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Doctoral Thesis

Explorations of Mental Health Professionals' Views on Hope and Austerity: The Synergy of a Paradox?

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Thesis Abstract

This thesis consists of a literature review, research paper and a critical appraisal. In an attempt to explore how mental health professionals conceptualise hope, and the factors which influence this, a thematic synthesis of eight qualitative papers was completed. Findings demonstrated that professionals understand hope to be: 'The dynamic driving force of the therapeutic process'. This theme provided a higher order conceptualisation of four additional themes, each encapsulating the factors which affect hope: 1) Experiencing and observing progress; 2) A joint venture: The role of the therapeutic alliance; 3) Trusting the process; and 4) Managing contextual barriers. While maintaining hope was regarded as essential to the role, contextual and systemic factors challenged professionals' capacity to maintain hope.

The research paper aimed to explore how austerity impacted on the work of psychological therapists. Thematic analysis of qualitative data yielded from 12 semi-structured interviews led to the development of six related themes: 1) "There's a general atmosphere of threat"; 2) "You're squeezed": Increasing pressure; 3) "It's just maths": Service users are becoming less of a priority; 4) "You're definitely more limited in what you're able to do"; 5) "It's just so upsetting": Added emotional strain; 6) A fight, flight or freeze response: The mediating role of hope. These findings demonstrate that working in a climate of austerity has provoked numerous challenges for therapists. Coping strategies were adopted, yet these were guided by therapists' level of hope.

Retaining hope in a time of austerity may seem paradoxical, however findings suggest that hope is integral for mobilising professionals to overcome the associated adversities. It is therefore imperative that clinical psychologists embrace the developing role of the profession, by innovating services and endorsing compassion at a systemic level, for hope to be fostered throughout mental health services.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from March 2016 to December 2016. The work presented here is my own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name: Hayley Higson

Date: 16th December 2016

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Firstly, I would like to thank all of the participants who took the time to be involved in this research. I would also like to express my sincerest thanks to my research supervisors, Suzanne Hodge and Ste Weatherhead for the countless meetings and draft reads. I have appreciated all of your feedback, re-assurance and support throughout this process.

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Finally, I would also like to express my thanks to all of the wonderful and inspiring people I met whilst on my innovative placement in Malawi, and to all of the people who made this placement possible. I learnt so much about life, compassion, community, and indeed hope. Tawonga!

This thesis is dedicated to my Grandad and my late step-father, Ian.

"There was never a night or a problem that could defeat sunrise or hope"

- Bernard Williams

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Section One: Literature Review

Hope in the context of mental health services: A thematic synthesis of professionals' views.

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Abstract

Hope is a term used in everyday language yet we lack consensus of its meaning. This synthesis explores how mental health professionals conceptualise their own experiences of hope within their work, and the factors which influence this. A systematic literature search was conducted over four databases. Following the application of inclusion and exclusion criteria, a total of eight qualitative papers were identified and included within the review. Thematic synthesis of these papers led to the development of five themes. The initial theme entitled: 'The dynamic driving force of the therapeutic process' offered an understanding of how professionals conceptualise hope and provided a superordinate theme, subsuming the four additional themes: 1) Experiencing and observing progress; 2) A joint venture: The role of the therapeutic alliance; 3) Trusting the process; and 4) Managing contextual barriers. These findings indicate that for mental health professionals, hope is an integral feature of their work, yet it is subject to a number of influences which ought to be considered by supervisors and service leads.

Key Practitioner Messages:

- Hope is relational and reciprocal, influenced by the therapeutic relationship and wider systems.
- Service leads should consider the importance of relationships and allow professionals adequate opportunities to enhance these.
- Burnout impacts on hope; while stress-management techniques may be useful at an individual level, managers should consider the systemic influences and apply practices which encourage hopeful working environments.

Key Words: Hope, Optimism, Staff, Relationships, Burnout, Qualitative

A number of definitions and models have been developed throughout sociological and psychological research which endeavour to conceptualise the phenomenon of hope. Rather than moving towards a shared understanding, the contradictory nature of these models only adds to the ambiguity surrounding the term. In an attempt to provide a précis of these diverse conceptualisations, dominant definitions and models of hope will be presented, considering their relationship with related constructs such as self-efficacy and optimism. The role of hope within the context of mental health will then be discussed before outlining the aims of the current synthesis.

The Oxford English Dictionary defines hope as "a feeling of expectation and desire". While some descriptions of hope reflect this definition by considering the role of expectation (e.g. Adams & Partee, 1998; Scotland, 1969), Snyder et al. (1991) go further, stating that hope entails specific cognitions regarding individuals' perceptions of their capacity to attain desired goals. According to Worgan (2013), Snyder et al.'s (1991) theory of hope is regarded as one of the most influential. Snyder et al. (1991) explained that hope is goal-directed and consists of two reciprocal cognitions: 'agency', the willingness to achieve goals; and 'pathways', the ways of attaining goals.

Snyder et al. (1991) acknowledged the similarities with self-efficacy theory (Bandura, 1982) yet they attempted to draw distinctions, explaining that while self-efficacy refers to specific behaviours in particular situations, their theory is more generic. Snyder (2002) postulates that the 'pathways' relate to a more generalised outlook regarding individuals' perceived ability to work towards goals, whereas self-efficacy is more concerned with "specific situational contingencies" (p. 257). Additionally, Snyder (2002) stated that within their theory, 'agency' is reflective of a person's intention to work towards goals as opposed to their ability to achieve goals. If an individual lacks self-efficacy however, then this will undoubtedly influence perceptions of 'agency' and 'pathways'. It seems therefore, that these

theories share more parallels than originally considered. Furthermore, questions remain regarding how control is incorporated into this theory and how hope is constructed when external factors obstruct the pathways to achieving goals.

While Snyder and colleagues (1991) conceptualise hope as a cognitive process, influencing behaviour and emotion, Averill, Catlin and Chon (1990) conceptualise it as an emotion, a notion supported by research conducted by Bruininks and Malle (2005). Indeed, others have attempted to demonstrate the multidimensional nature of hope by considering spiritual, cognitive, affective, behavioural and relational components within their descriptions (e.g. Clarke, 2003; Dufault & Martocchio, 1985; Farran, Herth & Popovich, 1995; Stephenson, 1991). From this perspective, Snyder et al.'s (1991) model appears reductionist, simplifying a complex and subjective phenomenon.

Optimism is a related construct to that of hope and is defined as "hopefulness and confidence about the future or success of something" (Oxford English Dictionary). The use of 'hope' as a descriptor of this concept implies similarities, and the emphasis on a positive outlook highlights an additional commonality. Optimism has however, been regarded as a distinct concept (Bruininks & Malle, 2006; Bryant & Cvengros, 2004; Bury, Wenzel & Woodyatt, 2016; Eagleton, 2015; Snyder, 2002). In their research, which attempted to differentiate the constructs, Bryant and Cvengros (2004) found that hope and optimism differ as hope relates to an individual's role in achieving desired goals, whereas optimism is a general positive attitude. By contrast, Bruininks and Malle's (2005) research found that hope was more aligned to wishful thinking, associated with less agency; optimism, they found, occurs when control of a desired outcome is present. These contradictory findings therefore suggest that while discrepancies between the terms may exist, the distinctions drawn may occur due to subjective variations and interpretations.

From a critical realist perspective, the pursuit of determining tangible definitions and distinctions between hope and optimism is a complex and artificial endeavour due to the influence of individuals' idiosyncratic views and experiences. Therefore, there is less of a focus on what hope and optimism actually are per se, but rather how individuals make sense of the phenomena. Hope within this review, is aligned with the definition provided by Dufault and Martocchio (1985) and as such is considered to be a multidimensional phenomenon, comprising of affective, affiliative, contextual, temporal, behavioural and cognitive components; an outlook towards a realistic, achievable and improved outcome. While Dufault and Martocchio's (1985) definition does not specifically address the association with optimism, their description includes 'generalised and particularised spheres' of hope. Particularised spheres include specific hopes, whereas generalised spheres encompass a broad positive outlook. This generalised sphere therefore corresponds with previous definitions of optimism (e.g. Bryant & Cvengros, 2004). Accordingly, hope and optimism are conflated within this review.

Hope, or indeed a lack of hope, is widely acknowledged in the arena of mental health. For example, research has demonstrated the role of hope in psychosis (Perry, Taylor & Shaw, 2007); substance misuse (Mathis, Ferrari, Groh & Jasoon, 2009) and recovery from psychological distress generally (Adams & Partee, 1998; Bonney & Stickley, 2008; Deegan, 1988). Ultimately, all of these studies demonstrate the role of hope in promoting psychological wellbeing. Therefore, instilling hope amongst mental health service users (SUs) may be viewed as a core feature of mental health service provision.

Nevertheless, there may be a number of challenges for SUs to maintain hope. One barrier could arise from anomie, which has been described as social disconnection and a loss of purpose within society thus reducing hope (Farren et al., 1995). While Cutcliffe and Herth (2002) indicate how stigma encountered by those experiencing mental health difficulties

contributes to anomie, it is also important to consider the wider influences of the socio-economic contexts in which people live. It can be surmised therefore, that increasing rates of social inequality (Wilkinson & Pickett, 2009) may exacerbate feelings of anomie and thus hopelessness[1]. This may be a particularly relevant amongst those claiming benefits in the United Kingdom (UK), given the related prejudices facing this population (Baumberg et al., 2012; Pemberton, Fahmy, Sutton, & Bell, 2015).

Despite the social influences on mental health, these are largely neglected in the conceptualisations and 'treatment' objectives of psychological difficulties (McGarth, Walker & Jones, 2016; Smail, 2005). Medical models of mental health may be particularly damaging to one's ability to sustain hope as they often locate problems within individuals at a biological level. While medication may be useful for the management of specific 'symptoms', it does not address the multiplicity of factors contributing to psychological wellbeing as is recognised within other models, such as the biopsychosocial perspective (Engel, 1977). Indeed, Ferraro (2016) cautioned that psychotherapy is subject to similar criticisms, suggesting that therapy can reinforce beliefs that difficulties encountered are the result of individuals' own "erroneous thoughts or attitude" (p. 19). Therefore, while these strategies attempt to alleviate psychological distress, the prevailing difficulties encountered by individuals as a result of socio-economic conditions continue to impact on their hope and indeed their mental health. In spite of this however, many individuals experiencing psychological distress are routinely referred to mental health services for support, which normally consists of medication and/or psychotherapy.

Research has highlighted a number of ways in which hope can be fostered within mental health settings. This can be done explicitly via specific therapeutic interventions

[1] Hopelessness is this review is used to describe a lack of hope and is not regarded as the complete absence of hope.

aimed at targeting hope, such as: solution-focused therapy (Reiter, 2010), motivational interviewing (Glassman, Kottsieper, Zuckoff & Gosch, 2013) or engaging in hope-focused dialogue with SUs (Herth, 2001). The therapeutic alliance has also been found to be an effective, indirect method of fostering hope with SUs (Cutcliffe, 2004).

The importance of the therapeutic relationship has been suggested due to the dynamic interaction of hope and hopelessness between SUs and mental health professionals (Farran et al. 1995). Hanna (2002) described hopelessness as 'contagious', therefore the reciprocal nature of this phenomenon could be fundamental for therapeutic outcomes, as SUs' hopelessness may be transferred to professionals and vice versa. Indeed, Coppock, Owen, Zargarskas and Schmidt (2010) found that therapists' own levels of hope was positively related to SU outcomes. This research also found that SUs' hope was less instrumental in affecting outcomes as SUs experiencing both high and low levels of hope benefited from therapy. These findings imply that the therapist's own state of hope may be more influential within the therapeutic dynamic than the SU's. However, Coppock et al. (2010) acknowledged the confounding role of the therapeutic alliance in these outcomes. As therapeutic rapport has been found to produce positive SU outcomes (Lambert & Barley, 2001; Norcross & Wampold, 2011), therapists who have higher hopes for SUs may foster better relationships, which could explain the results. Nevertheless, it seems imperative for professionals to reflect on their own levels of hope given the implications this may have for SUs.

There may be a number of challenges to professionals' capacity to sustain hope within their therapeutic work. Considering the cognitive dimensions of hope (e.g. Snyder et al. 1991), if professionals lack 'agency' or the self-efficacy (Bandura, 1982) to initiate change, they may lose hope. This perceived lack of capacity to influence change may be exacerbated by the socio-economic climate and the rising levels of poverty experienced by citizens as a

result of the global recession (Dagdeviren, Donoghue & Meier, 2016; Wilkinson & Marmot, 2003 cited in Fransquilho et al., 2016). As more people who encounter poverty are likely to access mental health services (Elliott, 2016), professionals working with them may encounter feelings of incompetence due to a perceived inability to effect change amongst this population (Kim & Cardemil, 2012), thus affecting their hope.

Hopelessness has been regarded as a facet and indicator of burnout (Friedman, 1985; Iliceto et al., 2013). Burnout is characterised as depersonalisation, emotional exhaustion and a lack of personal accomplishment (Maslach & Jackson, 1984). In their research, Pompili et al. (2006) found that burnout was linked to hopelessness and was more prevalent amongst psychiatric nurses, in comparison to nurses working in critical care and general medical wards. Indeed, it has been suggested that mental health professionals are specifically vulnerable to burnout due to the nature of the work (Pines & Maslach, 1978), and recent reports have continued to highlight this as a prevailing issue amongst UK mental health workers (British Psychological Society, 2016; Hacker-Hughes et al., 2016). However, it is not clear whether a lack of hope causes, or is caused by burnout.

Overall, it seems that hope is a significant area within mental health given its role in inciting change and improvements to psychological wellbeing. Hope appears to impact on SUs and the professionals working with them, yet it is also viewed as a dynamic interaction. The following synthesis therefore aims to explore how mental health professionals conceptualise hope and what influences this, in relation to their work.

Method

Search Strategy

Due to the complexities of defining and differentiating hope and optimism, both terms were explored and considered within the current synthesis. The aim of this review was to explore how mental health professionals conceptualise hope and optimism within their

clinical work, and to explore factors which influence this. Accordingly, papers were included if they:

i) Focused on professionals' reflections of their hope or optimism within their clinical work.

ii) Included a sample of professionals working in mental health settings.

iii) Were empirical research papers, employing qualitative analysis of the data.

iv) Were written in English.

Papers were excluded if they focused on professionals' hope in physical health or bereavement services. This was determined as conceptualisations of hope and optimism within these services entail additional nuances (e.g. Byrne & Byrne, 2015; Cutcliffe, 2004), which could interfere with the aims of this review.

A systematic literature search was conducted over four databases, throughout October 2016, to source appropriate papers: Cinahl (1994-2016); Medline (1977-2016); Psych Info (1989-2016) and Web of Science (1993-2016). Free text terms were searched in conjunction with relevant Thesaurus headings (or a similar function)[2] where available. Terms included: [Hope* OR Optimis*] AND ["Mental health" OR therapy OR counselling OR counseling OR psychotherapy OR *mental health services (exploded)*] AND [Attitude* OR belief* OR view* OR perception* OR conceptuali* OR *health personnel attitudes*] AND [Practitioner* OR therapist* or nurse* OR CPN OR psychiatrist* OR psychologist* OR "social worker*" OR *mental health personnel (exploded)*] AND [Qualitative OR "grounded theory" OR interview* OR interpret* OR narrative* OR phenomen* OR Them* OR IPA]. 1, 326 papers were yielded from the search. Titles and abstracts were reviewed and where necessary, full-texts were read to determine the papers' suitability. Overall, eight papers were included in the

[2] These headings are denoted in italics.

synthesis (Figure 1). Reference lists of these papers were also searched yet no additional papers were identified. Details of the eight studies are presented in Table 1.

"INSERT FIGURE 1"

"INSERT TABLE 1"

An additional paper by Cleary, Horsfall, O'Hara-Aarons, Jackson and Hunt (2012) met the inclusion criteria but was not included because the data obtained, which focused specifically on optimism, was reported in another paper that was included (i.e. Cleary, Horsfall, O'Hara-Aarons & Hunt, 2012).

Sælør, Ness, Borg & Biong (2015) included a sample of professionals working in a combined community mental health and substance misuse service. However, data were not specific to the substance misuse component of the role and professionals all worked with individuals experiencing mental health difficulties. Although the research objective of Sælør et al. (2015) was to explore professionals' role in 'inspiring hope', findings mainly consisted of participants' reflections on the role of their own hope and was therefore deemed suitable for inclusion. Similarly, Ryan, Merighi, Healy and Renouf (2004) did not aim to explore social workers' hope and optimism, yet the data obtained were relevant to this issue. As a result, this paper was also included.

Two papers included in the synthesis formed part of mixed methods studies (Kowalcky, 2013; Landeen et al., 1996). Atkins, Launiala, Kagaha & Smith, (2012) suggested that mixed method studies often lack the required amount of qualitative detail necessary to produce a high quality synthesis. Landeen et al. (1996) only reported the qualitative findings and Kowalcky (2013) completed her research as part of a thesis and as such, equal weighting was given to the quantitative and qualitative aspects of the research. Both papers were therefore included as they contained substantial details regarding the qualitative approaches and analysis. Additionally, although many systematic reviews

exclusively incorporate papers published in peer reviewed journals, this was not set as a limiter and theses were considered appropriate for inclusion. This was decided on the grounds of the rigorous processes undertaken to assess theses, and the completion of an additional quality appraisal for each paper included within this synthesis. Despite this however, only one thesis was included (i.e. Kowalcky, 2013).

Quality Appraisal

The Critical Appraisal Skills Programme (CASP, 2013) was employed to assess the quality of the papers included in the synthesis. The CASP distinguishes ten criteria to determine the quality of qualitative research (Table 2). Papers were not excluded on the basis of the quality assessment as Sandelowski, Docherty and Emden (1997) asserted that influential data may be omitted due to negligible errors. While all papers largely met the criteria, only two papers were regarded as 'very valuable' on the final CASP item. This was based on the guidance notes provided which offer three areas for consideration: 1) Do authors discuss the contributions of the research in relation to existing knowledge or understanding? 2) Do authors highlight areas for future research? 3) Do authors consider the transferability of the findings to diverse areas or populations? (p. 6). As such, none of the papers were regarded as 'not at all valuable' as they met at least one of these criteria. However, only those papers which met all three of these guidance notes were deemed to be 'very valuable'. Those rated as 'somewhat valuable' therefore demonstrated one or two of these components.

"INSERT TABLE 2"

Larsen, Stege and Flesaker (2013) employed 'Interpersonal Process Recall' as a means of data collection with a case study methodology. Additionally they employed, what they described as, 'basic interpretive inquiry' to analyse the data despite drawing on Braun and Clarke's (2006) thematic analysis process. It was not understood why these methods were used in unison therefore many of the CASP items were recorded as 'unsure'.

Nevertheless, their research was considered 'somewhat valuable' as they demonstrated contributions to the literature base as well as identifying opportunities for future research.

Additionally, Kowalcky (2013) indicated that she applied Interpretative Phenomenological Analysis (IPA) to analyse the data, however there was a lack of detail regarding her engagement with the interpretation process. The analysis appeared to be more aligned with thematic analysis, including a form of content analysis. As Kowalcky (2013) used a mixed method approach, her failure to engage fully with IPA could have emerged from a conflict of epistemology. Therefore, while IPA may have been appropriate to achieve the research objective, it was not clear that this method had actually been applied and thus the study lacked a degree of transparency. Transparency is regarded as a fundamental component of sound qualitative research (Yardley, 2000). However all of the papers, with the exception of Landeen et al. (1996), lacked elements of transparency as they failed to state their relationship with participants.

Analysis

Papers included in this review were analysed using the thematic synthesis method of Thomas and Harden (2008). This approach involves synthesising all data included in the papers' result sections and therefore differs from other methods such as meta-ethnography, which is limited to synthesising authors' conceptualisations (Shaw, 2012). The papers included within this review entailed diverse epistemological positions and methodologies. Therefore, thematic synthesis was employed as it provides the flexibility of analysing researchers' conceptualisations in conjunction with participants' quotes.

Corresponding with Thomas and Harden's (2008) approach, three stages of analysis were undertaken:

1) Line by line coding of the results

2) Development of descriptive themes

3) Development of analytical themes

Accordingly, line by line coding was completed across the eight papers' results sections. A total of 52 codes were then clustered to form 13 initial descriptive themes (Appendix 1-A). Thomas and Harden (2008) explain that the third stage of analysis should be completed to ensure that the synthesis 'goes beyond' the findings from primary research, a requisite of a qualitative synthesis (Thorne, Jensen, Noblit & Sandelowski, 2004). As such, these descriptive themes were reviewed in relation to the research questions, leading to the construction of five analytical themes (Appendix 1-B). Four themes were directly relevant to the factors influencing professionals' hope. One theme provided a conceptualisation of professionals' hope, which appeared to be a higher order analytical theme, summarising the four additional themes.

Findings and Discussion

The eight papers included in this review used samples of mental health nurses, social workers, therapists, psychologists and 'mental health clinicians'. The papers were published between 1996 and 2016 and were conducted in America, Australia, Canada, Norway and the UK.

Results of this synthesis revealed five analytical themes:

1) Experiencing and observing progress
2) A joint venture: The role of the therapeutic alliance
3) Trusting the process
4) Managing contextual barriers

These themes are subsumed under the fifth, superordinate theme of hope as:

'The dynamic driving force of the therapeutic process'

This theme emerged from the descriptive themes; however it also provided a higher order conceptualisation of the other four analytical themes. While the challenges of defining

hope or "putting it into words" were acknowledged (Niebieszczanski, Dent & McGowan, 2016, p. 425), the synthesis confirmed that hope was regarded as a subjective phenomenon (Cleary et al., 2012; Kowalcky, 2013; Larsen et al., 2013; Niebieszczanski et al., 2016; O'Hara & O'Hara, 2012; Ryan et al., 2004; Sælør et al., 2015). The subjective nature of hope, reflected in previous definitions (e.g. Clarke, 2003; Dufault & Martocchio, 1985; Farran et al., 1995), therefore leading to the understanding that each encounter with hope is individual.

