A Qualitative Study of Patients' Perceptions of Guided Self-Help for Anxiety

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ABSTRACT

OBJECTIVES. This study had three main aims to: i) add to the research into Guided

Self-Help (GSH) for anxiety; ii) explore perceptions by investigating expectations and

experiences; and iii) apply theories of learning, of self-efficacy and of the therapeutic

alliance to aid understanding of important influences on experiences. It was hoped

this would contribute towards developing more effective and acceptable GSH for

anxiety.

METHODS. A qualitative design using a semi-structured interview was used to

investigate 10 patients' perceptions of GSH for anxiety. Template analysis (King,

1998, 2007) was used to analyse the data. To ensure validity and trustworthiness, a

number of steps were used, including grounding in examples, transparency and

reflexivity.

RESULTS. The majority of participants expected GSH to be helpful and expected

more in relation to content (e.g., planning) and process (e.g., more direction).

Experiences of GSH were mixed and all participants were able to recognise changes.

Differences between experiences and expectations related to the process (e.g., more

face-to-face interaction was expected) content (e.g., more in-depth sessions was

expected) and outcome (e.g., more changes were expected). Some of the

improvements suggested were group sessions, more flexibility with appointment

times and periodic maintenance. Particularly salient influences on experiences were

self-efficacy, therapeutic alliance, the presence of a Practitioner and information,

engagement, meeting needs, knowledge and social network.

CONCLUSIONS. The findings from this study facilitated a critique of the theories of

learning, self-efficacy and therapeutic alliance. The main clinical implications and

future directions are to explore what information is provided about GSH, to

investigate improvements suggested and to research further the important influences

identified.

1 INTRODUCTION

1.1 General Introduction

The clinical effectiveness of psychotherapies for treating psychological problems is generally accepted (Department of Health; DH 2001). Although there are a number of different psychotherapies, much of the research has focused on Cognitive-Behavioural Therapy (CBT). The reasons for this are beyond the scope of this thesis. Please see Roth and Fonagy (2005) for a comprehensive review of psychotherapy research.

A recent report by Layard (2004) highlighted the impact of depression, anxiety and stress on individuals and society. The report argued the need for better access to evidence-based psychological therapies. This was echoed in a Government report (DH, 2006) that stated the public's desire for easier access to 'talking therapies'. These reports led to a Government initiative known as Improving Access to Psychological Therapies (IAPT).

To cater for the increased demand of psychological therapies, there have been two recent developments to services. Stepped-Care Models, provides a service model in which IAPT can be delivered (National Institute for Health and Clinical Excellence; NICE, 2009). The British Psychological Society (BPS) and The National Institute for Mental Health in England (NIMHE) have developed New Ways of Working (NWW) to encourage an expansion of the workforce to treat mental health problems (MHP; Lavender & Hope, 2007).

Research into how changes within mental health services can aid the treatment of psychological problems has tended to focus around two areas: i) services implementing a Stepped-Care approach; and ii) specific research into the

effectiveness of less intense interventions for mild to moderate psychological problems. These less intensive interventions generally involve self-help (SH) facilitated by a Practitioner. This is known as Guided Self-Help (GSH).

This thesis identifies a number of theories relevant to GSH. As this thesis places GSH within a psycho-educational context, learning theories are considered. As SH technologies are designed to promote self-efficacy (Richards, 2004), Self-Efficacy Theories (e.g., Bandura, 1977; Ajzen, 1991) are also considered. It is well established that therapeutic alliance is an important component to psychological therapies (e.g., Horvath & Luborsky, 1993; Ruglass & Safran, 2005). As GSH involves a Practitioner, therapeutic alliance is also considered.

To date, the majority of research into SH has focused on clinical outcome and cost effectiveness (e.g., Van Boeijen, Van Balkolm, Van Oppen, Blankenstein, Cherpanath, & Van Dyck, 2005). Less common is research investigating how people experience SH (Lucock, Mirza, & Sharma, 2007). The review generated by this study indicates there is limited research in clinical settings. Although some of the studies in this review focused on anxiety, there is no research specifically into experiences of GSH for anxiety. Other research into patients' experiences of primary care management has focused on depression (e.g., Richards et al., 2006). Therefore, investigating experiences of GSH for anxiety was considered to be an important area for further research.

This study uses a qualitative design to investigate patients' perceptions of GSH for anxiety. See the section below for further information.

1.1.1 Aims of the Study

The aims of this study were threefold. Firstly, this qualitative study hoped to contribute to the existing quantitative research by providing a more in-depth

understanding into GSH for anxiety. Secondly, the study aimed to explore patients'

perceptions of GSH for anxiety by investigating their expectations and experiences.

Thirdly, the study aimed to apply a number of psychological theories to aid

understanding of important influences on patients' experiences and how this impacted

on their responses to GSH for anxiety. Ultimately, it was hoped this study would

contribute towards developing more effective and acceptable GSH for people

experiencing anxiety. This has already been identified by Richards (2004) as an

important area for future research.

1.2 Chapter Overview

The chapter continues in section 1.3, by providing background information to

the research topic. This includes information on the treatment of MHP, focusing on

CBT. The social and political context that led to the implementation of GSH in

primary care services is then described. This starts with a brief description of the

Layard Report (2004), followed by Government policy, which led to IAPT. NWW

are then described followed by a description of the organisational model, known as

Stepped-Care. Both of these are important for understanding the context in which

IAPT is delivered. Finally, an explanation of GSH is given.

In section 1.4 theories relevant to SH are discussed, particularly theories of

learning, self-efficacy and therapeutic alliance as they appear most pertinent to SH.

Section 1.5 outlines a literature review of how people view and experience SH.

Section 1.6 provides the reason for focusing on anxiety, then section 1.7, provides a

definition of anxiety, prevalence rates and co-morbidity and finishes with an

examination of the commonalities underlying the different anxiety disorders. Section

1.8 introduces the study. Information about the manuals used by the Cambridgeshire

and Peterborough National Health Service (NHS) Foundation Trust (CPFT) and the service context are provided, followed by the research questions.

1.3 Background

1.3.1 Treatments for Mental Health Problems

A number of different treatments are available for MHP. Those most commonly used are medication and psychotherapies. Psychotherapies encompass a large number of different interventions: Kazdin (1986) identified over 400. These can be classified into seven major orientations: Psychodynamic; Behavioural and Cognitive-Behavioural; Interpersonal; Systemic; Supportive and experiential; Group therapies; and Counselling (Roth & Fonagy, 2005). It is not possible to describe all of these. A brief description of the theories underlying Behavioural and Cognitive-Behavioural therapies will be given as this informs GSH. For information on the other therapies refer to Roth and Fonagy.

Behavioural therapies have their roots in Classical Learning Theory, which is based on classical conditioning by Pavlov (1927) and operant conditioning by Skinner (1957). Classical Learning Theory argues that behaviour is a learnt response and positive or negative reinforcements strengthen the likelihood of whether a behaviour will be performed again. Although behavioural theories have been fundamental in our understanding of people's behaviour, it has been suggested that they neglect the role of cognitive processes (Roth & Fonagy, 2005). This has been addressed by cognitive theories, such as Social Learning Theory (Bandura, 1977) and Beck's Cognitive Model (Beck, 1964). Social Learning Theory argues that individuals evaluate the effect of a behaviour being 'modelled' to them and this evaluation depends on the conditions in which it is taking place (Bandura). The Cognitive Model

hypothesises that people's perception of events and how they construe a situation influences their behaviours and emotions (Beck). Although these theories differ in emphasis, a common theme for both is a belief that cognitive processes are important for determining people's behaviours. These theories led to the development of various forms of CBT (Beck, 2005), for example Rational-Emotive Therapy (Ellis, 1962). For the purposes of this thesis, a general overview of CBT will be outlined.

CBT integrates principles from behavioural and cognitive theories. It encourages people to recognise how their thoughts and beliefs impact on their behaviour and how this links to their feelings and physiology. It helps people to recognise unhelpful patterns of thinking and/or behaving and learn new more helpful patterns. CBT for people with anxiety and depression has been evaluated in Randomised Controlled Trials (RCTs), which are considered the gold standard of research (Abel & Kock, 1999), though they are not without limitations (see Grossman & MacKenzie, 2005). For example, a review of RCTs found that CBT was an effective treatment for depression, panic disorder and Generalized Anxiety Disorder (GAD), although may be less effective in more severe cases (Gaudiano, 2006). A Cochrane review of RCTs investigating psychological therapies for GAD found CBT to be more effective than treatment as usual or waiting lists (Hunot, Churchill, Teixeira, & Silva de Lima, 2007). It is not possible to summarise all the trials that have taken place here. Generally, findings from RCTs and reviews show that CBT can improve anxiety and depression depending on the severity. It also appears an effective treatment in comparison to waiting lists and controls. Based on findings such as these, NICE recommends CBT as a first-line treatment for people experiencing anxiety and depression (2004).

1.3.2 Social and Political Context for Psychological Therapies

In 2004 Layard produced a report entitled 'Mental Health: Britain's Biggest Social Problem'. This documented the social and economic impact of common MHP on society. Layard reported that 38 percent of people drawing incapacity benefits in the United Kingdom (UK) were doing so because of MHP. It was reported that depression, anxiety and stress reduces output due to time-off sick and unemployment. The Confederation of British Industry (CBI) estimated the economic and Exchequer (public services and lost taxes) costs of mental illness to be 25 and 21 billion pounds per year respectively. To reduce these costs, Layard advocated increasing the availability of early psychological therapies.

In 2006 the Government produced a White Paper called 'Our Health, Our Care, Our Say' (DH 2006). This was produced in response to the public's views on health and social care services. One recommendation in this report was to improve mental wellbeing by offering easier access to 'talking' therapies. The White Paper, in addition to Layard's report (Layard, 2004), led to the development of a new initiative known as IAPT.

1.3.3 New Ways of Working

The main purpose of NWW is to "improve the psychological well-being of the population" (p. 5, Lavender & Hope, 2007). To face the increasing demand for psychological services, NWW reports that an expansion of the psychological therapy workforce is needed. This requires other professionals to deliver psychological therapies, an increase in the number of applied psychologists, and better use of the large psychology undergraduate population, approximately 15,000 per year (Clark & Turpin, 2008). With regards to IAPT, NWW recommended that practitioners deliver

a full range of interventions, from GSH to formal therapy, depending on their

competencies.

1.3.4 Stepped-Care Models

IAPT uses a Stepped-Care Model for delivering and monitoring treatments so

patients receive the most effective and least resource-intensive treatment first,

matched to their needs (Needham, 2006). Although stepped models of care vary

between mental health services, there is a general step profile. Watchful waiting

occurs initially, followed by less intensive interventions. The most common of these

interventions require patient-initiated use of evidence-based materials, such as SH

books and manuals, computer programmes and internet sites. These are often

facilitated by Psychological Wellbeing Practitioners. Regular monitoring of patient

outcomes indicates whether treatments need to be more intensive and thus stepped up.

The steps then progress from brief and group interventions to specialised longer-term

psychological intervention, delivered by more specialist clinicians (NICE, 2009). The

main aim of Stepped-Care approaches is to provide low-cost community-based

treatments before using high-cost specialist services (Wolstenholme, Repper, Todd,

Monk & McKelvie, 2006). It is argued that by distributing available resources

according to the severity of psychological problems, effective treatments will be

ensured whilst simultaneously enhancing service delivery (Needham).

Two national demonstration sites, based in Doncaster and Newham, have been

researching the effectiveness of providing significant increases in evidence-based

psychological therapies. Whilst the Newham site provides a comprehensive CBT

psychological service, the Doncaster site provides enhanced access to 'lower

intensity' CBT interventions (British Association for Counselling and Psychotherapy;

BABCP, 2010). Reports so far indicate that these sites are hugely successful (DH,

2007). Specifically, a recent evaluation of these sites indicates that low-intensity

interventions (e.g., GSH) were particularly useful for treating a large number of

patients and achieving good recovery rates (Clark, Layard, Smithies, Richards,

Suckling & Wright, 2009).

1.3.5 Guided Self-Help

The IAPT Programme Board, supported by an IAPT Core Team, is

responsible for developing the guidance and materials for less intensive interventions

in collaboration with key professional bodies and national stakeholders (IAPT, 2008).

Trusts across the country have developed manuals, which Psychological Wellbeing

Practitioners 'guide' patients through. This has become known as GSH.

Using manuals has a number of advantages. These include reducing waiting

time, allowing patients to work at their own pace and providing a format in which

seeking help may be less stigmatized (Cuijpers & Schuurmans, 2007). It also enables

the delivery of therapy to be consistent between Practitioners. Perhaps most

importantly, it provides a resource for patients to access once they have completed

their treatment. However, there are also disadvantages to using manuals. Roth and

Fonagy (2005) highlight that any manualised therapy needs to be implemented

flexibly and using clinical judgement, as it is rare that patients present with just one

type of problem (see 1.7.2 Prevalence and Co-morbidity of Anxiety). Clinical

judgement develops with experience and therefore it is likely that a Practitioner's

experience will impact on the quality of the GSH delivered. Failure to complete or

improve from the GSH may reinforce feelings of helplessness and a lack of mastery,

in turn exacerbating symptoms of anxiety and depression. Patients may be reluctant

to 'step-up' and accept more intensive CBT as it is based on the same principles

which did not help previously (Cuijpers & Schuurmans).

1.4 Theories Relevant to Guided Self-Help

This thesis identifies a number of psychological theories relevant to GSH. These include theories of learning, self-efficacy, and therapeutic alliance, which has its roots in psychodynamic theory. Each of these will be addressed in turn.

1.4.1 Learning Theories

1.4.1.1 Definition of Learning

Learning is a hypothetical construct and can be defined as "the process by which relatively permanent changes occur in behavioural potential as a result of experience" (p.4, Anderson, 1995). This makes an important distinction between what people can do and what they actually do. There are a number of learning theories that present different views on the process of learning. Although theories differ as to how learning takes place, the underlying concepts of learning are 'assimilation' and 'accommodation', originally coined by Piaget (1970). 'Assimilation' refers to fitting information from the external world into existing schemas (a way of organising experience). 'Accommodation' refers to when individuals modify their schemas to fit the world (Piaget).

This thesis locates GSH within a psycho-educational context. Therefore, Kolb's Experiential Learning Model (Kolb, 1984) and Vygotsky's Social Development Theory (Vygotsky, 1978) will be explored in greater detail.

1.4.1.2 Kolb's Experiential Learning Model

According to Kolb (1984), experiential learning is best conceptualised as a continuous process grounded in experience. It is a holistic process that involves interactions between an individual and their environment. Through experiential learning individuals adapt to their world and attempt to resolve conflicts between opposed 'modes' of adaptation. At the crux of Kolb's Model are two continua. The

'perception' continuum encapsulates an individual's preferred emotional response to learning: feeling or thinking. The 'processing' continuum encapsulates an individual's preferred approach to learning a task: watching or doing. For learning to occur, Kolb proposes a learning cycle in which all four processes are present and each end of the continuum provides a step (see figure 1). 'Concrete experience' provides opportunities to learn from specific experiences and relate to other people and their feelings. 'Reflective observation' involves watching or observing others and searching for different perceptions before making a judgement. 'Abstract conceptualisation' involves analysing ideas systematically and making generalizations. 'Active experimentation' involves doing things and influencing others and events through action.

Figure 1: Kolb's Learning Cycle. Taken from Clark (2008, April 12).
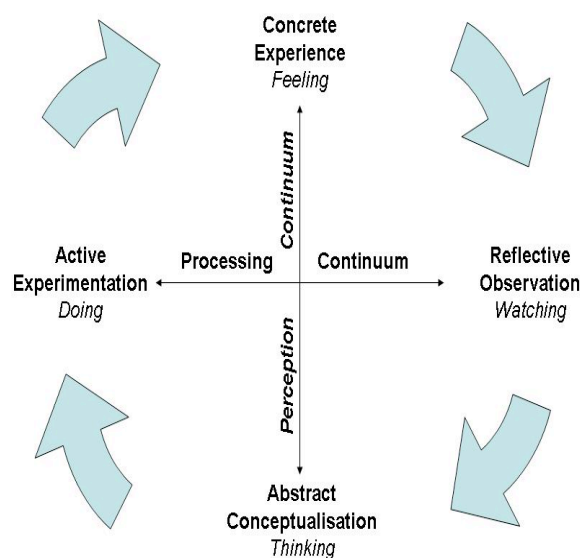
Kolb theorises that individuals move between the different 'modes' and that the most effective learning occurs when all four 'modes' are practised.

GSH provides all four 'modes'. The presence of a Practitioner enables patients to observe others and also helps them to reflect on their own observations

(Reflective observation). Patients are encouraged to talk about specific experiences and carry out behavioural experiments (Concrete experience), understand factual information about anxiety through reading the manual and listening to explanations from the Practitioner (Abstract Conceptualisation) and practise new behaviours (Active experimentation).

The model provides a useful way for conceptualizing the learning process and is applicable to GSH. However, it does not take into account the relationship an individual has with the person they are watching or the context in which this takes place. As Bandura (1977) highlights, these are both important aspects to consider. Further, although the model has been used to identify learning preferences it does not acknowledge how individual characteristics can influence learning.

1.4.1.3 Vygotsky's Social Development Theory

Although Vygotsky's (1978) Theory focuses on child development, language and thought, elements are applicable to adult learning. The theory emphasises the social environment, interactions and shared experiences in which learning takes place. This is in contrast to the Learning Cycle, which seems to focus more on the individual. Vygotsky's Theory promotes learning by encouraging individuals to take an active role and has three main themes. Firstly, before cognitive development occurs social learning needs to take place. Secondly, an individual who is more competent or capable than the learner for a particular task is known as the More Knowledgeable Other (MKO). Thirdly, learning occurs in the 'distance' between the learner's ability to perform a task under guidance and the learner's ability to solve a problem independently. This is known as the Zone of Proximal Development (ZPD).

The common conception of ZPD is that a MKO can provide guidance to help the learner develop competence to solve a problem. As the learner becomes more

familiar and competent with the task of problem-solving, the MKO adjusts their guidance according to the learner's performance. This leaves more for the learner to do until they can successfully perform the whole task independently. Within this general conception, three aspects are identified: i) that an individual working collaboratively with a more competent person can perform a greater number of tasks; ii) the importance of a MKO interacting with the learner; iii) the learner's 'properties', including their potential and/or readiness to learn (Chaiklin, 2003). The interactional support by which the learner is able to develop has become known as 'scaffolding'.

The theory has been applied widely within educational settings and is applicable to GSH in a number of ways. Patients are encouraged to work collaboratively with a MKO (i.e., Practitioner), who is more knowledgeable in using CBT techniques. The Practitioner provides 'scaffolding' for applying these techniques with the aim of encouraging the patient to do more as they become more competent. As such, patients are expected to take an active role in helping themselves to learn new ways to think and behave.

The theory highlights the importance of social interactions for understanding how learning can occur, identifies that the learner themselves brings characteristics to the process, and is clearly applicable to GSH. However, the theory does not take into account the characteristics the MKO brings to the process. Similar to Kolb's (1984) Model, the theory also neglects to consider how the relationship between the learner and MKO impacts on learning. The theory has also been criticized for the emphasis on guidance, which can be too helpful in some cases, leading the learner to develop dependency (Santrock, 2004).

1.4.1.4 Summary

Theories covered in this section provide a useful insight into how learning takes place and factors that influence this. Whilst Kolb's (1984) Model focuses on the individual learning cycle, Vygotsky's (1978) ZPD emphasises the importance of a MKO guiding the learner to develop their skills. However, neither considers the impact of the relationship with the observed individual or MKO involved in the learning process. The relationship between two individuals is particularly important within a therapeutic context (see section 1.4.3 Therapeutic Alliance). Although, Vygotsky's ZPD highlights that learner 'properties' are important for learning, neither theory takes into account the influence of the other individual's characteristics.

1.4.2 Self-Efficacy Theories

This section describes and appraises Bandura's Self-Efficacy Theory (Bandura, 1977) and the Theory of Planned Behaviour (TPB; Ajzen, 1991). A summary of these theories is provided and then the link between low self-efficacy, anxiety and SH is described.

1.4.2.1. Bandura's Theory

Bandura (1977) defined self-efficacy as a psychological construct "derived from four principal sources of information: performance accomplishments, vicarious experience, verbal persuasion, and physiological state." (p.191). He argued that whilst cognitive processes mediate change, these are influenced most by the experiences of achievement and mastery arising from effective performance. These experiences enhance self-efficacy and lead to decreases in defensive behaviour, such as avoidance.

Bandura (1977) hypothesised that self-efficacy influences how people feel and think, determines whether coping behaviour will be initiated, how much effort will be expended and the length of time it will be sustained when faced with adversity and

obstacles. Bandura (1986, as cited in Kok et al., 1992) argued that expectations of

self-efficacy vary along dimensions of magnitude, generality and strength.   As such,

self-efficacy estimates are context specific and vary depending on the perceived task

difficulty and situation. Kok and colleagues (1992) emphasise that perceived

difficulty does not necessarily imply an estimation of ability. For example, someone

may see a behaviour in a certain situation as very difficult yet also believe they can do

something about it.

Bandura (1977) argued that self-efficacy expectations and outcome

expectations are conceptually distinct and defined them separately (see Bandura, 1977

for further information). Critiques of the theory believe that Bandura's definitions are

ambiguous and argue that there is an inter-relationship between efficacy and outcome

expectations (Eastman & Marzillier, 1984). Furthermore, this theory does not take

into account other factors that may influence behavioural change.

1.4.2.2 Ajzen's Theory of Planned Behaviour

Ajzen (1991) placed the construct of self-efficacy within a more general

framework in the TPB. This theory identified three main factors on a person's

intention to perform a certain behaviour (Ajzen). These were: i) attitude towards the

behaviour; ii) subjective norm; and iii) perceived behavioural control. Attitude

towards the behaviour is the degree to which a person has a favourable or

unfavourable evaluation of the behaviour in question. Ajzen argues that this is

influenced by behavioural beliefs, which links the behaviour to a certain outcome and

the value of the outcome or to some other attribute, such as the cost incurred by

performing the behaviour. Subjective norm is the perceived social pressure to

perform or not to perform the behaviour. This is influenced by normative beliefs,

which is the likelihood that important individuals or groups approve or disapprove of performing the given behaviour.

Perceived behavioural control is similar to Bandura's (1977) theory of self-efficacy. This represents people's perception of the ease or difficulty for performing a specific behaviour. Ajzen (1991) made a distinction between actual control and perceived control, stating that resources will dictate to some extent the likelihood of behavioural control. Perceived behavioural control is influenced by control beliefs, which are based on past experience of the behaviour, second hand information about a behaviour, experiences of family and friends and other factors that increase or reduce the perceived difficulty of performing the behaviour. Ajzen argued that the more resources and opportunities individuals believe they possess, and fewer obstacles anticipated, the greater their perceived control. Similar to Bandura, Ajzen believed that perceived behavioural control varies across situations and actions.

A criticism of the TPB is the failure to fully mediate the influence of past behaviour (see Conner & Armitage, 1998). As such, Maddux (1993) proposed a revised TPB (rTPB), which has three distinct differences to the TPB. Firstly, with regards to past behaviour, the rTPB distinguishes between cues to decision (initiation phase) and cues to action (habit phase). Whereas the initiation phase refers to cognitions that may lead to behavioural intentions, the habit phase refers to when behaviour is elicited by an automatic response. Secondly, with regards to attitude, Maddux argued this concerned not just the attitude towards the new behaviour but also the old behaviour (Levy, Polman & Marchant, 2008). Thirdly, the rTPB proposed that self-efficacy should replace perceived behaivoural control. Consistent with Bandura (1977), Maddux argued that perceived behavioural control incorporates two independent constructs, self-efficacy expectations and outcome expectations.

Therefore, he recommended that perceived behavioural control, which largely reflects external factors (i.e. outcome expectations) and self-efficacy, which concerns internal factors, should be considered separately. Research by Terry and O'Leary (1995) supported this distinction. However, Ajzen (2002) refutes this suggesting that self-efficacy and controllability are synonymous.

Another criticism of the TPB is that it does not directly address issues of translating intentions into actions. Gollwitzer (1993) suggests that 'implementation intentions', commit individuals to a specific course of action when they encounter a critical situation. 'Implementation intentions' specify where, when and how, compared to goal intentions which specify what one will do (Sheeran, Milne, Webb, & Gollwitzer, 2005). It can be argued, therefore, that 'implementation intentions' help individuals overcome problems initiating and maintaining goal directed responses and contextual/situational threats. This may help to enhance people's self-efficacy.

1.4.2.3 Summary

Whilst there are clear differences between the two theories, they are similar with respect to self-efficacy varying across situations and behaviour. There appears to be an ongoing debate as to whether self-efficacy expectations and outcome expectations are conceptually distinct or synonymous. This has led to criticisms of both theories. Despite these criticisms the theories are useful for helping to understand psychological changes and provide useful frameworks for understanding the links between self-efficacy, anxiety and SH.

1.4.2.4 Self-Efficacy, Anxiety and Self-Help

McCarthy and Newcomb (1992) argue there are two dimensions to perceived self-efficacy. These are cognitive control and behavioural coping ability. Common

features found in anxiety are perceived lack of cognitive control and behaving in ways that maintain the problem(s). It is not surprising therefore that anxiety has been associated with a low sense of self-efficacy (Schwarzer, 1992).

Theories of self-efficacy state that psychological procedures can alter the level and strength of self-efficacy. These procedures aim to alleviate anxiety symptoms by increasing people's perceptions that they can cope effectively with the demands of a situation. Specifically, SH technologies are designed to promote self-efficacy by encouraging patients to learn skills and enhance their sense of mastery in managing their own symptoms and taking responsibility for their mental health (Richards, 2004). According to Schwarzer (1992), self-efficacy has an impact on levels of motivation, such that an individual with higher self-efficacy levels will be more likely to set themselves higher goals and stick to them.

1.4.3 Therapeutic Alliance

The section starts with various definitions of therapeutic alliance from different schools of psychology, before highlighting the generic aspects. Variations in therapeutic alliance are then described before focusing on therapist and patient characteristics that contribute towards an alliance. Finally, therapeutic alliance and GSH are explored.

1.4.3.1 Definitions of Therapeutic Alliance

Therapeutic alliance is a complex construct that originated from a psychodynamic perspective. Freud (1937, 1940, as cited in Kanzer, 1981) highlighted the importance of the "analytic pact" between the analyst and the patient whereby an atmosphere was created "suitable for a particular technique and therapeutic goal" (Kanzer, p.86). Zetzel (1956, as cited in Roth & Fonagy, 2005) argued that in order for therapy to be successful a conscious collaborative agreement between therapist

and patient was necessary. Others (e.g., Bowlby, 1988) argued that the alliance formed provides the patient with a different type of relationship, which they can compare to previous experiences that may not have been as positive. As such, the alliance can have a curative aspect. This curative aspect is emphasised by the humanist tradition, which argues that a therapist's empathy, congruence and unconditional acceptance of a patient can lead to therapeutic success (Rogers, 1951). In contrast, behavioural and social learning approaches emphasise the importance of how the patient perceives their therapist. They argue that if a therapist is perceived to be expert, attractive and trustworthy, this will strengthen the therapist's influence and increase the likelihood a patient will benefit (e.g., Strong, 1968, as cited in Roth & Fonagy). Three aspects of the therapeutic alliance have been identified by Horvath, Gaston and Luborsky (1993) as important. These are: i) the therapist's ability to present themselves as empathic, caring and helpful and the patient's ability to forge a personal bond; ii) agreement between patient and therapist in terms of expectations of the short- and medium- term goals for therapy; and iii) the patient perceives the interventions offered to be relevant and potent. Although these aspects suggest therapeutic alliance to be relatively stable, in reality this varies between and during sessions (Roth & Fonagy).

1.4.3.2 Variations in Therapeutic Alliance

Roth and Fonagy (2005) highlight the dynamic nature of therapeutic alliance and how events in therapy can influence it. They suggest that early improvement in therapy can lead to changes in patient perceptions of their therapist and therapy, viewing it more positively. This increases the likelihood of a positive alliance forming. However, it is not uncommon during sessions for a 'therapeutic rupture' to occur where there is a deterioration in the quality of the relationship between the

therapist and patient. This creates an opportunity for interpersonal relationships to be explored and has been argued as therapeutic in itself (Safran & Muran, 1996). Clearly, the therapeutic alliance is a complex set of processes and can be influenced by events that occur within therapy. There are also a number of therapist and patient factors that contribute to the alliance.

1.4.3.3 Therapist and Patient Factors Contributing to the Alliance

Ackerman and Hilsenroth (2001, 2003, as cited in Roth & Fonagy, 2005) have identified a number of therapist characteristics common to different therapeutic orientations that help develop a positive alliance. These include therapist qualities highlighted earlier (see section 1.4.3.1 Definitions of Therapeutic Alliance), in addition to therapist confidence and experience, and the perceived investment in the relationship. The therapist's abilities to reflect, explore, accurately interpret, enable emotional expression and be sensitive to different feelings (known as responsiveness) are also seen as important factors for fostering a positive alliance. Characteristics that are likely to develop a negative alliance are when a therapist is uncertain, rigid, critical and uninvolved. Over-structuring therapy, difficult silences, inappropriate use of self-disclosure and intensive interpretation of transference are also associated with poorer alliance.

Patient factors that contribute to the alliance include intrapersonal and interpersonal qualities. With regards to intrapersonal qualities, an individual's motivation, psychological status, optimism, psychological mindedness and positive perceptions of others have been associated with more positive alliance and better outcome (Piper et al., 1991b, as cited in Roth & Fonagy, 2005). Whether a patient perceives treatment to be credible, relevant and influential, may also contribute towards a positive alliance. With regards to interpersonal factors, a person's quality

of family and social relationships, for example their ability to maintain relationships, in addition to stressful life events, are associated with therapeutic alliance.

1.4.3.4 Therapeutic Alliance and Guided Self-Help

GSH is based on the premise that learning occurs with the help of an educator acting as a facilitator (as in Vygotsky's Theory, 1978).   This establishes an atmosphere in which learners feel comfortable to consider new ideas (Laird, 1985). However, some research suggests this is not always conducive to people improving. A meta-synthesis of qualitative studies investigating patient experience of GSH for depression found the presence of a therapist offering guidance for using SH materials generated ambivalence in patients about their own use of these materials and the role of the therapist (Khan, Bowers & Rogers, 2007).

There is also mixed evidence for whether the presence of a facilitator is beneficial. A "second order review" by Papworth (2006) reports that whilst some systematic reviews found no significant differences between therapist-assisted approaches and SH (e.g., Gould & Clum, 1993), other reviews found evidence that any level of therapist contact improved outcomes (e.g., Mains & Scogin, 2003).

1.5 Literature Review

A rationale for the literature review is provided. A description of the search protocol and selection criteria is given. The results and a critique of studies are then provided, followed by a discussion of the findings. Finally, conclusions and suggestions for future research are made.

1.5.1 Rationale

An initial search of the literature indicated a wealth of research into SH

interventions. These included media-based initiatives, groups, books and manuals.

As this thesis focuses on GSH, it was thought books and manuals were most relevant.

Therefore studies which focussed on groups and computer-based interventions, such

as online forums or CD ROMs, were not included.

<p style="text-align: center;">*1.5.2 Search Protocol*</p>

AMED (1985 to present), CINAHL (1982 to present), EMBASE (1980 to

present), MEDLINE In–Process & Other Non-indexed citations, MEDLINE (R)

(1950 to present), PsychINFO (1806 to present) and ingentaconnect were searched

on October 26, 2010. Terms associated with *self-help, anxiety, depression,* and

mental health were entered. The 'thesaurus mapping' facility showed there were

no additional terms associated with these topics. The keywords and Boolean

connectors entered and combined with the 'and' function were: i) Self-help OR

SH OR bibliotherapy OR minimal intervention*; ii) anxiety* OR depression* OR

mental health*; and iii) adult*.

Electronic searches were conducted on Behavioural and Cognitive

Psychotherapy (1994 to present) and Journal of Mental Health (1992 to present).

Titles of each article were viewed and if thought to be relevant the abstracts were

assessed. No more suitable articles were found. In addition, the reference list of

'Good practice guidance on the use of SH materials within IAPT services'

(Turpin, 2010) was checked.

1.5.2.1 Selection Criteria

A total of 406 articles were generated from the initial search. Duplicates

were removed and abstracts were searched for the key terms above. Exclusion

criteria included: Non-English language; studies in which substance misuse, eating

disorders, medical conditions, and/or post traumatic stress disorder were the main

focus, because of the additional complexity; articles about SH for carers of people with MHP as it was thought these may not be addressing MHP per se; articles describing the development of a service with no analysis; meta-analysis or meta-synthesis reviews and unpublished citations (e.g., dissertations). To optimise the inclusion of all suitable research, the reference lists of all relevant studies were also examined.

Initially, there were 28 articles related to books and manuals. Therefore, articles from 2004 and onwards were selected. There were two reasons for this. Firstly, it was thought that the more recent articles will have improved upon the previous research. Secondly, a number of meta-analyses have been done examining earlier research (e.g., Bower, Richards & Lovell, 2001; Den Boer, Wiersma, & Van Den Borsch, 2004).

1.5.3 Results and Critique of Previous Studies

Overall, 16 studies met the selection criteria. Of these, 10 were quantitative studies, one of which was mixed methods, and six were qualitative. All studies were from a clinical population. For ease of reading, studies will be discussed according to design.

1.5.3.1 Quantitative Studies

A summary of the aims of the research, participant information, research design, methods used to collect data, and findings can be found in table 1. Of the 10 quantitative studies, one investigated professionals' attitudes towards SH, five examined specific SH manuals (guided and 'pure'), and four researched SH materials.

Table 1: Quantitative studies in chronological and alphabetical order.

Reference	Aim	Participants	Design & Analysis	Data Collection	Main Findings
Willemse, Smit, Cuijpers, & Tiemens (2004)	To examine the effects of minimal-contact psychotherapy in primary care	107 patients with sub-threshold depression and 109 TAU	RT. Regression imputation model. ITT. Mann-Whitney U test	CIDI-Auto (Dutch Version); CES-D; RAND-36	1. Patients with sub-threshold depression can benefit from minimal-contact psychotherapy. 2. Incidence of MDD significantly lower in psychotherapy group than those in TAU. 3. Generally, participants satisfied/very satisfied with psychotherapy. 4. Participants discontinued intervention significantly less satisfied than those who completed.
Fletcher, Lovell, Bower, Campbell & Dickens (2005)	To investigate process and outcome of non-guided SH manual compared to control group	30 patients with anxiety and/or depression.	Pilot RCT. ITT analysis. Independent t-test; RCSC; Fisher's Exact test	HADS; 38-item CORE-OM	1. No significant differences between the two groups on measures of anxiety or depression. 2. Non-guided SH does not appear superior to waiting-list control. 3. High level of satisfaction with SH manual. 4. Priming effect of receiving a manual.
Mead, Macdonald, Bower, Lovell, Richards, Roberts et al. (2005)	To test the clinical effectiveness of GSH.	114 patients with anxiety and/or depression.	RCT. ITT analysis. Multiple regression	BDI; HADS; CORE-OM; SAS; Self-reported adherence; patient satisfaction; 8-item questionnaire concerning aspects of relationship with facilitator.	1. GSH does not provide additional benefit to patients on a waiting list for psychological therapy. 2. 'Pure SH' model, using the same manual, also reported no benefit (Fletcher et al., 2005). 3. Techniques in manual may have not been relevant to certain patients. 3. High levels of satisfaction concerning patients' relationship with facilitators.

