process** – After having discussed coding at the qualitative research forum at UEA and reviewing the article on thematic analysis by Braun and Clarke, I have decided to revise my methodology regarding coding. With my initial approach, each transcript appeared to produce between 150-200 different codes. It appears that this initial approach may have been too detailed and descriptive at this point, and instead I should be aiming to “index” the data and using the idea of “constant comparison” to look within each topic e.g. what are people saying about “silences”? Braun and Clarke (2006) talk about deciding between “a rich description of the data set, or a detailed account of one particular aspect.” In order to remain exploratory and maintain an inductive approach, I felt it would be helpful to aim for a rich thematic description, which Braun and Clarke (2006) state “might be a particularly useful method when you are investigating an under-researched area, or you are working with participants whose views on the topic are not known.” Also, the article mentions that “an inductive approach means the themes identified are strongly linked to the data themselves (Patton, 1990) [...] Inductive analysis is therefore a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher’s analytic preconceptions” which is in keeping with a critical realist approach as the analysis is data-driven, as opposed to a ‘theoretical’ thematic analysis. With regards to the ‘level’ at which themes are to be identified (semantic/explicit vs. latent/ interpretative), I have decided to identify semantic themes with a view to analysis then involving “a progression from description, where the data have simply been organized to show patterns in semantic content, and summarized, to interpretation, where there is an attempt to theorize the significance of the patterns and their broader meanings and implications (Patton, 1990)”. This is in contrast with the latent theme analysis which would “identify or examine the underlying ideas, assumptions, and conceptualizations - and ideologies - that are theorized as shaping or informing the semantic content of the data” which tends to come from a more constructionist approach.

I have decided to adopt a ‘broad brush’ coding approach initially to organise the data into broad topic areas then explore within each code and conduct more detailed coding, based on interesting perceptions, contradictions or assumptions. To do this I will use topic coding—labelling the topic being discussed. This could be considered a form of ‘initial coding’ or ‘open coding’, which is suitable for beginner-level coders and remains open to all possible theoretical directions (Saldana, 2013), which is in keeping with an inductive approach.

**Levels of coding** - There are so many different levels at which you could code, but I am keeping it simple by asking myself – “what are they talking about?” Not “what are they saying? What does this mean? Or what’s going on here?” This is an attempt to keep within topic coding and not drift into the realms of social constructionism or discourse analysis.

**“Techniques”** - I have added a code after coding transcript 3 called “techniques” as it struck me how often this person mentioned techniques (i.e. task) rather than the relationship. I am aware that this is somewhat theory-led as it links back to my knowledge of the therapeutic alliance, but it is a word that the participant used themselves on several occasions so it is rooted in the data, and I think I must acknowledge to some extent that coding does not happen in a theoretical vacuum, so it is normal that this will influence what I am noticing in the data as it relates to my research questions.

**“Attunement”** - I have added a code in transcript 4 called “attunement” despite this not being the participant’s own words. I am aware that this relates specifically to psychological theory, but it seems to capture the topic being discussed, even though the participant did not name it as “attunement” themselves. The extract mentions correctly identifying the person’s emotional state and responding appropriately.

**Understanding** – Patient understanding appears to play a massive role in telephone work and crops up in participants’ responses a lot. One clinician said “you’re able to see they’re getting it and that that alliance is part of that as well.” I have been wondering if the alliance via the phone has more emphasis on facilitating understanding than it would f2f?

**“Limiting”** – I added this code retrospectively towards the very end of transcript 5 as this was a word that came up a lot and I feel it relates to this person’s view of the alliance via telephone. It will be interesting to see if it comes up specifically in other interviews. I have searched the previous 4 interviews and it is not a word which came up specifically.

**“Disclosure”** – I have added this code during transcript 6 as this interview seems to go further than “anonymity” as it mentions what that anonymity can lead to – i.e. disclosure. I wonder if I have maybe missed some other examples of this in previous interviews, but having looked under “anonymity” there does not seem to be anything obvious.

**?Detecting and ?Doubt** – In transcript 6 this participant mentioned doubting what the client was saying or feeling, and also mentioned about “detecting” things over the phone too. I decided not to create codes for these specifically as I do not remember them coming up in other interviews, but I will keep this in mind and be on the lookout for any mentions in further transcripts in case I am wrong.

