

**Enhancing Psychotherapy for People with Psychosis by Understanding the Experiences  
and Attitudes of the Psychologist**

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### Statement of Originality

*This dissertation contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and to the best of my knowledge and belief contains no material previously published or written by another person accept where due reference has been made in the text. I give consent to this copy of my dissertation when deposited in the university library, being made available for loan and photocopying subject to the provisions of the copyright act 1968.*

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### **Statement of Authorship**

*This dissertation contains a manuscript for which I am a joint author. I made a significant contribution to the development of the research reported in the paper, as well as the writing of the manuscript.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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## Abstract

**Scope:** This thesis reviews and extends on research demonstrating that the combination of psychotic and substance use disorder presents treatment services and providers with a unique set of complexities. Treatment challenges in relation to engagement, alliance and retention are explored. A critical review of the relevant literature as well as manuscript prepared describing the study arising from this review is provided.

**Purpose:** The purpose of the current study is to better understand the experience of the treating psychologist when working with individuals with co-existing substance use and psychosis, with the aim of improving future therapeutic relationships.

**Methodology:** The study employed a qualitative methodology with an Interpretative Phenomenological Approach (IPA). We recruited psychologists working on an ongoing research trial, the Healthy Lifestyles Program (HLP), and conducted an in-depth qualitative analysis of their attitudes and impression of delivering face-to-face and telephone-based treatment to people with psychosis and nicotine dependence.

**Results:** Six psychologists were involved in the study, describing their experience of providing the HLP treatment to this population. Several themes emerged and according to IPA were categorised into superordinate and subordinate themes. The superordinate themes which emerged as central to the experience of HLP therapists included: the complex and unusual experience of working with people with psychotic illness, the importance of considering each client as an individual, and the many layers of interaction between therapist and client.

**Conclusions:** The current study highlights some important professional considerations for psychologists working with people experiencing psychotic illness.

Psychologists in our study expressed that alliance was a critical component of the likelihood of a successful therapeutic relationship and outcome. Our study substantiated what has been found in previous research; that stigmatising beliefs may act to hamper the relationship when working with this group. Although, psychologists expressed that they were mostly able to overcome this and establish a good working relationship, alliance, and connection, despite the complexities and challenges inherent in a psychotic population by the very nature of their symptoms and clinical presentation. Also, psychologists endorsed the potential for integrating a strong relationship, with a structured evidence-based treatment package, potentially utilising alternative treatment modalities (e.g. telephone) to traditional in-person approaches, although some concerns were raised about how this could be achieved. Along with this, psychologists in the current study indicated that processes of transference and counter transference are important clinical considerations for a psychologist developing relationships within this population.

**Implications:** The importance of appropriate training, reflective practice, clinical experience and ongoing supervision when working with people with psychosis and nicotine dependence is implicated. Further work is also required to determine the client perceptions of treatment offered within the HLP and other treatment programs for people with psychosis, along with both client's and therapist's impressions and experiences of treatment delivered via the telephone.

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## **Enhancing Psychotherapy for People with Psychosis and Substance Use by Understanding the Experiences and Attitudes of the Psychologist**

Psychotic disorders are considered the most debilitating of mental disorders (Jobe & Harrow, 2010). Those diagnosed with a psychotic disorder are consistently found to have poorer quality of life, higher burden of disease and reduced life expectancy (Gureje, Herrman, Harvey, Morgan & Jablensky, 2002; Goldner et al., 2002; Jobe & Harrow, 2010). Despite considerable development in evidence based treatments, it remains difficult to engage people with psychotic disorders in therapy and there is a trend for early discontinuation of treatment and poor treatment response (Nose, Barbui, Gray & Tansella, 2003). Co-morbidity of substance use in psychotic clients may extenuate barriers to treatment, linked with poorer treatment retention, engagement and response (Lambert et al., 2005 and Meier, Barrowclough & Dronmal, 2005).

The identified barriers to effective treatment delivery are weighted heavily on factors relative to the client, due primarily to a focus in research on client perspectives in treatment, with less investigation into the role of the therapist (Ackerman & Hilsenroth, 2003). While we know that the therapeutic relationship is critical to the outcome of therapy (Horvath & Symonds, 1991; Horvath, 1994; Horvath, Del Re, Fluckiger & Symonds, 2011 and Lambert & Barley, 2001), the influence of the therapist's attitudes, orientation and expectations is not as well understood (Horvath & Bedi, 2002). Current discussion about the therapeutic relationship has moved toward understanding how factors combine and interrelate to produce an outcome (Norcross and Lambert, 2011). It is suggested that exploring and understanding the synergy between the client, the therapist and the treatment outcome provides the most meaningful clinical information (Norcross, 2011; Norcross & Wampold, 2011). The purpose of this review is to explore various elements relevant to the treating clinician's capacity to

develop the therapeutic relationship and deliver treatment to people with a psychotic and substance use disorders.

### **The client, the therapist and the treatment**

Without doubt, factors relative to the client, the therapist and the treatment method will influence the outcome of therapy (Norcross, 2011; Norcross & Lambert 2011 and Norcross & Wampold, 2011). In the past, research has tended to rival these components, as if in a competition for importance and most significant contribution to treatment success (or failure). Norcross & Lambert (2011) summarised the results of a task force commissioned by the American Psychological Association, aimed at promoting rapprochement between advocates of evidence based treatment and supporters of the primacy of the therapeutic relationship. The outcome of this review promoted the significance of the therapy relationship, as well as endorsing that therapy must be adaptive to client characteristics and at the same time be integrated with evidence based treatment. They suggest that it is only through this integration that we can endeavor to provide the most efficacious psychological support to clients. This may be particularly important when working with complex clients groups such as people with psychosis, where unique relational aspects to treatment exist (Servais & Saunders, 2007) and there continues to be a struggle to develop and deliver evidence based treatments (Nose, Barbui, Gray & Tansella, 2003).

### **Psychosis and the therapeutic relationship**

The nature of psychotic symptoms may mean that from the outset there are additional challenges to the development of a sound alliance. Wright, Turkington, Kingdon & Basco (2009), outlined 15 primary client factors which may interfere with the therapeutic relationship, these included; paranoia, hostility, catatonia, hallucination, lack of insight, somatic delusions, hopelessness, low energy, grandiosity, impulsivity, social withdrawal,

thought disturbance, cognitive impairment, substance misuse and pre-existing relationship difficulties. As the majority (if not all) of these symptoms and behaviours form part of the defining or secondary features of most psychotic disorders, the establishment of a strong working relationship may be especially challenging within this population. It is important to note that even in the less acute phases of illness, many of these symptoms (particularly 'negative symptoms' like cognitive impairment, hopelessness, low energy and social withdrawal), will be ongoing for clients and will require understanding and facilitation in treatment, in order to reduce this barrier to alliance.

### **Substance use, psychosis and the therapeutic relationship**

Alliance may also be particularly important in treatment for people with substance misuse and psychiatric comorbidity (Petry & Bickel, 1999). In a large review of substance use treatment literature, Meier, Barrowclough & Dronmal, 2005, found that early alliance is a consistent predictor of engagement, retention and treatment response for substance users currently in treatment, with client factors such as motivation, treatment readiness and positive previous treatment experiences, impacting on alliance. Specifically examining alliance in co-existing psychosis and substance use, Barrowclough, Meier, Beardmore & Emerlsy, (2010), found that symptom severity and substance use measures were both unrelated to alliance. This is in contrast to earlier research, indicating that opioid use increases difficulty in retaining clients with comorbid psychiatric illness (Petry & Bickel, 1999). Given the limited and inconsistent information about factors contributing to alliance in people with coexisting substance use and psychosis substance using populations, as well as the frequency of comorbidity and the potential for both to impact negatively on the development of sound alliance, further investigation into factors contributing to alliance is required.

### **Therapeutic alliance and outcome**

Development of a sound therapeutic relationship is a critical component of treatment success (Martin, Garske, and Davis, 2000 and Lambert & Barley, 2001). Therapeutic alliance, which refers to the “collaborative and affective bond between therapist and client” (Martin, Garske & Davis, 2000; pg 441), is consistently found to be strongly related to therapy outcome, across different clinical populations and treatment orientations (Barber et al., 2000; Castonguay, Constantino, Holtforth, 2006; Horvath & Symonds, 1991, Lambert & Barley, 2000; Meier, Barrowclough & Donmall, 2005).

In a recent meta-analysis, Martin, Garske, and Davis (2000) examined 79 studies exploring alliance and outcome. They reported the association between the therapeutic alliance and outcome is moderate ( $r = .22$ ) and is consistent and independent of outcome measure used and type of treatment. The authors also concluded that the strength of the alliance is predictive of outcome.

Using a similar sample of studies, Lambert and Barley (2001) conducted a large review of psychotherapy outcome literature; including research controlled trials and meta-analytic reviews, and again concluded a reliable relationship between alliance and outcome. They deduced that common factors such as; empathy, regard, warmth and the therapeutic relationship account for about 30% of client improvement. There are some important limitations to this review when considering the importance of alliance for people with psychosis and co-existing substance use. It should be acknowledged that the majority of studies reviewed by Lambert & Barley examined the role of alliance in the treatment of mental illness such as depression, anxiety, or eating disorders. Also, the authors did not report the actual statistical associations, so results cannot be directly compared to previous or future research. Furthermore, a criticism of this early research was the failure to account for individual variability within the clients and therapists participating in the study (Baldwin, Wampold, & Imel, 2007).

Baldwin, Wampold, & Imel (2007), investigated the relationship between therapeutic alliance and treatment outcome in a more systematic and sophisticated manner than conducted previously. The researchers used multilevel modelling to map the path between variability within the client and variability within therapists (according to self rated working alliance). Their results indicated that only the therapist's variability in alliance scores predicted outcome, such that those with consistently higher working alliance scores across patients, produced better treatment outcomes. The authors concluded that a client experiencing a poor relationship with his/her therapist would likely have achieved a better outcome with a therapist who generally forms better alliances. This research utilised a large database of therapeutic relationships (331 clients seen by 80 therapists); treatment was conducted in natural clinical settings, and alliance was measured with an empirically validated tool (the client-rated Working Alliance Inventory; WAI; Horvath & Greenberg, 1989). The results provide further and more conclusive support for the critical importance of alliance and the key role of the therapist in developing the therapeutic relationship. Client diagnoses were not considered in this study, so again relevance to specific populations cannot be discerned.

Further developing our understanding of alliance, researchers have begun investigating the specific characteristics associated with the development of the therapeutic relationship. There is consensus that both technical and relational aspects contribute to the development of the alliance (Horvath, 1994; Horvath & Symonds, 1991; Martin, Garske & Davis, 2000; Hillard, Henry & Strupp, 2000), although technical factors have been significantly favoured in terms of research focus. This is possibly because these factors are easiest to measure directly. Research is also weighted heavily on factors relative to the client and how they contribute to alliance, with much less investigation into the role of the therapist (Constantino, Castonguay & Schut et al, 2001 and Ackerman & Hilsenroth, 2003).

In an attempt to rectify this, Ackerman and Hilsenroth conducted a systematic literature review of therapists' personal attributes and in session activities, and how they influence the therapeutic alliance (Ackerman & Hilsenroth, 2001, 2003). In the initial review, the authors explored factors contributing to poor alliance, followed later by investigation of positive factors contributing to alliance. Each review was conducted with the same methodological approach, using extensive search methods (electronic search through PsycLIT search engine as well a manual search for relevant references in the articles from the initial search and manual review of recent studies published in key journals), and a focus of specific search criteria "the relationship between therapist personal attributes of technical activity and alliance" (Ackerman & Hilsenroth, 2001, 2003). The reviewers indicated that therapist characteristics as perceived by the client, such as being flexible, open, honest, respectful, trustworthy, confident, warm and interested, contribute positively to alliance. While therapist characteristics such as being critical or distant, will contribute to a poor alliance (Ackerman and Hilsenroth, 2001). In both studies the authors found little variation in positive or negative outcome according to treatment orientation. A limitation of this research is the measurement of alliance at specific time points. This is a common problem with alliance research, and does not account for the dynamic and evolving client/therapist relationship. Along with this, their research did not consider the differences across clinical populations. There are known differences in the attitudes and perceptions of health professionals across clinical groups (Jorm, Kurten, Jacomb, Christenson & Henderson, 1999; Naeem et al, 2006 and Nordt, Rossler & Lauber, 2006) and this may have important and unobserved implications for the generalisability of findings, for example, to people with psychosis.

As there is little agreement about how best to measure alliance, all studies reviewed to date have attempted to quantify factors contributing to alliance, using a variety of structured



questionnaires or the labelling of specific factors. This quantification of measurement of alliance continues to limit this field of research, although indicating the strength of the relationship between alliance and outcome, it fails to provide an understanding of the complexity and depth of the client and therapist interaction (Goldfried & Davila, 2005).

While the importance of considering unique factors is acknowledged, exploring alliance as a mutual ongoing process, whereby a number of factors interrelate would provide more meaningful clinical information (Goldfried & Davila, 2005). Practically, this may mean that research needs to move toward qualitative analysis of the therapeutic relationship in order to better understand the complexity of the experience and the relationship. Another important implication is that examining alliance at discrete time points (as is required for quantitative analysis) may result in failure to recognise both the complex and evolving nature of alliance. A qualitative or extensive longitudinal approach may better account for this, providing a richer analysis of alliance as relationships develop across time. Further a sample, which allows consideration of the role of alliance specific to clinical populations, will provide important clinical information and improve capacity for tailoring treatment provision.

### **The psychological relationship**

The role of alliance in treatment outcome, although important across multiple fields of health care provision, is considered most crucial to the role psychologist (Orlinsky, Ronnestad, Willutski, 2004). Largely, research investigating the role of alliance explores psychotherapeutic relationships and outcome (e.g. Ackerman & Hilsenroth, 2001, 2003) reflecting a focus on the psychologist. As it is considered intrinsic that the psychologist have a capacity for engaging, empathising and collaborating with the client, it is particularly relevant to continue to explore alliance within this field.

### **Barriers to alliance and treatment development for schizophrenia**

**Professional stigma and schizophrenia.** In conjunction with the numerous symptoms and behaviors' associated with psychosis which are considered barriers to alliance, therapist attitudes may also influence treatment seeking and prevent a strong therapeutic relationship (Jorm, et al, 1999; Caldwell & Jorm, 2001; Nordt, Rossler & Lauber, 2006 and Servais & Saunders, 2007). It is suggested that increased stigma associated with psychotic disorders is a potential barrier to the development of alliance, in relation to the self-stigma experienced by the client (Corrigan, 2004) and also the stigmatising attitudes of the treating professional (Jorm, et al., 1999; Caldwell & Jorm, 2001; Nordt, Rossler & Lauber, 2006 and Servais & Saunders, 2007). This is a relatively new area of empirical research requiring further and much deeper exploration before it is clearly understood, particularly in relation to the psychologist.

Australian researcher Anthony Jorm and his colleagues conducted several surveys investigating the beliefs of mental health professionals and the general public in relation to treatment prognosis and experience of discrimination for people with depression or schizophrenia (Jorm, Korten, Jacomb, Christenson, Rogers & Pollit 1997a; 1997b; 1997c; 1997, Jorm et al., 1999, Caldwell & Jorm, 2001). These extensive research studies examined the beliefs of 702 clinical psychologists, 1580 psychiatrists, 1495 general practitioners and 980 mental health nurses. The authors found that professionals generally held poorer attitudes and expectancies in relation to treatment response and long term prognosis than the general public, for individuals suffering from psychosis. This was less pronounced for clinical psychologists, yet all health professionals were more likely than others to believe that people with schizophrenia would be discriminated against. The authors did not investigate specific attitudes or beliefs, or how attitudes and expectations may interfere with the delivery and outcome of treatment.