Reference	Aim	Participants	Design & Analysis	Data Collection	Main Findings
Reeves & Stage (2005)	To examine the use of an assisted SH treatment package	9 patients with mild to moderate stress/anxiety	Uncontrolled. Non-parametric tests	Zung anxiety Scale (Zung, 1971); CORE-OM	1. Significant improvement in symptoms at post-treatment and maintained at 3-month follow-up 2. Consistent findings with trial by Kupshik & Fisher (1999). 3. 75% patients found SH 'very helpful' & patients satisfied with intervention in general. 4. Most popular modules were learning relaxation techniques.
Lovell, Bee, Richards & Kendal (2006)	To evaluate levels of utilisation, effectiveness and acceptability of a new SH service	292 patients with MHPs.	Uncontrolled evaluation. Mixed Method. SPSS. RCSC. Thematic analysis	Service utilisation and efficiency measured by clinical audit data over 3-month period; 34-item CORE-OM; Semi-structured interviews	1. Significant improvements between baseline and three-month follow-up. 2. Practitioners and GPs reported moderate to high levels of satisfaction with model 3. Patients perceived intervention appropriate to needs, effective and highlighted potential therapeutic benefits 4. Success of provision dependent on providing sufficient support and information so interventions flexible and responsive to needs.
Philp, Lucock, & Wilson (2006)	Evaluate GSH for depression provided by a nurse.	15 patients with depression, anxiety, and/or stress	Uncontrolled pilot study. Paired t-tests	HADS	1. Statistical and clinically significant improvements in anxiety and depression 2. GSH increased choice and access to psychological intervention.

Reference	Aim	Participants	Design & Analysis	Data Collection	Main Findings
Ricketts, Parry, Forrest, Mettam, Houghton & Saxon (2008).	Develop and pilot GSH for panic and measure its effectiveness.	22 individuals with panic	Uncontrolled pilot study. Paired sample t-tests. RCSC.	Frequency of panic attacks (Febbraro, Clum, Roodman, and Wright,1999); Fear Questionnaire (Marks & Matthews, 1979); Modified version of Fear Questionnaire (Clark et al., 1994); and Agoraphobic Cognitions Questionnaire (Chambless, Caputo, Bright, & Gallagher, 1984).	1. Some changes made, particularly reduction in panic frequency and situational fear. 2. Not all clients benefitted from GSH 3. Effect sizes larger than bibliotherapy-only study by Febbraro et al. (1999), and comparable to GSH in Gould and Clum study (1995).
Farrand, Confue, Byng & Shaw (2008).	To examine: i) 'paraprofessionals' GMHW primary care clinics; ii) efficiency and effectiveness of these clinics; and iii) compare to previous study.	579 patients with depression and anxiety.	Uncontrolled repeated measures. Independent sample t-tests, Chi-square and ANOVA. RCSC.	Efficiency measured by number of support sessions, amount of total support and discharge destination; HADS.	1. Comparable levels of effectiveness achieved between GSH provided by 'paraprofessional' mental health workers and experienced mental health nurse (Lovell, Cox, Garvey, Raines, Richards, Conroy et al., 2003). 2. Improvements in problem severity were statistically and clinically significant. 3. Concerns over efficiency of the clinic, particularly in relation to longer support sessions and high drop-out rates.

Reference	Aim	Participants	Design & Analysis	Data Collection	Main Findings
MacLeod, Martinez & Williams, (2009).	To: i) assess practitioners' attitudes and knowledge of SH; ii) identify patient factors that predict success; and iii) identify potential drawbacks and problems.	254 Practitioners	Survey. Chi-square.	Questionnaire using likert-style rating scales.	1. SH widely used by practitioners 2. Patient factors most commonly identified as predicting a more successful outcome were: higher levels of motivation, expectancy/credibility, likely adherence, self-efficacy and lower degree of hopelessness. 3. Potential problems included low compliance and failing to detect a worsening of patients' clinical state.
Reeves, 2010.	Add to the evidence base for GSH.	43 participants with mild to moderate stress and anxiety.	Controlled between and within group trial. Independent t-tests and paired t-tests respectively. Chi-squared tests.	HADS, CORE, Satisfaction Questionnaire (Kupshik, 1998), Compliance Questionnaire (Kupshik).	1. Evidence of clinical effectiveness of GSH. 2. Levels of satisfaction quite helpful or very helpful: most helpful aspects were information on anxiety/stress and controlled breathing. 3. Contact with clinician valued.

SH = Self-Help; GSH = Guided Self-Help; RCT = Randomised Controlled Trial; RT = Randomised Trial; CORE-OM = Clinical Outcomes in Routine Evaluation outcome measure (Evans et al., 2000); SAS = Social Adjustment Scale (Cooper, Osborn, Gath, Feggetter, 1982); ANOVA = analysis of variance; ITT = intention-to-treat; RCSC = Reliable and Clinically Significant Change (Evans et al.); CIDI = Composite International Diagnostic Interview (Ter Smitten, Smeets, & Van Den Brink, 1998); MDD = Major Depressive Disorder; TAU = Treatment as usual; CES-D = Center for Epidemological Studies Depression Scale (Radloff, 1977); RAND-36 = Assessment of general health (Van der Zee & Sanderman,

1993); GMHW = Graduate Mental Health Worker; HADS = Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1982); BDI = Beck

Depression Inventory (Beck, Ward, & Mendelson, 1961).

MacLeod et al. (2009) investigated practitioners' attitudes towards SH. They found that SH materials were viewed favourably by practitioners and that patients' characteristics, such as higher levels of motivation and self-efficacy, were important for successful outcome. Similar findings were reported in an earlier study by Audin, Bekker, Barkham and Foster (2003). MacLeod et al. used a survey, which is considered to produce lower quality evidence compared to other methods, such as RCTs (Evans, 2003). It does not appear that the questionnaire used by MacLeod et al. was piloted. This is important to establish whether the questions asked mean the same to all respondents and to identify any comprehension difficulties (Boynton, 2004). The format of questionnaires also makes it difficult for an in-depth examination of complex issues (Beiske, 2002) and rely heavily on self-report, which can be affected by response bias (Bradburn, 1983). Although participants for this study were registered members of a well-known organisation, this may not be representative of other practitioners leading to biased responses (Greenhalgh, 1997). Nevertheless, the study had a large sample size increasing the likelihood of a range of views being reflected (Field, 2009).

The studies by Reeves and Stage (2005), Philp et al. (2006), Ricketts et al. (2008), and Mead et al. (2005) investigated specific GSH manuals developed by their services. Reeves and Stage found that patients using GSH, facilitated by a therapist, made significant improvements and that these were maintained at follow-up. The study used Likert scales, which are open to acquiescence bias. This is a tendency to agree to some extent with statements irrespective of their content (Johns, 2010). However, CORE-OM (Evans et al., 2000), a standardised evaluation system was also used (Mellor-Clark, Barkham, Connell & Evans, 1999). This is a suitable assessment

tool for clinical and research settings (Barkham, Gilbert, Conell, Marshall, & Twigg, 2005).

Similar to Reeves and Stage (2005), Philp et al. (2006) found that GSH delivered by a nurse was effective in treating depression and anxiety. Somewhat consistent with this, the study by Ricketts et al. (2008) found that although some changes were made in clients with panic, there were some who did not benefit. The three studies were uncontrolled pilot studies. Although this does not provide a strong evidence-base for clinical practice, this methodology identifies potentially beneficial interventions that require further investigation and evaluation (Evans, 2003). Further, the sample sizes for these studies were small, limiting the generalisability (Anderson et al., 2003). However, it is well known that recruiting participants to clinical studies that are representative of the population is difficult (Sadler, 2001).

In contrast to the above studies, both Meads et al. (2005) who investigated GSH and Fletcher et al. (2005), who investigated the same manual but with no guidance, found no additional benefits to patients. These findings contrast to other research, such as the meta-analysis by Scogin, Bynum, Stephens and Calhoon (1990), which found that SH treatments compared to controls had an overall treatment large effect size (r=0.96) and a review by Gellatly, Bower, Hennessy, Richards, Gilbody and Lovell (2007), which reported a growing evidence base of the effectiveness of SH interventions. As such, it is possible these findings are more indicative of the manual's effectiveness rather than SH in general. Nevertheless, the manual was found to have a priming effect: those patients who received a manual and went on to further therapy achieved better outcomes compared to those patients who had not been given a manual (Fletcher et al., 2005).

Both studies have a number of limitations. In the study by Meads et al. (2005), recruitment relied on staff identifying potential participants from information in referral letters. This may have biased the recruitment process leading to an unrepresentative sample (Greenhalgh, 1997). In the study by Fletcher et al. (2005) the sample size for this study was small (N=30), making it likely that it was underpowered (Cohen, 1988). This increases the probability of a Type II error: that is, not detecting an effect when one exists (Field, 2009). Both studies were RCTs. This methodology has strengths: in that it provides stronger evidence compared to other methodologies (Evans, 2003), and weaknesses: in that the ecological validity is limited (Simon, 2001). A strength of both studies was the use of procedures to ensure the research teams were blind to randomisation, preventing researcher bias (Simon, 2001).

Of the remaining four studies, three (Willemse et al., 2004; Farrand et al., 2008; Reeves, 2010) examined the effectiveness of GSH and one investigated SH services (Lovell et al., 2006).

The study by Willemse et al. (2004) found that patients with sub-threshold depression benefitted from minimal-contact psychotherapy. The main component of this was a SH manual, augmented by a face-to-face interview with a practitioner and six short telephone calls (maximum 15 minutes each). These calls were to support patients through the manual rather than of a therapeutic nature. These findings are consistent with the meta-analysis, which found that the effects of minimal-contact psychotherapy for depression are comparable to the effects of traditional psychotherapy and antidepressant medication (Cuijpers, 1997). Although this study adds to the evidence base, it was conducted in the Netherlands, which may not generalise to the UK (Willemse et al). Furthermore,

the sample sizes of each group (sub-threshold depression, N=107; TAU, N=109) were lower than the 200 needed in each group for achieving power (Cohen, 1988).

Similar to Willemse et al. (2004), Farrand et al. (2008) examined GSH clinics run by 'paraprofessionals'. These were GMHW who had little mental health training and experience. They found similar levels of effectiveness as compared to Lovell et al. (2003), which used experienced mental health nurses. This is consistent with the review by Gellatly et al. (2007) which reported that the level of experience of those providing GSH was not a significant factor in the effectiveness of GSH. It is also consistent with Williams and Martinez (2009) who found that how the facilitator engages and supports the patient is more important than his or her qualifications and professional background. A strength of this study was the large sample size (N=579). However, it was uncontrolled and therefore confounding variables were not taken into account (Field, 2009).

Reeves (2010) also found GSH to be effective. This study improved upon Farrand et al. (2008) by using a control group, which is helpful for identifying features salient to patients using GSH. Although the limited inclusion/exclusion criteria reflected a true clinical sample, this may have reduced the internal validity (Greenhalgh, 1997).

The studies by Willemse et al. (2004), Farrand et al. (2008), and Reeves, (2010) had high attrition rates. Although this is common in trials of psychological interventions (Fairhurst & Dowrick, 1996), this raises questions about how representative the samples are. Miller and Wright (1995) state that "attrition results in a potential threat of bias if those who drop out have unique characteristics such that the remaining sample ceases to be representative of the original sample" (p.921). As such, the findings from these studies need to be interpreted with caution.

Consistent with the majority of other studies, Lovell et al. (2006) found that a SH service was effective. Similar to MacLeod et al. (2009) it also found it was acceptable to clinicians and patients. This study used a mixed method design. Rocco, Bliss, Gallagher and Perez-Prado (2003) believe this methodology allows researchers to be insightful and highlights the importance of the phenomena being studied. With regards to the qualitative aspect, interviews were conducted over the telephone. This can lead to contradictory answers, increased evasiveness and response bias (Jordan, Marcus & Reeder, 1980). A strength of the study was the use of a third party to discuss themes identified, an important requirement for avoiding subjective judgements (Pope, Ziebland, & Mays, 2000).

In summary, the majority of the quantitative studies found that SH, particularly GSH, is effective in primary care settings. Two studies identified patient characteristics that are important for successful outcome and reported practitioners' views of SH materials (Lovell et al., 2006; MacLeod et al., 2009). A number of methodological weaknesses were found with the studies, particularly in relation to methodology and sample sizes. Only one study used a mixed methods design. However, a number of studies (Fletcher et al., 2005; Mead et al., 2005; Reeves, 2010) suggested that SH interventions could benefit from qualitative methods.

1.5.3.2 Qualitative Studies

Generally, qualitative studies have the advantage of providing richer data (Ashworth, 1997, as cited in Cutcliffe & McKenna, 1999). This is because it enables an in-depth exploration of complex phenomena (Strauss & Corbin, 1999). A summary of the aims of the research, participant information, research design, methods used to collect data, and findings can be found in table 2.

Table 2: Qualitative studies in chronological and alphabetical order.

Reference	Aim	Participants	Design & Analysis	Data Collection	Main Findings
Rogers, Oliver, Bower, Lovell, and Richards (2004)	To investigate patients' understandings of a primary care-based mental health SH clinic uses manuals, handouts and leaflets, videos and tapes.	Theoretical sampling, 15 patients with stress, anxiety and/or depression	Unspecified qualitative methods. NUD*IST.	Semi-structured interviews	1. Ethos underlying clinic well matched to patients' formulations of their problems. 2. Expectations about the purpose of clinic based on previous experiences. 3. Through experiences patients became aware of what SH involved. 4. Positive experiences contributed towards improvements in self-efficacy. 5. Differences between prior expectations and use of clinic. 6. Mechanisms of change identified: positive interactions with external and independent facilitator and learning from SH materials.
Lucock, Barber, Jones and Lovell (2007)	To investigate service-users' views of SH strategies and future research	Convenience sample, 49 service-users	Participatory action research. Thematic analysis.	Focus groups	1. Five strategies identified for managing lives: i) managing and structuring the day; ii) empowerment; iii) engaging others to help; iv) improving physical health and well-being; and v) spirituality for understanding the self and others. 2. Four sources of SH were found to be useful. 3. Five research priorities identified.

Reference	Aim	Participants	Design & Analysis	Data Collection	Main Findings
Lucock, Mirza and Sharma (2007)	To research service-users' views of a SH pack for anxiety	Purposive sample, 7 service-users with anxiety	Template analysis	Focus groups	1. Number of improvements to pack suggested: easier to read, cover less information, work with the pack as a group and more support to work through the pack. 2. Views on user participant identified.
Macdonald, Mead, Bower, Richards and Lovell (2007).	To investigate patients' perceptions of a 'minimal intervention' GSH.	Pragmatic sample, 24 adults with depression.	Constant comparison method (Strauss & Corbin, 1999). NUD*IST.	Semi-structured interviews; HADS; BDI.	1. Although unclear expectations about process, many patients expected a positive outcome. 2. Gaps between expectancies and experiences of process. 3. Difference in 'successful' outcome definitions between professionals and patients. 4. Concerns about maintaining improvement. 5. Perceptions that service unable to meet demands and impact of waiting lists found to influence patients' decisions to access further therapy.

Reference	Aim	Participants	Design & Analysis	Data Collection	Main Findings
Pratt, Halliday & Maxwell (2009)	To explore i) professionals' perceptions of the potential of SH for patients with MHP; and ii) service users' views of SH.	31 primary care professionals and 34 service-users.	Grounded theory.	Semi-structured in-depth interviews.	1. Professionals and service-users describe SH in different ways. 2. SH not perceived to be able to address the causes of mental distress. 3. Service-users fairly positive towards SH strategies. 4. Professionals need to be convinced that interventions are useful, effective and accessible.
Richardson, Richards, & Barkham (2010)	To test whether and to what extent authors have incorporated "common therapeutic factors" into SH books for depression.	Three SH books	Thematic analysis using four descriptions: highly prevalent; definitely prevalent; slightly prevalent; and little evidence	Based on framework analysis (Miles & Huberman, 1994).	1. Evidence that three SH books include examples of "common therapeutic factors" 2. SH books have potential to provide a valuable service to people with depression, but further work is needed to develop them. 3. Future generations of SH books should develop and investigate how factors, such as flexibility, responsiveness and alliance-rupture, can be woven into text. 4. SH programmes should be accompanied by guidance and support from mental health workers.

SH = Self-help; GSH = Guided self-help; GPs = General Practitioners; HADS = Hospital Anxiety and Depression Scale (Zigmond & Snaith,

1982); BDI = Beck Depression Inventory (Beck, Ward, & Mendelson, 1961); NUD*IST (Richards & Richards, 1991) = Computer

programme to assist qualitative data processing.

Rogers et al. (2004) found that the ethos underlying the clinic (to restore a sense of coping) was well matched to patients' formulations of their problems (i.e., perceived inability to cope). A number of other important areas were also identified (see table 2). The study appears relatively transparent and coherent (Smith, 2003). For example, reasons for adopting a qualitative approach were provided and a theoretical sample was appropriate given the iterative processes it employs to ensure robustness of an emerging theory (Marshall, 1996). The use of a dedicated computer package to facilitate analysis will have improved the rigour by helping searches for falsifying evidence (Murphy, Dingwall, Greatbatch, Parker & Watson, 1998). However, this may have prevented immersion in the data, identified as an essential part of the interpretative process (Waring & Wainwright, 2008). As the sample consisted of individuals who had completed treatment, it is not known what the views were of those who did not complete treatment. Thus, only a partial description of patients' understandings are provided (Macdonald et al., 2007)

Lucock, Barber et al. (2007) reported five strategies for helping service-users manage their lives. The study also identified research priorities, which are in line with policy guidelines (DH, 1999a,b). This was the only study that gained respondent validation, a method used to clarify and verify interpretations made from the research, which can increase the comprehensiveness of a study (Murphy et al., 1998). However, it also has the potential to confuse the researcher and findings (Willig, 2001). This study recruited participants from service-users' networks, which may have led to unbalanced views (Crawford, Aldridge, Bhui, Rutter, Manley, Weaver, et al., 2003).

Lucock, Mirza et al. (2007) suggested a number of improvements to a SH

pack for anxiety based on service-users' views. For example, difficulty with understanding the technical language led to a suggestion to make it easier to read. This is in line with recommendations made by Williams (2001) whereby SH materials should be delivered using "a format, structure, and content accessible to and understandable by the specific user" (p.235). Indeed, readability (Martinez, Whitfield, Dafters & Williams, 2008), along with cultural appropriateness and accessibility, are important factors to consider if SH interventions are to meet the needs of patients (Turpin, 2010). Good transparency and coherence was shown in documenting the stages of the research process. For example, data was analysed using a template analysis and the rationale for this was reported. Although purposive sampling was stated, it is unclear what type was used (Patton, 1990). A weakness of the study is the small sample size, meaning theoretical saturation may not have been achieved (Glaser, 1992).

Both studies by Lucock and colleagues (2007) used focus groups. Although this can lead to large amounts of detailed data in a relatively short time-period (Rabiee, 2004), members may feel uncomfortable with one another and find it difficult to engage in discussions (Krueger & Casey, 2000).

Macdonald et al. (2007) found that although patients had a lack of clear expectancies about the process, many expected a positive outcome. They also found important gaps between expectancies and experiences of psychological therapy relating to the process. This included the waiting list, sharing personal problems, despite the required "facilitative interpersonal style" being present, the credibility of strategies, and seeking insight into the 'cause' of problems, rather than symptom resolution. Often patients reported benefits from GSH in terms of magnitude and duration. This study also highlighted the impact of waiting lists on

patients' decisions to access further therapy. Although this study was part of a RCT, considered to be the 'gold standard of research' (Abel & Kock, 1999), the strict exclusion/inclusion criteria for participants will have limited the transferability of findings (Kuper, Lingard & Levinson, 2008). Similar to Rogers et al. (2007), the analysis was facilitated by NUD*IST (Richards & Richards, 1991) and therefore the same critique applies. Analyses of those who participated and those who did not, indicated that experiences were not influenced by demographic characteristics or BDI scores. Therefore, the sample reflects the diversity of a given population, an important aspect of qualitative research (Crabtree, Miller & Kuzel, 1992). This study also acknowledged how retrospective recall can bias accounts of expectations and experiences (Williams & Healy, 2001).

Pratt et al. (2009) explored professionals' perceptions of SH as well as service-users. They found differences between professionals and service-users descriptions of and attitudes towards SH. In line with MacLeod et al. (2009), although service-users were fairly positive towards SH, some with depression reported that a lack of motivation and confidence acted as a barrier to engaging with SH. This has the potential to reinforce views of self-blame. As such, this study suggests that clear information needs to be provided about what SH offers: a recommendation consistent with Khan et al. (2007). Detailed accounts of participants, analysis and data collection are provided and the sample size was large, suggesting theoretical saturation was achieved (Glaser, 1992). However, this may have prevented such an in-depth analysis, which is the 'raison-d'etre' of qualitative inquiry (Sandelowski, 1995).

Richardson et al. (2010) is the only study to have investigated the role of

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the therapeutic relationship in three SH books for depression: 'A SH Guide to Managing Depression' (Barker, 1997); 'Overcoming Depression' (Gilbert, 2000); 'Mind over Mood' (Greenberger & Padesky, 1995). They found evidence that all three books incorporated "common therapeutic factors", such as being accessible and negotiation of goals. Although this is an important area of research, this study has a number of limitations. For example, the theoretical literature, defined as "the underpinnings of the research method itself" (Smith, 2003, p.232), is not stated and therefore it is difficult to ascertain coherence (Yardley, 2000). There are no definitions for the categories used to analyse the data (e.g., 'highly prevalent'), limiting the transparency (Yardley, 2000). However, all three authors were involved in the analysis of data, reducing the subjectivity introduced by a single researcher (Pope et al., 2000).

Overall, all six studies contribute to a better understanding of how SH interventions are perceived and where improvements can be made. However, a number of limitations are highlighted in relation to transparency, coherence, commitment and rigour (Yardley, 2000).

1.5.4 Discussion of Previous Research

A comprehensive review of the research highlights a number of important themes: i) SH versus GSH; ii) whether SH interventions are psycho-educational, therapeutic or both; iii) therapeutic alliance; iv) self-efficacy; v) expectations; and vi) depression versus anxiety. These will be addressed in-turn.

1.5.4.1 Self-Help Versus Guided Self-Help

Of the 16 studies, four researched 'pure' SH (Fletcher et al., 2005; Lucock, Mirza et al., 2007; Pratt et al., 2009; Richardson et al., 2010) eight explored GSH (Farrand et al., 2008; Willemse et al., 2004; Macdonald et al., 2007; Mead et al.,

2005; Philp et al., 2006; Reeves, 2010; Reeves & Stage, 2005; Ricketts et al., 2008), and four investigated SH services (Lovell et al., 2006; Lucock, Barber et al., 2007; MacLeod et al., 2009; Rogers et al., 2004).

There is a long-standing debate about what types of SH interventions are more effective than others (Richardson, Richards & Barkham, 2008).   Five of the eight studies investigating GSH found that patients improved (Farrand et al., 2008; Willemse et al., 2004; Philp et al., 2006; Reeves, 2010; Reeves & Stage, 2005) and all studies reported to find the intervention helpful. In comparison, findings were mixed in those studies investigating 'pure' SH. For example, Fletcher et al. (2005) found that 'pure' SH did not lead to improvements and Richardson et al. (2008) concluded that SH programmes should be accompanied by guidance and support from professionals. Other studies made similar recommendations, such as Lovell et al. (2006) who concluded that the success of a SH service depended on sufficient support.

These findings are in line with the reviews by Mains and Scogin (2003) and Gellatly et al. (2007), which found that GSH is more effective than the provision of information alone. However, a number of books have been identified as beneficial for people with a range of MHPs (Williams, 2005). Further, research has shown that adding practitioner contact did not benefit clients (see Williams & Whitfield, 2001). For example, Furmark et al. (2009) found that bibliotherapy (and internet delivered CBT) for social anxiety can be effective without guidance. This contrasts with research by Rapee, Abbott, Baillie, and Gaston (2007) who found that 'pure' SH has limited efficacy for managing social phobia, whereas augmenting this with group sessions shows potential. Indeed, recent plans and implementations have focused on

Practitioners delivering low-intensity treatments through a variety of formats, such as telephone, email and groups (Bee et al., 2008).

Of those studies that investigated GSH, only Farrand et al. (2008) explicitly explored whether the type of professional offering guidance and length of the support session impacted on the effectiveness. They compared their findings with Lovell et al. (2003). Whilst Farrand et al. used 'paraprofessionals' and 2-hour support sessions, Lovell et al. used mental health nurses and 20-minute support sessions. Comparable levels of effectiveness were found, although there were differences in the efficiency of the clinics: the 'paraprofessional' clinic being less efficient. The optimal amount of therapist contact time and type of professional is another area which recent work has focussed on (Warrilow & Beech, 2009).

Research has also highlighted the importance of patient characteristics for whether SH or GSH should be used. For example, Newman, Erickson, Przeworski, and Dzus (2003) in a review of the literature, found that whilst 'pure' SH is most effective for the more motivated patents with simple phobias, 'minimal-contact' therapies demonstrated efficacy for the greatest variety of anxiety disorders. The importance of patient characteristics is highlighted further by the Doncaster and Newham evaluation, which found that commitment and persistence contributed towards improvements (Parry et al., 2009).

In summary, these findings indicate that the type of disorder and individual differences in motivation and other characteristics needs to be considered when deciding whether 'pure' SH or GSH would be most effective (Turpin, 2010). Furthermore, a report of the IAPT sites indicates that several sites tend to use a combination of guided and 'pure' SH (Glover, Webb, & Evison, 2010). Thus, rather than it be SH versus GSH, the recent emphasis is on what will work for the patient.

1.5.4.2 Are Self-Help Interventions Psycho-educational, Therapy or Both?

According to Turpin (2010), psycho-education is a more general approach, in which therapeutic information is provided. This involves written materials, support and advice from professionals, group discussions and teaching sessions. In comparison, GSH is a structured treatment method which requires the recipient to help themselves by working through the SH material with the support of another person (Lucock et al., 2007). This highlights the importance of Zygotsky's ZPD, in which the MKO 'guides' individuals in their learning.

Although SH interventions have very clear educational goals (Williams & Whitfield, 2001), a number of the studies highlight that these also include therapeutic elements. For example, Reeves and Stage (2005) found that the most popular modules were learning relaxation techniques, whilst Rogers et al. (2004) found that positive interactions with an independent facilitator and learning from SH materials helped patients to change. This shows that SH interventions are important for teaching patients how to manage their MHPs and that psycho-education is an important aspect of this process. This is consistent with Cuijpers and Schuurmans, (2007) who report that common components for SH interventions for anxiety are: psycho-education, relaxation, graded exposure, cognitive restructuring, and anxiety management and other techniques.

Most forms of psychotherapy stress the importance of a therapeutic relationship, which is considered to be an essential factor to patients' recoveries (Warrilow & Beech, 2009). Two studies highlighted the importance of interventions being therapeutic (Lovell at al., 2006; Richardson et al., 2010). Both studies emphasise therapeutic factors that enhance SH interventions, such as responsiveness and flexibility. As noted in section 1.4.3.3 Therapist and Patient Factors Contributing

to the Alliance, these qualities are important for developing a therapeutic alliance. The importance of a therapeutic alliance has been reported in the evaluation of the Doncaster and Newham sites (Parry et al., 2009) and highlighted by Turpin (2010) in 'Good Practice Guidance'. Therefore it appears that SH interventions are both psycho-educational and therapeutic. The therapeutic nature of GSH is emphasised further in the section below.

1.5.4.3 Therapeutic alliance

A number of studies referred to different aspects of the therapeutic alliance. Five studies (Macdonald et al., 2007; Mead et al., 2005; Reeves, 2010; Richardson et al., 2010; Rogers et al., 2004) identified empathy and a supportive environment as important. In the study by Reeves contact with a clinician was valued, whilst Mead et al. found high levels of patient satisfaction with facilitators. Reasons for these were not provided, which may be due to the quantitative designs. More specifically, Macdonald et al. found that, although facilitators demonstrated the required "facilitative interpersonal style", sometimes patients felt their desire for self-disclosure was not met. This was attributed to the structured confines of the GSH. However, one would expect that, regardless of the type of SH, an underlying theme to all SH is the opportunity to acknowledge and share thoughts and feelings.

Another aspect of therapeutic alliance highlighted by studies was related to the SH interventions. Richardson et al. (2010) referred to the importance of negotiating goals. Two studies referred to the importance of learning strategies (Fletcher et al., 2005; Rogers et al., 2004) and three studies found that patients were satisfied with the intervention in general (Fletcher et al., 2005; Willemse et al., 2004; Reeves & Stage, 2005). However, it is unclear whether patients perceived the strategies as credible. Only Lovell et al. (2006) reported that patients perceived SH interventions appropriate

to their needs and effective. In contrast, Macdonald et al. (2007) and Mead et al. (2008) found that for some patients' strategies were not seen to be relevant. However, this did not appear to be associated with poor therapeutic alliance. This contrasts with Ackerman and Hilsenroth (2001, 2003, as cited in Roth & Fonagy, 2005) who report that patients' perceptions of interventions are associated with the formation of a positive alliance.

Interestingly, no studies reported how patient and professional characteristics may contribute towards a positive alliance. Other research has shown these factors to be important. For example, Campbell and Smith (2003) found a number of patient characteristics, such as age, education, level of motivation, psychological mindedness and readiness for change to be important, whilst Banasiak, Paxton and Hay (2007) found the style of the facilitator (in this case the GP) was particularly important. Specifically, positive and negative characteristics were identified as the most and least effective aspects of treatment respectively. As such, patients' and professionals' contributions to the therapeutic alliance would be an interesting area to explore further.

1.5.4.4 Self-efficacy

Four studies (Lucock, Barber et al., 2007; MacLeod et al., 2009; Reeves, 2010; Rogers et al., 2004) explicitly reported that a belief in being able to cope was important. A common theme in these studies was the practical strategies people learnt, helping them to regain a sense of control over their lives (e.g., Reeves). In three of the studies, it is not clear whether positive outcomes impacted on levels of self-efficacy. Only Rogers et al. (2004) made a link between positive experiences (presumably influenced by positive outcomes) contributing towards improvements in self-efficacy.

Interestingly, two studies (Farrand et al., 2008; Macdonald et al., 2007) highlighted patients' concerns about having support available to maintain initial improvements and prevent relapse. This may be indicative of the facilitators playing an important role in enhancing the self-efficacy of patients. This conflicts slightly with the notion that self-efficacy is about a patient's *own* belief in being able to make changes. Further, the idea that SH encourages people to take responsibility to manage their own symptoms and mental health (Richards, 2004) is questionable if they continue to rely on external sources of help. That said, people often rely on external sources of help when struggling and this does not appear to have an impact on their self-efficacy. Thus, self-efficacy may relate to where people locate the responsibility for making changes: whether it is internal or external.

1.5.4.5 Expectations

Patient expectations have been identified as an important factor influencing implementation of SH (Turpin, 2010). Three studies reported findings related to expectations. Whilst Macdonald et al. (2007) reported that patients were unsure about what to expect and/or had expected positive outcomes, MacLeod et al. (2009) found higher levels of patient expectancy were associated with a more successful outcome. The other study (Rogers et al., 2004) found that participants often referred to whether they expected a "quick fix". These findings are similar to Mansell (2007) who found that expectations of what SH can offer were mixed. The importance of expectations has also been highlighted by the Doncaster and Newham evaluation, whereby the expectation of a patient impacted on a decision to access services and the lack of information giving meant a patient was unsure what to expect (Parry et al., 2009).

Rogers et al. (2004) and Macdonald et al. (2007) also found differences between what people were expecting and their actual experiences. Both reported that

expectations were unfulfilled. Reasons for this included experiences related to the process. To address this, guidance on the use of SH materials has been provided (Turpin, 2010). This encourages Practitioners to introduce SH materials sensitively so that expectations can be managed and provides information on how to choose the "right" materials.

1.5.4.6 Anxiety Versus Depression

Of the 16 studies, four explored anxiety and/or stress (Lucock, Mirza et al., 2007; Reeves and Stage, 2005; Reeves, 2010; Ricketts et al., 2008), three investigated depression (Willemse et al., 2004; Macdonald et al., 2007; Richardson et al., 2010), five investigated both anxiety and depression (Farrand et al., 2008; Fletcher et al., 2005; Mead et al., 2005; Philp et al., 2006; Rogers et al., 2004), and four were focussed on more general SH interventions and therefore a range of MHPs were present (Lovell et al., 2006; Lucock, Barber et al., 2007; MacLeod et al., 2009; Pratt et al., 2009).

Two of the four studies that investigated anxiety found that patients improved (Reeves and Stage, 2005; Reeves, 2010). In contrast, Rickets et al. (2008) found there were some patients with panic who did not improve. Reasons were not suggested as to why this was. These findings are consistent with the meta-analysis by Hirai and Clum (2006). They reviewed 33 studies that tested the effectiveness of SH interventions for individuals with anxiety and found that SH was moderately effective. However, they also found that SH interventions for treating the range of anxiety disorders were limited.

The three studies that investigated depression were generally positive. Willemse et al. (2004) reported that patients with sub-threshold depression can benefit from GSH and that patients were satisfied with their treatment. Similarly, Richardson

et al. (2010) found that SH books can be useful for patients with depression. However, the evidence in the wider literature is varied. For example, Whitfield and Williams (2006) in a review of SH books for depression report that the evidence for their effectiveness is varied. Similarly, Anderson et al. (2005) reported that there is little direct evidence of the effectiveness of SH books for depression and weak evidence for when patients are given additional guidance.

There was mixed findings for the studies that investigated both anxiety and depression. Whilst Fletcher et al. (2005) and Mead et al. (2005) found that patients with anxiety and depression did not improve from SH interventions, Philp et al. (2006) and Farrand et al. (2008) found that patients did improve. Rogers et al. (2004) found that patients' experiences led to changes, not just whether they improved, but their understanding of the interventions. These latter findings are somewhat consistent with the systematic review by Bower et al. (2001). They reviewed eight studies that examined the effectiveness of SH treatments for anxiety and depression and concluded that these had potential.

Finally, those studies that were not specific about the MHP found that patients (Pratt et al., 2009) and professionals (Lovell et al., 2006) were generally positive about SH interventions. However, as 10 studies were quantitative, information on how SH interventions are viewed is limited.

Of the six qualitative studies, only Macdonald et al. (2007) explored GSH for depression. Whilst there has been a meta-synthesis of qualitative studies of patient experience of primary care management for depression (Khan et al., 2007) there does not appear to be an equivalent for anxiety. There has also been qualitative research into developing a model of collaborative care for depression (Richards et al., 2006), patient experiences of receiving collaborative care for depression (Simpson, Richards,

Gask, Hennessy & Escott, 2008) and a qualitative study focusing on GP and patient

goals for depression management (Johnston et al., 2007). This suggests there is more

research exploring experiences of 'minimal interventions' for depression, as opposed

to anxiety.

In summary, there is a range of studies investigating anxiety, depression and

MHPs. Studies investigating anxiety and depression separately reported more

improvements compared to when the two were investigated together.

1.5.5 Conclusions and Future Directions

The literature review highlights a range of studies investigating SH

interventions and a number of different themes. However, there is limited research

into how people perceive and experience SH (Lucock et al., 2007). Khan et al. (2007)

argue that in order to develop more effective and acceptable SH for individuals it is

important to understand what their experiences are. Of the 16 studies, only

Macdonald et al. (2007) explored patients' perceptions of GSH for depression. There

appears to be no research into this area for GSH for anxiety. Although this study has

a number of strengths, there are also a number of limitations. In particular, this study

was not based in a routine clinical setting. More studies in clinical settings are

necessary, to ascertain whether findings are consistent and to provide practice-based

evidence. Therefore this thesis aims to help fill this gap by researching patients'

perceptions and experiences of GSH for anxiety in a routine clinical setting.

1.6 What is Anxiety?

As this study focuses on GSH for anxiety, it is important to clarify what is

meant by anxiety. This section starts with a definition of anxiety, followed by

information on prevalence and co-morbidity. Although there are a number of specific

anxiety disorders in which the thematic content and maintenance processes differ, there are common features shared by them all and, to some degree, commonalities in effective treatment interventions (Butler, Fennell & Hackmann, 2008). As this study is interested in identifying common themes for GSH for anxiety, the commonalities in the underlying processes and interventions across anxiety disorders are focused on.