**“Doubt”** – I have decided to create a code for this after all as it does come up multiple times in interview 6 and it does seem to have some bearing on the alliance so it might be important in my analysis.

**Non-verbals in the interviews** as well as over the phone – As I was coding transcript 6 I noticed a passage where the interviewee was talking about non-verbals from clients but I vividly remember her displaying those non-verbals as she was describing the process such as facial expressions and gestures which are not captured in the transcript or coding at all. This is interesting as it is almost like the process therapists go through is mirrored in the process I am going through as a researcher as I feel a lot of the non-verbals are lost via this method, which is a shame.

I get the sense from interview 7 that “disclosure” and “feeling comfortable” are closely linked... There could be a causal relationship here...

“Picking up” on things seems to be important and probably similar to this idea of “detecting” things, which at the moment I am coding under “missing important things”, but I might need to make this more specific as my code becomes larger.

In transcript 7 some of the inconsistencies are interesting and not necessarily captured in the coding. This person talked about telephone helping to “stay on track” and not go off topic, but then they later rationalise this as a result of lots of circumstances, and possibly even “might have been a coincidence that it was on the phone.” Does this reflect some underlying level of scepticism or doubt about the power of the telephone?

There is also something about the therapy/therapist coming to them, coming into their life, which might enhance the relationship in terms of a more equal approach – you’re not the one who has to make all the effort, someone is reaching out to you... “I think because you’re coming into their life rather than them coming into a clinic or somewhere to see you face-to-face, although I’m sure they forget about it as soon as the phone is hung up, it does feel more like they’re integrating that into their life, and so in a way it can be a kind of... That connection is built that way.” (Transcript 9)

Interesting thought from participant 8 – “So much information comes nonverbally, and also if you think that the crucial thing for the relationship is the therapeutic relationship, you know, I wonder whether the use of telephone affects the percentage of therapeutic relationship that makes a contribution to the treatment as a whole, and if it’s less than a face-to-face.”

There are some important themes emerging around “not knowing” – not knowing if they’re distressed, what they are feeling/ doing on the other end of the line, not knowing what they’re writing or whether they’ve even done the work, not knowing

what they look like, not knowing them really because you've never met. This may be linked to this idea of "detecting" things over the phone and how much harder this seems to be for clinicians than face to face. "Not knowing" may also be linked to "not seeing", which makes me think that the telephone seems to render the clinician quite impotent in many ways, there seems to be a power imbalance, like the telephone might empower patients but restrict clinicians, who have to relinquish some of that power.

**"Power"** - Following on from this I have added "power" as a code since the word "empowered" appeared in transcript 9 and seemed to re-emerge a few times.

**"Warmth"** – I have added this as a code as it seems to come up a number of times in transcript 8 and doesn't seem to be captured specifically by existing codes such as "empathy" or "connection" which are slightly different. I know this relates to the therapeutic alliance in some way so I feel it is relevant.

Should **"conveyor belt"** be another code? Or is it just within "PWP role"? If this comes up again I will make a new code.

Clinicians appear to be relatively unheard – it's not discussed in supervision, no one has asked them how they're finding it, it's presented to them as "this is how it is", and from interview 8: "I don't think they're that interested in doing it from clinicians' point of view, they're not interested in that. This is about getting people back to work, this is about getting people off unemployment benefit, the workers' view of it is pretty irrelevant I think."

**"Body language"** may need to be broken down to include a separate "gesticulating" code, and equally, "faces" may need to be refined to separate out "smiling" specifically, and "eye contact".

There seems to be something around the alliance being more distant, more clinical, more treatment focussed, less involved in the personhood of the client, e.g. transcript 10 "You're not distracted by anything other than by the task and the paper in front of you rather than the person and what they might be doing or getting sidetracked by something they've said."

Therapeutic relationship – out of sight out of mind? It is almost second nature, but possibly risks being neglected.

Transcript 11 talks about the focussed nature of the work helping to keep it "more contained, it feels safer", which is an interesting concept – maybe the 'limiting' nature of the telephone is actually a benefit? This interview also talks about how the relationship is very similar, but the ways it is achieved are different e.g. upskilling. However, there do seem to be contradictions in this person's transcript regarding same vs different.

There seems to be something running through the data regarding the telephone as a 'facilitator' – something which facilitates the PWPs doing their job as the role was



intended – time limited, focussed, contained, with the emphasis on empowering the client not a counselling approach.