Similar trends have also been demonstrated cross culturally (Naeem et al, 2006 and Nordt, Rossler & Lauber, 2006). Nordt, Rossler & Lauber (2006), investigated professional attitudes and stigmatization in employees of psychiatric inpatient and outpatient facilities across Switzerland. The authors compared the knowledge and attitudes of 1073 mental health professionals with 1737 members of the general public. Nordt and his colleagues found that health professionals were less likely to accept social restrictions (e.g, restrictions on the right to vote) for people with a mental illness than the general population, yet they held more stigmatising attitudes in relation to social functioning (such as capacity to engage in employment). Along with this, the authors found that professionals demonstrated increased feelings of social distance from people with schizophrenia, in comparison to those with other mental illnesses. Social distance is the proximity one desires between oneself and another person in a social situation (Baumann, 2000 and Marie & Miles, 2008). Low social distance has been described as contributing to feelings of commonality, or belonging to a group, based on the idea of shared experiences, whereas, high social distance implies that the person is separate, a stranger, or an outsider (Baumann, 2007). As social distance is a key component of the process of stigmatisation (Marie & Miles, 2008), this is both relevant and concerning. The study did not report independently on the attitudes of psychologists, but rather grouped psychologists with a broad range of other health professionals working in the field of mental health, including; general practitioners, psychiatrists vocational workers, social workers and physiotherapists.

Specifically examining the attitudes of clinical psychologists, Servais & Saunders (2007) found that psychologists harbor more negative attitudes toward people with psychosis in comparison with other client groups. Surveying 306 psychologists, they examined perceived effectiveness of treatment, understandability of client group, safety in presence of client, client worthiness, desirability to work with clients and similarity of themselves (to

specific client groups). Compared across clinical groups (moderate depression, borderline features and schizophrenia) as well a non-clinical sample, they found significant differences in attitudes and perceptions across groups. Most pronounced differences included difficulty with identification and feelings of social distance, from people with borderline features and schizophrenia. The authors also found that psychologists viewed themselves as least effective in relation to working with people with schizophrenia and most dissimilar from people with schizophrenia.

What these studies imply is that although health professionals, including psychologists, are generally expected to have more positive attitudes toward people with a mental illness, this seems not to be the case. In fact, in certain clinical populations such as psychotic disorders, research reflects poorer attitudes and increased stigmatization (e.g. Servais & Saunders, 2006). This somewhat unexpected finding may be considered in the context of Social Contact Theory (Allport, 1954), which for many years has guided our understanding of the processes of stigmatization. Social Contact Theory stipulates that under appropriate conditions interpersonal contact reduces prejudice between majority and minority group members, proposing that communication between groups allows understanding and appreciation and hence diminished stigma (Allport, 1954).

In the context of this theory, we would expect that health professionals, in comparison to the general public, with their increased experience, contact and knowledge of people with psychosis, ought to harbour less stigmatising attitudes. Allport states that in order for a reduction in stigmatising beliefs to occur, equal status, common goals, and relationship potential reconceptualisation is required, perhaps highlighting why there are difficulties noted by professionals in working with people with mental health problems. The studies reported above did not give an indication of the amount of contact the health professionals had working with people with psychosis. Due to the relatively small number of people who

experience psychotic illness it is possible that many of the professionals investigated had a limited experience in the field, particularly specific contact with clients. Another possibility is that professionals who had experienced contact or provided treatment for people with psychotic disorders did not experience the “reconceptualisation” required for reduced stigma, which would have been made all the more difficult by the very nature of the symptoms of psychosis. Servais and Saunders (2007) suggest that current diagnostic characteristics lead psychologists to focus on negative evaluations. They contend that what may occur to maintain stigma is that a clinical process of problem identification and symptom identification (such as risk assessment for likelihood of harm to self and others) may result in the confirmation rather than disconfirmation of negative attitudes (Servais & Saunders, 2007). In addition to this, psychologists consistently reported social distance and difficulty personally identifying with people with psychotic disorders, both key elements of the reconceptualisation process required for a reduction in stigma.

In order to address stigma and its relationship with alliance, future research should aim to develop a deeper understanding of how and where stigma exists amongst professionals who provide treatment to people with psychosis, particularly psychologists and how this is influenced by the experience of working with this client group. Through better understanding the experience of the psychologist, we can gain a more accurate understanding of how stigma influences the therapeutic relationship and how it can be overcome to improve the provision of treatment.

### **Attitudes, alliance and telephone therapy for people with psychotic disorders**

Due to the persistent difficulty in engaging and retaining clients with psychotic disorders in treatment (Nose, Barbui, Tansella & Gray, 2003), different ways of reaching those in need should also be considered. Telephone therapy is an emerging means for the

delivery of psychological treatment (Mohr, Siddique, Ho, Duffecy, Jinh, & Fokuo, 2010; VandenBos & Williams, 2000) and many benefits of incorporating multi-media technology into psychotherapy practices have been identified. These include; greater cost-effectiveness and time efficiency; increased likelihood of clients disclosing sensitive information due to greater anonymity and increased access to treatment for geographically remote or isolated clients (Emmelkamp, 2005). Despite this, there is some suggestion that doubts about the capacity to develop a strong therapeutic alliance with clients over the telephone may contribute to reluctance in extending this field of research (Newman, 2003). As well, risks that have been identified as associated with telephone therapy may perpetuate concern amongst clinicians about the safety and appropriateness of this form of treatment delivery, particularly in relation to clients with severe or complex presentations such as with people with psychosis.

Initial investigations into the risks and benefits of psychotherapy by telephone, identified some concerns in relation to safety, efficacy and ethical obligations (Hass, Bendeict & Kobos, 1996). Hass and his colleagues conducted a review of existing literature exploring telephone therapy as an adjunct to treatment as well as sole treatment. From their review, the authors concluded that the efficacy of past treatments has been poorly reported and cannot provide conclusive evidence of benefit. It is unclear how many studies the authors reviewed or if a systematic search of the literature was made. Also, the focus of the study included psychotherapy provided in a national “pay-per-call therapy service”, conducted in the late eighties and early nineties across America. The legitimacy of treatment and its delivery in this manner, remains in question and this method of research does not really allow for a thorough investigation of benefit by modality. The authors identified certain risks associated with telephone treatment, specifically; increased potential for violation of client privacy and decreased opportunity for responding to clients in a crisis

situation. However, these risks were stated without any evidence of appropriate comparison with traditional modes of treatment and any substantiation of increased risk.

Despite the limitations of this research review, the ideas raised reflect what appears to be the general view at the time, that is, that not enough is known about telephone therapy to merit its use, particularly with high risk clinical populations, such as those experiencing a psychotic disorder. Recent research has analysed the efficacy of telephone treatment in a much more transparent and systematic manner and found conclusive evidence of benefit in certain populations (Tutty, Spangler, Poppleton, Ludman, & Simon, 2010; Rollman et al., 2005; Roy-Byrne et al., 2005 & 2010). There is substantial evidence that telephone delivered psychotherapy can improve symptoms of depression (Tutty, Spangler, Poppleton, Ludman, & Simon, 2010) and anxiety (Rollman et al., 2005; Roy-Byrne et al., 2005 & 2010). To date there remains little investigation into the treatment of psychotic illness. It may be that some of the difficulties in establishing therapeutic alliance between people with psychosis and their therapist such as concerns about safety in presence of the client, as well as identification with the client may be addressed through increased use of this modality, although further investigation is required.

Day & Schneider (2002) conducted a comparison of a specific psychotherapy (cognitive behavioural therapy, CBT) across modalities of treatment. Three modes of treatment delivery including; face-to-face, telephone and video were compared in relation to therapeutic alliance (using a previously validated measure; the Vanderbilt Psychotherapeutic Process Scale [VPPS]; Strupp, Hartley & Blackwood, 1974) as well as treatment outcome (measured by symptom change, satisfaction level & problem resolution). In a sample of 80 participants who were clients presenting at a community support centre with range of difficulties (mild to average severity of symptoms), the authors found no difference in treatment outcome across the modalities. In relation to alliance, they found better alliance for

the telephone and video treatment condition, which in a sub-analysis, was accounted for by increased client participation in treatment. Interestingly, the telephone group were still required to attend the community centre in order to increase control over the research design. This means that some of the more accepted benefits of telephone delivery, such as ease of reaching remote and rural clients, affordability and convenience, were yet to show influence on treatment outcome. These results clearly support development and increased consideration of distance technology in psychotherapeutic practice. As the sample did not account for specific diagnosis and was represented largely by participants with less severe problems, results may not be applicable to more complex client groups.

Tutty and colleagues (2005) examined the benefit of telephone therapy for people experiencing depression. Six hundred participants were assigned to treatment either via telephone, face-to-face case management, or “treatment as usual”. Their outcome measure did not include any specific measurement of reduction in symptoms, but reflected client satisfaction with treatment. Participants were asked about their satisfaction and preference for treatment and 64% stated that they preferred the telephone treatment. This gives some indication that clients are receptive to and satisfied with telephone treatment, building confidence in use of telephone treatment despite lack of comparison with other modalities of treatment. Through use of a more commonly accepted measure of efficacy (such as symptom reduction or improved quality of life), as well as comparison with other modes of treatment delivery, this research may have been more effective in promoting the benefits of telephone therapy.

Following from this, Mohr and his colleagues (2002) compared the efficacy two psychological treatments delivered via the telephone to people with multiple sclerosis and co morbid depression. One hundred and twenty participants were assigned to three treatment groups; telephone administered cognitive behavioural therapy (CBT), telephone administered



supportive counselling and no treatment. Both telephone treatments produced significantly greater change than the control treatment. This suggests that telephone therapy is of benefit to this client group independent of the type of therapy used. Again, this study did not compare the benefits of telephone treatment in comparison to face- to -face or other modalities making it somewhat less influential in promoting its use.

In addition to this study, Mohr and colleagues (2010) later conducted a large review of studies examining different treatment modalities and found that treatment via the telephone and internet can be effective across several areas of mental health. However, they reported that the evidence base for efficacy is small, particularly outside of field of mood disorders (Mohr et al, 2010). With relevance to depression, it is proposed that telephone based treatment can be more cost effective, improve treatment adherence and more readily engage clients who are reluctant or unable to attend clinical settings (Mohr et al., 2010).

Research examining the use of telephone treatments for people with a psychotic disorder is very limited and generally focuses on telephoning as an adjunct to treatment (Mohr et al, 2010). A large randomised control trial examined the use of telephone therapy as a component of treatment for people experiencing their first psychotic episode (Peterson et al., 2005). Results indicated that the telephone integrated treatment improved clinical outcomes, both in the short and long term, whilst also improving treatment adherence (Peterson et al, 2005). Two smaller studies examined the use of teleprompting to assist with psychotropic medication compliance, also yielding positive outcomes (Beebe, 2001; Frangou et al., 2005). To our knowledge these are the only studies to examine the use of telephone interventions for individuals with a psychotic disorder. It is proposed that this is a significant gap in the literature, as people with psychosis are known to be amongst the poorest compliers to treatment and the most difficult to engage in regular psychotherapy (Nose, Barbui, Gray &

Tansella, 2003). Extending the evidence base for telephone treatment within this population may assist to reduce barriers for effective treatment.

Although telephone counselling now appears to be a more accepted (and sometimes preferred) mode of treatment for clients (Reese, Collie, Connolly, Daniel, 2005), little is known about the psychologists' corresponding attitudes and opinion. This is a problem, as ultimately it is the treating professional who decides on a course (and modality) of treatment, once a client presents for assistance. What is known seems to reflect uncertainty, reluctance and lack of support for this modality (Newman, 2004), which is clearly indicated in the lack of research in this field. No studies have directly examined the psychologist's perception of the benefit of phone treatments, however it has been noted that psychologists are initially uncomfortable with the idea of using technology for therapy (Newman, 2004).

Studies examining attitudes toward a broad range of innovative non face-to-face treatments, demonstrate that psychologists are reluctant to use technologies, due to concern they may interfere with the therapeutic relationship or increase attrition rates (Newman, 2004, Cook & Doyle, 2002; Emmelkamp, 2005). As therapeutic alliance is crucial to psychological treatment and is known to be a consistent predictor of therapeutic benefit (Ackerman & Hilsenroth, 2003, Crits-Christop & Connolly, 1999, Horvath and Symonds, 1991, Constantino, Castonguay & Schut, 2002; Marziali & Alexander, 1991, Martin, Garske, & Davis, 2000; Waddington, 2002) it is understandable that this perception promotes reluctance and apprehension amongst professionals. It is important to further explore these concerns, particularly in relation to working with people with psychosis via the telephone, where it appears unease may be most pronounced. Along with this, it is within this client group that telephone treatment could have considerable benefit given its potential for addressing some of the known barriers to treatment access for people with psychosis. These include: client reluctance or difficulty attending face to face appointments and client fear of

stigmatisation related to accessing mental health services (Appel & Oldak, 2007).

Progressing this field of research and understanding psychologists' attitudes and perceptions will assist us to ensure that treatment innovation is not hindered by misguided negative beliefs and the potential benefits in relation to treatment reach and accessibility can be fully realised and understood.

### **Provision of treatment using a structured manual**

It is often disputed that the results of research treatment programs fail to have “real world” significance and a capacity for being replicated in clinical settings (List, 2006).

Along with this, the structured and manualised nature of treatment in most research trials is identified by psychologists as limiting and a challenge for the therapeutic relationship (Addis & Krasnow, 2000). On the other hand, others endorse the use of manual based treatment in a belief that they help to promote evidence-based practice (EBP) (Addis & Krasnow, 2000).

Professional attitudes seem to reflect what has been a longstanding theme in the literature that the therapeutic relationship and use of EBP stand in opposition (Norcross & Lambert, 2011).

As we move toward an integrated focus between the therapeutic relationship and the provision of EBP, it is important to further consider psychologists' attitudes, experience and perceptions of this type of treatment delivery.

Addis and Krasnow (2000) surveyed eight hundred and ninety one practicing psychologists across Australia, regarding their attitude toward the use of treatment manuals. Psychologists were practicing in various therapeutic orientations, with a range of clinical experience. There was a strong endorsement of the notion that manualised treatment impinges on the development of the therapeutic relationship, despite promoting empirically supported intervention. This is the only study to our knowledge to examine psychologists' attitudes toward manualised treatment and while it has implications for research interventions, it does not explore the range of experiences and attitudes associated with

working within a research program. Also, because the survey was designed to examine specific attitudes it is difficult to gain a thorough understanding of the how attitudes and perceptions interact. Furthermore, a weakness of this research is the poor response rate (30%) and small number of participants with experience working within manual based treatment may mean that the results may not generalise well in clinical setting and may not adequately reflect attitudes of those with experience in such treatments. Further examination of how attitudes vary according to the context of treatment delivery, will broaden the scope of understanding the psychologists' experience and capacity to deliver treatment and how this interacts with alliance.

### **Healthy Lifestyles Program for people experiencing Psychotic Illness and Nicotine Dependence**

The Healthy Lifestyles Program (HLP) is a health behaviour intervention targeting cardiovascular risk in individuals with a psychotic disorder and comorbid substance use problems, in this case, nicotine dependence (Baker et al., 2011). Treatment within the HLP involves psychologists providing a structured, manual-guided intervention, designed around principles of motivational interviewing and cognitive behavioural therapy, as well as monitored provision of nicotine replacement therapy. Participants in the program are randomly assigned to one of two conditions; face-to-face treatment or a telephone-based control condition. HLP aims to compare the relative efficacy of the treatments in reducing cigarette smoking, improving diet and exercise, and in doing so, reduce the participant's overall cardiovascular risk profile (Baker et al., 2011). This extensive research program offers an avenue for exploring many of the factors highlighted as relevant to the development of treatment provision and therapeutic alliance when working with people with psychosis and substance use problems. HLP provides the opportunity to recruit psychologists who have had significant experience working with people with psychosis, allowing for a thorough

exploration of their attitudes and perceptions. Along with this, it facilitates the comparison of therapists' experiences of different modalities of treatment delivery, due to the face-to-face and telephone treatment designs. HLP being a research-based intervention, utilising a structured treatment manual, will also allow for the exploration of psychologists' experiences in this context; one that may potentially affect the development of a good therapeutic relationship. In particular, the HLP research project enables an exploration of how psychologists perceive the integration of evidence-based practice with the development of a strong therapeutic relationship.