A commonality which emerged however, was that professionals understood hope to be an essential and dynamic force within their work with SUs, with references to hope as a "process" (O'Hara & O'Hara, 2012 p. 48), "a roller-coaster" (Niebieszczanski et al., 2016 p. 430) and a "journey" (Kowalcky, 2013, p. 85; Niebieszczanski et al., 2016, p. 430). Furthermore, certain participants identified that the 'journey' was the premise of their work, describing hope as the essential component within this process (Kowalcky, 2013; Niebieszczanski et al., 2016; Sælør et al., 2015).

The motivating nature of hope within the therapeutic process was also identified. Larsen et al. (2013) reported that hope was influenced when professionals were able to identify "paths and ideas available for future work" (p. 479). Additionally, Niebieszczanski et al. (2016) found that hope was enhanced through "energising the individuals to work towards desired goals and outcomes" (p. 425), while O'Hara and O'Hara (2012) found that working towards goals provided SUs with "a sense of direction". The focus on goals (Kowalcky, 2013; Landeen et al., 1996; Larsen et al, 2013; Niebieszczanski et al., 2016; O'Hara & O'Hara, 2012), or the "happy ending" (Kowalcky, 2013, p. 89), was a core element of hope, therefore supporting cognitive models which describe hope as a goal-orientated concept (Synder et al., 1991). The importance of setting "realistic goals" however, was also regarded as significant (Kowalcky, 2013; Landeen et al., 1996; Niebieszczanski et

al., 2016) and could be construed as "doing reasonable hope", a term endorsed by Weingarten (2010), who identified that setting achievable goals facilitates motivation and action towards obtaining desired outcomes.

1) Experiencing and observing progress

This theme encapsulates the importance of professionals gaining evidence and experience of SUs' progress or movement forward throughout the therapeutic process. Experiencing and indeed acknowledging progress proved useful in developing and maintaining hope for professionals and was facilitated via feedback from SUs and colleagues.

Experiencing SUs' movement forward in the therapeutic process provided professionals with a sense of achievement as they could directly observe the benefits of their work, as Landeen et al. (1996) noted: "Many [participants] saw change and hope as closely related" (p. 462). Equally, hope was negatively influenced when SUs demonstrated steps backwards or if a lack of movement, i.e. "feeling stuck" (Niebieszczanski et al., 2016, p. 431), was apparent.

SUs themselves were instrumental in stimulating professionals' hope: "The clients themselves can inspire hope" (Landeen et al., 1996, p. 462). Whilst considering SUs' traumatic histories and their ability to attend sessions and even get out of bed each morning, one participant reflected: "How could I not feel hopeful?" (Kowalcky, 2013, p. 93). SU engagement and commitment to the work was perceived as hope-inspiring as professionals considered that this demonstrated a motivation for SUs to move forward in the therapeutic process: "She [SU] pushes herself, even though her symptoms are really significant and severe. She still comes" (Kowalcky, 2013, p. 93).

Direct observations of SU improvements were pertinent to this theme: "Seeing somebody who's been very ill get better certainly keeps me feeling very positive and very hopeful" (Landeen et al., 1996, p. 461). Progress was therefore evidence of SUs "taking

steps forward" (Kowalcky, 2013, p. 104). Furthermore, even in the presence of SU hopelessness, professionals' hope was harnessed if a change in direction of the work was perceived. For example: "I see that we're uncovering new ground all the way through here, [SU] appears to be getting more hopeless. But that is not bothering me, because we are really, truly unearthing new ground here" (Larsen et al., 2013, p. 480). While this quote challenges previous suggestions that SU hopelessness is contagious (Hanna, 2002), it emphasises the importance of professionals' ability to detect movement within the therapeutic process.

These observations appeared to impact on professionals' affect and relationship with their work. Niebieszczanski et al. (2016) identified how participants: "Described feeling great when an individual they worked with made progress" (p.431) as it provided them with a sense of "accomplishment and achievement" (p. 431). Therefore observing improvement could be regarded as positive reinforcement of their work (Guillot, 2013). Additionally, experiencing progress inspired professionals' confidence in their work and their ability to help SUs: "When I feel I can make an impact with people, I feel lucky in what I do and that I'm doing what I'm good at. And so it affects my hope" (Larsen et al., 2013, p. 478). Consequently, searching for signs of change or indeed acknowledging SUs' strengths provided further evidence of progress, thus influencing professionals' hope (Kowalcky, 2013; O'Hara & O'Hara, 2012; Ryan et al., 2004; Sælør et al., 2015). For example: "It's really recognising the strengths that each of these patients has, which gives me hope" (Kowalcky, 2013, p. 114). Additionally, the importance of identifying smaller achievements also proved significant: "It's those small steps that really do count sometimes…you begin to see little bits of something, even that can be quite rewarding" (Ryan et al., 2004, p. 420). Effort and commitment demonstrated by SUs was therefore a crucial factor in allowing professionals to

experience and observe movement forward in the therapeutic process, enabling them to maintain hope in their work.

Larsen et al. (2013, p. 480) identified how "signs that a client was not progressing (e.g. going back to an old story or behaviour)", negatively impacted on psychologists' hope. Landeen et al. (1996) also found that SUs' missed appointments or refusal of treatment affected professionals' hope. A similar view was reported by O'Hara and O'Hara (2012): "When clients struggle to participate fully in the therapeutic encounter, the therapist's hope for change is challenged" (p. 48). Participants in Niebieszczanski et al.'s (2016) study reported that seeing SUs re-enter services directly challenged hope as this was perceived as evidence that SUs had taken steps backwards. Rather than considering the SUs' readiness to change (e.g. Prochaska & DiClemente, 1983), professionals often questioned their role in SUs' lack of progress: "I was thinking, 'have I failed him? Did I not help him?'" (p. 431). The need for feedback and support from colleagues emerged as imperative in these circumstances. In their theme of 'perceptions of how an optimistic environment is fostered', "support, feedback or acknowledgement" (Cleary et al., 2012, p. 500) of professionals' work via those in management were viewed as fundamental to instilling hope. Furthermore, the acknowledgement of professionals' efforts by SUs and their families was also effective: "The client's satisfaction with the way things are and their families' appreciation – that's what keeps me hopeful" (Landeen et al., 1996, p. 463).

Receiving positive feedback or indeed observing shifts towards SU goals or improvements could therefore instil a sense of achievement in their work. This is vital given that a reduced sense of personal accomplishment is believed to contribute to the experience of burnout (Maslach & Jackson, 1984), which itself has been found to diminish hope (Pompili et al., 2006). Burnout also creates difficulties for mental health professionals in recognising achievements (Pines & Maslach, 1978). Therefore, a lack of perceived progress, caused by

burnout, could further affect professionals' ability to recognise strengths, thus perpetuating a problematic cycle. This may have implications for SU outcomes, given the reported influence of therapists' hope (Coppock et al., 2010), potentially causing further difficulties for professionals' sense of achievement.

2) A joint venture: The role of the therapeutic alliance

This second theme acknowledged the role of the therapeutic alliance in inspiring hope. While the therapeutic relationship has been found to be influential in determining SU outcomes (Lambert & Barley, 2001; Norcross & Wampold, 2011). This theme suggests that this alliance is also fundamental in allowing SUs and professionals to remain hopeful.

The importance of fostering a therapeutic alliance between professionals and SUs was regarded as a prominent factor enhancing professionals' hope (Kowalcky, 2013; Larsen et al., 2013; Niebieszczanski et al., 2016; O'Hara & O'Hara, 2012; Ryan et al., 2004; Sælør et al., 2015). For example: "Hope was strongly supported for psychologists when they felt a clear sense of connection with the client" (Larsen et al., 2013, p. 480). Similarly: "The importance of the therapeutic relationship as a foundation stone for hope within therapy was consistently acknowledged by participants" (O'Hara & O'Hara, 2012, p. 49).

Professionals worked to enhance this therapeutic alliance in a number of ways. Some talked about providing a "safe place" where SUs could openly share their difficulties, which was regarded as a necessary step for SUs to reach goals (Kowalcky, 2013, p. 108). Others acknowledged the specific qualities and skills required of professionals to enhance this relationship such as: energy, humour and charisma (Kowalcky, 2013, p. 107); "retaining a patient focus" (Cleary et al., 2012, p. 499); demonstrating "respect for clients" (Landeen et al., 1996, p. 462); "spending time … getting to know the whole person … rather than seeing just their mental health diagnosis" (Niebieszczanski et al., 2016, p. 428).

Additionally, Sælør et al. (2015) highlighted the importance of demonstrating authenticity, honesty and trustworthiness within the relationship. Participants within this study also spoke about the importance of embracing a non-judgemental approach towards SUs: "One gets a little careful not to … handing out 'hope' and 'no-hope' cards to people ... it has to do with, like, the respect for people" (p. 145). Furthermore, while participants in Niebieszczanski et al.'s (2016) study also recognised the importance of being non-judgemental, it was also acknowledged that this may be inevitable and thus professionals instead had "to try very hard not to make judgements about SUs" (p. 428). While Rogers' (1951) tenets of person-centred care are significant in establishing therapeutic rapport, they are also central components in fostering hope.

Relatedly, communication was regarded as a specific tool in allowing professionals to demonstrate person-centred care whilst also offering a method for achievements to be explored (O'Hara & O'Hara, 2012). Furthermore, communication provided a basis for hope fuelled dialogue which was regarded as a useful strategy to endorse hope (Kowalcky, 2013; Larsen et al., 2013; Ryan et al., 2004; Sælør et al., 2015). The importance of demonstrating hope via non-verbal communication was also observed (Kowalcky, 2013; Niebieszczanski et al., 2016; Sælør et al., 2015). For example: "Nurses demonstrated hope through their demeanour and interactions with other people: for instance by 'just carrying a positivity around with you'" (Niebieszczanski et al., 2016, p. 427). The importance of communicating hope to their SUs was viewed as important, as professionals regarded themselves as 'role models' for their SUs: "You become a role model so there's some learning by serving, by experiencing it, by talking about it, by a change of thoughts … we don't see it, but there's some exchange of energy, something that is contagious" (Kowalcky, 2013, p. 92).

The contagious nature of hope was referenced specifically within themes from two studies, namely "empathic hoping" (Larsen et al., 2013) and the "reciprocal relationship of

hope" (Niebieszczanski et al., 2016). Within these themes it was acknowledged that while professionals have a role to play in shaping SUs' hope, their own hope is also influenced by SUs: "My hope is very much affected by my client's hope. My level of hope is like a mirror for where she [SU] is" (Larsen et al., 2013, p.481). Similarly: "The nurses' hope influenced the SU's hope and vice-versa: 'It's a two way you know – it's collaborative'" (Niebieszczanski et al., 2016, p. 432). These findings therefore support assertions made by Hanna (2002) and Farran et al. (1995), who indicated that hope was a 'contagion' within the therapeutic dynamic. Conversely, a quote in the initial theme suggested that professionals' remained hopeful in spite of SU hopelessness (Larsen et al., 2013), which was facilitated by experiencing progress in the therapeutic process. Therefore SUs' engagement could be construed as presence of their hope, allowing professionals to maintain hope.

Collaboration also emerged as a significant aspect of this theme. Sælør et al. (2015) explained that: "Hope was a collaborative matter, where safe relationships were a perquisite" (p. 146). Collaboration included the premise that while this was a shared process, both parties also held an independent degree of responsibility. Therefore, when SUs demonstrated their responsibility, and indeed commitment to the process (as highlighted in the initial theme) professionals' hope flourished: "When the client's wellbeing seemed like a shared responsibility and clients were beginning to take enhanced responsibility for their growth, psychologists reported feeling hopeful" (Larsen et al., 2013, p. 481). Evidence of a sound therapeutic alliance and collaboration was therefore imperative in influencing professionals' hope.

3) Trusting the process

This theme summarises the importance for professionals of upholding trust in the therapeutic process in allowing them to remain hopeful:

> Trusting the process, [I have] hope for counselling and trust that things are going the way they need to be going … I trust that we're going to those dark places for a reason … good will come out of that. So, … I do hold hope in the session (Larsen et al., 2013, p. 477).

This trust appeared to be influenced by professionals' own evaluations of their competence as well as previous experiences, both within personal and professional capacities.

Professionals drew on specific tools and interventions which were regarded as helpful in inspiring hope for SUs and ultimately themselves. The use of narrative therapy and cognitive restructuring were identified by participants in O'Hara and O'Hara's (2012) study as being particularly useful. Others drew on goal setting, (Niebieszczanski et al., 2016; O'Hara & O'Hara, 2012), motivational interviewing and mindfulness practices (O'Hara & O'Hara, 2012). Providing information and psychoeducation were also deemed important (Kowalcky, 2013; O'Hara & O'Hara, 2012). Therefore, having trust in the interventions and the therapeutic process was significant in maintaining hope, as one participant in Niebieszczanski et al.'s (2016) study described it as: "Buying what you are selling" (p. 426).

Alternatively, Larsen et al. (2013) reported that: "Working with unfamiliar ways or with interventions that were new to the psychologists sometimes led to feelings of vulnerability", which ultimately impacted on their hope (p. 478). It was not clear why professionals found these specific interventions useful, however given the above quote, it could be due to professionals' familiarity with them. Additionally, with the exception of mindfulness, the future focus could trigger cognitive aspects of hope, i.e. allowing SUs to consider an improved future (Dufault & Martocchio, 1985), while also providing them with a sense of self-efficacy that this future could be achieved (Bandura, 1982).

Professionals' occupational experience seemed to influence their trust and confidence in the process and consequently their hope (Larsen et al., 2013; Ryan et al., 2004; Sælør et

al., 2015): "Over time dealing with similar situations does bring confidence" (Ryan et al., 2004, p. 419). Sælør et al. (2015) found that: "Participants spoke about 'collecting success stories' as a way to maintain their own conviction and hope" (p. 145). Therefore, holding onto positive experiences, particularly where difficulties were encountered, provided encouragement and hope amongst professionals (Sælør et al., 2015). This could be also be explained via self-efficacy theory (Bandura, 1982) as professionals who have gained experience in delivering specific interventions, may have gained evidence of their ability to successfully work with these strategies.

Trust in the process also emerged from professionals' personal experiences of adversity: "I think hope comes from my own personal experience of being really depressed" (Kowalcky, 2013, p. 86). These encounters provided professionals with evidence that overcoming difficulties is possible. While SUs may present with a range of experiences, that professionals may not have encountered, they were able to draw on personal experiences which provided them with an outlook that nothing is permanent and that change is possible. These experiences therefore facilitated a sense of confidence that improvements can be made, allowing them to trust the process and maintain hope.

Hope was further enriched if SUs were perceived as trusting the process (Larsen et al., 2013; Niebieszczanski et al., 2016; Sælør et al., 2015). This was evidenced from the therapeutic alliance and SUs engagement, demonstrating links to the previous themes. Larsen et al. (2013) commented: "Evidence of clients' trust in the therapeutic relationship served to deepen psychologist hope" (p. 480). Furthermore, this trust was enhanced when SUs demonstrated this through disclosures: "She [SU] is telling me her worst fears. And that is to be needy, so that to me is a very hopeful piece, that she has somehow figured out there's enough trust here" (Larsen et al., 2013, p. 480).

4) Managing contextual barriers

This final theme encapsulates the findings that various contextual factors created barriers in the therapeutic process and thus affected professionals' hope. These were referred to as "obstacles", or "twists and turns" (Niebieszczanski et al., 2016, p. 433) and were considered to be wider external and systemic factors. In an attempt to mitigate these difficulties, it seemed that specific practices were useful in sustaining hope, encouraging professionals to persevere throughout the process.

As indicated previously, hope was viewed as entailing relational features. However, it was also apparent that the relational and contagious nature of hope extended to the teams within which professionals worked (Cleary et al., 2012; Landeen et al., 1996; Niebieszczanski et al., 2016; Sælør et al., 2015). For example: "If your superior is somebody who doesn't have hope, then you can only go so far" (Landeen et al., 1996, p. 464). Similarly: "It's difficult to be optimistic everyday if I am working in a pessimistic work environment" (Cleary et al., 2012, p. 499). Therefore, the importance of team cohesion was regarded as imperative for fostering hope: "A hopeful team atmosphere or ethos was seen as important" (Niebieszczanski et al., 2016, p. 431). Sælør et al. (2015) indicated how communication was influential in fostering hope within working environments and Cleary et al. (2012) identified how a lack of communication created conflicts within teams, which impacted on hope: "Nurses fighting among themselves impedes therapeutic optimism" (Cleary et al., 2012, p. 499). Consequently, supportive teams fostered hope, while this became more difficult for those working in negative environments. Indeed, the pressures of working in a community mental health team and the related risk of burnout were additional factors affecting hope: "When we start helping others it's very easy for you to get burned out … it is very difficult sometimes to see the hope" (Kowalcky, 2013, p. 116).

Wider difficulties were also acknowledged as obstacles impeding on professionals' hope. The impact of socio-economic constraints on SUs (O'Hara & O'Hara, 2012), stigma (Landeen et al., 1996; O'Hara & O'Hara, 2012; Sælør et al., 2015), significant levels of adversity experienced by SUs (Kowalcky, 2013) and bureaucratic barriers to completing necessary work with SUs (Sælør et al., 2015), were identified as factors contributing to blockages in sustaining professionals' hope. In recognising the challenges, one participant in Kowalcky's (2013) research acknowledged the need to protect hope:

> Sometimes hope doesn't maintain itself as you hope, you have to work on it. I feel like a car, the gas is going low, and sometimes after years here, you have to take care of that gas, otherwise you're going to run out (p. 116).

The importance of self-care was evident in managing the barriers and thus sustaining hope (Kowalcky, 2013; Landeen, et al., 1996; O'Hara & O'Hara, 2012). Professionals also identified the need to engage in other activities in these contexts, such as: creative problem solving (Sælør et al., 2015) and supervision (Niebieszczanski et al., 2016; Sælør et al., 2015). These methods mirror similar coping strategies applied by mental health professionals when dealing with occupational stress generally (e.g. Bowden, Smith, Parker & Boxall, 2015). Therefore, stress management practices may be significant in supporting professionals to remain hopeful.

These strategies were particularly useful as they encouraged professionals to focus on the future, the goals of their work and thus facilitate a recovery focused outlook, which has been found to be positively correlated with mental health professionals' job satisfaction (Kraus & Stein, 2013). As a result, many professionals acknowledged the need to persevere despite these obstacles, identifying the need to "keep going" (Niebieszczanski et al., 2016, p. 427). Similarly: "Things don't always improve but you work with what you have and I guess I don't give up" (Ryan et al., 2004, p. 420). However, it was clear that while professionals

may continue to persevere, there were instances when they needed to "recognise the limits of their role" (Niebieszczanski et al., 2016, p. 432).

Clinical Implications

This synthesis found that mental health professionals conceptualise hope as: 'The dynamic driving force of the therapeutic process', which is subject to a number of influences. The findings demonstrate that hope is a reciprocal process between professionals and SUs; as such the therapeutic alliance is key in allowing hope to be maintained. However, the relational component of hope extends to teams, and professionals' hope can be challenged if a lack of hope is present throughout their working environment. Hope and burnout are inextricably linked; consequently, it is imperative for teams to foster hopeful working cultures.

The role of the therapeutic alliance is a well-established component of mental health intervention (Lambert & Barley, 2001; Norcross & Wampold, 2011). The therapeutic alliance comprises of shared goals, tasks and bonds (Lambert & Barley, 2001). 'Bonds' refers to the connection between SU and professional, and can be enhanced by patient-centred practices (Rogers, 1951) or 'common factors' such as warmth, empathy and congruence (Lambert & Barley, 2001). Given the findings that the alliance is imperative for fostering hope between SUs and professionals, the importance of this should continue to be disseminated and promoted amongst mental health professionals via teaching and supervision. Certain SUs accessing mental health services may experience attachment difficulties, which could create difficulties for them in forming bonds with professionals (Diener & Monroe, 2011). Therefore, it is important for service providers to facilitate practices which allow professionals the time and flexibility to develop and enhance these relationships.

Teaching and supervision could also be utilised to specifically explore the dynamic nature of hope. This could provide professionals with a reflective space to consider how hope, or hopelessness, may impact on their relationships with SUs. Lambert and Barley (2001) warn that stress and burnout may create difficulties in professionals' ability to foster therapeutic relationships with SUs. Therefore, supervision could further consider this issue and promote self-care practices.

Specifically working to increase self-compassion in supervisory contexts would enhance therapeutic outcomes for SUs (Gilbert, 2005). However, it could also diminish aspects of self-criticism and perfectionism (Neff, 2003) which hinder professionals' capacity to acknowledge their achievements, increasing the risk of burnout (Maslach & Jackson, 1984). Self-compassion has also been found to be beneficial in enhancing emotional intelligence (Neff, 2003). Emotional intelligence is regarded as the ability to understand and manage emotion and is consequently related to self-awareness (Salovey & Mayer, 1990). Promoting self-compassion via supervision may therefore lead to increased self-awareness. This would facilitate professionals' explorations of their own levels of hope and consider the effects of this within their work. Furthermore, working to increase self-awareness amongst professionals would provide them with the capacity to detect signs of work-related stress and thus implement necessary strategies accordingly.

Encouraging self-compassion amongst mental health professionals has been found to support stress-management (Raab, Sogge, Parker & Flament, 2015). Incorporating this within teams could therefore help professionals manage work-related stresses, and safeguard hope. This may be more pertinent for less experienced professionals, given the results from this synthesis which found experience was influential in allowing professionals to 'trust the process'. Indeed, Sodeke-Gregson, Holttum, and Billings, (2013) found that less experienced therapists were prone to work-related stress. Therefore, training programmes could seek to

entail components where stress-management techniques are considered. However, while this may help at an individual level, service providers should consider systemic strategies to inspire hope throughout teams.

Burnout has been associated with a perceived lack of accomplishment (Maslach & Jackson, 1984). This synthesis found that acknowledging achievements was also fundamental in fostering professionals' hope. Therefore, it is imperative for managers and clinical psychologists to encourage working cultures where positive reinforcement and recognition of professionals' successes and efforts is commonplace. As the relational dimension of hope extends to the teams surrounding professionals, this practice could serve to promote positive working environments which may further enhance professionals' hope and ultimately their work with SUs. While this may be challenging at times due to the wider systemic influences, clinical psychologists could endeavour to model hope within supervision and meetings as a way of nurturing hopeful working environments, which could influence others via social learning (Bandura, 1977). However, there is a paucity of research exploring the dynamic interaction of hope within systems and supervisory contexts, highlighting the potential for future research.