**Personhood** - The topic of ‘personhood’ seems to be an interesting idea which is emerging – some people describe feeling more removed from the ‘person’ which seems to have its advantages both for the session (easier to be boundaried) and for them personally (less likely to be recognised). However, this has drawbacks including less connection to the client, maybe the patients respects the sessions a little less because they’re just a ‘faceless person on the phone’, it makes remembering the client in supervision harder. Clinicians seem to be trying to overcome this by using strategies such as remembering and noting small personal details to come back to, to make the client feel valued and not just “another number”.

**Liberating** for the therapist to not worry about how their non-verbals are coming across, can yawn, drink tea etc but also liberating for the client not to be tangled up in the interpersonal interaction – e.g. less intimidating for social anxiety as per transcript 14.

Transcript 2 – they’re less **reliant** on you, the therapist becomes more **reliant** on them e.g. being honest, verbalising more, being in an appropriate location, reading out all their homework etc...

Not knowing seems to be disempowering – relying on them to have materials, verbalise everything, tell you important things.

## **Reflections – Analysis**

I have organised my existing codes in a visual 'mind map' to facilitate the process of thinking about links between codes and grouping codes together into 'themes'. In order to do this I have exported a list of all my "nodes" from Nvivo and I am transferring the pertinent ones onto the map. It is evident that many of the codes link together in more than one way, and I will need to be careful not to have sub-themes contributing to more than 1 theme. I am a little concerned that this map of codes does not answer my research question about the alliance, mainly as participants struggled to talk about the alliance specifically. In order to answer my research questions, I am not including codes on my mind map which seem completely removed from the idea of a therapeutic alliance e.g. 'Headsets' or 'Service structure'.

Following a conversation with my research supervisor, we discussed possibly answering the first research question with a narrative to explain the key finding that clinicians a) struggled to discuss the alliance, and b) seem to be more treatment-focussed - 'task' came up a lot more than 'bond'. Then I can answer the second and third questions using a thematic map and outlining the data-driven themes. Research question 4 has been discarded as it simply relates to the need to consider theory in the discussion.

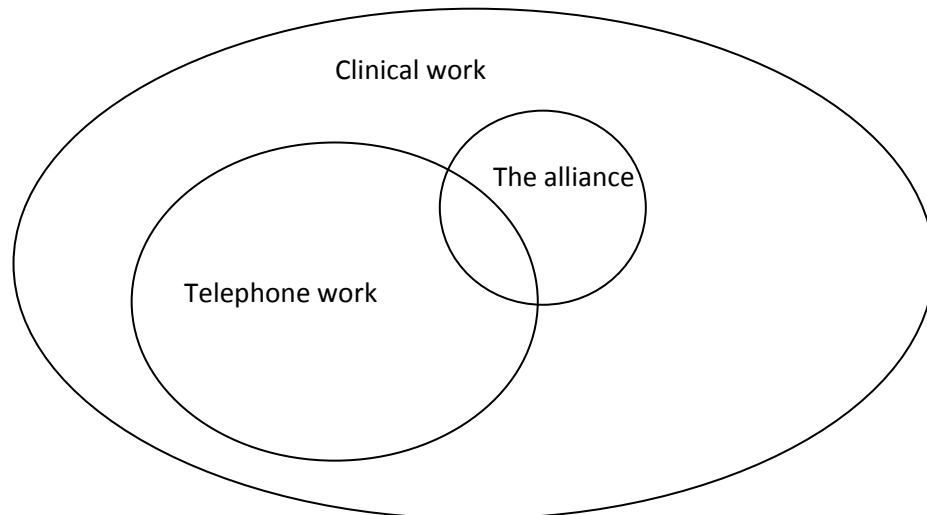
Therefore on my 'mind map' I have started to group codes according to themes. The idea of "telephone as a limiter vs telephone as a liberator" is probably too descriptive - simply a list of advantages and disadvantages of telephone work, which isn't really a thesis. It is also a concern that sub-themes may appear under both overarching themes, as some elements are both an advantage and a disadvantage. Therefore I am trying to focus more on the emerging ideas of 'power' (the clinician has to relinquish some power in the relationship, which empowers the client) and 'personhood' (some elements of personhood seem to be lost via the telephone, both for the "faceless" clinician and the more anonymous client, which again has its advantages and disadvantages). I am keeping very data-driven, even though this means I may not be able to answer my research questions about the alliance specifically, as the participants struggled to talk about this directly (which is an interesting finding in itself).