Examining psychologists' perceptions of a broad range of contributors to the therapeutic relationship will enhance and integrate our understanding of providing treatment of psychosis. Specifically, exploring the psychologists' perceptions of working with this client group and their awareness of stigmatising attitudes or other barriers to alliance, as well as their attitudes toward aspects of treatment delivery, will enhance and broaden our understanding of treatment provision. As suggested by Norcross and Lambert (2011), research must move toward identifying and understanding all elements of an effective relationship and how these combine into an 'evidence based relationship'. It is through understanding, identifying and calling professionals to reflection that we can move toward addressing the poor treatment response and ongoing relationship development required to improve outcomes for those experiencing a psychotic illness.

### **The importance of a qualitative approach**

There is little agreement about how best to measure alliance, and the majority of research in this area has attempted to quantify factors contributing to alliance using a variety of structured questionnaires or the labelling of specific factors. Although this approach has enabled a strong relationship between alliance and outcome to be established, continuing to

quantify alliance is a limitation of existing research, as it fails to provide an understanding of the complexity and depth of the client and therapist interaction (Goldfried & Davila, 2005). While the importance of considering unique factors is acknowledged, exploring alliance as a mutual ongoing process, whereby a number of factors interact, would provide more meaningful clinical information (Goldfried & Davila, 2005). Practically, this may mean that research needs to move toward qualitative analysis of the therapeutic relationship in order to better understand the complexity of the experience and the relationship. Another important implication is that examining alliance at discrete time points (as is required for quantitative analysis) may result in failure to recognise both the complex and evolving nature of alliance. A qualitative approach therefore may better account for this, providing a richer analysis of alliance as its development is recalled or monitored across time.

## **IPA**

IPA is the most common qualitative approach used in psychology (Biggerstaff & Thompson, 2008). Although historically established in health psychological research, IPA is emerging as a respected method for psychological research across several fields of psychology (Biggerstaff & Thompson, 2008). Influenced by phenomenology, IPA acknowledges both the existence of individual differences in ways of thinking, as well as the impact of human interaction and wider contextual factors (e.g. culture, environment) upon the individuals' views of the world and meanings that they ascribe to their experiences (Shaw, 2001; Smith, 1995). This approach contrasts with other qualitative methods, e.g. discourse analysis, which focus on the role of language used by people to describe their experience. Thus IPA is considered especially suited to studies that aim to relate findings to psychosocial theories that dominate current thinking within the healthcare professions (Biggerstaff & Thompson, 2008).

As a qualitative method IPA is differentiated by a focus on the researcher's reflexive involvement in the research process (Smith & Osborn, 2004). That is, the researcher has the capacity and is in fact required to explore and interpret meaning from what has been said. This is in contrast to other methods (e.g. discourse analysis, Potter, 1996), where the role of language in describing the person's experience is intrinsic. Given the clinical nature of our investigation and the researchers experience in understanding and interpreting the meaning and cognitions and her ongoing involvement in the field of interest, IPA is particularly suitable.

**Enhancing psychotherapy for people with psychosis and substance use by  
understanding the experiences and attitudes of the psychologist.**

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### **Abstract**

Research has consistently indicated that the combination of psychotic and substance use disorders presents treatment services and providers with a unique set of complexities, which compound the well-documented challenges of treatment engagement, alliance, retention and outcome associated with either of these conditions in isolation. The current study is among the first to focus specifically on issues related to the formation of alliance among this important clinical group. We recruited psychologists working on an ongoing research trial, the Healthy Lifestyles Program (HLP) and conducted an in-depth qualitative analysis of their attitudes and impression of delivering face-to-face and telephone-based treatment to people with psychosis and nicotine dependence. Utilising Interpretative Phenomenological Analysis, a number of themes central to the experience of HLP therapists were identified, namely: the complex and unusual experience of working with people with psychotic illness, the importance of considering each client as an individual, and the many layers of interaction between therapist and client. Due to the unique aspects of working with people with psychosis and nicotine dependence the importance of regular clinical supervision to target these issues is emphasized.

## **Introduction**

Psychotic disorders are considered the most debilitating of mental disorders (Jobe & Harrow, 2010). Those diagnosed with a psychotic disorder are consistently found to have poorer quality of life, higher burden of disease and reduced life expectancy relative to both the general population and people with other mental health problems (Gureje, Herrman, Harvey, Morgan & Jablensky, 2002; Goldner et al., 2002; Jobe & Harrow, 2010). Despite considerable development in evidence-based treatments for psychosis, it remains difficult to engage people with psychotic disorders in therapy and there is a trend for early discontinuation of treatment and poor treatment response (Nose, Barbui, Gray & Tansella, 2003). Comorbidity of substance use in psychotic clients is known to extenuate barriers to treatment, linked with increased ambivalence for treatment, poorer treatment response and outcome (Lambert et al., 2005 and Williams & Farrell, 2006).

Traditionally, it was thought that only client factors, such as motivation, impacted on engagement in treatment. What has now become clear is that both client and service factors are important, and equally contribute to treatment outcomes (Fiorentine, Nakashima & Anglin, 1999). For example, Fiorentine and colleagues (1999) revealed that the predictors of treatment engagement that accounted for the most variation in treatment engagement and outcome were the perceived helpfulness of the treatment and additional services along with the client-therapist relationship. These factors outweighed the influence of individual client characteristics. More recent research has confirmed these earlier findings, with the development of a sound therapeutic relationship, or therapeutic alliance, being consistently identified as a critical component of treatment success, regardless of mental disorder or therapeutic orientation (Martin, Garske, and Davis, 2000; Lambert & Barley, 2001; Castonguay, Constantino, Holtforth, 2006). In a large review of psychotherapy outcome

literature for depression, anxiety and eating disorders, Lambert and Barley (2001) reported that empathy, regard, warmth and the therapeutic relationship accounted for about 30% of client improvement across a range of randomized controlled trials and meta analyses.

### **Psychosis, substance use and the therapeutic relationship**

Researchers have proposed three key factors will contribute to the development of a good therapeutic relationship, and only one of these relates specifically to the client and their pre-treatment characteristics (DeRubeis, Brotman et al. 2005). Psychotic symptomatology presents unique challenges to the development of a sound therapeutic relationship. Wright, Turkington, Kingdon & Basco (2009), outlined 15 primary client factors which may interfere with the therapeutic relationship; paranoia, hostility, catatonia, hallucination, lack of insight, somatic delusions, hopelessness, low energy, grandiosity, impulsivity, social withdrawal, thought disturbance, cognitive impairment, substance misuse and pre-existing relationship difficulties. As the majority (if not all) of these symptoms and behaviours form part of the defining or secondary features of most psychotic disorders, the establishment of a strong working relationship may be especially difficult. It is thus surprising that little research has directly examined the impact of psychotic symptoms on the therapeutic relationship.

Alliance may also be particularly important in treatment for people with substance misuse and psychiatric comorbidity (Petty & Bickel, 1999). In a large review of substance use treatment literature, Meier, Barrowclough & Dronmal, (2005), found that early alliance is a consistent predictor of engagement, retention and treatment response for substance users currently in treatment, with client factors such as motivation, treatment readiness and positive previous treatment experiences, impacting on alliance. Specifically examining alliance in co-existing psychosis and substance use, Barrowclough, Meier, Beardmore & Emerlsy, (2010), found that symptom severity and substance use measures were both unrelated to alliance. This is in contrast to earlier research, indicating that opioid use increases difficulty

in retaining clients with comorbid psychiatric illness (Petry & Bickel, 1999). Given the limited and inconsistent information about factors contributing to alliance in people with coexisting substance use and psychosis substance using populations, as well as the frequency of comorbidity and the potential for both to impact negatively on the development of sound alliance, further investigation into factors contributing to alliance is required.

Client factors aside, therapist behaviours and attitudes are thought to influence client engagement and collaboration (Ackerman & Hilsenroth, 2003). In one of the only studies to examine therapeutic alliance from the therapist's perspective, Ackerman and Hilsenroth (2001, 2003) conducted a systematic review of therapists' personal attributes and in-session activities, and how they influenced the therapeutic alliance. The results indicated that therapist characteristics such as being flexible, respectful, trustworthy, confident, warm and interested, contributed positively to alliance (Ackerman & Hilsenroth, 2003), whilst those such as being rigid, anxious, critical or distant, contributed to poor alliance (Ackerman and Hilsenroth, 2001). Equally, the manner in which techniques and strategies are employed by therapists during the course of treatment will also impact on the formation of a good therapeutic bond. For example, too much structure, inappropriate self-disclosure and excessive use of silence or interpretation have been associated with poorer therapeutic alliance (Ackerman and Hilsenroth, 2001), with techniques such as exploration, noting past therapy success, facilitating affect expression and attending to the client's experience consistently related to better therapeutic alliance (Ackerman and Hilsenroth, 2003). However, little other research has directly examined the formation of alliance from the therapist's perspective, and even less has focused on the impact of psychosis on the therapist's attitudes and beliefs.

Thirdly, the therapeutic relationship is also thought to be heavily influenced by the transaction between client and therapist during the treatment process, and that the match

between client and therapist factors will interact to produce stronger or weaker alliance in the therapy setting. Such interactions are thought to include the expectations and attitudes each possesses about the other and the treatment process (Ackerman and Hilsenroth, 2003).

Although much is known about the impact of client-related factors on this process, and the particular difficulties psychotic symptoms bring to the therapeutic setting, much less agreement and evidence is available from the therapist's perspective, and virtually no research exists in relation to treating people with psychotic disorders.

Surveys of mental health professionals suggest that increased stigma exists in relation to people with psychotic disorders (Nordt, Rossler & Lauber, 2006), and that this may in turn pose a potential barrier to the development of alliance. For example, in a large scale survey of 702 clinical psychologists, 1580 psychiatrists, 1495 general practitioners and 980 mental health nurses, poorer attitudes and expectancies were held for treatment response and long-term prognosis for individuals experiencing psychosis relative to depression (Jorm et al., 1999). Specifically examining the attitudes of clinical psychologists, Servais & Saunders (2007) found that psychologists harbor more negative attitudes toward people with psychosis in comparison to other client groups. Across clinical groups (moderate depression, borderline features and schizophrenia) and a non-clinical sample, difficulties with identification and feelings of social distance were particularly expressed for people with borderline features and schizophrenia, and psychologists viewed themselves as least effective in working with people with schizophrenia and most dissimilar from this clinical group than all others (Servais & Saunders, 2007).

What these studies imply is that, for people with psychotic disorders, poorer attitudes and increased stigmatization are experienced by their treating health professionals. This is somewhat unexpected, given Social Contact Theory (Allport, 1954) where we would expect that health professionals, with their increased experience, contact and knowledge of people

with psychosis, ought to harbour less stigmatising attitudes. In order to address stigma and its relationship with alliance, future research should aim to develop a deeper understanding of how and where stigma exists amongst professionals who provide treatment to people with psychosis, particularly psychologists, and how this is influenced by the experience of working with this client group. Through better understanding the experience of the psychologist, we can gain a more accurate understanding of how stigma influences the therapeutic relationship and how it can be overcome to improve the provision of treatment and the treatment outcomes of this important clinical population.

### **Healthy Lifestyles Program for people experiencing Psychotic Illness and Nicotine Dependence**

The Healthy Lifestyles Program (HLP) is a health behaviour intervention targeting cardiovascular risk in individuals with a psychotic disorder and comorbid substance use problems, in this case, nicotine dependence (Baker et al., 2011). Treatment within the HLP involves psychologists providing a structured, manual-guided intervention, designed around principles of motivational interviewing and cognitive behavioural therapy, as well as monitored provision of nicotine replacement therapy. Participants in the program are randomly assigned to one of two conditions; face-to-face treatment or a telephone-based control condition. HLP aims to compare the relative efficacy of the treatments in reducing cigarette smoking, improving diet and exercise, and in doing so, reduce the participant's overall cardiovascular risk profile (Baker et al., 2011). This extensive research program offers an avenue for exploring many of the factors highlighted as relevant to the development of treatment provision and therapeutic alliance when working with people with psychosis and substance use problems. HLP provides the opportunity to recruit psychologists who have had significant experience working with people with psychosis, allowing for a thorough exploration of their attitudes and perceptions. Along with this, it facilitates the comparison of

therapists' experiences of different modalities of treatment delivery, due to the face-to-face and telephone treatment designs. HLP being a research-based intervention, utilising a structured treatment manual, will also allow for the exploration of psychologists' experiences in this context; one that may potentially affect the development of a good therapeutic relationship. In particular, the HLP research project enables an exploration of how psychologists perceive the integration of evidence-based practice with the development of a strong therapeutic relationship.

The role of alliance in treatment outcome, although important across multiple fields of health care provision, is considered most crucial to the role of the psychologist (Orlinsky, Ronnestad, Willutski, 2004). As it is considered intrinsic that the psychologist have a capacity for engaging, empathizing and collaborating with the client, it is particularly relevant to continue to explore alliance within this field.

### **The importance of a qualitative approach**

There is little agreement about how best to measure alliance, and the majority of research in this area has attempted to quantify factors contributing to alliance using a variety of structured questionnaires or the labelling of specific factors. Although this approach has enabled a strong relationship between alliance and outcome to be established, continuing to quantify alliance is a limitation of existing research, as it fails to provide an understanding of the complexity and depth of the client and therapist interaction (Goldfried & Davila, 2005). While the importance of considering unique factors is acknowledged, exploring alliance as a mutual ongoing process, whereby a number of factors interact, would provide more meaningful clinical information (Goldfried & Davila, 2005). Practically, this may mean that research needs to move toward qualitative analysis of the therapeutic relationship in order to better understand the complexity of the experience and the relationship. Another important implication is that examining alliance at discrete time points (as is required for quantitative

analysis) may result in failure to recognise both the complex and evolving nature of alliance. A qualitative approach therefore may better account for this, providing a richer analysis of alliance as its development is recalled or monitored across time.

Accordingly, the current study will take a qualitative approach in examining psychologists' perceptions of a broad range of contributors to the therapeutic relationship. Specifically, we aim to explore the psychologists' perceptions of working with clients with psychotic disorders in the context of the HLP research project, including the presence of potentially stigmatising attitudes or other barriers to alliance, and their attitudes toward aspects of treatment delivery. It is hoped that the result of this study will enhance and broaden our understanding of treatment provision both in the context of a research trial such as HLP and for people with psychotic disorders.



## Method

### HLP

Detailed methods for the HLP have been reported elsewhere (Baker et al., 2011). Of relevance to the current study, two treatment arms were delivered to participants.

**Session one (face-to-face delivery).** All participants received session one in face-to-face format, of approximately one hour's duration, conducted in research clinics associated with the HLP. The session comprised formal feedback to participants about their smoking status and other risk factors for cardiovascular disease. A case formulation regarding cardiovascular risk was developed in collaboration with the participant, using a motivational interviewing approach to facilitate consideration of changes in unhealthy behaviours associated with cardiovascular risk. At the conclusion of this session, participants were randomized to receive sixteen further sessions over nine months, delivered either face-to-face as per session one, or over the telephone (control).

**Nicotine replacement therapy (NRT).** All participants, regardless of treatment group, received free NRT to assist with cravings and withdrawal symptoms related to any smoking cessation attempts. Following the delivery of session one, participants received four weeks' supply of NRT to take with them, regardless of treatment allocation. The remaining NRT was provided to participants at weeks four, eight and fifteen.

**Sessions 2-17 (face-to-face delivery).** In addition to session one, this active treatment condition involved seven weekly, three fortnightly and six monthly treatment sessions, of one hour's duration, delivered face-to-face in research clinics associated with the HLP. The focus of each session, although manual guided, was designed to be flexibly implemented, with participants able to concentrate on smoking cessation, physical activity or

diet and nutrition as they preferred. Contingency reinforcement was integrated within these sessions, and focused on smoking cessation. Motivational interviewing and cognitive behaviour therapy were employed throughout.