Limitations

This review has developed a detailed and specific contextual understanding of how mental health professionals conceptualise hope and what they view as the factors which impact on their ability to sustain hope. While hope is considered a core component of mental health recovery models (e.g. Bonney & Stickley, 2008), this review highlights the importance of professionals' hope within the therapeutic process. Nevertheless, one drawback of this synthesis, relates to the convoluted nature of the terminology surrounding hope and optimism. Therefore, whilst papers in this review applied the terms 'hope' and 'optimism', authors and indeed participants may have been referring to distinct phenomena. Although

this was not overtly observed in the research papers reviewed, distinctions may have been implicitly held.

The studies reviewed were conducted in Western countries where populations are largely white. Specific participant demographics, regarding ethnicity and cultural backgrounds were largely absent in the papers reviewed, yet hope was construed in this review through a white, Western, Christian lens. Therefore, diverse cultures may uphold differing comprehensions of hope. Holt (2000) acknowledged the potential difficulties in translating hope across cultures. Relatedly, she explored how hope was viewed amongst people from the Dominican Republic and found that all her participants understood hope to be linked with faith in God. Therefore, caution ought to be exercised when considering the applicability of the findings from this synthesis to those from diverse cultures. Moreover, the association between religious beliefs and hope (Edwards & Jovanovski, 2016; Holt, 2000) may further influence conceptualisations of hope and thus impact on the generalisability of these findings. Future research could therefore aim to explore the association between faith and hope more explicitly.

A further limitation could be construed from a result of combining views from those working in diverse mental health professions. The heterogeneous roles assumed may therefore lead to different understandings of how hope influences their work. For example, the role of hope in the therapeutic process may feel more relevant for therapists or psychologists. Nevertheless the findings, particularly the importance of the therapeutic relationship, are transferable across professions. The translation of these findings to those working outside of mental health services however, could be explored in future research.

Finally, the critical appraisal of the eight papers highlighted some issues of concern, particularly given the lack of transparency in reporting (Yardley, 2000). Additionally, the sample in Sælør et al.'s (2015) research was from Norway, yet the paper was published in

English. Therefore translation may have compromised the data due to language idiosyncrasies or concepts being misconstrued. Overall, these problems led to difficulties in assessing the reliability of these papers which may have had implications for this synthesis.

Conclusion

This thematic synthesis highlighted how hope is construed, by mental health professionals, as 'The dynamic driving force of the therapeutic process'. This conceptualisation therefore exposed the significance of hope within the milieu of mental health professionals. This superordinate theme comprised of four related themes, explaining the influences upon professionals' hope. Experiencing progress throughout the therapeutic process, evidence of a therapeutic alliance and upholding trust all served to protect professionals' hope. However contextual issues such as negative working environments had implications on professionals' ability to sustain hope. While managing these barriers via self-care helps to protect hope, clinical psychologists have a pivotal role in supporting colleagues via supervision and the promotion of a positive working environments to instil hope at a systemic level.

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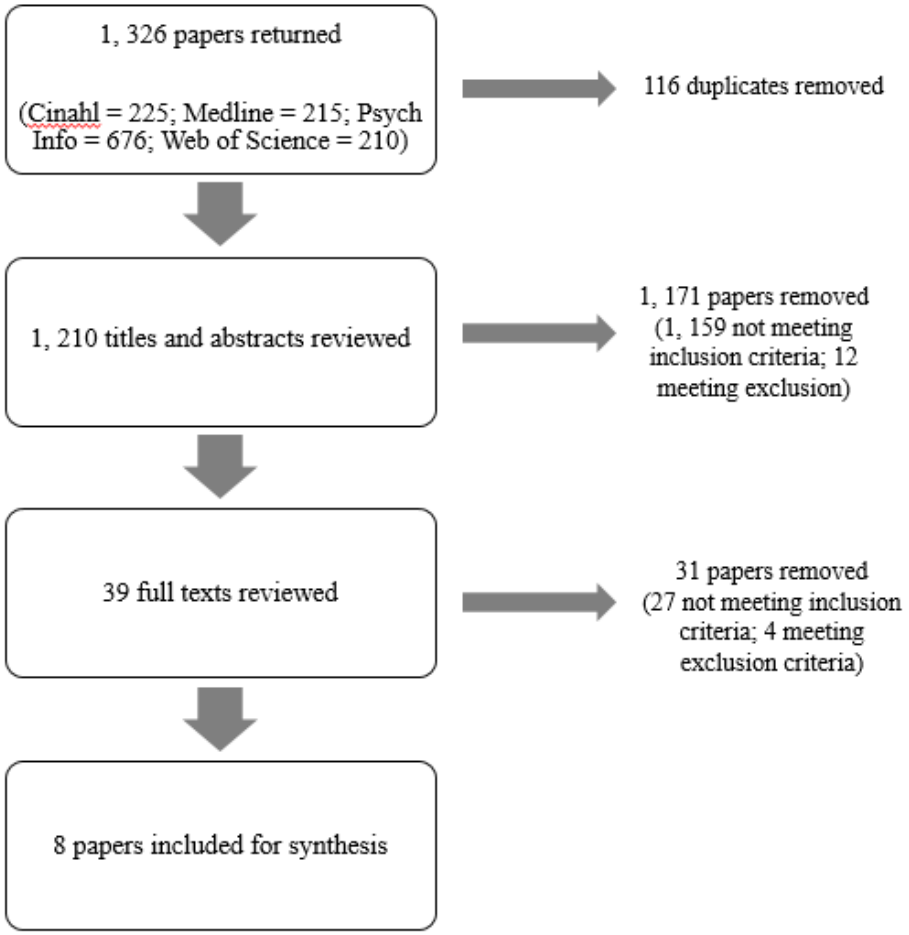


Figure 1: Flow chart of search process.

Table 1

Details of studies incorporated into current synthesis

Author/Year	Title	Research Question/Aim	Sample	Location	Analysis
Cleary, Horsfall, O'Hara-Aarons & Hunt (2012)	Mental health nurses views on therapeutic optimism.	To explore nurses' views on positive aspects of their role and therapeutic optimism.	40 Registered Nurses working in acute mental health settings.	Australia	Thematic analysis
Kowalcky (2013)	The dynamic gift of hope in psychotherapy.	To gain further understanding of how clinicians' make sense of hope.	8 mental health clinicians.	America	Interpretative phenomenological analysis
Landeen, Kirkpatrick, Woodside, Byrne, Bernardo & Pawlick (1996)	Factors influencing staff hopefulness in working with people with Schizophrenia.	To explore professionals' understanding of hope.	15 professionals working with people diagnosed with schizophrenia.	Canada	Thematic analysis
Larsen, Stege & Flesaker (2013)	'It's important for me not to let go of hope': Psychologists' in-session experiences of hope.	What factors influence therapists hope within their therapeutic work?	5 psychologists working with clients experiencing mental health difficulties.	Canada	'Basic interpretative inquiry'/ Thematic analysis
Niebieszczanski, Dent & McGowan (2016)	'Your personality is the intervention': a grounded theory of mental health nurses' beliefs about hope and experiences of fostering hope within a secure setting.	What are mental health nurses' beliefs about hope and their experiences of fostering hope in a forensic mental health setting?	10 qualified mental health nurses.	United Kingdom	Grounded theory

O'Hara & O'Hara (2012)	Towards a grounded theory of therapist hope.	To explore how therapists understand hope and how they use hope in their work.	11 therapists working recruited via a counselling and psychotherapy association.	United Kingdom	Grounded theory
Ryan, Merighi, Healy & Renouf (2004)	Belief, optimism and caring.	To explore the work of mental health social workers cross-nationally.	19 psychiatric social workers.	Australia and America	Grounded theory
Sælør, Ness, Borg & Biong (2015)	You never know what's around the next corner: exploring practitioners' hope inspiring practices.	How do practitioners within the field of mental health and substance abuse nurture and inspire hope?	8 professionals working in a community mental health and substance misuse service.	Norway	Thematic analysis

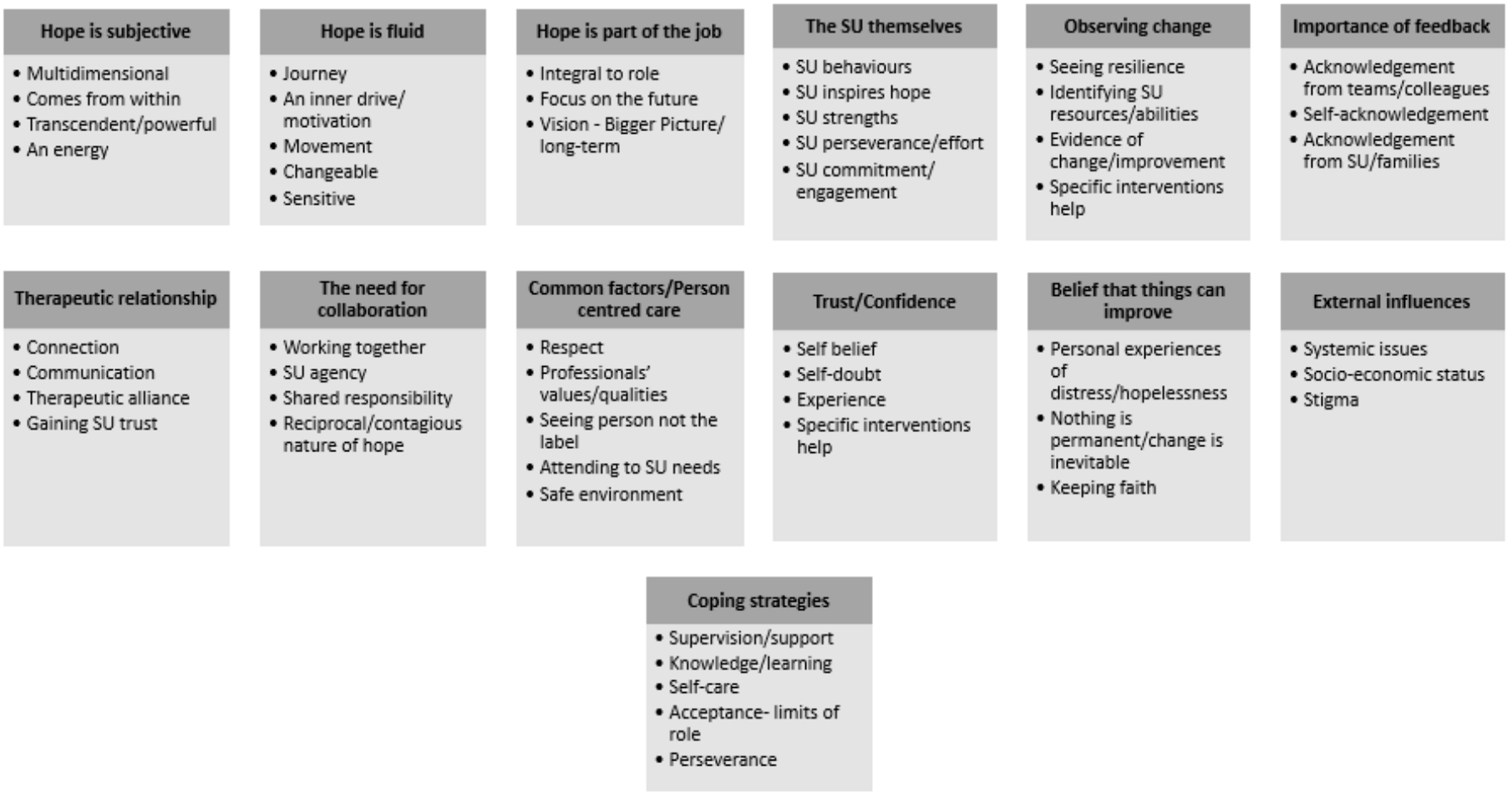
Table 2

Critical Appraisal of Studies utilising CASP criteria

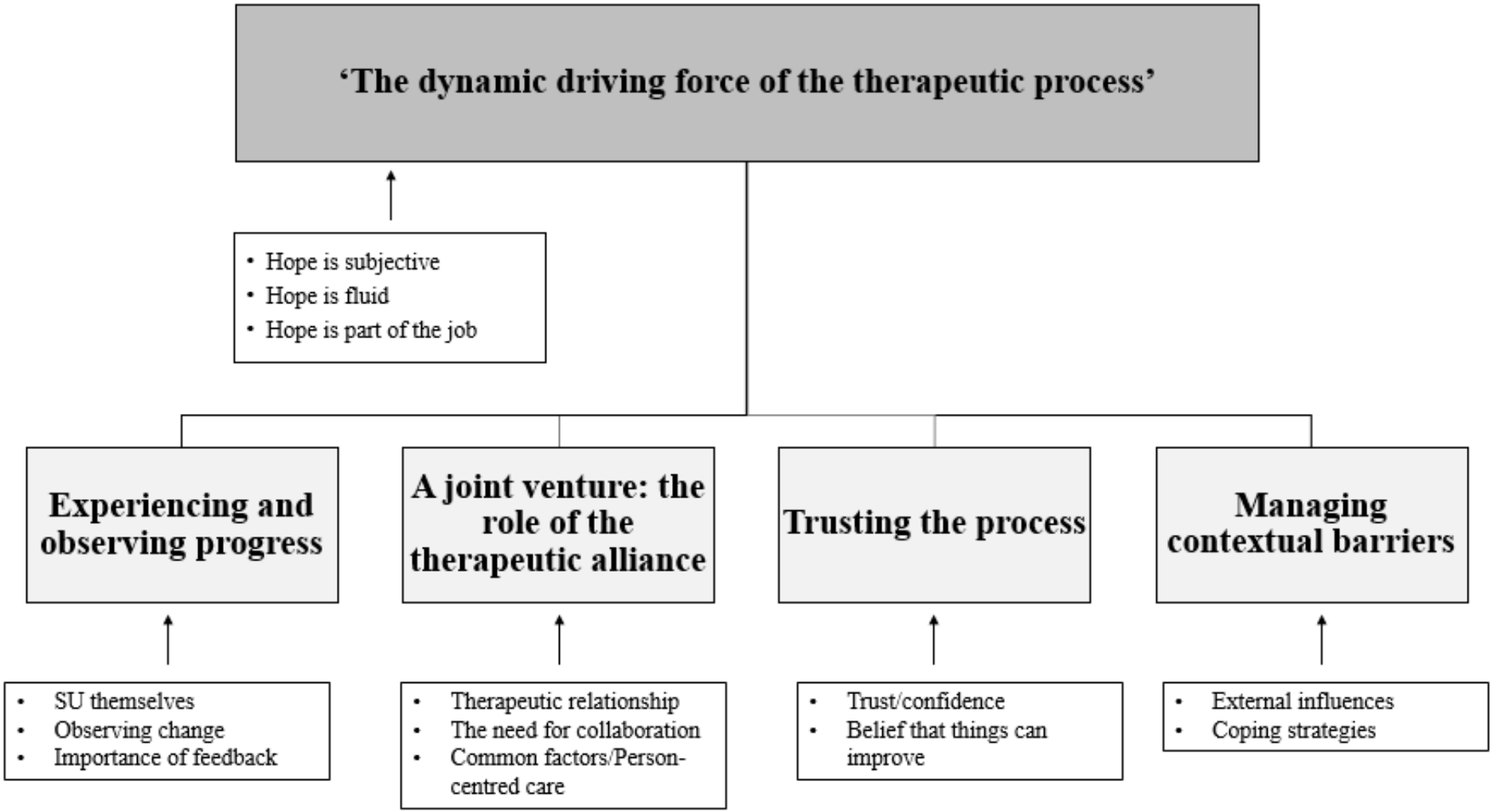
	Cleary, Horsfall, O'Hara-Aarons, Jackson & Hunt (2012)	Kowalcky (2013)	Landeen, Kirkpatrick, Woodside, Byrne, Bernado & Pawlick (1996)	Larsen, Stege & Flesaker (2013)	Niebieszczanski, Dent & McGowan (2016)	O'Hara & O'Hara (2012)	Ryan, Merighi, Healy & Renouf (2004)	Sælør, Ness, Borg & Biong (2015)
CASP Questions:								
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Unsure	Yes	Yes	Unsure	Yes
Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes	Unsure	Yes	Yes	Yes	Yes
Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Unsure	Yes	Unsure	Yes	Yes
Has the relationship between the researcher and	No	No	Yes	No	No	No	No	No

participants been adequately considered?								
Have ethical issues been taken into consideration?	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Was the data analysis sufficiently rigorous?	Yes	No	Unsure	Yes	Yes	Yes	Yes	Yes
Is there a clear statement of findings?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
How valuable is the research?	Somewhat	Somewhat	Somewhat	Somewhat	Very	Somewhat	Very	Somewhat

Appendix 1-A: Example of descriptive theme development from initial codes



Appendix 1-B: Example of analytical theme development from descriptive themes



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Section Two: Research Paper

Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

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Abstract

Objectives: This research aimed to explore the impact of the United Kingdom (UK) public funding cuts on the work of psychological therapists working in National Health Service (NHS), adult mental health services.

Method: Qualitative data were gathered from semi-structured interviews with 12 psychological therapists. The data obtained were then analysed using thematic analysis.

Results: Analysis led to the development of six related, superordinate themes: 1) “There's a general atmosphere of threat”; 2) “You’re squeezed”: Increasing pressure; 3) “It’s just maths”: Service users are becoming less of a priority; 4) “You're definitely more limited in what you're able to do”; 5) “It’s just so upsetting”: Added emotional strain; 6) A fight, flight or freeze response: The mediating role of hope

Conclusions: The findings expose a multiplicity of changes to the work conducted by therapists as a result of public funding cuts. These changes had implications for therapists’ psychological wellbeing and as such, services need to provide effective support to colleagues to safeguard against burnout and encourage staff retention within the NHS.

Key Words: Austerity, NHS, Therapists, Psychotherapy, Qualitative, Burnout.

Austerity measures were introduced in the UK in 2010 when a new UK government was appointed. The term ‘austerity’ is widely employed to describe a method of fiscal policy. Within this approach, public spending is reduced whilst simultaneously increasing taxes (Seidman, 2012). The implementation of austerity has involved a range of policies aimed at reducing public expenditure, including cuts to local authority budgets and measures to reduce NHS spending, as well as fundamental changes to the benefits system through the Welfare Reform Act (2012). These changes include, for example, the merger of several benefits into a single Universal Credit and cuts to housing benefits for those residing in social housing with a ‘spare’ bedroom.

As part of the drive to reduce the benefits budget, a programme of re-assessment of people’s eligibility for Employment Support Allowance (ESA), using the controversial Work Capability Assessments (WCAs) was introduced in 2011. This has resulted in many terminations of ESA for people living with long-term mental and physical health problems (Clifton, Noble, Remnant & Reynolds, 2013). The psychological ramifications of this process have received a great deal of attention, both in research literature and the media. Barr, Taylor-Robinson, Loopstra, Reeves and Whitehead (2015) found that re-assessments were positively related to increased mental health problems and suicide rates. While the government argued the findings were ‘misleading’ (Buchanan, 2015), a number of people have been reported to have taken their own life following WCAs (Calum’s List, 2016; Hassell, 2014; Spartacus Network, 2015). Furthermore, there has been an increase in suicide rates throughout the UK general population since the introduction of austerity, with confirmed suicide cases escalating from 5,608 in 2010, to 6,188 in 2015 (Office for National Statistics, 2015). There are a multitude of interrelated, confounding factors which contribute to an act of suicide (e.g. Hawton & van Heeringen, 2009), as well as problems in evaluating

suicide statistics. Caution should therefore be exercised when making conclusions surrounding the causation of suicides. Nevertheless, the implications of austerity related measures, for example by losing ESA, may reasonably be regarded as a contributory factor (Pring, 2016).

Austerity has arguably affected the most vulnerable people in society, namely those who were already in less privileged positions (Mattheys, 2015; O'Hara, 2014). Ultimately, the effects of austerity have reduced financial security, driving citizens into poverty (Hastings, Bailey, Bramley, Gannon & Watkins, 2015; Loopstra et al., 2015; The Centre for Local Economic Strategies, 2014). Consequently, more people are finding themselves in situations where they are unable to fund basic needs, such as food and shelter. According to Maslow's hierarchy of needs, as people encounter poverty and the related barriers to securing basic needs, they are also at risk of experiencing psychological distress (Maslow, 1957 cited in McLeod, 2007). Although debate exists regarding the origins of psychological difficulties amongst individuals living in poverty (Patel & Kleinman, 2003), research clearly demonstrates the high prevalence of mental health problems throughout this population (Das, Do, Freidman, MacKenzie & Scott, 2007; Patel, Araya, de Lima, Ludermir & Todd, 1999).

Negative social attitudes towards people experiencing poverty are often reinforced in public disclosures about benefits claimants and the resultant stigma further impacts on psychological wellbeing (Baumberg et al., 2012). Pemberton, Fahmy, Sutton and Bell (2015) found that negative social attitudes were often internalised by people in poverty, thus shaping attributions of their situation and altering their self-perception. These negative self-perceptions may therefore contribute to feelings of shame, which has been associated with the experience of depression (Kim, Thibodeau & Jorgensen, 2011). Indeed, shame has been found to be a common experience amongst those relying on food banks (Van der Horst,

Pascucci & Bol, 2014) and given the rising numbers of these operating throughout the UK since the implementation of austerity policies (Loopstra et al., 2015; Trussell Trust, 2016), it is logical to assume that many may encounter the associated psychological effects. Whilst poverty and the issues relating to this have consistently impacted on people within the UK (Tomlinson, Walker & Williams, 2008), it seems that austerity has served to magnify these problems and consequently more people are now seeking support for their mental health via the NHS (O'Hara, 2014; Spence, Roberts, Ariti & Bardsley, 2014). Although this could be a result of improved social dialogue surrounding mental health, the evidence reported above suggests that the psychological ramifications of austerity could play a key role.