At this point, as part of the analysis process I am following the Braun and Clarke (2006) guidelines and inspecting my codes for internal homogeneity and discarding any that do not have coherence. For example I have discarded the code "frustration" as the extracts within it do not cohere – some refer to clinician frustration, others to clients, some regarding patient choice, others the materials, practicalities of telephone work, or the sense of frustration at missing visual cues. These are all elements which I feel are captured elsewhere in other codes. Also I am discarding codes where just 2 or 3 participants have contributed as these are unlikely to be significant or they would have formed more prominent themes.

I have decided to discard any codes referring specifically to the client (e.g. : Patient benefits, Patient choice, Patient feedback forms, Patient motivation, Patient perceptions, Patient preference, Patient preparation, Patient understanding) as this is

essentially second-hand information on what the patient *might* be experiencing. As my research questions relate to the clinician's experiences specifically, I feel that this will help to maintain that focus.

Something I have noticed is that a lot of the data refers to telephone work generally rather than the alliance in particular, or just to their clinical work generally, or perhaps to the alliance but in general terms. The difficult task is separating out where these 3 meet – information about the alliance via the telephone specifically. It feels a bit like this:



“Time (taken)” – I am debating whether to include this on the mind map as on review of the codes, this group of extracts does not refer to any aspect of the therapeutic alliance really. It relates mainly to the practicalities of telephone – less time taken up for the client and sometimes less time taken up in the day for the therapist.

“Boundaries” – This code has caused me some difficulties in the analysis process as it seems to contribute to more than one theme yet it isn't distinct enough in itself to be its own theme. After reviewing the coded extracts it appears that there might be 2 separate processes happening in relation to boundaries and hence a need for the code to be sub-divided. The codes appear to relate to either interpersonal boundaries or session boundaries – session (e.g. physical) boundaries seem to be blurred because of the telephone – where it happens, when it happens, how formal the appointment should be; but interpersonal boundaries are made easier because of this element of distance – clients go off topic less, they ask less personal questions, they seem to see it less as a friendship and more as a clinical relationship perhaps, and for clinicians it would feel ruder to cut someone off when they are face-to-face. The distinction here is that participants are either talking about how it is easier to boundary *someone* over the phone because you are distanced, or how it is harder to boundary the *session* itself because the telephone blurs the lines of what a session entails. Hence possibly the clinician feels disempowered and yet the reduced sense of personhood here is helpful to maintain some boundaries. I have included the code “people talk less over the phone” here as it is part of “interpersonal boundaries are easier”. I have also collapsed

most of the codes under “informality” and “valuing appointments” under “session boundaries are blurred” as they refer to the same difficulties.

“Faces” – I have refined this code so that it now only includes the importance of faces in establishing a sense of the person (client or therapist) as previously it had included *any* mentions of faces including eye contact and other visual cues, but I feel these are captured adequately elsewhere (i.e. “non-verbal cues” and this refined code now has a clearer meaning to it.

“Just a chat” seems to relate to “going of topic” – and is actually saying that people are less likely to go off topic over the phone, so I have collapsed these together.

“Attunement” is a difficult one because some extracts refer to the idea of not knowing, or missing important things, which relates to the therapist having less power to respond appropriately, whereas other extracts refer to having less sense of the client as a person. I have re-coded this extract to pull it apart in relation to these differences, by coding the extracts as either “missing important things” or “less sense of client as a person”. I feel this relates to the technique of constant comparison as I am re-arranging my data in a fluid way by re-examining the grouping at the level of the coded extracts.

“Structure of sessions” – When I reviewed this code there was little coherence between the extracts, the data were very diverse, it appeared as if any mention of “structure” had been grouped here, but the group lacked any cohering meaning. Therefore I have re-coded some of the extracts within it which seemed to fit with the 2 new “boundaries” codes, and discarded the “structure of sessions” code itself as it lacks coherence or internal homogeneity. I also felt that there was a lot of extracts relating to structure of clinical work in general, not to telephone work specifically and certainly not to do with the alliance really.