1.6.1 Definition of Anxiety

The Cognitive "Specificity" Hypothesis argues that anxiety involves the perception of physical or psychosocial danger, with an underestimation of coping and rescue factors (Butler et al., 2008). This perception of danger can be immediate, as in the case of panic attacks, or more related to the future, as in health anxiety. People's anxiety can be related to a specific stimulus, such as in a snake phobia, or can be more general and involve worrying about everyday and future things, as in GAD. Underlying all anxiety disorders is excessive fear and avoidance of a feared situation. As such, an individual's anxiety is not given the opportunity to extinguish (Mowrer, 1960, as cited in Carr & McNulty, 2006).

1.6.2 Prevalence and Co-morbidity of Anxiety

In 2000, anxiety was found to be one of the most common mental disorders (Office of National Statistics; ONS, 2006). There were 44 cases of GAD per 1000 adults, and phobias, obsessive-compulsive (OCD) and panic were found to range from 26 to seven cases per 1000 adults (Singleton, Bumpstead, O'Brien, Lee & Meltzer, 2000).

Numerous surveys have shown that people often present with co-morbidity. Kessler, Chiu, Demler and Walters (2005) found co-morbidity rates were particularly high for GAD with a major depressive episode, panic disorder with agoraphobia and social phobia with agoraphobia. In 2001, Brown, Campbell, Lehman, Grisham, and

Mancill found that 43% of their patients attending an anxiety disorders clinic had more than one anxiety disorder and 28% had a mood disorder. They found that co-morbidity rates with a current mood disorder were highest for GAD (26%) and panic disorder with agoraphobia (24%). These data show that an anxiety disorder rarely occurs in isolation. This highlights the need for Practitioners to be flexible with which manuals they use and how they use them.

1.6.3 Commonalities Underlying Anxiety Disorders

The literature shows that although there are specific models for different anxiety disorders, there are common features underlying many of them (Butler et al., 2008). These include: i) dysfunctional appraisals; ii) cognitive biases; iii) avoidance and safety behaviours; and iv) positive reinforcement cycles between cognitions, symptoms, and behaviour (Wells, 1997). These commonalities lead to a number of common interventions across the anxiety disorders.

These interventions focus on cognitions and behaviour. The cognitive work involves challenging negative automatic thoughts and misinterpretations, and identifying thinking errors, such as 'mental filtering', 'catastrophisation' and 'personalisation'. The behavioural work involves decreasing avoidance and dropping safety behaviours, usually by carrying out behavioural experiments (Butler et al., 2008). Underpinning these interventions are the concepts of extinction and the role of avoidance (see Mowrer 1960). These interventions are in line with NICE guidelines for anxiety (DH, 2007) and direct much of the content of the manuals used for GSH.

1.7 This Study

This section starts with a description of the manuals used to treat anxiety and the service context. A brief outline of the method used and the rationale for this study is then provided, before the research questions are stated.

1.7.1 Manuals

IAPT services in the CPFT offer a range of GSH manuals, based on CBT, for a variety of anxiety disorders. These include 'Coping with Anxiety' in addition to more specific manuals, such as 'Coping with Panic'. All the manuals follow a similar format, beginning with psycho-education about anxiety or the specific problem, such as panic. This psycho-education includes facts about problems, helping to dispel common myths about them. Although the order in which information is provided varies, each manual includes information about the role of thoughts and/or behaviours in maintaining problems, and techniques for how to go about changing these. Many of the exercises in the manuals are behavioural. For example, in 'Coping with Anxiety' there is a section on 'Applied relaxation' and another on 'Distraction'. When new behaviours are put into practice, the manual encourages patients to process this cognitively: that is think about what this new behaviour means to them and restructure their cognitions accordingly. The manual for 'Coping with anxiety' also includes information on 'A good night's sleep' and identifying positives.

1.7.2 Service Context

This study was conducted in four clinical IAPT settings covering different geographical areas in the CPFT. Reasons for using four services were to: i) try to recruit people with different demographic characteristics and clinical information; and ii) ascertain whether common themes could be identified regardless of the different services. These services usually provide up to six sessions of GSH, using the manuals

described above, and normally involve face-to-face contact with a Psychological Wellbeing Practitioner. The experience of these Practitioners varied from 3 months and more, and all were either in the process of training or qualified. Although differences in experience may have an impact on the quality of GSH patients receive, it was thought important not to exclude less experienced Practitioners. This was because IAPT services tend to have a high turnover of Practitioners who go on to further their careers. Using Practitioners with a range of experience therefore offered a better reflection of the service context.

1.7.3 Method and Rationale

This study used a qualitative design to explore patients' perceptions of GSH for anxiety in routine clinical settings. A semi-structured interview was developed based on the literature review findings. By doing this it was hoped that an in-depth understanding of patients' perceptions would be obtained, in particular their expectations, experiences and views on what they consider to be important influences on their experiences.

1.7.4 Research Questions

In light of the above, this study aimed to address the following research questions:

1) What are patients' expectations concerning GSH for anxiety?

2) To what degree do patients' experiences of GSH meet those expectations?

3) Are self-efficacy and therapeutic alliance important influences on patients' experiences?

2 METHOD

2.1 Chapter Overview

This chapter aims to provide an overview of how the study was conducted and explains why methodological decisions were made. Section 2.2 describes the study design. This includes the rationale for a qualitative approach, ontological and epistemological position, rationale for using template analysis and rationale for using interviews. Section 2.3 describes the participants. This starts by describing the sample size and selection criteria, followed by assessment of anxiety and depression and then sampling. Section 2.4 describes the ethical considerations before and during the research. Section 2.5 describes the procedure, which includes the development of the interview guide, recruitment, the interview process, interview setting, outline of the data analysis and the feeding back of results to participants. Finally, section 2.6 describes validity and trustworthiness aspects. Excerpts from the researcher's reflective diary are provided from sections 2.4 to 2.6. Its relevance and importance are discussed in the final section.

2.2 Design

2.2.1 Rationale for Qualitative Approach

At assessment and review sessions of GSH, patients are given IAPT Patient Experience Questionnaires: Part 1 (PEQ1) focuses on patients' views and experiences of choices they had whilst accessing the service; Part 2 (PEQ2) focuses on how satisfied patients are with the service received (Care Services Improvement Partnership; CSIP, 2006/07). At the final session patients are also given an opportunity to discuss their experiences of the GSH, albeit with their Practitioner

(Z.Cooper, Psychological Wellbeing Practitioner, personal communication, November 6, 2009). Although data are gathered indicating patients' experiences of the GSH, there is little opportunity for people to elaborate on their experiences and important information may be lost. The importance of exploring patients' perceptions for improving the acceptability and effectiveness of GSH has already been highlighted. As such, an exploration of patients' expectations and experiences of GSH, in-depth, is necessary. This was also recommended by one of the IAPT Team Leaders (J. Clarke, personal communication, October 20, 2008). Research into SH appears to have identified self-efficacy and therapeutic alliance as important psychological constructs which impact on patients' experiences. Thus, it was also important to explore these, whilst allowing other previously unidentified factors to emerge.

Qualitative methods have been increasingly used in areas of health services research and health technology assessment (Mays & Pope, 1995). It is argued that such methods are well placed to explore patients' perspectives of interventions (Yardley, 1997), providing a rich source of information on different aspects of treatment (Bell, 2003). Qualitative research offers a variety of methods to develop understanding and investigate areas that are not easily quantifiable (Pope, Van Royen, & Baker, 2002). It considers context to be important and enables an in-depth exploration of complexities and processes involved in phenomena, such as lived experiences, feelings, thought processes, cultural and social issues (Strauss & Corbin, 1999). It is useful for generating hypotheses and allows a flexible approach to data collection and analysis. In qualitative research, the personal involvement of the researcher is emphasised. Therefore, it is important that researchers are transparent

about their assumptions and the impact they have on the research process (Elliott et al., 1999).

2.2.2 Ontological and Epistemological Position

Within qualitative research there are a number of different overlapping academic and professional approaches to common subject matter (Smith, 2003; Madill, Jordan & Shirley, 2000). This study occupies a critical realist position, similar to the stance taken by Snape and Spencer (2003). Critical realism argues that, although the social world exists independently of individual subjective understanding, this is only available through an individual's interpretations, which are interpreted further by the researcher. This compares to the realist tradition, which assumes that experience can be directly understood and that knowledge corresponds with truth (Farmer & Gruba, 2004).

In critical realism each person interprets their experiences through their own 'lens', which is influenced by their history, culture and society. This 'lens' impacts on how information is received and expressed. Critical realism emphasises the individual's interpretations of relevant research issues and accepts that different 'lenses' yield different types of understanding. It argues that external reality is diverse and multifaceted. To enhance understanding of our experience of reality, critical realism endorses an idea that information is gathered from multiple perspectives. In this study different participants provide these multiple perspectives.

2.2.3 Rationale for using Template Analysis

Different epistemological emphases help direct what methods are used. A template approach can be used within a range of epistemologies, from realist to more constructionist positions (King, 2007). Template analysis refers to a particular way of thematically analysing qualitative data (King). It has been

established as an appropriate methodology for exploratory research into people's experiences (e.g., Kent, 2000; King, Carroll, Newton, & Dornan, 2002) and is now well established in healthcare qualitative research (King, 2004).

King (1998) describes template analysis as occupying a position between grounded theory (Glaser & Strauss, 1967) and content analysis (Weber, 1985). Grounded theory is a method of analysing data without preconceived theories (Glaser & Strauss). Since previous research in this area suggests a number of theories, it would be difficult to analyse data using a grounded theory approach. In comparison, although content analysis uses either emergent or a priori coding, these are predetermined before data analysis takes place (Stemler, 2001). This was viewed as too restrictive for this study, where knowledge about patients' perceptions of GSH is still evolving. As such, it was not possible to create reliable and valid predetermined codes required for content analysis.

A template approach includes a priori and emergent themes. It facilitates both: a deductive approach, where existing knowledge from previous research is included and allows researchers to set their assumptions out explicitly; and an inductive approach, where themes emerge in the data analysis based on the research questions. Templates may be modified during the research to allow for unpredicted or novel themes to emerge (King, 1994). As such, template analysis provides a flexible approach to data. Comparison of the a priori template with the final template shows how the data have led to a changed understanding. This approach, therefore, uses a systematic and transparent process to data collection and analysis.

2.2.4 Rationale for Interviews

There are a number of reasons for using semi-structured interviews. Firstly, interviews are an ideal way to explore experiences and complex processes that cannot be captured through using questionnaires (Burman, 1999). Secondly, interviews can be modified during the research, to add topics that have not originally been included or drop those that are incomprehensible and repeatedly fail to elicit responses relevant to the question (King, 1994). Thirdly, interviews are more accessible to participants who prefer to be seen at their home.

2.3 Participants

2.3.1 Sample Size and Selection Criteria

In qualitative studies there is no set sample size (Mason, 1996). Forman and Arbor (2005) believe that due to an underestimation of how much information can be gained from data, researchers in health services tend to over-sample when using qualitative methods. At the same time, sample size should not be so small that it is not possible to achieve theoretical saturation (Leech, 2005). Theoretical saturation is a concept originating from grounded theory (Sandelowski, 1995) and refers to a point at which no new themes or patterns appear in the data.

Ten participants were interviewed. This was deemed an adequate sample size to achieve a broad representation of views and to demonstrate the occurrence of less common themes, whilst giving weight to a priori themes identified in previous research. However, due to time limitations, it was not possible to achieve data saturation (see section 4.5 Critical Appraisal).

The selection criteria for participants were purposefully broad in order to gain a range of perspectives. The following criteria were used to determine inclusion or exclusion of participants:

Inclusion criteria:

1. Aged between 18 and 65 years

2. Primary diagnosis of anxiety. This could take the form of generalized or health anxiety, phobias, OCD and panic, with or without agoraphobia. Due to the high rates of co-morbidity, participants were also included if they were experiencing depression, as long as their primary diagnosis was anxiety. Practitioners assessed anxiety using the seven-item Generalized Anxiety Disorder Assessment (GAD-7; Spitzer, Kroenke, Williams & Lowe, 2006) and depression using the nine-item depression scale from the Patient Health Questionnaire (PHQ-9; Spitzer, Kroenke, & Williams, 1999) from the IAPT Outcomes Toolkit (2008/9).

3. Completed or discontinued the GSH

Exclusion criteria:

1. Thought to be actively abusing drugs or alcohol during or following GSH. This was made on the grounds that it would it have influenced their perceptions and made it difficult to gain informed consent.

2.3.2 Sampling

Leech (2005) stresses the importance of providing reasons for the sampling schema. For this study, the sample needed to be representative of patients receiving treatment in a clinical setting. To achieve this in the allotted timeframe pragmatic sampling was used. This involved elements of both convenience sampling (i.e., selection of the most accessible participants) and purposive

sampling (i.e., the researcher actively selects the most productive sample to answer research questions; Marshall, 1996). Convenience sampling is often criticized for being the least rigorous technique, whereas purposive sampling is generally viewed to be a better approach (Marshall).

Efforts were made to study a broad range of participants by recruiting from four IAPT sites in the CPFT. This was based on the purposive sampling of maximum variation (Marshall, 1996). It was hoped this would lead to a sample representative of different ages, genders, ethnicity, living areas, socio-economic-status, presentations of anxiety, treatment outcomes and include treatment completers and non-completers. Although all participants who were interviewed had completed their treatment, the outcome of this varied. For a description of the participants see section 3.2 Relevant Information.

2.4 Risk and Ethical Considerations

Ethical approval was obtained from the relevant Local Research Ethics Committee (LREC; Appendix A) and Local Research and Development Governance (Appendix B). Due to recruitment difficulties a substantial amendment was submitted to the LREC and approved (Appendix C). The Research and Development Governance was subsequently informed. Guidelines for ethical practice were also followed (Hewitt, 2007).

2.4.1 Informed Consent

Practitioners were asked to give information packs to patients at the first session and to those who were currently receiving treatment. In addition, Practitioners where asked to send information packs to people who had completed or discontinued treatment in the previous six months. These information packs included

a letter inviting them to participate, with a slip at the bottom to provide their contact details (Appendix D), a participant information sheet (PIS) about the research rationale (Appendix E), a consent form (Appendix F) and a stamped addressed envelope. The researcher's contact details were also included should people have any queries. Interested participants were asked to complete the slip with their contact details and post it with the consent form. Potential participants were informed that should they agree to participate a letter would be sent to their GP informing the GP of their participation (Appendix G). Potential participants had from the time they were provided with the information packs until the end of February 2010 to decide whether they would like to participate. This deadline was set to ensure adequate time to allow in-depth data analysis.

Practitioners were encouraged to emphasise: i) the voluntary nature of the study; and ii) that patients' decisions would not impact on future treatment from the service. The researcher reiterated this when contact was made in writing (Appendix H), by telephone and at the interview. On each occasion potential participants had the opportunity to ask any questions concerning their participation.

The reason for using a digital voice recorder was explained: that the interview needed to be recorded for verbatim transcription. Participants were informed they could refuse permission, that the recorder could be switched off during the interview or wiped at any point during or after the interview. Consent for recording interviews was gained from all participants. Participants were informed that they were free to withdraw their consent at any point and could ask to see any data held about them. Participants were informed a professional transcription service might be used once all personally identifying information had been removed. All participants gave consent for this. Participants were informed

that, with their permission, quotes might be used within the write up of the research, however, all identifying information would be removed to help preserve anonymity. It was highlighted to participants that people who know them may be able to identify them by their use of language.

2.4.2 Confidentiality

Interviews took place at the participant's home or in a private room at one of the IAPT sites. Although the latter provided better protection for confidentiality and privacy, the majority of participants preferred the interview to take place in their home. Participants who chose to be interviewed at home were encouraged to arrange a time when there would be minimum interruptions.

A 'confidentiality policy' was included within the PIS and read to each participant before the interview. This stated exceptional circumstances in which the researcher could break confidentiality.

2.4.3 Data Protection and Anonymity

Interviews were recorded on a digital voice recorder. Principles set out by the Data Protection Act (1998) were adhered to for managing these recordings and other data. All participants were given an identification number so that their name and demographic details could be kept separate from the study data. Recordings were transcribed as soon as possible following the interview and each line of the transcript was numbered. Personally identifying references were replaced, for example '[city]' instead of 'Cambridge'. These transcriptions were then given the appropriate identification number. The recordings and transcriptions were kept in a locked filing cabinet and were destroyed on completion of the research. Only the researcher and supervisors had access to the raw data.

2.4.4 Managing Risk and Distress

The researcher tried to minimize the distress participants may have felt by encouraging them to take an expert position in which their opinion was respected. However, it was recognised that specific topics could have arisen which participants found distressing. If participants were to become distressed, the researcher would have asked whether they wanted to talk about their concerns, move on or terminate the interview. If any areas of concern were to become apparent during the interview, these would have been discussed with participants and they would have been reminded of the 'confidentiality policy'. If necessary, and if full consent was provided, these concerns would have then been discussed with the appropriate professional (i.e., GP or Practitioner) involved in their care. The need for this did not arise. However, there were occasions when issues arose that required further discussion, in order to assess whether these needed to be followed up. See section 2.4.6 Ethical Issues Arising During the Research.

Supervision for the researcher was available from her supervisor. On a few occasions this support system was accessed to discuss matters arising from interviews.

2.4.5 Other Issues

If participants, who completed or discontinued treatment up to six months prior to this study, had shown or reported difficulties, they would have been encouraged to speak to their GP.

Practitioners may have been concerned the research would scrutinize their own work. They were informed that the principles of informed consent, confidentiality, data protection and anonymity used for participants would also apply

to them. It was emphasised that Practitioners would not hear recordings and that

information gathered would be used to inform service provision, not clinical practice.

When interviews took place in participants' homes the researcher adhered

to the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). policy

'Working alone in safety' (Rospopa, 2008).

2.4.6 Ethical Issues Arising During the Research

During interviews there were topics that arose that required further

exploration. For example, one participant disclosed previous suicidal ideation.

The participant was asked whether this had been discussed with their Practitioner

to which they responded that it had. Protective factors were explored and the

participant clearly stated that there was no suicidal ideation at present. The

participant reported current contact with a number of mental health services.

Following this discussion it was felt that professionals involved in this

participant's care were aware of the situation and, as such, it was not necessary to

pursue this.

Excerpt from reflective diary:
The interview I did today showed that I have a clinical responsibility and obligation to explore information participants' give that implies a potential risk to themselves or others. As well as a researcher I am also a clinician and I don't think it is possible to separate the two. I found my skills developed during training enabled me to discuss the information that arose and make an informed decision that it was not necessary to take this further.

In many of the interviews participants reported that they had been feeling

anxious before the interview. When talking about their experiences, some

participants also spoke about how they often become anxious in the company of

unfamiliar people. The researcher highlighted that participants only needed to talk

about things that they were comfortable with. At the end of each interview the

participant was asked about their interview experiences and if relevant, how they

had found talking to an unfamiliar person.

> Excerpt from reflective diary:
> I feel positive that all participants reported finding the interview enjoyable and how many of them even reported benefitting from the opportunity to talk about their experiences. One participant spoke about what they needed to move things forward. They reported that for them it was important for someone to listen and not be too directive, and that they had to start pushing themselves. I was struck by this participant's honesty and it felt good that the participant had gained something from the interview. This highlighted how my research is a two-way interaction and that it is not just about collecting information from 'subjects'.

These issues highlight that from the study design to data collection, the

ethical conduct of research is not fixed. Rather, it needs to be continually

responsive to the personal and social situations that arise (Aita & Richer, 2005, as

cited in Hewitt, 2007).

2.5 Procedure

2.5.1 Development of the Interview Guide

Based on the research questions, interview questions were designed to

cover: i) initial expectations of GSH; ii) patients' experiences of GSH, including

helpful and unhelpful aspects; iii) the degree to which experiences meet

expectations; and iv) influences on patients' experiences. The content of the

interview guide was developed using the Client Change Interview Schedule

(Elliot, Slatick, & Uman, 2001) and with the help of IAPT clinicians and the

research supervisor. The interview consisted of several questions in each section.

Prompt questions were given when necessary to aid discussion and to explore

certain areas in more depth. These involved either specific questions or

illustrative examples to prevent leading responses in a particular direction.

Appendix I shows the preliminary interview guide.

2.5.2 Recruitment

Participants were recruited by the researcher first contacting Lead

Clinicians for each site to arrange a meeting to speak to Practitioners about the

study. This provided an opportunity to discuss the research and potential benefits

and/or risks. Practitioners with at least three months experience were asked if they

would be willing to provide information packs to their patients. Three months

experience was chosen as it was thought that by this time Practitioners would have

enough experience to be familiar with what their role involved. All Practitioners

were interested in being involved in the study and were provided with the

information packs described in section 2.4.1 Informed Consent.

Initially 100 information packs were distributed evenly across the sites.

Excerpt from reflective diary:
Having weighed up the advantages and disadvantages of whether to distribute the packs according to number of patients seen by an IAPT team, or distribute these evenly, I decided the latter was a better option.

Practitioners were asked to give information packs to all new referrals for GSH for

anxiety at the first session. This was to prevent Practitioners from selecting

'appropriate' participants, potentially biasing data. By giving information packs at

the first session it was hoped that patients who discontinued treatment would be

recruited, as well as those who completed treatment. Practitioners were provided

with a guide for introducing the study to try to keep the recruitment of participants

as consistent as possible (Appendix J).

However, there were a number of difficulties with this approach. Firstly,

although recruitment began on 13 October 2009 only ten information packs had

been given out by 26 November 2009. Practitioners reported that this was because

there had not been many referrals in which GSH for anxiety was relevant.

Secondly, Practitioners were finding it difficult to give out information packs in

the first session, due to the amount of material they already needed to cover.

Thirdly, on further discussion with Practitioners it became apparent that the

frequency in which they see patients differed between sites. At one of the sites

Practitioners tended to see patients every third week, meaning that if they were to

see patients for six sessions, this would be over 18 weeks (approximately 4

months). For the study to be finished on time recruitment needed to be completed

by the end of February 2010.

Consequently, a number of changes were made to the recruitment process,

following LREC approval of a substantial amendment (Appendix C).

Practitioners, if still willing, were asked to give information packs to all patients

currently receiving GSH for anxiety. Practitioners were also asked to send out

information packs to patients who had either completed or discontinued treatment

over the previous six months. By sending the information packs to patients who

had completed or discontinued treatment in the previous six months it was hoped

that patients who discontinued treatment would be recruited, as well as those who

completed treatment. This time 200 packs were distributed evenly across the sites.

Participants interested in volunteering replied, via post, to the researcher

indicating a preferred contact method. The researcher then contacted participants

to arrange an interview once their treatment had finished.

When arranging an interview the participant's address was requested. This

allowed for a letter to be sent reiterating the interview arrangements a week prior

to it taking place (Appendix H). A copy of the interview guide (Appendix I) was

also enclosed. Participants were then contacted by telephone a few days before the

interview to ascertain whether they were still willing to participate. All those who provided informed consent were interviewed.

2.5.3 Interview Process

An interview was scheduled with each participant at a convenient time and location for them. On arrival at the interview, participants were thanked for taking the time to talk about their perceptions, and reminded about the 'confidentiality policy' and their freedom to withdraw at any point during the interview. Participants were provided with copies of their consent forms. With permission, interviews were recorded using a digital voice recorder.

At the beginning of the interview demographic and clinical information was collected, including gender, age, ethnicity, where they lived, employment status, type of anxiety and treatment outcome (Appendix K). By interviewing a diverse range of patients the study hoped to identify common patterns that cut across individual variations. It was hoped this would enable the researcher to get an in-depth understanding of perceptions.

Qualitative interviews vary in their degree of structure and depend on the aims of the researcher (Mason, 1996). Although the preliminary interview guide was set before the interviews took place, this was used flexibly. After a few interviews had taken place it became apparent that participants often referred to previous experiences of MHP and treatments they had received for these. As such, the interview was modified to include questions about these areas. Although some participants initially struggled with a few questions, further prompting enabled them to answer these. Therefore, it was not necessary to exclude any questions (King, 1994).

There were also changes to some of the preliminary guide's content. A

typical change would be to encourage participants to develop their responses to previous questions and link them to other salient points in the interview guide. Another change was that the interview did not always start with the first question, as participants would often start with talking about whether they had improved. A further change to the interview was that questions were sometimes worded in a slightly different way to complement the language used by participants. These changes helped to build rapport with participants, enabling them to be more open and allowing new insights into patients' perceptions that had not been previously identified. It also helped prevent data from being limited by the researcher's prior assumptions.

However, there were aspects of the interview guide that remained the same. Firstly, all questions were covered, and prompts given if necessary. These were not necessarily in the same order as the interview guide. Secondly, participants' responses were frequently summarised using participants' own words to check understanding and to lead on to other questions. Thirdly, the researcher avoided questions that may have influenced participants' responses. Finally, at no point did the researcher offer her interpretation or opinions. If the researcher was explicitly asked, participants were directed back to their own experiences.

Interviews took between 30 and 75 minutes and were digital voice recorded for later transcription. Following the interview participants were encouraged to discuss their experiences of this. Participants were asked whether they would like to be contacted following the data analysis, to allow them the opportunity to respond to the interpretations made and to see if they agreed with these. This is known as respondent validation. Unfortunately, due to time constraints it was not possible to do this. Participants were informed about this (Appendix L).

2.5.4 Interview Setting

The majority of interviews took place in participants' homes, meaning the rooms varied considerably. Locations in which interviews took place were likely to have impacted on how comfortable participants' felt talking about their perceptions. Marshall (1996) highlights that qualitative research involves the studying of people in naturalistic settings. As such, settings in which interviews were conducted will have impacted on the trustworthiness of results (see Discussion).

2.5.5 Data Analysis

Template analysis involves seven steps (King, 1998, 2007) outlined below.

1. Development of Coding Template. An a priori template is created based on previous research and theories.

2. Familiarisation. Interviews are transcribed, read and re-read encouraging the researcher to become intimately familiar with the data.

3. Initial Coding. 'Coding' is the process of identifying themes and attaching labels to index them. 'Themes' are features of a participant's account that characterise particular perceptions and/or experiences researchers believe are relevant to the research questions. Features are generally defined as themes when they reoccur several times within and across transcripts.

Parts of a transcript relevant to the research questions are identified. If they are encompassed by one of the a priori themes, a code is 'attached' to the identified section. Where none of the existing themes seem applicable, an existing theme may be modified or a new theme devised. Redundant codes from the a priori template are dropped.

4. Producing an Initial Template. After reviewing and coding a number of

transcripts an initial template is developed. This reflects the a priori themes

identified before interviews took place and emerging themes from the data. The

template is organised hierarchically and similar themes are grouped together into a

smaller number of higher-order codes. These describe broader themes in the data.

5. Developing the Final Template. The initial template is applied to each

transcript in turn, coding all relevant segments and modifying it accordingly.

When significant changes are made to the template previous coding of transcripts

need to be adjusted. A pragmatic decision is made when to stop developing

themes.

6. Interpreting and Writing Up. The 'final' template is used to guide

interpretation of findings. Useful strategies to avoid simply summarising the contents

include listing themes to raise questions, prioritizing themes and openness (King,

2007).

7. Quality Checks. At one or more of the coding stages, quality checks are

carried out to ensure the data are not being systematically distorted by the

researcher's assumptions and preconceptions. For more information see section

2.6 Validity and Trustworthiness.

2.5.6 Feeding Back Results to Participants

Participants were informed that they would be given an opportunity to read

about results and give feedback either in writing or by telephone following

completion of the study (Appendix L).

2.6 Validity and Trustworthiness

The Introduction notes that there are several guidelines provided for reviewing

qualitative research (E.g., Yardley, 2000; Elliott et al., 1999). These have been

referred to throughout the study and are outlined below. In addition, the researcher attended an NHS Annual Meeting on Qualitative Research, which provided an opportunity to learn about what constitutes good research practice.

2.6.1 Validation

This is concerned with verifying the research findings. Throughout interviews, summarising and checking understanding was used to carry out informal member checking. Validation also occurred by discussing findings from this study in relation to other studies.

2.6.2 Grounding in Examples

Examples of raw data are used to demonstrate analytic procedures and showed how the researcher's understanding was developed.

2.6.3 Transparency

All aspects of the research process are documented. To help ensure coherence and transparency with the data analysis, an audit trail was created which documented steps taken and decisions made when moving from raw transcripts to the final interpretation of data (Yardley, 2000). This is summarised in the Results chapter and supplemented in Appendix M. These methods allow the reader to assess the fit between the data and interpretations made.

2.6.4 Situating the Sample

Elliott et al. (1999) emphasise the importance of helping the reader to judge situations in which findings may be relevant and to explore the degree of applicability beyond the specific context of the study. This is achieved by providing information about the sample and the situation. The researcher attempted to do this by describing basic demographic and clinical information of the participants, the interview settings and the context in which GSH takes place.

2.6.5 Commitment

As aforementioned in the Introduction, commitment refers to the author's engagement with data and can be demonstrated by extensive experience of using a particular qualitative approach (Smith, 2003). The researcher demonstrated commitment by going through data multiple times, from familiarisation through to coding data numerous times to develop the final templates (see Results).

2.6.6 Credibility Checks

The research supervisor and members of the qualitative research forum (QRF) discussed the initial template (see Results). The QRF is a group of Trainee and Qualified Clinical Psychologists who meet to discuss issues arising from their qualitative research. The group meets monthly and is facilitated by an experienced qualitative researcher. The credibility checks allowed the researcher to take a broader view on the data and enhanced reflexivity (see section 2.6.9 Reflexivity). This helps to ensure rigour (Yardley, 2000).

2.6.7 Impact and Importance

Great emphasis is placed on qualitative research demonstrating its value, both theoretically and practically. With regards to the former, the researcher attempted to draw on existing empirical material whilst being flexible to allow new ways of understanding participants' perceptions to emerge. With regards to the latter, it is hoped that findings from this study will be used to explore ways of improving GSH for anxiety.

2.6.8 Relevance to Participants

No financial incentives were offered for taking part in this study and no direct benefits to participants were expected. However, it was an opportunity for patients to express their views about the GSH and highlight areas where this can

be improved.

2.6.9. Reflexivity

Contemporary theory disputes the concept of a neutral observer and emphasises the impact on the research process of a researcher's personal and professional experiences, ontological beliefs, motivations, and theoretical orientations related to education and interests. As such, reflexivity is essential (Malterud, 2001). Therefore a reflective diary was kept throughout the research. This encouraged the researcher to think about the likely impact of her beliefs, assumptions and theoretical understandings. Reasons for decisions made have been provided and care was taken to question findings as they emerged in relation to assumptions. The QRF and supervision also provided a space for discussing the researcher's position and perceptions and highlighted areas that had not been previously considered.

2.6.10 Researcher's Position

I am in my late twenties and one of four daughters. From an early age my parents encouraged us to pursue interests, stressing the importance of learning and making the most of what we have got. This led to a belief in taking responsibility for making changes when possible. In difficult times I seek help from family and friends. My limited experiences of SH books and groups are that they are useful for thinking through and normalizing things: knowing that you are not alone and that other people share similar thoughts. I associate expectations with hope and when they are not met I am disappointed. I have an interest in the effectiveness of therapeutic interventions and feel passionate about preventing MHP. I think it is highly beneficial that psychological therapies are being made more widely available, though I wonder about the impact on people who do not improve.

During my training I have found that CBT is extremely useful for some people. It provides them with practical solutions, which they can apply in future situations. However, I have also found it does not suit everyone and believe that one 'panacea' does not fit all. As such, I believe it is important to offer people a range of psychological interventions. In therapy I often find that asking about what people expect is met with a blank expression. My experiences as a clinician have also highlighted what a difference therapeutic relationships can make to an individual's progress and that these relationships are dynamic.

My personal and clinical experiences, in addition to my review of the literature, influenced how I approached this study and what I initially expected to arise from the data. I thought that participants would sometimes find it difficult identifying their expectations. I expected that when participants spoke about expectations these would be positive. I anticipated some tension between participants experiencing the benefits of being guided through SH and the impact on their self-efficacy by requiring assistance with this. I believed that, for changes to occur, participants needed to take responsibility for themselves and those who took more responsibility were likely to benefit more. I thought that as participants improved, their belief in their abilities would increase. I expected the therapeutic alliance would also contribute to participants making changes. I assumed that making changes would impact on participants' experiences, but also thought there would be other factors that influenced experiences, such as not being alone. Finally, I thought people would be keen to talk about their experiences if they had either been really positive or negative and thought this would be reflected in the findings.

3 RESULTS

3.1 Chapter Overview

After this overview the chapter begins with section 3.2, which describes relevant information. This includes descriptive information about the sample, the validation process, the interview context, the use of quotes in helping to ground findings, and the management of the data.

Section 3.3 explains the data analysis process. This begins with describing the development of the coding template. Familarisation with the data is then described, followed by the initial coding. Producing an initial template is then described as well as revisions needed due to its size. One of these revisions included splitting the template into three to match the research questions. Revisions to each of these three templates are described in turn, before describing further coding to ascertain whether the revisions impacted on the templates' abilities to capture the data. The development of the final templates are then described, addressing each research question in turn. Full documentation of the themes in the first template is provided to demonstrate the audit trail, whereas key themes in the other templates are summarised, although the same process was used for all templates. This enables a clear and succinct overview of the most salient findings. To ensure transparency the steps for developing the template for Research Question One are illustrated in Appendix M.

Finally, section 3.4 provides a brief overall summary. Excerpts from the researcher's reflective account are provided throughout this chapter to help the reader understand the data analysis process.

3.2 Relevant Information

3.2.1 Description of Sample

Table 3 provides demographic and clinical information about the ten participants. Two participants were not White British, though they grew up in the UK. Four participants were experiencing anxiety problems and six were experiencing depression in addition to anxiety. Nine participants had a history of experiencing MHP ranging from two years (Participant 8) to approximately 27 years (Participant 7). Two participants were in the process of receiving further psychological input through the service. All participants appeared able to talk about their experiences openly.

Table 3: Participants' demographic and clinical information.

Participant	Age	Gender	Ethnicity	Type of area live in	Occupation	Highest qualification	Type of anxiety	Number of sessions	Outcome
1	46	F	WB	Rural village	Retired	Registered General Nursing & teaching	"Chronic" anxiety & depression	6	"A lot better"
2	56	M	WB	Rural village	PT work	City & Guilds	GAD & depression	6	"Not improved"
3	59	F	WB	Rural village	Voluntary work	City & Guilds	GAD & depression	5	"A lot better about things"
4	61	M	WB	Town	FT work	City & Guilds	Panic	5	"Much improved"
5	43	M	WB	Town	FT work	Degree	GAD & depression	8	"Some changes made, stepping-up"

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Participant	Age	Gender	Ethnicity	Type of area live in	Occupation	Highest qualification	Type of anxiety	Number of sessions	Outcome
6	47	F	WB	Village	PT work	Degree	Panic & agoraphobia	5 (4 phone; 1 face- to-face)	"No change"
7	45	F	Black Other	Town	Unemployed	Cookery qualification	Agoraphobia, panic & depression	6	"Better place at present"
8	27	F	White Other	City	FT work	Degree	Panic	8	"Improved"
9	30	F	WB	Village	FT work	Degree	Panic & depression	6	"Stepping-up"
10	33	F	WB	Village	FT work	Degree	GAD	6	"Improved"

F= Female; M = Male; WB = White British; FT = Full time; PT = Part time; GAD = Generalized anxiety disorder

3.2.2 Context of the Interviews

Nine of the ten interviews took place at participants' homes. The other interview took place in a private discussion room at one of the IAPT sites (see section 4.5 Critical Appraisal for further discussion).

3.2.3 Validation

Throughout the interviews informal member checking took place by summarising and checking out understanding. Although respondent validation had been planned, due to time constraints the researcher believed it was not possible to carry this out effectively. Although there are a number of advantages to using respondent validation, there are also limitations (Barbour, 2000). For example, a participant may endorse initial results attempting to please the researcher.

3.2.4 Quotations

Quotations from interviews are used to illustrate findings. This grounds findings in the data, allows the reader to evaluate findings and gives a voice to participants. Below is an explanation of marks used in quotations:

… = words missed out within a sentence

…. = words missed out between sentences

[text] = researcher's words, used to clarify

(1:146-149) = participant number: line numbers.