**Session 2-17 (control, telephone-based delivery).** Following randomization, participants in this minimal treatment (control) condition received telephone calls of approximately 10 minutes' duration, at the same intervals as the face-to-face condition (seven weekly, three fortnightly and six monthly). This condition was designed to control for the number of therapist contacts in the face-to-face condition. The content of these sessions included formal monitoring of smoking and NRT use, nicotine withdrawal symptoms, psychotic symptoms, mood, and diet and exercise activities. In place of telephone-based sessions at sessions four and eight, participants attended in-person sessions at the HLP research clinics for provision of NRT and formal monitoring.

### **The Current Study**

The current study focussed on the therapists who delivered the HLP treatment (either in-person or via the telephone).

### **Participants**

Participants were six psychologists (five females, one male) who had been providing therapeutic interventions on the HLP. All participants were provisionally or fully registered psychologists with a range of both clinical and research experience. The psychologists were from the four participating research sites of the HLP research project (Newcastle, Central Coast, Sydney (New South Wales) and Melbourne (Victoria), Australia) and represented diverse cultural and linguistic backgrounds.

Purposive sampling was employed, as is generally recommended within the qualitative approach utilised for the current study (Smith & Osborne, 2003), to ensure that the phenomenon of interest could be thoroughly explored. Participants' involvement in HLP treatment provision ensured they were psychologists who were experienced in providing therapy to people with a psychotic disorder and comorbid substance use (nicotine dependence), as well as different modalities of treatment provision (telephone and face-to-face, in a research and a clinical context).

## **Design**

The study employed a qualitative methodology utilizing Interpretative Phenomenological Analysis (IPA) .

Influenced by phenomenology, IPA acknowledges both the existence of individual differences in ways of thinking, as well as the impact of human interaction and wider contextual factors (e.g. culture, environment) upon the individuals' views of the world and meanings that they ascribe to their experiences (Shaw, 2001; Smith, 1995). IPA was judged to be the best approach for analyzing the present data as we were interested not only in individual constructs and perceptions, but also on the shared meanings of experience of the therapists (Chapman & Smith, 2002; Larkin, Watts & Clifton, 2006). Furthermore, given we were exploring novel areas of research, the exploratory style of IPA allowed for a deeper and unrestricted study of the psychologists' experiences.

## **Procedure**

HLP therapists were invited to participate in the study via an emailed information sheet detailing the broad aim and requirements of the study. Therapists were informed that the aim of the study was to explore their experiences and attitudes toward different modalities of treatment for people with psychosis. Also, they were notified that participation would

involve a one-to-one semi-structured interview (which would be recorded) of approximately 1 hour duration. Informed consent was requested for participation and participation was voluntary and not a requirement of their work on the HLP. The therapist's decision to participate in no way affected their employment within the research program or participating organisations, and the current study was conducted separately to the ongoing HLP research project.

Consenting participants were telephoned at an arranged time to complete their individual interview. All interviews were recorded using a digital recording system. To ensure consistency and reduce variability in the data collection, all interviews were conducted by the same interviewer (AS), who is a provisionally registered psychologist with clinical and research experience. Ethical approval was obtained from the Hunter New England Human Research Ethics Committee (08/12/17/5.10).

### **Data collection**

Data were collected through a semi-structured interview. Interviews and analysis were conducted until data saturation, the point at which no new information or themes are observed in the data, was reached. This occurs in the analysis when it becomes evident that themes or concepts are re-occurring in the data. Smith, (1995) suggests that when adopting IPA, the optimal number for this to occur would be six-eight participants. For the current study, it was determined by all raters and co-raters that data saturation had been reached after the sixth interview.

In accordance with IPA, it is recommended that the experience of participants be examined and interpreted in naturally occurring settings (Smith, Flowers & Larkin, 2009). Thus, interviews were via telephone in the participants' office of work. To ensure privacy

and remove any potential for distraction, a therapy room within the office was booked for the interviewer.

The interview was flexibly guided by a broad list of questions and prompts (see Table 1) aimed at exploring a range of experiences. The interviewer used this schedule to find a balance between providing the structure for relevant issues to be discussed, while allowing the participant to freely express their experiences. The interview was a reflexive process and the interviewer (AS) used clinical skills of active and reflective listening, probing, and advanced empathy to assist her to thoroughly and accurately explore the participants' experience.

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Insert Table 1 about here

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Interviews were conducted until data saturation was reached, that is, until no new themes emerged from an interview, and this occurred at the sixth interview. Data saturation implied that sufficient depth of information had been obtained and all themes were likely to have emerged in the data (Pope, Ziebland & Mays, 2000). Each interview was guided by the themes that had emerged from the previous interviews, as well as the interviewer listening for and probing for any novel themes. The interviewer gradually became aware of saturation, as participants were no longer adding new information. This was verified in the first stage of analysis, occurring after each interview, which involved the clustering and comparison of themes between each of the previous interviews. The interviewer regularly consulted with a researcher independent from the data collection process (FK-L) to corroborate the point at which data saturation occurred, including a detailed discussion of the analysis and themes emergent from each interview.

### **Analytic strategy**

The data were analysed using IPA, using the procedures outlined by Smith and Osborn, (2003). The aim was to create a comprehensive account of themes, which held significance for each of the individuals interviewed and the group as a whole. IPA is a cyclical process, and the researcher proceeded through several key iterative stages to analyse the data. The first stage was to engage with the text via a verbatim transcript developed by the interviewer (AS) after each completed interview. The interviewer read the transcription several times, making notes in relation to the cognitions of the participant and /or interviewer. Preliminary themes were identified and clustered into themes. This was completed for each interview, prior to commencing the next. Following completion of each interview the interviewer also re-read the previous interviews to consider emerging concepts from the interviewees.

The final stage of analysis was to link themes from each participant's experience together, and to ascribe meaning to those themes. The themes from all interviews were drawn together into a master list that reflected the group as a whole. A comparative process was then undertaken to identify ordinate themes. At this stage, the interviewer referred back to each participant's original transcript to ensure accurate meaning was derived. This was done by reviewing each theme and identifying and recording quotations from each transcript, reflective of this theme. Themes were then prioritised on the basis of their prevalence within the data, the richness of the particular passages that highlighted the themes, and how the theme assisted in clarifying and explaining the experience of the participants.

### **Procedure for trustworthiness and credibility in analysis**

The researcher had previously worked as a HLP therapist and was a provisional psychologist undergoing training as a clinical psychologist. This benefited her to be easily

immersed in the therapist's subjective experience, as well as provided her with the skills to explore, reflect on and interpret participant responses and the meanings they may hold, a process labelled in IPA as "reflexivity" (Finlay and Gough, 2003; Skultans, 1998). As the analysis was contingent upon the interpretations of the primary researcher, her experience is likely to have influenced the interview and interpretation of the data, therefore it was especially important to be aware of and transparent about any personal biases by acknowledging and exploring her role. Attention was paid to self-reflection when asking questions and interpreting responses. In addition, the 1<sup>st</sup>, 4<sup>th</sup> and 6<sup>th</sup> interviews were independently co-rated by the supervising researcher (FK-L), a chief investigator on the HLP, and the first four interviews reviewed by an independent expert who had not been involved in the HLP to date (MJ). A journal for self-reflection during transcription and interpretation was also used to assist with this process. The interviewer and co-rater each agreed on appropriateness of connections made between text and themes, appropriate clustering, representation of the original content within emergent ordinate themes, and the point at which data saturation occurred.

## Results

### Overview of Themes

Participants generally described their experiences of working with people with psychosis as an intricate interaction between themselves, the client and the treatment. Most participants emphasized the positive, yet challenging, experience of working with this client group. They each described their growth as therapists with this client group, regardless of previous experience with the target population and as a practicing therapist. Participants also described how working intensively with the target group influenced their experience of and capacity for developing the treatment relationship. The individuality of each client was also something that all participants experienced, and highlighted, as an important aspect of their work.

From the detailed process of analysis, three ordinate themes emerged. For two of these themes, two subordinate themes were also identified, which were salient in describing the meaning associated with each theme for participants, as outlined in Table 2.

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Insert Table 2 about here

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### Complex and unusual experience of working with people with psychotic illness

The complex and unusual nature of working with people with psychotic illness was a prominent theme for each of the participants. Although most participants expressed that their experience had been positive on the whole, each recalled stories of the complexity and unusual nature of their work. These recollections were related to their perceived experience of the client and also their own broader experience of providing therapy to this group. The



perception was varied among participants. For some it contributed to their interest and motivation, whilst for others the experience was described as being challenging and, at times, confronting. Some also described a transition or development in their understanding and response to the unusual nature of psychotic illness, with increasing experience of the population throughout the HLP. They spoke about initially being confronted and overwhelmed; yet with time and therapeutic contact, their experience developed more into feelings of confidence and intrigue.

**The challenging and confronting experience.** There was a prevailing sense that participants continued to struggle with their understanding of psychotic symptoms, despite experience with the population:

I certainly don't think that I have got my head around, or many people have got their head around, the real essence of psychosis, but I don't think...it's very difficult for people who haven't experienced it, or even anyone, I guess, to really comprehend. (Participant, P, 1)

The expression 'I certainly don't think that I have got my head around...' would reflect a sense of confusion in regard to P1s real understanding of what it is like to experience a psychotic disorder, despite significant experience working with this population. By identifying that not '...many people have got their head around...' psychosis, an attempt is being made to justify this inability, perhaps to further explain the difficulties participants generally expressed in establishing true and accurate empathy with their clients with psychosis. This sense of bewilderment was particularly apparent when P1 described his initial experiences of working within this population:

I think when I first started working I was kind of like, wide open-mouthed about the extraordinary experiences these people have. (P1)

The confronting nature of their work resulted in personal struggles to maintain confidence:

I remember getting very, very personally upset about their stories, you know, obviously not in front of them, but you know after, after doing my research and stuff, just...worrying and thinking and sort of feeling scared to go and do home visits...what would happen and all those sorts of things. (P6)

The emotional challenge faced by P6 was not to be overwhelmed by the real life experiences of her clients with psychosis, which tended to include significant trauma, social isolation, poor functional ability, and little hope for the future, but at the same time develop empathy for the client's current situation. Given the unpredictable nature of psychotic symptoms, the described difficulties empathizing with their client's symptoms and life situation, and the ways in which mental illness (and schizophrenia) is often portrayed in the media (e.g. violence, aggression), it is somewhat understandable that initial reactions to working with psychotic populations might include fear and hesitation, as indicated by the participant above. Again, the challenge for participant therapists working on the HLP trial was the (implied) pressure to identify, engage and retain these clients in treatment, potentially presenting the HLP therapists with a particularly unique clinical situation to navigate their way through.

**Complexity of illness is intriguing and motivating.** Participants also described the development or change in their perceptions and experience of working with people with psychotic disorders, such that the challenging and unusual nature of illness later contributed to motivation and interest:

I often look at working with people with psychosis as a bit of a window into all parts of human experience, which maybe we don't like to think about...it's more difficult to think about, so I always think of it as a unique experience. Every time I sit down with someone, it's a privilege in some ways, as these are experiences that you, not all, not everyone has the privilege to be a party too. (P1)

I find it really interesting to see the range of symptoms they do experience and then to also then see their recovery, and I acknowledge that there are quite a lot of challenges to working with people who are acutely unwell...but it, it's not something that makes it too hard for me. I find it really rewarding and particularly satisfying even working through some of the difficult times. (P6)

Despite P1s and P6s continued view that this is a challenging and complex client group, in time an element of intrigue and satisfaction is derived from this aspect of their work. As participants continued in their work they began to feel more comfortable and confident:

I think because I have been doing this for a while and I've seen um, extremes...from acutely disturbed clients in seclusion, through to community clients, I suppose I'm quite comfortable really and pretty, you know, open-minded and...nothing is going to shock me. (P6)

As P6 explained, with time and exposure, it seems that therapists became somewhat inoculated against the disbelief, upset and astonishment reported in the early stages of working with people with psychosis that influenced their perceptions of the therapeutic relationship. The feeling that '...nothing is going to shock me' implies that this experience will potentially generalise to wider populations, and suggests a perception that working with people with psychosis is to work at the hardest end of the mental health spectrum.

### **Each client is an individual**

All participants expressed that they viewed the clients they worked with as individuals. There was a sense that it was important to consider clients as unique, different from each other and separate from their diagnosis or symptoms. Participants talked about the importance of individual case conceptualisation in tailoring treatments as well as how hearing and understanding the individual's 'story' contributed to the development of the therapeutic relationship:

It was quite a lengthy assessment process and I think that gives you so much information...about the client that you can get a thread of a story, about their life, to a degree. (P5)

In recalling the initial 'lengthy' assessment process, P5 highlighted the importance of tailoring interventions to the individual, based on an in-depth understanding of their personal story. It may also be that this assessment process, which explored psychotic symptoms and experiences in detail, also served as an "inoculation" for participant therapists, exposing them early on in their relationship with clients to the "shocking" experiences they initially reported, and doing this prior to the treatment phase formally commencing.

Participants identified a shared reluctance to label the client as psychotic or make generalisations about them based on their diagnosis:

When they're not acutely psychotic, I don't really focus on that, I see them more as a person, you know, each of their own particular quirks and things, I don't really label it as psychotic in my mind. (P2)

I don't feel that I can make generalisations about everyone as a whole, because all the different patients that I have come across have presented their own challenges, as just, being... yeah, different. (P4)

The importance of the individual 'as a person' encourages P2 and P4 not to generalize and instead to marvel in the uniqueness of each person. The capacity for seeing the client as an individual becomes an important contributor, and indicator, to how well therapists were able to form a therapeutic and empathic connection:

For me it's all about...that each individual client is different, you know, getting to know them individually and...working on connecting with them. (P3)

### **The layers of interaction between therapist and client**

The importance of the interaction between the therapist and the client was elucidated by participants. Many explored their feelings in relation to engagement, motivation and confidence in therapy, through considering the processes of transference and counter-transference. The primary importance of alliance was suggested and participants expressed concern and anxiety about aspects of treatment they considered may challenge their alliance with the client.

Participants also identified a struggle with wanting to promote evidence-based practice, yet be flexible and continue to develop and maintain alliance with the client. Similarly they expressed concern that telephone therapy may interfere with their capacity to engage and develop rapport.

**Transference and counter-transference.** Participants detailed the experience of counter-transference, which occurred between clients and themselves, and how this influenced their personal emotions and engagement. Participants talked about the difficulty they had with not personalising or ‘taking on’ their client’s struggle:

It depended on how he presented as well, so if he was having a good day per se, it made me feel like I was getting somewhere and making progress with him, but on days when he was hostile and aggressive towards me...it made me feel unsure of what I um, it made me question my abilities to a certain extent. (P4)

He's just always insisting that it is too hard and he would quite eloquently express all the terrible things that happened in life, and really, I think, hit the nail on the head, quite often about the difficulties he had faced...not having a kind of model in life...he was adopted and also apparently, so it seems, treated very badly...and the impossibility really of his situation. It did occur to me...‘cause I always try to work out what annoys or frustrates me...that he was kind of presenting me with a bleak picture, which was kind of confronting for me, and you know, what do you do..., his best outcome is relatively modest. (P1)

These therapists, when challenged by clients' lack of progress or engagement, found this to be confronting to the point that it made them question their ability as clinicians, therefore possibly fuelling potential difficulties in the therapeutic relationship.