Similarly – “time (taken)” was also too broad to cohere as a single code or theme. Some clinicians felt telephone took less time out of their day, others felt it was the same by the time you write up notes and post things out etc. The only coherent meaning within this code related to the client – telephone takes less time out of the client’s day/ life, so I have refined this code to reflect that idea only, and placed all the relevant extracts under a new code called “telephone takes up less time for clients”.

For the code “Time (sessions)” there seems to be 2 different messages illustrated in these extracts – firstly that telephone sessions are shorter (possibly because it’s easier to “boundary” people), and secondly that everything takes longer on the phone e.g. the client has to read out all their homework, the minimum data set has to be verbalised, so clinicians have less time to attend to other aspects of the session, and possibly less flexibility or content as a result. Therefore I have split this code into 2 new codes: “telephone sessions are shorter” and “everything takes longer on the phone” and discarded any outliers (e.g. general comments about the time-limited nature of PWP work) for the sake of internal homogeneity.

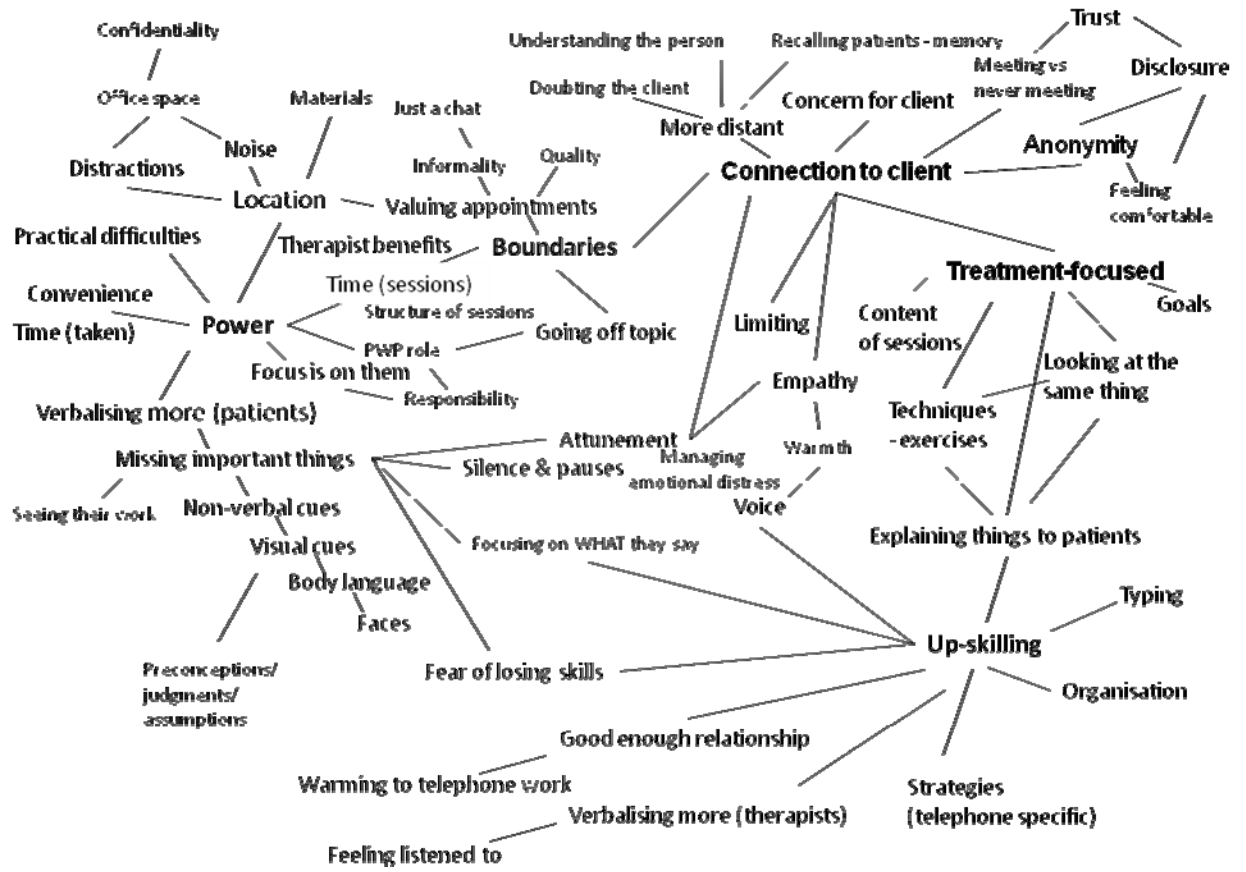
I am separating out “voice” as the coded extracts relate more to “upskilling” than the question of what is helpful or hindering for the alliance. I will revisit this code when I consider research question 3 as it does appear to be coherent in terms of how clinicians feel they are using their own voice more and also picking up on tone of voice from the client.