When different parts of the same transcript are in one quotation, different line numbers are noted with a semi-colon (e.g., 146;754).

3.2.5 Data Management

To begin with the researcher worked through the initial stages of data analysis by hand. This ensured a comprehensive understanding and allowed for immersion in

the data, identified as an essential part of the interpretive process (Waring &
Wainwright, 2008). However, once the initial templates were completed, NVivo
Version 8.0 (QSR International, 2007) was used to code the data and provided a
useful tool for identifying themes across and within participants.

To devise a clear set of definitions for how to apply each code, records on the
construction of codes were kept whilst coding all the transcripts. These records were
used when discussing the data analysis with the supervisor and the QRF.

3.3 Data Analysis

Throughout the analysis, guidelines by King (1998, 2007) on how to conduct
template analysis were utilized. During all steps of analysis, definitions of codes were
revised and sometimes included items that had been deleted. These revisions made
the codes broader as often they were too narrowly defined. For reasons of space it is
not possible to document all the revisions. However, sometimes examples are given
(see Appendix M for further illustration of how definitions were revised). The
definitions for each code are provided in the final templates.

3.3.1 Development of Coding Template

An a priori template was developed based on previous research and theory, as
identified in the literature review (see figure 2). This guided the research questions
and the interview schedule. Based on these, it was predicted the interview would give
information about *Expectations* (item 1), *Experiences* (item 2), *To what degree
experiences meet those expectations* (item 3) and *Influences on experiences* (item 4).
Research conducted to date shows that a number of themes impact on patients'
perceptions of GSH (see Introduction). These themes were included as codes. The

development of the preliminary a priori template before interviews started allowed the

researcher's initial assumptions to be set out explicitly.

Figure 2: Preliminary a priori template

1. Expectations
      1.1. What GSH would involve
      1.2. Outcome from GSH
2. Experiences
      2.1. Sessions
            2.1.1. Positive/Helpful
            2.1.2. Negative/Unhelpful
      2.2. Facilitator
            2.2.1. Positive/Helpful
            2.2.2. Negative/Unhelpful
      2.3. Treatment manual
            2.3.1. Positive/Helpful
            2.3.3. Negative/Unhelpful
      2.4. Activities undertaken
            2.4.1. Positive/Helpful
            2.4.2. Negative/Unhelpful
      2.5. Service as a whole
            2.5.1. Positive/Helpful
            2.5.2. Negative/Unhelpful
      2.6. Overall experience
            2.6.1. Positive/Helpful
            2.6.2. Negative/Unhelpful
3. To what degree experiences meet expectations
      3.1. Experiences do meet expectations
      3.2. Experiences do not meet expectations
      3.3. Reasons for experiences meeting or not meeting expectations
4. Influences on experiences
      4.1. Reasons for experiences
            4.1.1. Inside therapy
            4.1.2. Outside therapy (e.g., service delivery)
      4.2. Outcome of GSH
      4.3. Reasons for outcome
            4.3.1. Self-efficacy
            4.3.2. Therapeutic alliance
                  4.3.2.1. Expertise/competence of Practitioner
                  4.3.2.2. Interpersonal style of Practitioner
                  4.3.2.3. Interaction with Practitioner
                  4.3.2.4. Agreement over goals
                  4.3.2.5. Patient's perception of intervention

3.3.2 Familiarisation

The researcher transcribed five transcripts and the remaining five were

transcribed by a professional transcription service. Transcripts that were transcribed

professionally were checked for accuracy. To assist familiarisation with the data, all

interviews were read and then re-read. Whilst reading through the text, notes were added in bold italics (black, then red) when something of relevance to the research was identified.

3.3.3 Initial Coding

Three transcripts were selected for coding using the a priori template on the basis they would expose the template to a range of data. Transcripts were chosen to reflect the range in demographics and outcomes. These transcripts were: Participant 9, a White British 30-year-old female who experienced panic and depression and was "stepping-up"; Participant 7, a Black Other 45-year-old female who experienced agoraphobia, panic and depression and was in a "better place at present"; and Participant 4, a White British 61-year-old male who experienced panic and was "much improved".

During coding of these transcripts, notes were made about possible changes to and/or difficulties with the a priori template. Some item codes were modified and new item codes were identified when established item codes did not fit with the data. Relevant text was then coded and attached to an appropriate part of the template. At the end of coding each transcript, modified and new coding items were included into the a priori template before applying it to the next transcript.

3.3.4 Producing An Initial Template

Following the coding of the three transcripts, a number of changes to the preliminary a priori template were made and an initial template was constructed (see figure 3). For all the templates from here onwards, a priori themes are in red and emergent themes are in black.

Figure 3: Initial template

1. Expectations:
    1.1. General expectations of psychological input
    1.2. What GSH would involve

1.2.1. Knowledge about GSH before receiving input
1.2.2. 'Root cause'
1.3. Unsure what to expect
1.3.1. Limited or no knowledge about GSH before receiving input
1.4. No expectations
1.5. Outcome from GSH
1.5.1. Helpful
1.5.2. 'Cure'
1.6. Changes in expectations
2. Experiences:
2.1. Experience of anxiety/other MHP
2.1.1. Length of MHP
2.2. Previous experiences of treatment for MHP
2.2.1. Previous psychology input
2.2.1.1. Unhelpful
2.2.1.1.1. Reasons
2.2.2. Other professional input in past
2.2.3. Alternative treatments
2.2.4. Medication
2.3. Experience of GSH
2.3.1. Sessions
2.3.1.1. Meeting needs
2.3.1.2. Spacing
2.3.1.3. Practicalities
2.3.2. Guidance
2.3.2.1. Helpful
2.3.2.2. Unhelpful
2.3.3. Materials
2.3.3.1. Manual
2.3.3.1.1. Helpful
2.3.3.1.2. Unhelpful
2.3.3.2. Other resources
2.3.3.2.1. Helpful
2.3.3.2.2. Unhelpful
2.3.4. Activities undertaken
2.3.4.1. Helpful
2.3.4.2. Unhelpful
2.3.4.3. Difficult
2.3.5. Medication
2.3.5.1. Helpful
2.3.5.2. Unhelpful
2.3.6. Service as a whole
2.3.6.1. Positive/Helpful
2.3.6.2. Negative/Unhelpful
2.3.7. Overall experience
2.3.7.1. Positive/Helpful
2.3.7.2. Negative/Unhelpful
2.3.7.3. Interesting
2.3.7.4. Mixed
2.3.7.5. Hard/Difficult
2.3.8. Changes in experiences
3. To what degree experiences meet expectations
3.1. Experiences do meet expectations
3.2. Experiences do not meet expectations
3.3. Experiences different to expectations

3.4. Reasons
      3.4.1. Missing
            3.4.1.1. Treatment
            3.4.1.2. Practitioner style
      3.4.2. Realistic
4. Influences on experiences:
    4.1. Participant contributions
      4.1.1. Participant characteristics
      4.1.2. Awareness
      4.1.3. Readiness
      4.1.4. Motivation
      4.1.5. Ability to reflect and understand
      4.1.6. Understanding
      4.1.7. Ability to learn and apply techniques
    4.2. Participant's perception of intervention
      4.2.1. Relevance
      4.2.2. Potent
      4.2.3. Practitioner's expertise/competence
    4.3. Self-efficacy
      4.3.1. Responsibility
      4.3.2. Belief in own abilities
      4.3.3. Change in belief
      4.3.4. Attributed to other factors (e.g., medication)
    4.4. Practitioner contributions
      4.4.1. Presence of Practitioner and information
      4.4.2. Therapeutic alliance
            4.4.2.1. Practitioner qualities/characteristics
            4.4.2.2. Interpersonal style of Practitioner
            4.4.2.3. Interaction with Practitioner
            4.4.2.4. Agreement between Practitioner and participant
    4.5. Knowledge
      4.5.1. Knowledge about anxiety
      4.5.2. Knowledge of service
    4.6. Contributions outside therapy
      4.6.1. Social network
      4.6.2. Other professionals' (e.g., GPs) support
      4.6.3. Medication
    4.7. Changes
      4.7.1. Recognition of changes made
      4.7.2. Changes still to be made
      4.7.3. No changes made

It is clear from figure 3 there were a number of substantial changes to the template. The changes to the different items were as follows:

Item 1 *Expectations*. The main changes to this item were inserting four new codes: *General expectations, Unsure what to expect*, *No expectations* and *Changes in*

expectations based on the three transcripts. Lower-level codes were added to some of these to indicate sub-level themes emerging.

Item 2 *Experiences*. In addition to information collected on participants' experiences of the GSH, there was also information about their experiences of anxiety and/or other MHP and previous input they had received. As such, codes were inserted to reflect these three themes: *Experience of anxiety/other MHP*; *Previous experience of treatment*; and *Experiences of GSH*. Lower-level codes were added to all three codes to indicate emerging sub-themes.

Changes were also made to the existing lower-level codes for *Experiences of GSH*. Where appropriate these codes were changed from *Positive/Helpful* and *Negative/Unhelpful* to a code that encapsulated the emerging themes. For example, rather than the *Sessions* being *Positive/Helpful* or *Negative/Unhelpful*, it seemed that *Meeting needs, Spacing* and *Practicalities* were a better reflection of data. The other main changes to this item were: the replacement of *Facilitator* with *Guidance* as it appeared to be the case that participants spoke about their experience of the latter rather than the former; and *Treatment manual* was changed to *Materials* to allow for the incorporation of other materials referred to in the transcripts.

Item 3 *To what degree experiences meet expectations*. The main change to this item was the insertion of a code, *Experiences different to expectations*. Lower-level codes were added to the code *Reasons* to reflect emerging themes in the three transcripts.

Item 4 *Influences on experiences*. There were several changes to this item. Due to the amount of information for *Inside therapy* this was changed to five main codes: *Participant contributions*; *Participant's perception of intervention; Self-efficacy; Practitioner contributions;* and *Knowledge*. Lower-level codes were added

to each of these codes to indicate themes emerging from the three transcripts. *Therapeutic alliance* became a sub-code of *Practitioner contributions*. The code *Outside therapy* was renamed to *Contributions outside therapy* in order to maintain consistency. Three codes of this higher-order theme were identified: *Social network; Other professionals' support*; and *Medication.*

The code *Outcome of GSH* was renamed *Changes*, as this appeared to capture themes better. Lower-level codes were added to reflect differences in data for this theme.

3.3.4.1 Revisions to the Initial Template

The initial template was assessed by the researcher and supervisor and was considered too long. Clarke and Gibbs (2008) state this is a common problem experienced for first-time qualitative researchers. Consequently, the template was revised to make it shorter and include higher-level themes. To capture the richness and complexities of the data the template was divided into three to match the research questions. The numbers of each item were changed accordingly. Each template and the revisions made will be documented in turn.

3.3.4.1.1 Template 1: 'Expectations'.

Definitions were revised to include the contents of previous items. For example, the lower-level code for *Unsure what to expect* (item 1.3) was removed and included in the definition. Following an examination of the template at the QRF a further revision was made to it. It was noted that *Outcome from GSH* (originally item 1.5) overlapped with *General Expectations* (item 1.1). Consequently *Helpful* (item 1.5.1) and *'Cure'* (item 1.5.2) became lower-level codes for *General Expectations*. The name of this code was then changed to *Outcome from GSH* as this seemed to capture the data better. Figure 4 shows the revised initial template.

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Figure 4: Revised initial template 'Expectations'

1. Expectations:
      1.1. Outcome from GSH
            1.1.1. Helpful
            1.1.2. 'Cure'
      1.2. What GSH would involve
            1.2.1. Knowledge about GSH before receiving input
            1.2.2. 'Root cause'
   1.3. Unsure what to expect
   1.4. No expectations
   1.5. Changes in expectations

Members of the QRF also questioned whether participants had any negative expectations. This highlighted the influence of the researcher's assumptions on the data analysis and encouraged her to see if negative expectations were present in the data.

3.3.4.1.2. Template 2: 'Experiences'.

There were a number of changes made to the lower-level codes for each of the codes relating to experiences. *Length of MHP* (originally item 2.1.1) was removed as this appeared to be part of *Experience of anxiety/other MHP* (item 1.1). All the lower-level codes for *Previous experiences of treatment for MHP* (item 1.2) were summarised into two codes *Helpful* (item 1.2.1) and *Unhelpful* (item 1.2.2). *Experience of GSH* (item 1.3) lower-level codes were revised as follows: *Process* (item 1.3.1) to include *Guidance* (previously coded separately); *Content* (item 1.3.2) to include previous codes *Materials* (item 2.3.3) and *Activities undertaken* (item 2.3.4)*; Practicalities* (item 1.3.3) to include previous codes in *Sessions* (item 2.3.1). *Medication* (previously item 2.3.5) was removed as it appeared to be separate to GSH and already featured in template three. The other three lower-level codes remained the same, although their item numbers changed accordingly.

The only change to item 2 *To what degree experiences meet expectations* was to remove all lower-level codes for *Reasons* (originally item 3.4). A definition for

this item was created to take these previous codes into account. Figure 5 shows the

revised initial template.

Figure 5: Revised initial template 'Experiences'

1. Experiences:
      1.1. Experience of anxiety/other MHP
      1.2. Previous experience of treatment for MHP
            1.1.1. Unhelpful
            1.1.2. Helpful
      1.3. Experience of GSH
            1.3.1. Process
            1.3.2. Content
            1.3.3. Practicalities
            1.3.4. Changes in experiences
            1.3.5. Service as a whole
                  1.3.5.1. Positive/Helpful
                  1.3.5.2. Negative/Unhelpful
            1.3.6. Overall experience
                  1.3.6.1. Positive/Helpful
                  1.3.6.2. Negative/Unhelpful
                  1.3.6.3. Interesting
                  1.3.6.4. Mixed
                  1.3.6.5. Hard/Difficult
2. To what degree experiences meet expectations
      2.1. Experiences do meet expectations
      2.2. Experiences do not meet expectations
      2.3. Experiences different to expectations
      2.4. Reasons

3.3.4.1.3. Template 3:'Influences'.

A number of revisions were made to item 1 *Influences on experiences*,

including changes to the levels of coding.

Excerpt from reflective diary:
As I revise item 1 I'm questioning where self-efficacy and therapeutic alliance fit in. If I make these themes lower-level codes does this imply that they are part of a bigger picture rather than important themes in their own right? Having re-read the three transcripts these two constructs appear to be more general themes and therefore I believe these need to be higher-level codes. At present, therapeutic alliance focuses on the Practitioner, however, I know from the literature that the patient also contributes to this. It makes sense to re-organise the codes to reflect this.

One of the main changes was to make *Therapeutic alliance* (item 1.2) a

higher-order code so that it was at the same level as *Self-efficacy* (item 1.1). The only

change to *Self-efficacy* was to delete the lower-level code *Attributed to other factors* (previously item 4.3.4) as this was subsumed in *Medication* (item 1.6.3). Changes to *Therapeutic alliance* (item 1.2.) were as follows: *Practitioner* (item 1.2.1.), *Participant* (item 1.2.2.), *Interaction between Practitioner and participant* (item 1.2.3), and *Agreement between Practitioner and participant* (item 1.2.4) were added as level-three codes. For *Practitioner* (item 1.2.1) the codes *Quality* (item 1.2.1.1) and *Interpersonal style* (item 1.2.1.2) were included as lower-level codes. For *Participant* (item 1.2.2) the codes *Characteristics* (item 1.2.2.1), *Perception of intervention* (item 1.2.2.2) and *Perception of Practitioner's expertise/competence* (item 1.2.2.3) were changed to lower-level codes. Definitions for these codes were also revised. For example, two of the previous lower-level codes for *Participant's perception of intervention* (item 1.2.2.2) were used for the definition of this item.

Other changes were to include the themes coded in *Readiness* (previously item 4.1.3) to *Ability to reflect and understand* (previously item 4.1.7) into a single higher-order code *How participant engages* (item 1.4). *Presence of Practitioner and information* (item 1.3) was changed from a level-three to a level-two code. The revised initial template is shown in figure 6.

Figure 6: Revised initial template 'Influences'

1. Influences on experiences:
      1.1. Self-efficacy
            1.1.1. Responsibility
            1.1.2. Belief in own abilities
            1.1.3. Change in belief
      1.2. Therapeutic alliance
            1.2.1. Practitioner
                  1.2.1.1. Qualities/characteristics
                  1.2.1.2. Interpersonal style
            1.2.2. Participant
                  1.2.2.1. Characteristics
                  1.2.2.2. Perception of intervention
                  1.2.2.3. Perception of Practitioner's expertise/competence
            1.2.3. Interaction between Practitioner and participant
            1.2.4. Agreement between Practitioner and participant
      1.3. Presence of Practitioner and information
      1.4. How participant engages

3.3.4.2 Further Coding

Coding then took place using the revised initial templates, starting with two different transcripts to expose the templates to new sets of data. This was to prevent the revised templates from becoming too refined, based on data from the three transcripts used previously. Transcripts were chosen to reflect a range in demographics and outcomes. These transcripts were: Participant 2, a White British 56-year-old male who experienced GAD and depression and felt he had not improved; and Participant 8, a White Other 27-year-old female who had experienced panic and had improved. Following this a number of changes were made to the revised templates.

3.3.4.2.1 Template 1: 'Expectations'.

The main change to this template was the insertion of a new code *Practicalities* (item 1.2.2) under *What GSH would involve* (item 1.2) to reflect an emerging theme about exercises. The item number for *'Root cause'* was changed accordingly. Figure 7 shows the new initial template.

Figure 7: New initial template 'Expectations'

```
1. Expectations:
        1.1. Outcome from GSH
                1.1.1. Helpful
                1.1.2. 'Cure'
        1.2. What GSH would involve
                1.2.1. Knowledge about GSH before receiving input
                1.2.2. Practicalities
                1.2.3. 'Root cause'
```

| **1.3. Unsure what to expect** |
| **1.4. No expectations** |
| **1.5. Changes in expectations** |

3.3.4.2.2 Template 2: 'Experiences'.

The main change to this template was the insertion of the code *Changes* (item

1.3.4) from the third template. The definition was also revised to make explicit that

changes could be due to the GSH and/or other reasons.

Excerpt from reflective diary:
I have been grappling with where the code *Changes* (previously item 1.7)
should go. The more I read the transcripts the more I think including *Changes*
into the "Experiences" template makes sense. This is because increasingly it
seems that whether changes were made or not is one aspect of a participant's
experience. I'd assumed when creating the guide that making changes would
influence an individual's experience. However, there are a number of
participants who don't perceive many changes and yet this doesn't
necessarily influence their experience.

Other changes to this item were a revision to the name and definition for the

code *Previous experience/knowledge of treatment for MHP* (item 1.2), to include

knowledge of treatment, and further revisions to definitions for other items. Figure 8

shows the new initial template.

Figure 8: New initial template 'Experiences'

1. Experiences:
    1.1. Experience of anxiety/other MHP
    1.2. Previous experience/knowledge of treatment for MHP
        1.2.1. Unhelpful
        1.2.2. Helpful
    1.3. Experience of GSH
        1.3.1. Process
        1.3.2. Content
        1.3.3. Practicalities
        1.3.4. Changes
            1.3.4.1. Recognition of changes made
            1.3.4.2. Changes still to be made
            1.3.4.3. No changes made
        1.3.5. Changes in experiences
        1.3.6. Service as a whole
            1.3.6.1. Positive/Helpful
            1.3.6.2. Negative/Unhelpful
        1.3.7. Overall experience
            1.3.7.1. Positive/Helpful

1.3.7.3. Interesting
1.3.7.4. Mixed
1.3.7.5. Hard/Difficult
2. To what degree experiences meet expectations
    2.1. Experiences do meet expectations
    2.2. Experiences do not meet expectations
    2.3. Experiences different to expectations
    2.4. Reasons

3.3.4.2.3 Template 3: 'Influences'.

The majority of changes to this template were revisions to code definitions to allow them to capture the range in data. There were also a few changes to codes. A new code *Circumstances* (item 1.9) was inserted to capture this as an emerging theme. *Practitioner Qualities* (item 1.2.2.1) and *Practitioner Interpersonal style* (item 1.2.2.2) were merged and the definition revised, as it was difficult to disentangle these from one another. This code also moved from a level-four to a level-three code. Finally, *Contributions outside therapy* (item 1.6) was removed as it appeared unnecessary and item numbers were changed accordingly. The new initial template is shown in figure 9 below.

Figure 9: New initial template 'Influences'

1. Influences on experiences
    1.1. Self-efficacy
        1.1.1. Responsibility
        1.1.2. Belief in own abilities
        1.1.3. Change in belief
    1.2. Therapeutic alliance
        1.2.1. Practitioner qualities and interpersonal style
        1.2.2. Participant
            1.2.2.1. Characteristics
            1.2.2.2. Perception of intervention
            1.2.2.3. Perception of Practitioner's expertise/competence
        1.2.3. Interaction between Practitioner and participant
        1.2.4. Agreement between Practitioner and participant
    1.3. Presence of Practitioner and information
    1.4. How participant engages
    1.5. Knowledge
        1.5.1. Knowledge about anxiety
        1.5.2. Knowledge of service
    1.6. Social network
    1.7. Other professionals' (e.g., GPs) input

| 1.8. Medication |
| 1.9. Circumstances |

3.3.5 Developing the Final Templates

Following the revisions and further coding, the three new initial templates appeared able to capture the range in data. Coding then took place using these templates, starting with the five transcripts that had been initially coded. This was done to verify the new initial templates before using them with the other transcripts. The same process used to produce the initial template (without the revisions) was used to develop the final templates. Whereas previously the three templates were used concurrently to code transcripts, to develop the final templates coding for each research question was conducted sequentially.

For this thesis, it is not possible to examine and interpret every code for the three templates to an equal level of depth (King, 2004). To demonstrate the data analysis process the final template for Research Question One will be documented in full. This aims to provide a clear trail for the reader by describing each of the codes and providing quotes for each one. For Research Questions Two and Three those codes of the final templates referred to most will be used to help build an understanding. Each research question will now be addressed in turn.

3.3.5.1 Research Question One: What Are Patients' Expectations Concerning Guided Self-Help for Anxiety?

A few changes were made to the initial template for this question to develop the final template. One of the main changes was the insertion of a new lower-level code *Unhelpful* (item 1.1.3) under *Outcome from GSH* (item 1.1). The possibility of negative expectations had been highlighted by the QRF. It was important to include this as it contrasts to times when participants were expecting the GSH to help. *No*

expectations (item 1.4) was deleted as there was very little information collected on this, and although two participants initially described themselves as having no expectations, they then went on to talk about what clearly were expectations. Another change involved renaming the code *Practicalities* (item 1.2.2) *Content and Process* and revising the definition so it incorporated both practicalities (e.g., exercises) and the process of doing these. This also helped prevent confusion with *Practicalities* (item 1.3.2) in template two. To be clear which codes were not to be used for coding the instruction *DO NOT CODE* was added to two items. Other changes included revising definitions to make codes less specific. For example, previously the definition for *'Unsure what to expect'* (item 1.3) was that participants were unfamiliar with what GSH would involve. This was changed to allow for those participants who were aware of what GSH would involve, but were still unsure about what to expect. The final template is shown in figure 10.

Figure 10: Final template 'Expectations'

1. Expectations: *SECTION HEADING ONLY (DO NOT CODE) Sections in the script that suggest what participants expected.*
       1.1. Outcome from GSH: *(DO NOT CODE) Statements that refer to what participants thought would happen following GSH.*
              1.1.1. Helpful: *Comments that refer to what participants hoped to gain from the GSH, generally, and specifically, in relation to their anxiety.*
              1.1.2. 'Cure': *Comments that refer to whether GSH would remove anxiety.*
              1.1.3. Unhelpful: *Comments that suggest participants find it difficult to think there might be any gain.*
       1.2. What GSH would involve: *(DO NOT CODE) Statements that refer to what participants thought the GSH would be like.*
              1.2.1. Knowledge about GSH before receiving input: *Comments that indicate whether participants were familiar or not with what GSH would involve.*
              1.2.2. Content and process: *Comments that suggest expectations about what GSH would entail, e.g., exercises and type of guidance.*
              1.2.3. 'Root cause': *Comments that suggest GSH would involve understanding why participants experience anxiety.*
       1.3. Unsure what to expect: *Comments that suggest participants were unsure what to expect from GSH.*
       1.4. Changes in expectations: *Comments that suggest what participants expected altered over the course of GSH.*

3.3.5.1.1 Analysis of sections from the final template.

1.1. Outcome from GSH. All participants talked about what expectations they had about the outcome from GSH. Participants spoke about these when asked generally about what their expectations were or when prompted about what they might gain.

1.1.1. Helpful. Nine of the participants expressed hopes about the treatment helping them. For some participants these hopes were general "…my expectations were, well it's going to help me…a lot." (8:107-108). Other participants were more specific, their hopes relating to two main areas: anxiety "I was hoping to come out of it, where I could control how, or have more control over the anxiety." (2:270-271); and changes to their life, "I'm hoping, you know, I can lead a more normal life." (1:169-170); "…I wanted to gain a fuller life basically." (6:686).

1.1.2. 'Cure'. Two participants referred to whether GSH would remove anxiety. Whereas one of them put " …a lot of hope into thinking it was like gonna miraculously cure me." (9:268-269), the other participant spoke about how "…it's not gonna be cured and sorted in six weeks." (7:692).

1.1.3. Unhelpful. For this code the responses related to participants not feeling hopeful about making changes. For example, one participant spoke about "…expecting to stay like a donkey…" (4:1617-1618), whilst another talked about how "…at the time I didn't think anything would help me." (1:828). Both participants attributed these expectations to being unwell.

1.2. What GSH would involve. Most participants were asked specifically about what they thought the GSH would involve, however three participants were not asked about this directly. Whereas Participants 3 and 6 spoke about this without prompting, Participant 1 made no reference to what she thought GSH would involve.

One of the challenges of semi-structured interviews is that questions vary according to responses given, thereby influencing the information obtained (see section 4.5 Critical Appraisal).

  1.2.1. Knowledge about GSH before receiving input. Eight participants talked about whether they were familiar or not with what GSH involved.   For those participants who were familiar this was often discussed in relation to their understanding of the principles underlying GSH, by referring directly to CBT "[So can you tell me about any expectations that you had about the GSH?] Well, I didn't have any specific expectations, but I'd heard that cognitive-behavioural therapy can be very useful…and that it was more a practical tool." (3:1-5), or by referring to what CBT involves, "The only thing I thought it was going to be, is like, I say they change the way you think…" (7:898-899). Participants varied in the amount of information they knew about the treatment. Two participants who were very familiar with what it involved actively requested it, "Well, I think I was quite knowledgeable about CBT to start with, 'cos I read a lot of books….I just read a lot of stuff about it, and I actually requested it from my GP." (8:7-9). This compares to one participant who was familiar with CBT and highlighted their concerns about the GSH being similar to this "I said I was concerned about it being like CBT, I did ask her, 'This isn't just CBT?'" (5:843-844). Other participants knew some information, "I knew only a little bit. I've read a little bit, you know, articles here and there…but not…huge detail on it." (9:322-325). Two participants talked about being less knowledgeable about what it would involve, although they had come across the principles before receiving input "I'd heard about this cognitive-behaviour, but I didn't know how it would help me." (4:1622-1623); "…you know, I think it was explained, but I didn't actually take it on

board as to what it exactly, it meant." (2:307-309). This last quote appears to highlight that although explanations are provided these are not always processed.

1.2.2. Content and process. Responses for this code were mainly concerned with expecting more in relation to what would be covered "Maybe a bit more on sort of planning for, for making changes." (10:1011); "I was hoping, and I thought it was gonna be was changing my thinking." (7:709-710) and how these changes would be brought about "…I was hoping that there was gonna be more pressure on me…" (9:271). A couple of exceptions to this were the participants who had requested it from their GPs "…I knew the type of exercises I would have to do…" (8:529-530); "That it would be very practical, which it turned out to be." (3:48).

1.2.3. 'Root cause'. Four participants referred to expecting the treatment to get to the 'root cause', "…to try and get to the 'root' of the problem." (9:330-331). One participant discussed her understanding that GSH is not about getting to the 'root' and yet still expecting it, "I knew that it wasn't about causes, but I think it's still hard to get away from that, so I think probably on some level I was expecting that…" (10:1004-1008).

1.3. Unsure what to expect. What is interesting about this code is that, although all participants spoke about expectations in relation to outcome and the majority talked about what they expected GSH would involve, seven participants also spoke about not being sure what to expect, "I guess I wasn't 100 percent clear what I was gonna expect…" (9:342); "I wasn't sure what to expect. I hoped it wasn't just CBT because I had a negative impression of that." (5:807-808). Perhaps this was because participants were having to think about their expectations retrospectively.

1.4. Changes in expectations. Three participants highlighted expectations as a dynamic process. One participant shared how her expectations increased as she made

improvements, "I think it changed, as I realized…I was getting a little bit better. I realized I could learn to deal with my problem…and then my expectations did get higher, 'cos I thought I could get better." (1:890-893). Another referred to how her expectation was different at the end to what it was at the start of the GSH:

[So from what you're saying, it sounds like from the six weeks of

treatment…you were able to learn things, but you can't expect to

actually…get to the 'root cause' of things, and do all that work in six weeks?]

No, and that's what I was hoping for when I actually went. (7:701-704)

Excerpt from reflective diary:
I had assumed that participants would find it difficult talking about their expectations. Although some participants were unsure about what they expected I am pleasantly surprised by the variety of responses. My own understanding of expectations meant I only asked about what participants had hoped to gain. A couple of participants highlighted that expectations may be low. This led me to reflect on the interview guide by giving me direct experience of how my own 'lens' impacts on how I see the world and the importance of asking balanced questions to access other people's perspectives.

3.3.5.1.2 Summary.

Participants described a range of different expectations, including what they expected in terms of outcome, and what they thought the GSH would involve. Although these were both a priori themes they were developed to include a number of lower-level themes that emerged from the data. In addition, an emergent theme about being unsure what to expect was included as many participants spoke about this. Although only a few referred to changes in their expectations, it was considered important to include this in the final template as it highlights an idea that expectations are a dynamic process.

3.3.5.2 Research Question Two: To What Degree do Patients' Experiences of Guided Self-Help Meet Those Expectations?

The main changes to the template for this question was the deletion of the code *Reasons* (item 2.4) and the insertion of two new codes *Some experiences meet expectations* (item 2.2) and *Improvements* (item 3). *Reasons* was deleted because it overlapped substantially with the other codes for item 2. *Some experiences meet expectations* was added as this was not covered by an existing code and provided more depth. *Improvements* was added as this too was not covered by an existing code. It seemed important to include this as, during analysis, improvements appeared as a key theme in many of the participants' discussions about their experiences and complements the study's aim to improve GSH for anxiety.

Other changes included deleting *Interesting* (item 1.3.7.3) and *Hard/Difficult* (item 1.3.7.5), as the code *Mixed* (item 1.3.7.3) appeared broad enough to include these experiences, and merging *Process* (item 1.3.1) and *Content* (item 1.3.2) into one code (item 1.3.1), as comments arising in these overlapped substantially. Often participants referred to how they experienced the Practitioner. However, this was in relation to the guidance, content and/or practicalities, and therefore, it seemed a separate code was not necessary.

Excerpt from reflective diary:
As I apply the template to the transcripts I'm finding that participants sometimes refer to how they experienced the Practitioner. Does this need to be a separate code?

Keeping notes on this during the analysis I'm finding in the majority of cases these references appear to be in relation to how they experienced the guidance and/or content and sometimes how they experienced the practicalities. It seems that how participants view the Practitioner is more of an influence on how they experience the guidance, content and practicalities and therefore is better placed in the third template.

Again, to be clear which codes were not to be used for coding the instruction *DO NOT CODE* was added to six items. Further changes included redefining codes to make them broader. The final template is shown in figure 11.

Figure 11: Final template 'Experiences'

1. Experiences: *SECTION HEADING ONLY (DO NOT CODE) Sections in the script when participants refer to experiences.*

    1.1. Experience of anxiety/other MHP: *Statements that indicate impact of anxiety/other MHP on themselves and others. Also whether experienced stigma associated with anxiety/MHP.*

    1.2. Previous experience/knowledge of treatment for MHP: *Statements that indicate participants have experienced or are aware of what treatment is available, either psychology, medication and/or alternative therapies.*

        1.2.1. Unhelpful: *Comments that imply aspects of input unhelpful.*

        1.2.2. Helpful: *Comments that imply aspects of input were helpful.*

    1.3. Experience of GSH: *(DO NOT CODE) Statements in which participants refer to how they experienced particular aspects of their GSH.*

        1.3.1. Content and process: *Comments about how participants experienced guidance, materials, manual and activities undertaken.*

        1.3.2. Practicalities: *Comments that refer to spacing, timing, waiting period and setting.*

        1.3.3. Changes: *(DO NOT CODE) Statements in which participants refer to changes made or not and attribute these to GSH and/or other reasons.*

            1.3.3.1. Recognition of changes made: *Comments that imply participants recognise changes made (including using previous helpful strategies again) and experienced benefits.*

            1.3.3.2. Changes still to be made: *Comments that imply participants believe there are areas they can still make changes.*

            1.3.3.3. No changes made: *Comments that refer to things remaining the same following session or overall.*

        1.3.4. Changes in experiences: *Comments that suggest what participants experienced changed within and between sessions.*

        1.3.5. Service as a whole: *(DO NOT CODE) Statements that refer to how participants experienced the whole service.*

            1.3.5.1. Positive/Helpful: *Comments that refer to positive and/or helpful experiences.*

            1.3.5.2. Negative/Unhelpful: *Comments that refer to negative and/or unhelpful experiences.*

        1.3.6. Overall experience: *(DO NOT CODE) Statements that indicate participants overall experience of GSH.*

            1.3.6.1. Positive/Helpful: *Comments that suggest participants' experience was positive and/or helpful.*

            1.3.6.2. Negative/Unhelpful: *Comments that suggest participants' experience was negative and/or unhelpful.*

            1.3.6.3. Mixed: *Comments that suggest participants' experience was varied.*

2. To what degree experiences meet expectations: *SECTION HEADING ONLY (DO NOT CODE) Statements that refer to how much participants' experiences met their expectations and how they made sense of this.*

    2.1. Experiences do meet expectations: *Comments that refer to experiences meeting expectations.*

    2.2. Some experiences meet expectations: *Comments that refer to some experiences meeting expectations.*

    2.3. Experiences do not meet expectations: *Comments that refer to experiences not meeting expectations.*

    2.4. Experiences different to expectations: *Comments that imply experiences were not the same as participants' expectations.*

3. Improvements: *Comments where participants suggest improvements to service based on their experiences.*

3.3.5.2.1 Analysis of sections from the final template.

To answer Research Question Two, participants' experiences of GSH needed to be identified. To put participants' experiences of the GSH into context, their *Experiences of anxiety and other MHP* (item 1.1) and *Previous experience/knowledge of treatment for MHP* (item 1.2) will be summarised briefly. Those codes most relevant to building an understanding of participants' *Experiences of GSH* (item 1.3) will then be highlighted.

All of the participants spoke about their experiences of anxiety and how this impacted on themselves and others. Three participants referred to stigma, whether this was self-stigma or perceived stigma from work colleagues. Nine participants had experienced other MHP before and talked about these. Nine participants spoke about previous treatments they had received, whether psychological, medication or alternative therapies, and one participant spoke about how previously she accessed support from her GP. A few participants referred to previous knowledge of treatment. This differed from the 'Expectations' template code *Knowledge about GSH* (item 1.2.1) as it refers to knowledge of different types of treatment, and not just knowledge of GSH. Their experiences varied as to whether previous input was helpful, for example, "I had the group therapy…that always helps me." (6:1310-1314) or unhelpful, "I've had counseling before…it just really irritated me, and didn't feel like at all useful." (10:1041-1043); "I came off the [medication] because I hated them. They stopped me from working." (5:161-162).