Hannigan and Allen (2011) found that mental health nurses perceived changes to their roles due to the evolving, and increasing needs of the service users (SUs), and they suggested that austerity could influence this further. It is likely that psychological therapists could encounter similar challenges given the comparable working contexts, although this remains to be explored. Falconnier and Elkin (2008) found that economic issues commonly present in a therapeutic context, therefore the socio-economic issues impacting on SUs are likely to be encountered by therapists. Working therapeutically with people experiencing financial hardship has however, been found to entail unique complexities (Thompson et al., 2015). Indeed, research has found that individuals who encounter financial difficulties also experience challenges in accessing support due to psychological and practical barriers (Appio, Chambers & Mao, 2012; Levy & O'Hara, 2010). Flexible and person-centred service provision has been found to mitigate these challenges, allowing SUs to benefit from therapy (Ammerman et al., 2005; Kim & Cardemil, 2012; Pugach & Goodman, 2015). However, working flexibly may prove challenging in the current context; at the same time as demand for services has been escalating, austerity policies have led to increasing pressures on

the NHS to reduce spending (McDaid & Knapp, 2010; O'Hara, 2014). As services look to make efficiency savings, the emphasis on setting and meeting targets is prioritised (Department of Health (DoH), 2012), and the scope for working in flexible and potentially more time-consuming ways with SUs is diminished.

Service inflexibility may also have implications on therapists' ability to harness a sound therapeutic alliance with SUs. The importance of the therapeutic relationship is widely acknowledged in relation to positive therapeutic outcomes (Lambert & Barley, 2001; Norcross & Wampold, 2011) and is particularly significant when working with those experiencing financial hardship (Thompson, Cole & Nitzarim, 2012). There are however, specific factors to consider when working to establish rapport with SUs with low-incomes. For example, Krupnick and Melnikoff (2012) suggested that a lack of awareness regarding SUs' contexts commonly causes ruptures in the therapeutic relationship. Similarly, Abrams, Dornig and Curran (2009) found that negative experiences of those in authority, amongst women from deprived backgrounds, creates vigilance towards any indication of a lack of empathy, which may further impact on the therapeutic relationship.

Lambert and Barley (2001) explain that the therapeutic relationship is enhanced via shared tasks, goals and bonds. Therefore, service-led requirements for therapists to meet targets, as has been witnessed since the increased focus on competition in service provision, may create incongruence between therapists' and SUs' goals. Additional conflicts within this domain may also emerge from government initiatives to impose therapy on those receiving ESA (Ross, 2014). Consequently, these discrepancies may lead to ruptures in the alliance, thus limiting the efficacy of therapy.

Communicating hope towards SUs on low-incomes has been identified as particularly important therapeutically (Overholser, 2016). However, the current socio-economic context

may create barriers to therapists doing this as inflexible service provision has been found to challenge therapist hope (Sælør, Ness, Borg, & Biong, 2015). Similarly, Thompson et al. (2015) found that therapists, working with SUs with low-incomes, routinely encountered systemic flaws which created limitations in their work, causing them frustration, which may also impact on their ability to sustain hope. Therapist hope is a pertinent issue to consider, particularly in relation to SU therapeutic outcomes, as Coppock, Owen, Zagarskas and Schmidt, (2010) found it to be positively related to SU outcomes. Indeed hopelessness has been found to be related to low mood (Mirander, Fontes & Morroquin, 2008). Therefore, therapists themselves may be susceptible to psychological difficulties due to a lack of hope arising in their work.

A UK survey conducted by the BPS and New Savoy (2016) exploring the wellbeing of psychological therapists, reported that stress and perceptions of failure were commonplace. Indeed, exhaustion and a perceived lack of accomplishment are key components of burnout (Maslach & Jackson, 1984) and has historically been viewed as a salient issue for mental health professionals due to the emotional demands of the role (Pines & Maslach, 1978). Hacker-Hughes et al. (2016) reported on the increasing rates of sickness amongst mental health professionals, suggesting that greater pressures placed on staff, alongside increased rates of bullying within the workplace may be to blame. Therefore, while mental health professionals may encounter a vulnerability to burnout due to the nature of their role, this risk is amplified with the added pressures of working in a context affected by austerity.

Clinical psychologists work directly with SUs, and may themselves be vulnerable to the difficulties presented above. However, they also provide supervision and consultation within multi-disciplinary teams. The role of supervision and managerial support has been found to be influential in supporting therapists who may be at risk of burnout (Sodeke-

Gregson, Holttum & Billings, 2013). Therefore, clinical psychologists may have a vital role in supporting colleagues working in conditions of austerity.

There is a paucity of empirical research exploring the impact of austerity on the work conducted by psychological therapists. The aim of this research was to therefore address this by exploring the experiences of qualified therapists working in NHS adult mental health services. Accordingly, this research aimed to answer the following research questions:

1) How, if at all, have policies implemented under the UK government's austerity programme impacted on the work of psychological therapists?
2) Have therapists' roles and professional identities changed as a result of the austerity policies?

Method

Design

Qualitative data were gathered from semi-structured interviews with 12 participants. Subsequently, Braun and Clarke's (2006) six stage model of thematic analysis was employed to analyse the data. The research, underpinned by phenomenological epistemology, aimed to explore how therapists experienced their work during a time of austerity.

Phenomenology is regarded as a research methodology, philosophy (Usher & Jackson, 2014) and an epistemology (Willig, 2012). Broadly, phenomenology aims to gain insights into individuals' subjective comprehension of a phenomenon (Giorgi & Giorgi, 2008). The aim of understanding how people construe their experiences suggests a link between relativist and realist positions, as individuals encounter an objective reality but afford meaning to this via subjective interpretations (Harper, 2012; Willig, 2012).

Traditionally, the importance of 'bracketing off' researchers' assumptions was regarded as a fundamental aspect of phenomenology (Usher & Jackson, 2014). However,

many rejected this on the basis of hermeneutics, whereby researchers are also acknowledged as people existing in, and making sense of the world, thus a divide in the paradigm emerged (Usher & Jackson, 2014). At one side is descriptive phenomenology, which aims to remain close to participants' accounts of a phenomenon. At the other is interpretative phenomenology, where researchers' interpretations are actively pursued (Finlay, 2009; Smith, Flowers & Larkin, 2009). Finlay (2009) argues however, that rather than viewing these paradigms as dichotomies, they can be understood as lying on a continuum. Therefore, while interpretation may be inevitable within descriptive phenomenology, it is not actively encouraged (Finlay, 2009).

Thematic analysis was chosen over other pure phenomenological methodologies due to the additional layer of flexibility offered by the approach (Braun & Clarke, 2006). This was considered a necessary feature given the broad focus of the research questions. Nevertheless, the central tenets of descriptive phenomenology were adopted as the analysis endeavoured to remain close to participants' accounts.

Research Credibility

Yardley (2008) suggests that the following criteria should be considered by researchers to promote best practice and thus produce high quality research:

1) Sensitivity to context
2) Commitment and rigour
3) Transparency and coherence
4) Impact and importance.

Relatedly, these criteria were considered throughout the research process, facilitated by the use of a reflective log (Appendix 2-A). Supervisory support was also provided; specifically,

supervisors listened to initial interview recordings and reviewed the process of theme development.

Reflexivity, outlining the context of the person behind the research, is fundamental in providing transparency (Yardley, 2000). Accordingly, it is important to acknowledge that I am a British Caucasian woman and by Savage's (2015) class definition model, I am regarded as 'technical middle-class'. I have worked in NHS adult mental health services since 2008, firstly as a primary care mental health worker and later as a cognitive behavioural therapist before commencing clinical psychology training in 2013. Consequently, my previous roles have provided me with direct experience of the phenomenon under investigation as I worked in these services during the implementation of austerity. Additionally, I am an active member of the Psychologists against Austerity group. Therefore, my own experiences and opinions of austerity may have influenced the research. Supervision was pivotal in limiting the impact of this bias. My supervisors, aware of my views regarding austerity, often embraced a critical stance to challenge my assumptions, thus allowing me to develop self-awareness and consider alternative perspectives.

Two participants were previous work colleagues of mine. Crowley (2010) identified that it is not uncommon to recruit acquaintances within qualitative research, stating that it can prove beneficial in establishing rapport. However, Crowley (2010) cautioned that familiarity may hinder participant disclosure and creates the potential for assumptions to be made about what is already known between the researcher and participant. Awareness of these potential barriers meant that I was able to seek clarification when it was thought that assumptions were being made. While it was not apparent that these participants held back in relation to their disclosure, the familiarity between us may have implicitly contributed to a degree of reservation.

Participants

Participants were included in the study if they were:

1) A Health and Care Professions Council registered psychologist or a fully accredited therapist (accredited via the appropriate body for the therapy they deliver) by one of the following professional bodies: Association of Cognitive Analytic Therapy; British Association for Behavioural and Cognitive Psychotherapies; British Association for Counselling and Psychotherapy; United Kingdom Council for Psychotherapy.

2) Currently working with adults, aged 16 years or older, in NHS mental health services[1].

3) Currently delivering 1:1 psychological therapy to SUs. This criterion was created to avoid recruiting people who exclusively facilitate therapy via the computer or telephone. This is because working exclusively by these methods may have particular implications for therapists' identities, and telephone therapy has been suggested to involve specific issues regarding therapeutic rapport (e.g. Webb, 2014).

Participants were excluded from the study if they:

1) Worked outside of the UK.[2]

2) Could not speak English.

A total of 12 participants were recruited and interviewed. The sample consisted of five cognitive behavioural therapists, six psychologists and one counsellor, working in primary care (Improving Access to Psychological Therapies (IAPT) services: n = 6), secondary care (n = 5) and inpatient services (n = 1). Four participants identified as male and eight as female. Ten participants described themselves as 'White British' and two as 'White Irish'. Ages ranged from 27 to 59, and the length of time working in adult mental health

[1] This criterion was purposefully broad to include those working in all areas of adult mental health.
[2] Due to the focus on UK policy.

ranged from 1 to 38 years. Participants were recruited from across the UK, including the North West (n = 7), Norfolk (n = 1), Suffolk (n = 1), London (n = 1), Scotland (n = 1) and Wales (n = 1). All participants were given the opportunity to provide a pseudonym to ensure anonymity.

Procedure

Ethical approval for the study was obtained from the researcher's university ethics committee. Subsequently, a recruitment flyer (Appendix 2-B) was advertised on social media platforms and via professional mailing lists. Prospective participants were requested to make contact to obtain further details. Upon expressing an interest, participants were sent an information sheet (Appendix 2-C) and were asked to make further contact if they wanted to pursue their involvement. Semi-structured interviews were then arranged with participants and took place either face-to-face (n = 5), over the telephone (n = 4) or by Skype (n = 3).

At the start of each interview participants were asked to complete a consent form (Appendix 2-D) and to provide demographic information (Appendix 2-E). Where interviews took place via telephone or Skype, consent was sought by requesting a verbal response for each item. This information was audio recorded and saved as a separate file on a university secured space. A topic guide (Appendix 2-F) was utilised to facilitate the interview structure and was shared with participants. However, this guide was not followed rigidly, allowing participants the flexibility to discuss their experiences (Smith et al., 2009). The interviews lasted between 43 and 83 minutes, they were audio recorded and subsequently transcribed verbatim.

Analysis

Thematic analysis of the data was completed by following the six stage method outlined by Braun and Clarke (2006), this included:

1) Familiarising yourself with the data: Following the interviews audio recordings were transcribed. Transcriptions were read at least twice and key notes added.

2) Generating initial codes: Notes and quotations formed initial codes (Appendix 2-G).

3) Searching for themes: Each code was collated in relation to the research questions, leading to the development of prospective themes (Appendix 2-H).

4) Reviewing potential themes: These tentative themes were scrutinised across the data set, leading to the generation of six, superordinate themes.

5) Defining and naming themes: Titles and summaries of each theme were then formulated.

6) Producing the report: Correspondingly, these themes will now be presented.

Findings

Analysis of data led to the development of six inter-related, superordinate themes:

1) "There's a general atmosphere of threat"
2) "You're squeezed": Increasing pressure
3) "It's just maths": Service users are becoming less of a priority
4) "You're definitely more limited in what you're able to do"
5) "It's just so upsetting": Added emotional strain
6) A fight, flight or freeze response: The mediating role of hope

The relationship between the themes is represented in Figure 1. Whilst all participants conceptualised austerity as "cuts" to welfare expenditure, they also acknowledged the prevailing sense of threat these cuts created (1). Although a distinct theme in its own right, elements of threat also permeated subsequent themes. In response, participants experienced service-related pressures, causing them to feel "squeezed" (2).

These pressures contributed to perceptions that SUs were becoming less of a priority within the system (3). Furthermore, this shift in service focus, alongside wider socio-economic issues, resulted in participants feeling limited in their capacity to influence meaningful change for SUs. Indeed, many reported how SUs' re-entry into services exacerbated this feeling but also intensified the pressures (4). All of these themes entailed implications for participants' emotional wellbeing, which encompassed a threat of burnout (5). Consequently, participants reacted with a fight, flight or freeze response, determined by their level of hope (6).

"INSERT FIGURE 1"

1) **"There's a general atmosphere of threat"**

It feels like everyone is threatened within the service. Everybody's scraping by, managing, trying to do their best to maintain the service to clients (Joleen).

This theme encapsulates the sense of threat experienced by all participants working in the context of austerity. Participants understood austerity to be the government's agenda to reduce welfare expenditure. However, they also acknowledged the related sense of threat this created for them and the SUs.

When reflecting on his previous work in the NHS, Lewis stated: "Things [cuts] hadn't bitten, there wasn't the same sense that 'bloody hell everything is under threat'". Lewis therefore acknowledged existing threats in the NHS but felt these had been exacerbated by austerity. Furthermore, Lewis also perceived a threat that things were going to get worse, likening austerity to a swamp: "It's a fucker of a swamp and I think it's guna get deeper and nastier and more full of unpleasant things as we go forward".

The threat of NHS privatisation was reported by nine of the participants: “I really do fear for the privatisation of the NHS, I think we are dangerously close” (Paul). Acknowledging the enduring threats of privatisation, Martin felt that this threat was currently more pronounced due to austerity: “As long as the NHS has been standing there have been people trying to hack it to pieces … at the moment it feels like the most concerted effort”.

These threats were actively induced in Mark’s service via communication from management: “There’s a lot of fear tactics, definitely. There was a lot of things about ‘ooh well, Virgin Care are hovering in the background, do you want to lose your pension?’” Additionally, Jessica and Mark referred to explicit threats to their jobs and salaries: “There was talk of re-banding us all and us all having to re-apply for our jobs” (Jessica). While these threats created a sense of job insecurity, other participants considered fears that privatisation would provoke increasing levels of social inequality (Lewis, Martin). Indeed, Tamara referred to the implications of privatisation on her own family, and Paul described the pride he felt for the NHS and a fear of losing this: “It would be a great loss to … something that Britain should be very proud of in its history. The NHS is an extraordinary creation”.

Although certain participants experienced threats to job security, there was acknowledgement that these threats were more pertinent for SUs:

> The people I'm working with have a much more pronounced sense of threat in terms of, erm, of their benefits, of what they might be able to claim or the sense of fear that things will be taken away from them (Lewis).

Consequently, participants had concerns regarding further cuts and the related financial implications this would have for SUs. There was also recognition that these threats impacted upon SUs’ well-being. When considering the threat of SUs losing ESA via WCA, Mary stated: “It fills them with dread, and I've had people feeling suicidal”. Similarly: “They

[SUs] feel hopeless, their environments are crap, no wonder their mental health's crap" (Christina).

Participants considered the rising demand for their services yet they expressed fears that this would intensify due to cuts to non-statutory organisations (Christina, Jessica, Lola). Indeed, participants described fears over services' capacity to meet this demand due to the limited resources, resulting from NHS budget cuts (Lola, Mark, Paul).

2) "You're squeezed": Increasing pressure

> *Everybody's feeling pressure to some level … [it] seems to be the way it is to ensure that the service doesn't lose funding (Joleen).*

Due to threats of NHS privatisation and increased demand for their services at a time when NHS funding diminished, participants felt increasing pressures. The introduction of competitive practices in certain services intensified these pressures and participants employed terms such as feeling "squeezed" (Christina, Jessica, Joleen, Mark, Simone) or "stretched" (Joleen, Martha) in relation to their work. Highlighting the physical consequences of these pressures, Simone reported: "You're squeezed. They want every drop of blood from you (laughs)".

Competition was encouraged by the publication of participants' outcome scores with clients: "They're guna be publishing our results, I just don't think I can cope with that personally, I find that quite difficult you know?" (Mary). In Tamara's service this was established practice, as managers scrutinised individuals' outcome scores in weekly meetings, creating frustration and anxiety for Tamara: "I don't want to compete with people … it becomes a competition and that's not what it should be about".

Christina, Jessica, Joleen and Simone, who all worked in IAPT services, expressed a common narrative within their workplace about needing to take work home due to the lack of capacity to meet necessary demands during their contracted hours. Although there was acknowledgement of the theoretical ability to take back time owed, participants felt unable to do that given the increasing pressures: "Staff are routinely working over their contracted hours" (Simone).

Increased pressures led to time constraints. In an attempt to manage this Christina's service abandoned team meetings as staff: "just didn't have the time". Other participants acknowledged increasing levels of isolation within their work due to reductions in formal and informal peer support: "We used to have like a casework supervision group … it was really useful … you used to talk about your cases with each other, that's been took off us" (Mary). It was also acknowledged that there was generally less capacity to reflect: "There's less space for, kind of, just thinking things through" (Martin). Additionally, when talking about her clinical work and the lack of reflection time, Christina stated:

> You've not got time to sit down and think about that person and what might be best for them… you're doing it at night when you come home … because you've not had time to do it in the space you've been given.

Paul explained that increasing pressures arose due to limited resources resulting from austerity and the related impacts on NHS budgets: "The lack of resources adds to the stress". Christina, Joleen, Mark and Simone concurred with this, acknowledging that problems with IT, estates and staffing all intensified the pressure. Furthermore, as a result of reduced resources, there was a sense of instability due to constant change: "They are always trying to juggle the resources they have to meet the demand … services aren't stable. Stability comes with having your necessary resources in place" (Paul).

3) "It's just maths": Service users are becoming less of a priority

> *They've [services] lost contact with what we're about. We're about care aren't we? We are about caring for people and making things better. It's not anymore. It's about ticking boxes, that's what it's become (Christina).*

Participants perceived a change in service ethos as a result of increasing pressures, with SUs becoming less of a priority. When considering the pressures placed upon her, Joleen stated: "It feels like it [clinical work] gets de-prioritised quite a lot". Indeed, an emphasis on discharging SUs from services "getting them in and out" (Mark) was evident throughout the data. It transpired that while some services concentrated on statistics, others adjusted referral criteria in an attempt to mitigate the increasing pressures. For example, in Paul's service, SUs could not access psychology until basic needs, such as housing, were met. Similarly, Mary stated that in her area "each service has become quite restrictive", in terms of the referrals they would accept.

The increasing focus on targets (e.g. SU outcomes and waiting lists) were most prevalent amongst those working in IAPT services. Simone stated: "Austerity plus the IAPT model is a bit of a lethal combination". However, Tamara also spoke about the prioritisation of statistics in her non-IAPT, inpatient service and stated that some SUs were aware of this: "They come in and it's like, no one cares we're just a number". Moreover, problems in quantitatively evaluating intervention effectiveness were commonly reported, with participants describing the limitations of self-reported measures: "I've seen it before like some people's clients are people pleasers and they'll say they're getting better … The scores

mean jack shit, let's all get over the scores" (Tamara). Additionally, Simone highlighted the difficulties of evaluating statistics in this line of work:

> There's this model of X number of staff, you see X number of clients. No consideration of the emotional impact of the work we do, of the, the locations we are, the sessions we're in, the local need. It's just maths. X number of staff equals X number of clients.

The focus on statistics caused frustration for many but for Lewis and Lola, this was less of an issue; interestingly, both were psychologists working in services outside of England. The emphasis on statistics created further pressures for most participants as there was the threat that if set targets were not met, they would be monitored: "If we don't meet those targets we would then be put under a performance review ... I know of at least two people within our team that has happened to" (Jessica). Furthermore, if professionals in her service routinely failed to meet targets Jessica stated: "It would go to disciplinary proceedings". This was an issue raised by others (Joleen, Mary, Simone), while Martin spoke about the financial implications for his team if targets were not met, indicating that his service would "incur fines".

Furthermore, there was recognition that this shift in focus induced a level of inflexibility and restriction to participants' work: "At [session] six if they're not improving you may have to finish seeing them, so it's become quite rigid and, and very, kind of, crippling" (Mary).

4) "You're definitely more limited in what you're able to do"

> *I've got a lot more skills but it feels like a waste. So I'm being paid a certain salary and you can't really make the difference that you want to make in that context (Martha).*

The level of inflexibility and restrictions, alongside a greater focus on targets and throughput, meant that participants felt frustrated and powerless that they could not effect meaningful change for SUs within the therapeutic context. It was recognised that socio-economic difficulties created barriers for SUs attending therapy and these broader issues ultimately impacted on therapeutic outcomes: "It's a massive issue and it messes up the therapy really 'cause it brings something else in" (Mary).

Participants felt that it was the increasing pressures which led to limitations in their ability to effect change: "You're not given the right amount of, erm, time to kind of work with people" (Mary). Similarly, Mark and Jessica acknowledged that therapy had become "much more, fast pace" (Mark). Jessica spoke about the impact this change of pacing had on her ability to develop the therapeutic relationship with SUs:

> Previously you had two, three even four sessions to really kind of get to know the person, for them to form that relationship with you... but you're having that quick assessment and then you're straight in with 'right this is what we're doing'.

This led Jessica to conclude that she could not do "proper CBT" with SUs. Similarly, when discussing working with SUs with trauma histories, Martha stated:

> Unless you agree, okay they can come for 30 sessions or however many session they need, then that piece of work is never actually going to get done … So that's very frustrating, it feels futile. It feels silly really. That feels like a waste of money.