Transference was also identified in relation to the therapist presenting as comfortable and confident:

There is a risk that if you're disorganised, or things aren't working, that the client will see that and potentially lose confidence in you....you know they need to feel confident in you, even though I guess the role of the therapist is to guide, you're not doing the work for them, but yes they have to have a certain level of confidence in you that you can assist them. (P5)

Consequently, P5 identified the need for clients to have confidence in her as a clinician, over-and-above the treatment she was delivering. Perhaps this is a function of treatment being manualized, structured and pre-programmed as it was in the HLP research trial. In this context, it may have been especially important for clients to look to their therapists to make them feel like individuals, and be committed to tailoring this one-size-fits-all treatment to their particular needs. This may have also assisted the development of rapport and the therapeutic relationship, and facilitated disclosure and connection to the therapeutic process. It is through this developing inter-confidence that the personal capacity of the therapist to assist the client is developed:

I think because I am quite comfortable, a lot of my barriers are down and I, maybe, I don't know, maybe that's noticeable to the client and it makes them feel at ease or comfortable, because I am not worried about what they're going to say. (P6)

**Primacy of Connection.** Through much of their discussion, participants identified the primary importance of maintaining an alliance and connection with the client, which was viewed as being critical to treatment. Participants spoke about the anxiety they experienced when they felt that they were not being client-directed or facilitating strong rapport. There

seemed to be an underlying concern that some aspects of treatment were 'risky' in terms of maintaining the relationship:

Looking at their strengths and ah, not judging them and being where they are, I think that is really important, connecting with them, I think that's really, really important. I think if not anything else, if you can connect with them, um, then there's that relationship built, then they do take that away with them when they're not in the session. (P3)

It's more than just like an educational intervention, it's more about the connection, the human experience. (P3)

In relation to this, participants spoke about their struggles with implementing evidence-based interventions in a manner that promoted alliance with the client. Most expressed a level of anxiety about following an evidence-based, pre-programmed, agenda; despite seeing it as important. A flexible approach was suggested as crucial to successfully implementing a more structured treatment:

Yeah that's been difficult as well, trying to use the manual in the best way for the client, rather than just sticking to it like a robot... I guess more of a person-centred approach and that's sort of been hard for me, to put my agenda aside of helping people in a person-centred way, umm as opposed to keeping the fidelity. (P2)

Similarly, participants expressed concern about the capacity for developing rapport over the telephone:

I think it's less personal, you know, I don't know, I wouldn't personally prefer it... if they come in and you meet with someone, I suppose it warms them up, if they walk into the building...you look at them, you know all that is all part of it. (P2)

I don't know, but you know, without face-to-face contact, I think that, you know, there is just a difference in the way that you can relate to people and that people will open up so many different avenues, if you are sitting face-to-face with someone. (P6)

Despite the group endorsing the many advantages of this modality of treatment and reporting that they felt many clients had benefitted significantly from this there was some uncertainty about the use of telephone therapy, and it was used with reluctance, primarily due to concerns relating to rapport.

Contradictorily within the expression of concern about telephone treatment, there was an element of support. Participants who spoke about concern in relation to establishing rapport over the telephone, also were able to describe advantages of telephone treatment such as the capacity for creating an engagement with clients with psychosis, who would not otherwise participate in treatment (for example when working with hostile, isolated or extremely paranoid clients):

A bit of a disadvantage that you can't sort of see, um, their face, you can't pick up on all the non-verbals, to be able to hear a lot more of their message and build a lot more rapport with them...but then again it's not such a disadvantage in that I wouldn't recommend it, I think that, not just in this program but in other programs, the advantages do outweigh the disadvantages, of phone therapy. (P3)



## **Discussion**

Our study examined the experiences and attitudes of the psychologist, in relation to a range of factors with the potential for enhancing or impinging on treatment of people with psychotic and substance use disorders. Several qualitative themes emerged relevant to the treatment relationship, which may have important implications for considering how psychologists reflect on their practice and continue to develop a capacity to relate and deliver treatment to this clinical group.

### **Main findings and Interpretations**

We found that the psychologists' experience of working with people with a psychotic disorder is one of complexity, described by the professional as both unusual and intriguing. Psychologists expressed that the complexity of illness and the often intriguing nature of symptoms can be challenging in terms of relating with the client. This is in line with the available literature, which indicates that professionals may have more difficulty identifying with a psychotic population (Servais & Saunders, 2007) and experience decreased feelings of commonality or shared experience as a result (Nordt, Rossler & Lauber, 2006). Extending on this, we also found that psychologists perceive that delivering treatment to this group is in many ways unique from their other treatment relationships and certainly dissimilar to more general life experiences. Servais & Saunders (2007) agree that such experiences are also likely to contribute to feelings of difference and dis-identification as was identified in their study. Our findings further suggest that psychologists may have difficulty conceptualising and relating to clients in this clinical population, potentially diminishing their capacity for accurate empathy and the development of sound alliance. As alliance is fundamental to treatment and highly predictive of treatment outcome (Castonguay, Constantino & Holtforth, 2006), it is important to continue to raise awareness of this potential barrier to treatment and relationship development within this population, and to regularly address these issues in

clinical supervision and professional development of therapists working with psychotic populations. The primary researcher acknowledges a professional perspective of alliance as a fundamental component of treatment and was guided by her experiences clinically with this client group.

Another important finding emerged from our results, and indicated that the capacity for change existed in the psychologist's interpretation and perception of working with people with psychosis as a function of increasing experience with this population. Congruent with Allport's (1954) Social Learning Theory, we found that psychologists indicated an improved capacity for identifying with clients and a more positive experience of intrigue and interest (rather than concern or fear) as their experience within this population developed. Confidence and familiarity emerged as important components of this experience. As per Allport (1954), dissimilarity and uncertainty contribute to stigma, with contact and familiarity required to alleviate the stigma. As anticipated from our review of the literature and understanding of social contact theory, psychologists described that with greater exposure and contact with a psychotic population, they felt more comfortable and confident, and related examples of decreasing stigma over the course of their career. Although not specifically mentioned by the study participants, it is possible that the weekly clinical supervision offered throughout the HLP, which focussed on presenting cases and troubleshooting difficult clinical issues identified by the HLP therapists, may have also facilitated the process of destigmatization. Although the interviewer (AS) was in the early stages of her career she was aware that she felt personally comfortable and confident in working with this client group. As this was somewhat divergent from the ideas expressed by some less experienced participants she aimed to be particularly to the expression of stigmatising beliefs, difficulties and challenges.

The study results also revealed several themes that were not unique to working with psychotic populations, and could be applied to any therapeutic work with any population. For example, participant therapists described a process of self-examination and blame when clients did not progress through treatment in the intended or desired manner. It may have been more a function of working on a research trial that contributed to this tendency among therapist participants rather than working with clients with psychosis. Therapists may have felt more inclined to blame themselves for things not progressing in an ideal way due to a perception that, at least for HLP, the treatment was evidence-based, shown in pilot research to be efficacious, pre-planned and developed by a panel of “experts” in this area. Therapists, upon reading the summarized research results related to the pilot of HLP, may have felt that, when treatment did not proceed according to plan, the only thing left to question may have been their ability to implement the treatment protocol. In reality, there is a broad range of responses to treatment reported in the research literature, including alternative outcomes to treatment success. Perhaps therapists in the HLP trial at least, placed undue pressure on themselves to achieve (or assist clients to achieve) success, which, when coupled with the challenges of a psychotic population, may have meant that therapeutic relationships were somewhat more difficult to establish and maintain.

The study results also identified the critical importance of perceiving and treating the client as an individual. Psychologists viewed that the individuality of the client is critical in the development of the relationship and must be integrated with evidence-based treatments. This was a somewhat unexpected finding, in light of previous research indicating that psychologists may harbour stereotypical attitudes when working with psychotic populations and therefore find it difficult to individually conceptualise the client (Servais & Saunders, 2007, Nordt, Rossler & Lauber, 2007). Although this was clearly present in the initial stages

of working with clients with psychosis, therapists in the HLP trial found ways to overcome this bias, and to develop meaningful therapeutic relationships with their clients, probably because they had committed to working on the HLP, and were somewhat “forced” to find an acceptable way of working with the group. Given that the psychologists in this study were participating in a structured research trial, where adherence to treatment was being monitored, anxiety about adapting the treatment to suit the individual may have been stronger and may have contributed to the saliency of this theme. This finding may also reflect professional response to recent guidelines about evidence-based practice (Norcross, 2011; Norcross & Wampold, 2011). A move towards highlighting the importance of individual tailoring of treatments (Norcross & Wampold, 2011) and integration of “best available research, clinical expertise and patient characteristics” (Norcross, 2011) is one that appears to be upheld by the professional attitudes expressed within our study. Our findings support the relevance of promoting individual conceptualisation of clients in guiding treatment provision, particularly when working with clients experiencing psychotic illness, and that this can realistically be achieved even when working to a structured, pre-programmed evidence-based treatment package.

We also found that psychologists experience many levels of interaction between themselves and their clients, which they perceive are critical to relationship and treatment. This, too, is consistent with research by Norcross (2011) and the notion that many factors, such as treatment type, individual client factors, factors relative to the therapist and other relationship factors, are relevant to the treatment relationship. Interestingly, our study revealed that psychologists’ consideration of these factors was often expressed as, or reflected, a consideration of transference and counter-transference processes. As psychologists involved in this study were delivering a cognitive and behavioural-based treatment, this reflective practice was somewhat unexpected (given that transference is

historically associated with psychodynamic approaches to treatment). As the interviewer's theoretical orientation was based primarily within a Cognitive Behavioural Therapy framework, these concepts were novel to her and required careful consideration and exploration, when interviewing participants and when analysing the data. In the current study, the role of transference and counter-transference in therapy was expressed as particularly important when working with psychotic disorders in relation to confidence and motivation in treatment. Possibly it is the severity and chronic nature of psychotic disorders, as well as the complexity of factors requiring consideration in treatment of this population, which results in personal struggles in a therapist to maintain confidence and motivation, and could potentially be transferred to the client and damage the relationship. Similarly, the negative symptoms characteristic of many psychotic disorders, including lack of motivation, confidence and feelings of hopelessness, could also (and did) counter-transfer to the therapist, providing an additional challenge to alliance.. These findings support research indicating that transference (and counter-transference) is a key component of the therapeutic relationship and one that is now considered by therapists working with a range of therapeutic orientations (Cartwright, 2011). Future research into the impact of transference and counter-transference on alliance when working with people with psychotic disorders may be important in developing our understanding of alliance for this population.

Our findings also imply direct support for the importance of alliance (or a connection) in treatment. Psychologists expressed the primary importance of alliance when working with this client population. Consistent with our review of the literature, it was viewed that a sound therapeutic relationship is a critical component of treatment success (Martin, Garske, and Davis, 2000 and Lambert & Barley, 2001). Psychologists in our study perceived that alliance was a critical component of the likelihood of a successful therapeutic relationship and outcome, which is in line with previous literature (Castonguay, Constantino, Holtforth, 2006;

Meier, Barrowclough & Donmall, 2005). Our participants felt that they were able to establish a good working relationship, alliance, and connection with many study participants, despite the complexities and challenges inherent in a psychotic population by the very nature of their symptoms and clinical presentation. This finding adds to the accumulating evidence for the importance of alliance when working with people experience psychotic illness.

In relation to alliance, an important component of this theme that emerged from our study was the notion that treatment via the telephone is perceived as less successful in terms of maintaining rapport and developing alliance. Our results are consistent with previous investigations into psychologists' attitudes (e.g. Newman, 2004), reflecting a reluctance and concern about telephone-based treatment. Within our study, as the telephone treatment was designed as a brief monitoring control intervention (10 minutes' duration), concerns regarding alliance may have been related to the content of this treatment condition, rather than necessarily the mode of treatment delivery. This aside, despite some concern about the capacity for alliance psychologists expressed that they were also aware of the potential benefits of telephone treatment, such as improved capacity to engage clients who may not otherwise participate in treatment that required in-person attendance at a clinic. Further research is required to investigate the benefit of telephone treatment within this population. The results from our study suggest that professional attitudes regarding the potential for developing alliance over the telephone may need to be addressed in order to facilitate the uptake of this treatment modality. As well, further research investigating the efficacy of telephone treatments, with a direct comparison of modality, for people with psychotic and coexisting substance use disorders, will help to extend our understanding of the potential of this modality.

## **Limitations**

The study has several limitations that should be considered when evaluating the present conclusions and implications. Although rigorous standards for interpreting and analysing the qualitative data were applied, the researchers' experiences and subjectivity may have affected results. The interviewer (AS) was a psychologist working within the field of psychotic disorders, who has had some previous professional contact with participants. Therefore it is possible that her subjective experience may have unintentionally guided participant responses or influenced interpretation of the data at times. Although validity checks were included in the analysis phase as a precaution against this potential bias, we cannot be certain that this experience did not affect the data collection phase of the study.

In addition to this, although this study attempted to explore psychologists' attitudes toward telephone treatments, the sample of participants interviewed had only limited experience of this modality, and this was confined to the HLP trial. It is thus difficult to ascertain if the experiences were relevant to the particular treatment delivered by participating HLP psychologists, or can be considered as more generally reflective of telephone treatment for psychosis. Further, we do not currently have data on the treatment outcomes of HLP trial participants with psychosis to determine whether alliance or telephone treatment affected a person's treatment response.

### **Future Directions and Clinical implications**

The current study highlights some important professional considerations for psychologists working with people experiencing psychotic illness. Specifically, the difficulties in developing alliance with people with co-existing psychotic and substance use disorder reported by psychologists (particularly in the early stages of their career), highlights the importance of appropriate training, reflective practice and clinical experience and ongoing supervision when working within this field. Experience and clinical exposure may

be especially relevant to working with people with psychosis, as contact and familiarity appear to be important in developing the psychologist's capacity to overcome stigmatising beliefs and develop a strong therapeutic relationship. As well, the impact of transference and counter-transference processes has important implications for reflective practice and the psychologist's confidence and motivation in treatment of people with psychotic disorders. Despite the complexities and identified challenges inherent in working with psychotic populations, it seems that developing meaningful therapeutic relationships are possible, even in the context of active symptoms, and that therapist and client can work together on a structured evidence-based treatment package, potentially utilising alternative treatment modalities (e.g. telephone) to traditional in-person approaches. Further work is also required to determine the client perceptions of treatment offered within the HLP and other treatment programs for people with psychosis, along with their impressions and experiences of treatment delivered via the telephone.



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## Tables

Table 1

### *Interview Schedule Utilised in the Current Study*

Interview Theme	Question/Prompts
Working with people with psychosis	<p>How would you describe your experience of working with people with psychosis?</p> <p>What do you think of providing treatment to this client group?</p> <p>How do you feel about your work?</p> <p>How does working with this population compare to working with other clinical populations? Prompt feelings and thoughts,</p>
Telephone delivery of treatment	<p>What do you think of providing therapy over the telephone?</p> <p>Can you describe what you feel are the strengths and weakness of this modality for treatment delivery?</p>
Structured treatment	<p>What is your experience of working within</p>

	a research program like?
	How do you feel about providing therapy in this way?



Table 2

*Superordinate and Corresponding Subordinate Themes Describing the Therapist's Experiences of Providing Therapy to People with a Psychotic Disorder and in Different Treatment Modalities.*

Superordinate	Subordinate
Complex and unusual experience of working with people with psychotic illness	<p>The challenging and confronting experience</p> <p>Complexity of illness is intriguing and motivating</p>
Each client is an individual	
Layers of Interaction between therapist and client	<p>Transference of engagement, motivations and confidence</p> <p>Primacy of connection</p>

*Note.* Superordinate themes reflected experiences expressed by all participants. Although these themes have unique and important meaning, they are also interrelated.

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## Appendix A. Ethics Approval and Information Sheet

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## **Appendix A. Ethics Approval including Information Sheet and Consent Form**



23 August 2011

## HUNTER NEW ENGLAND NSW HEALTH

Professor Amanda Baker  
Centre for Brain & Mental Health Research  
HNE Mental Health  
Calvary Mater Newcastle

Dear Professor Baker

Re: Improving the Healthy Lifestyle of People with Psychotic Disorders (08/12/17/5.10)

HNEHREC Reference No: 08/12/17/5.10  
NSW HREC Reference No: HREC/10/HNE/420  
NSW SSA Reference No: SSA/08/HNE/421

Thank you for submitting a request for an amendment to the above project. This amendment was reviewed by the Hunter New England Human Research Ethics Committee. This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review.

I am pleased to advise that the Hunter New England Human Research Ethics Committee has granted ethical approval for the following amendment requests:

- For the addition of Ms Amanda Seal as student researcher;
- For additional qualitative information regarding therapists' perceptions of and experiences in the Healthy Lifestyles treatment through interviews; and
- For the Therapist's Information and Consent Form (Version 2 dated 16 August 2011)

For the protocol: Improving the Healthy Lifestyle of People with Psychotic Disorders

Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of 5 years from the date of the approval letter of your initial application, after which a renewal application will be required if the protocol has not been completed. The above protocol is approved until February 2014.