Similarly I am separating “focussing on WHAT they say” as this seems to relate to “upskilling” more than my existing themes regarding power and personhood, therefore I will consider a new theme around “upskilling” or adapting to the telephone.

At this stage of the analysis I am reviewing the data at the level of the coded extracts to establish where the codes belong and to refine my sub-themes and themes. I have collapsed similar codes such as “body language” and “visual cues” into the sub-theme of “non-verbal cues” as they are all very similar. I have considered organising the data in different ways, with prominent themes such as “non-verbal cues”, “boundaries” and “connection to the client” but these are either too vague, too descriptive (not an analysis) or overlapping. The most distinct and sense-making analysis of the data involves the 4 themes supported by the sub-themes detailed in my “developed thematic map”. I have separated the codes surrounding the idea of “upskilling” and “treatment focus” as I feel they are separate themes in themselves. In order to progress I am considering their validity in relation to the entire data set by re-reading the transcripts and re-coding where necessary, as per Braun and Clarke (2006).

# Appendix I

## Visual Mind Map



## Appendix J Letter of Ethical Approval

Faculty of Medicine and Health Sciences Research Ethics Committee



Celine Webb  
PGR Office  
Elizabeth Fry Building  
UEA  
Norwich  
NR4 7TJ

Research & Enterprise Services  
West Office (Science Building)  
University of East Anglia  
Norwich Research Park  
Norwich, NR4 7TJ

Telephone: +44 (0) 1603 591720

Email: [fmh.ethics@uea.ac.uk](mailto:fmh.ethics@uea.ac.uk)

Web: [www.uea.ac.uk/researchandenterprise](http://www.uea.ac.uk/researchandenterprise)

17<sup>th</sup> September 2013

Dear Celine,

**Project Title: Clinicians' experiences and perspectives of the therapeutic alliance during cognitive behavioural therapy (CBT) telephone consultations in primary care. Reference: 2012/2013 - 77**

The amendments to your above proposal have been considered by the Chair of the Faculty Research Ethics Committee and we can confirm that your proposal has been approved.

Please could you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the Committee. Please could you also arrange to send us a report once your project is completed.

The Committee would like to wish you good luck with your project.

A handwritten signature in blue ink that reads 'Yvonne Kirkham'. The signature is written in a cursive style with a large initial 'Y'.

Yvonne Kirkham  
Project Officer

Cc Dr Deirdre Williams by email

## Appendix K Letter of R&D Approval from NSFT

Norfolk and Suffolk 

NHS Foundation Trust

Research and Development  
The Knowledge Centre  
Hellesdon Hospital  
Drayton High Road  
Norwich  
NR6 5BE

Telephone 01603 421255

E mail: [RDofficemailbox@nsft.nhs.uk](mailto:RDofficemailbox@nsft.nhs.uk)

Miss Celine Webb  
Trainee Clinical Psychologist  
University of East Anglia  
PGR Office  
Elizabeth Fry Building  
University of East Anglia  
Norwich  
NR4 7TJ

21<sup>st</sup> October 2013

Dear Miss Webb,

**Re: 2013MH25 Clinicians experiences of the therapeutic alliance in telephone CBT**

Thank you for submitting the above project for local research governance approval. I am pleased to inform you that your project has been given full approval and you may begin your research at the following site:

- Norfolk & Suffolk NHS Foundation Trust

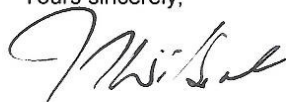
I have enclosed two copies of the Standard Terms and Conditions of Approval. Please sign both copies returning one copy to the Research and Development office, at the above address, and keeping the other in your study file. Failure to return the standard terms and conditions may affect the conditions of approval. **Under the agreed Standard Terms and Conditions of Approval you must inform the R&D department of any proposed changes to this study and submit annual progress reports to the R&D department.**

Any researcher(s) whose substantive employer is not the Norfolk & Suffolk NHS Foundation Trust must have a Letter of Access or Honorary Research contract and evidence of Good Clinical Practice (GCP) training before coming on site to conduct their research in this project. Please note that you cannot take part in this study until you have this documentation. If a Letter of Access / Honorary Research Contract has not been issued – please contact us immediately.