1.3. Experience of GSH. Participants were asked generally about how they found the GSH. Sometimes participants were prompted about specific aspects of the GSH (see Discussion for challenges of semi-structured interviews).

1.3.1. Content and process. All participants spoke about experiences in these areas. There were some instances in which content or process were referred to

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separately. However, the majority of times participants referred to experiences that included both. These experiences varied between participants, in which some found the experience of doing an activity difficult yet the guidance helpful:

> I were on the platform, and there were loads and loads of people on the platform, and I just left, I just couldn't do it…and I cried and cried about it, because I was really upset….I think it really helped that I went back, and [the Practitioner] was just like, 'Okay', she wasn't just mental….she was like, 'Okay, you need to take it slowly'… (8:231-243)

Whereas others appeared to find neither the guidance nor activity suggestions helpful:

> …the Practitioner wanted me to get in the car everyday and go somewhere I hadn't been before….I don't realistically have the time…so I just sort of said, 'Well I can't', 'Well where are you going to go tomorrow then?' I said, 'Well, I'll go to the [shop], 'But you always go the [shop], go somewhere else'…so she was very bossy. (6:306-321)

Participants' experiences also varied according to different aspects of the GSH. For example, although one participant appeared to have a good experience of the activities and guidance "…[the Practitioner] didn't bamboozle me…she didn't throw too much at me at once." (4:569-572), initially he found the manual difficult to understand, "…it was just so many bits of paper." (4:1036). Another participant spoke about how although he did not find the activities helpful, the process of GSH was helpful for getting him to start using previous coping strategies again, "But what the process did do, is forced me to get back into doing hypnosis myself." (2:18-19).

1.3.2. Practicalities. All participants spoke about their experiences of the practicalities of receiving GSH. Again, experiences varied between participants and for different aspects of the practicalities. For example, whilst one participant found the spacing of sessions helpful, "We had a big gap in the middle, I think we had

about, either a month or two months in the middle…that was a really useful gap…" (10:312-315), the timing of sessions sometimes created difficulties for her, "Childcare was really difficult, so the fact it's always in daytime hours…that was hard." (10:609-612). Five participants appeared to experience the waiting period between referral to receiving help as reasonable, "I was told, 'You're going to have to wait a long time', and then she said eight weeks, I said, 'Well, I've had these symptoms for two years, eight weeks isn't much to wait really.'" (8:29-31). This compares to one participant who experienced a six-week waiting period as a "Big gap. Big problem." (4:176-177).

Five participants received the GSH in other venues besides their homes. One participant specifically commented on their experience of the venue, "…it was a really dingy room, down this horrible corridor, and I just thought this isn't very nice." (6:1293-1294). For this participant the majority of her sessions took place over the phone, which she also found unhelpful.

1.3.3. Changes. All participants spoke about changes spontaneously. Sometimes this was followed up with prompt questions to gather more information. Reasons for making or not making changes were attributed to both GSH and other factors. This theme was kept within *Experiences of GSH* (item 1.3) because it seemed that whether participants made changes or not was part of their experience of the GSH.

1.3.3.1. Recognition of changes made. All participants referred to making changes and the majority spoke explicitly about these. Sometimes participants made comparisons with how they were before the GSH and the researcher believed this was illustrative of participants' recognising changes made.

There appeared to be five main areas in which participants were able to recognise changes. Firstly, many participants referred generally to managing their anxiety better, "…if I get anxious now, I find I can cope with it." (1:125); "…before I

was pulling at little threads….now they're ropes, now I got something to really, to pull myself up on." (4:1585-1587). Secondly, participants identified specific behaviours that have changed, "I've been on the computer, I know how to go through it, whereas before I was terrified of it." (7:454-455); "I started to think to myself, 'No I'm not that bad, don't be silly, stop it, go away, turn it onto something else, change the subject, turn the record over'….well, in the past I would have dwelled on it." (4:501-505). Thirdly, many participants talked about changes in how they relate to themselves, "…now I'm a bit more gentle with myself…" (8:410). Fourthly, two participants recognised changes made socially, "The main changes were, that after having started the therapy, I then found it easier to get on with people." (5:969-970). Fifthly, a few participants discussed changes in where they attributed their problems, "…I tended to in the past blame other people, and think, you know, why's he made me feel like that, but I realized, the only person that makes me feel like that is me…" (3:418-420).

1.3.3.2. Changes still to be made. Four participants referred to areas they can still make changes. These appeared to be making general improvements, "I mean, I still got a way to go." (1:161), or more specific things, "I should imagine, as I'm getting more organised and moving on, I'll start thinking a little bit more positive, and with this [Organisation] thing, [the Practitioner] says she'll put me on a [Course], so that will also help." (7:860-863).

1.3.3.3. No changes made. Although all participants were able to recognise changes made, five participants also felt there were areas in which no changes had been made. Two participants referred to still avoiding things, "I haven't been able to confront some of my biggest fears." (9:202-203), whilst the others were more concerned with the feelings of anxiety remaining, "I've still got this anxious feeling in

here, all the time, where effectively I'm worrying about all these things. Now what I want to do is get rid of that worry, 'cos I don't need it." (2:704-706).

1.3.6. Overall experience. All participants referred to their experiences in more general terms, which was interpreted as evidence of their overall experience.

1.3.6.1. Positive/Helpful. Three participants reported only positive experiences, "I think…that therapy was really good….There's nothing unhelpful…as in nothing that was negative." (5:610;621); "There's nothing that sticks out in my mind as being negative." (8:386).

1.3.6.2. Negative/Unhelpful. One participant found their overall experience to be negative "I was disappointed this time…I seem to have achieved nothing." (6:387-388). This may have been due to a lack of changes attributed to the GSH.

1.3.6.3. Mixed. Six participants seemed to have mixed experiences. For five participants, these were related to the GSH in which they found it hard, "It's not easy, it's hard work." (7:583) and felt a range of experiences, "It was really, it was interesting, it was difficult. I mean those first three sessions were incredibly draining, and really difficult…" (10:765-767); "It's not been easy….I think I had a very good experience." (1:497;782). For one participant, although his experience of the GSH was positive, he felt negative about the waiting period, "…the only negative is I didn't get it early enough." (4:1418).

2. To what degree experiences meet expectations. All participants were asked directly about whether their experiences met their expectations. Occasionally participants found this difficult to answer, as they had been unsure about what they expected. However, with further prompting, all participants appeared able to reflect on their experiences and expectations.

2.1. Experiences do meet expectations. Three participants spoke about how their expectations had been met. These referred to the process, "I went to seek the

help…I got the guidance I needed." (7:594-595) and outcome, "[How did your experiences meet those expectations?] I think I would say fully...because of the progress I made." (8:510-513).

> Excerpt from reflective diary:
> This finding surprises me. Initially, I didn't think experiences would meet expectations as participants spoke about expecting more in relation to content and process. Then when I think about this further I'm surprised that so few experiences did meet expectations, as many participants were able to recognise changes on some level. I think this highlights the complexities of this construct. Just because someone makes improvements does not mean their experiences have met their expectations.

2.2. Some experiences meet expectations. Two participants varied in whether their experiences met their expectations. For one participant, his expectations were met in relation to feeling better, though unmet in terms of what the GSH would involve:

> [Do you think your experiences met your expectations?] I do feel that I'm better, because of going through the process, whichever one worked…but I still feel I need…something to solve, I think solve the problem, you know get to the 'root cause'. (2:994-1004)

For the other participant, her expectations which were met appeared general, compared to specific experiences of the content and process which did not match her expectations, " […so was your experience what you expected?] It was. There was less face-to-face interaction than I expected. I expected the sessions to be more, to be more intense, to be maybe more sort of probing, or in-depth…" (10:966-971). Considering the range in expectations and experiences it was surprising that not more participants had experiences in which some met their expectations and others did not.

2.3. Experiences do not meet expectations. Two participants had experiences that did not meet their expectations. These responses were about, generally, expecting more, '[How much do you feel that your experiences met your

expectations?] Well, I don't…I don't. I did expect more, I definitely expected more."
(6:1271-1274) and, specifically, about expecting more in terms of content and process
"I just think there's a lack of exposure to actually really confront the problems."
(9:308-309).

2.4. Experiences different to expectations. Three participants had experiences
that were different to what they expected. For two participants their experiences
exceeded their expectations, "I think it worked better than I thought it…I mean, I
heard that it can be very useful, and very helpful, but I think I was pleasantly
surprised at how good it was." (3:167-170); "…it was better than what I thought I
might be expecting." (5:1444-1445). Whereas Participant 3 knew what the GSH
would involve and specifically requested it from her GP, Participant 5 had previously
experienced CBT as negative and, although was unsure what to expect, was hoping
that it would be different. The other participant's experiences were different to her
expectations in that she appears to change her expectations to match her experiences:

> I think, my expectations would be…let's put it this way, my goal would be to
> never suffer from anxiety again, that's never going to happen with me…my
> expectations are high, but I have to bring myself, goals down, because I'm
> never going to be 100 percent better." (1:905-911)

This highlights how expectations and experiences are interlinked and further
demonstrates their dynamic nature.

3. Improvements. Regardless of whether participants' experiences met their
expectations, many commented on how to improve the treatment they received.
These improvements appeared to relate to four main areas. Firstly, changes to the
content and process were suggested, "I think group sessions…can help as well."
(9:728); "I just think, maybe, it should be a little bit longer, and go to a bit more of the
'root' of the problems." (7:971-972). Secondly, improvements to the practicalities, "I

think the waiting list would be as minimum as possible, would be useful." (10:258-259);

> I don't like to say, well, you know, you're going to have to work in the
>
> evenings, because I work in the day, but I think there is really need for it
>
> because…it's difficult to say to your boss, 'I've got to go.' (5:1235-1238)

Thirdly, suggestions about maintaining progress, "Periodic maintenance of what you've learnt, it's really worthwhile, otherwise you could easily go straight back into your old ways." (9:561-562). Fourthly, having more options available, besides GSH and medication "I think that we also need to look at what other avenues are out there, because different people react to different things in different ways." (2:571-573).

3.3.5.2.2 Summary.

Participants had a range of experiences in many different aspects of their GSH. Those thought most relevant to Research Question Two were highlighted: content and process, practicalities, changes and overall experience. This showed that experiences varied for individual participants, as well as between participants. To what degree experiences met participants' expectations also varied and appeared evenly spread across four themes. For some participants their experiences did meet their expectations, for others some of their experiences did meet their expectations but at other times they did not. Two participants found their experiences did not meet their expectations at all, whilst others found their experiences were different to what they had expected. With regards to what degree, this is difficult to state as it requires quantification and the range of expectations and experiences make this hard (see Discussion for critique of the research questions).

A number of participants suggested improvements to the GSH in terms of content and process, practicalities, maintaining progress and having more options

available. Suggestions for improvements were made regardless of how much experiences met expectations.

3.3.5.3 Research Question Three: Are Self-Efficacy and Therapeutic Alliance Important Influences of Patients' Experiences?

The main change to this template was to include a theme about *Meeting needs* that seemed to permeate the codes from *Therapeutic alliance* (item 1.2) to *How participant engages* (item 1.4). As such, the final template deviates from a purely linear structure, which is not uncommon for this type of analysis (e.g., King, 2004).

There were a number of codes that overlapped with one another for this template. However, they were kept separate because the focus of each code was slightly different. For example, although there was some overlap between *Responsibility* (item 1.1.1), *Belief in own abilities* (item 1.1.2) and *How participant engages* (item 1.4), the former two focus on slightly different aspects of self-efficacy and the latter includes other aspects necessary for individuals to engage in treatment, such as being aware of the problem and readiness. There were also links between different items, for example, *Presence of Practitioner and information* (item 1.3) and *Characteristics* (item 1.2.2.1). This emphasises the complexities of the constructs and difficulties of using a linear template (see Discussion). To be clear which codes were not to be used for coding the instruction *DO NOT CODE* was added to four items. Again, definitions were revised. The final template is shown in figure 12.

Figure 12: Final template 'Influences'

1. Influences on experiences: *SECTION HEADING ONLY (DO NOT CODE) Sections in the script that suggest possible influences on participants' experiences.*

    1.1. Self-efficacy: *(DO NOT CODE) Statements that suggest factors associated with self-efficacy.*

        1.1.1. Responsibility: *Comments that imply whether participants take ownership of problems.*

        1.1.2. Belief in own abilities: *Comments that imply participants are confident with their abilities.*

        1.1.3. Change in belief: *Comments that suggest belief in abilities changes over the course of GSH.*

    1.2. Therapeutic alliance: *Statements that suggest processes/factors associated with therapeutic alliance.*

        1.2.1. Practitioner's qualities and interpersonal style: *Way Practitioner is with participant in terms of personality and guidance.*

        1.2.2. Participants: *(DO NOT CODE) Statements where participants refer to themselves.*

            1.2.2.1. Characteristics: *Comments that suggest qualities/personality/age of participants and what they value are important to them.*

            1.2.2.2. Perception of intervention: *Statements that suggest how participants view sessions and activities in terms of relevance and potency for self and others.*

            1.2.2.3. Perception of Practitioner's expertise/competence: *Statements that suggest participants consider abilities of Practitioners.*

        1.2.3. Interaction between Practitioner and participant: *Statements that suggest that relationships between Practitioners and participants influence how participants experience GSH.*

        1.2.4. Agreement between Practitioner and participant: *Statements that suggest importance of Practitioners and participants holding the same opinion of what to expect for outcome and from each other.*

    1.3. Presence of Practitioner and information: *Statements that indicate both are important.*

    1.4. How participant engages: *Comments that imply being aware of the problem, readiness, motivation, ability to reflect, understand, learn and apply techniques.*

> **Meeting needs**

    1.5. Knowledge: *(DO NOT CODE) Statements that indicate knowledge.*

        1.5.1. Knowledge about anxiety: *Comments that suggest participants are familiar with psycho-education and facts about anxiety e.g., not alone.*

        1.5.2. Knowledge of service: *Comments that suggest awareness of system and what supports are available for Practitioners and participants.*

    1.6. Social network: *Statements that indicate participants view social support, recognition and sharing of information as important.*

    1.7. Other professionals' (e.g., GPs) input: *Statements that indicate relationships with other professionals are important.*

    1.8. Medication: *Statements that suggest participants view medication as influencing their experience.*

    1.9. Circumstances: *Comments that suggest employment, finances, and life events may impact on experiences.*

3.3.5.3.1 Analysis of sections from the final template.

All participants were asked generally about possible influences on their experiences. Three participants initially found this difficult, however with prompts

they were able to discuss this. Participants were also asked specifically about how they accounted for the changes made. Each participant varied in what they thought influenced the changes they made. Influences on experiences were also found by interpreting the data from examples given (Mason, 2002).

As Research Question Three focuses on self-efficacy and therapeutic alliance, these items will be highlighted. However, there were a number of emergent themes that also seem important. Those referred to most will be documented.

1.1. Self-efficacy. All participants referred to aspects of self-efficacy when discussing influences and there was some overlap between these. For the majority of cases this was in relation to changes made.

1.1.1. Responsibility. All participants referred to the issue of responsibility. Many highlighted the importance of taking responsibility to make the most of their GSH, "It's up to you, the person, to get out of it what you put in." (1:515); "…it's down to me, it's my life and I gotta do the work." (7:570-571). More specifically, participants often referred to needing to take responsibility to make changes, "I feel like the process was mine, and that changes happen, because of how I kind of went through the process." (10:942-943). This quote highlights an idea that taking responsibility encourages the participant to believe in their abilities to make changes. Other participants made similar comments:

> …if I compare this treatment [GSH] to just being given antidepressants…the
> difference is huge…when I was taking antidepressants I was able to do things,
> but when I stopped taking them, I attributed the fact I was able to do these
> things to the antidepressants….now, you know, I don't have this
> [medication]…I know it was me who did it. (8:427-441)

Two participants seemed less eager to take responsibility for making changes, "[so it sounds like you feel responsible for making the progress that you have?] No…

no…because of the process of cognitive therapy, it made me look at other things." (2:835-838). One participant appeared to not want to take responsibility for his life, "I don't think I'm the best person to be put in charge of my life." (5:937-938). Although these participants were able to recognise changes made, they were also the ones who where either 'stepping-up' (Participant 5) or reported no improvements (Participant 2).

1.1.2. Belief in own abilities. Eight participants referred to a belief in themselves to make changes. This was based on having accomplished what they set out to do, "I can bring change, I can make things happen and change because I've done it." (3:435-436), previous experiences and verbal persuasion, "…you've done it before, you've done it loads of times, you've done it recently…you've done it when you were feeling a lot more anxious." (8:717-715).

For many of these participants, beliefs in their abilities were encouraged by their Practitioner "…as we got to the sixth session, I did start worrying then, without her how will I cope, but she managed to make me believe in myself, that it was me doing the work not her…"(1:721-723). This quote highlights the participant's concern about no longer having support. Other professionals also encouraged participants to believe in their abilities, "…she made me feel better, and all the GPs…as they both said, 'You're the one that's doing it.'" (4:660-662). This quote illustrates how, although participants may initially not feel responsible for making changes, professionals support them to take responsibility and believe in themselves.

For one participant, her belief in her abilities seemed to be dependent on being familiar with a place:

I'm meeting my cousin for lunch, that's going to be in [place], which I haven't driven to for a long time…but I know [place], I used to work there, I know it very, very well, so I'm going to be able to do that. (6:525-527)

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This highlights that beliefs can be context specific. Two participants (5 and 9) did not refer to a belief in their own abilities. Interestingly, these were also the participants who made less changes as a result of the GSH and were 'stepping-up'.

1.1.3. Change in belief. Three participants referred to changes in their beliefs. The majority of times this related to an increase in their beliefs based on being able to do something:

> I couldn't deal with anything at first, but after a few sessions I began to realize that I had to do something to help me, and I started reading the manual, and it started to make sense to me…and it was almost like, I wanted to reach that goal, that I could get a bit better. (1:852-857)

For one participant, there was also a decrease in his belief due to an event occurring during the GSH, "This came right in the middle of this, and I thought, what the bloody hell. I felt totally brought right back down, to that, because I'd been gaining so much confidence." (4:844-846). Although this participant had a set back, his overall outcome was "much improved". This suggests that, despite a low belief in his abilities at this time, he was able to overcome this challenge. It also highlights that belief in abilities can vary in magnitude.

1.2. Therapeutic alliance. All participants referred to aspects of therapeutic alliance, though some were highlighted more than others. The importance of meeting needs seemed to permeate the lower-level codes for this item.

1.2.1. Practitioner qualities and interpersonal style. Nine participants thought the Practitioner's personality and guidance influenced their experiences. The majority of the time this was positive, both generally:

> …she didn't patronize me. She talked to me and explained things on the paper, and when she could see I couldn't quite get the gist of it, she decided that it was better to show me on the computer screen… (4: 392-395)

And in instigating changes, "I found she listened…but she was going over everything to 'Right, okay, now we're gonna work on techniques to get forward, to put you in a better place', which is something I probably needed." (7:339-344).

However, there were two participants who had negative experiences due to the Practitioner's qualities and interpersonal style. For one participant this impacted on her overall experience, " …if I was talking, she'd say 'Can you be quiet, it's my turn now', and she was very…I found it very difficult." (6:253-255). For the other participant this influenced one of her sessions, "…that session was completely, was a waste of time, because I was so cross with her for being unprofessional enough, that I could see that she was judging me." (10:661-663). This participant later stated that it was not unprofessional, rather due to inexperience (see section 1.2.2.3 Perception of Practitioner's Expertise). For both participants, it seems the way the Practitioner related to them did not match their needs.

1.2.2. Participant. All participants referred to themselves when discussing influences on their experiences. This covered three areas, characteristics, their perception of the interventions and perception of the Practitioner's expertise.

1.2.2.1. Characteristics. Nine participants highlighted how their own characteristics influenced their GSH experiences. For the majority of participants this concerned how they approached the GSH, "I could just sit around and not tackle it, but I'd hate that. I like to sort things out.' (3:430-431); "I'm one of these people that I think wanna please…so I come home then and start doing more, so I come back and tell her I've done more" (7:448-452). Sometimes it was related to how they responded to the GSH, "…being a 50-year-old person, I think it's just harder for me to try and take certain things on board…" (2:601-602). These quotes highlight the importance of the GSH complementing the participants' characteristics.

1.2.2.2. Perception of intervention. It was clear that whether participants viewed the GSH as relevant and potent influenced their experiences, particularly with making changes. For many participants the GSH was seen as applicable, effective and met their needs:

…in terms of therapy…that's the nature of it, that I really really like, is the fact every week I had to come in and I had to say, 'Okay, I've done that homework', 'cos I would always leave with stuff to do…whether it was writing a diary, or like putting myself into situations that made me uncomfortable…and I felt like I was moving forward… (8:193-201)

For some participants aspects of the GSH were seen as effective "…there are a few things she's told me that do work, which is good, which is the breathing thing, which I think is really useful." (5:287-289), whereas other aspects were not, "…she said about making timetables and it might work. I never really proved it does." (5:470-473). For a few participants it was neither applicable nor effective and did not meet their needs:

…if a problem comes up, even though I know what the worst that could happen is nothing to really worry about, it doesn't stop me from worrying about it….That's why I feel, for me, that if I could find a 'root cause' and work on that, I think it could solve a lot of problems. (2:120-125)

1.2.2.3. Perception of Practitioner's expertise. Five participants referred to the abilities of the Practitioner. One participant shared her curiosity about the level of expertise, "I'm sure that she's totally qualified, and she was really good….this is just a little thought in my head, whether it would be different with someone else who's fully qualified." (3:218-221). Another participant thought the Practitioner's level of experience was evident when handling a difficult situation in session, "…maybe if she had a bit more experience of doing it, then she would have been able to handle it in a

more subtle way." (10:751-752). For one participant it seemed the Practitioner was not considered professional and therefore did not meet his needs, "…what I feel I need is somebody, a professional that can guide me through…" (2:504-505).

1.2.3. Interaction between Practitioner and participant. Nine participants appeared to have mainly positive interactions with their Practitioners, regardless of whether changes were made or not. This was often linked to the Practitioner's qualities and interpersonal style, "We got on well, she was easy to get along with." (9:824); "She was really friendly and I felt really well cared for in that way…so I didn't have any problems about opening up." (8:150-153). One participant highlighted the importance of the relationship for being able to benefit from the GSH, "If she hadn't been so nice and kind and understanding, and I couldn't relate to her, I don't think the program would have necessarily worked." (1:999-1002).

There were occasions when the interactions were not so positive, however, these appeared to have been worked through "So when I actually saw her…and said to her how I felt, and I told her I was gonna come in and say 'Look, obviously this isn't for me' it sort of turned around real quick." (7:308-310). When asked about what "real quick" meant the participant replied the Practitioner had continued with the session, then checked whether she wanted to come back. The participant then went on to say, "I felt like she was listening." (7:324-325), implying this participant's needs were met.

For one participant, the interactions were mostly negative. Again, these were linked to the Practitioner's qualities and interpersonal style, "I just didn't get on with her…I didn't like her attitude…" (6:291-295). In addition, the way the Practitioner presented did not meet the needs of the participant. This was highlighted when the participant spoke about the questions asked at the start of each session "…they weren't necessarily the answers that I wanted to give, and if I tried to give another

answer, 'No, you have to stick to that'….there wasn't even a 'How are you today?'" (6:779-781;790-791). This had a direct bearing on this participant's overall experience, which was negative.

    1.2.4. Agreement between Practitioner and participant. Six participants highlighted the importance of agreement in terms of outcome and what to expect from one another. Two participants appeared to agree with their Practitioner about what to expect in terms of outcome from the GSH. For example, one participant having experienced a "backwards step", reported "…[Practitioner] did point out that this will happen, it could go on for a long time, the thing is to manage it….work with it you know, and I do." (4:1332-1336). With regards to what to expect from one another, three participants appeared to have the same opinion as their Practitioner, "…knowing I would have to put in some effort…" (8:121), whereas two participants did not seem to be in agreement with their Practitioner:

> …she tried to make me start at the bottom and do one achievement, and then
> go to…because the big one would be somewhere like [Shop]…but I just said
> 'But I want to just go to the [Shop] and see if I can do it.' (6:811-818)

Again, this implies that what this participant wanted to do was not met.

    1.3. Presence of Practitioner and information. Seven participants emphasised the importance of having both the Practitioner and information. Two participants referred to how their anxiety stopped them from being able to engage with the manual by themselves, "…I couldn't have done it on my own with the manual, I needed my therapist…" (1:690-693);

> I needed someone to talk to me, I'm not the brightest soul in the sky but I'm
> not thick either….if anyone is in my way of thinking…you need a one-to-one.
> No disrespect, but bits of paper didn't help me at all because...this thing to me
> was a form of confusion. (4:219-222;974-977)

These quotes highlight how *Meeting needs* is important. The latter quote also highlights the link with *Characteristics* (item 1.2.2.1).

A few participants spoke about the importance of a Practitioner for completing activities, "The fact that I knew I'd tell her the following week how it had gone….which is why having face-to-face contact is so important. If it had been on the computer, I just wouldn't have done it." (10:382-387). One participant spoke about the importance of having a Practitioner to maintain morale, "I think it was, in particular, very important when I had…failure or something along the way….if I'd been on my own, maybe I would have been a bit more…down about it." (8:215-225).

1.4. How participant engages. Four themes emerged from the data that seemed to influence the participants' engagement with the GSH and subsequent experience. These were: i) awareness of problem; ii) readiness; iii) motivation; and iv) ability to reflect, understand, learn and apply techniques. All participants spoke about engagement, although some themes were referred to more often. For this code, participants explicitly discussed themes or the content was interpreted by the researcher as evidence of the theme.

Two participants identified awareness of the problem as important, "…the basic thing was accepting I got a problem." (4:1205). Two participants also spoke about being at the point where they were receptive to receiving help, "…when I first started we didn't get anywhere. I wasn't ready for the programme….I couldn't deal with it initially, it was just too much…" (1:522-526). Four participants identified motivation as an important influence, "[What do you think influenced your experiences?] I suppose the fact I wanted to get it sorted out, I really did." (3:266-268). It seemed the driving force behind their motivation was wanting to change "I wanted to change" (5:934) and the discrepancy between how they were before the anxiety, "…this was just all so against what my normal way is." (4:1279).

All participants implied that being able to reflect, understand, learn and apply techniques was important. Sometimes participants referred to this directly, "Every time you feel down or low, always remember to ask yourself questions and challenge your thoughts" (9:701-702); "I've worked through my anxiety, and I have learnt ways to cope" (1:381), other times it was interpreted from what they said:

> …thinking about work, going to the gardening and that, the fact you know, that I don't make good tea, and I mean this all goes back to when my first husband said to me, 'You can't make tea to save your life', so I always thought I couldn't make tea properly….and the truth is that I make tea, and everyone drinks it and no-one complains so, you know, just based on one person saying it is just ridiculous. (3:89-99)

This quote highlights the participant's ability to reflect, make sense of things (i.e., understand), learn from it and apply a technique to challenge her thoughts. One participant reported that, despite applying techniques, his problem remains, "I still work through the same process, which…as I say, I realize I've always done that anyway….it's just that the bottom line, doesn't solve my problem." (2:1045-1049). It was thought this contributed towards his mixed experience of the GSH. Again, the importance of *Meeting needs* for participants to engage seems to underlie this code.

1.5. Knowledge. This theme emerged from the data and indicates the importance of knowledge influencing participants' experiences. It highlights how knowledge can help people regain a sense of control.

Excerpt from reflective diary:
For me, knowing things helps me to feel in control. I wonder whether knowing about anxiety and how the service works helps people to feel more in control? I think this is really important for people who feel out of control in other areas of their life.

1.5.1. Knowledge about anxiety. Four participants highlighted the important influence of knowing about anxiety. Some alluded to the importance of psycho-

education, "I suppose it's knowing as well, being told…'Okay, so you're experiencing anxiety, you experience panic attacks, it's incredibly uncomfortable but nothing will happen….you will feel uncomfortable. Ten minutes later your anxiety will go down'…" (8:730-742). Others referred to facts about anxiety, "…there's one in four people who are wandering around dealing with it, it just made…that one in four statistic, kind of a bit more real for me." (10:584-588). These seemed to indicate to participants that they were not alone in their experiences, "I think I realized there's a lot of people like me." (1:403-404).

   1.6. Social network. Six participants emphasised this as an important influence on their experience. Five participants spoke generally about the influence of social support. Most of the time this was positive, "…other influences, I think mainly are just the fact that I have these other friends…" (5:971-972); "…what [Practitioner] did and what she said was important, but at the same time my wife's support, my friend's support…" (4:1785-1786). There were two participants who highlighted that support could also be detrimental, "…my brother's supportive but…he can be too much….and make me more anxious…" (7:943-944). Two participants identified recognition from others as important, whether it existed, "…the mobile phone will go and it'll be [family friend's] number…'Hi panic man…how you doing today? Just thought I'd give you a quick ring to see what'…she just seems to get it right…" (4:1569-1572), or not, "…[Mother-in-law] doesn't understand how I feel at all, she said 'You don't suffer from anxiety' I said 'I do'". (6:922-923). One participant highlighted the importance of sharing information with others for influencing her experience of making changes, "I've kind of opened up a lot to my friends, and I've realized that a lot of people experience similar things…" (8:475-477).

3.3.5.3.2 Summary.

Participants highlighted that self-efficacy and therapeutic alliance are important influences, not just for influencing change but also other experiences of the GSH. In addition to the a priori themes, a number of other important influences emerged. These were: the Presence of Practitioner and information; How participant engages; Knowledge; Social network; Other professionals' input; Medication; and Circumstances. In addition, an emergent theme, Meeting needs, seemed to permeate the codes related to Therapeutic alliance, Presence of Practitioner and information and How participant engages. As it was not possible to review every emergent theme, those themes referred to the most were highlighted.

3.4 Overall Summary

Due to the sheer size of results only a brief overall summary is provided. Findings showed that participants had a number of different expectations for the GSH. There was a range in whether their experiences of the GSH met these expectations and several improvements were suggested. A number of important influences on both making changes and other experiences were identified. These indicated that in addition to self-efficacy and therapeutic alliance, there are other influences that are important to consider. For all three templates, the majority of the a priori themes were kept, although some of these were modified. Codes were also inserted to reflect emergent themes.

Findings, limitations, strengths, clinical implications of the research and future directions will be considered in the next chapter.

4 DISCUSSION

4.1 Chapter Overview

This chapter aims to interpret and discuss findings for the three research questions in relation to existing knowledge (sections 4.2 to 4.4). The discussion for each research question will be organised according to the higher-order codes in each template. Section 4.5 critiques the study by reviewing strengths and limitations, as well as discussing validity and trustworthiness. Section 4.6 highlights clinical implications and future directions. Finally, section 4.7 provides a summary and conclusions.

4.2 Research Question One: What Are Patients' Expectations Concerning Guided Self-Help for Anxiety?

The data provided an insight into the expectations of patients receiving GSH for anxiety. Consistent with Mansell (2007) these expectations were mixed. Findings also showed some similarities and differences with the three previous studies (Macdonald et al., 2007; MacLeod et al., 2009; Rogers et al., 2004) that reported expectations. With regards to similarities, these were in relation to expecting the GSH to be helpful, what GSH would involve, and participants being unsure what to expect (see sections 4.2.1 Outcome from Guided Self-Help to 4.2.3 Unsure What to Expect). With regards to differences, this related to expectations changing (see section 4.2.4 Changes in Expectations).

4.2.1 Outcome from Guided Self-Help

Results showed that the majority of participants expected the GSH would be helpful. Two studies (Macdonald et al., 2007 & MacLeod et al., 2009) identified in the literature review reported explicitly or implied similar findings: that GSH would

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be helpful. Two participants also referred to whether the GSH could 'cure' them of their anxiety, a theme previously identified by Rogers et al. (2004). An unexpected finding was that two participants (1 and 4) highlighted that expectations were not always positive. Although these participants expected the GSH to be unhelpful, both appeared to engage with the treatment and were able to make improvements. This contrasts to the study by MacLeod et al. which found that patients with higher levels of expectancy had more successful outcomes. Interestingly, both participants who expected the GSH to be unhelpful, also stated the importance of having a Practitioner (see section 4.4.3 Presence of Practitioner and Information) and attributed their low expectations to being unwell. In the MacLeod et al. study, it is not known if patients with lower expectations attributed these to being unwell. Importantly, this finding suggests that an individual's illness can impact on their expectations.

4.2.2 What Guided Self-Help Would Involve

Similar to other studies (Macdonald et al., 2007; Rogers et al., 2004), participants in this study highlighted that their understanding of what GSH would involve was based on knowledge of CBT. Although previous experiences of CBT were not always positive, participants appeared able to keep 'open minds'. An additional finding in this study was that those participants who knew a lot about the treatment actively requested it. This finding may be because this study took place in a clinical setting, where patients can request input, compared to clinical trials, where there are often strict inclusion/exclusion criteria. This appears consistent with the Doncaster and Newham evaluations (Parry et al., 2009) where expectations of patients impacted on whether they accessed services. Although it is not stated, knowledge of what GSH involved may have influenced this. This could be because people with knowledge of GSH have different expectations to those who are not familiar with

what it involves. These expectations may then direct whether patients access services.

For some participants, although they were informed of what the GSH would involve, their understanding of it was not clear until they experienced the treatment. This has been previously reported by Macdonald et al. (2007) and Rogers et al. (2004), highlighting an idea that although information can be given to patients it is not necessarily always understood or retained.

Interestingly, this study found participants expected more in relation to content (e.g., planning) and process (e.g., more direction). No previous studies (e.g., Willemse et al., 2004; Farrand et al., 2008; and other studies in the literature review) have reported this. This may have occurred because interviews took place at the end of treatment and gave participants an opportunity to reflect on their experiences. However, the study by Macdonald et al. (2007) was also conducted once treatment was finished, yet they reported that patients had a lack of clear expectancies about the process. Consistent with Macdonald et al. this study found participants expected the GSH would get to the 'root cause' of their problem.

4.2.3 Unsure What to Expect

Despite participants having knowledge about the GSH prior to receiving treatment, many of them were unsure about what to expect. This appears consistent with Macdonald et al. (2007) and Parry et al. (2009). However, the timing of the interview at the end of treatment may have also contributed towards why participants were unsure about their expectations (see section 4.5 Critical Appraisal).

4.2.4 Changes in Expectations

Importantly, unlike previous studies in the literature review, this study found expectations were a dynamic process. Although it could be suggested that these findings occurred as a result of the timing of interviews, Macdonald et al. (2007), who

also conducted interviews at the end of treatment did not report this. This finding was unexpected: although the researcher had assumed self-efficacy would change as patients improved, an idea that expectations could change had not been considered.

4.3 Research Question Two: To What Degree do Patients' Experiences of Guided
Self-Help Meet Those Expectations?

To answer this question it was essential to establish what participants' experiences were. This highlighted the importance of understanding experiences of GSH, in the context of participants' experiences of anxiety and other MHP, and previous experience or knowledge of treatment. Although participants appeared to have mixed experiences of past treatments, this did not appear to impact on how they experienced the GSH. Rather, participants seemed to perceive GSH as another opportunity to receive help for their difficulties.

Findings for this question indicate that patients' experiences varied as to whether their expectations were met. One of the reasons for this study was to improve the acceptability of the GSH being offered. Although participants were not asked directly about improvements many participants made suggestions, regardless of whether their experiences met their expectations. Again, findings in this area showed some similarities and also differences with the literature in the Introduction. For example, similar to previous studies (e.g., Reeves & Stage, 2005, Lovell et al., 2006), participants' were able to recognise changes (see section 4.3.1.3 Changes). In comparison to other studies (e.g., Willemse et al., 2004; Mead et al., 2005), participants in this study explicitly referred to how they experienced the setting (see section 4.3.1.2 Practicalities).