Approval has been granted for this study to take place at the following sites:

- University of NSW
- North Sydney Central Coast Health
- Neami Hunter
- Neami Hunter Region

Hunter New England Human Research Ethics Committee  
(Locked Bag No 1)

(New Lambton NSW 2305)

Telephone (02) 49214 950 Facsimile (02) 49214 818

Email [hnehrec@hnehealth.nsw.gov.au](mailto:hnehrec@hnehealth.nsw.gov.au)

[http://www.hnehealth.nsw.gov.au/research\\_ethics\\_and\\_governance\\_unit](http://www.hnehealth.nsw.gov.au/research_ethics_and_governance_unit)

- Neami Sydney
- Salvation Army – William Booth House, Surrey Hills
- Salvation Army Lake Macquarie
- Salvation Army Central Coast

The *National Statement on Ethical Conduct in Human Research (2007)* which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- A report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is February 2012. A proforma for the annual report will be sent two weeks prior to the due date.
- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.
- All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.
- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
  - any serious or unexpected adverse events
    - Adverse events, however minor, must be recorded as observed by the Investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the Investigator or his deputies considers the event to be related to the trial substance or procedure.
    - Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Professional Officer of the Hunter New England Human Research Ethics Committee as soon as possible and at the latest within 72 hours.
    - Copies of serious adverse event reports from other sites should be sent to the Hunter New England Human Research Ethics Committee for review as soon as possible after being received.
    - Serious adverse events are defined as:
      - Causing death, life threatening or serious disability.
      - Cause or prolong hospitalisation.
      - Overdoses, cancers, congenital abnormalities whether judged to be caused by the investigational agent or new procedure or not.
  - Unforeseen events that might affect continued ethical acceptability of the project.

If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gorrard, the Professional Officer of the Hunter New England Human Research Ethics Committee as soon as possible.

Hunter New England Human Research Ethics Committee  
(Locked Bag No 1)

(New Lambton NSW 2305)

Telephone (02) 49214 950 Facsimile (02) 49214 518

Email [hnehrec@hnehealth.nsw.gov.au](mailto:hnehrec@hnehealth.nsw.gov.au)

[http://www.hnehealth.nsw.gov.au/research\\_ethics\\_and\\_governance\\_unit](http://www.hnehealth.nsw.gov.au/research_ethics_and_governance_unit)

**HUNTER NEW ENGLAND  
HUMAN RESEARCH ETHICS COMMITTEE**

**APPLICATION FOR VARIATION OF ETHIC APPROVAL  
FOR RESEARCH INVOLVING HUMANS  
VERSION: August 2010**

YES:

This form is to be used for requesting approval for proposed variations to research projects involving humans which have already been approved by Hunter New England Human Research Ethics Committee of Hunter New England Health.

Variations requiring approval may include, but are not limited to, additions to the research plan, or changes to investigators, study population, recruitment of participants, acquisition of human tissue, access to personal records, research instruments, or participant information and consent documentation. Variations must be approved before they are implemented.

You are expected to have read the *National Statement on Ethical Conduct in Human Research* (2007) and incorporated the ethical principles therein as part of your research plan. The Statement applies to all human research and is not restricted to health research. It is available at [www.nhmrc.gov.au/publications/synopses/e35syn.htm](http://www.nhmrc.gov.au/publications/synopses/e35syn.htm)

Care should be taken in the preparation of the application, ensuring that all questions are fully answered and that the application is professionally presented.

Answers to questions must be:

**Typed** using a font size no smaller than Arial 10pt or Times New Roman 11pt.

Expressed in plain English. Prior knowledge should not be assumed. Where it is necessary to use technical terms these must be explained.

Enter the answer in the space provided – this can be expanded if insufficient although answers should be as concise as possible while at the same time providing the required detail. Do not answer questions with "see attached" or "refer to funding application".

Submission:

Submit the original version of the completed application for variation and attachments as required as well as an electronic version of the completed application for variation and attachments as required to [NEHREC@hnehealth.nsw.gov.au](mailto:NEHREC@hnehealth.nsw.gov.au)

Applications may be posted to

Hunter New England Human Research Ethics Committee  
Hunter New England Health  
Locked Bag 1  
New Lambton NSW 2305

or Hand Delivered to

Hunter New England Health Research Ethics Unit  
Administration Building  
Lockout Road  
New Lambton NSW 2305

Please Contact

Dr Nicola Gerrard  
Manager Research Ethics and Governance  
Tel: 49214950 or 49214943  
Email: [hnehec@hnehealth.nsw.gov.au](mailto:hnehec@hnehealth.nsw.gov.au)

**HUNTER NEW ENGLAND  
HUMAN RESEARCH ETHICS COMMITTEE**

**APPLICATION FOR VARIATION OF ETHIC APPROVAL  
FOR RESEARCH INVOLVING HUMANS  
VERSION August 2010**

**CHIEF INVESTIGATOR or PROJECT SUPERVISOR** (first named on the approval notification)

Name: Title / first name / family name	Professor Amanda Baker	
Qualifications & position held:	PhD, MPsych (Clin), BA (Hons); Professor	
Organisational unit & mailing address:	Centre for Brain and Mental Health Research	
Telephone and Fax:	P: (02) 40335721 F: (02) 40335692	
Email address:	Amanda.baker@newcastle.edu.au	

**TITLE OF PROJECT** (as it appears on the approval notification)

Healthy Lifestyle intervention for cardiovascular disease risk reduction among people with psychotic disorders

**IS THIS RESEARCH BEING CONDUCTED AS**

**SINGLE CENTRE RESEARCH** (ie only within Hunter New England Health)

☐

**MULTI CENTRE RESEARCH**

☒

If so, please name those sites for which approval from the Hunter New England Human Research Ethics Committee extends:

University of NSW  
Northern Sydney Central Coast Health  
The Alfred Hospital, Melbourne

**APPROVAL DETAILS**

What is the Hunter New England Human Research Ethics Committee reference number for the project?

08/12/17/5.10

What was the date of approval from the Hunter New England Human Research Ethics Committee,  
04/02/2009

**STUDENT RESEARCH**

Is the research being completed as part or whole of a degree or qualification?

Yes

X

No

If YES: Name of student:

Vanessa Clark

Name of student:	Amanda Searl	Student No:	3006197
School/Faculty/Campus	University of Newcastle	University Drive, Callaghan, 2308, NSW	
Telephone and Fax:	0425360823	(02) 4033 5692	
Email address:	a3006197@uon.edu.au		
Course of study:	Master of Clinical Psychology		
Principal supervisor:	Dr Frances Kay-Lambkin		

### 7.3 Deletion of research personnel (leave blank if not applicable)

For each person who is leaving the research team, please provide the following details.

Name: Title / first name / family name	
Organisational unit	
Email address:	
Previous role on research project	
Reason for leaving project (brief statement)	

*Copy table and repeat for each additional person as required.*

### DETAILS OF PROPOSED VARIATION

Using Plain English, provide details of the proposed variation(s) to the research protocol. Where appropriate, present in terms of from the existing protocol to the new protocol.

*(Attach the original of any documents that are new or revised as a result of the variation, eg advertisements, participant information sheets, surveys, clinical protocols.*

*For revised documents, please highlight changes and identify them with VERSION # and DATE.)*

The proposed variation to the Healthy Lifestyles project is that additional qualitative information regarding therapists' perceptions of and experiences in the Healthy Lifestyles treatment be collected. Specifically, we propose to conduct individual interviews with each of the Healthy Lifestyles staff members who delivered treatment to participants on the trial.

The aim is to gain rich qualitative insight into psychologists' experiences of delivering treatment to individuals with psychosis. Within this, we aim to provide a greater depth of understanding regarding psychologists' attitudes toward providing psychological treatment across different modes of delivery (telephone or face-to-face) and in different contexts (research or clinical settings).

Information will be gathered through a semi-structured interview of approximately 1 hour duration. The interviewers' intention will always be to use questions as a guide for conversation, with the aim of facilitating discussion of each the specific aims in greater depth. The semi-structured interview style will be crucial to this flexible information gathering.

Principle researcher Frances Kay-Lambkin will select 6-8 participants to be approached for data collection. To assist us to explore a diverse range of experiences, therapists will be sourced from the four participating research sites (Newcastle, Central Coast, Sydney and Melbourne) with varying degrees of experience.

### JUSTIFICATION FOR VARIATION

Why is the variation necessary?

The proposed variation will allow a deep exploration of therapists' factors (including: expectation, perceptions and attitudes) influencing the delivery of treatment to people with a psychotic disorder. People with psychosis have a history of poor treatment participation and response [1], including early discontinuation of treatment [1, 2]. Despite considerable development in evidence based treatments, barriers to the delivery and success of treatments remain poorly understood and methods of effectively engaging and retaining clients are limited [2]. A recent study suggests that mental health professionals exhibit poorer attitudes & expectancy in treatment outcomes for people with a psychotic disorder [3]. To our knowledge no studies have explored how these factors may contribute to the therapeutic relationship, treatment delivery or treatment outcomes within this client group. In general, studies investigating how therapists' attitudes and beliefs influence the therapeutic alliance indicate that therapist characteristics such as being critical or distant will contribute to a poor alliance [4]. As well the therapists' experience of difficulties in practice is a particularly strong predictor of poor therapeutic alliance [5]. As the development and strength of the alliance is related to treatment outcome [6, 7], furthering our understanding of these factors is a crucial consideration in developing psychological care for this complex client group.

The proposed variation will also develop our understanding of the therapists' attitudes and beliefs towards using phone therapy. 'Tele-care' is an emerging mode of treatment delivery and the benefit of use is well established in mood disorders [8]. There is little research however, into telephone treatment for psychotic disorders, yet this is a group who demonstrates such difficulty in maintaining regular face to face contact [1]. One potential barrier is that psychologists may be uncomfortable with the idea of using technology for therapy, with the perception it interferes with the therapeutic relationship [9]. To our knowledge this will be the first study to examine psychologist's attitudes toward phone therapy for this client group. Providing an avenue for developing understanding and potentially reducing barriers to treatment innovation.

The proposed variation will further understanding about the provision of treatment within a research context. It is often disputed that the results of research treatment programs have "real world" significance and a capacity for being replicated in clinical settings [11]. Along with this, the structured and manualised nature of research treatment has been identified by psychologists as limiting and a challenge for the therapeutic relationship [12]. In contrast other psychologists in the same study reported a belief that manualised treatment promotes evidence based practice [12]. This is the only study to our knowledge to examine psychologist's attitudes toward manualised treatment and while it has implications for research interventions, it does not explore the range of experiences and attitudes associated with working within a research program. Further exploration of how attitudes vary according to the context of treatment delivery, will broaden the scope of understanding the psychologists experience and capacity to deliver treatment.

#### References

1. Nose, M., Barbui, C., Gray, R., & Tansella, M. (2003). Clinical interventions for treatment non-adherence in psychosis: meta-analysis. *British Journal of Psychiatry*, 183, 197-206.
2. Barnett, S., Chua, W-J., Crits-Christoph, P., Gibbons, M. B., Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training*, 45, 247-267.
3. Jorm, A. F., Jacomb, P. A., Christensen, H. (1999). Attitudes towards people with a mental disorder: a survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry*, 33, 77-83.
4. Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, 38, 171-185.
5. Nissen-Lie, H. A., Monsen, J. T., Ronnestad, M. H. (2010). Therapist predictors of early patient-rated working alliance: A multilevel approach. *Psychotherapy Research*, 20, 627-646.
6. Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy. *Psychotherapy*, 38(4), 357-361.
7. Meyer, B., Pilkonis, P. A., Krupnick, J. L., Egan, M. K., Simmens, S. J., & Sotsky, S. M. (2002). Treatment expectancies, patient alliance, and outcome: Further analyses from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 70, 1051-1055.

8. Reese, R. J., Cotte, W., Conoley, C.W., & Brossert, D. F. (2005). Attractiveness of telephone counselling. *Journal of Counseling Psychology*, 49, 233-242.
9. Newman, M. G. (2003). Technology in psychotherapy. *Journal of Clinical Psychology*, 60, 141-145.
10. List, J.A. (2006). Field Experiments: A Bridge between Lab and Naturally Occurring Data. *Advances in Economic Analysis and Policy*, 6(2), 1747-1756.
11. Addis, M. E., & Krasnow, A. D. (2010). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology*, 68(2), 331-339.

#### RESEARCH PARTICIPANTS

Does the variation involve recruiting new participant groups, or changing the way in which participants are to be recruited?	Yes	X	No	
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If YES, provide full details using the following headings:

**What is the participant group?** Psychologists providing therapy on HLP

**What is the number of participants involved and what is the justification for choosing this number?** 6-8 participants, as it is considered the optimal number for our interpretive phenomenological approach.

**From where will the participants be recruited?** Healthy Lifestyles Treatment program (HLP)

**How and by whom will participants be approached to receive the invitation to participate?** HLP therapists will be invited to participate in the study via an emailed information sheet detailing the broad aim and requirements of the study. They will be notified that participation will involve a one-to-one semi-structured interview (which will be recorded) of approximately 1hour duration. All therapists will be informed that participation is voluntary and is not a requirement of their work on the HLP. They will also be told that their decision to participate or not, will in no way affect their employment within the research program or participating organisations. Informed consent will be requested and participants will be asked to provide email confirmation of participation.

**How much time will participants have to consider the invitation to participate?** Therapists will be given one week following provision of the information sheet and consent form to consider the invitation to participate. At the conclusion of this week, therapists will be contacted via email to discuss participation in the study.

#### ETHICAL CONSIDERATIONS

What ethical considerations, if any, are raised by the proposed variation? (Refer to the *National Statement on Ethical Conduct in Research Involving Humans*, section 1 and other sections relevant to the project.)

Only participants who provide informed consent to participate will be included in the study. This will be indicated by email consent reply.

There is a small potential risk for psychosocial harm to participants because assessment questions will refer to their professional capacity and work with a complex client group. It is possible that participants may experience some emotional discomfort whilst relaying this information. This potential risk for harm will be addressed by: i) informing the participant that they may discontinue the interview at any time ii) by ensuring there will only be a single interviewer who will have an understanding of the therapy and client group and who will use clinical interviewing skills to create a non-judgemental, warm and receptive climate iii) the option of referral to further services or peer debriefing if required.

The data obtained will be kept for 15 years (in accordance with the State Records Act NSW and the

Joint NHMRC/AVCC Statement and Guidelines on Research Practices). However, names and addresses will be destroyed after 5 years. Hard copies of interview transcripts will be data entered on a password protected electronic database that is accessible only to the research team and is back up on a daily basis to a secure server.

Transcriptions of interviews will not include participant name or other potentially identifiable information (e.g. discussion of specific suburbs, acquaintances, events etc). Reference to potentially identifiable situations or other information that is relevant to the research question will only be transcribed in general terms and themes. Interviews will be recorded digitally, and stored as computer audio files on a secure server, accessible only to the research team. Transcribed interviews will be stored as computer files. File names will only specify the participant code (not any identifying information) and will be stored in secure password protected files accessible only to the researchers.

Participants will be advised and reminded throughout the interview that they are under no obligation to consent to the audiotaping of their interview session. They will also be advised that, if they do agree to the audiotaping, the interviewer will give them the opportunity at the beginning and end of the interview to revise this decision. Participants will also be free to stop and edit the audiotape at any time during the interview. At the conclusion of the interview, participants will be given the opportunity to review the audiotape, and make any deletions they feel are necessary.

As this research is a descriptive study, summarising general trends regarding therapists experiences, attitudes and perceptions, results will only be made available to participants, upon request, in their summarised format at the conclusion of the analysis phase.

Please note that this variation is to conduct further research with the staff associated with the Healthy Lifestyles Treatment program, and not participants with mental health problems who were the target group for the study.