The efficacy of therapy was questioned by most participants and this was commonly triggered by SUs re-entering the system, exacerbating the pressures: “It makes no bloody sense because they’re guna relapse and that’s going to cost them far more money in the long-term” (Tamara). However, for Lewis, Lola and Simone this was less of an issue as they accepted that certain SUs may regularly re-enter services due to their level of need.

Nevertheless, difficulties regarding accessibility for SUs experiencing financial hardship were also considered as an issue impacting on therapy, resulting in many disengaging with the process:

> People’s ability to travel has been severely curtailed … you will have people say ‘well I can’t possibly come to your assessment clinic at X because, erm, because I can't afford to get there’, err and that's a big, big problem (Lewis).

Some participants had the ability to offer home or community based visits (Jessica, Mark, Martin). However, this was rarely executed due to the existing pressures. Mark, in particular, voiced his frustration with this given the value he placed upon in vivo work: “It's a different type of therapy and for me, for certain types of problems, the most effective therapy. What would take 12 sessions, you can deal with in an hour and a half”.

5) “It’s just so upsetting”: Added emotional strain

> *I didn’t realise how emotional I was about it…I got upset ‘cause I feel so bad for patients and erm, I’m angry. I’m swearing a lot. It’s good that I feel so passionate because a part of me actually thought I felt a bit despondent (Tamara).*

Working in the context of austerity entailed emotional implications for participants. Participants described how threats, pressures, perceived limitations of their role and the

acknowledgement of the de-prioritisation of SUs within the systems, contributed to added emotional strain. Participants consequently described an underlying threat of burnout within their work.

There were times during the interviews when participants became emotional. Some cried, whilst others became angry: “It makes me feel sad. I feel emotional now thinking about it. It makes me feel like… (Cries) I’m crying now!” (Christina). Similarly: “It's kind of frustrating, it makes you kind of feel angry” (Mary). Feelings of anxiety due to the prospect of further cuts was also present: “I worry about other cuts” (Lola). Furthermore, just as they felt SUs had become less of a priority within services, participants also felt they themselves had become devalued: “It’s [NHS] changed, it’s really impersonal, you’re a nobody really” (Christina).

Additionally, many questioned their role within the current system, with a sense of internal conflict about being part of something that could perpetuate or create difficulties for SUs: “You kind of get to the point where sometimes you're not quite sure if actually what's being delivered is almost unhelpful” (Joleen). Similarly, when talking about the potential for the system to exacerbate SUs’ difficulties, Martha stated:

> I dunno, it taps into something about being a let-down or not cared about, you know? All of those things: rejected, ignored. These sort of like relational patterns that they’ve [SUs] experienced in childhood. It’s being repeated again but on a huge scale.

This was a view shared by others: “It’s feeding into their core beliefs, ‘maybe I am not worthy’” (Tamara). Additionally:

> The messages people have received, not the messages as clinicians we tend to give, is that “I’m unhelp-able” and actually no! If you had a roof over your head and food in

> your belly and you weren't sick, you probably wouldn't be depressed or anxious (Simone).

The combinations of emotions experienced in relation to the work and the threat of burnout was directly referred to by certain participants: "People can very quickly fall into feeling a bit more hopeless and that burnt out kind of feeling" (Martin). Equally, when considering burnout, Mark stated: "You're riding on a wave", explaining a fear that working in this context would inevitably lead to burnout. Tamara, talked about the need to put strategies in place to prevent burnout as she did not see the NHS as a trustworthy source of support if she was to become psychologically distressed. Additionally, it was acknowledged that the effects of this added emotional strain extended to a systemic level: "It's [morale] very poor, it's very poor, err, morale's poor" (Paul).

6) A fight, flight or freeze response: The mediating role of hope

> *How do you remain professional, but also fight for what you think your client deserves? I think it's difficult and ultimately that's why I'm going part-time (Martha).*

In response to austerity, and the related implications for their work, participants described a number of coping strategies. These strategies corresponded with a fight, flight or freeze response, yet these responses overlapped and were guided by participants' level of hope.

Some participants would 'fight' against the system by working outside of their roles to offer practical support to SUs with issues such as housing (Lola) and finances (Christina, Mary). This approach, inspired by hope, also seemed to protect hope as the benefits of their practical support could be seen in the short-term, which appeared to reinforce this response.

Five of the participants were CBT therapists and all of these participants acknowledged the need to draw on additional skills, particularly third-wave CBT, to address SUs' needs: "I'm sure not many people are doing CBT to be honest if they're experienced therapists, or very little CBT. I'm guessing most people are … using lots of different skills … depending on their background". In this context Christina used social work skills and third-wave CBT. Lola explained how "stepping outside" of her role to work more flexibly was most helpful for her SUs and enhanced the therapeutic relationship: "It's meant that I've been able to develop a better relationship with the person I work with because I am considering all those different aspects".

Lewis and Martin considered the importance of influencing change via systemic means. There was a strong sense of hope amongst these participants specifically which served to enhance their 'fight' response, the importance of which was described by Martin:

> I'm not prepared to give up though. It's not guna take me. I'm guna keep kind of pushing back, keep, kind of, fighting what I can, 'cause actually nothing's guna change if you just like sit back and let it slide, you've gotta kind of keep fighting, keep pushing forward, keep the hope alive.

Others acknowledged that maintaining a 'fight' response becomes increasingly difficult due to increasing pressures which seem to diminish hope thus, activating 'freeze' or 'flight' responses. 'Freeze' responses accounted for ways in which participants remained in work, adhering to the pressures placed upon them without challenge and was related with acceptance: "It is just the way it is" (Jessica). Despondence however, initiated a 'flight' response. When reflecting on the rationale for her career break and reduction in working hours Tamara stated: "Everything feels quite hopeless at times".

Indeed, a loss of hope in positive change contributed to participants' reduction of working hours (Christina, Joleen, Martha, Mary, Simone, Tamara) which could be regarded as an explicit 'flight' response. High rates of staff sickness was an issue discussed by many, while sickness could be the result of embracing a prolonged 'fight' response, it could also be perceived as an underlying 'flight' response. Mark explained that his own sickness absence was a direct result of "burnout". While Lewis suggested other possible confounds, others were clear that staff sickness was a result of "stress" (Martin) and "exhaustion" (Simone).

Discussion

As a result of austerity, therapists reported an increased, pervasive atmosphere of threat within their occupational environments. According to Skinner, Edge, Altman and Sherwood, (2003), threats produce negative emotions and as such, individuals are likely to react with innate fight, fight, freeze responses. The findings from this research support this view as participants considered the impact of these threats on their working culture, which impacted on them emotionally. Consequently, participants adopted fight, flight or freeze responses, determined by the presence of hope.

Certain threats experienced (e.g. NHS privatisation) could be understood in terms of job insecurity which comprises of fears of losing employment, and thus income, but also threats of losing valued occupational qualities (Greenhalgh & Rosenblatt, 2010). Direct clinical work is often regarded as the most valued component of a therapist's role (Southall, 2009) and many are prompted to pursue a career of this nature to 'help' those in need (Norcross & Farber, 2005). Job insecurity may therefore be exacerbated by acknowledging SUs are less of a priority in the system as this shift detracts the focus away from the most important aspect of therapists' roles. Additionally, recognising the limitations to their role, and their inability to adequately help SUs, may intensify this insecurity and threaten their professional identity.

Professional identity is associated with social identity (Schein, 1978 cited in Adams, Hean, Sturgis & Clark, 2006) and relatedly, instability or threats to this identity can have implications on psychological well-being (Haslam, Jetten, Postmes & Haslam, 2009), which could account for the added emotional strain experienced. Therefore, therapists who embraced a 'fight' response, by stepping outside of their usual roles to offer practical support, may have done so to continue helping SUs, which may have served to protect their professional identity.

The findings indicated that hope was relevant amongst the coping responses adopted by participants. Snyder et al.'s (1991) cognitive theory of hope, emphasises the role of goals. According to this theory individuals must possess the willingness and capacity to achieve goals for hope to prevail. Acknowledging the prevailing social issues impacting on SUs may therefore have created difficulties for participants in their perception of their ability to attain goals, and to truly help their SUs. This could have impacted on their hope, activating 'flight' or 'freeze' responses. The presence of hope was found to provoke a 'fight' response, however if chronic negative results are encountered, therapists may lose hope and thus the motivation to persevere, resulting in learned helplessness (Seligman, 1975), which could account for the 'freeze' responses reported.

Niebieszczanski, Dent and McGowan (2015) highlighted the importance of reflection for managing therapist hopelessness. However, the current study found that increasing service pressures led to a lack of capacity to reflect and access informal support. Smith, Li, Dykema, Hamlet and Shellman (2013) identified informal support as particularly beneficial for therapists working with low-income SUs. Furthermore, connection with colleagues has been identified as an important coping mechanism for mental health professionals (Bowden,

Smith, Parker & Boxall, 2015). Therefore, reducing opportunities for support and reflection could have further implications for therapists' wellbeing and the quality of their work.

Therapists' wellbeing could be further affected by role-conflict, given its relationship with job insecurity (Keim Landis, Pierce & Earnest, 2014). Conflict may arise as therapists aim to support SUs, whilst simultaneously adhering to additional, often competing, service-led demands. As mentioned previously, therapists often embark on their career to help SUs (Norcross & Farber, 2005), therefore evidence of participants questioning their role within an unhelpful, potentially damaging system, suggests the presence of cognitive dissonance (Festinger, 1962). Consequently, participants' coping styles, such as adopting a 'flight' response by reducing working hours, could be guided by intentions to minimise the psychological implications associated with this cognitive dissonance.

Implications and Recommendations

Austerity measures have introduced a number of factors which hold the potential for inducing stress amongst therapists. Regular exposure to stress, alongside existing emotional implications of the work, could therefore cause burnout (Pines & Maslach, 1978). The psychological implications of burnout hinder work-related performance and contribute to sickness absence, suggesting that it is in organisations' interests to support their employees (Foresight Report, 2008). This is of particular significance as the Berwick report (2013) and Francis report (2013) highlighted that insufficient staff support resulted in poor service provision. While stress management programmes are offered in some NHS trusts (e.g. Marx, Strauss, Williamson, Karunavira & Taravajra, 2014), staff may struggle to access these due to existing pressures. Focusing on stress-management programmes as a solution however, implies that difficulties encountered stem from therapists' lack of resilience and inability to manage stress, therefore neglecting the systemic issues which undoubtedly have a role.

Therefore, clinical psychologists could work to bridge the gap between NHS provider and commissioner services. This could be achieved by applying consultation and teaching skills to educate commissioners, and other relevant professionals, on the consequences of work-related stress so that services adapt practices accordingly. Indeed, professionals in commissioning roles may benefit from shadowing therapists to fully understand the nature of the role. Additionally, psychologists could directly support colleagues through offering reflective spaces as a way of reducing isolation and enhancing therapeutic skills. As therapists' ability to recognise accomplishments may be obstructed by burnout (Maslach & Pines, 1978), psychologists could also promote practices aimed at recognising positive achievements.

The inflexibility of services was also described by participants. This inflexibility could be understood via the threat-rigidity model (Staw, Sandleands & Dutton, 1981). This model explains that when an organisation encounters threat, in this case NHS budget cuts and privatisation, they react with rigid 'well-learned' responses and fail to consider alternative, viable solutions. Psychologists could therefore support organisational leaders to consider innovative practices. One specific example could be developing community-based approaches, which would address accessibility issues for low-income SUs (Kim & Cardemill, 2012).

The Equality Act (2010) states that organisations have a 'duty' to make 'reasonable adjustments' for people viewed as 'disabled'. The term 'disability' includes those experiencing mental health difficulties. NHS services may be failing to meet this objective as participants' perceptions of the limitations to the work were exacerbated when SUs disengaged due to accessibility issues. Many people from deprived positions are subjected to stigma from healthcare professionals (Appio et al., 2012). Therefore, the barriers

experienced could arise due to covert systemic discrimination and professionals could draw on this legislation if it is thought that a specific population are being ostracised via current practices. Furthermore, as people from low-incomes are vulnerable in society, revisions to the Act may be required to protect them and ensure they have equal access to healthcare.

Exclusion from services on the basis of socio-economic status may also be regarded as an infringement of human rights (DoH, 2007). Human rights may be further implicated due to the prioritisation of statistics and targets over increasingly complex individual mental health needs. Despite acknowledgement of the dangers of prioritising targets over SU care in the Francis report (2013), it seems that this is overlooked in mental health service provision, therefore this needs to be addressed with urgency. Favouring positivist, epistemological approaches within CBT research, National Institute for Clinical Excellence (NICE) guidelines and IAPT services was identified by Williams (2015), and was considered a cumulative issue within mental health. Payment by results policies reinforce this approach, largely measuring intervention effectiveness via quantitative 'clustering tools' or self-report questionnaires, (DoH, 2012). Participants, particularly those working in IAPT services, recognised the limitations of these measures in assessing meaningful aspects of SUs recovery and expressed the need for more qualitative, patient-centred evaluations of therapeutic outcomes. Therefore, alternative methods of evaluating service efficiency ought to be considered, highlighting a potential avenue for future research. Accordingly, payment by results policies should consider including qualitative evaluations to support the reliability of quantitative measures.

The socio-economic issues affecting SUs were widely acknowledged alongside the limitations of influencing change at this level within a therapeutic context. Psychologists are well positioned to apply skills outside of the therapy room to meet the needs of SUs.

Mallinckrodt, Miles and Levy (2014) specifically encourage psychologists to embrace the 'scientist-practitioner-advocate' model to influence policies and macro-level systems as a means of advocating for SUs oppressed by issues of social injustice. Fulfilling this role may therefore inspire hope and allow front-line staff to uphold a 'fight' response. Consequently, it is imperative, for clinical psychology training and continuing professional development programmes to support professionals in acquiring, and developing, these necessary skills.

Limitations

A significant limitation of this research is the possible presence of bias. Participants may have been motivated to partake in this research by pre-existing beliefs about austerity. Indeed, those encountering difficulties within their work may have been more inclined to participate. Consequently, it is possible that this research provides an overly negative view of working in the context of austerity. The use of the term 'austerity' throughout the advertisement of this research may have been particularly influential in participants' decision to take part. The application of neutral terminology within the research title and description may have limited this bias and is therefore a factor to consider for future research into this area.

Burnout and job insecurity have been found to be factors influencing younger, less experienced employees (e.g. Keim et al., 2014; Sodeke-Gregson et al., 2013). The majority of the sample included in this research were younger employees that were relatively new to their careers, which could have had implications on the findings. Therefore future research could explore the experiences of those who have worked in the NHS for a longer period. Finally, the findings from this research may not be limited to NHS adult mental health services, therefore prospective research could explore the impact of austerity across diverse services.

Summary

This research found that therapists experienced an increased sense of threat in their work due to austerity. Despite acknowledgements of the historical challenges encountered by the NHS, it seems that austerity has exacerbated these difficulties, creating inflexible and largely ineffective service provision. The results of which have implications on therapists' emotional wellbeing which increases the risk of burnout. Services therefore need to support professionals so that this risk of burnout can be reduced and staff are more likely to remain working within the NHS.

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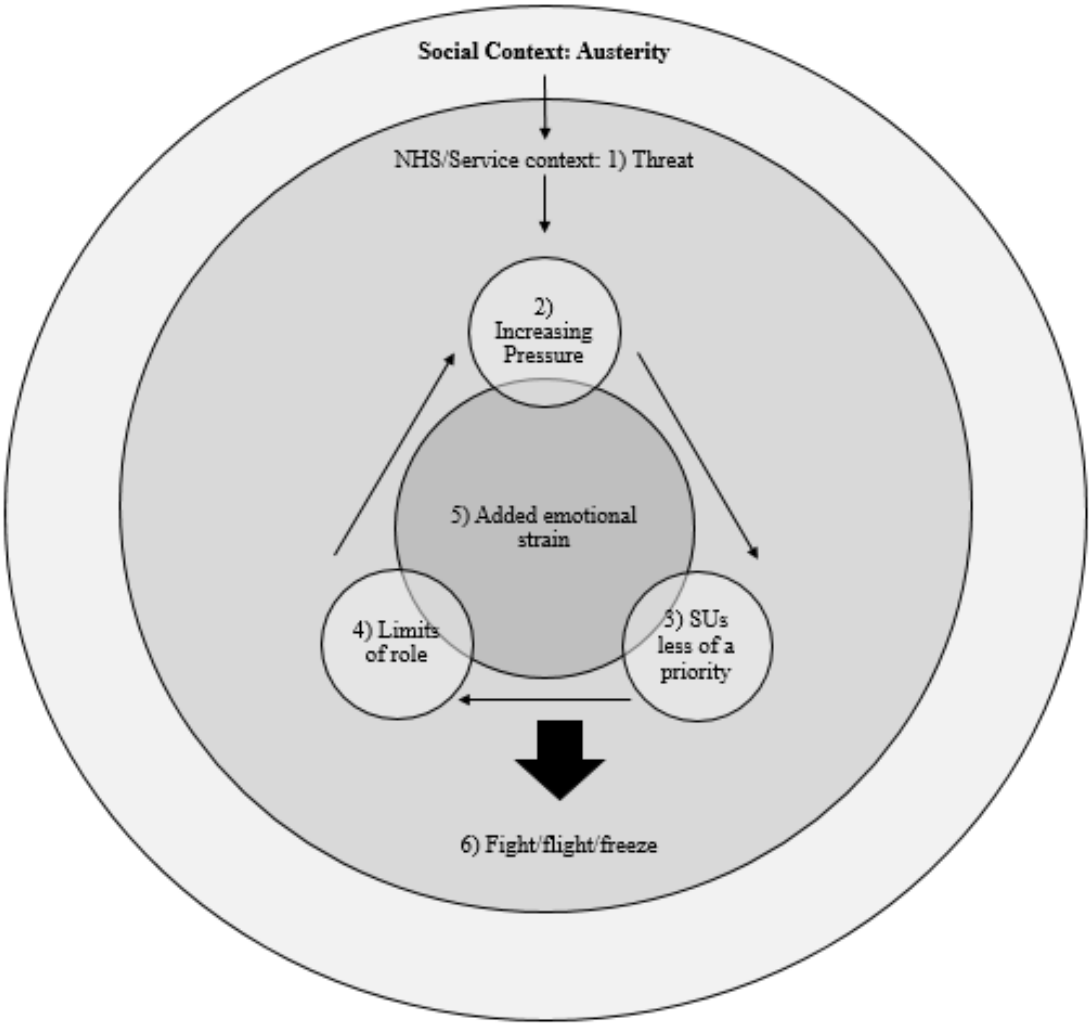

Figure 1. Conceptual diagram of themes.

Appendix 2-A: Excerpt from reflective log

Notes taken following Interview - Paul

Referral criteria – patients have to 'have their basic needs met' before they access psychology. Something didn't sit right with me here. There's something about compassion that seems to be missing, not from the clinician but the system. It seems that there's a sense of keeping people out, yet if people aren't having their basic needs met then surely these are the most vulnerable people that actually need that help? Pressures of the demand makes that more difficult.

A change in the NHS - there was also something present about the initial pride of joining the NHS (ID badge, group belonging) which has changed, now described as a sinking ship – sense of threat, worries about the future.

"The government are out to get me" – quote from a patient, participant felt that that was not entirely off the mark: "there's always a nugget of truth in the delusion". There seems to be a sense that the systems are unhelpful for people, they are not helping.

Next interview: Try to stick to one question at a time; ask more open-ended questions.

Appendix 2-B: Recruitment Flyer

Health & Medicine | Lancaster University

Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

Are you a HCPC registered Psychologist or an accredited psychological therapist?

Do you deliver psychological therapy to adults within a NHS mental health setting?

I am a trainee clinical psychologist. As part of my doctoral research I aim to explore whether policies introduced under the UK government's deficit reduction programme have impacted on the therapeutic work conducted by psychologists and psychological therapists.

If you answered yes to the above and think you would like to participate, or if would like further details please contact Hayley Higson on: **07508375624 or h.higson@lancaster.ac.uk**

Appendix 2-C: Participant Information Sheet

Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

My name is Hayley Higson and I am a third year trainee clinical psychologist studying at Lancaster University. As part of the course trainees are required to complete a research project. This sheet will provide you with some details about the project that I will be conducting. It is very important that you read this information carefully and take time to consider if you would like to participate. If after reading this you have any questions about the study please do not hesitate to contact me. My details are located towards the end of this information sheet. If you do make contact or request further details you are in no way obliged to take part.

What is the study about?

I aim to explore the experiences of professionals who provide psychological therapy to adults accessing NHS mental health services at a time when policies introduced under the UK government's deficit reduction programme may be impacting both directly on their clients and on the services in which they work. I aim to explore how this is experienced by these professionals and the impact this may have on their role or professional identity.

What would taking part involve?

If after reading this information you decide you would like to take part in the project, you are asked to contact me on the number or email address provided towards the end of this sheet. We will then arrange a convenient time and location to conduct the interview. This could be face to face (at Lancaster University or your home address) or via Skype/telephone, depending on your preference and the distance of your location from Lancaster. Travel expenses can be reimbursed to a maximum of twenty pounds. Please be aware that if you opt to have an interview via Skype, entire security of that data cannot be guaranteed due to Skype's own terms and conditions. However all transcriptions and recordings taken from that

interview will be kept secure. If you would like the interview to take place during work hours and/or at your place of work you will need to seek permission from your line manager and advise me of any procedures which I would need to follow for this to be arranged.
The interview with me will last up to 90 minutes, during which you will be asked to provide some demographic information and written or recorded verbal consent (depending on whether the interview is face to face or via Skype or telephone). I will then ask you some general questions about your experiences of working with adults in a NHS mental health setting during the current socio-political context. You will be able to take a break at any point in the interview and you may also stop the interview at any point if you decide you do not wish to continue.

Will the information I share be confidential?

All of the information you provide in this study will be confidential unless I feel there is a risk to your safety or the safety of someone else. If I feel that I need to talk to someone else about anything you have said, then I will aim to discuss this with you initially.
The interviews will be audio recorded and will then be anonymised and typed up by me into a written transcript. The recording and transcripts may be seen by my research supervisors. Their details are provided at the bottom of this sheet. This will be done to check the quality of my work. The recordings and the transcripts will be encrypted and stored on a secure University internet server. These will be deleted by the research coordinator after ten years following the successful completion and examination of the project.