4.3.1 Experience of Guided Self-Help

4.3.1.1 Content and Process

As in other studies (e.g., Farrand et al., 2008; Willemse et al., 2004; Mead et al., 2005), this study found participants' experiences of the content and process varied: some participants found the GSH helpful as it offered them support to put practical strategies into place, other participants did not find this helpful. Similar to the studies by Reeves and Stage (2005) and Reeves (2010), this study found that participants preferred some aspects of the GSH over others. In line with Lucock, Mirza et al. (2007), there were also some participants who found the manual difficult to understand. The importance of a manual's readability for helping patients to engage with GSH has been emphasised previously if SH interventions are to meet the needs of patients (Martinez et al., 2008; Turpin, 2010).

Significantly, the idea that participants had expected more in relation to content and process (as noted above) suggests their experiences in these areas failed to address important issues. This is somewhat consistent with two studies (Ricketts et al., 2008; Mead et al., 2005), which found that GSH was not relevant to all patients. However, whereas the two studies found this contributed towards reduced treatment effectiveness, findings from this study suggest this was not always the case. Although there were some participants who did not improve as much as they wanted to, many of the participants who expected more were still able to make changes (see section 4.3.1.3 Changes).

4.3.1.2 Practicalities

This study found that participants had negative experiences related to inflexibility of appointment times and that spacing the sessions to suit the participant was beneficial. These findings highlight the need for services to be responsive to patients' needs, also identified by Lovell et al. (2006). A further finding in this study

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was that a participant found the waiting list a negative experience. However, Macdonald et al. (2007) did report that waiting lists impacted on patients' decisions to access further therapy. Interestingly, no previous studies (e.g., Willemse et al., 2004; Pratt et al., 2009; and other studies in the literature review) explicitly referred to how patients experienced the setting. In this study, one participant specifically commented on the "really dingy room" (6:1293) where one of her sessions took place. Although it is only one participant, this highlights that the environments in which sessions take place are an important consideration. More information on this may have been gathered had the researcher specifically asked about it (see section 4.5 Critical Appraisal).

4.3.1.3 Changes

Findings from this study indicated participants were able to recognise changes in five main areas. These were managing their anxiety better, changing specific behaviours, how participants related to themselves, improvements socially and to where participants attributed their problems. Similar findings have been reported in two of these areas. Firstly, previous studies (Willemse et al., 2004; Reeves & Stage, 2005, Lovell et al., 2006; Philp et al., 2006; Lucock, Barber et al., 2007; Ricketts et al., 2008; Farrand et al., 2008; Reeves, 2010) have found SH interventions led to general improvements and managing anxiety better. Secondly, although the majority of participants in this study reported specific behavioural changes, similar to Ricketts et al. (2008), there were some who felt there were changes still to be made. This complements the meta-analysis by Hirai and Clum (2006) who found that SH interventions for anxiety were moderately effective. Furthermore, that six of the ten participants had depression in addition to anxiety, and were able to make behavioural changes, is in line with the review by Bower et al. (2001) which indicated SH for depression and anxiety had potential.

These findings also imply that participants perceive changes as a continuous process, echoing findings from Macdonald et al. (2007) who reported that service-users often report benefits in terms of magnitude. However, unlike Macdonald et al. this study did not find that patients and Practitioners differed on definitions of "successful" outcome. This may be because expectations of Practitioners were not directly elicited. Further, measures used by Practitioners to indicate outcome were not consulted (see section 4.5 Critical Appraisal). However, this study did find that it was important for both 'agents' to be in agreement about what to expect in terms of outcome (see section 4.4.2.6 Agreement Between Practitioner and Participant).

Similar to Fletcher et al. (2005) and Mead et al. (2005), this study also found there were areas in which no changes were made. Specifically, some participants were concerned that feelings of anxiety were still present. However, anxiety is a 'normal' human emotion. GSH is about learning how to manage this and build resilience, rather than getting "rid" (Participant 2) of it. This suggests patients may sometimes benefit from further psycho-education about anxiety (see section 4.4.6 Knowledge). This highlights the importance of psycho-education in GSH (Cuijpers & Schuurmans, 2007). Furthermore, learning how to live well in the presence of anxiety is fundamental to the 'Recovery Model' (Mental Health Foundation, 2010).

4.3.1.4 Overall Experience

Consistent with a number of previous studies (Willemse et al., 2004; Fletcher et al., 2005; Mead et al., 2005; Reeves & Stage, 2005; Lovell et al., 2006; Pratt et al., 2009; Reeves, 2010; Rogers et al., 2004), this study found participants had experiences that were positive. Similar to Fletcher et al. and Mead et al. this was regardless of whether they made changes. This study also found that for some participants experiences were mixed and for one participant their overall experience

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was negative. Pragmatic sampling is likely to have influenced this finding (see section 4.5 Critical Appraisal).

4.3.2 Experiences Do Meet Expectations

This was an unexpected finding considering participants' experiences were varied and many had expected more in relation to content and process. The interview guide may have encouraged participants to refer generally to whether their experiences met their expectations, at the expense of considering the different aspects of their treatment (see section 4.5 Critical Appraisal). Nevertheless, this finding is important because it shows that patients' experiences can meet their expectations. Both Rogers et al. (2004) and Macdonald et al. (2007) that explored whether experiences met expectations found differences. As such, these will be referred to in section 4.3.5 Experiences Different to Expectations.

4.3.3 Some Experiences Meet Expectations

This finding indicated that for some participants aspects of their experiences met their expectations, such as feeling better, whilst their experiences of what GSH involved did not meet their expectations. The researcher thought that more participants would have felt their experiences of outcome met their expectations. This was because the majority of participants had expected positive outcomes and all appeared able to recognise changes made (see section 4.3.1.3 Changes). This implies that what is perceived to be an "outcome" by the researcher is different to participants' perceptions, highlighting the impact of an individual's 'lens' on building an understanding. Importantly, the finding that some experiences met expectations highlights that experiences and expectations are complex and depend on a number of different aspects that have multiple rather than linear relationships. It also provides evidence that the interview guide did not always influence participants into giving general answers.

4.3.4 Experiences Do Not Meet Expectations

This study found that for two participants their general experiences and more specific experiences related to content and process did not meet their expectations. This finding was not surprising, considering participants had expected more in relation to content and process. This finding is noteworthy because it highlights the importance of eliciting patients' expectations so that these can be discussed. It also provides further evidence that patient expectations are an important factor to consider when implementing SH interventions (Turpin, 2010).

4.3.5 Experiences Different to Expectations

This finding is consistent with previous studies (Macdonald et al., 2007; Rogers et al., 2004), which identified that expectations were different to experiences. Importantly, whereas these studies reported that expectations were unfulfilled, this study found that for some participants experiences exceeded expectations. Further, this study found that a participant altered her expectations, due to these being different to her experiences. This is significant because it demonstrates that as patients gain experience their expectations can change. Consistent with Rogers et al. this complements the finding reported earlier that through experience participants gained a better understanding of what GSH involved.

4.3.6 Improvements

Important findings emerged from the data related to improvements. These covered four main areas and were general, rather than specifically related to GSH for anxiety.

Similar to Lucock, Mirza et al. (2007), this study found participants suggested group sessions to improve the contents of the GSH. Improvements were also suggested to the process by going into more depth. This contrasts with Lucock, Mirza et al. who found service-users wanted less information covered. The difference in

findings may be because the latter study was investigating SH without guidance. Thus, service-users may have been concerned about having to understand the information by themselves. This may explain why Richardson et al. (2010) recommend SH interventions are accompanied by guidance and support from mental health workers.

In line with Lovell et al. (2006), suggestions were also made about improving practicalities with regards to flexible appointment times. An additional suggestion in this study was to keep waiting lists to a minimum. Although Macdonald et al. (2007) highlighted the importance of waiting lists to patients, they did not suggest improvements.

Consistent with Lucock, Mirza et al. (2007), another improvement suggested in this study was periodic maintenance. However, there is a limit on how much support can be offered. Not only is there a finite workforce but, with continued support, patients are at risk of becoming dependent on the input of services, a concern also raised by Farrand et al. (2008). This is also one of the main criticisms of the ZPD (Vygotsky, 1978).

The other improvement suggested was having more options available. This would ensure that interventions are responsive to patients' needs (Lovell et al., 2006; Turpin, 2010) and enable increased choice (Philp et al., 2006).

4.3.7 Summary

For Research Question Two participants referred to whether their experiences met their expectations in relation to process, content and outcome. Participants did not refer to whether their experiences met their expectations in relation to practicalities. This is understandable, given that patients did not refer to this when discussing their expectations of GSH for anxiety (Research Question One). However, participants did make suggestions about how to improve practicalities. This is

important because it highlights the need to be aware of all four aspects (i.e., process, content, outcome and practicalities), when exploring how to improve GSH (see section 4.6 Clinical Implications and Future Directions).

4.4 Research Question Three: Are Self-Efficacy and Therapeutic Alliance Important Influences on Patients' Experiences?

Findings from this study indicate that self-efficacy and therapeutic alliance are important influences on patients' experiences. As expected they are not the only influences and a number of other important influences emerged. In particular, a theme about 'meeting needs' appeared to permeate a number of other themes. These findings are compared with previous studies (e.g., Willemse et al., 2004; Rogers et al., 2004; and other studies in the literature review) and, when relevant, the models of Kolb (1984) and Vygotsky (1978).

4.4.1 Self-Efficacy

Theories of self-efficacy (Bandura, 1977; Ajzen, 1991) provide a framework to explain and predict psychological changes. This study found that for the majority of cases participants referred to self-efficacy when talking about changes, providing support for the theories. However, there are also aspects of both theories that are challenged. Possible reasons for these are suggested.

4.4.1.1 Responsibility

In line with Richards (2004), this study found that taking responsibility was important for participants to make changes and to believe in their own abilities. Those participants who were less eager to take responsibility were also the ones who made less changes. This finding suggests that by taking responsibility participants start learning how to cope. According to the Cognitive "Specificity" Hypothesis (Butler et al., 2008), anxiety involves an underestimation of coping factors. By

learning skills and experiencing improvements participants enhance their sense of mastery in being able to cope (see section 4.4.1.3 Changes in belief), enabling them to regain a sense of control over their lives, an important factor in managing anxiety. This is consistent with Rogers et al. (2004) and Reeves (2010), which found that learning practical strategies enabled patients to regain a sense of control. This supports the TPB (Ajzen, 1991) whereby control beliefs are fundamental to whether people perform a certain behaviour.

4.4.1.2 Belief in Own Abilities

Consistent with Bandura's (1977) theory, performance accomplishment appeared to be the principal source of information for participants believing in their abilities. Participants also spoke about beliefs in their abilities in relation to verbal persuasion, another source of information identified by Bandura. When participants used verbal persuasion, this involved referring to past experiences of a behaviour. This provides support for Ajzen (1991) who argued that past experiences of a behaviour influenced perceived behavioural control. Although Bandura and Ajzen both identified support from family and friends as an important factor for self-efficacy/perceived behavioural control, this study found that reference to this was within the context of their social network (see section 4.4.7 Social Network) rather than belief in their own abilities. An explanation for these findings is given in section 4.5 Critical Appraisal.

In addition, findings from this study suggest that other professionals contributed towards participants believing in their abilities, indicating that others can contribute towards building self-efficacy. This complements Ajzen's (1991) TPB whereby second hand information about a behaviour influences perceived behavioural control. Consistent with Farrand et al. (2008) and Macdonald et al. (2007), there was concern that once support was removed participants would no longer be able to cope.

This is significant as it provides further evidence that participants need to perceive themselves as responsible for making changes.

Results from this study found that for one participant self-efficacy was context specific. Although this was just one case it provides evidence supporting both Bandura's (1977) and Ajzen's (1991) theories. Importantly, the finding that those participants who did not refer to a belief in their abilities made less change is consistent with MacLeod et al. (2009) who found higher levels of self-efficacy predicted a more successful outcome.

4.4.1.3 Change in Belief

This study found that for some participants their belief in their abilities increased over the course of GSH. This is an important finding, which provides evidence that for some patients GSH is able to promote self-efficacy (Richards, 2004). Furthermore, promoting self-efficacy can help build resilience, complementing the 'Recovery Model' (Mental Health Foundation, 2010). A similar finding was reported by Rogers et al. (2004), who found positive experiences contributed towards improvements in self-efficacy.

For some participants, increases in belief appeared to be related to outcome. This contrasts with Bandura (1977) and Maddux (1993) who argued that efficacy expectations and outcome expectations are conceptually different. In line with Eastman and Marzillier (1984), this study found that: i) the immediate outcome of an action is important for changing beliefs; and ii) that an individual's expectation of outcome, can be heavily influenced by how much an individual believes he or she is capable of performing the action necessary to bring about the outcome. This is consistent with Ajzen's (1991) perceived behavioural control. These findings are best demonstrated with the following quote, with annotations:

I couldn't deal with anything at first, (suggests efficacy expectation low) but

after a few sessions I began to realize that I had to do something to help me,

and I started reading the manual, (action) and it started to make sense to me

(immediate outcome, participant's belief changes: she is able to successfully

execute the action)…and it was almost like, I wanted to reach that goal, that I

could get a bit better (outcome expectation increases). (1:852-857)

This quote also illustrates that as the participant's belief in her abilities changed her

goals became higher. This suggests an inter-relationship between efficacy and

outcome expectations, complementing Schwarzer (1992), who believes self-efficacy

impacts on levels of motivation.

An additional finding from this study was that an event occurred which

decreased a participant's belief in his abilities. This provides further evidence of how

self-efficacy varies in magnitude and according to the context, supporting Bandura's

(1977) and Ajzen's (1991) theories.

4.4.1.4 Summary

Importantly, these findings show that although GSH can alter the level and

strength of self-efficacy for some participants, this is not universal. However, all

participants were able to learn skills and recognise changes made. This suggests there

are other important factors that influence whether patients experience changes.

4.4.2 Therapeutic Alliance

Within the literature, therapeutic alliance is often associated with outcome (see

section 1.4.3.1 Definitions of Therapeutic Alliance). Findings from this study suggest

that therapeutic alliance provides a useful framework for understanding what

influences experiences, beyond making changes. Further, this study found that

therapeutic alliance consists of a number of aspects identified in the Introduction.

This highlighted a range of different definitions for therapeutic alliance. For example,

whilst Rogers (1951) argues the alliance can have a curative aspect, Horvath et al. (1993) identified three aspects to be important. These are: i) the therapist's ability to present as empathic; ii) agreement between patient and therapist for short- and medium- term goals for therapy; and iii) patients' perception of the intervention as relevant and potent. Whilst some of these aspects have remained the same (e.g., Perception of intervention) others have been modified slightly (e.g., Agreement between Practitioner and participant) in the process of undertaking the research.

4.4.2.1 Practitioner Qualities and Interpersonal Style

This study found that a Practitioner's qualities and interpersonal style influenced patients' experiences on all aspects of GSH (i.e., content and process, practicalities, changes, and overall). Although the majority of the time Practitioners were perceived as empathic and supportive, there were occasions when these qualities were perceived to be missing. For Participant 6 this seemed to impact on both her overall experience and treatment effectiveness. For Participant 10 this influenced her experience of one session, but not her treatment effectiveness. Importantly, these two participants highlight that although negative characteristics do not always influence the overall therapeutic alliance, it can influence experiences and whether changes are made. This is somewhat consistent with Banasiak et al. (2007) who reported that a facilitator's negative characteristics were the least effective aspects of treatment. This finding demonstrates that certain therapist qualities, such as empathy (Rogers, 1951) are important. It is also consistent with previous studies (Macdonald et al., 2007; Mead et al., 2005; Reeves, 2010; Richardson et al., 2010; Rogers et al., 2004; Williams & Martinez, 2009) that identified empathy and a supportive environment as important. It also provides further evidence of the need for interventions to be therapeutic, in addition to psycho-educational. The importance of this was highlighted by a number of authors, including Lovell at al. (2006), Parry et al. (2009),

Richardson et al. (2010), and Turpin (2010). Furthermore, these findings highlight

the importance of a facilitator's characteristics for helping the learning process, which

is not identified in either Kolb's Learning Cycle (Kolb, 1984) or the ZPD (Vygotsky,

1978).

In contrast to Macdonald et al. (2007), this study found no participants

reported on whether desires for self-disclosure had been met. Moreover, this study

did not find evidence supporting Khan et al. (2007), who reported that if a facilitator

was perceived to have negative characteristics this would impact on a patient's self-

efficacy. This may be because participants were never asked directly about these

issues (see section 4.5 Critical Appraisal).

4.4.2.2 Participant Characteristics

Consistent with MacLeod et al. (2009) findings from this study indicated that

participants' characteristics influenced experiences in relation to how they approached

and responded to the GSH. For some participants how they responded to the GSH

appeared to impact on their ability to make changes (e.g., Participant 2). In line with

Piper et al. (1991b, as cited in Roth & Fonagy, 2005), this study found that participant

characteristics are an important aspect of therapeutic alliance and these relate to

engagement (see section 4.4.4 How Participant Engages). Significantly, that

participant characteristics are an important influence highlights the need to consider

these in relation to learning. This appears to be neglected in Kolb's Experiential

Learning Model (Kolb, 1984).

4.4.2.3 Participant Perception of Intervention

This study found that for all participants this aspect of therapeutic alliance

influenced their experiences, particularly in relation to making changes. In line with

Lovell et al. (2006) the majority of participants perceived the intervention as effective

and appropriate to their needs. As such, many participants were satisfied with their

treatment, a finding reported by Fletcher et al. (2005), Willemse et al. (2004) and

Reeves and Stage (2005). However, consistent with Mead et al. (2005) and Ricketts

et al. (2008) there were some participants who did not find the intervention applicable

or effective. This range of perceptions is not surprising given the different

characteristics of participants and mixed expectations they had.

In addition, this study found that although participants perceived that certain

strategies worked and other strategies did not, this did not appear to impact on their

view of the overall therapeutic alliance. This supports findings from Mead et al.

(2005) and Macdonald et al. (2007), where perception of strategies did not impact on

therapeutic alliance. This suggests that although the perception of the intervention is

important, there are other aspects of the therapeutic alliance construct that are also

important. This finding is significant because it highlights the complexities of

therapeutic alliance.

There were no findings in this study that suggested early improvements in

therapy changed the participants' perception of the GSH. This is inconsistent with

Roth and Fonagy (2005), who believe that early improvements can lead to a change in

perceptions. However, this does not mean it did not happen, only that it was not

reported by any of the participants interviewed.

4.4.2.4 Perception of Practitioner's Expertise

Those participants who referred to the abilities of the Practitioner reported

mixed opinions. For Participant 3, she considered whether her experience would have

been different had the Practitioner been fully qualified. Although Participant 10

thought the Practitioner was inexperienced this did not appear to reduce the treatment

effectiveness for this participant: she was still able to make changes. It did, however,

influence her experience of one of the GSH sessions. For Participant 2 the Practitioner

was not considered professional. This appears to have contributed partly towards his

overall experiences, that were mixed, and a lack of changes made. These findings are somewhat consistent with the researcher's assumption that a Practitioner's experience and expertise could impact on the quality of the GSH. However, these findings contrast to Farrand et al. (2008), who reported that 'paraprofessional' clinics had comparable effectiveness to clinics run by experienced mental health professionals (Lovell et al., 2003). It is also inconsistent with the review by Gellatly et al. (2007) who found that level of experience did not impact on effectiveness.

4.4.2.5 Interaction Between Practitioner and Participant

Interactions varied between Practitioners and participants. These interactions, particularly negative exchanges, appeared to be important influences on experiences. Similar to Rogers et al. (2004) many participants reported positive interactions. This suggests they were satisfied with their relationships, a finding reported by Mead et al. (2005). Notably, although there were occasions when interactions suggested a 'therapeutic rupture' had occurred, these appeared to provide an opportunity for exploring relationships. This appeared therapeutic in itself and is consistent with Safran and Muran (1996). This also provides further evidence of the therapeutic nature of GSH. Interestingly, in this study participants referred to a Practitioner's qualities and interpersonal style when discussing interactions. However, no participants explicitly referred to how his or her characteristics may have interacted with a Practitioner's. Instead, participants tended to refer to his or her characteristics when discussing interactions with interventions. Although this study demonstrated that the quality of interactions appears to be an important influence, neither Kolb's (1984) nor Vygotsky's (1978) learning models refer to this.

4.4.2.6 Agreement Between Practitioner and Participant

Importantly, whereas agreement on goals was identified by Horvath et al. (1993) as one aspect of therapeutic alliance, this study found that agreement was

broader than this: Participants referred to agreement both in terms of outcome and what to expect from one another. This is somewhat consistent with Richardson et al. (2010) who highlighted the importance of negotiating goals. Again, although this appears to be an important influence, this does not feature in either Kolb's (1984) or Vygotsky's (1978) learning theories. As such, this is a limitation of both models.

4.4.2.7 Summary

Findings from this study suggest that although participants' experiences varied on different aspects, a negative experience on one aspect did not necessarily impact on the overall therapeutic alliance. However, each aspect of therapeutic alliance did influence participants' experiences of the GSH. As such, findings in this study complement Parry et al. (2009) and Turpin (2010) who stress the importance of therapeutic alliance in SH interventions. These findings also indicate GSH to have therapeutic aspects, as well as psycho-educational, supporting the studies by Lovell et al. (2006), Parry et al. (2009), Richardson et al. (2010), and Turpin (2010). Further, findings from this study indicate that a Practitioner's qualities and interpersonal style, quality of interactions, and agreement between Practitioner and participants, are important areas missing from both Kolb's (1984) and Vygotsky's (1978) learning theories.

4.4.3 Presence of Practitioner and Information

A key finding from this study was that participants required information and the input of a Practitioner. Without the additional input, two participants reported they would not have been able to engage with the information. For others, the Practitioner provided motivation and helped to maintain morale in the face of adversity. Following the 'events paradigm' (Llewelyn & Hardy, 2001) in the sudden gains and psychotherapy process research, that the presence of a Practitioner and information were important for maintaining morale and engaging with the material

could be identified as an "event that is likely to contain the effective ingredients of change" (p.4, Llewelyn, Elliott, Shapiro, Hardy & Firth-Cozens, 1988). Other process research has shown 'non-specific' factors such as encouragement, reassurance and explanation to be important for maintaining morale (e.g., Garfield, 1997). Further, that Practitioners helped patients to maintain morale suggests they were being responsive to patients' needs at a particular moment in their treatment. Change-theory process research has identified that appropriate responsiveness, in which therapists are able to provide patients with a sense of security, can lead to therapeutic change (e.g., Hardy, Shapiro, Stile & Barkham, 1998). It is not possible to explore all of the sudden gains and psychotherapy research in this thesis. For a comprehensive review please refer to Llewelyn and Hardy. However, it does provide further evidence that factors, such as a Practitioner's qualities and interpersonal style (see section 4.4.2.1) and meeting needs (see section 4.4.5) are important in GSH. It also adds further evidence that GSH needs to be therapeutic.

The importance of both Practitioner and information is consistent with Vygotsky's ZPD (Vygotsky, 1978) and Lucock, Barber et al. (2007) who found that engaging others was helpful. It is also consistent with the literature, which demonstrates that GSH is more effective than un-facilitated SH (e.g., Mains & Scogin, 2003). However, as noted in the Introduction, there are a number of factors that need to be considered when deciding whether GSH or 'pure' SH would be most effective (Turpin, 2010). These included the type of disorder and individual differences in motivation.

Although interactions varied as to how positive they were, none of the participants referred to ambivalence about the role of the Practitioner. Rather, similar to Reeves (2010), most participants appeared to value the input from Practitioners highly. This finding was unexpected because it contrasts with the meta-synthesis by

Khan et al. (2007). Moreover, it directly contradicted the researcher's assumption, that the presence of a Practitioner could cause some tension with the patient's use of SH, impacting on their self-efficacy. Instead, this study found Practitioners and other professionals enhanced participants' beliefs in their abilities rather than undermined them (see section 4.4.1.2 Belief in Own Abilities). This finding may be because the meta-synthesis by Khan et al. involved depressed patients, in which deterioration in relationships is common (Carr & McNulty, 2006), whereas this study focused on anxiety, where the presence of another individual can provide reassurance (Butler et al., 2008).

4.4.4 How Participant Engages

One of the main findings from this study was that participants' engagement with GSH influenced their experiences of it. This engagement consisted of four themes: i) awareness; ii) readiness; iii) motivation; and iv) ability to reflect, understand, learn and apply techniques. Each of these is addressed in turn, with regards to the literature.

An original finding in this study was that patients' awareness of a problem is an important influence on experiences. Similar to Campbell and Smith (2003), this study also found that readiness is an important influence. As such, the Transtheoretical Model of Change (Prochaska & DiClemente, 1983), which provides a framework for assessing an individual's readiness to change, may be worth considering when investigating this area. This model proposes that changes to a behaviour occurs in five distinct stages: i) pre-contemplation, in which individuals have not considered changing a behaviour; ii) contemplation, where a person is prompted to start thinking about change; iii) preparation, whereby a person prepares to undertake the desired change; iv) action, where individuals modify their behaviour, experience or environment to meet their goals and/or overcome their problems; and v)

maintenance, where people practice the new behaviour to prevent relapse and consolidate gains made.

In line with MacLeod et al. (2009), Newman et al. (2003), and Parry et al. (2009) motivation was important for helping participants engage with the GSH. This clearly relates to Participant Characteristics (see section 4.4.2.2). Consistent with Rogers et al. (2004), this study found that a participant's ability to learn is important. An additional finding in this study was that a participant's ability to reflect, understand and apply techniques is important. This is consistent with Kolb's Model (1984), which theorises that four 'modes' are necessary to enable learning to take place: 'Concrete experience'; 'Reflective observation'; Abstract conceptualisation'; and 'Active experimentation'.

4.4.5 Meeting Needs

A significant finding in this study was the importance of 'Meeting Needs'. This permeated the following themes: Therapeutic alliance; Presence of Practitioner and information; and How participant engages. Lovell et al. (2006) were the only other study reviewed that explicitly highlighted the importance of meeting needs. However, its presence or absence has been acknowledged in other studies: Richardson et al. (2010) emphasised that SH books need to develop factors such as flexibility and responsiveness, in order to meet the needs of different people; Mead et al. (2005) found that techniques in their manual may not have been relevant, suggesting that these did not meet patients' needs. Mead and colleagues also reported no benefits from GSH. Thus, this study provides further evidence that meeting needs is an important area to consider for improving the effectiveness of GSH (see section 4.6 Clinical Implications and Future Directions).

4.4.6 Knowledge

This study found that knowledge is an important influence. The researcher's anecdotal experience is that knowledge about anxiety can enhance understanding and help individuals to feel less overwhelmed. In this study, having knowledge about anxiety appeared particularly important. The majority of participants were able to develop their understanding through psycho-education and facts. However, there were some participants who may have benefitted from further psycho-education. This highlights the importance of the psycho-educational element of GSH (Cuijpers and Schuurmans, 2007) and that SH has educational goals in addition to therapeutic goals (Williams & Whitfield, 2001). As expected, this study also found that an important influence was that participants did not feel alone.

The researcher assumed that gaining an understanding of anxiety helps to restore a sense of control. This fits with the Cognitive "Specificity" Hypothesis (Butler et al., 2008), which implies that perception of danger and underestimation of coping and rescue factors undermine an individual's sense of control. Through restoring a sense of control participants are able to take responsibility for themselves and have a greater belief in their own abilities to make changes. Importantly, this suggests a link between knowledge and self-efficacy.

4.4.7 Social Network

A unique finding in this study was that a social network is an important influence and that this is not always positive. This provides evidence in support of the TPB where social approval or disapproval is important for determining whether a specific behaviour is performed (Ajzen, 1991). No studies in the literature reviewed (e.g., Willemse et al., 2004; Rogers et al., 2004) found that recognition from others influenced experiences. Similar to Lucock, Barber, et al. (2007), this study found that sharing information with others was important.

Importantly, findings from Research Question Three identified a number of key influences in addition to self-efficacy and therapeutic alliance. Many of these influences go beyond whether participants can make changes, to other experiences (i.e., process and content). Notably, findings for this research question suggest links between different themes, for example knowledge and self-efficacy. Although template analysis provides a useful structure for writing up results, linear templates make it difficult to highlight relationships between the different themes. See the section below for further discussion of the pros and cons of template analysis. Findings from this question also provide further evidence that GSH is both therapeutic and educational, and that there are many factors to consider for what contributes towards effective GSH. In addition, findings for this question can be understood within the context of the learning theory models and highlight areas not considered by either model.

4.5 Critical Appraisal

Qualitative researchers stress that research data needs to be embedded in the context in which it was produced (Elliott et al., 1999; Yardley, 2000). Therefore, it is essential the analysis and discussion of findings involve careful reflection on the ways in which the data have been shaped by the research process itself. Reflexivity also needed to take into account that the researcher's position and perspectives, and theoretical understandings shaped the research (Malterud, 2001). In line with Malterud, throughout the research process a reflective diary was kept. The aim of this was to think about the impact of the researcher on the study, from devising the research questions through to the data analysis and interpretation. In this section the

reflective diary is drawn upon and excerpts given to provide a critical appraisal of the research.

One of the main strengths of this study was it involved a routine clinical setting. However, conducting research in a clinical setting and using pragmatic sampling meant the perspectives of patients who discontinued treatment were not represented. This contrasts to the study by Willemse et al. (2004), who found that participants who discontinued treatment were significantly less satisfied than participants who did complete treatment. As such, it would have been useful to gain insights into these patients' perceptions and elucidate what influences their experiences. This could have 'shed light' on whether patients discontinued because they were less satisfied, had negative experiences, and/or were not interested in pursing GSH. This may have led to other improvements being suggested.

As this study involved a clinical sample it was not possible to gain access independently. Similar to the study by Mead et al. (2005), this study's recruitment relied on others, that is, the Practitioners giving or sending out information packs. This is likely to have influenced which patients agreed to participate and led to an unrepresentative sample (Greenhalgh, 1997). For example, how Practitioners presented the study when giving out packs and relationships between Practitioners and patients may have influenced how packs were received. The recruitment method used meant there were a number of points where attrition could occur. These included information packs being given to patients, patients returning the consent form and their contact details, arranging, then attending an interview, and finally, completing the interview.

To overcome these limitations a different recruitment method could have been used. Instead of relying on patients sending the consent form to the researcher, Practitioners could have introduced the study to patients and if patients were willing

they could have signed a 'consent for contact details' form. This would have enabled the researcher to contact patients directly and talk through what the study involved. This may have led to a broader sample and reflected a wider range of perspectives than those interviewed in this study. Although no studies in the literature reviewed used this approach, many of the researchers had the advantage of being placed within the service (e.g., Farrand et al., 2008; Reeves, 2010).

Providing a financial incentive for participating may have also helped recruitment and encouraged those who discontinued to participate. However, although the use of monetary incentives could have potentially increased participant numbers, (Gould & Clum, 1993) the quality of data may have been affected: participants may have been less motivated to voice their views. Participants in this study appeared motivated by wanting to improve the GSH offered, hence improvements were suggested regardless of their experiences.

Due to time constraints it was not possible to achieve data saturation, identified as an important aspect of qualitative research (Glaser, 1992). However, there were a number of themes that occurred within and across the different transcripts, suggesting that some saturation did occur. Although the sample size was small, it did allow a comprehensive data analysis. According to Sandelowski (1995), this is the 'raison-d'etre' of qualitative inquiry.

Although qualitative research enables in-depth analysis, it is time consuming and labour intensive (Pope et al., 2000). This means that the scope of research is often limited. The local nature of the research also limits the wider relevance of findings. However, similarities and differences with other studies were identified and attempts made to situate the sample. This allows the reader to explore the applicability of findings beyond this study (Elliott et al., 1999).

The interview guide was purposefully broad to avoid leading responses in a particular direction. However, this meant participants were not always asked the same questions, and therefore, information about particular areas was not always gathered. As such, it may have been useful to ask directly about specific areas. For example, like in the study by Lucock, Mirza et al. (2007), it may have been useful to ask directly about participants' expectations and experiences of the different aspects of GSH, such as the manual, Practitioner and setting, rather than see whether participants referred to this. This would have led to more data being gathered and enabled a more in-depth analysis of participants' expectations and experiences of these aspects. Similarly, it could have been useful to ask specifically about whether: i) participants' desires were met; and ii) Practitioners' qualities and interpersonal styles affected participants' beliefs in their abilities. However, these questions are very leading. A further difficulty with the interview guide was that asking about whether experiences met expectations in general terms may have led to participants giving an overview. However, the fact that some participants found aspects of their GSH met their expectations, whilst other aspects did not, suggests the question did not necessarily influence participants into giving a general answer. It would have also been useful to have piloted the interview guide prior to the study to identify potential issues (Boynton, 2004).

An ethical dilemma for qualitative research is what constitutes data and what to include (Mason, 2002). In consideration of this, it is important to describe the contexts in which data was collected, the method used, and how it was recorded (Yardley, 2000). This is because these will have impacted on the data gathered and shaped the findings presented (Murphy & Dingwall, 2001).

Nine of the ten interviews were conducted in participants' homes. These participants appeared comfortable to discuss their perceptions. Although there were

some interruptions, such as a telephone call, participants were able to re-engage with the conversation where it had been left. Once interviews were finished and the digital voice recorder switched off, some participants would make further comments in relation to the interview. These comments were similar to ones previously reported when recording. Therefore, the researcher decided these additional comments would not be recorded as part of the data. The interview that took place at one of the IAPT sites felt more formal than the others. Although the participant appeared to engage, the researcher felt there were some areas where the participant may have expanded further had they been in a different setting.

The method of conducting the interview after patients had completed their GSH required retrospective recall. This uses the entire treatment as the 'unit' of experience, thereby focusing on global perceptions. Similar to Macdonald et al. (2007), retrospective accounts may have been 'coloured' by the treatment outcome. To overcome this, it may have been useful to conduct more than one interview focusing on different stages of the GSH. This may have elicited information on processes involved prior to, as well as during, the intervention (Rogers et al., 2004). However, this would have both ethical and logistical difficulties. With regards to the former, conducting an interview whilst patients were still receiving treatment may have impacted on this treatment. With regards to the latter, interviews require participants to set aside time and people may have been reluctant to do this repeatedly. Williams and Healy (2001) report that using one interview can mean the analysis underestimates the degree to which people's experiences change over time. However, both *Changes in expectations* (item 1.4) and *Changes in experiences* (item 1.3.5) were identified as themes, indicating that a single interview was able to reflect changes that occurred during GSH. Finally, the process by which data was recorded led to some information being selected over others.

> Excerpt from reflective diary:
> Reading 'Deciding what counts as data' in Mason (2002) highlights the complexities of doing qualitative research. I hadn't considered whether my own memories and unwritten interpretations of the interview interaction would count as data. Nor had I really given much thought to the fact that a transcription is "partial partly because it is an inadequate record of non-verbal aspects of the interaction" (p. 77).

Guidelines for the ethical practice of research were also followed (Hewitt, 2007). This was important because the official guidelines and ethical codes of practice are insufficient to allow the researcher to navigate possible ethical dilemmas that arise during the research. The ethical practice included using transparent consent procedures and continually assessing each participant's willingness to participate until the interview was completed (Hewitt, 2007). The researcher used her skills as a Trainee Clinical Psychologist to help develop relationships with participants and to prevent participants from feeling judged. However, it was recognised that the researcher may not have been aware if participants felt this. When sensitive issues were explored, consideration was given to whether the participant needed other support mechanisms. It was hoped that this helped participants share their experiences openly, meaning the data gathered reflected their views.

According to King (1998; 2007), template analysis provides a systematic and transparent method of data analysis. However, as Fontana and Frey (1998) highlight:

> Asking questions and getting answers is a much harder task than it may seem at first. The spoken or written word has always a residue of ambiguity, no matter how carefully we word the questions and report or code the answers.
> (p.47)

By using the interview guide flexibly, and using a less structured approach to analyse and interpret data compared to other forms of analysis (e.g., content analysis), findings that emerged will have been influenced by the researcher's position and literature reviewed (Malterud, 2001). Explicitly stating assumptions allows the reader

to assess how these assumptions have shaped the researcher's findings (Marshall, 1985). In line with Devine and Heath (1999), reflexivity enabled the researcher to document her assumptions and compare and contrast findings with her prior expectations. This confirmed some assumptions whilst others were challenged. For example, whereas self-efficacy and therapeutic alliance had been considered important influences in relation to making changes, during the analysis it became apparent that these constructs influenced other experiences besides making changes. Furthermore, whereas initially it had been assumed that making changes would be an important influence, the researcher found that whether changes were made was an experience rather than an influence. This was subsequently moved to template two. Throughout the coding, changes were made to templates, evidencing that initial assumptions were changed by the data.