#### GOVERNANCE CONSIDERATIONS

Please advise if this variation will have any implications for governance such as changes to the site specific assessment form or the regulatory documentation.	Yes	No	X
---	-----	----	---

If Yes, please advise the change and the documentation affects (and submit accordingly.)

#### REVISED DOCUMENTATION

Please list all the documentation that needs to be revised and is being submitted with this application for variation (ensure that the version numbers and dated are also revised)

See Attachments  
Participant Information Copy  
Consent Form Copy for participant

#### DECLARATION

In signing this application, I declare that:

1. The research protocol conforms to the *National Statement on Ethical Conduct in Human Research (2007)*, which I have read.
2. The required number of any documents that are new or revised as a result of the variation, are attached, eg advertisements, participant information sheets, consent forms, surveys, clinical protocols.
3. The variation will not be implemented prior to receiving approval from the ethics committee(s).



4. I make this application on the basis that the information it contains is confidential and will be used by Hunter New England Health for the purposes of ethical review and monitoring of the research project described herein, and to satisfy reporting requirements to regulatory bodies. The information will not be used for any other purpose without my prior consent.

5. I agree to the title of my research being listed for reporting purposes as required by Hunter New England Health, NSW Health or the NHMRC

YES ☒

NO

☐

If you object to the title of your research being included could you please provide a valid reason for its omission from the reporting process.

---

---

Signature of chief investigator/project supervisor:	<i>Amanda Baker</i>
Date:	19 <sup>th</sup> July 2011

PLEASE ENSURE AN ELECTRONIC COPY OF THIS FORM AND ATTACHED DOCUMENTS IS SUBMITTED TO

[HNEHREC@HNEHEALTH.NSW.GOV.AU](mailto:HNEHREC@HNEHEALTH.NSW.GOV.AU)

Part letterhead for Centre for Brain and  
Mental Health Research, University of  
Newcastle

Associate Professor Amanda Baker  
Senior Clinical Psychologist  
McAuley Centre, Calvary Mater Hospital  
Phone: 02 4033 5690 Fax: 02 4033 5692  
E-mail: [amanda.baker@newcastle.edu.au](mailto:amanda.baker@newcastle.edu.au)

Dear [Therapists name]

Re: Healthy Lifestyles Project – Exploration of Therapists Attitudes and Experiences.

I am writing to advise you that we will be conducting a study exploring psychologists' experiences and attitudes toward treatment for people with psychosis. We are interested in listening to your experiences of working with people with a psychotic disorder on the HLP. Please read the information that follows, as it explains in detail what participation will involve. If you agree to participate please reply by email with the completed consent form attached. Please reply within 10 working days.

#### Information Sheet (Version 1, 2 July 2011)

##### What is involved?

Participation will involve a one-to-one informal interview over the telephone, to help us understand more about your opinions and experiences. This interview will be recorded and will take approximately 1 hour to complete.

##### How will we use your information?

Data collected will be used by Amanda Searl (Research Assistant) towards partial completion of a Master of Clinical Psychology, under the supervision of Dr Frances Kay Lambkin.

Your participation is entirely voluntary and you can decline to participate at any stage. Participation is not a requirement of their work on the HLP and your decision to participate or not, will in no way affect your employment within the research program or participating organisations.

Where permission is granted, the interview will be recorded and unidentifiable password protected audio files will be only accessible to researchers directly involved in the study.

If you decide you are interested in participating, we will then arrange an appropriate time to carry out the interview.

If you wish to speak to someone about this aspect of the study, you can contact Amanda Searl on (02) 4035716 or 0425360623.

Thank you again for your role within the project and for considering participation.

Regards,

Amanda Baker  
Chief Investigator  
Healthy Lifestyles Project  
Centre for Brain & Mental Health Research

Joint letterhead for Centre for Brain and Mental  
Health Research, University of Newcastle

Professor Amanda Baker  
Senior Clinical Psychologist  
McAuley Centre, Calvary Mater Hospital  
Phone: 02 4033 5690 Fax: 02 4033 5692  
E-mail: amanda.baker@newcastle.edu.au

### Consent Form

*Please attach completed form and reply by email.*

I, \_\_\_\_\_, agree to participate in the Healthy  
Lifestyles Project – Exploration of Therapists Attitudes and Experiences.

I understand that only the research team consisting of Amanda Searl and supervisor Dr Frances Kay-Lambkin, as well as chief investigator Dr Amanda Baker will have access to the data. All information I provide is completely confidential and will not be passed on to any other person, except as required by law.

I acknowledge that I have read the attached information sheet, explaining the nature and aims of the project, and the statement has been explained to my satisfaction.

Before agreeing to participate I have been given the opportunity to ask any questions relating to the project and have received satisfactory answers.

I am aware that I may not necessarily personally benefit from participation in this project.

I understand that the interview in which I participate will be audiotaped for later transcribing by the research team, and give my permission for this to occur. I understand that audiotapes will not contain my name or any other identifying information that links the audiotape to me.

I understand that I can withdraw from this project at any time, I do not have to give my reasons for withdrawing and this will not affect either my current or future treatment. This also applies to my consent to audiotaping the interview.

I agree that data gathered during the course of this project may be published providing that names or identifying information is not used.

**CONSENT BY PARTICIPANT:** I hereby certify that I have read and understood all the information provided, and that I have been allowed to ask questions. Healthy Lifestyles Project – Exploration of Therapists Attitudes and Experiences.

23 August 2011

## HUNTER NEW ENGLAND NSW HEALTH

Professor Amanda Baker  
Centre for Brain & Mental Health Research  
HNE Mental Health  
Calvary Mater Newcastle

Dear Professor Baker

**Re: Improving the Healthy Lifestyle of People with Psychotic Disorders (08/12/17/5.10)**

**HNEHREC Reference No: 08/12/17/5.10**  
**NSW HREC Reference No: HREC/10/HNE/420**  
**NSW SSA Reference No: SSA/08/HNE/421**

Thank you for submitting a request for an amendment to the above project. This amendment was reviewed by the Hunter New England Human Research Ethics Committee. This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review.

I am pleased to advise that the Hunter New England Human Research Ethics Committee has granted ethical approval for the following amendment requests:

- For the addition of Ms Amanda Searl as student researcher;
- For additional qualitative information regarding therapists' perceptions of and experiences in the Healthy Lifestyles treatment through interviews; and
- For the Therapist's Information and Consent Form (Version 2 dated 16 August 2011)

**For the protocol: Improving the Healthy Lifestyle of People with Psychotic Disorders**

Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of 5 years from the date of the approval letter of your initial application, after which a renewal application will be required if the protocol has not been completed. The above protocol is approved until February 2014.

Approval has been granted for this study to take place at the following sites:

- University of NSW
- North Sydney Central Coast Health
- Neami Hunter
- Neami Hunter Region

Hunter New England Human Research Ethics Committee  
(Locked Bag No 1)  
(New Lambton NSW 2305)

Telephone (02) 49214 650 Facsimile (02) 49214 618

Email [hnehrec@hnehealth.nsw.gov.au](mailto:hnehrec@hnehealth.nsw.gov.au)

[http://www.hnehealth.nsw.gov.au/research\\_ethics\\_and\\_governance\\_unit](http://www.hnehealth.nsw.gov.au/research_ethics_and_governance_unit)

- Neami Sydney
- Salvation Army – William Booth House, Surrey Hills
- Salvation Army Lake Macquarie
- Salvation Army Central Coast

The *National Statement on Ethical Conduct in Human Research (2007)* which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- A report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is **February 2012**. A proforma for the annual report will be sent two weeks prior to the due date.
- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.
- All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.
- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
  - any serious or unexpected adverse events
    - Adverse events, however minor, must be recorded as observed by the Investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the Investigator or his deputies considers the event to be related to the trial substance or procedure.
    - Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Professional Officer of the Hunter New England Human Research Ethics Committee as soon as possible and at the latest within 72 hours.
    - Copies of serious adverse event reports from other sites should be sent to the Hunter New England Human Research Ethics Committee for review as soon as possible after being received.
    - Serious adverse events are defined as:
      - Causing death, life threatening or serious disability.
      - Cause or prolong hospitalisation.
      - Overdoses, cancers, congenital abnormalities whether judged to be caused by the investigational agent or new procedure or not.
  - Unforeseen events that might affect continued ethical acceptability of the project.
- If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand, the Professional Officer of the Hunter New England Human Research Ethics Committee as soon as possible.

## **Appendix B. Extended Methodology**

## **Extended Methodology**

### **Design**

The study employed a qualitative methodology utilizing Interpretative Phenomenological Analysis (IPA) .

Influenced by phenomenology, IPA acknowledges both the existence of individual differences in ways of thinking, as well as the impact of human interaction and wider contextual factors (e.g. culture, environment) upon the individuals' views of the world and meanings that they ascribe to their experiences (Shaw, 2001; Smith, 1995). IPA was judged to be the best approach for analyzing the present data as we were interested not only in individual constructs and perceptions, but also on the shared meanings of experience of the therapists (Chapman & Smith, 2002; Larkin, Watts & Clifton, 2006). Furthermore, given we were exploring novel areas of research, the exploratory style of IPA allowed for a deeper and unrestricted study of the psychologists' experiences.

### **Procedure**

HLP therapists were invited to participate in the study via an emailed information sheet detailing the broad aim and requirements of the study. Therapists were informed that the aim of the study was to explore their experiences and attitudes toward different modalities of treatment for people with psychosis. Also, they were notified that participation would involve a one-to-one semi-structured interview (which would be recorded) of approximately 1 hour duration. Informed consent was requested for participation and participation was voluntary and not a requirement of their work on the HLP. The therapist's decision to participate in no way affected their employment within the research program or participating organisations, and the current study was conducted separately to the ongoing HLP research project.

Consenting participants were telephoned at an arranged time to complete their individual interview. All interviews were recorded using a digital recording system. To ensure consistency and reduce variability in the data collection, all interviews were conducted by the same interviewer (AS), who is a provisionally registered psychologist with clinical and research experience. Ethical approval was obtained from the Hunter New England Human Research Ethics Committee (08/12/17/5.10).

## **HLP**

Detailed methods for the HLP have been reported elsewhere (Baker et al., 2011), see Appendix E for figure summarising HLP study design. Of relevance to the current study, two treatment arms were delivered to participants.

**Session one (face-to-face delivery).** All participants received session one in face-to-face format, of approximately one hours' duration, conducted in research clinics associated with the HLP. The session comprised formal feedback to participants about their smoking status and other risk factors for cardiovascular disease. A case formulation regarding cardiovascular risk was developed in collaboration with the participant, using a motivational interviewing approach to facilitate consideration of changes in unhealthy behaviours associated with cardiovascular risk. At the conclusion of this session, participants randomized to receive sixteen further sessions over nine months, delivered either face-to-face as per session one, or over the telephone (control).

**Nicotine replacement therapy (NRT).** All participants, regardless of treatment group, received free NRT to assist with cravings and withdrawal symptoms related to any smoking cessation attempts. Following the delivery of session one, participants received four weeks' supply of NRT to take with them, regardless of treatment allocation. The remaining NRT was provided to participants at weeks four, eight and fifteen.



**Sessions two-seventeen (face-to-face delivery).** In addition to session one, this active treatment condition involved seven weekly, three fortnightly and six monthly treatment sessions, of one hours' duration, delivered face-to-face in research clinics associated with the HLP. The focus of each session, although manual guided, was designed to be flexibly implemented, with participants able to concentrate on smoking cessation, physical activity or diet and nutrition as they preferred. Contingency reinforcement was integrated within these sessions, and focused on smoking cessation. Motivational interviewing and cognitive behaviour therapy were employed throughout.

**Session two-seventeen (control, telephone-based delivery).** Following randomization, participants in this minimal treatment (control) condition received telephone calls of approximately 10 minutes' duration, at the same intervals as the face-to-face condition (seven weekly, three fortnightly and six monthly). This condition was designed to control for the num of therapist contacts in the face-to-face condition. The content of these sessions included formal monitoring of smoking and NRT use, nicotine withdrawal symptoms, psychotic symptoms, mood, and diet and exercise activities. In place of telephone-based sessions at sessions four and eight, participants attended in –person session at the HLP research clinics for provision of NRT and formal monitoring.

## **The Current Study**

The current study focussed on the therapists who delivered the HLP treatment (either in-person or via the telephone).

## **Participants**

Participants were six psychologists who have been providing therapeutic intervention on the HLP program. Five female and one male psychologist participated. All participants

were provisionally or fully registered psychologists with a range of both clinical and research experience. Participants were from the four participating research sites (Newcastle, Central Coast, Sydney and Melbourne) with diverse cultural and linguistic backgrounds.

Purposive sampling was employed, as is generally recommended within this approach (Smith & Osborne, 2003), to ensure that the phenomenon of interest could be thoroughly explored. Participants' involvement in HLP treatment provision ensured they were psychologists who had experienced providing therapy to people with a psychotic disorder, as well as different modalities of treatment provision as described above. Ethical approval was obtained from the Hunter New England Human Research Ethics Committee, (08/12/17/5.10).

## **Procedure**

HLP therapists were invited to participate in the study via an emailed information sheet detailing the broad aim and requirements of the study (See Appendix B, Information Sheet). Therapists were informed that the aim of the study was to explore therapist's experiences and attitudes toward different modalities of treatment for people with psychosis. Also, they were notified that participation would involve a one-to-one semi-structured interview (which would be recorded) of approximately 1 hour duration. Informed consent was requested for participation and all therapists were informed that participation was voluntary and is not a requirement of their work on the HLP (See Appendix B, Consent form). They were told that their decision to participate or not, would in no way affect their employment within the research program or participating organisations.

Participants who agreed to participate were phoned at an arranged time to complete their interview. All interviews were recorded using a digital recording system. To ensure consistency and reduce variability in the data collection all interviews were conducted by the

same interviewer, who is a provisionally registered psychologist with clinical and research experience.

### **Data collection**

Data was collected through a semi-structured interview. As it recommended that the experience of participants be examined and interpreted in naturally occurring settings (Smith, Flowers, Larkin, 2009), interviews were via telephone in the participant's office of work. To ensure privacy and remove any potential for distraction, a therapy room within the office of both interviewer and interviewee was booked.

The interview was flexibly guided by a broad list of questions and prompts (See Appendix D. Interview schedule) aimed at exploring a range of experiences and attitudes. It was considered important to develop a schedule in advance in order to consider outcomes of the interview, as well as anticipate difficulties that may arise (Smith and Osborn, 2003). The interviewer used the prepared schedule to find a balance between providing the structure for relevant issues to be discussed, while allowing the participant to freely express their experiences and co-determine the interaction. Specifically, issues in relation to treatment expectations and experience of working with people with psychosis were explored. Along with this the interview explored therapists' attitudes toward providing face-to-face in comparison to telephone interventions, as well as the experience of treatment provision within a research program. Interviewing techniques outlined by Smith & Osborn (2003) were observed, including: taking time to speak slowly and allow thoughtful response; allowing and using silence; using minimal probes and prompts; asking one question at a time; and observing and monitoring the effect of the interview on the interviewer.

Interviews were conducted until data saturation was reached to determine a sample size of six. Data saturation means that sufficient depth of information had been

obtained and all themes were likely to have emerged in the data (Pope, Ziebland & Mays, 2000). The interviewer gradually became aware of saturation, as participants were no longer adding new information.

### **Analytic strategy**

IPA is a cyclical process and the researcher proceeded through several key iterative stages to analyse the data (for a detailed description of the Analytic process see Appendix E, Detailed procedure for Interpretative Phenomenological Analysis). The first stage was to encounter with the text. The researcher recorded a verbatim transcription of each interview, following its completion. The researcher read the transcription several times, making notes in relation to the thoughts and feelings of the participant and /or interviewer, as well as emerging psychological themes. Preliminary themes were identified, grouping themes together as clusters and tabulating themes in a summary table. This was completed for each interview, prior to commencing the next. Following completion of each interview the researcher also re-read previous interviews to compare and consider themes.