Do I have to take part?

You are under no obligation to participate in this study. If you decide to participate, you have the right to change your mind and withdraw from the study before and during the interview. If you decide to withdraw from the study after the interview has taken please, please be aware that it might not be possible to extract your data completely from the study. This is because following the interview your data will be anonymised and pooled with the other participants' data.

Are there be any benefits to taking part?

There are no direct benefits to taking part in the study but it is hoped that the results will help to develop a better understanding of an area of work that we currently know little about. The

results may also be used to develop policy and services to support professionals working with the changing needs of clients.

Are there any risks from taking part?

It is not anticipated that there should be any risks from taking part in the research. However, it is possible that issues might come up in the interview that you find difficult or distressing. You may wish to take these issues to your supervisor or line manager. Alternatively you may also seek support from your GP or by calling The Samaritans on 0845 790 9090.

What will happen to the results of the research project?

The anonymised results from this study will be written up as a thesis. This thesis will be submitted for examination by the university and may also be submitted for publication in academic journals. I may also present the findings at conferences and training/teaching events. I will also prepare a summary of the research findings which will be made available to you if you wish.

Who has reviewed the project?

The project has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee, and the University Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study?

You can obtain further information about the study by contacting myself:

Hayley Higson (Chief Investigator/Interviewer) - Trainee Clinical Psychologist, University of Lancaster, 07508375624, h.higson@lancaster.ac.uk

Further Contacts:

Academic Supervisors:

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Complaints procedure:

If you have a complaint please contact:

Professor Bill Sellwood
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Professor Roger Pickup
Associate Dean for Research
Faculty of Health and Medicine Division
of Biomedical and Life Sciences
Lancaster University
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Thank you for taking time to read this information. If you have read the information and would like to participate in the research, please contact Hayley Higson on: 07508375624 **or h.higson@lancaster.ac.uk**

Appendix 2-D: Consent Form

Title of Project: Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

Name of chief investigator: Hayley Higson (Trainee Clinical Psychologist)

Please tick each box

1. I confirm that I have read the information sheet dated 25/03/16 version one for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐

3. I understand that once my data have been anonymised, analysed and pooled with other participant data, (approximately two weeks after the interview has taken place) it will not be possible for it to be withdrawn from the study. ☐

4. I understand that the anonymised information collated, including demographic data and quotations may be used in publications, reports, conferences and training events. ☐

5. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case confidentiality will be breached. ☐

6. I agree that if interviews are taking place on NHS sites and/or during my working hours I confirm that I have sought permission from my line manager and have informed the chief investigator of any necessary processes to comply with. ☐

7. I understand and agree that if the interviews are taking place via Skype, the researcher cannot guarantee complete security of my data outside of the limits set by Skype. ☐

8. I understand that my interview will be audio recorded and then transcribed. I understand that audio recording and transcripts will be encrypted and stored on a secure hard drive and hard copies of data will be stored securely at the university until ten years after the project has been submitted when all electronic and hard data will be destroyed by the university research coordinator. ☐

9. I give my permission for all of the supervisors involved to listen to the audio recording of my interview/see a copy of the interview transcript. ☐

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

11. I would like to be provided with a summary of the results upon completion of the study. If so, please state preferred contact method and details:

……..……

Name of participant:

Date:

Signature:

I have explained and defined in detail the research procedure in which the respondent has consented to participate. Furthermore, I will retain one copy of the informed consent form for my records.

Name of chief investigator: Hayley Higson

Date:

Signature:

Appendix 2-E: Demographic Information Sheet

Please complete the following details.

Age:

Gender:

Ethnicity:

Location of work:

Designation and current area of work e.g. inpatient/primary care etc.:

Length of time working in this area:

Length of time qualified:

Accrediting body:

Length of time you have been accredited:

Appendix 2-F: Topic Guide

Title: Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

Job role

- Client population/demographics
- Therapeutic modality
- Working environment

Austerity

- Meaning/understanding
- Specific policies/procedures of importance
- Relationship to job role

Clients' needs

- Referrals
- Key issues/patterns
- What helps/what does not help

Socio-economic context

- In the therapy room
- Outside of the therapy room
- Changes/key issues/patterns

NHS working

- Ethos
- Perspectives of job role
- Job satisfaction

The future

- Job role
- Clients' needs
- NHS working

Is there anything else you wish to add?

Thank you for taking part – any questions?

Appendix 2-G:

Example of transcript including initial notes and codes - Paul

Notes:	Transcript:	Codes:
Lack of access to psychology due to lack of resource Psychology another role – consultation (not same for therapists?) Unfair system – inequality Sense of uneasiness over not fulfilling role/duty Substandard service – due to lack resource Dissatisfaction, anxiety Don't like refusing the opportunity service to someone: forced into it 'Now'- implication resources used to be there Opportunity for innovation	I - And, kind of thinking about that 1:1 work, you said there's a definite role for it, are there any barriers that you're seeing, any patterns or key issues that are coming out, that might be kind of- P - Massively, *Massively*! So first of all erm in our service, erm, you know, erm, not everyone is being seen by a psychologist because the resources simply aren't there and often at times, erm the way a referral is accepted is that we have to do a consultation with members of staff and the truth of the matter is that really I think everyone that's taken to consultation could benefit from individual work but, err, we simply can't offer everyone that, that opportunity and so decisions have to be made, who to prioritise and who not and so, erm, not everyone is getting an equal opportunity at, at, err, recovery you know and likewise erm, I'm not sure we're necessarily, erm, fulfilling our professional duty in the service we provide. I - Can you say a little bit more? P - You know, it's a substandard service, it's a substandard service that's, what I am saying and that's, I am not blaming *any* individuals I'm actually blaming the lack of resource I - And what's that like for you, kind of working, knowing that it's a, this substandard service? P - Deeply dissatisfying, at times anxiety provoking because you know err, I, I, I am the person who always has to make the judgement, whether someone gets seen for therapy or not, so I know I'm denying someone the opportunity sometimes to be seen. I don't like having to make that decision but I feel I'm forced into it because again the resources aren't there now, I also want to be optimistic and say that if anything, one thing this does provide is also an opportunity to	**Lack Resource** **Problem solving – ways to deliver / do job** **Against values – job dissatisfaction** **Opportunity**

Role of community interventions – optimism Need for 1:1 therapy	innovate services so I do think that change can also happen on a broad level you know, the more groups there are available to kind of catch a broader group of service users, the better, the more erm kind of, recovery orientated community, activities and services there are to stimulate people to go out and live their lives, Great! All of that should happen still and be, kind of the next sort of, development of services in terms of managing this challenge but at the same time we still need individual rooms in which people can talk about their deepest anxieties and fears. I - Absolutely, and kind of just to go back to what you said about erm the referrals coming through and you having to prioritise who gets individual therapy and who doesn't, how is that decision made, how do you prioritise?	**and Optimism**
Referral criteria – basic needs met, stability. Barriers to engagement in therapy if these needs are not met. Presence of a degree of flexibility Precious time	I - So erm, I mean there is sort of a checklist which is really just sort of agreed by all the professionals, so it's not your own erm judgement coming in at this point, so the first one is, is that err, there has to be a degree of stability in the person's life in terms of Maslow's hierarchy of needs you know, they to have a, shelter, somewhere to live and err, you know there's, there's a, there's enough stability in their lives that erm err, yeah their basic survival needs aren't threatened because if they are in survival mode then actually the real therapy is getting them out of that dangerous situation you know, similarly if someone's in an abusive relationship, sometimes it might be wise to address that first before doing therapy with the person err, also in terms of risk, simply if the risk is so high the person's not stable enough to get to therapy then sometimes they'll work towards stabilisation before the person's considered for it but then again sometimes I do see people who are highly suicidal when I start with them, so there's no hard and fast rules, these are sort of guidelines so, so stability is a key thing. Also, and this itself is an economic issue, whether or not the person has been assigned a care co-ordinator because if the person hasn't been assigned a care co-ordinator err, then the psychologist will have to be the care co-ordinator. Now we were given specific err, sort of instruction by our manager not to become care co-ordinators because that's feeding into our precious time. I - Right okay, (Pause)	**SU threat** **Need for basic needs to be met** **Barriers to accessing services** **Time** **Waiting list**

Lack of resource – impact on waiting lists – back to patients waiting Sinking ship – not keeping afloat Threat of privatisation of NHS Pride in NHS	P - You know erm, and so the reason why someone may not have been assigned a care co-ordinator yet is because they're still on the waiting list, waiting for a care co-ordinator, the reason why they are on the waiting list is because there aren't enough care co-ordinators you know? I - So it's going back to that lack of resource again? P - Lack of resource, back to that lack of resource, I, you know I think it's worth, erm, using this sort of metaphor, erm, when I was talking to my dad about my new job and stuff he was proud of me but I described it as a sinking ship in some ways, you know? That erm, it doesn't feel like we are keeping afloat and I really do fear for the privatisation of the NHS, I think we are dangerously close, dangerously close and it would be a great loss to, err, something that Britain should be very proud of in its history. The NHS is an extraordinary creation. Err, probably one of the greatest contributions that Britain has made in terms of, err, you know, setting a model for, for how things should be done politically	**pressures** **Lack Resource** **Uncertainty in NHS**

Appendix 2-H: Example of Theme Development

Theme one: "There's a general atmosphere of threat"

Codes:	Supporting evidence:
NHS privatisation; SU threat of financial insecurity and related consequences; Stigma/judgment SU feel threats; Social issues causing mental health problems – threat of this increasing Anxiety about the future – fear it will get worse Uncertainty in NHS; Constant change; Confusion in services; Lack of resource; Impact on third sector: third sector services are essential;	"If we don't provide the service somebody else will, so there's always, so there's always, and not particularly at this place at work, but other places I've worked, I know that there's been an air of, erm, particularly somewhere else I worked, of that, a private company will come in. So if you can't do it, somebody else will". (Joleen) "There was a lot fear tactics, definitely, there was a lot of things about 'ooh well virgin care are hovering, do you want to lose your pension?'...One very significant thing about austerity is there's less money in the pot and they wanted to re-band us all from band 7 to band 6 and there was all these changes coming in and you've gotta do essentially 33.3% extra work every week, but you're, but we're guna re-band you from a band 7 to a band 6" (Mark) "Yeah constant kind of cuts and trying to save on budgets erm and thinking about how that's affecting the services that we're providing but also then like the, thinking about the third sector as well that, that, often they've picked up a lot of the cuts which have happened because of austerity measures and then where, when Brexit happened I, it kind of sent me in a spin because I, I suppose I hadn't really thought about it because they have (third sector services), in our local area, they have been providing erm a lot of like the backfill really to services, so they've been supporting a lot of our statutory services (Lola) "I described it (NHS) as a sinking ship in some ways, you know? That erm, it doesn't feel like we are keeping afloat and I really do fear for the privatisation of the NHS, I think we are dangerously close, dangerously close and it would be a great loss to, err, something that Britain should be very proud of in its history. The NHS is an extraordinary creation" (Paul). "It feels that there is a threat" (Martin) "I see people who are on the threshold so they do have the basic physical securities in place but they always fear they're guna be taken away from them, do you see what I mean? So erm, I mean this is, this is part of the problem" (Paul)

Threat of not meeting targets; Threat of job security;	"I've had people erm, who have been going to food banks, I've seen, and you know, people are worried about losing their homes if they don't go to these meetings as well, so you end up working with all of that as well and, and it's kind of like real, it's real so erm they could very well lose their homes" (Mary) "People just haven't got money have they, to live, let alone anything else. Lots of loans sharks going on as well, where I work". (Christina) "I perceive there has been a massively increased sense of threat to both, as I was saying, so the security of the NHS but also in terms of the people I'm working with have a much more pronounced sense of threat in terms of, erm, of their benefits, of what they might be able to claim or the sense of fear that things will be taken away from them and in some cases have been taken away from them quite recently, sometimes at quite a pronounced and very, very debilitating level" (Lewis)

Author Guidelines: Psychotherapy Research

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•There is no word limit for articles but authors should include a word count with their manuscript.

•Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

Please supply all details required by any funding and grant-awarding bodies as an acknowledgement in a separate Funding paragraph as follows:

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Section Three: Critical Appraisal

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CRITICAL APPRAISAL

This critical review will provide an overview of the thesis as a whole, placing an emphasis on context; my own context, the societal and professional context in which this research sits, and the contextual relationship between the research paper and literature review. Finally, the hopes I have for how this research could influence future policy and practice will also be presented

Rationale: Why I Chose this Topic

There are many factors that influenced my decision to conduct this research project. Firstly, it is important to consider my own socio-economic status and my relationship with this. Of the many different classifications systems used to describe class, I prefer Savage's (2015) class definition system as it offers more than one classification of middle-class. I identify myself as 'technical middle class' because although I feel more affiliation to a working class identity as a result of my family background, it is important for me to acknowledge that my income and my lifestyle afford me a level of privilege that a number of my family members do not share. I have directly seen and felt the effects of austerity upon these family members and as a result, I feel very passionate about the psychological implications of austerity and social inequality.

An additional reason for choosing this research topic came from my previous working history, firstly as a primary care mental health worker and subsequently as a cognitive behavioural therapist (CBT) working in National Health Service (NHS), primary care mental health services. I began this work in 2008 and at the start of my career I enjoyed the flexibility and person-centred focus of this work. Cancellation and 'Did Not Attend' policies existed but were used only where necessary, rather than as a method of exclusion from services. As such I was able to respect the external demands and issues which arose for Service Users (SUs).

Gradually however, the flexibility of my work altered. I was unable to offer in-vivo work and became increasingly frustrated when being informed that I could not continue to see people past a certain number of sessions. Despite contesting these seemingly arbitrary statistical cut-off points, referencing the National Institute for Clinical Excellence guidelines, my challenges proved futile and I was working in a way that was incongruent with my values. I became frustrated that I was not making the difference I wanted to make. I became exasperated by having to inform SUs that while they may not have felt that changes had been made, the key was for them to persevere with the interventions we had discussed. I say 'discussed' as my ability to plan specific behavioural experiments or engage in in-vivo work was severely curtailed by an increasing pressure to see a certain number of SUs each day. I was losing hope in the system and my ability to help SUs.

In response, I considered the clinical psychology career pathway. I saw this as an opportunity to gain influence. I knew that I was working in a flawed system and I wanted to be able to change that. However, my experiences throughout clinical psychology training and related placements reminded me of the difficulties encountered in my previous roles. As a result, I became aware of the socio-economic and wider scale influences and this awareness again seemed to diminish my hope that changing the system was possible.

My hope however, was restored following my attendance at a conference entitled 'Beyond the Therapy Room' in June 2015. This was when I truly started to consider how change could be influenced by the profession through the application of skills at a macro-level. Furthermore, this was where I also became aware of the 'Psychologists against Austerity' activist group. Subsequently, I became a member and supported the development of a North West branch of this group. This therefore influenced my thesis choice as I directly wanted to provide psychologically informed research in the arena of austerity.

Clearly, I have developed strong views regarding austerity and social inequality. I also believe that participants who volunteered to take part in this research held similar beliefs. Accordingly, there is a strong possibility that this research is biased by professionals sharing a similar view of austerity and a shared vision to disseminate the psychological consequences of such policies. Indeed, participants who took part may have been influenced by specific difficulties they had encountered within their work, and concomitantly, psychological therapists who had not encountered such challenges in their work may have been less inclined to be involved.

My views of austerity alongside my working history meant that during the interviews I felt very much aligned with the participants, which meant that I was therefore embracing 'insider status' (Gallais, 2008). 'Insider status' can be useful for gaining "in-depth empathetic access to and interpretation of data" (Gallais, 2008, p. 151). This alliance may have allowed participants to feel at ease during the interviews, and thus facilitated more honest disclosures (Usher & Jackson, 2014). However, Gallais (2008) acknowledged that 'insider status' increases the risk of researcher bias and it is important to acknowledge the degree of bias within this research. While the use of supervision and reflective logs allowed me to minimise the effects of this, Yardley (2008) suggests that bias is an inevitable aspect of qualitative research. Furthermore, Yardley (2008) argues that bias may actually have benefits to research, as it can be useful in exposing "hidden or oppressed meanings" within the data (p. 237).

While presenting these insights on the factors that may have influenced the research, it also seems relevant to acknowledge my context as a trainee in this process. Throughout training qualified psychologists are generally in a position of power as they routinely assess my work, via assignments or placements. Relatedly, I noticed that when interviewing psychologists specifically, I was conscious that my interview style may have been subject to

evaluation, which evoked feelings of anxiety. Consequently, I felt particularly uneasy when attempting to embrace a critical stance or seek further clarification on certain points. While supervision and reflection helped me to acknowledge this, I was aware that earlier interviews may have been less effective due to this anxiety and as a result may have influenced the quality of the data obtained.

Providing a Context to the Findings

The research paper aimed to establish whether austerity, namely the public funding cuts implemented by recent UK governments, had impacted on the work of psychological therapists. An additional aim was to consider if the changes in their work, associated with the cuts, had implications for psychological therapists' professional identities. A qualitative design was used to address these research objectives. Semi-structured interviews were conducted with 12 psychological therapists working in National Health Service (NHS) adult mental health settings. Thematic analysis of the data identified six inter-related themes: 1) "There's a general atmosphere of threat"; 2) "You're squeezed": Increasing pressure; 3) "It's just maths": Service users are becoming less of a priority; 4) "You're definitely more limited in what you're able to do"; 5) "It's just so upsetting": Added emotional strain; 6) A fight, flight or freeze response. Overall, these findings demonstrated that a shift in the work and the identities of professionals had occurred due to public funding cuts.

During the interviews and throughout the analysis of the data, it became apparent that hope appeared to mediate how professionals managed the challenges they encountered within their work. Consequently, it seemed that most participants were losing hope in their work and indeed the NHS, although there were differences in the ways this manifested itself. While Tamara described herself as a "hopeful person" it was evident that her perceived lack of control in her situation diminished her hope. Martin and Lewis talked about a future where, in spite of the possible difficulties facing the NHS, there was still a possibility of

helping SUs, either directly or indirectly and consequently hope was implicitly held. Interestingly both Martin and Lewis responded to their difficulties by embracing a 'fight' response, therefore it became apparent throughout my research that the presence of hope seemed important in determining how participants responded to the challenges. The ability to uphold hope and embrace a 'fight' response may be guided by individual differences and the presence of power, with certain factors such as gender and occupational position facilitating or inhibiting this response. I therefore wanted to explore this construct further, leading to the emergence of the literature review topic.

The literature review aimed to explore how mental health professionals conceptualised hope and what they perceived to be the factors which impact on this. A systemic literature search of four databases identified eight qualitative papers relevant to these objectives. Thematic synthesis of these papers led to the development of five themes. The overarching theme was that hope was viewed as 'The dynamic driving force of the therapeutic process'. While offering insights into how professionals understood hope, it also subsumed the four additional themes, which offered clarity regarding how hope was maintained: 1) Experiencing and observing progress; 2) A joint venture: The role of the therapeutic alliance; 3) Trusting the process; and 4) Managing contextual barriers. Consequently, it emerged that hope was a fundamental aspect of the therapeutic process that was subject to a number of influences.

The interaction between the findings from the research paper and literature review are reminiscent of Gilbert's (2009) compassion-focused model of affect regulation (Gilbert, 2009). According to this model emotion comprises three crucial states: i) threat ii) drive and iii) contentment. The threat system is regarded as the survival system, alerting individuals to threats and inducing feelings such as anxiety and anger. People are believed to respond to this state via fight, flight or freeze responses (Gilbert, 2009). Three key themes from the

research i.e. 1) “There's a general atmosphere of threat”; 5) “It’s just so upsetting”: Added emotional strain; and 6) A fight, flight or freeze response: The mediating role of hope, directly reflect this state. Hope was relevant to the ‘fight’ responses and thus the ‘threat’ state, yet it is also linked with the ‘drive’ state. The drive state is regarded as a ‘resource-seeking state’ and as such is viewed as the motivating system, eliciting feelings of excitement and pleasure. Within the literature review, hope was regarded as integral to the work of mental health professionals, and in line with the drive state, this could be understood due to its motivational properties.

While all the states are inter-related, Gilbert suggests that the link between the threat and drive systems is especially intricate. At a basic level, if people encounter threats they may continually strive to safeguard against them, therefore initiating the drive state. Gilbert (2009) asserts that functioning predominantly between threat and drive states is unlikely to bring about long-lasting hope, happiness and well-being. The practice of compassion is therefore regarded as a way for people to navigate towards a contentment state, establishing a balance between the three systems and concurrently enhancing psychological well-being (Gilbert, 2009). Furthermore, hope may also be maintained via the practice of compassion as Yang, Zhang and Kou, (2016) found these constructs to be positively related.

Findings from the research paper however, indicated that compassion, namely systemic compassion, was largely absent. This may be a product of the focus of the study and the interviews, being specifically upon austerity, and would therefore benefit from exploration in future research. Nevertheless, the present findings provide indications of this gap at a service level, where the individual needs of SUs were becoming less of a priority, as services became more geared towards statistics than person-centred outcomes.

Policy and Practice Implications

Functioning solely between drive and threat states in work could lead to staff burnout (Patsiopoulos & Buchanan, 2011). Burnout in turn can lead to psychological difficulties and promote 'depersonalisation' or 'compassion fatigue' (Joinson, 1992; Maslach & Jackson, 1984; Thompson, 2013). A succession of damning reports have previously highlighted widespread abuse and neglect within the healthcare systems; cases included Mid-Staffordshire hospital and Winterbourne View (Hehir, 2013). Following an investigation of Mid-Staffordshire hospital, The Francis Report (2013) concluded that prioritising targets over patient care was a contributory factor in the problems which developed and as such, promoted the need for compassion within services. The current research has highlighted that adult mental health services in the UK continue to prioritise targets over SU care, indicating the need for these issues to be addressed with urgency to safeguard professionals and service users.