Commitment, identified by Yardley (2000) as an important requirement of qualitative research, was demonstrated by going through the data multiple times. Initially, one template was used for the research questions and coding was done concurrently. This allowed the researcher to get an overview of the different themes. Due to the size of the template this was then separated into three initial templates to match the three research questions. For developing the final templates, coding of each research question was completed sequentially. This enabled an in-depth analysis for each question and attempted to prevent the coding of one research question being influenced by the others. However, some overlap between the three templates was likely because of the complexities of expectations and experiences. In particular, templates two and three were both concerned with experiences and trying to differentiate experiences from influences on experiences was challenging at times. This could have been avoided by better wording and more focused research questions.

However, as this was only identified at the coding stage it was not appropriate to

reword the questions.

> Excerpt from reflective dairy:
> Whilst coding the data I'm struggling with the research questions. The problem with question two is that you need to know what people's experiences are to be able to answer it. It's also difficult to differentiate experience from what influences it. Had I been aware of this earlier I would have phrased my research questions differently. For example, Research Question Two could have been 'What are patients' experiences and how do self-efficacy and therapeutic alliance relate to this?'. Then Research Question Three 'How do experiences of GSH meet patients' expectations?'. This would be better than 'To what degree' as it does not imply quantification. However, as the interview guide was based on the research questions and data collected has been shaped by that it does not make sense to change my questions now.

Following guidelines by Elliot et al. (1999), credibility checks were used to

scrutinise the initial template, revised initial template and interpretations. The

researcher did this by discussing these with both her supervisor and at the QRF. Due

to time constraints it was not possible to gain respondent validation. Participants were

contacted about this and sent a summary of the research findings, inviting them to

give feedback (Appendix L). Nevertheless, respondent validation would have

provided a further opportunity for the researcher to check the influence of her

assumptions on the interpretation of data (Murphy et al., 1998). However, frequent

summarising and informal member checking during the interview enabled the

researcher to check her understanding. It may have been useful to consult

Practitioners for their views on the results and whether they fit with their experiences

and knowledge of using GSH with anxious patients. However, this may have

'muddied' the water (Willig, 2001), rather than clarified and verified interpretations,

and may have led to reflecting Practitioners' views rather than patients.

The a priori template identified themes the researcher was aware of at the

beginning of the research. Whilst data was being gathered, the researcher continued

to read about different theories. This highlighted information that had not previously

been considered. For example, reading more on self-efficacy highlighted different theories about this. Had this been known at the outset, the preliminary a priori template would have looked different. However, findings that emerged in relation to self-efficacy were data driven and allowed for slight differences to emerge. This illustrates the iterative process of qualitative research (Kuper, Reeves, & Levinson, 2008).

This study brings together a number of different theories. These are mostly relevant to Research Question Three. It may have been worthwhile using a theory related to expectations to broaden out the theoretical context for Research Questions One and Two. However, as the study already included a number of theories, the amount of depth that could be given to any one theory was already limited. Aspects of theories familiar to the researcher were challenged by the emerging data. This was reflected on and influenced the subsequent analysis, which is to be expected in qualitative research (Pope et al., 2000). For example, Bandura's (1977) argument that self-efficacy has two distinct components (efficacy and outcome expectations) was challenged by some of the participants' accounts. Further, the emphasis on self-efficacy and therapeutic alliance within the SH literature does not adequately consider the importance of other influences that can contribute towards patients' experiences of GSH.

4.6 Clinical Implications and Future Directions

Importantly, Research Question One highlights that although patients have some knowledge about what GSH involves, many are unclear about what to expect until they have experienced it. Although this finding is likely to have been shaped partly by the research method, it may be worthwhile exploring whether different formats of presenting information, such as leaflets, are helpful in enhancing patients'

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understandings. At present the teams send out an information sheet about GSH, but have no 'official' leaflets (A.Bishop, IAPT Team Leader, personal communication, December 14, 2010). Providing clear information has been previously recommended (e.g., Pratt et al., 2009; Hirai & Clum, 2006; Khan et al., 2007). By using different formats, patients have more opportunities to learn what GSH involves. This may help patients make an informed decision as to whether GSH is suitable for them.

As noted in section 4.5 Critical Appraisal, it would be helpful for future studies to research expectations using specific models. This would help direct the research and contribute further to our clinical and theoretical understanding of expectations.

Findings from Research Question Two provide further evidence that providing information about what to expect in relation to process, content, outcome and practicalities could help inform patients about the GSH. In addition, it may be worthwhile for Practitioners to explain what patients can expect from them. This could help the implementation process (Turpin, 2010), as well as help patients and Practitioners work towards a common goal and build a therapeutic alliance.

One of the main findings from this question was that change is just one aspect of patients' experiences. This highlights the need to consider other experiences related to GSH. For some participants, although they were not able to make as many changes as they would have liked, their experiences of GSH still appeared positive. It could be argued that these experiences helped to create a therapeutic foundation for future input, should they need it. Furthermore, for those patients who need to 'step-up', if their previous experiences of GSH have been mostly positive, this may mean they are more receptive to further input, as was the case in the study by Fletcher et al. (2005). However, that previous experiences of input, whether medical, psychological or alternative, did not appear to influence how participants in this study approached

the GSH, may mean this is not the case. Nevertheless, it is an area that is worth investigating further. In addition, although only two participants in this study were 'stepping-up', it would be informative to explore experiences of more patients in this position. This might identify salient issues that could be used to improve the GSH further.

Although services have finite resources, it may be worth investigating whether some of the improvements suggested are viable options to further develop the accessibility and effectiveness of GSH. For example, both qualitative and quantitative research into the effectiveness of group GSH sessions will allow services to: i) evaluate the impact of different formats on treatment outcomes; and ii) assess which formats are more acceptable to particular patients. This complements the recent plans and intentions for delivering GSH through different formats (Bee et al., 2008). In-turn, it could help services tailor their resources more efficiently, which is particularly important in times of restricted resources.

Research Question Three suggests it would be valuable to explore what patients would like to be in place and/or occur for their needs to be met. This may help explain why some patients do not improve despite other important influences being present, such as a positive therapeutic alliance. Findings from this question also suggested the importance of patients perceiving themselves as responsible to make changes. For GSH to be effective as possible, it is crucial to investigate this area further.

Although previous research (e.g., Macdonald et al., 2007; Reeves, 2010) has investigated self-efficacy and therapeutic alliance, this appears to be within the context of making changes. Importantly, this study found that these influence other experiences of GSH and are not limited to changes. Moreover, these findings also provide further evidence that therapeutic aspects are just as important in GSH as

psycho-education. The researcher's assumptions and wording of the third research question may have shaped this finding. As such, future studies need to think carefully about how to phrase research questions.

Particularly important findings were other influences on experiences, besides self-efficacy and therapeutic alliance, for example, how a participant engages. Aspects of how a participant engages have been highlighted by previous studies (e.g., Campbell & Smith, 2003; MacLeod et al., 2009; Newman et al., 2003; Parry et al., 2009). However, exploring these influences further could lead to a better understanding of GSH. This could then be used to tailor the GSH so that it is more acceptable for patients and, importantly, meets their needs (Turpin, 2010).

It may have been useful to have considered Weiner's Attributional Model (Weiner, 1985) to understand the interactions between people's expectations of success, their behaviour and perceptions of locus and controllability. However, this study was interested in patients' expectations and experiences rather than determinants of a particular behaviour. Nevertheless, this does provide further evidence that other constructs beyond self-efficacy and therapeutic alliance are worth considering in future studies.

At a local level this study has implications for service provision. Findings suggest that GSH can be made more acceptable to patients by considering practicalities, such as how sessions are spaced. When difficulties arise in sessions, it could be worth exploring with patients which aspects of their experience they are unhappy with. For example, a patient may be struggling with an aspect of the therapeutic alliance (e.g., perception of the intervention). Identification and discussion of this could help tailor the GSH to meet the needs of the patient better. Alternatively, the therapeutic alliance may be good, but the patient may have low self-efficacy or require more information about anxiety.

Overall, although the sample size was small, information gathered from this study has provided an insight into patients' perceptions of GSH. This information has clinical implications that are worth exploring further. Future research could expand on this study's findings by recruiting more participants and targeting those who have discontinued. It is well known that this patient group is difficult to recruit (Sadler, 2001). One suggestion to overcome this would be to use a 'consent for contact details' form described in section 4.5 Critical Appraisal.

Although this study had hoped to gain respondent validation, due to difficulties recruiting and time constraints this was not possible. This highlighted the difficulties of conducting research in a clinical setting. It is important that future studies consider practicalities of this and allow ample time for the research process.

Only a small number of studies have directly explored patients' perceptions of GSH. For services to offer more acceptable and appropriate treatment it is important that patients are given opportunities to talk about their experiences and for this information to be used to improve the service offered.

4.7 Summary and Conclusions

Overall this research addressed some of the methodological limitations found in the literature reviewed. Specifically, this study used participants from a routine clinical setting. This study also aimed for quality with respect to validity and trustworthiness as outlined by Yardley (2000) and Elliott et al. (1999). Recommendations for ethical practice were also followed (Hewitt, 2007). Using a qualitative design gave patients an opportunity to talk openly with an external researcher about their perceptions. This enabled an in-depth exploration and a better understanding of specific issues related to expectations, experiences, and influences on experiences. By doing this the study hoped to contribute towards making GSH for

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anxiety more acceptable and appropriate. This is highlighted in the literature as an important area of further exploration (e.g., Rogers et al., 2004). Using template analysis enabled a broad range of existing theories to be brought together, integrated and critiqued with respect to findings. It also allowed for the emergence of new findings, which highlighted areas (e.g., meeting needs) that are worth exploring both in research and for service development. Future studies could be improved further by wording questions differently, researching other influences identified, gaining respondent validation, having a larger sample size and recruiting patients who discontinued GSH.

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APPENDICES

NHS

National Research Ethics Service

Cambridgeshire 3 Research Ethics Committee

Victoria House
Capital Park
FULBOURN
Cambridge
CB21 5XB

Telephone: 01223 597597
Facsimile: 01223 597645

04 September 2009

Miss Ruth Easby
University of East Anglia
Doctorate Programme in Clinical Psychiatry
MED, University of East Anglia
Norwich
NR4 7TJ

Dear Miss Easby

Study Title:	**A Qualitative Study of Patients' Perceptions of Guided Self-Help for Anxiety.**
REC reference number:	**09/H0306/60**

Thank you for your letter of 27 August 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter: from Ruth Easby		03 July 2009
Protocol	1	29 May 2009
Investigator CV: Ruth Easby		
REC application (Lock Code: 24545/48305/1/271)		03 July 2009
Scientific Critique Report from Professor Malcolm Adams		01 July 2009
CV of Adam Malcolms, Academic Supervisor		
Compensation Arrangements: letter from Tracy Moulton at UEA		03 July 2009
Letter of invite for patients with interview time/date	1	29 May 2009
Demographics Information Sheet	1	29 May 2009
Preliminary Interview Questions	2	05 June 2009
Participant Information Sheet	2	18 August 2009
Participant Consent Form	2	18 August 2009
Letter of invitation to participant	2	18 August 2009
GP/Consultant Information Sheets	1	18 August 2009
Guide for Primary Care Worker	1	27 August 2009
Information Pack		
Supervisor CV: Narendra Keval		
Response to Request for Further Information		27 August 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

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- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0306/60	Please quote this number on all correspondence

Yours sincerely

pp

Mr Stuart Kent
Vice-Chair

Email: lynda.mccormack@eoe.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Ms Tracy Moulton
                Research Office
                University of East Anglia
                Norwich
                Norfolk NR4 7TJ

                Professor Malcolm Adams – Co-Director of the Doctoral Programme
                in Clinical Psychiatry
                Doctoral Programme in Clinical Psychiatry
                MED, University of East Anglia
                Norwich
                Norfolk NR4 7TJ

                Ms Natercia Godhino – R & D Manager
                R & D Office
                Cambridgeshire & Peterborough Foundation Trust
                CPFT
                Douglas House
                18 Trumpington Road
                Cambridge CB2 8AH

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the National Patient Safety Agency and Research Ethics Committees in England

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Cambridgeshire and Peterborough **NHS**

NHS Foundation Trust

Understanding mental health, understanding people

Please reply to:
Natercia Godinho
R&D Manager
R&D Office
Douglas House
18 Trumpington Rd
Cambridge CB2 8AH

R&D ref:M00368
Ethics ref: 09/H0306/60
Date: 29/09/2009

Tel: 01223 746145
Fax: 01223 746162
E-Mail: natercia.godinho@cpft.nhs.uk
Website: www.cpft.nhs.uk

Miss Ruth Easby
University of East Anglia
Doctorate Programme in Clinical Psychology
University of East Anglia
Norwich, NR4 7TJ

Dear Miss Easby

Study title: A qualitative study of patient's perceptions of guided self-help for anxiety

Thank you for applying for NHS permission to Conduct Research for the above named project. A site specific assessment has been conducted by the R&D based on the information provided on the site specific information and in accordance to the Research Governance Framework For Health and Social Care for research appraisal. The study therefore has been granted <u>full</u> approval on the basis described in the application form, protocol and supporting documentation.

Trust approval of the above research applies to the research sites listed on the application form. Any changes to the above research should be communicated to this Trust and to the relevant Ethics Committee, and protocols followed accordingly.

Sponsor: University of East Anglia

End date of Sponsorship: 30/09/2010

Funder: No external funding

Protocol: March 3rd, 2009

Ethics

In accordance with the Department of Health's Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opnion

HQ Elizabeth House, Fulbourn Hospital, Cambridge CB21 5EF.
T 01223 726789 **F** 01480 398501 **www.cpft.nhs.uk**

In partnership with the University of Cambridge

If your study has been adopted onto the Portfolio it is the responsibility of the Accrual Data Contact (ADC) to upload any and all accrual data (recruitment data) relating to this Trust to the NIHR and to liaise with the local Principal Investigator and the R&D Office on such accrual.
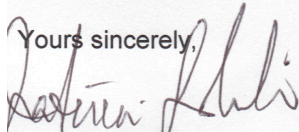
Final Reports

At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the Trust intranet site to ensure findings are disseminated as widely as possible to stakeholders.

Failure to comply with any of the above may result in withdrawal of Trust approval.

On behalf of this Trust, may I wish you every success with your research.

Yours sincerely,

Natercia Godinho
R&D Manager

NHS

National Research Ethics Service

Cambridgeshire 3 Research Ethics Committee

Victoria House
Capital Park
FULBOURN
Cambridge
CB21 5XB

Tel: 01223 597733
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07 December 2009

Miss Ruth Easby
Trainee Clinical Psychologist
Cambridgeshire and Peterborough NHS Foundation Trust
University of East Anglia
Doctorate Programme in Clinical Psychology
MED, UEA, Norwich
NR4 7TJ

Dear Miss Easby

Study title:	**A Qualitative Study of Patients' Perceptions of Guided Self-Help for Anxiety.**
REC reference:	**09/H0306/60**
Amendment number:	**Amendment #1**
Amendment date:	**26 November 2009**

The above amendment was reviewed at the meeting of the Sub-Committee held on 03 December 2009. The amendment concerned the following proposals:

1) Changes to Protocol:
a) Participants - locations for recruitment
b) Informed Consent - provision of information
c) Other issues
d) Recruitment
e) Timescale
Consequent changes to PIS and Consent Form.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter by email from Ruth Easby		26 November 2009
Notice of Substantial Amendment (non-CTIMPs)	Amendment #1	26 November 2009
Participant Consent Form	3	26 November 2009
Participant Information Sheet	3	26 November 2009
Protocol	2	26 November 2009

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority

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Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.
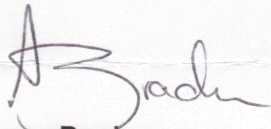
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

09/H0306/60:	**Please quote this number on all correspondence**

Yours sincerely

Anna Bradnam
REC Assistant Co-ordinator

E-mail: Anna.Bradnam@eoe.nhs.uk

Enclosures: *List of names and professions of members who took part in the review*

Cc: Tracy Moulton
Research, Enterprise & Engagement Office
The Registry, University of East Anglia
Norwich
NR4 7TJ

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority

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Cambridgeshire and Peterborough NHS
Foundation Trust

Version 2, 18.08.2009

04.01.2010

Dear Sir/Madam

I am inviting you to participate in a research study. Information about what this study involves is provided on the information sheet. Participation within this study is voluntary.

If you are interested in participating please read the information sheet and complete the consent form. If you have any queries about this study then please contact the research team using the information provided on the information sheet.

If you decide to take part please complete the slip below with your contact details. Please post this along with the consent form to the address on the stamped addressed envelope provided for you.

I look forward to hearing from you.

Yours faithfully

Ruth Easby
Trainee Clinical Psychologist
Supervised by Malcolm Adams and Narendra Keval

I ……………………...………………… would like to participate in this research study.

My contact details are:

Phone number: ……………………………………………

Mobile number: ……………………………………………

The best time to contact me is in the:
(please circle which time)

      Morning   Afternoon   Evening

Email address: …………………………………………………………………………

CHECKLIST

I have included the following in the envelope:

☐   Contact details

☐   Consent form

APPENDIX E

Version 3, 26.11.2009

INFORMATION SHEET

PATIENTS' PERCEPTIONS OF GUIDED SELF-HELP FOR ANXIETY

This research is for a thesis as part of the requirements of the University of East Anglia (UEA) Clinical Psychology Doctorate, involving:

Ruth Easby   Malcolm Adams
Trainee Clinical Psychologist   UEA Course Director
Tel: 07828 814467   Tel: +44 (0)1603 593600
Email: R.Easby@uea.ac.uk   Email: M.Adams@uea.ac.uk

Narendra Keval
UEA Course Clinical Director
N.Keval@uea.ac.uk

Address for research team:
Postgraduate Programmes Office
Room 2.01, Elizabeth Fry Building
Faculty of Health
University of East Anglia
Norwich
NR4 7TJ

Information about the research

We would like to invite you to take part in a research study.   Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Part 1 tells you the purpose of the study and what will happen if you take part. Part 2 gives you more detailed information about the conduct of the study. Please contact Ruth Easby or Malcolm Adams if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

PART 1

Purpose of the research.

This study is investigating people's perceptions of Guided Self-Help for anxiety. This will involve exploring people's expectations and experiences of Guided Self-Help. People's experiences of Guided Self-Help materials are

beginning to be investigated. However, there is still little information about people's expectations of the treatment and important influences on their experiences. Further information will help us to better understand how people respond to Guided Self-Help. This in turn will help us to understand how experiences impact on the effectiveness of Guided Self-Help. The aim is to use information gained to adapt and improve Guided Self-Help treatment for people with anxiety.

Why have I been invited?

We are recruiting people who have recently received Guided Self-Help for anxiety. This is because we are interested in people's experiences of Guided Self-Help for anxiety. We are interested in both people who have completed treatment and those who have not. We have provided your IAPT worker with the information pack to give or send to you so you can decide whether or not you would like to take part. This study aims to recruit between 10 and 15 people.

Do I have to take part?

No, it is up to you to decide. This information sheet describes the study. We have provided contact information for Ruth Easby, Malcolm Adams and Narendra Keval if there is anything that is not clear or you would like more information. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This will not affect future treatment you may receive from the service.

What will happen to me if I take part?

If you decide to take part you will need to complete the consent form. This indicates that you are willing to take part in the study. You will be asked to provide a contact telephone number or email address and post this with the consent form in the stamped addressed envelope.

If you decide to take part a letter will be sent to your GP to inform them. Your GP will not have access to any personally identifying information as all information gathered is confidential unless there are exceptional circumstances in which this confidentiality needs to be broken. Please see Part 2 for further information.

On receipt of the consent form you will be contacted by Ruth Easby to arrange an interview. Any questions or concerns you have can be discussed during this telephone conversation. During this conversation you will be asked to provide the name of your GP and surgery address so a letter can be sent to inform them of your participation within this study.

If you have already finished or discontinued treatment, the interview can be arranged between now and February 2010. If you are still receiving treatment, the interview will be scheduled for when treatment is completed or discontinued. You will be asked to provide an address so that a letter can be sent stating location, time and date of the interview a week before the interview is scheduled to take place. The interview guideline will also be enclosed. This will be followed up by a telephone call a few days before to

check that you are still willing to participate and answer any questions or concerns you may have at this stage.

The interview will last for approximately an hour.   Interviews will take place in a private room at one of the IAPT sites within the Cambridgeshire and Peterborough Trust or at your own home. Once all interviews are completed, if willing, you will be contacted for feedback on the initial interpretations and explanations of the information gathered. This is to check whether you agree with the findings. The feedback is voluntary and will not impact on future treatment you may receive from the service.

The study aims to interview a diverse range of people. Therefore, at the beginning of the interview information about your personal details will be collected. This includes your gender, age, ethnicity, area you live in, employment status, type of anxiety and treatment outcome.

Key areas covered in the interview will include expectations of Guided Self-Help, helpful and unhelpful aspects of Guided Self-Help, and your perceptions of the benefits.

The interview will be voice recorded. This ensures that the interview is recorded and transcribed accurately. You can refuse to be recorded, request the digital recorder to be turned off or wiped at any point. You are free to withdraw your consent at any point and ask to see data about you.   This will not affect future treatment you may receive from the service.

Will I be paid?

Unfortunately there are no funds for paying you if you decide to participate. However, your travel expenses will be reimbursed.

What will I have to do?

You will need to be available for an interview. This will last for approximately an hour. We would like you to be as honest as possible with your answers to interview questions. Once all interviews are completed, we will offer you the opportunity to give feedback on the initial findings. Again, we would like you to be as honest as possible with your views on the information gathered.

What are the possible disadvantages and risks of taking part?

You will be asked to consider your expectations and experiences of the Guided Self-Help.   This may lead to you feeling distressed. If this should happen you will be asked whether you would like to talk about your concerns, whether you would like to continue, move on to a different question or stop the interview completely. If the interviewer has any concerns these will be discussed in relation to a 'confidentiality policy'. This 'policy' states that information gathered is confidential unless there are exceptional circumstances in which this confidentiality needs to be broken. Confidentiality will be broken if the interviewer believes there is risk to yourself or somebody else, or the researchers are required to do so by law.

It is recommended that you contact your doctor if you still require help or information for emotional difficulties. They will be able to advise you on local resources and refer you on if appropriate. There are also a number of useful websites.

- The British Association of Behavioural and Cognitive Psychotherapies (http://babcp.com). This site offers a 'user's area' with information on mental health difficulties.

- The Changing Minds website (http://www.rcpsych.ac.uk/campaigns/cminds). This site is produced by the Royal College of Psychiatrists and provides information and advice about mental health problems.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get will help improve the Guided Self-Help treatment of people with anxiety.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or possible harm you might suffer will be addressed. The detailed information on this is given in part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in part 2.

If the information in Part 1 has interested you and you are considering participation, please read Part 2 before making any decision.

PART 2

What will happen if I don't want to carry on with the study?

If you withdraw from the study, we will destroy all identifiable material. This includes the consent form, personal detail sheet, recordings and any transcripts completed.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers Ruth Easby and/or Malcolm Adams who will do their best to answer your questions (see contact information at beginning of sheet). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the IAPT site.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential, except for exceptional circumstances. This is in line with the 'confidentiality policy' mentioned above.

Information will be collected using a digital voice recorder during the interview. The recordings will be transcribed as soon as possible following the interview. Any information about you that has personal identifying details will be removed from the transcript to prevent you being recognised. Recordings will be given a patient study number to protect your privacy. A professional transcriber outside of the research team may be involved. However, all personally identifying information will have been removed prior to this. The recordings and transcriptions will be kept in a locked cabinet and destroyed once the research is completed.

What will happen to the results of the research study?

Quotes from the interview may be used within the write up of the study. All identifying information will be removed to protect your privacy. For example, 'Cambridge' will be replaced with '[city]'.

Findings from the study will be written up in a thesis. There will be the opportunity to attend a presentation about the findings from the research with the chance for questions afterwards. The findings will also be fed back to the services involved. This aims to improve the service provision of Guided Self-Help for anxiety. The study may also be published informing future research.

Who is organizing and funding the research?

Ruth Easby is responsible for organising this study. Funding for the administration process of the study has been provided by the University of East Anglia (UEA).

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Cambridgeshire 3 Research Ethics Committee.

Further information and contact details.

If you would like further information please access the following contact points:

1) General information about research:
   INVOLVE (http://www.invo.org.uk/). This site promotes public involvement in NHS, public health and social care research.

2) Specific information about the research and advice about whether you should participate:
   Ruth Easby and Malcolm Adams (contact details provided at beginning of sheet).

3) Who to approach should you feel unhappy with the study:
   NHS Complaints Procedure
   (http://www.opsi.gov.uk/si/si2006/20062084.htm).

Cambridgeshire and Peterborough **NHS**
Foundation Trust

Version 3, 26.11.2009
Participant Identification Number:

CONSENT FORM

Title of Project: Patients' perceptions of Guided Self-Help for anxiety
Name of Researchers: Ruth Easby. Supervisors: Malcolm Adams, Narendra Keval

Please initial box

1. I confirm that I have read and understand the Participant Information Sheet Version 3 dated 26.11.2009 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 medical care or legal rights being affected.

3. I understand that my GP will be sent a letter informing them of my participation within the study.

4. I understand that information collected during the study will be looked at by the research team, including Ruth Easby, Malcolm Adams and Narenda Keval. I give permission for these individuals to have access to my information I have provided for this research study.

5. I understand that information collected will be kept confidential within the research team, except in exceptional circumstances.

6. I understand that interviews will be voice recorded and that I am free to refuse recording, request the digital recorder to be turned off or wiped at any time. I am aware that this will not affect my future treatment from the service.

7. I understand that a professional transcriber may be involved once all personally identifying information has been removed.

8. I agree to direct quotations from the transcript being used if necessary. If quotations are used I understand that any personally identifying information will be removed.

9. I agree to take part in the above study.

_____   _____   _____
Name of participant   Date   Signature

_____   _____   _____
Name of person taking consent   Date   Signature

When completed, 1 copy for participant; 1 copy for researcher file (original)

Cambridgeshire and Peterborough NHS
Foundation Trust

Version 1, 18.08.2009

Date

Dear *Dr……….*

I am writing to inform you that *participant name* has volunteered to participate in a qualitative study on patients' perceptions of Guided Self-Help for anxiety. This will involve one interview that will last for approximately an hour.

Should you have any questions or concerns about this study then please do not hesitate to contact myself or my supervisors. Please see contact details below:

Ruth Easby   Malcolm Adams
Trainee Clinical Psychologist   UEA Course Director
Tel: 07828 814467   Tel: +44 (0)1603 593600
Email: R.Easby@uea.ac.uk   Email: M.Adams@uea.ac.uk

Narendra Keval
UEA Course Clinical Director
N.Keval@uea.ac.uk

Address for research team:
Postgraduate Programmes Office
Room 2.01, Elizabeth Fry Building
Faculty of Health
University of East Anglia
Norwich
NR4 7TJ

The study has been reviewed and given favourable opinion by Cambridgeshire 3 Research Ethics Committee.

Yours sincerely

Ruth Easby
Trainee Clinical Psychologist
Supervised by Malcolm Adams and Narendra Keval

Cambridgeshire and Peterborough NHS
Foundation Trust

Version 1, 29.05.2009

Dear *Name*

Thank you for agreeing to take part in this research project. An interview about your experiences of the Guided Self-Help you received for your anxiety has been arranged on the *date* at *time*. This will take place at *location*. Please find a copy of the interview guide enclosed.

The interview will last for approximately an hour. It will be recorded by a digital voice recorder. You may refuse permission to be recorded, request the digital voice recorder to be switched off during the interview or wiped off at any point during or after the interview.

You are free to withdraw from this interview at any point. You may also see data held about you at your request.

I will be calling you a few days prior to the scheduled interview to see whether you are still willing to participate. If so, I will confirm the date, time and location of the interview.

Your participation in this study will not impact on future treatment you may receive from the service. It may inform service provision and taking your time to participate is greatly appreciated.

Please feel free to ask me any questions or raise any concerns you have at this stage.

I look forward to speaking to you.

Yours sincerely

Ruth Easby
Trainee Clinical Psychologist
Supervised by Malcolm Adams and Narendra Keval

Version 2, 05.06.09

Preliminary interview questions

Below are a few examples of the type of questions that will be used within the interview. The interview may be modified during the research to add in topics that have not originally been included or to drop those that are incomprehensible and repeatedly fail to elicit responses relevant to the question (King, 1994).

Introduction

Thank you very much for letting me talk to you today and for helping me with my study.

I want to talk to you about your experiences of Guided Self-Help. For example, about your expectations and what you think contributed towards your experiences. It is really important to hear the views of people receiving services, so that we can begin to build up an idea of what the experience is like from your point of view.

You don't have to talk about anything that you don't want to. What you say will be kept private. The only exception to this is if you talk about wanting to hurt yourself or someone else. I would need to pass this information on but would let you know first.

If you have any questions, at any time, please ask me. If you don't understand what I have said please let me know and I can explain in a different way.

Expectations:

Please tell me as much as you can about any expectations you had about the Guided Self-Help?

- (prompt question to be used if necessary) Please tell me about any thoughts/feelings/attitudes you had about what the Guided Self-Help would involve?

- (prompt question to be used if necessary) Can you tell me what you thought you might gain from receiving Guided Self-Help?

Experiences:

Can you tell me about your experiences of the Guided Self-Help?

- (prompt question to be used if necessary) Can you tell me about any positive experiences you had?

- (prompt question to be used if necessary) Can you tell me about any negative experiences you had?

Was your experience what you expected?

- (prompt to be used if necessary) Did your experiences meet or not meet your expectations? What do you think may be the reasons for this?

Can you sum up what has been helpful, if anything, about your Guided Self-Help?

- (prompt question to be used if necessary) For example, are there general aspects or specific events?

Can you sum up what kind of things have been unhelpful, hindering, negative or disappointing for you?

- (prompt question to be used if necessary) For example, are there general aspects or specific events?

Has anything been missing from your treatment?

Important influences on experiences:

In general, what do you think influenced your therapy experience?

- (prompt question to be used if necessary) What do you think contributed towards your Guided Self-Help experience? What do you think made it more or less helpful?

Please tell me whether you were able to make any personal changes as a result of the Guided Self-Help.

If you made changes, how do you account for these? In other words, what do you think might have brought these changes about?

- (prompt question to be used if necessary) Can you tell me whether you think it may have been things inside and/or outside of therapy?

If you did not make changes, what do you think the reasons are for this?

- (prompt question to be used if necessary) Can you tell me whether you think it may have been things inside and/or outside of therapy?

Process of interview:

Please tell me about anything else that we haven't spoken about that you think is important. Are there any areas you think are important that have not been asked about?

Finally I wanted to talk to you about what it was like for you to do this interview. Please tell me a bit about how you have found this interview today?

<u>Finish:</u>

Thank you very much for talking to me today. I will now take the tape away to work on it; you can have a copy of the tape if you want to – would you like a copy of the tape?

When I start to analyse and interpret the information collected today would you be interested in spending some time looking at it to make sure I have understood what you said? How does that sound?

Version 1, 27.08.2009

PATIENTS' PERCEPTIONS OF GUIDED SELF-HELP FOR ANXIETY

PRACTITIONER'S GUIDE FOR INTRODUCING THE STUDY

Please give the pack to your patient at the end of your first session.

Below is a guide for how to introduce the study:

I've been asked to give you this pack from a clinical psychology trainee from the University of East Anglia. For her thesis she is investigating people's perceptions of Guided Self-Help for anxiety.

Inside the pack is an information sheet that tells you the purpose of the study, what will happen if you take part and information about the conduct of the study.

Your participation within the study is voluntary and your decision to participate will not impact on future treatment from the service.

If your patient continues to ask questions about the study tell them that the information sheet describes in detail what the study involves. If they have further questions it is best to speak to the researcher whose contact details are provided within the pack.

Cambridgeshire and Peterborough **NHS**
Foundation Trust

Version 1, 29.05.2009

DEMOGRAPHICS INFORMATION SHEET

Study title: Patients' Perceptions of Guided Self-Help for Anxiety

Participant Identification No:

Participant's age…………………………………………………………………

Gender. …………………………………………..……………………………..

Ethnicity………………………………………………………………………….

Type of area live in………………………………………………………………..

Occupation………………………………………………………………………..

Type of anxiety…………………………………………………………………….

Treatment outcome………………………………………………………………...