The final stage of analysis was to link themes from each participant's experience together and interpret meaning. The themes from all interviews were drawn together into a master list of themes, reflected by the group as a whole. A comparative process was then undertaken to identify superordinate and subordinate themes. Superordinate themes were major themes, identified by all participants and subordinate themes describe the different meanings and cognitions associated with those themes (Smith, . At this stage, the researcher compared back to each participant's interview to ensure accurate meaning was derived. This was done by reviewing each theme and identifying and recording quotations from each participant's transcript, which reflect this theme. Themes were then prioritised on the basis of their prevalence within the data, the richness of the particular passages that highlight the

themes as well as how the theme will assist to clarify and explain the experience of the participants.

### **Procedure for trustworthiness and credibility in analysis**

The researcher also worked as a HLP therapist and was a provisional psychologist undergoing training as a clinical psychologist. This benefited her to be easily immersed in the therapist's subjective experience as well as provided her with the skills to explore, reflect on and interpret participant responses. As her experience is likely to have influenced the interview and interpretation of the data, it was especially important to aware of and transparent about any biases. Attention was paid to self-reflection when asking questions and interpreting responses. In addition, the 1<sup>st</sup>, 4<sup>th</sup> and 6th interview was co-rated by the supervising researcher and the first four interviews reviewed by an independent expert, who has not been involved in the HLP to date. A journal for self-reflection during transcription and interpretation was also used to assist with this.

More detailed description of the analytical process in the Manuscript...how did themes emerge (not simply responses to direct questions), how were we sure that data saturation was reached, and more detail on your role as a clinical psychologist in the analysis (kind of a reflective section on your role, what you brought, etc.) - to determine credibility of the analysis. Then address these issues in the discussion.

## **Appendix C. HLP Study Design**

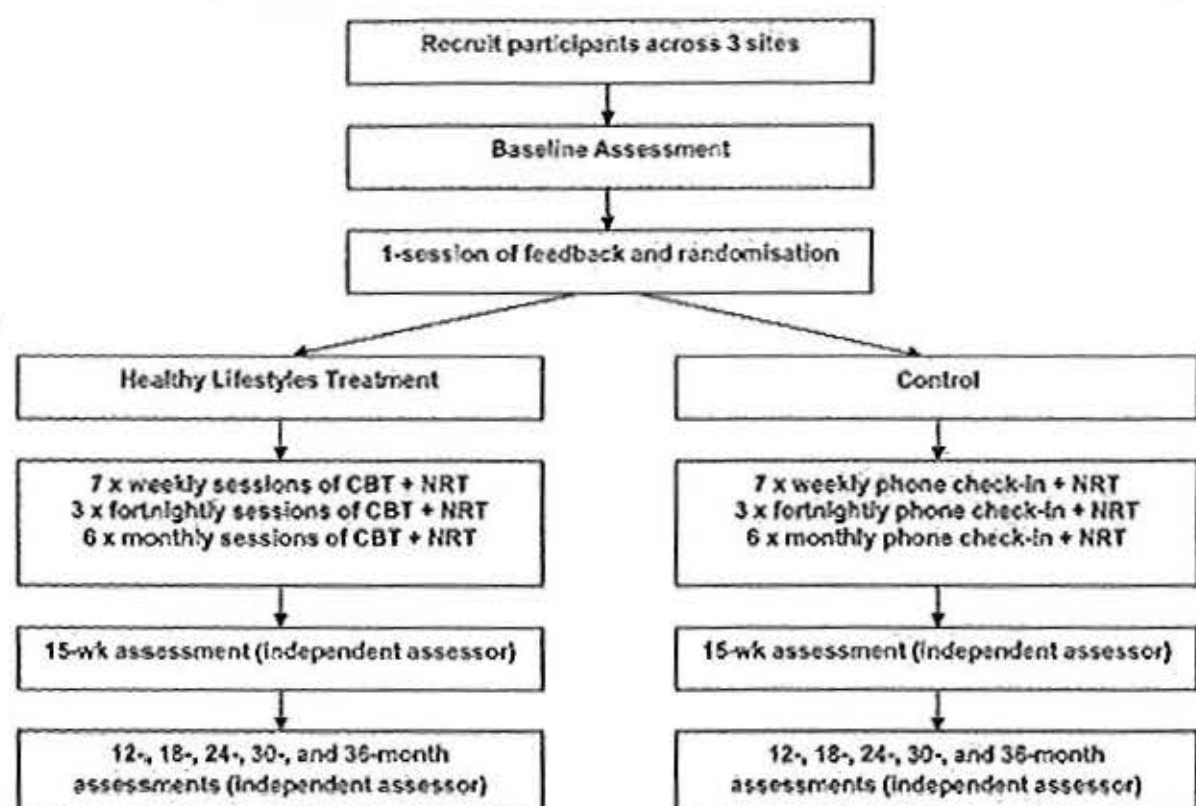


Figure 1. HLP Study Design

## **Appendix D. Interview Schedule**



**Interview Schedule- Psychologists Experiences of Working with People with Psychosis****Working with people with psychosis**

- How would you describe your experience of working with people with psychosis
- What do you think of providing treatment to this clients group?
- How do you feel about your work?
- How does working with this population compare to working with other clinical populations? Prompt feelings and thoughts,

**Telephone Delivery of treatment**

- What do you think of providing therapy over the telephone?
- Can you describe what you feel are the strengths and weakness of this modality for treatment delivery?

**Structured Treatment**

- What is your experience of working within a research program like?
- How do you feel about providing therapy in this way?

## **Appendix E. Detailed Procedure Undertaken for Interpretative Phenomenological Analysis**

**Detailed Procedure Undertaken for Interpretative Phenomenological Analysis**

1. Verbatim transcription of the interview was recorded; this may have included pauses, laughing, tone, minimal prompts and other expression.
2. Text from verbatim transcription was converted into a table with three columns for initial analysis. Columns were labelled: Transcription , Notes and Psychological Themes.
3. Transcription was then thoroughly read for the first time making any notes/reflections about the text in column two- 'Notes'. The Notes column summarised thoughts and made any initial formulations about the meaning of text.
4. Transcription was then read for a second time, writing down statements in the third column- "Psychological Themes" to reflect the psychological meaning of the text/notes and any themes reflective of the meaning of the text. The label or psychological theme was a sentence or word reflective of textual meaning. During this stage, the analysers focussed ensuring that every line of text was represented somewhere and all themes accurately reflected meaning.
5. In a separate document, a chronological list of the psychological themes was created, identified in the order in which they occurred in the transcript. All themes were included.
6. A new document was created which contained a table with two columns and several rows. Themes were then grouped together into similar concepts and entered into individual cells of the table.
7. Once all psychological themes were in one cell of the Table, each cell was labelled by considering the meaning of themes included in that cell.

**Steps 1-7 were completed for each interview prior to commencing the subsequent interview.**

8. Each interview was allocated a colour (e.g. Purple). The Step 5 table was cut up into individual cells (label and related psychological themes) and each cell was pasted onto the colour allocated to that interview.
9. Psychological themes (individual cells) across interviews were then considered, with each colour describing psychological themes expressed by individual participants. Similar Psychological themes were grouped across participants. During this process the analyser repeatedly referred back to the original text to ensure accurate representation of the label/psychological themes and to consider meaning behind the theme. Labels were not always retained in their original form.
10. These groups of themes, which were compiled into a separate envelope for each were retained as superordinate themes. Each person must have contributed to an envelope in order for it to be retained as a superordinate theme. Participants may have expressed different perspectives (e.g. Positive and negative) on the same theme, but in order for a theme to be retained as a superordinates theme, it must contain a contribution/perspective from each participant.
11. Following this a process of 'textual grounding' occurred. An excel spreadsheet containing the following: a column for the superordinate theme, a column for the participant number, and a column for a text quotation was created. For each superordinate theme, the participant number and the actual text (quotation/s from the transcript) related to that superordinate theme was recorded. This was completed for all interviews and all superordinate themes.
12. A copy of the original interview transcript was then referred to and each superordinate theme allocated a specifying colour. Text reflecting each theme was then highlighted

in this colour. This was completed for all interviews for each superordinate theme sequentially.

13. A table was then created labelling superordinate and corresponding subordinate themes.

**Appendix F. Table for Analysis of Themes: Textual Grounding Process**

Complexity contributes to interest

Can be challenging/confronting for the therapist

I will assume one"

- 1 "I certainly don't think that I have got my head around, or many people have got their head around the real essence of psychosis, but I don't think it's very difficult for people who haven't experienced it, or even anyone, I guess to really comprehend"
- 1 "There are some aspects I think that tend themselves more, or symptoms that people experience that tend themselves more easily than that to others"
- 2 "It's hard to not to try to make sense of their values in life"

- 2 "I guess the kind of feelings of, ah, um, sadness, I guess I would be unsure of myself how I would provide treatment to someone with current psychotic symptoms, like if they were having hallucinations or delusions"

- 2 "I guess in a way it's a bit like me having a sense of like ohh, the lives of others, that there is a separation, I guess about them"

It's hard I find, because with this population, not only do they have drug and alcohol issues, you know um as well as smoking, but also have other difficulties in their lives, no difficulties with housing, difficulties with relationships, so it's just that all together"

- 3 "The more complex a client is the more you feel "oh my god, what am I going to do and you know, how are they going to change, it sort of gets you, well it gets me down"

- 4 "Working with psychosis or psychotic patients, there's a lot, yeah there is a few more challenges and you just kind of you know, that's what expected working with psychiatric patients" "It was a big learning curve for me and I did need a lot of supervision to understand what was happening and you know, how best to deal with a client like this or the situations they could potentially present themselves"

- 4 "The people, I work with are all, um they can be challenging at times, but it also depends on, you know the severity and chronicity of their illnesses"

- 4 "It just means that when I approach him, in my dealings with him, I have to be constantly prepared for all different circumstances"

- 5 "I had a couple of clients who were experiencing increased psychotic symptoms, and with that you know, there was varying degrees of insight around their changing symptoms, but also that involved they tended to move backward as far as their goals, so when there was an increase in symptoms people would often revert to their previous coping strategies"

- 5 "I think because I have been doing this for a while and I've seen um, extremes, like you know, from acutely disturbed clients in seclusion, through to community clients, I suppose I'm quite comfortable really and pretty, you know, open minded and pretty, you know nothing is going to shock me"

- 6 "I remember getting very, very personally upset about their stories, you know obviously not in front of them, but you know after, after doing my research and stuff, just you know, worrying and thinking and sort of feeling you know scared to go and do home visits, um you know what would happen and all those sorts of things"

- 6 "I find it really interesting to see the range of symptoms they do experience and then to also then see their recovery and I acknowledge that there are quite a lot of challenges to working with people who are acutely unwell, but it, it's not something that makes it too hard for me. I find it really rewarding and particularly satisfying even working through some of the difficult times"

- 6 "He doesn't tend to remember previous conversations, so have have to constantly, um, which I have learnt, not to assume that he remembers what we have previously talked about, um he, I make sure when I am talking to him, and to avoid misunderstanding that I start from the very beginning and actually explain how things or what needs to be discussed so that he understands it all. Um, another challenging aspect as well is to keep him on track, he tends to, he is very tangential, and that kind of feeds into his, um he's got a lot of grandiose ideas and it's about, it's a few juggling act I find to um, be able to let him have his say about what he feels is important but also keep what you know, our agenda is, what we need to cover, um he would be the most challenging person that I have very hard to work with"

Layers of Inter

- 1 "So there's this kind of externalizing of putting outside of personal responsibility involved which can be frustrating"

- 1 "He's just always insisting that it is too hard and he would quite eloquently express all the terrible things that happened to life, and really, I think, hit the nail on the head, quite often about the difficulties he had faced, not having a kind of model in life, he was adopted and also apparently, so it seems, treated very badly, and the impossibility really of his situation and it did occur to me, cos I always try to work out what annoys or frustrates me and it did occur to me that he was kind of presenting I me with a blank picture, which was kind of confronting for me, and you know, what do you do... his best outcome is relatively modest"

Transference of engagement, motivations and

- 1 "I am trying to convey, perhaps that this was as new, meant that I perhaps, not, feel their frustration perhaps and didn't give them the chance so much to change"

- 2 "Yeah so those ones can be quite difficult for me to get, um to just help, there's a sense of me, what can I do for you"

Primacy of Connection

- 2 "I guess particularly the ones who are merely existing as opposed to kind of having goals, I find it frustrating when their sort of not, not really in touch with any sort of goals, or working towards anything"
- "Yeah that's been difficult as well, trying to use the manual in the best way for the client, rather than just sticking to it like a robot... I guess more of a person centred approach and that's sort of been hard for me, to put my agenda aside of helping people in a person centred way, even as opposed to keeping the fidelity"
- "A bit of a disadvantage that you can't sort of see, um, their face, you can't pick up on all the non-verbals, to be able to have a lot more of their message and build a lot more rapport with them... but then again it's not such a disadvantage in that I wouldn't recommend it, I think that, not just in this program but in other programs, the advantages do outweigh the disadvantages, of phone therapy"
- "It's more than just like and educational intervention, it's more about the connection, the human experience"
- "One the most rewarding is obviously when there's, when there's outcomes, um when the participants sort of um are are motivated to do the interventions... um the most challenging thing is, is um I think maybe in this client group, their um, you know, their, their ambivalence is just quite strong and sometimes the patience of working through that is quite strong"
- "It's less personal, you know, I don't know, I wouldn't personally prefer it... If they come in and you meet with someone, I suppose it warms them up, if they walk into the building...you look at them, you know all that is all part of it."
- "Looking at their strengths and do not judging them and being where they are, I think that is really important, connecting with them, I think that really, really important, if you can connect with them, um, then there's that relationship built, then they do take that way with them when their not in the session."
- "It depended on how he presented as well, so if he was having a good day per se, it made me feel like I was getting somewhere and making progress with him, but on days when he was hostile and aggressive towards me, I um, , it made me feel unsure of that I um, it made me question my abilities to a certain extent"
- "It's about being patient and letting them have that and not being judgemental, but then also getting them to focus on what's important in the session, which can be a challenge"
- "There is a risk that if you're disregarded or things aren't working that the client will see that and potentially lose confidence in you...you know they need to, you know feel confident in you, even though I guess the role of the therapist is to guide, your not doing the work for them, but you they have to have a certain level in confidence in you that you can assist them"
- "I think the client's genuinely feel listened to , when you are able to show them that you have heard their experiences, you have heard their story"
- "I think because I am quite comfortable a lot of my barriers are down and I, maybe, I don't know, maybe that's noticeable to the client and it makes them feel at ease or comfortable, because I am not worried about what they're going to say"
- "I keep saying to myself look, were planning a road and you know, it will happen over time and we'll hopefully see that"
- "I don't know, but you know, without face-to-face contact, I think that, you know, there is just a difference in the way that you can relate to people and that people will open up so many different avenues, if you are sitting face-to-face with someone."
- I think we are going down the wrong path if we sort of pathologise everything, you know, there's a real person in there"
- "When their not acutely psychotic I don't really focus on that, I see them more as a person, you know, each of their own particular quirks and things, I don't really label it as psychotic in my mind"
- "I think um, going in open, not making assumptions based on what you read in the referred and the situation and able going in the moment and being with them at that moment, at looking at their strengths and not judging them and being where they are, I think that's really important, connecting with them, I think that's really, really important"
- "For me it's all about, that each individual client is different, you know getting to know them individually and you know working on connecting with them."
- "I don't feel that I can make generalisations about everyone as a whole, because all the different patients that I have come across have presented their own challenges, as just, being... yeah different"
- "It was quite a lengthy assessment process and I think that gives you so much information, um, about the client that you can get a thread of a story, about their life, to a degree"
- "Like I said it is always interesting, there's always something that you can learn from each client, particularly when you see them through their different stages of symptoms."





## **Appendix G. Journal Submission Details**

### **Journal Submission Details**

It is the intention of the authors to submit 'Enhancing Psychotherapy for People with Psychosis by Understanding the Experiences and Attitudes of the Psychologist' for publication with the Journal of Clinical Psychology. The Authors intend to submit the manuscript pending feedback from this thesis submission.

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