If you have any queries regarding this or any other project, please contact, Tom Rhodes, Research Facilitator, at the above address.

The reference number for this study is: **2013MH25**, and this should be quoted on all correspondence.

Yours sincerely,



**Dr Jon Wilson**  
Deputy Medical Director (Research)



Chair: Gary Page  
Acting Chief Executive: Andrew Hopkins  
Trust Headquarters: Hellesdon Hospital,  
Drayton High Road, Norwich, NR6 5BE  
Tel: 01603 421421 Fax: 01603 421440 [www.nsft.nhs.uk](http://www.nsft.nhs.uk)





**Appendix L**  
**Letter of R&D Approval from CPFT**

Cambridgeshire and Peterborough   
NHS Foundation Trust

*Understanding children, young people and families*

**Research and Development Department**

Joint Research Office  
Box 277  
Addenbrooke's Hospital  
Hills Road  
Cambridge  
CB2 0QQ

Direct Dial: 01223 596472 ext 6472  
E-mail: [beth.muldrew@cpft.nhs.uk](mailto:beth.muldrew@cpft.nhs.uk)  
[www.cpft.nhs.uk](http://www.cpft.nhs.uk)

10 October 2013

R&D Ref: M00566

Dr James Clarke  
IAPT Team Manager  
Cambridgeshire and Peterborough  
NHS Foundation Trust  
Union House, 37 Union Lane  
Chesterton  
Cambridge CB4 1PR

Dear Dr Clarke

**Re: Clinicians' experiences of the therapeutic alliance in telephone CBT**

In accordance with the Department of Health's Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opinion from an ethics committee and approval from the Department of Research and Development (R&D) prior to commencement.

R&D have reviewed the documentation submitted for this project, and has undertaken a **site specific assessment** based on the information provided in the SSI form, and I am pleased to inform you that we have no objection to the research proceeding within CPFT.

**Sponsor: University of East Anglia**

**Funder: University of East Anglia**

**End date: 03/02/2014**

**Protocol: Version dated 30 August 2013**

**Conditions of Trust Approval:**

- The project must follow the agreed protocol and be conducted in accordance with all Trust Policies and Procedures especially those relating to research and data management. Any mobile devices used must also comply with Trust policies and procedures for encryption.
- You and your research team must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998 and are aware of your responsibilities in relation to the Human Tissue Act



HQ Elizabeth House, Fulbourn Hospital, Cambridge CB21 5EF.  
T 01223 726789 F 01480 398501 [www.cpft.nhs.uk](http://www.cpft.nhs.uk)

A member of Cambridge University Health Partners

2004, Good Clinical Practice, the NHS Research Governance Framework for Health and Social Care, Second Edition April 2005 and any further legislation released during the time of this study.

- Members of the research team must have appropriate substantive or honorary contracts with the Trust prior to the study commencing. Any additional researchers who join the study at a later stage must also hold a suitable contract.
- You and your research team must provide to R&D, as soon as available, the date of first patient first visit.

**If the project is a clinical trial under the European Union Clinical Trials Directive the following must also be complied with:**

- the EU Directive on Clinical Trials (Directive 2001/20/EC) and UK's implementation of the Directive: The Medicines for Human Use (Clinical Trials ) Regulations 2004;
- the EU Directive on Principles and Guidelines for Good Clinical Practice (EU Commission Directive 2005/28/EC); and UK's implementation of the Directive: The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006;

#### **Amendments**

Please ensure that you submit a copy of any amendments made to this study to the R&D Department.

#### **Annual Report**

It is obligatory that an annual report is submitted by the Chief Investigator to the research ethics committee, and we ask that a copy is sent to the R&D Department. The yearly period commences from the date of receiving a favourable opinion from the ethics committee.

Please refer to our website [www.cpft.nhs.uk](http://www.cpft.nhs.uk) for all information relating to R&D including honorary contract forms, policies and procedures and data protection.

Should you require any further information please do not hesitate to contact us.

Yours sincerely



pp Stephen Kelleher  
Senior R&D Manager

Cc Sue Steel, Contracts Manager, University of East Anglia