Email sent to participants to explain why the researcher was unable to do respondent validation and to inform them when to expect a summary of the research findings.

```
Dear X

Thank you for participating in my research about Patients'
Perceptions of Guided Self-Help for Anxiety.

The data analysis took me longer than expected so unfortunately there
is not time to check out my interpretations with you before I submit
my thesis on 1st July.  I'm very sorry about this.  However, in order
to complete the research properly there will be the opportunity for
you to hear about the results and give feedback either in writing or
over the telephone. As such, I will be in touch after July.

Kind Regards

Ruth Easby
Trainee Clinical Psychologist
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Email sent to participants about the summary of the research findings.

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Dear X

Please find attached the summary of my research findings. I would
greatly appreciate any feedback on these.

Would you be interested in attending a presentation about the
research? I am also asking the other participants to get an idea of
whether they are interested.

Kind Regards

Ruth Easby
Psychologist
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SUMMARY OF RESEARCH FINDINGS

PATIENTS' PERCEPTIONS OF GUIDED SELF-HELP FOR ANXIETY

Purpose of the research.
This study investigated people's perceptions of Guided Self-Help for anxiety. This involved exploring people's expectations and experiences of Guided Self-Help. It was hoped this would help us to better understand how people respond to Guided Self-Help. The aim is to use the information gained from this study to adapt and improve Guided Self-Help treatment for people with anxiety.

Participants.
Ten people were interviewed in total. Of these, seven of you were female and three of you were male.

Findings from the research.
This study had three questions. A summary of the findings from each of the questions is outlined below.

What Are Patients' Expectations Concerning Guided Self-Help for Anxiety?
A range of different expectations was described. Many of you expressed hopes about the treatment helping you either generally or with your anxiety. Two of you were doubtful about how it could help.

Most of you had expectations about what the GSH would involve. These were based on knowledge of GSH or previous experience of Cognitive-behavioural therapy (CBT). The majority of you expected more in relation to the content (e.g., planning for the future) and process (more direction). Some of you expected the GSH to get to the "root cause" of your problem(s). Although most of you had expectations about what GSH would involve, many of you were also unsure about what to expect.

A few of you highlighted how your expectations changed over the course of your GSH.

To What Degree do Patients' Experiences of Guided Self-Help Meet Those Expectations?
To answer this question, your experiences of GSH needed to be identified. To understand these experiences, experiences of anxiety and other mental health problems and previous experience/knowledge of treatment for mental health problems were identified.

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Experiences of anxiety and other mental health problems and previous treatment/knowledge

Most of you had experienced mental health problems before and had treatment for these in the past.   These treatments were either psychological, medication or alternative therapies. Some of you accessed support from your GPs.   There was a range in whether these treatments were helpful or not.

Experiences of the GSH

These were varied. For some of you doing an activity was difficult yet you found the guidance helpful. For others neither the guidance nor activity suggestions were helpful.   Many of you had mixed experiences about the different aspects of the GSH. For example, although the activities and guidance were helpful, to begin with the manual was difficult to understand. Others spoke about how the process of GSH was helpful for getting them to start using previous coping strategies again.

All of you spoke about your experiences of the practicalities of receiving GSH. This covered a number of topics: the spacing and timing of sessions; the waiting period; and venue in which the GSH took place. For all of these, there was a range of experiences.

You all spoke about changes. There appeared to be five main areas in which changes were recognised: i) managing anxiety better; ii) changes to specific behaviours; iii) how you related to yourselves; iv) social changes; v) where the problem(s) were attributed to. For some of you, there were changes still to be made. These were related to general improvements or more specific things, such as joining an organisation. There were also some of you who felt there were areas in which no changes had been made. These were still avoiding things and the feelings of anxiety remaining.

Overall your experiences were either positive/helpful, negative/unhelpful or mixed, in which GSH was "hard", "interesting", and "draining".

Degree to which experiences meet expectations
     Experiences do meet expectations

Three of you spoke about how your expectations had been met. This related to the process, in which you got the guidance you needed, and outcome, where you made the changes you wanted. This finding surprised me as many of you had spoken about expecting more in relation to content and process.

     Some experiences meet expectations

For two of you your expectations were met in relation to feeling better, but unmet in what the GSH would involve.

     Experiences do not meet expectations

For two of you your experiences did not meet your expectations. This was because you had expected more. In particular, you had expected more "exposure to actually really confront the problems."

Experiences different to expectations

Three of you had experiences different to what you expected. For two of you, your experiences exceeded your expectations, the GSH working better than you thought. Someone else changed her expectations to fit with her expectations.

Improvements

Regardless of whether your experiences met your expectations, many of you commented on how to improve the GSH you received. These improvements were related to four main areas. Firstly, changes to the content and process were suggested. This included group sessions and sessions to be more in-depth. Secondly, changes to the practicalities. These focused on reducing the waiting lists and offering evening appointments. Thirdly, periodic maintenance was suggested as a way to maintain improvements. Fourthly, having more options available, besides GSH and medication.

Are Self-Efficacy and Therapeutic Alliance Important Influences on Patients' Experiences?

Self-efficacy refers to the strength of an individual's belief in their capabilities to do a specific task (Bandura, 1979). Therapeutic alliance is a complex construct. It is made up of a number of aspects, such as the relationship between a patient and Practitioner, a patient's evaluation of the effectiveness of an intervention, and agreement over goals (Roth & Fonagy, 1996).

There was a huge range in what you all thought influenced your experiences. Those referred to most were self-efficacy, therapeutic alliance, engagement with the GSH, presence of a Practitioner and information, knowledge, and social network. Meeting needs was also identified as an important influence. This seemed to run throughout some of the other influences already mentioned. As such, this is referred to within the other influences. The influences are outlined below.

Self-efficacy

You all referred to aspects of this. Most of you highlighted the need for you to take responsibility for making the most of the GSH and more specifically, being able to make changes. The majority of you referred to a belief in yourselves to make changes. These were based on achieving what you set out to do, previous experiences and verbal persuasion.

For many of you, your Practitioners encouraged beliefs in your abilities. However, beliefs in your abilities also depended on the context in which the specific behaviour was taking place. Some of you spoke about how your belief in yourself changed as you progressed through the GSH.

Therapeutic alliance

All of you referred to aspects of this.   Most of you thought that the Practitioner's personality and guidance influenced your experiences. For the majority of the time this was positive. Practitioners explained things, listened to your worries, and helped you to put things into place to make changes. However, for some of you the Practitioner's personality and interpersonal style

led to negative experiences. It seemed that the way the Practitioner was did not meet the needs for some people.

All of you referred to yourselves when discussing influences on your experiences. These related to: characteristics, for example, how you approached and responded to the GSH; perceptions of the GSH, whether it was applicable, effective and met your needs; and perception of the Practitioner's expertise, related mainly to his or her level of experience.

The majority of you had positive interactions with your Practitioner. This was regardless of whether changes were made or not. This was often linked to the Practitioner's qualities and interpersonal style. The importance of the relationship for making changes was also highlighted. However, there were occasions when the interactions were not so positive. For some of you, these appeared to be worked through, for someone else the negative interactions did not meet her needs and impacted on her overall experience.

Some of you emphasised the importance of agreement between yourselves and your Practitioner. This was related to what you expected in terms of outcome and from one another. Whether there was agreement impacted on whether your needs were met. That is, where there was agreement, needs were met, where agreement was missing, needs were not met.

Many of you also emphasised the importance of having both a Practitioner and information. There were three main reasons for this.   Firstly, people's anxieties stopped them from being able to engage with the manual by themselves. Secondly, the Practitioner helped people to complete activities. Thirdly, Practitioners helped to maintain morale when things became difficult.

Engagement with the GSH
Four themes appeared to be related to this. Firstly, some of you identified awareness of having a problem important for engaging with the GSH. Secondly, two of you highlighted the importance of readiness for being able to work on your problem(s). Thirdly, some of you spoke about the importance of being motivated. Finally, many of you stressed the importance of an ability to reflect, understand, learn and apply the techniques you were taught. Again, the importance of the GSH meeting your needs for engaging with it was highlighted.

Knowledge
This related mainly to understanding about anxiety. Some of you mentioned the importance of psycho-education, that is, being taught how anxiety works and the impact it has on your physical sensations, thoughts, and behaviour. For many of you, knowing facts about anxiety, such as how many people it effects, was important. Knowing that you were not alone was also very important.

Social network
Some of you spoke about how social support from family, friends and professionals, was an important influence on your experiences. For most of

you this was a positive influence. However, for two of you, sometimes this support could be detrimental. For someone, sharing information with others helped her with making changes.

Further information.

If you would like further information please contact Ruth Easby:

Email: R.Easby@uea.ac.uk
Address: Postgraduate Programmes Office,
            Room 2.01, Elizabeth Fry Building
            Faculty of Health
            University of East Anglia
            Norwich
            NR4 7TJ

Many thanks to all of you for helping me with this study. Without your participation it would not have been possible to complete. My thesis is dedicated to all of you.

The following illustrates the development of the 'Expectation' template, from the preliminary a priori template to the final template. An excerpt from Participant 9's transcript is included to show the process of data analysis, from raw data to writing up and interpretation for Research Question One. Comments made during the coding, and quotes from other participants are also included to illustrate further the data analysis process for the 'Expectation' template.

Step One: Development of Coding Template

An a priori template was developed based on previous research and theory, identified in the literature review.

Preliminary a priori template

1. Expectations:
      1.1. What GSH would involve
      1.2. Outcome from GSH

Step Two: Familarisation

Transcripts were read and re-read to encourage familiarisation. Annotations were made in black and red bold italics (first and second reading respectively).

266   R: Okay, okay. I guess if we start off with erm, if you can tell me as much as

267   possible about what your expectations were from the Guided Self-Help?

268   P: Hm. Erm I guess I put a lot of hope into it thinking it was like gonna

269   miraculously cure me. ***Expectations = 'cure'*** *Lot of hope*

270   R: Mm hm.

271   P: Erm and I was hoping that there was gonna be more pressure on me

272   *Expectation of more pressure* but I know it's a Guided Self-Help but I do think

273   there's a lack, a bit of lack of putting pressure on me to actually make me do

274   Certain things. ***Pressure missing from treatment.*** Erm, and I think in theory

275   it all sounds very nice to say oh well if you built up, you start off by speaking in

276   a small group or … ***More direction?*** *Understands theory doesn't translate*

277   *into practice?*

278   R: Uh huh.

279   P: … or in front of your team and over time you'll be able to speak in front of your

280   whole of your organisation and this kind of thing. *Understands through*

281   *practice confidence grows*

282   R: Uh huh.

283   P: It's not gonna happen unless I'm picked up and made to do it. ***Pressure***

284   ***missing from treatment.***

285   R: Uh huh.

286	P:	In a, perhaps in a erm, situation that's set up by this kind of service. ***Service***
287		***set up 'practice' situations*** Say there's a lot of other people who have the
288		same problems so you can practice of something I don't know. So, yeah,
289		Having, having the kind of environments where you can practice things that are
290		causing you difficulties. ***Helpful to have environment to practise*** *before*
291		***Doing it at work. Too big a jump? Readiness?***
292	R:	Okay. So kind of an environment where you could practice that but not actually
293		your work environment.
294	P:	Yes. ***Smaller steps?***
295	R:	So it's almost like kind of your first step?
296	P:	Yes, yes. ***Smaller first step?***
297	R:	To have that, to then go into the work environment.
298	P:	Yes. ***Helpful to have environment to practise before doing it at work***
299	R	do it.
300	P:	Yes, because I mean it's even meetings, it's not just about public speaking, I can
301		be in a meeting and I'm, I can't speak in front of people because I just have this
302		real negative view of myself. ***Recognises how perceives self – impacts on***
303		***being able to contribute to meetings. Impact on self-esteem?***
304	R:	Mm hm.
305	P:	Erm and I have to be really comfortable with people and know then erm and you
306		get all negative thoughts going through your head. ***Recognises NAT*** I recognise
307		all the symptoms now from doing the Guided Self-Help. ***Recognising symptoms***
308		***helpful?*** But I just think there's a, a lack of exposure to actually really confront
309		the, the problems. ***Awareness of symptoms, lack of exposure. Initial***
310		***stages worked through – later ones*** *still* ***require input? Expectation that***
311		***she'll have to 'face' a situation?***
312	R:	Okay. So it would've been helpful if …
313	P:	Yes.
314	R:	… you'd have had that?
315	P:	Yes. ***Helpful to have confronted situations***
316	R:	Kind of slight more, I suppose someone pushing you a little bit more?
317	P:	Yes.
318	R:	To confront those situations.
319	P:	Yes. ***Helpful to have been 'pushed' to confront situations***
320	R:	Erm did you know anything about Guided Self-Help, what it involved or cognitive
321		behaviour therapy before you had the therapy?
322	P:	I knew only a little bit. ***Knew little info about GSH/CBT before started*** I've
323		read a little bit, you know, articles here and there. ***Read some information***

324		*before GSH – familiar with some ideas? Different to Part 8-7?* Erm but
325		not, not huge detail on it.
326		***Knew little info about GSH/CBT before started***
327	R:	Mm hm. And had you had any thoughts or feelings about it before you started
328		the Guided Self-Help?
329	P:	Erm (pause) I just thought it was a much better way of dealing with my
330		problems rather than taking medication, to try and actually get the 'root' of the
331		problem. ***Expectations – better way of dealing with problems Vs meds.***
332		***Get to the 'root cause'***
333	R:	Uh huh.
334	P:	To try and, well not fix it necessarily but find a way of making things better.
335		***Expectations – make things better. Not fix it - compares to before where***
336		***states wanted a 'cure'. Example of how expectations can change –***
337		***dynamic process?***
338	R:	Uh huh.
339	P:	So while you're just taking tablets, the problem's still there isn't it? ***Problem***
340		***still present when taking meds***
341	R:	Uh huh, okay. And were your experiences what you expected?
342	P:	Erm (pause) I guess I wasn't 100% clear what I was gonna expect,
343		***Expectations unclear*** but I think it goes back to what I was saying
344		before about I was expecting a little bit more push. ***Expecting more 'push'***

Step Three: Initial Coding

The preliminary a priori template is applied to the transcript.

266	R:	Okay, okay. I guess if we start off with erm, if you can tell me as much as
267		possible about what your expectations were from the Guided Self-Help?
268	P:	Hm. Erm I guess I put a lot of hope into it thinking it was like gonna
269		miraculously cure me. **1.2.** ***Expectations = 'cure' Lot of hope***
270	R:	Mm hm.
271	P:	Erm and I was hoping that there was gonna be more pressure on me
272		***Expectation of more pressure*** but I know it's a Guided Self-Help but I do think
273		there's a lack, a bit of lack of putting pressure on me to actually make me do
274		certain things. **1.1.** ***Pressure missing from treatment.*** Erm, and I think in theory
275		it all sounds very nice to say oh well if you built up, you start off by speaking in
276		a small group or …**1.1.** ***More direction? Understands theory doesn't translate***
277		***into practice?***
278	R:	Uh huh.
279	P:	… or in front of your team and over time you'll be able to speak in front of your

280		whole of your organisation and this kind of thing. ***Understands through***
281		***practice confidence grows***
282	R:	Uh huh.
283	P:	It's not gonna happen unless I'm picked up and made to do it. **1.1.** ***Pressure***
284		***missing from treatment.***
285	R:	Uh huh.
286	P:	In a, perhaps in a erm, situation that's set up by this kind of service. ***Service***
287		***set up 'practice' situations*** Say there's a lot of other people who have the
288		same problems so you can practice of something I don't know. So, yeah,
289		having, having the kind of environments where you can practice things that are
290		causing you difficulties. ***Helpful to have environment to practise before***
291		***doing it at work. Too big a jump? Readiness?***
292	R:	Okay. So kind of an environment where you could practice that but not actually
293		your work environment.
294	P:	Yes. ***Smaller steps?***
295	R:	So it's almost like kind of your first step?
296	P:	Yes, yes. ***Smaller first step?***
297	R:	To have that, to then go into the work environment.
298	P:	Yes. ***Helpful to have environment to practise before doing it at work***
299	R	do it.
300	P:	Yes, because I mean it's even meetings, it's not just about public speaking, I can
301		be in a meeting and I'm, I can't speak in front of people because I just have this
302		real negative view of myself. ***Recognises how perceives self – impacts on***
303		***being able to contribute to meetings. Impact on self-esteem?***
304	R:	Mm hm.
305	P:	Erm and I have to be really comfortable with people and know then erm and you
306		get all negative thoughts going through your head. ***Recognises NAT*** I recognise
307		all the symptoms now from doing the Guided Self-Help. ***Recognising symptoms***
308		***helpful?*** But I just think there's a, a lack of exposure to actually really confront
309		the, the problems. **1.1.** ***Awareness of symptoms, lack of exposure. Initial***
310		***stages worked through – later ones still require input? Expectation that***
311		***she'll have to 'face' a situation?***
312	R:	Okay. So it would've been helpful if …
313	P:	Yes.
314	R:	… you'd have had that?
315	P:	Yes. ***Helpful to have confronted situations***
316	R:	Kind of slight more, I suppose someone pushing you a little bit more?
317	P:	Yes.

318 R: To confront those situations.

319 P: Yes. *Helpful to have been 'pushed' to confront situations*

320 R: Erm did you know anything about Guided Self-Help, what it involved or cognitive

321   behaviour therapy before you had the therapy?

322 P: I knew only a little bit. *Knew little info about GSH/CBT before started* I've

323   read a little bit, you know, articles here and there. *Read some information*

324   *before GSH – familiar with some ideas? Different to Part 8-7?* Erm but

325   not, not huge detail on it. **1.1. - awareness of process before receiving help?**

326   *Knew little info about GSH/CBT before started*

327 R: Mm hm. And had you had any thoughts or feelings about it before you started

328   the Guided Self-Help?

329 P: Erm (pause) I just thought it was a much better way of dealing with my

330   problems rather than taking medication, to try and actually get to the 'root' of the

331   problem. **1.1.** *Expectations – better way of dealing with problems Vs meds*

332   *Get to the 'root cause'*

333 R: Uh huh.

334 P: To try and, well not fix it necessarily but find a way of making things better. **1.2.**

335   *Expectations – make things better. Not fix it – compares to before where*

336   *states wanted a 'cure'. Example of how expectations can change –*

337   *dynamic process?*

338 R: Uh huh.

339 P: So while you're just taking tablets, the problem's still there isn't it? *Problem*

340   *still present when taking meds*

341 R: Uh huh, okay. And were your experiences what you expected?

342 P: Erm (pause) I guess I wasn't 100% clear what I was gonna expect, **Neither 1.1.**

343   **or 1.2.** *Expectations unclear* but I think it goes back to what I was saying

344   before about I was expecting a little bit more push. **1.1.** *Expecting more 'push'*

Excerpt from reflective diary:
I am finding the process of coding difficult to do as many of the codes overlap, i.e., expectations of what GSH would involve links to what she thought was missing from her treatment. There seems to be some sort of general expectation about what she had wanted from the GSH, e.g., 'facing' the problems. She spoke about wanting to get to the 'root cause' of the problem. She replied that she knew a little about what the treatment would involve beforehand - is there something about being aware of what GSH would involve? She refers to being unsure what to expect and this seems an important thing to include. Is this because it links to my own assumptions that participants would find it difficult to talk about what their expectations were? I want to be able to capture in more detail the different type of expectations she

had in relation to outcome: both wanting to manage better and find a 'fix'. I need to be alert to whether these themes arise in other transcripts.

Step Four: Producing an Initial Template

The themes identified in the reflective diary above were added to the preliminary a priori template. This template was applied to Participant 7 and revised further before it was applied to the transcript for Participant 4 to produce an initial template. Examples of quotes and comments made when coding transcripts are shown below:

Participant 7
- Clearly not sure what to expect - I don't know what I expected to be honest. ***Didn't know what to expect*** (line 849).
- Overlap with couple of items. Expectation about getting to the 'root cause' and that expectations can change - […you were able to learn things, but you can't expect to actually kind of get to the 'root cause' of things, and do all that work in six weeks?] No, and that's what I was hoping for when I actually went. ***Example of how expectations can change – dynamic process?*** (lines 701-704). Although participant doesn't explicitly state her expectations changed think it's a good illustration of this.
- Refers to 'cure', not that wanted it but that wasn't expecting it - it's not gonna be cured and sorted in six weeks. (line 692). Participant 9 also referred to 'cure'. Rather than code it as *'Fix' things*, it will be better to use *'Cure'* as both participants used this word. Definition needs to include fact that wasn't expecting a 'cure' - *Comments that refer to whether GSH would remove anxiety*. Need to be alert to whether this arises in other transcripts.

Participant 4
- Begins with saying had no expectations. Also unclear about what to expect - I didn't have expec- eh erh, to be honest ***No expectations*** [my name], I didn't have expectations, I didn't know what to expect…***Didn't know what to expect.*** (lines 1722-1724).
- Later states wanted GSH to help him get better - I hope this is going to help, **General expectations would help** hope it's going to do something (lines 1759-1760).

The changes to the template following coding of the three transcripts were the insertion of *General expectations* (item 1.1), *Unsure what to expect* (item 1.3), *No expectations* (item 1.4.) and *Changes in expectations* (item 1.6). Lower-level codes were added to reflect the sub-level themes emerging, e.g., *'Cure'*. From here onwards, the a priori themes are in red and the emergent themes are in black.

Initial template

1. Expectations:
   1.1. General expectations of psychological input
   1.2. What GSH would involve
      1.2.1. Knowledge about GSH before receiving input: *Comments that suggest participants familiar with what treatment would involve.*
      1.2.2. 'Root cause': *Comments that suggest GSH will involve understanding why participants experience anxiety.*
   1.3. Unsure what to expect

227

> **1.3.1. Limited or no knowledge about GSH before receiving input:** *Comments that suggest participants not familiar with what treatment would involve.*
> **1.4. No expectations**
> **1.5. Outcome from GSH**
> > **1.5.1. Helpful:** *Comments that suggest participants will manage/feel better.*
> > **1.5.2. 'Cure':** *Comments that refer to whether GSH would remove anxiety.*
> **1.6. Changes in expectations**: *Comments that suggest what participants expected altered over the course of GSH.*

Revisions to Initial Template

Due to the length of the template it was revised. A definition was added to *General Expectations* (item 1.1) to include what participants wanted (previously part of another item) and the lower-level code for *Unsure what to expect* was removed. Following the QRF a further revision was made to the template. It was noted that *Outcome from GSH* (originally item 1.5) overlapped with *General Expectations* (item 1.1). Consequently *Helpful (*item 1.5.1) and *'Cure'* (item 1.5.2.) became lower-level codes for *General Expectations*. The name of this code was then changed to *Outcome from GSH* as this seemed to capture the data better.

Revised initial template

> **1. Expectations:**
> > **1.1. Outcome from GSH:** *Statements that refer to what participants had hoped to gain and/or what they wanted from the GSH.*
> > > **1.1.1. Helpful:** *Comments that suggest participants will manage/feel better.*
> > > **1.1.2. 'Cure':** *Comments that refer to whether GSH would remove anxiety.*
> > **1.2. What GSH would involve**
> > > **1.2.1. Knowledge about GSH before receiving input**: *Comments that suggest participants familiar with what treatment would involve.*
> > > **1.2.2. 'Root cause':** *Comments that suggest GSH will involve understanding why participants experience anxiety.*
> > **1.3. Unsure what to expect:** *Comments that suggest participants not familiar with what treatment would involve.*
> > **1.4. No expectations**
> > **1.5. Changes in expectations:** *Comments that suggest what participants expected altered over the course of GSH.*

Members of the QRF also questioned whether participants had any negative expectations. This alerted the researcher to see whether this was present in the data.

Further Coding

The revised initial template was then applied to the transcripts for Participants 2 and 8. Quotes and comments whilst coding transcripts are shown below:

Participant 2
- Expectation of wanting it to work. This fits with *Helpful* (item 1.1.1) - I was hoping to come out of it, where I could control how, or have more control over the anxiety. ***Expectation of gaining more control*** (lines 270-271).
- Expectation that it would be more practical - I was expecting erm… a bit more hands on ***Expectations – more practical*** (lines 142-143).

- Unsure about what GSH involved - you know, I think it was explained, but I didn't actually take it on board as to what it exactly, it meant. **GSH explained but not processed - didn't know what it involved?** (lines 307-309). Rephrase instruction for *Knowledge about GSH* (item 1.2.1) to include fact not familiar - *Comments that indicate <u>whether participants were familiar or not</u> with what GSH would involve.*

Participant 8
- Aware of what it involved. Shows there's a range of what patients knew before receiving the GSH - I knew the type of exercises I would have to do... (529-530).

Further changes were the insertion of *Practicalities* (item 1.2.2), a revision to the definition for *Knowledge about GSH* (item 1.2.1) to include when participants were not familiar with what it involved.

New initial template

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1. Expectations:
 1.1. Outcome from GSH: *Statements that refer to what participants had hoped to gain and/or what they wanted from the GSH.*
  1.1.1. Helpful: *Comments that suggest participants will manage anxiety/feel better/improve.*
  1.1.2. 'Cure': *Comments that refer to whether GSH would remove anxiety.*
 1.2. What GSH would involve
  1.2.1. Knowledge about GSH before receiving input: *Comments that indicate whether participants were familiar or not with what GSH would involve.*
  1.2.2. Practicalities: *Exercises putting things into place.*
  1.2.3. 'Root cause': *Comments that suggest GSH will involve understanding why participants experience anxiety*
 1.3. Unsure what to expect: *Comments that suggest participants not familiar with what treatment would involve.*
 1.4. No expectations
 1.5. Changes in expectations: *Comments that suggest what participants expected altered over the course of GSH.*

Step Five: Developing the Final Template

The new initial template was applied to all 10 transcripts. Selection of quotes and comments made when coding transcripts for different participants are shown below:

Participant 1
- Further evidence that expectations changed over course of GSH - I think it changed, as I realized I….I was getting a little bit better. **Expectations changed as getting better** I realized I could learn to deal with my problem, **Recognition that can learn important for expectations changing?** …erm…and then my expectations did get higher, 'cos I thought I could get better. **With belief that could get better, self-efficacy improved and expectations changed?** (lines 890-893).

Participant 4

- Expectation not going to help. Thought this was because had no expectations but further reflection think it reflects an expectation that GSH wouldn't be helpful - No I didn't have any …to be honest, I I think I was expecting to stay like a donkey… **No expectations – things stay the same – hopeless?** (lines 1617-1618).

Participant 5

- Unsure what to expect - I wasn't sure what to expect. I hoped it wasn't just CBT because I had a negative impression of that. **Expectations – unsure** (lines 807-808). This needs to be differentiated from the code *Knowledge about GSH before receiving input* (item 1.2.1). Code *Unsure what to expect* (item 1.3) needs to allow for fact some participants were aware of what it would involve but were still unsure - *Comments that suggest participant unsure what to expect from GSH.*

Participant 10

- Talks about knowing GSH not about getting to 'root cause' but on some level still expecting this. Also expectation about what would be covered - I knew that it wasn't about causes, **Awareness focus of GSH not about causes** but I think it's still hard to get away from that, so I think probably on some level I was expecting that **Recognition that GSH not about cause but still expecting it.** but then I, it, it's not, it's about moving forward and getting steps. **Awareness GSH more about moving forward** Maybe a bit more on sort of planning for, for making changes. (lines 1004-1011).
- Practicalities suggests things like location, settings etc. It's more about what participants expected in relation to content (e.g., exercises) and process.

A number of changes were made to develop the final template. *Unhelpful* (item 1.1.3) was inserted and *No expectations* (item 1.4) was deleted. The code *Practicalities* (item 1.2.2) was renamed to *Content and Process*. The instruction *DO NOT CODE* was added and definitions revised. The final template is shown below followed by the application of it to the excerpt from Participant 9's transcript.

Final template

> **1. Expectations:** *SECTION HEADING ONLY (DO NOT CODE) Sections in the script that suggest what participants expected.*
> **1.1. Outcome from GSH:** *(DO NOT CODE) Statements that refer to what participants thought would happen following GSH.*
> **1.1.1. Helpful:** *Comments that refer to what participants hoped to gain from the GSH, generally, and specifically, in relation to their anxiety.*
> **1.1.2. 'Cure':** *Comments that refer to whether GSH would remove anxiety.*
> **1.1.3. Unhelpful:** *Comments that suggest participants find it difficult to think there might be any gain.*
> **1.2. What GSH would involve:** *(DO NOT CODE) Statements that refer to what participants thought the GSH would be like.*
> **1.2.1. Knowledge about GSH before receiving input**: *Comments that indicate whether participants were familiar or not with what GSH would involve.*
> **1.2.2. Content and Process:** *Comments that suggest expectations about what GSH would entail, e.g., exercises and type of guidance.*
> **1.2.3. 'Root cause':** *Comments that suggest GSH would involve understanding why participants experience anxiety.*

266	R:	Okay, okay. I guess if we start off with erm, if you can tell me as much as
267		possible about what your expectations were from the Guided Self-Help?
268	P:	Hm. Erm I guess I put a lot of hope into it thinking it was like gonna
269		miraculously cure me. **1.1.2.** *Expectations = 'cure'* *Lot of hope*
270	R:	Mm hm.
271	P:	Erm and I was hoping that there was gonna be more pressure on me **1.2.2.**
272		*Expectation of more pressure* but I know it's a Guided Self-Help but I do think
273		there's a lack, a bit of lack of putting pressure on me to actually make me do
274		certain things. **1.2.2.** *Pressure missing from treatment.* Erm, and I think in theory
275		it all sounds very nice to say oh well if you built up, you start off by speaking in
276		a small group or …*More direction?* *Understands theory doesn't translate*
277		*into practice?*
278	R:	Uh huh.
279	P:	… or in front of your team and over time you'll be able to speak in front of your
280		whole of your organisation and this kind of thing. *Understands through*
281		*practice confidence grows*
282	R:	Uh huh.
283	P:	It's not gonna happen unless I'm picked up and made to do it. **1.2.2.** *Pressure*
284		*missing from treatment.*
285	R:	Uh huh.
286	P:	In a, perhaps in a erm, situation that's set up by this kind of service. *Service*
287		*set up 'practice' situations* Say there's a lot of other people who have the
288		same problems so you can practice of something I don't know. So, yeah,
289		having, having the kind of environments where you can practice things that are
290		causing you difficulties. *Helpful to have environment to practise before*
291		*doing it at work. Too big a jump? Readiness?*
292	R:	Okay. So kind of an environment where you could practice that but not actually
293		your work environment.
294	P:	Yes. *Smaller steps?*
295	R:	So it's almost like kind of your first step?
296	P:	Yes, yes. *Smaller first step?*
297	R:	To have that, to then go into the work environment.
298	P:	Yes. *Helpful to have environment to practise before doing it at work*

299	R	do it.
300	P:	Yes, because I mean it's even meetings, it's not just about public speaking, I can
301		be in a meeting and I'm, I can't speak in front of people because I just have this
302		real negative view of myself. ***Recognises how perceives self – impacts on***
303		***being able to contribute to meetings. Impact on self-esteem?***
304	R:	Mm hm.
305	P:	Erm and I have to be really comfortable with people and know then erm and you
306		get all negative thoughts going through your head. ***Recognises NAT*** I recognise
307		all the symptoms now from doing the Guided Self-Help. ***Recognising symptoms***
308		***Helpful?*** But I just think there's a, a lack of exposure to actually really confront
309		the, the problems. **1.2.2.** ***Awareness of symptoms, lack of exposure. Initial***
310		***stages worked through – later ones still require input? Expectation that***
311		***she'll have to 'face' a situation?***
312	R:	Okay. So it would've been helpful if …
313	P:	Yes.
314	R:	… you'd have had that?
315	P:	Yes. ***Helpful to have confronted situations***
316	R:	Kind of slight more, I suppose someone pushing you a little bit more?
317	P:	Yes.
318	R:	To confront those situations.
319	P:	Yes. ***Helpful to have been 'pushed' to confront situations***
320	R:	Erm did you know anything about Guided Self-Help, what it involved or cognitive
321		behaviour therapy before you had the therapy?
322	P:	I knew only a little bit. **1.2.1.** ***Knew little info about GSH/CBT before started*** I've
323		read a little bit, you know, articles here and there. **1.2.1.** ***Read some information***
324		***before GSH – familiar with some ideas? Different to Part 8-7?*** Erm but
325		but not, not huge detail on it **1.2.1.**
326		***Knew little info about GSH/CBT before started***
327	R:	Mm hm. And had you had any thoughts or feelings about it before you started
328		the Guided Self-Help?
329	P:	Erm (pause) I just thought it was a much better way of dealing with my
330		problems rather than taking medication **1.1.1.**,to try and actually get to the 'root' of the
331		problem.**1.2.3.** ***Expectations – better way of dealing with problems Vs meds***
332		***Get to the 'root cause'***
333	R:	Uh huh.
334	P:	To try and, well not fix it necessarily but find a way of making things better.**1.1.1 + 1.4?**
335		***Expectations – make things better. Not fix it – compares to before where***

states wanted a 'cure'. Example of how expectations can change –

337   *dynamic process?*

338   R: Uh huh.

339   P: So while you're just taking tablets, the problem's still there isn't it? *Problem*

340   *still present when taking meds*

341   R: Uh huh, okay. And were your experiences what you expected?

342   P: Erm (pause) I guess I wasn't 100% clear what I was gonna expect, **1.3**

343   ***Expectations unclear*** but I think it goes back to what I was saying

344   before about I was expecting a little bit more push. **1.2.2.** *Expecting more 'push'*

Step Six: Interpreting and Writing Up

   Analysis of sections from the final template.

   During this stage, the researcher reviewed the notes made, compared and contrasted the participant's accounts and searched for patterns and connections. Quotes taken from the transcript for five of the codes are highlighted below so the readers can examine the process of abstraction.

   1.1.2. 'Cure'. Two participants referred to whether GSH would remove

anxiety. Whereas one of them put " …a lot of hope into it thinking it was like gonna

miraculousy cure me." (9:268-269), the other participant spoke about how "…it's not

gonna be cured and sorted in six weeks." (7:692).

   1.2.1. Knowledge about GSH before receiving input. Eight participants talked

about whether they were familiar or not with what GSH involved. For those

participants who were familiar this was often discussed in relation to their

understanding of the principles underlining GSH, by referring directly to CBT "[So

can you tell me about any expectations that you had about the Guided Self-Help?]

Well I didn't have any specific expectations, but I'd heard that cognitive-behavioural

therapy can be very useful…and that it was more a practical tool." (3:1-5), or by

referring to what CBT involves, "The only thing I thought it was going to be, is like, I

say they change the way you think…" (7:898-899). Participants varied in the amount

of information they knew about the treatment. Two participants who were very

familiar with what it involved actively requested it, "Well, I think I was quite knowledgeable about CBT to start, with 'cos I read a lot of books….I just read a lot of stuff about it, and I actually requested it from my GP." (8:7-9). This compares to one participant who was familiar with CBT and highlighted their concerns about the GSH being similar to this "I said I was concerned about it being like CBT, I did ask her, 'This isn't just CBT?'" (5:843-844). Other participants knew some information, "I knew only a little bit. I've read a little bit, you know, articles here and there…but not…huge detail on it." (9:322-325). Two participants talked about being less knowledgeable about what it would involve, although they had come across the principles before receiving input "I'd heard about this cognitive-behaviour, but I didn't know how it would help me." (4:1622-1623); "…you know, I think it was explained, but I didn't actually take it on board as to what it exactly, it meant" (2:307-309). This last quote appears to highlight that although explanations are provided these are not always processed.

1.2.2. Content and Process. Responses for this code were mainly concerned with expecting more in relation to what would be covered "Maybe a bit more on sort of planning for, for making changes." (10:1011); "I was hoping, and I thought it was gonna be was changing my thinking." (7:709-710) and how these would be brought about "…I was hoping that there was gonna be more pressure on me…" (9:271). A couple of exceptions to this were the participants who had requested it from their GPs "I knew the type of exercises I would have to do…" (8:529-530); "That it would be very practical, which it turned out to be." (3:48).

1.2.3. 'Root cause'. Four participants referred to expecting the treatment to get to the 'root cause', "…to try and get to the 'root' of the problem." (9:330-331). One participant discussed her understanding that GSH is not about getting to the

'root' and yet still expecting it, "I knew that it wasn't about causes, but I think it's still hard to get away from that, so I think probably on some level I was expecting that..." (10:1004-1008).

1.3. Unsure what to expect. What is interesting about this code is that although all of the participants spoke about expectations in relation to outcome and the majority talked about what they expected GSH would involve, seven participants also spoke about not being sure what to expect, "I guess I wasn't 100 percent clear what I was gonna expect…" (9:342); "I wasn't sure what to expect. I hoped it wasn't just CBT because I had a negative impression of that" (5:807-808). Perhaps this was because participants were having to think about their expectations retrospectively.

Discussion

The findings are explained in the context of previous research and the research methodology and suggestions are made for how to explore improving the GSH. This is best illustrated in a couple of excerpts from the discussion.

4.2.2 What Guided Self-Help Would Involve

Similar to other studies (Macdonald et al., 2007; Rogers et al., 2004), participants in this study highlighted that their understanding of what GSH would involve was based on knowledge of CBT. Although previous experiences of CBT were not always positive, participants appeared able to keep 'open minds'. An additional finding in this study was that those participants who knew a lot about the treatment actively requested it. This finding may be because this study took place in a clinical setting, where patients can request input, compared to clinical trials, where there are often strict inclusion/exclusion criteria. This appears consistent with the Doncaster and Newham evaluations (Parry et al., 2009) where expectations of patients impacted on whether they accessed services. Although it is not stated, knowledge of what GSH involved may have influenced this. This could be because people with

knowledge of GSH have different expectations to those who are not familiar with what it involves. These expectations may then direct whether patients access services.

For some participants, although they were informed of what the GSH would involve, their understanding of it was not clear until they experienced the treatment. This has been previously reported by Macdonald et al. (2007) and Rogers et al. (2004), highlighting an idea that although information can be given to patients it is not necessarily always understood or retained.

Interestingly, this study found participants expected more in relation to content (e.g., planning) and process (e.g., more direction). No previous studies (e.g., Willemse et al., 2004; Farrand et al., 2008; and other studies in the literature review) have reported this. This may have occurred because interviews took place at the end of treatment and gave participants an opportunity to reflect on their experiences. However, the study by Macdonald et al. (2007) was also conducted once treatment was finished, yet they reported that patients had a lack of clear expectancies about the process. Consistent with Macdonald et al. this study found participants expected the GSH would get to the 'root cause' of their problem.

4.6 Clinical Implications and Future Directions

Importantly, Research Question One highlights that although patients have some knowledge about what GSH involves, many are unclear about what to expect until they have experienced it. Although this finding is likely to have been shaped partly by the research method, it may be worthwhile exploring whether different formats of presenting information, such as leaflets, are helpful in enhancing patients' understandings. At present the teams send out an information sheet about GSH, but

have no 'official' leaflets (A.Bishop, IAPT Team Leader, personal communication,

December 14, 2010). Providing clear information has been previously recommended

(e.g., Pratt et al., 2009; Hirai & Clum, 2006; Khan et al., 2007). By using different

formats, patients have more opportunities to learn what GSH involves. This may help

patients make an informed decision as to whether GSH is suitable for them.