This could be achieved by endorsing compassion at a systemic level throughout mental health services. While interventions such as Schwartz rounds have been initiated in an attempt to achieve this objective (Thompson, 2013), findings from this research indicate that due to increasing pressures, therapists may not have the capacity to engage with these programmes. Therefore, services need to consider a compassionate, flexible approach to allow professionals to attend related programmes which could positively impact on professionals' hope and psychological wellbeing and thus reduce the experience of burnout and its associated consequences.

The research paper highlights how many of the challenges currently experienced within the NHS and other public services stem largely from higher level societal and political influences. Dominant neo-liberalist ideology encourages us to maintain our position within the drive state, working hard to increase profits, which ultimately maintains the status quo

and societal inequalities. These ideological norms are regularly reinforced by mainstream media, which has a significant role in promoting the pursuit of materialistic goals, further pushing people into a drive state (Gilbert, 2009). Compassion is largely neglected within this ideology. This is evidenced as those who are unable to meet these social expectations, for example those who cannot work or who are in receipt of benefits to supplement the income from their low paid jobs are viewed less favourably as their role in creating profits for society is deemed negligible. These individuals are very often excluded from society and are further subject to criticism via media misrepresentation (Baumberg et al., 2012; Pemberton, Fahmy, Sutton & Bell, 2016). Many people in these positions are led to internalise these criticisms, reinforcing feelings of psychological distress (Pemberton et al, 2016). At the same time, the gap between the rich and the poor increases and compassion diminishes (Grewal, 2012; Wilkinson & Pickett, 2010).

This lack of compassion throughout society has detrimental implications for both individuals and the systems operating to support such individuals. Smail (2005) encouraged conceptualisations of psychological wellbeing to encompass the role of 'distal power', i.e. the wider influences on psychological wellbeing such as economic, politics, culture and ideology. Smail pointed out that "being human entails suffering" (p. 93). However, he also asserted that while some may benefit from individual psychotherapy, more needs to be done to tackle the substantial issues originating from the distal powers. Similarly, Harper (2016) reported that despite the growing number of available psychotherapies, therapy predominantly seems to be 'reactive' as opposed to 'preventative'. He encouraged psychologists to work within the 'preventative' stages, calling for services to raise awareness of psychological wellbeing and intervene early.

The argument for psychologists to use their skills at the macro-level is a well-supported argument (e.g. Thomas, 2016; Weatherhead, 2016; White, 2008). Engaging with

these distal powers may require additional skills, which may well suggest adjustments are needed for clinical psychology training and post-qualification Continuing Professional Development. The British Psychological Society accreditation processes could play a pivotal role in assuring that training courses effectively prepare future psychologists to engage within these relevant and necessary domains.

In 1989 Mowbray's Management Advisory Service report (cited in Richardson, 2015), explored the added value of clinical psychology within health care services. This report indicated that the uniqueness of clinical psychology hinges on the profession's capacity to integrate diverse models and theories, as well as drawing on additional skills such as teaching and consultation (Kat, 2015). While it did not emerge as a theme from this research, data obtained from the interviews, with CBT therapists specifically, indicated that many were trained in more than one modality of therapy and were routinely incorporating an integrated approach to their work. The increased 'competition' from other therapeutic professions highlights the importance of truly embracing the consultation and teaching elements of clinical psychology. Doing so increases the potential to make long-lasting and effective changes to our society, drawing on these skills to target changes to the 'distal powers' (Smail, 2005).

Findings from the research paper also demonstrated the limitations of psychotherapy during a time of austerity. The limitations for those encountering financial hardship were specifically found to impede accessibility and maintenance of therapy. This led me to consider the 'middle-class' nature of therapeutic work and research (Appio, Chambers & Mao, 2012; Kim & Cardemil, 2012; Levy & O'Hara, 2010). It seems therefore, that people who are vulnerable to psychological distress may be excluded from accessing necessary support. Indeed, punitive systems which appear to be designed to exclude them from services at any opportunity are likely to reduce the likelihood of such individuals seeking help in the

future. These reflections have led me to question whether, rather than being a helpful process, individual therapy could be regarded as a tool of the powerful elite. Indeed, Ferraro (2016) indicated how psychotherapy can be used to "produce subjects who conform to the alienated individualism of austerity capitalism: each person her own entrepreneur, manager, disciplinarian, panopticon" (p.19), suggesting therefore that covert agendas of psychotherapy are complicit with neo-liberalist ideology.

Overall these reflections on the limitations of individual therapy suggest a need to improve and innovate services. Therefore, community psychology practices should be considered within this objective. Community psychology seeks to encourage psychological wellbeing at the macro-level, integrating and addressing a number of related areas such as environmental and political issues (Orford, 2008). Given findings that austerity and its consequences induces a sense of threat and disconnection, community psychology informed interventions could work to directly tackle this as part of service provision. As such it seems relevant to acknowledge, and embrace, the developing role clinical-community psychology. While there may be challenges in achieving this development, clinical psychologists could apply their skills to educate, inform and influence commissioners of the benefits of such interventions in order to gain support. Therefore, highlighting the additional need for clinical psychologists to embrace the role of 'activist psychology' (Zlotowitz, 2015). My own hope regarding the future centres on my ability, and that of the profession, to succeed in developing these aspects of clinical psychology.

Additional Contextual Insights

In June 2016 I was lucky enough to undertake an innovative placement in Malawi, which is considered to be one of the world's poorest countries (World Bank, 2016). Indeed my visit confirmed for me that many civilians faced significant levels of poverty. However, what struck me most was the sense of community, which was overwhelmingly demonstrated.

From my experience it appeared that individuals, regardless of their economic status, largely cared for one another and supported each other wherever possible. Despite the obvious challenges people encountered, there was a deep sense of connection and compassion between people. Adjusting to life back in the UK after this visit was an extremely challenging experience and one that confirmed to me just how much a sense of community and compassion can have upon one's psychological wellbeing. Therefore, working to restore this sense of community, connection and compassion within the UK is something I feel very passionate about.

Completing a literature review on hope in 2016 appeared somewhat ironic given the political climate. Writing a thesis itself entails an intricate relationship with hope, yet writing a thesis in the wake of the massive political shifts following the referendum on whether the UK should leave the European Union (EU), and the 2016 United States presidential election contributed to additional difficulties with my own level of hope. Additionally, media coverage of hate crime, 'NHS failings', war, refugees, increasing rates of poverty and homelessness undoubtedly impacted on my own sense of hope in humanity. Furthermore, interviewing participants shortly after the 'Brexit' referendum could have been a particular challenge, which may have impacted on participants' responses in the interviews. The findings of the literature review supported previous assertions regarding the reciprocal nature of hope (Farran, Herth, & Popovich, 1995; Hannah, 2002). Therefore, my own levels of hope may have influenced participants and vice-versa, which may have impacted on the content of the discussions within the interviews.

In July 2016, the 'Brexit' result of the EU referendum provoked numerous changes to the Conservative government and the newly appointed chancellor declared that he would aim to scale back Britain's austerity policies (Parker, Allen & Brown, 2016). Despite subsequent reports disputing this (Ahmed, 2016), this prompted me to reflect on how the findings of this

research would be construed if austerity was abandoned, given that the specific aim of this research was to explore the impact of austerity on the practice and context of therapists working in the NHS. Specifically, I wondered if this research would be discounted if austerity was no longer perceived as a relevant issue.

Research into austerity has led me consider the association between political ideology and mental health practice. I reached the conclusion that the current austerity regime is part of a wider neo-liberal ideological agenda aimed at the privatisation of public services. Therefore, whilst this research has focused specifically on the impacts of 'austerity', its findings are reflective of the experience of working within NHS mental health services in this longer-term historical context. As a result, in my opinion, while neo-liberal ideology dominates, the NHS will continue to face threats and psychological therapists will continue to experience the difficulties reported in this research. Consequently, I believe that clinical psychologists should continue to embrace the 'activist practitioner' stance (Zlotowitz, 2015) and ensure that this message is shared, via accessible methods, to individuals within our society.

Conclusion

In summary, this critical appraisal endeavoured to provide additional context underpinning the thesis. While reflecting on this process I also outlined my hopes for the future. It seems that in order to manage the current challenges facing NHS mental health services, two new areas of clinical psychology are emerging in practice, namely activist psychology and clinical-community psychology. It is therefore imperative that as a profession we engage with these roles to continue to innovate service provision, which effectively supports people in our society.

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Section Four: Ethics Section

Ethics Application for Research Paper

Providing therapy in a time of austerity: The impact of public funding cuts on the role of psychological therapists.

Hayley Higson
Trainee Clinical Psychologist
Lancaster University

Correspondence to be addressed to:

Mrs Hayley Higson
Doctorate in Clinical Psychology
Division of Health Research
Lancaster University
Lancaster
LA1 4YG

Approval Letter: Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Applicant: Hayley Higson
Supervisors: Suzanne Hodge and Steve Weatherhead
Department: Health Research
FHMREC Reference: FHMREC15078

31 May 2016

Dear Hayley

Re: Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.
Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Diane Hopkins (01542 592838 fhmresearchsupport@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,

Dr Diane Hopkins
Research Development Officer

CC Ethics@Lancaster; Professor Roger Pickup (Chair, FHMREC)

FHMREC Application Form

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research involving direct contact with human participants

Instructions

1. Apply to the committee by submitting:
    a. A **hard copy** of the University's **Stage 1 Self Assessment (part A only)** and **Project Questionnaire**. These are available on the Research Support Office website: LU Ethics
    b. The completed application **FHMREC form**
    c. Your full research proposal (background, literature review, methodology/methods, ethical considerations)
    d. All accompanying research materials such as, but not limited to,
        1) Advertising materials (posters, e-mails)
        2) Letters/emails of invitation to participate
        3) Participant information sheets
        4) Consent forms
        5) Questionnaires, surveys, demographic sheets
        6) Interview schedules, interview question guides, focus group scripts
        7) Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing handbooks or measures which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submit the FHMREC form and all materials listed under (d) by email as a **SINGLE attachment in PDF format** by the deadline date. **Before converting to PDF ensure all comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.***

3. Submit one collated and signed paper copy of the full application materials in time for the FHMREC meeting. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.

4. Committee meeting dates and application submission dates are listed on the FHMREC website. Applications must be submitted by the deadline date, to:

    Dr Diane Hopkins
    B14, Furness College
    Lancaster University,
    LA1 4YG
    d.hopkins@lancaster.ac.uk

5. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application.

6. Attend the committee meeting on the day that the application is considered, if required to do so.

1. **Title of Project**: Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

ETHICS APPLICATION

2. **Name of applicant/researcher**: Hayley Higson

3. **Type of study**

☒ Includes *direct* involvement by human subjects.

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. Please complete the University Stage 1 Self Assessment part B. This is available on the Research Support Office website: LU Ethics. Submit this, along with all project documentation, to Diane Hopkins.

4. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught PG projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters dissertation ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

Applicant Information

5**. Appointment/position held by applicant and Division within FHM** Trainee Clinical Psychologist

6**. Contact information for applicant**:

E-mail: h.higson@lancaster.ac.uk **Telephone**: [redacted] (please give a number on which you can be contacted at short notice)

Address: Faculty of Health and Medicine, Clinical Psychology-Division of Health & Research, Furness College, Lancaster University, LA1 4YG

7. **Project supervisor(s), if different from applicant**: 1) Dr Suzanne Hodge and 2) Dr Stephen Weatherhead

8. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**: 1) Lecturer in Health Research 2) Clinical Psychologist and Clinical Tutor

9. **Names and appointments of all members of the research team (including degree where applicable)**

Hayley Higson – Trainee Clinical Psychologist; Dr Suzanne Hodge – Academic Supervisor; Dr Stephen Weatherhead – Academic Supervisor.

The Project

NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. **Summary of research protocol in lay terms (indicative maximum length 150 words**):

In 2010 the UK government implemented austerity measures in an attempt to manage the financial deficit. Since then social inequality amongst the UK population has grown and more people are seeking support for related mental health difficulties. Simultaneously cuts to welfare expenditure and ultimately NHS recourses mean that staff are working harder to support people accessing mental health services. However with so many wider influences outside of the therapy room, this research aims to explore how therapists and psychologists negotiate the potential barriers to therapeutic outcomes and what implications this has, if any, upon their existing role and professional identity.

11. **Anticipated project dates (month and year only**)

Start date: June 2016 End date December 2016

12. **Please describe the sample of participants to be studied (including maximum & minimum number, age, gender**): Participants will be NHS staff, working in therapeutic roles within adult mental health settings. This project will aim to recruit between 10 and 15 participants. If more than 15 participants express an interest in taking part, participants will be recruited on a 'first come, first serve basis'.

Participants will be included if they are:

1) A HCPC registered psychologist OR a fully accredited therapist (accredited via the appropriate body for the therapy which they deliver) by one of the following professional bodies:

• Association of Cognitive Analytic Therapy (ACAT),

• British Association for Behavioural and Cognitive Psychotherapies (BABCP),

• British Association for Counselling and Psychotherapy (BACP),

• United Kingdom Council for Psychotherapy (UKCP)

2) Currently working with adults, aged 16 years or older, in NHS mental health services. This criterion is purposefully broad to include therapists and psychologists working in all areas of adult mental health, including inpatient and outpatient services. Furthermore, 16 year olds are include as they can access primary care mental health services directly.

3) Currently working in the delivery of 1:1 psychological therapy to service users. This criterion has been formed to avoid recruiting people who exclusively facilitate computerised CBT (where their role in the delivery of the specific intervention is often limited). Furthermore, it will avoid recruiting

professionals who solely offer therapy via the telephone or internet. This is because working exclusively over the telephone/internet may already have implications on therapists' identities and working over the telephone has been known to entail specific features with regards to building therapeutic rapport (e.g. Webb, 2014).

Participants will not be included in the study if they:

1) Are not currently working in the UK. This is because the focus of the research is specifically UK policy context.

2) Do not speak English. This was decided as the likelihood of therapists working in the NHS who cannot speak English is deemed to be low and if so, these workers may encounter a host of diverse and specific needs which may supersede the discussions in the interviews.

13. **How will participants be recruited and from where? Be as specific as possible**.

Details of the research will be disseminated via a recruitment flyer (Appendix A) through social media sites (i.e. Twitter and Facebook). Permission will also be requested for the information to be sent out via professional mailing lists (e.g. British Psychological Society (plus their Special Interests Groups), ACAT, BABCP, BACP, UKCP, and the North West Psychological Professions Network. Potential participants will be requested to express their interest by making contact with the chief investigator, either via telephone or email.

14. **What procedure is proposed for obtaining consent**?

Participants will complete consent forms at the start of each interview if the interviews are being conducted face-to-face. If however, interviews take place via the telephone or Skype, participants will be sent a consent form prior to the interview. The consent form will also be read aloud and each participant will be asked if they consent to each item. This information will be audio recorded and transcribed and stored as electronic data.

15. **What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.**

Participants may experience distress by participating in this research as the conversations may touch on emotive areas such as work-related stress, therapeutic helplessness or challenges to professional identity. If this occurs participants will be invited to take a break and where necessary interviews will be terminated. Details of support networks available to participants (supervisors/ line manager/GP) are included on participant information sheet along with the number for The Samaritans helpline. This will be revisited if participants become distressed during interviews.

Participants will be informed that they have the right to withdraw from the study. However they will also be notified that once their data has been anonymised and pooled with other participants' data, it will not be possible to extract their specific data. They are therefore encouraged to inform the chief investigator as soon as possible if they decide to withdraw after the interview has taken place. It will be indicated that this should be no later than two weeks post interview.

16. **What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the**

sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

There could be some potential risks of lone working if conducting face-to-face interviews at participants' homes. As a precaution for this, the Lancaster University Lone Working policy will be followed. A 'buddy' (a specified colleague) will be identified before each face-to-face interview takes place. The chief investigator will provide their buddy with the participant details and interview arrangements (i.e. the chief investigator's whereabouts and the time of scheduled interviews) in a sealed envelope. If the buddy has not heard from the chief investigator by an agreed time, the buddy will open the envelope to obtain the necessary details. Steps will then be taken to make contact with the chief investigator. If no contact is made then the allocated buddy will inform the team manager and then the police. If contact is made, the buddy will destroy the participant information in a confidential manner (i.e. via confidential waste disposal).

Recruitment via Facebook will not be done from the participants own personal account due to the links this has to personal information. Instead, colleagues and relevant professional groups will be asked to share the recruitment flyer on behalf of the chief investigator. Additionally, if recruitment is successful via social media, any further correspondence between the chief investigator and potential participants will be executed via email/telephone and not social media.

17. **Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study**.

It is hoped that the results will help to develop a better understanding of an area that is currently lacking in research. The results may also be used to develop policy and services to support professionals working with the changing needs of clients

18. **Details of any incentives/payments (including out-of-pocket expenses) made to participants**:

Participants will be reimbursed for travel expenses for up to £20. In order to claim these expenses they will need to provide receipts from public transport or to complete a mileage form.

19. **Briefly describe your data collection and analysis methods, and the rationale for their use. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality**.

Qualitative data will be collected via semi-structured interviews whish are anticipated to last between 60-90 minutes. Interviews may take place via skype, telephone or can be conducted face-to-face, depending on the participants' preference and location. All interviews will be audio-recorded, transcribed verbatim by the chief investigator and analysed using thematic analysis. The six step method developed by Braun and Clark (2006) will be followed:

1) Familiarising yourself with the data

2) Generating initial codes

3) Searching for themes

4) Reviewing potential themes

5) Defining and naming themes

6) Producing the report

As the research aims to gain an understanding of that the experiences are for individuals delivering therapy at times of austerity, the thematic approach will be influenced from a phenomenological perspective (Willig, 2012).

Each participant will be asked to provide a preferred pseudonym and this will be applied to their transcripts and quotes used in the main report to provide anonymity.

The limits of confidentiality will be explained to each participant at the beginning of each interview and this will be an area also included on the consent form. If any disclosures made by a participant indicate safeguarding issues or malpractice in any way then confidentiality will be revisited and the interview will be terminated. This would then be reported to the supervisors and the relevant safeguarding practices will be followed.

20. **If relevant, describe the involvement of your target participant group in the *design and conduct* of your research**.

The recruitment flyer has been reviewed by a CBT therapist, a Psychological Wellbeing Practitioner (PWP), an Occupational therapist, a psychologist and two trainee clinical psychologists. This was done as a way of establishing if the eligibility of differing professions was clear from the information provided. The participant information sheet has been reviewed by a CBT therapist and a PWP.

21. **What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998**.

Electronic participant identifiable information will be stored under the chief investigators personal account on the secure university server. All forms of participant identifiable information will be stored securely until the project has been examined, following this the chief investigator will delete this information.

Hard copies of the consent forms and demographic information sheets will kept securely by the chief investigator in a lockable cabinet in a secure office for the duration on the project. Upon successful completion of the project, this information will be scanned into the computer system, encrypted and stored as electronic data. All hard copies will then be destroyed by the chief investigator.

All electronic data will be stored on the chief investigator's personal account on the secure university server until the project has been examined. Once completed and successfully examined, and in line with the university procedure for long term data storage, the encrypted transcriptions will then be sent securely using university supported file transfer software, to the Research Coordinator who will save the files in password-protected file space on the university server. Encryption details and the date the data should be deleted will be sent securely to the Research Coordinator separately. This data will be held for ten years following examination and then deleted by the Research Coordinator.

22. Will audio or video recording take place? ☐ no ☒ audio ☐ video

If yes, what arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

The interview recordings will be uploaded as electronic data and will be encrypted and saved to the chief investigator's personal account on the secure university server. This will be done as soon as

possible after each interview as it is not possible to encrypt recordings on the Dictaphone. Once this has been done the recordings will be deleted from the Dictaphone by the chief investigator. The transcriptions of these interviews will also be encrypted and saved on the chief investigator's personal account on the secure university server.

23. **What are the plans for dissemination of findings from the research? If you are a student, include here your thesis**.

Only the members of the research team will have access to raw data (this is outlined in the participant information sheet). The research will be written into a report and will be submitted as part of the Doctorate in Clinical Psychology Thesis.

It is hoped that summary the project will be submitted to a peer reviewed journal for publication and presented at relevant training, teaching events and conferences.

Participants will also be offered a summary of the findings of the research.

24. **What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC**?

The chief investigator is co-chair of the North West Group – Psychologists Against Austerity. It will be extremely important for the chief investigator to remain aware of their own reflexivity throughout this project. This will be facilitated through the use of a reflective diary and supervision.

Signatures: Applicant: .....

Date: .....

*Project Supervisor (if applicable): .....

Date: .....

*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

Research Protocol

Project Title: Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

Trainee/ Chief Investigator: Hayley Higson

Research/Academic Supervisor:

Dr Suzanne Hodge

Phone: 01524 592712

Email: s.hodge@lancaster.ac.uk

External Supervisors:

Dr Stephen Weatherhead

Phone: 01524 592974

Email: s.weatherhead@lancaster.ac.uk

Introduction

Since 2010, the UK government has implemented a programme of 'austerity' policies as a means of managing the financial deficit. These austerity measures have included cuts to welfare expenditure and tax increases, which have led to the emergence of a myriad of social and financial difficulties, particularly amongst the most vulnerable people in society (Hemmingway, Coxon, Munday & Ramsay, 2013). It has been argued that this has led to increases in poverty and social inequality (Oxfam Case Study, 2013). As a result of these austerity measures, together with the associated problems of social inequality, it has been shown that more people have encountered psychological distress (e.g. Hemmingway, Coxon,

Munday & Ramsay, 2013; Knapp, 2012; Spence, Roberts, Ariti & Bardsley, 2014). Reportedly, more people are seeking support for mental health difficulties as a result, creating a higher demand upon mental health services (Dormon, 2015; Insight Research Group, 2012 cited in PAA Briefing paper, 2015).

If people are not having their basic physiological needs met as a result of the socio-economic conditions in which they are living, this may take priority in a therapeutic setting, particularly considering this with Maslow's Hierarchy of Needs (McLeod, 2007). In addition to basic physical needs, people experiencing poverty are suggested to encounter a number of related psychological needs that may arise in the therapeutic setting. For example, Pemberton, Fahmy, Sutton & Bell (2015) found that the negative social attitudes towards people experiencing poverty, were often internalised shaping their understanding of their situation and ultimately resulting in an altered self-perception. Additionally, Pemberton et al (2015) reported on the negative portrayal of people living in poverty, often promoted by the UK government and media, which could further impact on an individual's psychological well-being. Such negative perceptions may, in turn, give rise to feelings of 'shame' and 'humiliation' which have been linked to the occurrence of depression (Kim, Thibodeau & Jorgensen, 2011; Brown, 1996 in PAA Briefing Paper, 2015).

Many of these issues could be viewed as wider scale factors that cannot be resolved in a therapeutic setting. This could create frustration for both clients and therapists which could be retained within the therapy room, with the possibility of rupturing the therapeutic relationship. Furthermore, the acknowledgement of the extensive socio-economic issues may give rise to a lack of hope in the usefulness of therapy and the specific interventions. This lack of hope may be shared amongst clients and therapists alike and given its role in facilitating change, a lack of hope may be detrimental for the client and therapeutic outcomes regardless of the clients' contexts (Coppock, Owen, Zagarskas & Schmidt, 2010; Hanna,

2002). Interestingly, high levels of hopelessness experienced by therapists in these contexts could also be harmful for their own psychological wellbeing as research has found links between hopelessness and low mood (e.g. Miranda, Fontes & Morroquin, 2008; Smith, Alloy & Abramson, 2006). Interestingly, in a recent survey exploring staff wellbeing, the BPS and New Savoy (2016) demonstrated that of the psychological professionals who completed the survey, 70% reported feeling stressed and 49.5% expressed feeling that they are a failure. These finding could therefore be linked to the role of hope within the therapeutic setting and this proposed research aims to explore this further.

The wider scale difficulties presented by clients could also impact on the professional roles of therapists and psychologists which may lead to a shift in their professional identity. Professional identity can be understood through the lens of Social Identity Theory (Adams, Hean, Sturgis & Macleod Clark, 2006). This theory explains that individuals' identity is formed and upheld by the social groups within which people identify themselves as members. In terms of professional identity, this is formed specifically within working environments; people form skills and knowledge and compare this to alternative professions (Adams et al., 2006). As with Social Identity Theory, if group identity is perceived as stable and meaningful then members of the group experience positive benefits to their psychological wellbeing, including a positive sense of self-worth and self-esteem (Haslam, Jetten, Postmes & Haslam, 2009). However, if changes to group or professional identity are experienced, then this can have negative implications for individuals' psychological wellbeing (Haslam, et al., 2009).

Hannigan and Allen (2011) argue that austerity measures have directly led to alterations in the mental health nursing role in response to the changing needs of services users as a result of the difficulties facing them. The proposed research aims to establish if this change in role and professional identity also exists amongst professionals delivering 1:1

psychological therapy. This is directly related to the role of clinical psychologists, as professionals conducting direct therapeutic work and formulating people's difficulties, considering the wider systemic and socio-political context. However, it is also of relevance when considering the indirect roles of clinical psychology, promoting psychological wellbeing through consultancy and leadership roles.

The implementation of austerity-related policies is likely to have impacted directly on the function of mental health services within the NHS, intensifying the existing pressures within services (Roberts, Marshall & Charlesworth, 2012). Since market forces have been introduced to the NHS via commissioner-provider service splits, efficiency in NHS working has been prioritised with services receiving financial rewards for achieving set targets, such as reducing service user waiting times (Department of Health, 2012). This target driven ethos, coupled with funding cuts and the increasing demand for mental health services, has led to many professionals encountering growing pressures to increase caseloads in order to achieve targets (Clatworthy, 2014). The current research aims to establish what effects, if any, these competing demands have, upon the therapeutic work of front line psychological therapists. In Cognitive Behavioural Therapy for example, methods such as in vivo work and Socratic questioning are viewed as significant tools in facilitating cognitive shift, however this often takes time and thus may be less likely to be employed in the current NHS environment.

Perhaps more significant than the implications for the use of specific models however, is the potential impact on underlying therapeutic processes of working in conditions where there are intense pressures on resources. In particular, the establishment of a sound therapeutic alliance between therapist and client has been shown to be critical to good therapeutic outcomes (Lambert and Barley, 2001). Lambert and Barley (2001) suggest that the therapeutic alliance consists of three elements: tasks, goals and bonds. It could be argued

that the current resource pressures in the NHS may have implications which could have the potential to undermine these elements and thus jeopardise the therapeutic alliance. For example, if a therapist is required to work to the goals of discharging a service user after a certain number of sessions, this may conflict with the service user's goals, which could lead to ruptures in therapeutic alliance and thus therapeutic outcomes. The initiative set up by the government in 2014, to impose therapy on those in receipt of Employment Support Allowance (Ross, 2014) presents an even more fundamental challenge to the therapeutic alliance by creating the potential for complete divergence between the goals of service users and therapists or psychologists. The current research aims to explore how therapists working in the NHS manage to balance the, often diverse, needs of clients with externally imposed service demands. Furthermore, navigating this balance may further impact on professionals own emotional wellbeing, with pressures and increasing caseloads potentially leading to compassion fatigue or burnout (e.g. Maslach and Florian 1988). Paradoxically, these issues could further impact on the therapeutic alliance, therefore highlighting a further issue to consider within this proposed research.

Rationale

As indicated above, there is a lack of empirical research exploring policies introduced under the current UK government's austerity programme. More specifically, there does not seem to be any research available which explores the impact of these policies on the work conducted by therapists and psychologists who work with those accessing mental health services. The overall aim of the current research is therefore to begin to address this gap by exploring the impact of policies implemented under the UK government's austerity programme on the work of psychological therapists. This will be achieved by interviewing NHS front line staff who deliver psychological therapies to adults in mental health services to explore their experiences further.

Research Questions:

1) How, if at all, have policies implemented under the UK government's austerity programme impacted on the work of psychological therapists?
2) Have therapists' roles and professional identities changed as a result of these austerity policies?

Method

Design

A qualitative approach will be used to explore how policy measures and cutbacks in services, introduced in the UK from 2010 under the current government's austerity agenda, have influenced therapeutic work conducted within NHS adult mental health services. Participants will be recruited via social media and relevant professional mailing lists (further details of these lists are provided within the 'recruitment and procedure' section). The research aims to gain an understanding of how people make sense of their subjective experiences of working therapeutically with clients under conditions of austerity. Therefore, the data will be analysed from a phenomenological epistemological perspective (Willig, 2012), using thematic analysis.

Participants

Participants will be NHS staff, working in therapeutic roles within adult mental health settings. This project will aim to recruit between 10 and 15 participants. If more than 15 participants express an interest in taking part, participants will be recruited on a 'first come, first serve basis'.

Participants will be included if they are:

1) A HCPC registered psychologist OR a fully accredited therapist (accredited via the appropriate body for the therapy which they deliver) by one of the following professional bodies:

    - Association of Cognitive Analytic Therapy (ACAT),
    - British Association for Behavioural and Cognitive Psychotherapies (BABCP),
    - British Association for Counselling and Psychotherapy (BACP),
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2) Currently working with adults, aged 16 years or older, in NHS mental health services. This criterion is purposefully broad to include therapists and psychologists working in all areas of adult mental health, including inpatient and outpatient services. Furthermore, 16 year olds are include as they can access primary care mental health services directly.

3) Currently working in the delivery of 1:1 psychological therapy to service users. This criterion has been formed to avoid recruiting people who exclusively facilitate computerised CBT (where their role in the delivery of the specific intervention is often limited). Furthermore, it will avoid recruiting professionals who solely offer therapy via the telephone or internet. This is because working exclusively over the telephone/internet may already have implications on therapists' identities and working over the telephone has been known to entail specific features with regards to building therapeutic rapport (e.g. Webb, 2014).

Participants will not be included in the study if they:

1) Are not currently working in the UK. This is because the focus of the research is specifically UK policy context.

2) Do not speak English. This was decided as the likelihood of therapists working in the NHS who cannot speak English is deemed to be low and if so, these workers may encounter a host of diverse and specific needs which may supersede the discussions in the interviews.

Recruitment and Procedure

Details of the research will be disseminated via a recruitment flyer (Appendix A) through social media sites (i.e. Twitter and Facebook). Permission will also be requested for the information to be sent out via professional mailing lists (e.g. British Psychological Society (plus their Special Interests Groups), ACAT, BABCP, BACP, UKCP, and the North West Psychological Professions Network. Potential participants will be requested to express their interest by making contact with the chief investigator, either via telephone or email (i.e. their preferred method of contact).

At this initial contact the chief investigator will seek to answer any questions the participant may have, and will ensure that participants meet the inclusion/exclusion criteria. Participants will be sent an information sheet (Appendix B), either by post or email. If the criteria are met and the participant wishes to proceed, a suitable time will be arranged to conduct a semi-structured interview. A choice of methods to conduct the interviews will be offered (face-to-face, Skype or via telephone). If participants opt to complete the interviews during their working hours and/or at their place of work, they will be asked to seek permission from their line managers and to identify what processes need to be followed and where necessary, the chief investigator will fulfil the relevant R&D procedures. However if permission is not granted, the interviews will take place outside of working hours and off NHS sites. Face to face interviews may be arranged to take place at Lancaster University or at participants' homes. Travel expenses can be reimbursed to a maximum of twenty pounds.

Where face-to-face interviews take place, the Lancaster University lone working policy will be followed. A 'buddy' (a specified colleague) will be identified before each face-to-face interview takes place. The chief investigator will provide their buddy with the participant details and interview arrangements (i.e. the chief investigator's whereabouts and the time of scheduled interviews) in a sealed envelope. If the buddy has not heard from the chief investigator by an agreed time, the buddy will open the envelope to obtain the necessary details. Steps will then be taken to make contact with the chief investigator. If no contact is made then the allocated buddy will inform the team manager and then the police. If contact is made, the buddy will destroy the participant information in a confidential manner (i.e. via confidential waste disposal).

Data Collection

Semi-structured interviews between the chief investigator and the participant will be carried out to obtain the data. These interviews will last between 60-90 minutes. Before the interviews take place, informed consent will be obtained through the use of a consent form (Appendix C). If interviews are scheduled to take place over Skype or telephone, this form will be sent to participants prior to the interview, either via email or post. The consent form will include details of the study as well as the limits of confidentiality and their right to withdraw from the research. This consent form will highlight that once the data has been anonymised and pooled with other participants' data, it will not be possible to extract the participant's data so they are encouraged to inform the chief investigator as soon as possible if they decide to withdraw after the interview has taken place (no later than two weeks post interview).

A topic guide will be employed as the interviews will be semi-structured (Appendix D). Demographic information will also be collected from each participant before each

interview (Appendix E). When conducting interviews over the telephone or via Skype, the calls will be taken in a private office. All the interviews will be audio-recorded by use of a Dictaphone. The recordings will subsequently be transcribed verbatim and analysed by the chief investigator. Recordings and transcriptions will also be shared with both academic and field supervisors so that they can monitor the research.

Data Storage

The interview recordings will be encrypted and saved to the chief investigator's personal account on the secure university server. This will be done as soon as possible after each interview. Once this has been done the recordings will be deleted from the Dictaphone by the chief investigator. The transcriptions of these interviews will also be encrypted and saved on the chief investigator's personal account on the secure university server. Paper copies of participant identifiable information will be kept in a lockable cabinet in a secure office. Electronic participant identifiable information will be stored under the chief investigators personal account on the secure university server. All forms of participant identifiable information will be stored securely until the project has been examined, following this the chief investigator will delete this information.

Hard copies of the consent forms and demographic information sheets will kept securely by the chief investigator in a lockable cabinet in a secure office for the duration on the project. Upon successful completion of the project, this information will be scanned into the computer system, encrypted and stored as electronic data. All hard copies will then be destroyed by the chief investigator.

All electronic data will be stored on the chief investigator's personal account on the secure university server until the project has been examined. Once completed and successfully examined, and in line with the university procedure for long term data storage,

the encrypted transcriptions will then be sent securely using university supported file transfer software, to the Research Coordinator who will save the files in password-protected file space on the university server. Encryption details and the date the data should be deleted are securely sent to the Research Coordinator separately. This data will be held for ten years following examination and then deleted by the Research Coordinator.

Analysis

The data will be analysed using Thematic Analysis. The six step method developed by Braun and Clark (2006) will be followed:

1) Familiarising yourself with the data
2) Generating initial codes
3) Searching for themes
4) Reviewing potential themes
5) Defining and naming themes
6) Producing the report

As the research aims to gain an understanding of how experiences are made sense of by individual research participants, the thematic approach will be conducted from a phenomenological perspective (Willig, 2012).

Ethics

As previously mentioned, participants will be required to provide informed consent to participate in the research. During face-to-face interviews a consent form will be completed by the participant directly. Where interviews take place via telephone or Skype participants will be sent a consent form ahead of the scheduled interview date either by email or post. This consent form will then be completed during the interview by the chief investigator reading out each item and asking if the participant agrees. This conversation will be recorded

as a separate file from the interview recording. These audio consent files will be retained for long-term storage. Participants will be made aware that their participation is voluntary and details of their rights to withdraw will be detailed on the consent form. Additionally, as it is not possible to guarantee complete security of Skype calls, this information will be shared with participants via the information sheet and will be revisited at the start of each interview conducted via Skype, by specifically addressing the item in the consent forms.

The limits of confidentiality will be explained to each participant at the beginning of each interview and this will be an area also included on the consent form. If any disclosures made by a participant indicate safeguarding issues or malpractice in any way then confidentiality will be revisited and the interview will be terminated. This would then be reported to the supervisors and the chief investigator would then follow relevant safeguarding procedures. In instances where significant and immediate risks are identified, this will be passed on to the police by the chief investigator.

Data obtained will be anonymised throughout the write up of the research through the use of pseudonyms. Participants may experience distress by participating in this research as the conversations may touch on emotive areas such as work-related stress, therapeutic helplessness or challenges to professional identity. If this occurs participants will be invited to take a break and where necessary interviews will be terminated. Details of support networks available to participants will be included on participant information sheets and this will be revisited if participants become distressed during interviews.

Recruitment via Facebook will not be done from the chief investigator's personal account due to the links this has to personal information. Instead, colleagues and relevant professional groups will be asked to share the recruitment flyer on behalf of the chief investigator. However, as twitter is used as a professional account, the chief investigator will

promote the research directly on this platform. Furthermore, it will be clarified that contact between participants and the chief investigator should be undertaken via email and telephone as opposed to social media sites.

Timescales

It is hoped that ethical approval for the study will be granted by June 2016. Data collection will begin in July 2016. It is hoped that recruitment and transcription and analysis of the results will be completed by October 2016. The research paper is due to be submitted in December 2016 and the completed research paper will be submitted for publication in March 2016. The journals identified for publication at this stage include: The British Journal of Clinical Psychology or The Journal of Consulting and Clinical Psychology.

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Appendix 4-A: Recruitment Flyer

Health & Medicine | Lancaster University

Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

Are you a HCPC registered Psychologist or an accredited psychological therapist?

Do you deliver psychological therapy to adults within a NHS mental health setting?

I am a trainee clinical psychologist. As part of my doctoral research I aim to explore whether policies introduced under the UK government's deficit reduction programme have impacted on the therapeutic work conducted by psychologists and psychological therapists.

If you answered yes to the above and think you would like to participate, or if would like further details please contact Hayley Higson on: **07508375624 or h.higson@lancaster.ac.uk**

Appendix 4-B: Participant Information Sheet

Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

My name is Hayley Higson and I am a third year trainee clinical psychologist studying at Lancaster University. As part of the course trainees are required to complete a research project. This sheet will provide you with some details about the project that I will be conducting. It is very important that you read this information carefully and take time to consider if you would like to participate. If after reading this you have any questions about the study please do not hesitate to contact me. My details are located towards the end of this information sheet. If you do make contact or request further details you are in no way obliged to take part.

What is the study about?

I aim to explore the experiences of professionals who provide psychological therapy to adults accessing NHS mental health services at a time when policies introduced under the UK government's deficit reduction programme may be impacting both directly on their clients and on the services in which they work. I aim to explore how this is experienced by these professionals and the impact this may have on their role or professional identity.

What would taking part involve?

If after reading this information you decide you would like to take part in the project, you are asked to contact me on the number or email address provided towards the end of this sheet. We will then arrange a convenient time and location to conduct the interview. This could be face to face (at Lancaster University or your home address) or via Skype/telephone, depending on your preference and the distance of your location from Lancaster. Travel expenses can be reimbursed to a maximum of twenty pounds. Please be aware that if you opt to have an interview via Skype, entire security of that data cannot be guaranteed due to Skype's own terms and conditions. However all transcriptions and recordings taken from that

interview will be kept secure. If you would like the interview to take place during work hours and/or at your place of work you will need to seek permission from your line manager and advise me of any procedures which I would need to follow for this to be arranged.

The interview with me will last up to 90 minutes, during which you will be asked to provide some demographic information and written or recorded verbal consent (depending on whether the interview is face to face or via Skype or telephone). I will then ask you some general questions about your experiences of working with adults in a NHS mental health setting during the current socio-political context. You will be able to take a break at any point in the interview and you may also stop the interview at any point if you decide you do not wish to continue.

Will the information I share be confidential?

All of the information you provide in this study will be confidential unless I feel there is a risk to your safety or the safety of someone else. If I feel that I need to talk to someone else about anything you have said, then I will aim to discuss this with you initially.

The interviews will be audio recorded and will then be anonymised and typed up by me into a written transcript. The recording and transcripts may be seen by my research supervisors. Their details are provided at the bottom of this sheet. This will be done to check the quality of my work. The recordings and the transcripts will be encrypted and stored on a secure University internet server. These will be deleted by the research coordinator after ten years following the successful completion and examination of the project.

Do I have to take part?

You are under no obligation to participate in this study. If you decide to participate, you have the right to change your mind and withdraw from the study before and during the interview. If you decide to withdraw from the study after the interview has taken please, please be aware that it might not be possible to extract your data completely from the study. This is because following the interview your data will be anonymised and pooled with the other participants' data.

Are there be any benefits to taking part?

There are no direct benefits to taking part in the study but it is hoped that the results will help to develop a better understanding of an area of work that we currently know little about. The

results may also be used to develop policy and services to support professionals working with the changing needs of clients.

Are there any risks from taking part?

It is not anticipated that there should be any risks from taking part in the research. However, it is possible that issues might come up in the interview that you find difficult or distressing. You may wish to take these issues to your supervisor or line manager. Alternatively you may also seek support from your GP or by calling The Samaritans on 0845 790 9090.

What will happen to the results of the research project?

The anonymised results from this study will be written up as a thesis. This thesis will be submitted for examination by the university and may also be submitted for publication in academic journals. I may also present the findings at conferences and training/teaching events. I will also prepare a summary of the research findings which will be made available to you if you wish.

Who has reviewed the project?

The project has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee, and the University Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study?

You can obtain further information about the study by contacting myself:

Hayley Higson (Chief Investigator/Interviewer) - Trainee Clinical Psychologist, University of Lancaster, 07508375624, h.higson@lancaster.ac.uk

Further Contacts:

Academic Supervisors:

Dr Suzanne Hodge

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Complaints procedure:

If you have a complaint please contact:

Professor Bill Sellwood

Programme Director

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Professor Roger Pickup

Associate Dean for Research

Faculty of Health and Medicine Division of Biomedical and Life Sciences

Lancaster University

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Thank you for taking time to read this information. If you have read the information and would like to participate in the research, please contact Hayley Higson on: **07508375624 or h.higson@lancaster.ac.uk**

Appendix 4-C: Consent Form

Title of Project: Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

Name of chief investigator: Hayley Higson (Trainee Clinical Psychologist)

Please tick each box

1. I confirm that I have read the information sheet dated 25/03/16 version one for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐

3. I understand that once my data have been anonymised, analysed and pooled with other participant data, (approximately two weeks after the interview has taken place) it will not be possible for it to be withdrawn from the study. ☐

4. I understand that the anonymised information collated, including demographic data and quotations may be used in publications, reports, conferences and training events. ☐

5. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case confidentiality will be breached. ☐

6. I agree that if interviews are taking place on NHS sites and/or during my working hours I confirm that I have sought permission from my line manager and have informed the chief investigator of any necessary processes to comply with. ☐

7. I understand and agree that if the interviews are taking place via Skype, the researcher cannot guarantee complete security of my data outside of the limits set by Skype. ☐

8. I understand that my interview will be audio recorded and then transcribed. I understand that audio recording and transcripts will be encrypted and stored on a secure hard drive and hard copies of data will be stored securely at the university until ten years after the project has been submitted when all electronic and hard data will be destroyed by the university research coordinator. ☐

9. I give my permission for all of the supervisors involved to listen to the audio recording of my interview/see a copy of the interview transcript. ☐

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

11. I would like to be provided with a summary of the results upon completion of the study. If so, please state preferred contact method and details: ☐

……..……

ETHICS APPLICATION

Name of participant:

Date:

Signature:

I have explained and defined in detail the research procedure in which the respondent has consented to participate. Furthermore, I will retain one copy of the informed consent form for my records.

Name of chief investigator: Hayley Higson

Date:

Signature:

Appendix 4-D: Topic Guide

Title: Providing therapy in a time of austerity: the impact of public funding cuts on the role of psychological therapists.

Job role

- Client population/demographics
- Therapeutic modality
- Working environment

Austerity

- Meaning/understanding
- Specific policies/procedures of importance
- Relationship to job role

Clients' needs

- Referrals
- Key issues/patterns
- What helps/what does not help

Socio-economic context

- In the therapy room
- Outside of the therapy room
- Changes/key issues/patterns

NHS working

- Ethos
- Perspectives of job role
- Job satisfaction

The future

- Job role
- Clients' needs
- NHS working

Is there anything else you wish to add?

Thank you for taking part – any questions?

Appendix 4-E: Demographic Details

Please complete the following details.

Age:

Gender:

Ethnicity:

Location of work:

Designation and current area of work e.g. inpatient/primary care etc.:

Length of time working in this area:

Length of time qualified:

Accrediting body:

Length of time you have been accredited: