

Factors that influence the uptake and continuing practice of Interpersonal
Psychotherapy by frontline mental health clinicians following formal
training

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ABSTRACT

Interpersonal Psychotherapy (IPT) was initially developed by Gerald Klerman and colleagues in 1968 as a time limited treatment for depression in a research setting. Since then international empirical studies have proved IPT to be an effective treatment for a wide age range of patients, from differing cultural groups, in a variety of psychiatric conditions such as affective disorders, Markowitz and Weissman (2004), anxiety disorders, Lipsitz, Markowitz, Cherry & Fyer (1999) and eating disorders, Agras, Walsh, Fairburn, Wilson & Kraemer (2000).

Providing access to evidence based treatment is a focus of New Zealand mental health guidelines, and recommendations have been made for the dissemination and implementation of talking therapies throughout the sectors of New Zealand mental health care (Te Pou., 2007, 2009, 2012). Interpersonal Psychotherapy is one of the few recommended therapies.

A review of emergent literature had identified a gap in current research specifically investigating factors that influence the uptake of IPT by mental health clinicians in New Zealand. However, international studies show the uptake of evidence based treatments like IPT by frontline clinicians following training can be variable (Paley, Shapiro, Myers, Patrick & Reid, 2003), (Reay, Stuart & Owen, 2003), and (Sin & Scully, 2008). Te Pou., (2012) concluded that there is variability of access to talking therapies in New Zealand, and that this must be addressed to meet demand by 2020.

This small study examined factors that influence the uptake and continuing practice of IPT, by frontline clinicians following training. Purposive sampling identified three cohorts of Post Graduate IPT students from Otago University who were at year one, year three, and year six post training, from which eight students consented to participate in the research.

Applying Interpretative Phenomenological Analysis methods, semi-structured recorded interviews explored the participants' personal experiences to understand the individual experiences of clinicians before, during and after training as IPT therapists, in order to

explore what aspects of these experiences may have influenced their decisions related to practising IPT, and the extent to which these clinicians have continued to use IPT in routine clinical practice. Demographic data and a research diary provided additional contextual data. The qualitative data was analysed progressively, first from an idiographic perspective, generating emerging themes from individual interviews, and then searching for convergence and divergence in the emergent themes across the groups of participants.

The data was drawn together in a structured format and the findings were presented in an interpretative narrative summary, evidenced by extracts from the original data. This information was then integrated with the demographic data.

In the discussion three factors that may influence the implementation and dissemination of IPT were highlighted. The first factor being core and post graduate training in psychological interventions, the second related to the involvement of supportive multi-disciplinary teams committed to the practice and supervision of PSIs, and the third area was the impact of role perception on the participants' ability to practice psychological interventions. The research concluded with suggestion for potential future research in the areas of training, team development and role definition.

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CHAPTER 1: INTRODUCTION

This introductory chapter will provide a description of the study context including:

- A brief history of Interpersonal Psychotherapy in the context of mental health treatment.
- An outline of the current practice of Interpersonal Psychotherapy
- An overview of Interpersonal Psychotherapy training in New Zealand
- The researcher's background relevant to the research question.
- The aims of the study
- A description of the research environment
- Definition of the key terms
- An outline of the structure of the thesis

BACKGROUND TO THE STUDY

History of Interpersonal Psychotherapy

The treatment of mental illness is a relatively new science. Throughout western cultures until the 18th century, limited understanding rendered mental illness a mysterious phenomenon steeped in superstition and fear. People with a mental illness who could not be cared for by their families were often imprisoned by order of local magistrates, or were left to wander in a life of isolation and poverty (Morris, 1988). At the beginning of the 19th century The County Asylum Act of 1808, An Act for the Better Care and Maintenance of Lunatics, Being Paupers or Criminals in England, later to become known as 'Wynne's Act', was passed by the British Parliament. Wynne's Act stated that only doctors could certify people insane and the act empowered The Justices of the Peace to establish and maintain asylums and workhouses from local rates. The 'Institutional Era' lasted well into the 20th century until the emergence of pioneers in psychotherapy, such as Freud and Jung, and the development of psycho-pharmaceuticals in the 1950s. By the 1960s these advances

in psychotherapy and pharmacotherapy allowed the treatment of many people with a mental illness to be community based. The plan for deinstitutionalisation began to take shape and community treatment alternatives developed (Rowe et al., 2001).

In 1957 Adolf Meyer published 'Psychobiology: A Science of Man', in which he adopted a psychobiological approach to the understanding of psychiatric disorders in the context of patients' attempts to adapt to their environment (Meyer, 1957). One of Meyer's associates, Harry Stack Sullivan had already described a link between psychiatric conditions and interpersonal relationships in his book, 'The Interpersonal Theory of Psychiatry' (Sullivan, 1953). These works coupled with John Bowlby's masterful works on attachment and loss (Bowlby, 1969; Bowlby, 1973), were to provide the theoretical underpinning for the development of Interpersonal Psychotherapy (IPT) (Klerman & Weissman, 1993).

The development of IPT began in 1968 during clinical trials into evidence based approaches to prevent relapse in depressed outpatients, following the reduction of acute symptoms of depression using pharmacology (Klerman & Weissman, 1993). To ensure consistency between therapies used in their research, three researchers Klerman, Weissman and Paykel set out, not with the expressed intention of developing a new psychotherapy, but to standardise and operationalise what they believed to be reasonable and current practice with depressed patients (Weissman, Rounsaville & Chevron, 1982). A training programme for psychotherapists was developed and trialed with the resulting manual 'Interpersonal Psychotherapy for Depression' being published in 1984 (Klerman, Weissman & Rounsaville, 1984). This manual has since undergone a number of revisions, and the model has been further adapted to treat other psychiatric disorders, and aspects of the approach continue to be developed.

The Current Practice of Interpersonal Psychotherapy

There is a body of evidence for the efficacy and effectiveness of IPT in a variety of psychiatric disorders over a wide range of patient groups. For example individuals with: eating disorders, bipolar disorder, dysthymic disorder, recurrent depression, depression when HIV positive, antenatal and postpartum mood disorders and substance abuse (Weissman, Markowitz & Klerman, 2000). In more recent years further applications of IPT have been researched, including those for adolescent skills training (Young, Mufson & Gallop, 2010), for borderline personality disorder (Markowitz, Bleiberg, Pessin & Skodol, 2007; Bateman, 2012) with current developments for group use in veterans with posttraumatic stress disorder (Ray & Webster, 2010). The International Society for Interpersonal Psychotherapy (2013) cites over 250 empirical studies validating the use of IPT, with IPT and Cognitive Behavioural Therapy (CBT) being recognised as the two most widely investigated therapies for the treatment of depression (Weissman, 2007).

As a relatively young psychotherapy IPT is already being practised worldwide, beyond its country of origin the United States of America. National Organisations of The International Society for Interpersonal Psychotherapy have been established in Sweden, France, Netherlands, Portugal, England, Greece, Israel and Australia. In the last decade, feasibility studies have produced favourable outcomes in more diverse populations for example, youth living in Internally Displaced Person camps in North Uganda (Verdeli, et al., 2008), and Sudanese refugees in Cairo (Meffert et al., 2011).

In 2007 Te Pou, the National Centre of Mental Health Research, Information and Workforce Development in New Zealand produced the document 'We Need to Talk' calling for greater access to quality talking therapies in mental health and addiction services and listed IPT as an evidenced based therapy for use in New Zealand. The follow up report 'We Need to Act' (Te Pou, 2009) included IPT in the stepped care framework for the planning and introduction of talking therapies in specialist mental health and addiction services based on evidence from the UK National Institute for

Clinical Excellence (NICE) (2009). This framework provides five tiers of service matching appropriate levels of service to client need. Under this framework IPT is one of the recommended treatments to be offered in both primary and specialist mental health services to people with moderate to severe disorders. To be delivered by psychologists, counsellors, psychotherapists and mental health and addiction clinicians trained in IPT and the number of people training in IPT in New Zealand was noted to be on the increase (Te Pou, 2009).

With growing evidence over the last 30 years for the efficacy of IPT in an increasing number of mental health disorders, and the call for mental health consumers to have access to a range of quality talking therapies, one might expect to see IPT being offered as a treatment in specialist mental health and addiction services throughout New Zealand. However IPT has not been widely accessible to patients across publically funded Mental Health Services, with available treatment limited to specialist services or by referral to participate in clinical trials such as the Christchurch Studies led by Joyce and Luty (Luty et al., 2010). IPT may be accessed in the private sector through private therapists practicing IPT. However, the International Society for Interpersonal Psychotherapy has listed only one certified practitioner in New Zealand.

Interpersonal Psychotherapy Training

In 2000 The International Society for Interpersonal Psychotherapy (ISIPT) was formed as a professional scientific organisation, providing worldwide access to conferences, research, training, supervision and dialogue. This organisation facilitates further debate on a range of training issues such as curriculum accreditation and credentialing processes which are too numerous to list in this thesis but can be accessed at <http://interpersonalpsychotherapy.org/>

Training in IPT is designed for mental health professionals who have already been exposed to some psychotherapy training and have had at least two years clinical

experience with their chosen patient group. Training is based on the use of the manual developed by Weissman et al., (2000), alongside IPT videotapes, teaching seminars and supervised case work. Current certification requires the successful completion of three recorded cases supervised by a certified IPT practitioner. IPT training is available through Universities in Canada, UK, Europe, Asia, New Zealand and Australia. In New Zealand IPT training is available through post graduate study with Otago University.

Researcher's Nursing Practice in Relation to the Research Question

Motivation for the development of the research questions came from the researcher's personal experience of integrating IPT training into clinical practice. Reflections on relevant aspects of these experiences are identified throughout the research and explicitly acknowledged in the spirit of 'reciprocity of perspectives' (Schutz, 1953), an understanding that the sharing of constructs and assumptions allow people to interact and engage, and to challenge and develop perceptions through the interchangeability of standpoints. The following brief outline of the researcher's background relevant to the research question defines the researcher's context in relation to this study.

My UK training was through a dedicated School of Nursing within a university affiliated training hospital. Registered psychiatric nurse training in England during the 1980s provided comparatively limited opportunities for academic study. However, from a personal perspective compensation was afforded by comprehensive supervised clinical practice training in a broad range of therapeutic interventions, for example: Milan Family Therapy, Moreno Psychodrama, Transactional Analysis and Rogerian Client Centred Therapy. This early introduction to talking therapies ignited a passion that has remained at the heart of my professional work.

After undertaking formal training through the University of Otago I gained approval from the District Health Board to offer IPT as part of my routine outpatient practice

here in New Zealand. IPT is an evidence based time limited therapy used in the treatment of psychiatric disorders outlined earlier in this chapter. Clients are referred to me following a multi-disciplinary clinical review of their presentation and treatment options. During the consent process the IPT model is fully explained to the client, including the rationale for recommending IPT as a treatment in relation to their individual health needs, and to how this treatment fits with any other treatment being offered, for example medication. The client's understanding of the therapy is discussed and clarified and written handout 'Introduction to Interpersonal Psychotherapy', devised by the author, informed by the IPT manual (Weissman et al., 2000) is provided for the client to take home for reference and is illustrated in Appendix I. An initial treatment plan is developed, typically this would include a course of 12 to 16 sessions of IPT, usually taking place once a week, with each session lasting 50 minutes. Case management work and crisis management is completed in addition to IPT as required to meet the needs of the individual. As part of my practice I undertake regular IPT clinical supervision with a certified IPT supervisor. In addition the client's progress is presented to the multi-disciplinary community care team on a regular basis for clinical review, and the length of treatment may be extended if required. At the end of treatment the client is usually discharged back to primary care.

The experience of offering IPT in this setting has been positive in terms of job satisfaction, professional development and patient outcomes, including feedback from my clients. It has been my subjective experience that people who have engaged in IPT treatment as part of case management in this setting have generally required specialist mental health care for a shorter length of time, compared with those who received case management alone.

Alongside my own positive experiences of practising IPT, there have been significant steps taken towards encouraging the use of psychological interventions in mental health care in New Zealand over the last decade. Mental Health Services in Canterbury are researching mentalization-based treatment for adults with borderline

personality disorder, as described by Bateman and Fonagy (2006). Regional Workforce Coordinators from the National Centre of Mental Health Research, Information and Workforce Development have reported that District Health Boards are funding training courses in a variety of talking therapies (Te Pou, 2012).

Despite these encouraging developments, it is notable that the use of IPT is not widespread in New Zealand. IPT training is available as a post graduate qualification, has become integrated into Psychiatric Registrar programmes, and is included in National Depression Guidelines as an example of a ‘very valuable approach’ to be offered by mental health clinicians (Te Pou, 2009, p. 30). However there is little evidence of IPT practice amongst my colleagues post-training outside of the research arena. Why an effective evidence based therapy, listed in National Guidelines as a recommended treatment is not more widely practiced, informed the development of the research question.

Lofland Snow, Anderson and Lofland (2005) note that many research publications emerge out of the researcher’s personal biography and so it was in this context I formulated my own research question to ask: what are the factors that influence the uptake and continuing practise of Interpersonal Psychotherapy by frontline mental health clinicians following formal training?

ABOUT THE RESEARCH

Aims of the Study

The aims of this study are to:

- Explore the personal experiences of clinicians who have trained in IPT before, during and after training as therapists: their areas of training and clinical experience prior to engaging in the IPT training programme, the

characteristics of the service where IPT is being introduced, and their personal experience of implementing IPT into their area of clinical practice.

- Identify the aspects of their experiences that may have influenced their individual decisions related to the initial implementation of IPT.
- Establish the extent to which these clinicians have continued to use IPT in routine clinical practice and factors that may have influenced their decisions related to continuing practice.

The resultant data will be analysed and discussed with a view to recommending potential areas for future research and practice that may inform the implementation and continuing practice of IPT, and therefore potentially increase the availability of IPT treatments for patients.

The Research Environment

This research was conducted through the University of Otago, Department of Psychological Medicine in Christchurch New Zealand. The University of Otago offers a number of workshops and courses in IPT, and also partners the Canterbury District Health Board in the psychiatric registrar training programme, which includes supervised IPT case studies. IPT training at the University was initially introduced in 2005, with papers running over four semesters leading to a Post Graduate Diploma in Health Science endorsed in IPT. There have been three cohorts of students who had trained in IPT at the date of this study. These students were ideally placed to provide data on the uptake of IPT following training. They came from a variety of disciplines and worked in a variety of clinical settings based throughout New Zealand.

In addition to providing postgraduate training in IPT, the Department of Psychological Medicine is one of the leading institutes conducting research in IPT

and has published data from a number of influential research studies for example Joyce, McKenzie and Carter (2007), and Luty et al., (2010).

Definitions & Key Terms

The participants in this study had all completed postgraduate IPT training at Otago University through the Department of Psychological Medicine. They were from a range of professional groups including, counsellors, doctors, psychiatrists, nurses, social workers and mental health support workers, but they shared the common goal of seeking to become qualified IPT practitioners. For the purpose of this study the terms ‘participants’, ‘clinicians’, ‘mental health clinicians’ and ‘IPT therapists’, will be used to encompass all of these disciplines, except when examining the demographic data when specific disciplines will be identified.

Te Pou (2007) defines talking therapies as “*A broad term covering a range of therapeutic approaches, all of which involve talking, questioning and listening in order to understand, educate and assist with people’s problems.*” (Pg. 8). This broad term may encompass many therapeutic modalities; likewise the research studies examined in the course of this study utilised a vast array of terms such as, ‘evidence based psychological interventions (PSIs)’, ‘talking therapies’, ‘counselling’, ‘psychotherapy’, and ‘psycho-social interventions’ to include both generic and specific therapeutic interventions, along with more definitive specific models such as ‘Cognitive Behavioural Therapy’ and ‘Interpersonal Psychotherapy’. For the purposes of this study where specific models are referred to, the full title of the model or its acronym will be used, whilst reference to generic groups of therapies or non-defined therapies will utilise terms reflected in the literature being discussed.

The research work undertaken for this study will be referred to as the study or the research. The author will primarily be referred to as the researcher, or at times the interviewer or analyst in context with the text.

OUTLINE OF THE STRUCTURE OF THE THESIS

Chapter I will introduce the research by first outlining the history and current place for IPT, both in New Zealand and internationally. A specific description of IPT training available in New Zealand, will provide a context to the researcher. Following this will be a description of the aims of the study, the research environment, and definitions of the terminology used, concluding with an overview of the structure of the thesis.

Chapter II introduces the relevance, purpose and concept of the literature review. The development of a review framework provides structure for the search strategies and a data base of relevant literature. The process is described as a progressive coherence which moves through a review of current knowledge regarding the introduction of IPT into a clinical setting, identifying gaps in the research and defining four areas of interest related to the research questions. A narrative review of the search results describes and reviews the findings.

Chapter III gives a comprehensive introduction to the issues on which the research rests identifying the researcher's preconceptions and assumptions and examines the theoretical and philosophical orientation guiding the methodology principles, with a justification of the choice of methodology. A description follows of how the research design was developed by considering credibility, ethical issues, participant sampling, recruitment, and consent. The framework for the semi-structured interview is then presented and the pilot interview discussed. A description of the process of interviewing and transcription is then followed by the detailing of stages of Interpretative Phenomenological Data Analysis. This chapter concludes with a summary discussion which includes the relevance and the limitations of the research.

Chapter IV provides a detailed description of the processes and strategies of Interpretative Phenomenological Analysis (IPA) applied to the study. The first participant's interview is progressed through the initial stages of analysis to provide a

number of emergent themes. The resultant data, together with data generated from the succeeding seven interviews is then examined for patterns across the cases. Identifying both the unique and the shared constructs of the accounts from each participant assists to develop a system which manages the data and produces a set of emergent themes and superordinate themes for the whole participant group.

Chapter V presents the hierarchy of themes for the study, and then provides a concise written summary of the findings and a schematic diagram to illustrate the emergent themes and the superordinate themes. The sample, the areas of research enquiry and the use of transcript excerpts are described, followed by a detailed explanation of the superordinate themes and the themes. In the second section of the chapter a detailed interpretative analysis of the emergent and superordinate themes is illustrated with transcript extracts and contextual data, including demographic data.

Chapter VI provides a summary of findings in relation to the research question and relevant literature, and discusses implications and recommendations for further research.

CHAPTER 2: LITERATURE REVIEW

INTRODUCTION

This study will investigate ‘factors that influence the uptake and continuing practice of Interpersonal Psychotherapy (IPT) by frontline mental health clinicians following formal training’. The literature review will provide a synthesis and analysis of relevant published works related to the implementation and dissemination of evidence based psychological interventions (PSIs) into clinical settings. It will also identify the concepts and themes that informed the study.

The objectives of the review are:

- To establish a context for the practice of IPT by frontline clinicians in New Zealand mental health services.
- To review national and international studies that described the experiences and perceptions of clinicians and researchers who have implemented evidenced based psychological interventions including IPT, into clinical practice.
- To identify any variables not previously considered in the development of enquiry.

This chapter begins with an outline of the search strategies, describing preliminary searches and the rationale for the selection of databases and search terms that were applied to inform the development of a literature review framework. The validity and quality of the literature that was included in the searches will be discussed, and the exclusion and acceptance criteria will be defined. The chapter continues with a description of the sources and the sequences of the literature searches, and how the retrieved data was processed, including the development of a database.

The literature will be investigated and the review will discuss the effectiveness of the searches, and the varying research methods and strategies. Any significant controversies or inconsistencies in findings, unanswered questions, or gaps in the research, will be highlighted to provide a progressive coherence of the body of knowledge pertinent to this study. The review is organised into the following sections:

- Background to the study, providing context of IPT practice by frontline clinicians New Zealand.
- The relationship between clinical training and practice prior to therapy training, and the implementation of IPT or similar psychological interventions into routine practice following training.
- Aspects of service provision and team involvement that may enhance or challenge the ability of clinicians to practice talking therapies in a mental health setting.
- The understanding and perception of the role of mental health clinicians in relation to implementing and disseminating PSIs into clinical practice. This section was identified as the review unfolded, and is supplementary to the original research questions.

A summary concludes the chapter.

LITERATURE REVIEW FRAMEWORK

The risk of tangential investigation was mitigated by the literature review framework developed by the author, and described below. The aim of the framework was to provide structure and a point of reference to ground the searches in relevant areas.

Preliminary Searches

Broad preliminary searches were carried out to identify appropriate databases, determine key terms, and establish the availability of suitable relevant scientific research. These initial searches were conducted on a trial and error basis to determine which elements were to be included in the literature review framework. These accessed a wide range of databases including the Ovid SP databases; Allied and Complimentary Medicine (AMED), EMB Reviews, Ovid MEDLINE, Ovid Nursing Database, Psych INFO, Your Journals, EMBASE and Psych Extra , and the Cumulative Index to Nursing & Allied Health (CINHAL) database.

Key Terms

Keywords, ‘interpersonal psychotherapy’, combined with a number of experimental key terms, for example ‘therapist training’, ‘community mental health services’ and ‘continuing practice’ were applied. Results of these preliminary searches indicated that restricting searches to ‘interpersonal psychotherapy’ would not provide adequate data to inform the research. The addition of additional terms for example ‘Cognitive Behavioural Therapy (CBT)’ and ‘Motivational Interviewing (MI)’ produced research that was beyond the relevance and scope of this study. A more successful strategy proved to be the inclusion of the more generic terms ‘psychological interventions’, ‘psychotherapy’ and ‘psychotherapy brief’. With these terms the percentage of relevant articles to be investigated increased considerably.

To further refine the search terms, a review of sample articles retrieved through the preparatory searches provided information about the type of research studies that would inform the research questions, and gave indicators to additional keywords. For example the Australian pilot study by Reay, Stuart and Owen (2003), described implementing IPT into a community mental health setting and included data on clinician training and experience, and followed with detailed information about therapist participation and barriers to implementation. This study provided valuable,

comprehensive information for the research and was identified through the application of the key terms ‘interpersonal psychotherapy’ and ‘community mental health’. Further trial searches were initiated with the aim of finding similar research studies, using the keywords ‘interpersonal psychotherapy’ combined with ‘cost effectiveness’, ‘pilot’, ‘feasibility’, and ‘training’ or ‘competence’. Initial indicators of research volume and relevant article titles suggested the success of these terms was variable, but all yielded sufficient relevant studies for a comprehensive review.

Preliminary Search Results

Results of the preliminary searches enabled a stratagem to be established to achieve manageable and relevant data including seminal works. These were then incorporated into the literature review framework set out in Appendix II. The framework defined a structured search rationale and a set of search terms, to evidence and contextualise the background to the research in the first instance, and then to address the following questions relevant to the research:

- Does prior training and clinical experience influence the post training practice of IPT?
- What are the characteristics of services which enhance talking therapy provision and enable clinical staff to practice their discipline?

Exclusion and Acceptance Criteria

Search exclusions were identified as editorials, articles published in newspapers, websites where sources could not be verified, and research literature published more than fifteen years ago with the exception of seminal works. Resources available were limited to those in the English language. Although it excluded a small number of studies from Europe and Asia the number was not considered sufficient to be of significance.

Acceptance criteria were established as governmental publications and discussion documents and research articles published in respected scientific journals, texts and seminal works.

THE SEARCHES

In order to capture a broad spectrum of relevant data the literature searches spanned a range of sources. The University of Otago Library was utilised to conduct the main database searches. When articles were unavailable through these sources, the loan services of other New Zealand and Australian libraries were used. For statistical data and governmental publications, reputable websites for example World Health Organisation and New Zealand Ministry of Health were accessed. Wiley Online Library and Google searches proved efficient for cited articles, as did direct publisher searches for example, The Lancet on line. In addition a number of texts and articles were purchased, or accessed from the private libraries of the researcher and colleagues. Further sources of information were those articles serendipitously revealed during searches for other data or recommended by colleagues following academic discussion.

The search and review of the literature was completed in stages, the first was a preliminary review described above conducted during the initial stages of the development of the research proposal. Much of the data resulting from this review was utilised in the background to the study. This was followed by a second stage of exploratory searches which were devised to inform the development of the literature review framework. The third stage was an in depth review; results from this review were recorded in the main literature database. Throughout the study an ongoing review process with updated searches and email alerts to highlight new research proved to be productive as further studies on implementing psychological interventions into clinical practice were published. It was during this extended ongoing literature review process that the area perception of role definition began to

develop and was added to the review framework to address a further question relevant to the research:

- What impact does the perception of role definition have on the acceptance of clinicians to practice PSIs in a mental health service?

TREATMENT OF RETRIEVED DATA

The literature review framework was applied to each area of enquiry in turn, beginning with background to the research.

The first database e.g. CINAHL was selected and the key term interpersonal psychotherapy was coupled, in turn with secondary terms identified in the review framework. The terms used were: clinical practice, evidence based practise, talking therapies, patient outcomes, mental health and psychological interventions. For each list of results achieved, the exclusion criteria were applied. The resultant list of titles was then scanned and all obviously inappropriate topics were deleted. The abstracts of the remaining titles were read to select articles for further appraisal. Final selection occurred when the full text of each publication was appraised. This process resulted in a more manageable number of articles of sufficient validity and interest to the research to be reviewed in full. All articles accepted for inclusion were printed and labelled to identify the article number, the number of the search, the database and keywords used.

The database contained a summary of the content of each publication for ease of reference throughout the study. This procedure of search, review and database entry was repeated for each data base and the whole process reapplied for each search term in the literature framework for each of the remaining areas of interest to the research.

THE FINDINGS

Background to the Study

“Without adequate mental health services and supports, persons with mental illnesses cannot grow and prosper. Without the positive contributions of persons with mental illnesses, communities are thwarted and countries cannot achieve their full potential.”

Vijay Ganju Secretary General,
World Federation for Mental Health. (p. 3, 2011)

According to health statistics compiled by the World Health Organisation (World Health Organisation (WHO), 2012) one in four people worldwide will be in need of mental health care during their lifetime, with the leading cause of disability being depression. Key results from Te Rau Hinengaro: The Mental Health Survey (Oakley Browne, Wells & Scott, 2006) showed that two in five of the population of New Zealand had met criteria for a mental disorder under the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) at some time in their life before the survey interview; with an estimated life time prevalence for anxiety disorders as one in four, and one in five for mood disorder. A comparison study (Moussavi et al., 2007) conducted on behalf of WHO concluded that the impact of depression on functioning was 50% more serious than that of angina, asthma, diabetes and arthritis. In response to this issue the World Health Assembly has called upon the international community to take action (WHO, 2012). On World Mental Health Day in October 2012, the World Federation for Mental Health launched ‘Depression: a Global Crisis’ (Marcus, Yasamy, Van Ommeren, Chisholm & Saxena, 2012). This publication aimed to draw specific attention firstly to the pervasive nature of depressive disorders; often with adolescent onset, frequent relapse, and multiple symptoms resulting in impaired functioning, all factors that make depression the leading cause of disability worldwide, as measured by years lost because of disability, and secondly to the solution. “...*efficacious and cost effective treatments*

are available to improve the health and the lives of millions of people around the world....” (p. 8). The World Federation for Mental Health recommend a lifespan approach to prevention and treatment that includes anti-depressant medication and brief structured psychotherapy for example IPT. The Ugandan clinical trial for IPT Group (Bolton et al., 2003) was cited as evidence of an effective treatment in resource-constrained settings.

Despite evidence and international concern, there is a dissonance in the burden of mental illness and the resources afforded to specialist mental health services. The WHO (2003) found that skilled and educated mental health workforces are limited throughout its member states, and that initial treatment can be delayed for many years. One might assume lack of treatment for sufferers of mental disorder is only a problem in poorer, developing countries with underfunded health care systems, but there is strong evidence to the contrary. Despite the hefty health dollar that supports the sophisticated health services of the west, the Mental Health Atlas produced by WHO (2011) showed the proportion of total health spend on mental health was a mere 2.4% in upper middle income countries, and 5.1% in high income countries. In a large multi-country survey conducted by the World Mental Health Survey Consortium (Demyttenaere et al., 2004) the results showed that in low-income countries 76–85% of people with severe mental disorders did not receive any treatment in the previous 12 months and in high income countries the proportion was as much as 35–50%. These figures are consistent with those presented by the WHO (2003): *“In developed countries with well-organized health care systems, between 44% and 70% of patients with depression, schizophrenia, alcohol-use disorders and child and adolescent mental illnesses do not receive treatment in any given year.”* (p. 36).

With attention turned to evidence based treatments that can offer cost effective and feasible treatment of mental illness, WHO (2010) have developed an ‘Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialised Health Settings.’ The preferred treatment options are described as psychological

supports combined with medication or psychotherapy, and IPT is recommended as a treatment option for mood disorders. In Australia and the United Kingdom where health systems are most akin to those in New Zealand, work is underway towards similar goals in policy and funding development for mental health services. Organisations such as Beyond Blue (The Victorian Centre of Excellence in Depression and Anxiety), the National Institute for Clinical Excellence (NICE), and the UK Mental Health Foundation have exemplified treatment guidelines and foundation documents for policy change that have also been adapted for New Zealand.

Beyond Blue have produced a series of treatment guides including: 'A Guide to What Works for Depression' (Jorm et al, 2013), which reviewed psychological, medical, complimentary and lifestyle interventions and interventions that are not available but have been researched. This publication is readily available as a resource to clinicians looking for personal guidance. It recommends IPT as an effective treatment for depression. In the UK, guidelines for evidence based treatment of depression (NICE, 2007) recommend a serotonin reuptake inhibitor (SSRI), or a high-intensity psychological intervention of either CBT or IPT for people who experience persistent sub threshold depression, or those who have mild to moderate depression which has shown inadequate response to initial interventions. A similar recommendation is made for people with moderate and severe depression, and for those with eating disorders. An earlier version of these guidelines NICE CG23 (2004), informed the discussion document 'We Need to Talk: The Case for Psychological Therapy' from the NHS, (2006), a collaborative project produced by The Mental Health Foundation, Mind, Rethink, The Sainsbury Centre and Young Minds. This influential work also included the recommendation for IPT and CBT as frontline treatments and concluded that timely access to evidence based psychological therapies could reduce the economic and social burden of mental disorder. This founding document was adapted to the New Zealand context, and subsequent work conducted by Te Pou and discussed below, has shaped thinking, policy planning and workforce development in New Zealand this century.

Te Pou developed a discussion document 'We need to Talk' (Te Pou, 2007), one of the significant publications of interest to this research. This identified that service users, family members and clinicians agreed that improved access to evidence-based therapies was needed, and recommended that talking therapies should be included in the updated National Service Framework. Te Pou recognised the broad scope and anecdotal nature of the document; nevertheless the findings and recommendations of the project were pragmatic and relevant to the continuing work of Te Pou and this research study. The following year 'We Now Need to Listen' (Te Pou, 2008) provided a process for further in-depth consultation, and feedback from these documents was then incorporated into 'We Need to Act' (Te Pou, 2009). It was notable that that much of the feedback received indicated that most current nursing and social work training at undergraduate and degree level did not include sufficiently comprehensive mental health content. It suggested that professionals entering mental health services would likely lack the required communication skills including basic therapeutic engagement and counselling skills. This document provided recommendations to include training and cultural best practice for talking therapies and developed a talking therapies framework, placing IPT on the table of therapies suitable for a New Zealand context. This information was also incorporated into 'A Guide to Talking Therapies' (Te Pou, 2009) compiled by the Royal Australian and New Zealand College of Psychiatrists. The 2009 guide provides information and recommendations on various therapies including IPT, how they work, who they are likely to work for and how to go about finding a professional therapist.

'Talking Therapies: Where to next?' (Te Pou, 2012) concludes that there is variability of access to talking therapies in New Zealand, and that this must be addressed to meet demand by 2020. This report draws on national and international resources including the 'Improving Access to Psychological Therapies- Implementation Plan' (Department of Health, 2008) and the workforce capacity tool made available to New Zealand. It applies a New Zealand context to the development of a national strategy for talking therapies. Aims of the plan include:

increased availability, consistency in standards and improved equity of access to talking therapy and it sets out strategies that include training, competency skill sets and workforce identification data, to support the implementation of the plan.

All these publications concentrate on choice of treatment for individuals and cite the NICE (2004, 2009, 2012) guidelines as evidence to recommend talking therapies, including IPT and link to a number of quality health initiatives for New Zealand. The Ministry of Health (MOH) ‘Identification of Common Mental Disorders and Management of Depression in Primary Care’ (New Zealand Guidelines Group, 2008), developed for the management of depression in primary care, ‘Let’s Get Real’ (Ministry of Health (MOH). 2007, 2008, 2010) that involved mental health stakeholders to develop a plan for building a workforce with suitably trained clinicians to support the mental health framework set out in ‘Te Tahuhu – Improving Mental Health’ (MOH. 2005-2015), and to inform ‘Blueprint II’ (Mental Health Commission, 2012) the national strategy for talking therapies.

‘Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015’ (MOH 2006), identifies the availability of a wide range of mental health professions as being integral to the implementation of ‘Te Tahuhu – Improving Mental Health 2005-2105’ (MOH, 2005), through providing leadership in areas such as professional development, workforce training and cultural and clinical standards of care. It states that service users can expect to have access to a wider range of treatment choices and approaches to care, including psychological therapies, and lists specific actions that include how DHBs will be able to demonstrate an expansion of the range of effective and integrated services including evidence based psychological therapies. The challenges of this task were acknowledged by Bearsley-Smith et al., (2007)

“The challenges of linking research and practice in health services are well documented. With the increased pressure on services to deliver and document evidence-based practice, the issues concerning integration of evidence and practice are increasingly important.” (p. 5).

The Relationship between Clinical Training and Practice and the Implementation of IPT

Literature searches were aimed at identifying research studies most likely to outline therapy training prerequisites, and then follow the clinicians through training to implementation of the therapy and beyond. Results of the preliminary searches suggested this information was a by-product of studies that trained clinicians in IPT when the study was: a pilot study introducing IPT into clinical practice or piloting an adaptation of IPT, a feasibility study in a particular setting or a study of therapist competence. Keywords ‘interpersonal psychotherapy’ coupled with ‘training’, ‘pilot’, ‘community’, ‘feasibility’ and ‘therapist competence’ were entered into the CINHAL and OVID databases respectively. The use of the word ‘training’ yielded a number of child and adolescent papers that evaluated patient training courses implemented as part of therapy, and therefore not relevant to this study. Eighty seven articles of interest were identified overall and a review of the resultant literature showed that studies did not fit neatly into the individual areas of enquiry; rather there was an overlap of results for prior training and clinical experience. Studies that were concerned with training programmes fell into two main categories. The first category was education frameworks for example registrar programmes, which generally did not list training prerequisites. These studies tended to be concerned with recommendations for training modalities. The second, and by far the most productive group of studies, included those training therapists for clinical trials or feasibility trials. These usually gave brief detail of the participant sample, for example ‘mental health nurses with previous experience of counselling or psychotherapy’ (Paley, Shapiro, Myers & Reid, 2003), but did not go into the content of training or the extent of prior experience.

An area of concern in the research enquiry was the perception of limited skill training in therapeutic engagement and psychological interventions for mental health professionals. In the previous section of this chapter, ‘background to the study’, it was identified that mental health policy changes have been developed in recognition

of the need to provide evidence based treatments that compliment or provide an alternative to pharmaceutical treatments for a range of mental health treatments. In addition the MOH has identified that current training does not meet the needs of contemporary mental health practice. Mental Health Nursing and its Future: A discussion framework (MOH, 2006), found good examples of clinical training programmes had been developed overseas: *“UK and Australia literature exemplifies innovative clinical training programmes that have developed in response to policy change.”* (p. 14). These programmes focus on undergraduate education training which includes; consumer orientated training, multidisciplinary team and clinical placement training, and primary health and rural and remote training.

‘We Need to Act’ (Te Pou, 2009) reported that much of the feedback from the mental health sector stakeholders indicated that current nursing and social work training did not include comprehensive mental health content, and suggested that professionals entering mental health services would be more likely to lack the required communication skills including basic therapeutic engagement and counselling skills. The report provided 16 action points including:

“Enhance staff training in basic engagement and counselling skills”

and

“Draft curriculum content for basic counselling and engagement skills that could be used across disciplines as best practice for undergraduate work.” (Te Pou, 2009, p. 69).

These results indicated that core training for mental health professional was inadequate for the provision of evidence based talking therapies and without such training clinicians were unable to gain clinical experience in psychotherapeutic interventions. IPT training provides techniques and extensive supervision but the question remains is prior training and experience a predictor in the implementation of IPT following training?

Talbot et al., (2005) reported that masters' level therapists expressed a high level of professional comfort with IPT. In a UK study Paley et al., (2003) reported on the experiences of mental health nurses who trained and implemented psychodynamic interpersonal psychotherapy, 'Hobson's Conversational Model'. These mental health nurses all had previous experience of counselling or psychotherapy, and expressed a wish to develop therapy skills in an evidenced based therapy. The outcome suggested that clinicians with prior experience were able to successfully implement and sustain the practice of psychodynamic psychotherapy. Problems highlighted were the personal anxieties of the participants and included concerns amongst peers of being shamed or criticised, and similar concerns of being 'exposed' during videotaped supervision. They also reported surprise at the initial difficulty in applying a model, that was 'deceptively simple' in training but complex in practice. These issues were addressed in extensive ongoing weekly supervision which included audio-taped supervision, group supervision and self-supervision (using self-noting of audio tapes). Paley et al., (2003) concluded the implementation of evidenced based practice had provided practice based evidence, a high level of commitment from the therapists, who were able to be offered appropriate skills to meet consumers demand for talking therapies. Interestingly however, they reported that two years into the project work was still required to provide 'organizational infrastructure' and 'strategic vision' necessary to disseminate the model. This research was similar to that of others who also reported barriers to implementation (Brooker, 2001), (Fadden, 1997) and (Tarrier, Barrowclough, Haddock & McGovern, 1999).

A New Zealand study trained therapists for a clinical trial to compare the efficacy of IPT and CBT in people receiving out-patient treatment for depression (Luty et al., 2010). In this study experienced psychiatrists, a senior registrar and clinical psychologists who had previous training in either IPT or CBT trained in both IPT and CBT and took part in regular supervision. Competence and adherence measures applied during study showed that these therapists maintained their competence and

showed a 90% adherence to protocol. This study did not follow the therapists after the trial was complete; therefore no data was available regarding continuing practice.

A significant study that reviewed the findings from manual guided training programs for IPT was conducted by Rounsaville, O'Malley, Foley and Weissman (1988). It concluded that experienced, dynamically trained therapists were able to achieve a high competence level in IPT after comparatively brief training and that adherence could be maintained over a long period. However some trainees with lower initial competency were found to be unable to adhere to the manual even after a number of training cases. In conclusion they 'strongly advocated' the use of videotape-guided supervision to improve accuracy of supervisor ratings and this was seen as particularly important for less-experienced therapists.

These studies are examples of research that show mental health clinicians with prior therapy training and clinical experience are able to quickly achieve competence and adherence after training in an evidence based therapy, and that this can be maintained over long periods. However, literature has also argued that IPT could be taught successfully to non-specialist inexperienced staff. Bearsley-Smith et al., (2007) investigated feasibility, acceptability and sustainability of implementing evidence based intervention into a community service for the purposes of a clinical trial. They suggested that IPT was a particularly valuable treatment in rural areas where there was a shortage of mental health specialists, because of its 'ease of delivery' by a 'broad range' of mental health professionals. However this research did not provide data on the evaluation of the study.

A further influential paper by Clougherty, Verdeli, Mufson and Young (2006) documented two IPT trials in culturally diverse community settings. In these trials local therapists from each community were trained to ensure cultural safety and to reduce the logistical barrier of a remote area. A key feature of these studies was weekly supervision; however there was variance in the model used, because phone and group peer supervision were the only option for therapists working in

geographically distant locations. They concluded that IPT could be delivered effectively in diverse settings by therapists with varying levels of training despite challenges of culture and training resources.

A further group of therapists were highlighted in a comprehensive study of psychodynamic interpersonal therapy training for counselors working in primary care (Guthrie, Mackay, Chew-Graham, Moorey & Sibbald, 2004). These therapists had prior training and experiences of counselling but were not psychiatrically trained. Counselors who had not received any formal training in psychodynamic psychotherapy but had a British Association of Counselling-accredited qualification in counselling underwent an intensive mixed format training course followed by weekly supervision. The study assessed for adherence to the model, patient outcomes, therapist behaviour and effectiveness. Guthrie et al., (2004) concluded that primary care counselors could be trained to deliver psychodynamic psychotherapy.

In summary a number of studies suggest those with prior training and clinical experience in psychotherapeutic interventions can reach and maintain competence more quickly than those who do not. In contrast other studies present an equally compelling argument that IPT can be provided by non-specialist staff, without prior therapy training, particularly in resource poor or diverse communities.

What are the characteristics of services which enhance talking therapy provision and enable clinical staff to practice their discipline?

Each study specifically acknowledged the importance of supervision, both as a training tool and essential to the maintenance and further development of therapist competence. For example supervision, was considered 'critical' as a training method by Holloway and Neufeldt (1995). Najavits and Strupp (1994), provided a model of effective therapist behaviours, in their process-outcome study, and suggested that therapist's relational skills had more impact on outcomes than technical skills, and

professional reflection aided the development of therapist competence. Chouliara et al., (2011) recommended placing greater emphasis on relational models and supervision in core mental health training, and practice, however difficulties in accessing suitable structured clinical supervision were highlighted as a barrier to the practice of PSIs (Rounsaville, Chevron, Weissman, Prusoff & Frank, 1986). In a randomised controlled trial Heaven, Clegg and Maguire, (2005) concluded that clinical supervision following communication skills training enhances the clinical effectiveness of such training programmes. Using a quasi-experimental design Bradshaw, Butterworth and Mairs (2007) found that nurses experienced significant difficulties in implementing psychological interventions. They suggested this was in part due to the difficulties of accessing suitable supervision to support ongoing practice. This paper reinforced the development of new models of clinical supervision to support nurses in the workplace.

A further area of interest was the recommendation for therapeutic skills training to be embedded in core training. Skills training may occur during practice placements in a variety of mental health services. This concurs with Ministry of Health policy and workforce development planning (Te Pou, 2009) discussed earlier in the review. A review of postgraduate psychotherapy training on psychiatry programmes by Ravitz, (2004), highlighted gaps between what is taught and what is practiced, and called for comprehensive measures for the evaluation of effectiveness. Ravitz (2004) suggested that significant advances in therapy education call for the inclusion of manualised, time limited therapy such as CBT and IPT, and greater attention to the evaluation of competence and integration of technology tools. Looking at best teaching practices, Ravitz (2004) suggests that face to face supervision in a ‘master-apprentice model’ extended over time, “...*effectively teaches learners to apply knowledge in action, and become experts rather than technicians.*” (p. 233). However, this may not address issues for novice therapists and therefore Ravitz (2004) also suggests that the provision of basic skills *early* in training, particularly group learning through taped supervision provides an opportunity to develop ‘reflective capacity’.

The theme of early training is also considered by Lichtmacher, Eisendrath, Stuart and Haller, (2006) who tracked the process of incorporating IPT into a residency training programme. These researchers wanted to provide ‘state-of-the-art clinical training’ and saw that evidence based treatment was an essential requirement. They concluded that implementing IPT training provided a ‘cornerstone’ for learning evidenced based treatments and core psychotherapy concepts. This literature provides similar conclusions to the New Zealand policy and workforce development documents discussed at the beginning of this section of the review.

Providing good quality post graduate training for IPT has not been a problem in New Zealand Mental Health services. As with prior training and clinical practice discussed earlier, an area for exploration is whether trainees returning to the clinical setting implement therapy into routine practice. Studies by Brooker and Repper (2002), McCann and Bowers (2005), and Lichtmacher, Eisendrath and Haller (2006) all concluded that not only was supportive workforce leadership essential for change but leaders needed to give permission and provide the impetus to make the necessary changes to introduce new treatments. Lichtmacher et al. (2006) introduced ‘change champions’ to promote IPT and used workshops to address barriers to practice. Van Rijn et al., (2008) also considered how new knowledge might translate to practice and suggested that a framework ensuring effective communication between education providers and clinical settings in the early stage of clinical placements should be built into training programmes. Providing a framework for improved communication and ‘user-responsive’ education, where design and development should respond to the user's behaviour and environment was also a topic in Trenchard, Burnard, Coffey and Hannigan (2002), a discussion paper that considered the importance of applying the multi-disciplinary model to training.

An Australian study, Reay, Robertson and Owen (2002), outlined the processes for integrating IPT into a perinatal mental health service and concluded that using a

quality improvement approach was a positive factor in implementation. Strategies included involving clinical staff in the review process, a multi-disciplinary IPT workshop, monthly follow-up supervision for small groups of staff led by the trainer, and the use of outcome measures the clinicians were already used to administering. Reay et al., (2002) concluded that obstacles to implementing evidence based practice can be anticipated and recommend involving clinical staff in the planning, implementing and evaluation. This study suggested that follow-up supervision provided ‘crucial support’ in the application of IPT and recommended “...development of local expertise to continue training and supervision of mental health professionals.” (Reay et al., 2002, p. 213).

In a UK survey, trainees and their managers were asked to examine factors that support and limit the education and practice of evidenced based psychological interventions (PSIs). Key findings from this study (Sin & Scully, 2008) included “a strong association between PSI training and career progression” (p. 161), and identification of support mechanisms for implementation. Recommendations were aimed at both a service and strategic level. These included the development of policies and protocols to ensure protected practice time, increased support for graduates to aid dissemination of skills to teams, and managerial support to reduce barriers to practice, for example protected caseloads and staffing levels. In addition, they noted that an increased emphasis on practice and training should be incorporated into service and staff development, job descriptions, service frameworks and staff appraisals.

Hurley (2010) highlighted the commitment of the therapist, significant organisational, team and financial support as essential to incorporate talking therapies into mental health services. He identified a need for professional leaders to consider how they might respond to trainees who return to work environments and wish to practice their skill. Furthermore this paper discusses the issue of nurses requiring encouragement to remain affiliated to the nursing profession when the

perception of other disciplines may prevent them from practicing therapy. In such cases nurses may choose to leave the profession to order to use their therapy training.

To address this question ‘what are the characteristics of services which enhance talking therapy provision and enable clinical staff to practice their discipline?’ it is also relevant to consider the barriers to practice. Te Pou, (2009) reported on key issues that created barriers for nurses in practicing talking therapies. For example *“many nurses argue that a key barrier to adopting a stronger therapeutic nursing approach in mental health is seen as the strong influence of the medical model.”* (p. 51). Nurses who do go for training then return *“to an environment in which their new-found therapy skills are not supervised or supported, and further development is not planned; thus they are often not able to use their skills.”* (p. 52).

Paley et al. (2003) also identified practical barriers in implementing psychodynamic interpersonal psychotherapy as inadequate facilities, availability of rooms and difficulty prioritising time for both therapy and supervision. Similar themes were reported by Doyle, Kelly, Clarke and Braynion, (2007) and Mathers (2012) who found that trainees reported time pressures as a barrier to implementing PSIs, in particular the time needed to complete assessment tools required to evaluate patient progress. It was perceived that managers supported the introduction of PSI in theory but in practice failed to provide the necessary resources of staff and structured therapeutic time for nurse-patient interactions.

In summary the literature suggests that clinicians returning to practice following formal training in talking therapies are often faced with complex and challenging environments. Recommendations to address barriers include collaborative involvement of all stake holders throughout the process of planning, dissemination and continuing practice of talking therapies.

Role Perception

A review of literature that explored 'role' perception was conducted after the research data had been collected and analysis had begun. Retrospective searches in this area of enquiry were prompted by participant focus on the perception of 'role' as a barrier to implementing and disseminating IPT into routine practices in areas that practice in a medical model. Many articles addressed brief psychotherapeutic interventions rather than IPT itself but gave an interesting insight into the perceptions and experiences of psychiatric nurses offering therapy. A high proportion of the participants identified with a nursing background but as this study was not aimed solely at nurses search terms were broadened to include 'mental health clinician' 'psychiatrist', 'social worker' and 'allied health worker'. The parameters of these searches were incorporated into the literature review framework.

The findings from both the literature review and the data analysis of this study suggest 'role' is a barrier to the practice of IPT, however there is no evidence that role should define whether a therapist is suitable to practice. An open trial of IPT for moderate to severe depression concluded there is no difference in responses to IPT when patients are treated by psychologists, psychiatric registrars, doctoral students, clinical nurses, social workers or occupational therapists (Santor & Kusumakar, (2001).

Crawford, Brown, Anthony and Hicks (2002) identified a gap between theoretical knowledge and the application of evidence based practice (EBP), in part because of the demand variances of clinical settings. They suggested that the conventional approach a policy makes to evidence based treatment is to provide education that focusses on doctors, rather than nurses who historically have 'subservient, non-academic' status. Whilst this may not be the case in the education of nurses who wish to develop psychotherapy skills in IPT, the issue of clinical role perception in relation to implementing an evidence based practice such as IPT is worthy of investigation. Crawford et al., (2002) argue that nurse's day to day working life

includes the management of contradictions between the perceived importance of EBP and a variety of practical constraints. They suggest an alternative approach to tackling the issue of 'role'. Rather than seeing nurses as 'ignorant luddites' resistive to change, there should be a focus on the training of practitioners of EBP themselves in how to educate and transform the culture of their workforce in a manner that is sensitive to the complexities of managing the nursing role (Crawford et al, 2002).

The issue of transferability into clinical settings was also considered in an evaluation of five short training courses in PSIs (Forrest, Masters & Milne, 2004). The staff, who consisted mainly of nurses with varying levels of experience, attended the courses and evaluation took the form of interviews conducted with the course attendees, service users, managers and course facilitators or lecturers. Results showed that although most participants had been unable to transfer knowledge into practice in a formal way participants *had* reported hidden benefits from training including an increase in clinician confidence and a rethinking of attitudes and approaches to work. A medical model reliant on medication as therapy had previously dominated practice, and was challenged by a shift in the nurses' perception of their role, and a desire to 'hand more control to service users' and 'engage in joint working.' These short courses resulted in a change in thinking that may be incorporated into team training to enhance acceptance of mental health workers returning to clinical settings after therapy training.

A paper by Fourie, McDonald, Connor and Bartlett (2005), looked specifically at the role of the nurse in an acute mental health setting in New Zealand and provided an insight into the incompatibility of current role definition and the practice of talking therapies. Fourie et al., (2005) describe the focus of New Zealand inpatient care as being rapid assessment and stabilization, with high acuity and high bed demand. They suggest this model has assisted in the development of new roles for nurses as organisational managers. Increasing management and audit systems that make demands upon nurses' time removes them from the direct contact with patients. This is a view shared by Whittington and McLaughlin, (2000), and is not entirely a recent

issue; Porter (1993) suggested that nurses would prioritize organisational efficiency over patient's needs. It has been suggested that the complexity of inpatient nurse roles has made it increasingly difficult to clearly define their role. O'Brien (1999) concluded that New Zealand nurses were unable to articulate evidenced based knowledge that underlies their practice, and this may be a barrier to implementation of EBP including talking therapies.

The role of the nurse in relation to the practice of talking therapies was examined as part of strategic planning and was raised as one of the key issues Te Pou (2009), *"The role of nurse as 'therapist' appears to have been somewhat lost in the 1970's as a result of the move to generic working..."* (p. 51). They identified nurses, particularly those working in acute inpatient units, as a profession that *"can revert to the 'medical model' as no current model of nursing integrates nursing and talking therapies."* (p. 52). Littlejohn (2003) called for a 'new paradigm for psychiatric nurses' to practice as an autonomous discipline separate from medicine or psychology. Whether this is a *new* paradigm or a return to the role of the 'nurse therapist' seen in the 1970's is worthy of discussion. The concept of the therapeutic nursing role was the foundation of the theory of Peplau's interpersonal relations (Peplau, 1952). Moyle (2003) acknowledged the traditional therapeutic nursing role as the 'essence of mental health nursing' ...when practiced with clear ethical boundaries, and suggested a confusion exists for *"mental health nurses who have been educated to provide professional patient care without emotional attachment..."* (p. 108). Moyle called for further research to validate existing and investigate new models that define and acknowledge the nurse role within the multi-disciplinary team, and for nursing education to ensure an appropriate emphasis be placed on the essential components of the therapeutic relationship (Moyle, 2003).

A number of studies considered ways to constructively address issues of role as a barrier, in particular highlighting the importance of interdisciplinary communication and joint training initiatives. Chouliara et al., (2011) recommended placing greater emphasis on 'relational models' in core mental health training, supervision and

practice. In a reflective account of a role transition from community psychiatric nurse to CBT therapist, Binnie (2008) described an ideological shift as being the most significant requirement - moving from the role of community nurse that operated under a medical model, "*influenced by the dominant profession namely psychiatry*" (p. 1275), to a biopsychosocial model provided a more holistic way of viewing mental disorder. Confidence to practice was seen as an important element in role transition for nurses. In a UK pilot of Solution Focussed Therapy (SFT) training and implementation, Hosany, Wellman and Lowe (2007) followed up training participants with a questionnaire after three months. Nurses reported an improved culture of engagement, were better able to structure one on one sessions and felt confidence that they had 'skills of real value'. The importance of good staff morale and validation of nurses' roles has also been highlighted by Brooker et al., (1999), and this is a view shared by Hurley (2010) who concluded that effective training in talking therapies is best conducted in formal educational settings *and* in work-based sites using effective mental health role models. Importantly Hurley (2010) recognised the need to grow the interfaces between nursing, psychology, medicine and social work, in order to break down barriers to practice. Mufson (2010) also suggested that multi-disciplinary problem solving within the organisational structure and care setting was a keystone to the successfully implementation IPT for adolescents in a community mental health setting.

SUMMARY

The literature review revealed a number of complex and interrelated systems and practices that influence and create barriers to implementing, disseminating and maintaining the practices of IPT or similar psychological therapies into routine practice in current mental health settings.

There was clear evidence that although those with prior training and experience in psychological interventions can quickly achieve and maintain competence, clinicians of all disciplines and non-specialist staff can be successfully trained to provide IPT in

a number of settings when given the appropriate supports (Rounsaville et al., 1988; Santor & Kusumakar, 2001; Talbot et al., 2005; Cloughery et al., 2006; Luty et al., 2010; Bearsley-Smith et al., 2007). However the review also highlighted that clinicians who return to practice following formal training in psychological interventions face barriers to practice including incompatible models of care, lack of resources (including time) and differing role perceptions that operate to inhibit functional interdisciplinary communication and practice (Rounsaville et al., 1986; Raey et al., 2003; Paley et al., 2003; Forrest et al., 2004; Fourie et al., 2005; Doyle et al., 2007).

This review suggests a system-contextual perspective is required to address issues of adequate core psychological training, supervision and barriers to practice that includes a collaboration between educators, policy makers, multi-disciplinary clinicians and consumers (Chouliara et al., 2011; Crawford et al., 2002; Reay et al., 2002; Littlejohn, 2003; Ravitz, 2004; Lichtmacher et al., 2006; Van Rijn et al., 2008; Sin & Scully, 2008, Hurley, 2010; Mufson 2010).

The literature review provided findings that were both instrumental in guiding the development of the interview schedule, and in the spirit of circularity provided opportunity for further investigation when the researcher returned to consider a new area of literature as the theme role perception was revealed in the data.

CHAPTER 3: METHODOLOGY

INTRODUCTION

This study employs an Interpretative Phenomenological Analysis (IPA) approach based on that described by Smith, Flowers and Larkin, (2009), and aims to understand the individual experiences of clinicians prior to, during, and after training as IPT therapists, and then explore what aspects of these experiences may have influenced the clinicians' decisions related to practising IPT.

This chapter will first discuss theoretical and philosophical orientations, preconceptions and choice of methodology as they evolved throughout the development of the research study. This will be followed by a detailed description of IPA and how applied to the design, including the method of participant sampling and recruitment, ethical considerations and the consent process. The interview methods, question development and pilot interview will be discussed and the chapter will conclude with a framework for the collection and analysis of the data.

PREPARATION FOR THE RESEARCH PROCESS

Bryman (2008) describes the research process as being based on the researcher's assumptions with regard to what is valid. The following summary is an outline of the preparation and rationale for the choice of methodology and design of this study. As the research progressed the design elements were refined and will be reported in later sections of this chapter.

Prior to commencement of this study the researcher had completed formal training in (IPT) and had introduced this treatment approach into routine practice at a community mental health service, but observed that the use of IPT was not widespread amongst similarly trained colleagues outside of the research arena. Thus the initial research question development was informed by the researcher's experience, coupled with the results of a preparatory literature review. However, there was limited available prior literature that specifically examined the uptake of

IPT by clinicians following formal training, in clinical settings as opposed to research environments. Articles of influence related to the development of the research included a pilot study by Reay, Stuart and Owen (2003) on the introduction of IPT into a community mental health service. This paper concluded that IPT may be effectively offered as a treatment by mental health clinicians with appropriate training, but reported a significant drop-out rate amongst participating clinicians in the study. In addition relevant discussion papers prepared by the New Zealand National Centre of Mental Health Research, Information and Workforce Development (Te Pou) recommended better access to talking therapies (Te Pou, 2007), and listed IPT as a “*very valuable approach*” (Te Pou, 2009, p. 30).

The primary aims of this study were;

- Explore the personal experiences of clinicians who have trained in IPT before, during and after training as therapists: their areas of training and clinical experience prior to engaging in the IPT training programme, the characteristics of the service where IPT is being introduced, and their personal experience of implementing IPT into their area of clinical practice.
- Identify the aspects of their experiences that may have influenced their individual decisions related to the initial implementation of IPT.
- Establish the extent to which these clinicians have continued to use IPT in routine clinical practice and factors that may have influenced their decisions related to continuing practice.

The researcher was aware of three cohorts of students who had completed the Otago University programme for training IPT therapists and these students were ideally placed to provide an ‘insider’s perspective’ (Conrad, 1987).

Early consideration was given to the most appropriate way this data might be collected, analysed and presented. With little prior data available to build upon, a

collection method was required which would provide flexibility to pursue areas of interest which had developed out of the:

- researcher's experiences
- questions arising from the literature
- new areas of enquiry emerging during the research process

A number of data collection methods were examined including: internet survey, postal questionnaire, telephone interview and structured face to face interviews. However, each of these methods was discounted because the researcher considered that they may not offer sufficient opportunity to explore potentially complex or ambiguous qualities of individual experiences. Smith and Osborn (Breakwell, (Ed). 2004), argue that questionnaires constrain the participants to short responses that best serve to test a researcher's pre-defined hypotheses.

The inductive nature of this study guided the author to consider that a more appropriate method of gathering the relevant data would be to conduct individual interviews, and that open ended questions posed through face to face interviews would be most likely to provide an effective method of eliciting in-depth accounts of the individual participant's experiences. Larkin, Watts and Clifton (2006) suggest a coherent, third person account that gets as close to the participants view as is possible, may be captured through semi-structured interviews. It was anticipated that data collected through in-depth interviews would need to be recorded and transcribed verbatim by the researcher to capture the richness of the data and the textual elements of the interview.

IPA methodology describes the use of audio recordings for interviews (Larkin et al., 2006). Prior to the study the researcher also considered the option of using video recordings, and to this end had engaged in a number of informal discussions with colleagues about their attitudes towards being interviewed, using either video or audio recording equipment, and most had expressed a preference for audio recording. The primary reasons given were that colleagues believed they would feel less comfortable to talk in front of a camera, and that they could more easily disregard the

presence an audio recorder. The researcher concluded that an audio recording may be less intrusive for participants, and that any potential risk that important data would not be captured using this method may be mitigated by the use of a research diary, and by the researcher transcribing the data shortly after the interview concluded. Please note that a five point likert scale mentioned in the information sheet for participants had been discussed in the planning stage of the proposal but was not used and was left in the information sheet for the participants in error.

The research concept was initially discussed with members of Otago University's Department of Psychological Medicine to gain feedback and to consider potentially difficult issues. One area of concern was, as a practicing IPT therapist, the researcher's personal interest in the study raised the potential for bias. This concern was a factor in the choice of IPA methodology, which employees the intersubjectivity of the researcher as an integrated process of IPA (Smith, Flowers & Larkin, 2009). IPA addresses concerns for personal values, perspectives and biases through continual reflection in the research diary, the transparency and rigour in treatment of the data and as a specific focus for supervision (Smith et al., 2009). A similar concern was the researcher's established relationships with some of the potential participants. This issue was addressed in the sampling and consent processes, and was monitored through the reflective processes of using a research diary, the repeated review of interview recordings, and again was a focus of supervision. These concerns are acknowledged in the limitations of the study.

Consideration was given to the limitations of a potentially small sample size that might be yielded by purposive sampling. Whilst this limitation was acknowledged, it was accepted that all the potential participants were in essence experiential experts on the specific phenomenon being studied, and the data they could provide would be rich in detail. An alternative that was considered was to extend participant sampling to include clinicians trained in a comparable therapy, for example CBT. This option was not taken up because results of the prior literature review indicated the number of clinicians training and practicing CBT was far greater than that of IPT. Therefore inclusion of this group had the potential to both skew the results for IPT, and take the participant numbers beyond the scope of a Masters study.

Guest, Bunce and Johnson (2006) concluded that when applying purposive sampling, saturation for the purpose of data presentation, development of meaningful themes and useful interpretations is achievable when using in-depth interviews with a sample size of six. It was anticipated that a minimum of six interviews was viable from the potential population size of twenty one.

A research proposal was submitted to the Board of Studies for consideration. The proposal satisfied the ethics criteria for low risk research involving human participants, in line with Otago University Ethics Policy. The proposal was accepted under Category B, and as such was subject to audit by the Committee following approval by the Head of Department for Psychological Medicine.

The Calendar Wheel Model of a research timeline developed by Seaman (1987), and adapted by the author to guide the study is illustrated in Figure 3.1. The model is based on a circular design having temporal appreciation of phenomena and connection, suggestive of the dynamical process of research.

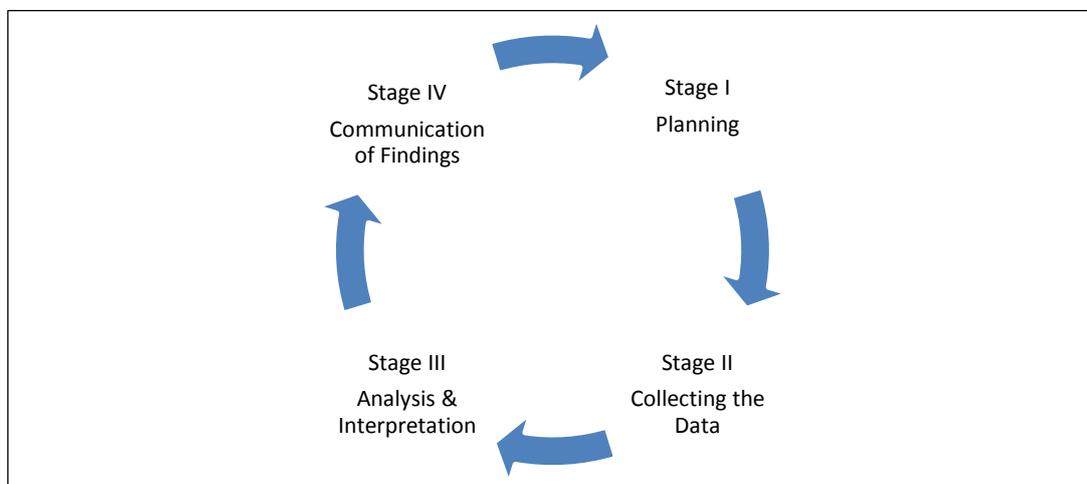


Figure 3. 1 Seaman's (1987) Calendar Wheel Model

THE RELATIONSHIP BETWEEN THEORY AND THE RESEARCH

The process of defining the theoretical underpinnings of the research served to inform a consistent use of language and the preparation an appropriate data collection method, ensuring the evaluation remained congruent with the methodology. Bryman (2008) considered methodology to be intrinsically connected to the researcher's philosophy

“Methods are not simply neutral tools: they are linked with the ways in which social scientists envision the connection between different viewpoints about the nature of social reality and how it should be examined.” (p. 4).

Given that the researcher's world view shapes the style of research methods and the design of the study, a key question in the process of this research development has been that of what may be regarded as acceptable knowledge for the particular discipline, in this case psychiatry. Nurses specialising in psychiatry learn to build rapport with people through carefully attending to personal accounts. This is an interactive process because in order to engage with another's experience successfully, it is important to reflect on one's own personal life experiences and to identify preconceptions and assumptions. This process of inter-subjective meaning enables an understanding of an individual's world view and recognition of the validity of their experiences. This paradigm may be linked to the general tenets of phenomenology, the philosophical study of 'being', as described by Bryman (2008).

Phenomenology is an approach nurses relate to because it is seen as sharing the values of nursing. Increasingly nurse researchers apply this method because it privileges the individual and their experiences, and provides a vehicle with which to examine the qualities and identify the essence of a person's experience (Balls, 2009). However phenomenology per se cannot be viewed as a straightforward research methodology, and the following understanding of the historical development of two contrasting elements of phenomenology assisted the researcher to clarify whether the study was to be approached from a descriptive or interpretative stance. Balls (2009)

considered that without sufficient clarity from the beginning the value of the research may be significantly reduced.

A unifying feature of the varying approaches to phenomenological research lies within the dissatisfaction that influential scientists such as Husserl and Heidegger felt with early natural science models which “*attempt to take an external or de-humanised position on the phenomena and so to see them from a sideways perspective*” (Glendinning, 2008, p. 41). In Larkin’s presentation of IPA (2012) he describes phenomenology as lying somewhere between that of objective empirical realism, a real perception of a real external world, and the relativist view of social constructionism, with its subjective construction of the meaning of the world through language, meaning and practice. Larkin (2012) characterises the ‘descriptive transcendental’ approach of Husserl, and Heidegger’s ‘interpretative existential’ concepts as being two important ‘phases’ of phenomenology.

The first phase, Descriptive-Transcendental Phenomenology, is a methodology widely attributed to Husserl, whose original work *Ideas: a General Introduction to a Pure Phenomenology*, Husserl (1913), was translated by Boyce-Gibson in 1963, and his student Stein, whose original work of 1916, *On the Problem of Empathy*, was translated by Stein (1989). These authors describe a key concept of phenomenology as one that looks to transcend personal and contextual elements of what is experienced, in order to examine the science of how it is experienced through psychological processes of perception, consciousness and awareness. This method reduces our understanding of experience back to its core. To achieve this Husserl and Stein considered it necessary to reflect upon, identify and then suspend assumptions, ‘bracketing’ out cultural influence or personal experience. This process of ‘eidetic abstraction’ serves to identify the essential properties of the phenomena to be studied, leaving the scientist free to examine the experience itself. Applying this research methodology offers rigor through maintaining objectivity, however this can only be achieved by putting aside the researcher’s prior knowledge of the experience (Balls, 2009).

In contrast Interpretative or Hermeneutic-Existential Traditions of Phenomenology as progressed in Heidegger's seminal work *Being and Time* (1927), translated by Macquarie & Robinson in 1962, built upon in the influential publication *Phenomenology of Perception* (Merleau-Ponty, 1945), translated by Smith in 1962, and is more concerned with the ontological question of existence or 'Dasein,' 'being in the world'. These works focus on our engagement in activity and relationships through which we perceive the world, continually developing meaningfulness as a function of our relationship to it, with observation and language being the conduit through which this meaning is made. This approach acknowledges that to step out of one's existence to 'bracket out' experiences and preconception completely may not be possible. Rather it views science as an interpretation based on a person's observations from within that existence. Thus it may be more helpful to recognise bias and assumptions as inextricable factors in the research process, and acknowledge aspects that may have driven the enquiry before putting them aside (Smith et al., 2009).

IDENTIFICATION OF ASSUMPTIONS AND PRECONCEPTIONS

The formulation of a clinical research question based on clinical experience takes account of the researcher's motives, presuppositions and personal history to subsequently shape the inquiry (Caelli, Ray & Mill, 2003). Acknowledging the researcher's inevitable and inextricable involvement with the research or 'thrownness' as described by Heidegger, (1927, Trans. 1962), and identifying assumptions and preconceptions during the process of developing this study, became a further factor guiding the choice of whether a descriptive or an interpretative phenomenological approach would be most appropriate for this study.

Prior to commencing this research, the researcher's observation that few colleagues appeared to be using IPT outside of the research arena, prompted a process of naive enquiry considering the questions: Are clinicians practising IPT, and if so where, when and how, and if clinicians are not using IPT what stops them from doing so? The researcher's uninformed assumption that the practice of IPT may be restricted by health policies was examined during the embryonic stages of the research

investigation. Findings of the preparatory literature review served to challenge this preconception, by identifying one of the authorities shaping the structure and funding of health organisations, the New Zealand's National Centre of Mental Health Research, Information and Workforce Development, as an organisation advocating the use of IPT (Te Pou, 2009). They recommended not only that therapy should be offered, but that patients should have a choice as to which therapy they receive (Te Pou, 2007). Development of the researcher's thinking assisted in putting aside this particular misconception and negative connotation, and to view this as an altogether more complex question. This did not remove completely the notion of barriers to practice being present, but progressed the investigation to ask: Do barriers actually exist, if so at what level in the hierarchy, and what might be the reasons for these barriers? Acknowledging these assumptions allowed the enquiry to be re-constructed in a cultural framework of symbolic interactionism (Bryman, 2008), advancing the question further to consider: If individual's are continually interpreting meaning from the symbolic inference of their environments, and then acting on the basis of this imputed meaning, what were the influences behind the role being adopted by the participants in the construction of this reality? This was not a straightforward question to be asked directly in an interview, but could be investigated through interpretive analysis of the participants' narratives of their personal experiences. Larkin et al., (2006) suggests that research questions are often pitched at an abstract level that cannot be addressed by a singular question, rather the interview should facilitate the discussion of relevant topics.

The Qualitative Descriptive Model, reviewed and disseminated by Sandelowski (2000), provided a framework to investigate the individual's experience of IPT from the participants' perspective, and to report the facts in everyday language. Qualitative Description had initially been identified by the researcher as a suitable model to guide the study, because it "*stayed close to the data and surface of words and events.*" (Sandelowski, 2000, p. 334). However as the research progressed, and the philosophical constructs along with the framework for the enquiry began to take shape, the need for a more interpretative approach became apparent, and Interpretative Phenomenological Analysis (Smith et al., 2009) was selected.

The principles of this methodology and how they inform the research design are briefly described below.

INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Originally developed specifically for research in psychology, Interpretative Phenomenological Analysis (IPA) has gained momentum over the last two decades and is increasingly being adopted by disciplines concerned with the human, social and health sciences. Drummond and colleagues conclude:

“Interpretative Phenomenological Analysis offers an adaptable and accessible approach to phenomenological research intended to give a complete and in-depth account that privileges the individual. It enables nurses to reach, hear and understand the experience of participants.”

(Drummond, Hendry, McLafferty & Pringle, 2011, p. 20).

IPA as manualised by Smith et al., (2009), is described as a qualitative method that applies a phenomenological approach, in that it recognises that individuals have different life experiences, personalities and motivations which impact on how they perceive and engage with the world. The aim of IPA is to explore and make sense of the subjective meaning of the experiences of individual participants. The IPA researcher engages in an interpretative process of detailed examination and is concerned with exploring the experience in its own terms, to find out what a person thinks and feels about the particular event or aspect of their life being studied. Conrad (1987) described this attempt to get close to the participants personal world as taking an ‘insider perspective’, that access to such a perspective is both dependent on and complicated by the researchers own concepts which assist the researcher to make sense of how the participant makes sense of their world. Smith (2004) describes this complex two stage process as double hermeneutic.

HOW INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS IS APPLIED TO THE RESEARCH DESIGN

The IPA methods described in Smith, Flowers & Larkin (2009) were applied in this research study and summarised below. A more detailed description of the methods will follow in the sections later in this chapter.

Larkin et al., (2006) discuss two complementary commitments of Interpretative Phenomenological Analysis:

“The phenomenological requirement to understand and ‘give voice’ to the concerns of the participants”.

“The interpretative requirement to contextualize and ‘make sense’ of these claims and concerns from a psychological perspective.”

(p. 102).

This research aims to *give voice* to the participants as they provide a narrative account of their experiences of IPT, and to apply an interpretative process to that narrative to explore what may have influenced their decision to practice IPT. The primary question is formulated on the prior assumption that it will elicit data sufficient to produce a *“coherent, third person and psychologically informed description”* (Larkin et al., 2006, p. 104). IPA employs purposive sampling to understand the specific phenomenon from the perspective of the particular group, Otago University students, who have completed training in IPT.

Data collection in IPA is designed to allow the individual to provide a detailed account of their experience in their own words. For this study the researcher developed a framework of prompts to be used to guide recorded semi-structured interviews. This framework was tested in a pilot interview and then reviewed and refined before proceeding with data collection. The IPA approach recognises that sometimes it may be useful to collect additional data to contextualise the interview material (Smith et al, 2009). Alongside the interview a research diary recorded

observational data that could not be captured in audio recordings and demographic data was collected in a written format. Sandelowski (2000) discusses the use of mixed methods such as these as being at the 'technique level,' and suggests that as techniques are not tied to paradigms or methods they can be used innovatively for the purpose of triangulation, as are applied in this case to ensure corroboration of the data.

Adopting an idiographic approach, IPA first considers the individual participant, approaching each case on its own terms, and then seeks to cautiously carry forward this data, to be built on or extended with subsequent accounts, to provide more general statements about the participants as a group as described by Smith and Osborn (in Breakwell,(Ed)., 2004).

IPA is a structured approach to the analysis and writing up of data, and the following summary of that recommended by Smith and Osborn (in Breakwell, (Ed)., 2004) was applied. Beginning with the first transcript and relevant contextual data, IPA engages in a systematic search for emerging themes, moves on to forge connections between the themes and then attempts to establish superordinate themes for the first case. The process is repeated for each transcribed interview, before looking for patterns recognisable between the cases. The data is then translated into a structured narrative account, introducing the topic and each superordinate theme in sequence, with the use of verbatim extracts from the interviews, which 'give voice' to the participants in the final write up. (Smith et al., 2009) The results section is followed by discussion relating the analysis to any relevant literature and implications of the study.

In summary, this research study adopts a design typical of IPA, in that it employs purposive sampling of a relatively small number of participants, capturing verbatim accounts through semi-structured interview, supported by a research diary, and demographic data to contextualise the interview material. Intensive and detailed analysis proceeds to ascribe patterns of meaning, reported in a thematic form and validated with narrative accounts including extracts of the personal accounts and contextual data.

PARTICIPANT SAMPLING PROCESS

Smith et al., (2009) suggest that the process of finding a sample must be theoretically consistent with the general paradigm of qualitative research and in particular with the orientation of IPA. Congruent with the philosophy of qualitative phenomenological research, the number of participants involved in the study is based on a combination of pragmatic acceptance of the restrictions imposed by the research process, and the understanding of the infinite nature of experience of phenomena. The richness of the data collected is considered more important than the number of participants in the study (Schneider, Elliot, LoBiondo-Wood & Haber, 2003).

Consistent with the orientation of IPA research, the population to be sampled was selected purposively on the basis of the insight the participants could offer to the particular experience, implying that they “*represent a perspective rather than a population*” (Smith et al., 2009, p. 49). This study sets out to investigate the experiences of a particular group, that being clinicians who have completed IPT training in New Zealand. In light of the specific area of research, purposive sampling was the most appropriate method of recruiting participants and the researcher identified Otago University students from past IPT Certificate of Competence training programmes made up of three cohorts who were six, three and one year post training, as being representative.

The second requisite of IPA sampling is that of finding a homogeneous sample, seeking uniformity of factors relevant to the study, but also allowing for the analysis of patterns of convergence or divergence within the participant group (Smith et al., 2009). The target group were homogenous in all factors relevant to the study, in that they were all clinicians trained in health science disciplines, with a minimum of two years post graduate clinical experience of working in a mental health setting, and had undertaken a post graduate qualification in IPT. They were however from a varied demographic, being male and female people of varying ages, at three different points post training, from a number of professional health disciplines and were working in a variety of settings. This data may be useful for a later comparison study beyond the resources of this research.

The very specific population identified for this study limited the number of potential participants, thus enabling the entire population to be sampled, and for saturation to be achieved despite the small numbers. Indeed the IPA model is said to “*challenge the traditional linear relationship between ‘number of participants’ and the value of research.*” (Reid, Flowers & Larkin, 2005, p. 22). Instead, IPA guides the researcher to consider that three to six participants will be sufficient to develop the meaningful points of difference and similarity in the accounts of the participants. Similarly Guest et al., (2006) concluded that in qualitative research saturation is likely to occur more quickly if a primary interest is to render metathemes, and suggested a sample of six participants be sufficient to develop meaningful themes and useful interpretations.

Limitations of Purposive Sampling

Purposive sampling of small highly specified population groups of this nature may also impose limitations on the study. Potential limits considered in this research were:

- small sample size,
- the limits on transferability to other populations,
- the risk of attrition impacting on the feasibility of the study,
- the risks of bias created by locality of sampling.

The areas of potential bias were identified as the researcher’s prior experience and professional investment in IPT, along with an already established relationship with some of the participants. The intersubjectivity of the researcher’s relationships, both with the study and its participants has been discussed earlier in this chapter as an area of concern highlighted in the preparation for the research process, when identifying assumptions and preconceptions, and as part of the IPA methodology. In summary these relationships are perceived as being part of the very nature of the hermeneutic perspective of the research. Caelli et al, (2003) and Reid et al., (2005) argue that the articulation of assumptions, preconceptions and beliefs along with ensuring reflexivity in the interpretation processes and transparency of the results serve to

provide benchmarks for good practice and rigor. To assist with this process the acknowledgment of the possibility of influence was raised as particular focus for supervision. This will also be discussed as part of the recruitment process and ethical considerations.

Seaman (1987) suggests that a study with a small sample such as this may be viewed as research designed to test the research elements and the feasibility of conducting a larger study, allowing these limitations to be acknowledged and accepted as issues that may be addressed by later in-depth research. Smith et al., (2009) apply a similar inductive logic to sample-specificity, suggesting that research is detailed and in context to the setting, with the potential for subsequent studies with a similarly detailed methodology, to amass further data cumulatively.

Smith et al., (2009) frame transferability as being less about empirical generalizability, and more about theoretical transferability, and invite the reader to make connections in the study analysis with their own experiences and existing literature. Thus evaluation of IPA research conducted for example in New Zealand, achieved through in-depth analysis designed to be both contextual and transparent, could be transferred to those situations identified as being familiar to clinicians and researchers who may be working in similar areas for example Australia.

The risk of attrition was certainly considered during the development of the study. It was predicted that the very specific nature of research would be of interest to the potential participants, because it was something they had personal experience of and was of professional interest. The potential study sample size was 20 (excluding the researcher), and an ideal sample size had been defined as being between three and six (Reid et al., 2005); therefore it was anticipated that with a 40% response there remained further room for a degree of attrition before the viability of the study came onto question. Pragmatically however, the options were limited; this was the target population and without them the research question would have to be revised considerably.

RECRUITMENT

The administrative section of the Department of Psychological Medicine was approached to identify the exact number of potential participants from their data base who could be invited to join the study on the researcher's behalf. The university administrator provided a list of 18 of the 20 potential participants. To avoid perceived coercion, the initial approach to potential participants was an invitation to participate, sent out by the university course administrator. There was a 50% response rate and of the nine respondents who agreed to have their details forwarded to the researcher for the process of consent, eight went on to consent to participate in the study. One potential participant who initially agreed to participate, and arranged an interview was unable to attend because of a change in scheduled workload and geographical distance, and their name was withdrawn.

ETHICAL CONSIDERATIONS

Ethical principles for medical research involving human subjects described in the World Medical Association Declaration Helsinki: Ethical principles for medical research involving human subjects (2008), the National Ethics Advisory Committee Ethical Guidelines for Observational Studies: Observational research, audits and related activities (2012), and Otago University Ethical Practices in Research and Teaching Involving Human Participants (2012) were adhered throughout this research. Because this research satisfied the ethics criteria for low risk research involving human participants, it fell into Category B of the Otago University Ethics Policy, and was audited by the Otago University Human Ethics Committee after being approved by the Head of Department for Psychological Medicine. Details related to the application were submitted to the Health Research Council as part of their accreditation process.

The ethical considerations specific to this research are:-

1. Respect for autonomy and capacity for self-determination, attended to through the process of informed consent.

To ensure timely provision of written information about the study, a comprehensive information sheet for participants, (see Appendix III), was enclosed with a letter inviting participants to take part in the study, (see Appendix IV). Participants who were interested in taking part then made contact with the researcher to discuss any queries and to arrange a mutually convenient time and place for an interview. A second copy of the information sheet was made available at the time of the interview, and participants were given time to read this and discuss any queries they might have before reading and signing the consent form for participants, (see Appendix V). The consent form reiterated key points from the information sheet stating: the voluntary nature of participation, the option to withdraw at any time, safeguards for storage of data, an outline of the general line of questioning and the open-ended questioning technique, and the intention to publish results of the project.

2. Protection of participants, addressed by maintaining the confidentiality throughout the research process.

Participants' names were substituted with gender neutral pseudonyms throughout the research. Secure storage of raw data has been achieved with recorded interviews and written text being stored on the researcher's personal password protected information technology devices, and when not in use the hard copy was held in the researcher's locked storage facility. All data has been accessible only to the researcher and her supervisors. At the conclusion of the project all personal information is to be destroyed, other than that raw data on which the project depends, which is retained by the university in secure storage for a period of five years. The collated data has been presented in this thesis and any published results will be available through the university library.

3. Recognition of the principles of partnership, participation and protection embedded within the Treaty of Waitangi.

The Treaty was respected with a Pukenga Atawhai - *Maori mental health worker*, being consulted during the development of the study and remaining available to provide supervision and guidance on cultural safety throughout the research.

4. Beneficence and non-maleficence.

The 'Information to Participants Sheet' formed part of the consent process and was explicit in detailing the general line of questioning and the open-ended questioning technique to be applied. It also informed participants of their right to decline to answer any question or withdraw from the study without disadvantage at any time, should the line of questioning develop in such a way that they become hesitant or uncomfortable. There were specifically defined opportunities for participants to discuss any concerns at the point of arranging an interview time, and prior to commencing the interview.

Integrity and participant risk issues considered were:-

1. That the researcher knew many of the potential participants personally as either fellow IPT students at Otago University, or as colleagues within Mental Health Services.

The collegial relationships were all across-services; none of the participants had worked directly with the researcher, or had at any time been accountable to the researcher, although some of them had been involved in an IPT peer supervision group with the researcher. Awareness of potential for coercion in the recruitment process was addressed by the initial contact with participants coming directly from the University. During the interview and analysis process the researcher remained mindful of any existing relationships between the researcher and participants and maintained a neutral stance throughout. The issue of existing relationships was highlighted as a focus for supervision.

2. Potential for participant distress.

It was recognised that the questions were of a personal nature in that they were designed to explore the educational background and training experiences of participants, their previous and current clinical experience and to investigate the organisational and cultural systems of their working environments. During the

consent process participants were informed of the aims of the research and four general areas of enquiry, however the nature of semi-structured interviews leaves potential for the participant to travel into unexpected territory when reflecting on their experiences. The potential for distress in the reflective process of articulating these personal experiences was acknowledged. The researcher adopted a respectful, non-judgemental stance and observed carefully for any verbal or non-verbal cues of hesitancy or distress as the interview developed. A plan was devised in the event of unanticipated sensitive issues coming to the fore during the interview. This included the option to discuss, stop or postpone the interview, and to explore options with the concerned participant for support or assistance from sources such as clinical supervisors, professional advisors or in counselling available through employment assistance programmes. If this occurred, the researcher would seek specific verbal consent before continuing.

3. Potential for personal bias.

The research enquiry was primarily based in an area of professional interest and personal experience of the researcher. In light of this, the risk of personal bias in the data collection, analysis and presentation of findings was identified explicitly in this research and addressed through transparency and rigour in the adherence to the methodology and use of regular supervision. Regular use of supervision was also planned to anticipate and identify any unanticipated safety issues.

CONSENT PROCESS

To eliminate any potential or perceived potential for coercion of participants, the initial invitation to participate was sent via email from Otago University Department of Psychological Medicine. Respondents made contact via return email with expressions of interest which were forwarded to the researchers and a direct contact was made either through personal email or telephone. This contact provided ample opportunity for questions, and a mutually convenient time and place for the interview to take place was agreed.

Prior to starting the interview, a second copy of the information to participants was provided. After the participant had read it, any questions were addressed and the consent form was discussed and signed.

INTERVIEW DEVELOPMENT AND PILOT INTERVIEW PROCESS

Interview Methods

In keeping with IPA methodology (Smith et al., 2009) data was collected through semi-structured interviews, designed to elicit detailed first person accounts of the participant's experiences. To capture richness of data provided by the participant's narrative, questions were framed in an open-ended manner to encourage reflection and the development of ideas. To this end the interviewer employed an interview guide as a prompt but avoided asking pre-determined questions, choosing rather to encourage participants to explore the meaning of their experience of IPT in their own words. At any point where the interviewer did not grasp a full understanding of the response, clarification was sought by probing questions, for example "Can you tell me a little more?" or suggesting they might expand with specific examples or anecdotes of the experience.

In combination with the semi-structured interview the interviewer used a research diary to provide context to the interview and support to themes identified in the analysis, as described by Schneider et al., (2003). A simple self-completion Demographic Questionnaire set out in Appendix VI was also completed by the participants.

Question Development

The researcher began question development by reviewing the criteria set out in the IPT manual (Weissman, Markowitz & Klerman. 2000, p. 375). IPT training was developed for a range of mental health clinicians for example, psychiatrists, psychologists, psychiatric social workers, nurses, with psychotherapeutic training who have at least two years clinical experience in psychotherapy in their chosen

clinical field. Further recommendations are that prior to undertaking IPT training clinicians are assessed to determine that they are able to relate to patients with ‘warmth, empathy and interest’ and to build a therapeutic alliance, that they have no rigid attachment to an ‘alternative therapeutic belief system’ and that the therapist should be able to practise reflectively when relating to different kinds of patients. The training programme described in the manual includes the use of the manual, didactic seminars and the completion of three supervised cases, and was adopted by Otago University in the development of the IPT training programme undertaken by the participants of this study.

Four primary questions guiding the research emerged from the IPT manual (Weissman et al., 2000) outlined above, discussions with tutors experienced in facilitating IPT training courses, existing literature, and the researchers experience of training in and introducing IPT into clinical practice. They were defined early in the research process:

- ‘Is training, prior to IPT training, a predictor for incorporating IPT into clinical practice?’
- ‘Does clinical experience prior to IPT training influence the post-training practice of IPT by clinicians?’
- ‘What are the characteristics of services that enhance talking therapy provision and enable clinical staff to practice their discipline?’
- What are the trainee therapist’s positive and negative experiences of introducing IPT into their clinical practice?

It is important to emphasise that these areas of enquiry would have been too abstract to elicit a narrative of participant experience, and were not designed to be posed as direct questions to the participants; rather they were to be used in the development of an interview schedule as a guide to keep the interviewer on track. Smith et al., (2009) acknowledges the often abstract nature of qualitative inquiry, and recommends the interview plan be aimed at approaching the research question ‘sideways,’ facilitating relevant discussion to allow the research question to be answered through analysis of

the data. Advancement of each of these guiding questions is discussed below, and informs the Interview Schedule illustrated in Appendices VIII.

The first area of enquiry ‘Is training prior to IPT training a predictor for incorporating IPT into clinical practice?’ aims to invite the participants to talk about their training programmes prior to commencing IPT training, for example Bachelor of Nursing and Registrar programmes, and also continuing professional development in programmes of clinical relevance prior to IPT training. Whilst this research does not extend to examining therapist competence or effectiveness, the enquiry aimed to explore participant’s experience of prior training to examine areas that may have affected confidence and identification with the model. Talbot et al., (2005), found that masters’ level therapists expressed a high level of professional comfort with IPT methods. A review of manual guided training programmes completed by Rounsaville et al., (1988) concluded that experienced dynamically trained therapists were able to achieve a high level of competence in IPT after comparatively brief training. In this study the researcher expanded the question prompts to capture the participants’ prior training experiences in the areas that may be transferrable to elements of IPT manualised training:-

- the use of a biopsychosocial formulation model,
- psychotherapeutic skills,
- clinical practice of supervised cases.

A United Kingdom paper reporting on the personal reflections of nurses undertaking training in the Conversational Model (Paley, Shapiro, Myers, Patrick & Reid. 2003), found that a high standard of training leads to high levels of commitment, with ‘evidence based practice leading to practice based evidence.’ As one might expect the researcher found no literature that challenges the idea that education does anything but assist therapists, but it is not the aim of this research merely to concur. What this question seeks is the essence of the participants’ experiences of prior training and to identify more explicitly, what, if any areas of this training influenced a decision to practice IPT.

To address this first enquiry the interview schedule begins with the explanation that these first questions relate to training prior to commencing IPT training and opens with the question:

‘Can you tell me about your training programme?’

The participant is encouraged to respond with a detailed description of their primary training programme. If initially the resulting narrative does not include areas of prior training that are relevant to IPT training, additional questions are asked for example ‘During this training programme what training did you undertake in assessment?’ Which may lead to ‘Could you describe the focus on formulation models?’ And if further expansion is required ‘What experience did you get in biopsychosocial formulation?’ These secondary enquiries are used as prompts only if the participant requires this assistance to expand on their narrative. The questions do not necessarily follow a particular order; instead an attempt is made to move with the participant to maintain the fluidity of thought, and a continuing rapport. This process is then repeated for each of the subsequent training programmes the participant may have completed prior to IPT training.

The second area addresses the enquiry ‘Does clinical experience prior to IPT training influence the post-training practice of IPT by clinicians?’ by considering similar questions to those already identified in prior training and adapting them in relation to clinical practice. Strupp, Butler & Rosser (1988) found evidence that training manual approaches appeared to be most effective with therapists who are already skilful in therapy. Rounsaville et al., (1988) concluded that general dimensions of the psychotherapy process, including therapist warmth and patient difficulty, are highly correlated with ratings of therapist competence and performance of IPT. It may seem an obvious conclusion to reach that prior experience would enhance the ability and desire to practise however, Paley and colleagues (2003) found conflicting evidence in their study looking at the Conversational Model. On one hand they found mental health nurses with previous experience in counselling and psychotherapy developed a strong personal identification with the model, and that many were actively looking for an alternative to practising Cognitive Behavioural

Therapy. On the other hand this study also revealed that worry about competence and not being able to use previously acquired skills from other models had a negative impact, and that prior experience effectively made the model seem deceptively simple but harder to apply in reality. In this literature Paley and colleagues cite similar research by Mackay, West, Moorey, Guthrie and Margison (2001) who discuss how trainees felt restricted and compelled to stick with a new model, experiencing conflict with personal therapeutic identity, which Paley concluded may be to do with their core profession or previous level of therapeutic training.

As the interview moved into the third area of enquiry to consider ‘What are the characteristics of services which operate to enhance talking therapy provision and enable clinical staff to practice their discipline?’ The interviewer shifted the timeline of experience for the participant to the point of post IPT training. With the aim of exploring the clinical practice environments, the discussion was expanded with the use of several prompts to maintain focus on the following identified areas of relevance, service provision, staffing mix, models of practice, the culture of teams at the clinical and managerial level, and support available. Studies completed outside of New Zealand identify a lack of support along with organisational and managerial cultural factors as key barriers to implementing a new therapeutic intervention into routine clinical practice (Brooker, 2001), (Fadden, 1997) and (Tarrier, Barrowclough, Haddock & McGovern, 1999). In New Zealand Te Pou, (2009) states *“To further talking therapies services need to provide a structure and environment in which all clinicians are continually up-skilled, have a career path, are supervised and valued.”* (p. 7) and Crowe and Luty (2005,) recommend *“some restructuring of current models of service delivery...”* as a *“...useful starting point”* (p. 132) to enable nurses to provide IPT as an intervention that might improve outcomes for consumers of mental health services. The closing question in this section was designed to encourage more personal reflection by the participants by asking them about their attempts to introduce IPT into the clinical areas they have just discussed.

The fourth and final enquiry ‘What are the positive and negative experiences of introducing IPT into clinical practice?’ aimed to understand what it was like for participants as they attempted to transfer skills learnt in training into a sustainable

clinical practice. Miller's (2010) American study investigated what creates and sustains commitment to the practice of psychotherapy in community mental health services, and identified six themes: balance of work life passions, adaptiveness and openness, transcendence (defined as the belief 'practice of psychotherapy has extraordinary significance'), intentional learning 'seeking' new skills and knowledge, personal fit with the role and passion-supporting beliefs.

The prompts for this enquiry encouraged participants' reflection of experiences in managing or creating opportunities for practice by discussing practicalities such as: the availability of suitable clients, logistics of the setting for conducting therapy, and what dual roles therapist might have to take on. Concluding this section of the interview were additional questions about supervision and multi-disciplinary team supports, whether IPT was used, how it worked out for the participant and what changes they would like to see to assist in the implementation of IPT skills in their clinical settings.

Pilot Interview

A pilot interview was conducted to highlight any problematic issues with the interview design. Because the sample size was small, it was not viable to include one of the IPT students in the pilot; therefore a Social Worker trained in CBT was approached to take part. The pilot was a valuable opportunity to test-drive the data collection process and included the informed consent process, a complete interview, substituting CBT for IPT and a practice run at using the recording equipment.

From the pilot interview the researcher was able to obtain useful feedback on her interview technique and what it was like to be a participant being interviewed. Feedback also highlighted some areas of enquiry that required clearer and more explicit questions to guide the participant. During the pilot interview the interviewer attempted to take some notes but found this interfered with participant rapport and a decision was made to use a research diary, completed just after each interview. The positive feedback received gave the researcher confidence to proceed.

FRAMEWORK FOR THE COLLECTION AND ANALYSIS OF DATA

The study sample consisted of clinicians who are one, three or six years post training in IPT. Each clinician was invited to participate in one 60 minute audio recorded interview using the prepared interview schedule. The researcher contacted the individual participants by telephone to negotiate a convenient place and time for the interview. Every effort was made to find a place familiar to the participant that was quiet and comfortable and promoted a relaxed atmosphere, with the final venue being chosen by the participant.

Prior to commencing the interview, where appropriate, the interviewer arranged for the provision of tea, coffee and water, set up unobtrusive recording equipment and made minor adjustments to the seating in the room to ensure comfort and a relaxed atmosphere for the participants. During this process there was an opportunity to chat and build rapport with the participant before discussing any questions the participant may have about the research and going through the informed consent process with them. The interviewer explained she was not looking for particular answers but wished to hear from the participants about their experiences and thoughts related to IPT.

During the interview open-ended questions and prompts provided elements of focus to guide enquiry, and in order to capture unpredicted data, as participants shifted focus the interviewer remained conscious of the need to facilitate opportunities for the participant to expand on areas of that were important to them (Bryman, 2008). Pauses allowed for further reflection and amplification of answers, however there were times when the interviewer found difficulty in resisting the pitfall of following the normal conversational dynamic of filling pauses with her own assumptions and opinions on the topic. This was acknowledged as a limitation of being a novice researcher working alone and was highlighted as an area for supervision. The researcher found that her interviewing techniques improved with the progression of the research. At the end of the interview the interviewer thanked the participant for their time and provided information about plans for dissemination of findings with an

opportunity to discuss the findings and recommendations at a lunch hosted by the researcher for the participants when the research was completed.

It was accepted that a transcribed interview can only preserve some details of the interaction and there is potential for misrepresentation; however in terms of the verbal element of the transcription every care was taken to accurately record the transcript by replaying the recording many times until a verbatim account was achieved. Following each interview a research diary was completed with the aim of examining the researcher's own personal values, perspectives and any biases, and to note any non-verbal communication in subscripts to contextualise the interview process. The researcher completed transcription within the week after each interview with the aim of becoming familiar with the data and providing time to think about the layout of data in readiness for the analysis stage. Interviews were transcribed and included interviewer comments on behaviour and body language to contextualize the experience of the interview (Schneider et al., 2003). In deciding how much to transcribe, for example length of pauses, non-verbal noises such as laughter, the researcher was guided by IPA methodology which requires a transcript showing all words spoken by everyone present, but acknowledges it is unnecessary to transcribe data that will not be analysed (Smith et al, 2009). The transcript was set out to clearly define who was speaking with wide margins to allow for notes and analysis coding. The final transcript was checked by reading it again as the interview was replayed.

DATA ANALYSIS

Smith et al., (2009) describes the essence of IPA as lying in its analytic 'focus' which

“directs our analytic attention towards our participants attempts to make sense of their experiences” (p.79).

Data analysis occurred concurrently with the research intervention, with the researcher reflecting on and interpreting the meaning of the phenomena from the beginning of the research process. Schneider et al., (2003) describes the focus of the analysis as shifting across the process, examining parts and then the whole

experience and then re-examining the individual aspects of the experience to identify themes and construct meanings.

Protocols for IPA analysis were closely adhered to in order to assist the novice researcher to stay true to the spirit of IPA and to aid the validity of the study.

Biggerstaff and Thompson (2008), identify IPA as having a number of iterative stages: which are described in depth in Chapter 4.

SUMMARY

Following the process from proposal stage this chapter has summarised an overview of the preparation of this study, including the pragmatic choices made to formulate a research project suitable for Masters level study. The primary aim was identified as: To understand the individual experiences of clinicians prior to, during and after training in IPT, and then explore what aspects of these experiences may have influenced the clinicians' decisions related to practising IPT in a mental health setting to address the research enquiry.

CHAPTER 4: METHOD FOR ANALYSIS OF THE FINDINGS

INTRODUCTION

This chapter will provide a detailed description of the processes and strategies of Interpretative Phenomenological Analysis (IPA) applied to the study as the first participant's interview is progressed through the initial stages of analysis to provide a number of emergent themes. The resultant data, together with data generated from the succeeding seven interviews is then examined for patterns across the cases. Identification of both the unique and the shared constructs of the participant's accounts assist the development of a system to manage the data and to produce a set of master tables of emergent themes and superordinate themes for the participant group. Randomly assigned gender neutral names are used to protect participants' confidentiality.

THE STAGES, PROCESSES AND STRATEGIES OF IPA

Using an IPA approach the researcher reflectively engages with the data to understand the participant's point of view (Smith, 1996). There is no prescriptive method, rather a set of principles, processes and strategies which can be adapted to the analytic task. The flexible methodology allowed the researcher to explore, analyse and interpret the data, in an iterative and inductive cycle. Adhering to the ideographic commitment of IPA (Reid, Flowers & Larkin, 2005) the analysis began with a single case.

Step 1: The aim of this stage was to position the participant as the principle focus of the analysis, reconnecting the researcher with the participant's voice through a process of reading and re-reading the first verbatim transcript, whilst simultaneously listening to the audio recording to gather inflections and expressed emotion that added texture and depth to the analysis. During this procedure the researcher reflected on personal observations, preconceptions and internal processes, which were recorded as notes in a research diary. In addition to acknowledging and attempting to bracket off preconceptions, this form of 'free' or 'open', coding

described by Smith (1996), provided an opportunity to capture first impressions of the participant's account and possible further connections.

Figure 4.1, an extract from the researcher's diary, in unedited note form, demonstrates the free flow of the textual recording.

Extract from Research Diary Interview 1 – Bailey

Participant articulate and thoughtful in reflection - belies limited faith in self -? connection - emphasis on role perception significant. Reflection ? leading to some decisions to move on.

Clinical experiences before IPT: worked in general for a long time. Looking for more personal relationships, getting nowhere fast, task orientated work. Identified "*It was the conversations that made a difference to people.*" After direct entry programme into mental health: horrified, culture shock, "*asylum.*" Looking at roles, "*...confounded me that we called ourselves mental health nurses but had no informed ways; methods, techniques, of moving people forward...*" Felt needed more training, "*...didn't see any nurses with any advanced tools and techniques with which to do that.*" Was supported by professional leader to do IPT training. "*Mental health nursing is a great opportunity to get alongside people in and invite them to a process that they identify as useful... is it the words we use that are hugely important.*" Opportunities for psychotherapeutic interventions are "*purely opportunistic*". Team using behaviour and medication and dx planning. No biopsychosocial formulation or PSIs other than opportunity. Supervision, influential person, mentor role, supportive in looking at roles and staff dynamics and 'horror' at ward culture. Felt isolated. There had to be something more to mental health nursing

Figure 4.1: Extract from Researchers Diary Interview 1

The researcher's diary was designed, not as an accurate representation of the transcript, but to capture the researcher's active engagement with the data, and any early interpretation of the participant's narrative of their lived experience. This account of 'how the analyst thinks the participant is thinking' was described by Smith (1996) as a 'double hermeneutic' process. The diary was expanded as the analysis progressed through further readings of the transcript and was then reserved as contextual data that was reviewed during the latter interpretative stage of the analysis. However not all ideas were utilised, with some being discounted or revised as the analysis developed and the researcher gained a deeper understanding of the meaning the participants' accounts.

In the first exploratory reading, evidence of the emerging themes was detectable. For example, a statement in Bailey's description of early mental health clinical practice identified what Bailey considered important; a desire to practice therapeutically:-

"It was the conversations that made a difference to people." Bailey p. 8

The participant's use of language offered a psychological perspective to the narrative with a sense of bewilderment at the disparity between a personal concept of therapeutic engagement and the systems available in some clinical settings to work in this manner:

"It confounded me that we called ourselves mental health nurses but we had no informed ways; methods, techniques, of moving people forward."

Bailey p. 8

It was important to provide a focussed method to extract the subjective data in a way that assisted the researcher to bracket off internal processes, which were inevitable when reviewing emotive subject matter. This issue was addressed in step two.

Step 2: Consistent with IPA methods set out by Smith et al., (2009) the reading was systemised to develop rigour and focus. A line by line reading and re-reading of the interview examined the verbatim transcript for semantic content. A system of coding was employed to identify:

- things of import to the individual participant, '*descriptive comments*',
- the meaning of those things for the participant, '*linguistic comments*'
- the ways in which the participant's stance in relation to those things is characterised '*conceptual comments*'. (Larkin, Watts & Clifton, 2006)

For this purpose the transcript was formatted in three columns; the central column set out the interview transcript, and the right hand column was used for notation, leaving the left column for further analysis and the identification of emerging themes.

In Figure 4.2, an excerpt from Bailey’s transcript demonstrates the analytic process of ‘meaning making’ as the participant talks about their experience of being an undergraduate student on a mental health clinical placement and the researcher becomes familiar with the transcript.

<i>Emerging Themes</i>	<i>Transcript</i>	<i>Exploratory Comments</i>
	<i>Interview 1 Bailey</i>	descriptive <i>linguistic</i> <u>conceptual</u>
	<p><i>I remember feeling really out of place and spending a lot of time going through filing cabinets and reading books and things like that and feeling kind of detached from what was going on...</i></p> <p><i>I didn't know what was going on, I couldn't see what was going on and I don't remember getting a mentor at all actually.</i></p>	<p>negative experience of feeling <i>out of place</i> keeping busy but avoiding patient interaction, <i>detached</i></p> <p><u>Out of depth</u></p> <p><u>Not feeling confident/competent</u></p> <p><i>Couldn't see, going in blind, unprepared, unsupported, unable to help, isolated</i></p>

Figure 4.2: Excerpt of Interview 1 Transcript – Step 2 Exploratory Commenting

In this extract Bailey describes looking through filing cabinets in the office to keep busy. The linguistic comments identify the importance of the participants words ‘out of place’, ‘detached’, and ‘couldn’t see’, The metaphoric content of these words link to the more interpretive conceptual notes, in which the researcher ascribes meaning to the participants concerns of isolation and loss of self-confidence. The researcher was aware of a degree of professional knowledge that was not possible to bracket off. Smith and colleagues (2009) concluded that the relationship between the researcher’s perceptions and the developing concepts for the participant may be used to test meaning for key areas of concern and referred to this as a ‘Gadamerian dialogue’, “A *dialogue between what we bring to the text, and what the text brings to us.*” (Smith et al., 2009, p. 26).

With a deeper understanding of the participant’s concerns, assisted by the exploratory commentary, it was necessary to temporarily shift the emphasis away from the original transcript of participant’s narrative, in order to focus more closely

on the interpretive aspects of the initial noting and exploratory comments as the researcher moved to the third stage of IPA.

Step 3: The process of development of the emerging themes required the researcher to re-examine the descriptive, linguistic and conceptual notation whilst remaining mindful of the intricacy of the ‘interrelationships, connections and patterns’ across the data. By focusing on specific areas of the transcript, a synthesis of the participant’s words and researcher’s interpretation assisted the development of emerging themes. Figure 4.3 illustrates emerging themes within the area of therapeutic practice in training.

<i>Emerging Themes</i>	<i>Transcript</i>	<i>Exploratory Comments</i>
	<i>Interview 1Bailey</i>	descriptive <i>linguistic</i> <u>conceptual</u>
Value of clinical aspect of training for therapeutic practice	<i>I had three clinical placements. The theory was all about critiquing the DSM IV and the sociology of mental health, so the theory didn't actually assist me in any way shape or form, with the clinical practice of mental health nursing.</i>	Theory was not helpful for clinical practice. <i>Did not assist in any way shape or form. <u>Seeking to feel competent</u></i>
Importance of competence in role		<i>On the 'back foot'</i>
The influence of training on confidence practice therapeutically	<i>Which kind of put me on the back foot... So I learnt stuff as I went along really and did lots of reading and asked lots of questions....</i>	Learning on the job <u>Unsupported, left to it</u>

Figure 4.3 Excerpt of Interview 1 Transcript - Step 3 Development of Emerging Themes

Once this process was complete for the first interview, the emerging themes were assessed for significance and relevance and classified as emergent themes. Two or more closely related emergent themes were grouped under the heading of superordinate theme. The resultant data was organised into a table as illustrated in Table 4.1.

EMERGENT THEMES AND SUPERORDINATE THEMES - Interview 1 Bailey		
Superordinate Themes	Key words	Page
<i>Emergent Themes</i>		
Focus on therapeutic practice in training		
<i>Non-specialist area academic</i>	medically biased/on the back foot	5/6
<i>Non-specialist area clinical</i>	feeling detached/could not see/very nurse	4
Focus on therapeutic practice in clinical practice		
<i>Non-specialist area</i>	influenced most/ horror/confounded	8
<i>Influence of senior clinicians</i>	supervision	
Focus on team involvement in the delivery of PSIs		
<i>Non-specialist area confidence</i>	tall poppy/isolated/being judged/stepping on toes	16/18
	opportunistic/time factor/not confident	9/10/18
Role Perception		
<i>Other disciplines</i>	very very adamant not nurse's work	13
<i>Self</i>	would not give voice to detail/key nurse paperwork	12
	saw what I didn't want to be/conversations	
	made a difference to people, had to be more.	8

Table 4.1 Table of Emergent Themes and Superordinate Themes – Interview 1

The table was not considered definitive and both the understanding of the themes and the hierarchy of the themes were modified as subsequent interviews were examined. At times when previously unidentified or unpredicted themes occurred in succeeding participant narratives, the earlier transcripts were reviewed again to search for patterns, correlations or divergences which may have been overlooked. Table 4.1 highlights four areas that appeared to be important to the participant. The first three areas identified as superordinate themes, closely correlated to three of the areas of enquiry that had originally been developed to guide the interview; therapeutic practice in prior training, therapeutic practice in prior clinical experience, and experience of team involvement in the delivery of PSIs.

An area of importance to the participant was identified that had not been specifically targeted as an area of enquiry, and that was one of role perception. The participant gave accounts of experiences throughout a nursing career that seemed to have assisted in the defining the participant's perception of the nursing role, and was identified as the emergent theme 'perception of professional discipline'. The transcript also contained accounts relating to interdisciplinary role perception and

the consequent potential for team members from different disciplines to create barriers to practice within the multi-disciplinary team. This emergent theme was called ‘perception of other disciplines’.

The following passage provided insight into the participant’s lived experience of role perception in clinical practice and illustrates the significance of the emergent themes.

“I think you have to consider the history of (Unit A). The nurse consultant was very supportive and had been wanting for a long time for the nurses to be offering more informed intervention. However, in the history of (Unit A), the psychologists have been very very adamant that it is actually not nurse’s work.”

Bailey p. 12

Together the two compatible emergent themes ‘perception of professional discipline’ and ‘perception of other disciplines’ were identified as the fourth superordinate theme ‘focus on role perception’

Step 4: Moving to the next case. The process of IPA is a somewhat subjective one, however keeping notes throughout and systematically repeating steps one to three for each of the remaining seven participants ensured transparency and provided an opportunity for the researcher to keep returning to the data, checking and re-checking, thus applying rigour to the analysis. The researcher remained cognisant of the importance of keeping an open mind and, to the extent that it is possible to do so, bracketing off findings from preceding interviews.

At the conclusion of this process there was a significant data set for each of the participants including, a transcript with exploratory comments and emerging themes, a research diary, a table of relevant quotations from the participant transcript, and an individual participant table of emergent themes and superordinate themes. Review of this data found increasing evidence of divergence in the accounts according to the participant’s personal experiences. For example in the following two extracts from interview transcripts, two participants talk about very different experiences when discussing peer support, supervision and other things that might enable the practise

of an evidence based psychological intervention in their clinical practice following IPT training:

“All of those are in place. They are intrinsic again to (the project) so we have supervision once a week and also we have ongoing peer support, so at any time we have access to our psychiatrist and colleagues also working on the same (project) obviously are really available. We do group supervision but there is always the option that I could see one of the other therapists, or (Dr A) for instance. That I need to park up and talk about this and I have done that on one or two occasions.”

Avery p. 15

Contrasted with:

“I haven't had it (peer support). In fact I encountered tall poppy syndrome from (Manager A) who reflected back, ... I had done some training in CBT and I spent some time at the (A Unit, a therapeutic service), I came back on the ward (B unit non-specialist area) and I was using a little bit of different language, ... that colleagues had indicated I was better than them. I was shocked, absolutely gobsmacked...Because I could see that I was threatening their practice by behaving differently.”

Bailey p. 16

A key feature in the disparity of the two accounts is in the description of the characteristics of the two clinical environments. Avery's account described a culture dedicated to therapeutic engagement where the clinician's received support, whereas Bailey's account described a culture unable to accept the clinician's change of language to incorporate a therapeutic vocabulary. The two participants were of the same discipline, with similar qualifications, but the first participant's clinical experience post IPT training was in a service that supported the practice of PSIs and the second participant's clinical experience post IPT training was in a service that did not routinely practice PSIs. These two divergent accounts were classified into the emergent themes 'experience within area specialising in PSIs', and 'experience in a non-specialist area' respectively. Although the two themes represent accounts of very different personal experiences, they were both descriptions of similar factors, in this case peer support in the delivery of PSIs. The compatibility of the two emergent themes drew them together to sit within the superordinate theme 'C focus on experiences of team involvement in delivery of PSIs.'

The succeeding participants' accounts also showed evidence of commonalities in areas of importance to the participant, and followed patterns similar to those seen in the development of the first participant's data. The four superordinate themes which had been identified for the first participant were also evident in each of the succeeding participants' accounts. However, it was the richness of the data within the divergence and commonality of these experiences that required further exploration. Smith et al., (2009) described the dynamic process of engagement with the data as involving "...flexible thinking, processes of reduction, expansion, revision, creativity and innovation." (p. 81).

The process of IPA in this study was not a linear one and the boundaries between the stages of analysis remained flexible to allow for the researcher to revisit previous elements, checking and rechecking and for the process to flow iteratively with aspects of analysis merging across the steps until saturation is achieved.

Step 5: Searching for connections across the themes involved first developing a system to manage the quantities of data produced. Themes had been identified for each of the eight participant interviews and the aim of this stage was to look for patterns, divergences or oppositional relationships, connections between the themes and to assess the frequency of themes across the group. This was achieved by returning to the transcript notation and representing each theme every time it presented, with a key word or phrase. This was written on a 'post-it' note, and numbered to identify the individual participant interview and the transcript page for reference purposes. The notes were then laid out, and arranged until they formed interrelated clusters.

A number of IPA strategies suggested in the manual written by Smith et al., (2009), were employed at this stage, the first one being 'abstraction', putting associated subjects together to 'build a cluster'. At times this meant returning to the transcript to check the participant's meaning behind the keywords and this process resulted in a number of emergent themes and subordinate themes.

Identification of ‘polarization of themes’ is also a strategy employed by IPA (Smith et al., 2009) and as the analysis progress this became of particular relevance to this study. It had already been established that two groups of participants had provided a divergence of accounts for similar aspects of training and clinical practice; in areas that did not routinely practice evidence based PSIs in an informed or formally accepted way, and in areas that recognised embraced and accepted PSIs as part of routine evidence based treatment. Checking for connections across the groups in this way served to confirm the significance of this pattern which had been identified earlier.

In sample sizes larger than one to three participants IPA recommends a further strategy, ‘identification of recurrent themes’, to classify superordinate themes when they present across a significant proportion of the sample. In this study superordinate theme classification was established when a theme was recurrent in half or more of the participant’s accounts. The presence of emergent themes and superordinate themes for each participant were counted and the results are set out in Table 4.2.

This strategy also provided the opportunity to explore connections across the themes for each individual participant to reveal a further facet of the data. It was known from the individual transcripts which of the participants had practiced IPT after completing their training. This information was incorporated into the identification of recurrent themes shown in Table 4.2 and the results indicated that the participants could be divided into the following two groups:

Group 1. Clinicians who have used IPT into their clinical practice following IPT training

Group 2. Clinicians who have not IPT in their clinical practice following IPT training

The results showed that participants from each of the two groups identified more closely with a particular set of themes. This commonality has been highlighted within the data in Table 4.2.

Recurrent Themes Across Cases									
Superordinate Theme <i>Emergent Theme</i>	Interview No.								Present in half the sample
	<i>1</i>	2	3	4	<i>5</i>	6	<i>7</i>	<i>8</i>	
A Focus on Academic Training									
<i>Academic implementing PSIs</i>	<i>n</i>	y	y	y	<i>n</i>	y	<i>n</i>	<i>n</i>	yes
<i>Clinical implementing PSIs</i>	<i>n</i>	y	y	y	<i>y</i>	y	<i>n</i>	<i>n</i>	yes
<i>Academic not implementing PSIs</i>	<i>y</i>	y	n	n	<i>y</i>	y	<i>y</i>	<i>y</i>	yes
<i>Clinical not implementing PSIs</i>	<i>y</i>	y	n	y	<i>n</i>	y	<i>y</i>	<i>y</i>	yes
B Focus on clinical practice Prior to IPT training									
<i>In Area routinely implementing PSIs</i>	<i>n</i>	y	y	y	<i>n</i>	y	<i>n</i>	<i>n</i>	yes
<i>In Areas not implementing PSIs</i>	<i>y</i>	y	n	y	<i>y</i>	y	<i>y</i>	<i>y</i>	yes
C Focus on clinical practice After IPT training									
<i>Team involvement in areas embracing PSIs</i>	<i>n</i>	y	y	y	<i>n</i>	y	<i>n</i>	<i>n</i>	yes
<i>Team involvement in areas not embracing PSIs</i>	<i>y</i>	n	n	y	<i>y</i>	n	<i>y</i>	<i>y</i>	yes
D Focus on role perception									
<i>Self - Positive</i>	<i>n</i>	y	y	y	<i>n</i>	y	<i>n</i>	<i>n</i>	yes
<i>Other disciplines - Positive</i>	<i>n</i>	y	y	y	<i>n</i>	y	<i>n</i>	<i>n</i>	yes
Key									
n = Theme not present Participants' results in <i>italic</i> type have not practiced IPT since training									
y = Theme present Participants' results in emboldened type have practiced IPT since training									

Table 4.2 Recurrent Themes Across The Cases

Reviewing the convergence and divergence, the commonality and individuality served to retain “...an idiographic focus on the individual voice at the same time as making claims for the larger group.” (Smith et al., 2009, p. 107)

Step 6: Looking for patterns across cases: Attention was returned to the participants’ voice with a further re-examination of the interview transcripts. Four files were created, one for each of the superordinate themes and including the emergent themes nested within. All relevant quotations from the transcripts were entered into the appropriate files. The files were laid out together to allow the analysis to move across them looking again for connectivity and inter-relationships. Mapping patterns across cases in this way and then re-checking the findings against the identification of recurrent themes findings in Table 4.2, provided evidence of a link between the

two groups of participants who provided the polarized accounts of training and clinical practice and experience in the emergent themes, and participant Group 1 and Group 2 identified earlier in step five:-

Participant's accounts of experience of practice in areas that routinely used PSIs were identified as being present in Group 1. Clinicians who have used IPT into their clinical practice following IPT training.

And

Participant's accounts of experience of practice in areas that were not using PSI's were identified as being present in Group 2. Clinicians who have not used IPT in their clinical practice following IPT training.

DEMOGRAPHIC DATA						
Age	Work	Identified Discipline	Professional Affiliation	Tertiary Education	Primary Qualifications and PGrad Study Prior to IPT Training	Years qualified in IPT
48	Therapy Service Research	MH Nurse	NZRCpn	Poly Uni	Degree PGdip MH area Specialising in PSIs	6yrs
46	Adult Inpatient	MH Nurse	NZRCpn	Poly Uni	Dipolma/Degree PG Cert MH area not specialising in PSIs	4yrs
40	Therapy Service	MH Nurse	RMN/NZRN	Uni Poly	Diploma PG Cert CBT	4yrs
42	Private Practice	Psychiatrist	RANZCP	Uni	MBChB FRANZCP	4yrs
45	Adult Comm	MH Nurse	NZRCpN	Poly Uni	Degree PG Cert MH area not specialising in PSIs	1yr
61	Therapy Service	Therapist	NZAC	Poly Uni Ash' Hall Other	Dip Nursing PG Cert x 2 in MH area Specialising in PSI Psychotherapy Seminar Gestalt training	4yrs
28	Adult Comm	Psychology	-	Uni	BA Hons Psychology MSc Psychology in MH topic not specialising in PSIs	1 yr
26	Adult Comm	Psychology	-	Uni	BA Psychology PG Cert MH topic not specialising in PSIs	1 yr
NB Gender data has been removed because no evidence could be found to link to findings, and because incorporating gender details may have compromised confidentiality for some participants.						

Table 4.3 Table of Demographic Data

The demographic data charted in Table 4.3 was linked to the data in the identification of recurrent themes in Table 4.2 and examined for evidence of other relationships across the two groups of participants. This process looked for confirmation that the commonalities present in the areas of training, clinic experience and role perception were also divided by whether these factors were experienced in services that supported the practice of PSIs across all the disciplines and services that did not.

The researcher reflected on personal observations, preconceptions and internal processes recorded in a research diary, and positioned the participant as the principle focus of the analysis as IPA processes and strategies were followed through a six step process in the analysis of the findings. Applying an exploratory commentary of descriptive, linguistic and conceptual elements to the transcript, matters of concern or importance, the meaning of those matters for the participant, and the participant's stance in relation to them were identified. Coding of the resultant emergent themes and mapping of patterns across the themes identified recurrent superordinate themes which was linked to demographic data. The iterative process of checking and rechecking of the data for convergence and divergence, commonality and individuality ensured both an idiographic focus and the identification of claims for groups of the participants.

CHAPTER 5: THE FINDINGS

INTRODUCTION

This chapter will set out the hierarchy of themes for the study, and then provide a concise written summary of the findings and a schematic diagram to illustrate the emergent themes and the superordinate themes. The sample, the areas of research enquiry and the use of transcript excerpts will be described, and will be followed by a detailed explanation of the superordinate themes and the themes.

In the second section of the chapter a detailed interpretative analysis of the emergent and superordinate themes is illustrated with transcript extracts and contextual data, including demographic data and the results of participants' responses on the demographic questionnaire.

Please note in order to contain the work within the acceptable length of a masters level thesis not all of the data analysis work is included in the findings chapter, however all of the participant's verbatim quotations in Chapters five and six have been through rigorous IPA processes described in Chapter 4.

HIERARCHY OF THEMES

The researcher engaged with the data in a hermeneutic process of meaning making to understand the lived experience of the participant. An analytic commentary was applied to the participant's narrative to assist in the development of themes as part of an interpretative phenomenological analysis. Consistent with IPA the hierarchy of the themes were defined as follows:

- Themes

Themes of all kinds were defined as things that 'mattered,' being of concern or importance to the participant or the 'meaning' of those matters identified in participants' experiences and perceptions.

- Emerging Themes

In the first stage of analysis, constructs within the participant's account that the researcher had identified as important to the participant, were referred to as 'emerging themes'.

- Emergent Themes

An appraisal of the relevance and significance of the emerging themes was carried out in the third and fourth stages of the analysis. This process of assessment and classification consolidated the data into a smaller number of significant 'emergent themes' that became part of the findings.

- Superordinate Themes

When two or more emergent themes were identified as being compatible, they were positioned together as a broader theme in a small cluster called a 'superordinate theme.' Smith et al., (2009) referred to these clusters of emergent themes as nesting within the 'superordinate theme'.

CONCISE SUMMARY OF THE FINDINGS:

Data from the interview transcripts showed that participants' accounts of clinical and training experiences were polarized between when the participant's experience was in an area where the practice of PSIs was recognised, accepted and embraced, and when the participant experience was in an area where PSIs were not practiced routinely. This divergence of accounts was represented as two emergent themes:-

1. Experience within an area specialising in PSIs
2. Experience within a non-specialist area

The emergent themes 1 and 2 occurred together in three areas of the data classified into superordinate themes as follows:

- A. Focus on experience of therapeutic practice in prior training
- B. Focus on experience of therapeutic practice in prior clinical experience
- C. Focus on experience of team involvement in delivery of PSIs

Emergent themes 1 and 2 also occurred together in a further superordinate theme:

- D. Focus on experience of role perception

Superordinate theme D had not been targeted in the interview schedule but emerged from the transcripts as the analysis progressed.

Aspects of superordinate themes were linked to the broad areas of focus guiding the research enquiry; however the richness of the data and the frequency of recurrence across cases were not equal for all the themes, nor were the themes totally independent of each other. The variances, divergences and interrelatedness of these themes were significant to the findings and are discussed in depth later in the chapter.

A schematic diagram representing the emergent themes and the superordinate themes is shown in Figure 5.1.

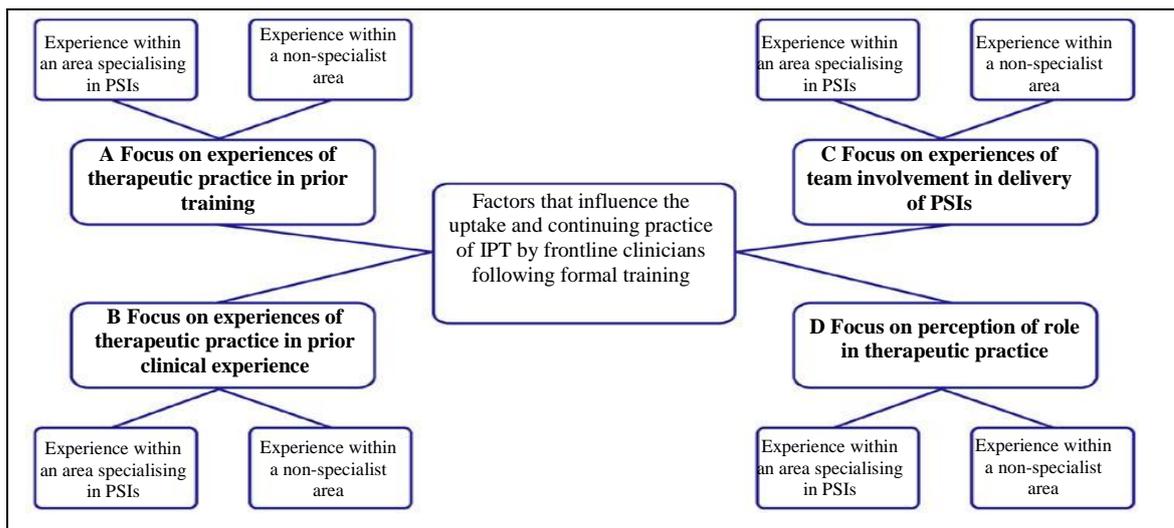


Figure 5.1 Emergent Themes and Superordinate Themes

THE SAMPLE

The sample consisted of eight participants the majority of whom were female. Their age range was mid-twenties to early sixties. Two participants were under thirty, five were aged between forty and fifty and one was over sixty. They had all completed graduate studies in at least one of the following areas: medicine, nursing or psychology. Four participants had completed their professional degree through a polytechnic institute; one had an English university diploma and the remaining three participants had completed their first degree through a university. All of the participants had completed postgraduate education in mental health subjects, half of which had been in areas of mental health that specialised in psychotherapeutic interventions. A further commonality of all the participants was that they had worked in a mental health or therapy service for a minimum of two years (prior to completing post graduate IPT training) for a minimum of one year.

All of the participants were characterised by a desire to practice in a biopsychosocial model and to offer psychotherapeutic interventions as part of their routine practice. During IPT training they had all practiced IPT in at least two supervised cases. At the time of the interviews it had been either one, four or six years since the participants had completed their IPT training. Following IPT training half of the participants had provided IPT in a twelve to sixteen week course of treatment for some or all of their clients at some point. The remaining participants had expressed a wish to continue practice but had been unable to offer this treatment within the service where they worked, and cited funding or team philosophy as reasons why they had been unable to do so. However, all of the participants who were not able to offer IPT as a full course of treatment reported that they had incorporated aspects of IPT strategies into routine therapeutic interventions with patients when appropriate. Examples of the some of the strategies participants reported using were; linking mood symptoms to interpersonal difficulties, communication analysis and a circle of closeness.

USE OF TRANSCRIPT EXTRACTS IN THE FINDINGS

IPA was primarily designed as a methodology for studies with a sample size of one to three participants; however it may be adapted to studies with a larger sample. This

study with a sample of eight participants yielded eight hours of interview transcript, therefore the interpretative analysis of the themes was supported by only the most relevant and representative extracts from the transcripts. Including all relevant extracts for each theme would have become unwieldy and created unnecessary repetition for the reader.

AREAS OF RESEARCH ENQUIRY

In the development of the interview schedule four broadly defined areas of enquiry were identified as a guide for the interviewer, to elicit a comprehensive narrative of the experiences of each participant as they progressed with their story of career development and clinical practice including the practice of IPT.

The four broad areas to guide the enquiry were:-

1. Is training, prior to IPT training, a predictor for incorporating IPT into clinical practice?
2. Does clinical experience prior to IPT training influence the post-training practice of IPT by clinicians?
3. What are the characteristics of services which operate to enhance talking therapy provision and enable clinical staff to practice their discipline?
4. What are the trainee therapist's positive and negative experiences of trying to introducing IPT into their clinical practice?

THE SUPERORDINATE THEMES AND THE EMERGENT THEMES

Because a connection between some of the broadly defined areas of enquiry and the superordinate themes was identified it was important to remember that the IPA approach adopted by the researcher collected data from semi-structured interviews that were guided by an interview schedule, or prompt sheet; the interview schedule was designed to provide the *basis* for a conversation *beginning* with four broad areas of

enquiry for discussion, from which the expressed interests of the participants developed and emerged. When applying an IPA approach the resulting data may emerge to clearly address areas of research enquiry or may be very different from what the researcher might have anticipated.

In this study four superordinate themes were identified across the participants' accounts, and although some of the superordinate themes related to the broad areas of enquiry, the narratives within the themes were not predictable. The themes varied in weight of significance and in some cases there was an overlap of content across more than one theme. The first three superordinate themes related to areas of enquiry, and a fourth superordinate theme (D) was identified that not been specifically targeted by the interview enquiry:-

- A. Focus on the experience of therapeutic practice in prior training
- B. Focus on the experience of therapeutic practice in prior clinical experience
- C. Focus on the experience of team involvement in delivery of PSIs
- D. Focus on the experience of role perception

Polarizations in the participants' narratives emerged and were shown to be of particular relevance to the findings of this study. To reflect the significance of the two groups of contrasting accounts, they were prioritized as two emergent themes:

- Experience within an area specialising in PSIs
- No experience within an area specialising in PSIs

The polarisations of the narratives are discussed individually within each of the superordinate themes.

Superordinate Theme A: Focus on Experiences of Therapeutic Practice in Prior Training

The participants were asked to reflect on the focus on therapeutic practice in both the academic and clinical components of their training and whether this may be a predictive factor in the uptake and continuing practice of IPT. The researcher acknowledges that in some part, these areas of enquiry were driven by professional knowledge of having completed hospital based psychiatric training within the UK nursing system, and then later having been a clinical tutor on a New Zealand Bachelor of nursing degree course where mental health clinical placements are six weeks long, with an optional elective placement of nine weeks in the third year.

All of the participants had a minimum of a graduate degree in their discipline and post graduate qualifications in a mental health topic. Despite some significant similarities in qualifications, the individual accounts of the participant's personal experiences of training differed significantly in one particular aspect. Accounts of training undertaken in a mental health area where PSIs were routinely practiced, and training in a mental health area where PSIs were not commonly practiced, generated a stark difference in reported experience, and in the value of that experience. Because participants had all completed more than one training, some reported experiences in both areas, and when this occurred both experiences were included in the findings.

The area of enquiry that looked at the focus on therapeutic practice in prior training resulted in four coded areas of emergent themes:

1. Academic training experience within an area specialising in PSIs.
2. Academic training experience within a non-specialist area.
3. Clinical training experience within an area specialising in PSIs.
4. Clinical training experience within a non-specialist area.

Emergent theme 1: academic training experience within an area specialising in PSIs.

Four of the participants reported on previous academic training that incorporated psychological interventions and evidence based therapeutic treatments. For the purpose of the study this type of training is referred to as ‘areas specialising in PSIs.’ The accounts of academic training in this area were brief and appeared to afford less significance to the participants than the accounts of experiences of working with patients and staff in clinical training. The participants reflected that their academic training, although necessary and relevant as a knowledge base for aspects of their work, was not as helpful for the delivery of talking therapies as their experiences of working with patients in a clinical setting, or the influence of senior clinicians that they worked with. Some participants found that when they returned to clinical practice following academic training, deficits or gaps in their clinical work were highlighted and it was this that led to them looking for more specific therapy training.

In this extract Avery discusses post graduate mental health studies in a specialist field:

“...but certainly the co-existing paper, the disorders paper, that was heavily focussed on working with people, and the interpersonal dynamics.”

p. 5 Avery

It was notable that there was only a briefest mention of the academic focus on working with people and interpersonal dynamics, before the discussion moved on to the area of this training that seemed to hold more relevance and hence more value for the participant, and that was the direct work with a case load of patients and the value of clinical supervision of that work with a psychiatrist on the team:

“...there was an advance assessment skills paper, where you had to have a patient case load. Also with that I had quite a lot of supervision with Dr B, so that I honed my skills too. So it wasn't all presenting case presentations, it was also meeting with Dr B once a month or whatever, and going through cases.”

p. 5 Avery

Avery acknowledged that academic studies assisted with a progression towards a personal goal of working therapeutically, ‘I knew a lot more about working with people’, but also exposed what Avery described as ‘gaps’ in practice skills.

“The other thing was that, that’s how I got into IPT, because I realised once again - I knew a lot more about addictions, I knew a lot more about working with people - but there was a gap at working with them in a more therapeutic level and that is where I thought I need to do some more training, to have a framework.”

p. 11 Avery

Another participant Reece talked about primary training in a specialist mental health field, and the early recognition of the importance of having confidence to communicate therapeutically with surety is highlighted when the participant reflects back to students concerns about how to engage with patients.

“There was a lot of communication skills training, I am trying to think. There were specific modules on communication. I don’t know whether it was because it appealed to me, but I can remember doing those classes much more vividly than I can remember doing sort of the assessment stuff. Maybe that sort of reflects your concerns about when you are a student – how am I going to talk to people?”

p. 2 Reece

Reece also made a comparison to clinical practice training and gave weight to the value of working with senior clinicians:

“...What I used after my nurse training was probably more learning from clinicians when you were on placement, about how they thought about people’s problems...there were a lot of people around, old school nurses who had done training in dynamic therapy and things like that. Which I had always been quite interested in...so I can remember talking to other nurses about it.”

p. 2 Reece

Like Avery, Reece describes a feeling that academic training was inadequate for the therapeutic work required in clinical practice, and talks about ‘being out of my depth.’ However Reece seemed confident that training would follow a natural progression, and the researcher interpreted a sense of commitment and enjoyment, from tone of voice, in the comment ‘yeah I’d be into IPT.’

“Well the CBT model that the (service B) subsequently adopted was the Fairburn Oxford model and part of that model has an IPT component...we did what we would call general interpersonal work...and I was really out of my depth and that made me think I need to do some reading about IPT ...because I had already done the eating disorders paper...so I thought yeah I’d be into IPT, so it followed on from CBT.”

p. 7 Reece

The confidence Reece has in the flow of training and the expectation of being able to practice once trained was nurtured by the team involvement, illustrated here as Reece acknowledges the value in the support and influence of senior clinicians:

“Yeah and I mean lots of support for that as well. You know, the psychiatrist gave me clinical supervision so I could undertake training in these different psychotherapies, which is really good.”

p. 8 Reece

Similar emphasis was also evident in the following extracts from the account of a psychiatric registrar training programme which included academic therapy training. The first extract demonstrates the higher value placed on the clinical aspects of the training.

“There’s probably more emphasis given to the clinical aspects rather than the theory but we did quite a lot of grounding in theory. So in leading up to the exams we had pre-clinical type assessments, but then they also incorporated a lot of clinical scenarios. So whilst it was important to have a fundamental understanding of the basic science behind it, its clinical application was probably more important and more assessed.”

p. 1 Jamie

This narrative follows a similar pattern to the two previous participants, as Jamie immediately connects the discussion of theoretical aspects of specialist training to the support and influence of senior clinicians:

“And then also during our first half of our training we had one day a week where we would undergo training to sit the exam and to go through all the stuff, and part of that was group supervision as well and also the likes of Dr C and Dr A coming in to talk about IPT, cognitive behaviour therapy and then others came in to talk about self-psychology, dynamic, analytical work that sort of thing. We were very fortunate.”

p. 2 Jamie

After many years of training and experience in the field of counselling, Alex completed academic training in psychology and psychotherapy seminar training. In the following series of extracts Alex discusses how academic training offered a structured approach and an understanding of the importance of evidence based interventions.

“I did a science degree in psychology and it was all evidence based and that was very foreign in the counselling world...It was more, a very structured approach...So you know when I finished I was looking for a model...you know I just did not want to go back to non-researched based interventions.”

p. 1 Alex

Alex describes seeing the IPT training as a vehicle to bridge the gaps between a new found understanding of evidence based practice achieved through academic training, and translation into clinical practice. There is an a detectable note of enthusiasm and enjoyment as Alex recalls the excitement of finding what could be interpreted as a long sought after missing link.

“And so when I found out about IPT it seemed to, it was structured, it was researched based and there was a model to intervene with those two, you know with depression and relationship conflict so you know it was like finding a pot of gold at the end of the rainbow...So assessment and formulation I learnt that in IPT, so there was some gaps, it was exciting because it made sense.”

p. 2 Alex

As the narrative progresses, Alex expressed confidence in the broad theoretical knowledge base; but again comes back to a sense that prior academic training had left questions, and a seemingly long search to fill the gap between knowing about evidenced based practice and having the practical skills and a suitable model to implement it into practice.

“It didn’t feel quite gutsy enough...I felt a bit at sea. I was good theoretically, but I had a lot of knowledge about different models, but no, beside Gestalt which wasn’t really a model for me, it didn’t suit my personality. So I was looking for something a bit more secure and structured and it wasn’t until I found IPT I thought ah I’ve been waiting for this for years.”

p. 3 Alex

In the descriptions of academic training experience within an area specialising in PSIs it is noteworthy that the participant’s accounts were phrased positively. The researcher interpreted this as an indication of satisfaction, because although participants had all identified gaps in training, they also placed value on academic work in areas that could be connected to patient contacts, communication, offering evidenced based treatment and the support or influence of senior clinicians who acted as role models or offered supervision.

Emergent theme 2: academic training experience within a non-specialist area

Six of the participants reported experiences of academic training that incorporated mental health components of training based on a medical model of diagnosis and treatment, and learning focused on the classification of disorders rather than interpersonal dynamics or communication skills. Participants' examples of this type of training included a comprehensive nursing degree programme, some post graduate mental health papers that were not seen to include psychotherapeutic engagement and pre-clinical psychology degree programmes. For the purpose of the study this training is described as 'non-specialist' areas. In the following extracts the participants are responding to enquiries about theoretical training in a biopsychosocial model, therapy skills or more advanced communication training, and similarities in their accounts of the theoretical component of their training emerge:

"It was very medically based I think... The theory was all about critiquing the DSM IV and the sociology of mental health, so the theory didn't actually assist me in any way shape or form with the clinical practice of mental health. Which kind of put me on the back foot really."

p. 2 Bailey

Considering tone of voice and the linguistic interpretations in this extract the words "didn't actually" seemed to have significant meaning, the inflection on the words here are suggestive of 'surprisingly' or 'believe it or not'. When this extract is examined in context with the rest of the transcript it indicates that Bailey is incredulous that the experience of mental health training did not assist in clinical practice. In this account Bailey talks about 'clinical practice', which from the transcript analysis is interrupted as meaning a variety of activities with patients that are informed by a biopsychosocial assessment and rely for their implementation on good communication and a therapeutic relationship. The metaphor of 'being on the back foot', infers a feeling of being disadvantaged from the outset, and raises questions as to the impact this may have on confidence to practice PSIs, particularly for this participant who reported similar experiences in other non-specialist areas of mental health training and practice.

Avery's account of comprehensive nurse training in a non-specialist was brief:

It was still quite medicalised, we had a component in it, I think it was like a one semester focussing on mental health...that would be the closest, sort of within mental health arena. So yes it was limited, definitely limited. I did my nursing degree...and that was very theoretical, um so it didn't really touch on this, or working with people as such in that way."

p. 4 Avery

The account provided the statement about the academic training 'it didn't touch on this,' and is suggestive of this training being disconnected, and unrelated to clinical practice: 'working with people' was interpreted as being of lesser significance to Avery for this training, because of more relevant training reported elsewhere in the transcript. During a discussion around a prior academic training course content Sam talks briefly about post graduate mental health papers and notes a 'distinctly different' focus of these 'non-specialist' papers completed in 2000, as compared to the biopsychosocial model applied more recently in the IPT advanced practice paper. The researcher interpreted this as also being a reflection of Sam's personal perception of a shift in contemporary mental health practice away from the more traditional medical model that related to Sam's personal experiences of changing clinical practice area discussed in later themes.

"The forensic paper here was very much on the forensic side of life so your risks and everything else, it (a biopsychosocial model) was in there but it was definitely not prevalent. It wasn't the main focus... it would have been in IPT advanced practices, it was definitely much more of a focus in that. It was distinctly different, cos I did a forensic paper in 2000 so there's been a big shift (in mental health models) between 2000 and ... 2009-10."

p. 2 Sam

Alex had completed very specific psychology, psychotherapy and general nursing training but had still felt that mental health assessment using a biopsychosocial formulation model was a bit of a mystery.

"I remember you guys, you know the people who were more specifically psychiatrically trained, they used to talk about formulation and I didn't know what formulation was... Well probably I remember you guys could do formulations easily. And those formulations were like learning a new dance step to me and I had to write down what the steps were because I couldn't quite get it right. So yea it was, that was quite, well I enjoyed it but it wasn't easy."

p. 8 Alex

Leigh alluded to learning about ‘disorders’ which was understood from the context of the discussion to mean diagnosis, symptoms and treatment, and ‘things’ which appears to reference other areas of theory that at this point seemed of lesser relevance to the participant. Leigh prioritizes ‘the main problem’ as being the lack of training in direct communication skills in a ‘one on one’ therapeutic session with a person.

“Undergrad the main problem is that they don’t really do much of, it’s all theoretical so we learnt a lot about the disorders and things but we didn’t actually learn one on one with the person.”

p. 1 Leigh

Leigh also talked about how knowledge gained in academic training made sense when linked to the IPT model which Leigh learnt about in clinical practice.

“So we did probably do our biopsych stuff there, (at university) but not really a big focus on it. I would say I learn all that working...through working with clients that you develop it more... I hadn’t heard of it (IPT) until I started working here so it’s quite bizarre. Either it wasn’t big enough to talk about or whether that university didn’t put a main focus on it... I guess we unpacked people and then put them back together, a big thing was attachment theory and that was taught...so when I read about IPT and the attachment side I was like ‘well this make complete sense...”

p. 3 Leigh

The importance of working ‘with the person’ is evident here and is also recognisable in most of the transcripts.

In the final example data in Chris’s interview follows a similar pattern to the previous participants, by only briefly touching on academic training before moving the discussion on to the area of clinical practice, which the participant seemed to consider more relevant.

“So I chose cognitive psychology, perception psychology, so nothing much with mental health really. It’s more about like fundamental Pavlov psychology studies. I mean undergrad is quite general...post grad everything was clinical practice, its’ really all, you know application and current situation... We did an assignment on an actual patient.”

p. 1 Chris

There were two notable differences between the two themes of academic training. The participants in the group who described academic training in areas specialising in PSIs were clear in their accounts that they had identified gaps in their training, however they also used positive language with phrases that included ‘very fortunate,’ ‘looking for more,’ and ‘which was really good.’ This is compared with the participants who described academic training in non-specialised mental health areas, who although they identified the training as being ‘not helpful,’ did not report the training as being a catalyst to identify specific gaps. This group of participants used more negative phrases for example, ‘it didn’t actually assist,’ ‘didn’t really touch on this,’ ‘the main problem is’. The researcher interpreted this as an indication that although both groups identified academic prior training as lacking in some areas in terms of therapeutic clinical practice, the participants who experienced academic training in more specialized areas had a more positive and valued experience.

There was also an overlap of the emergent theme ‘academic training experience within an area specialising in PSIs’ and the emergent theme ‘clinical practice experience within an area specialising in PSIs.’ All the participants who undertook training in an area specialising in PSIs also reported on clinical experience in an area that accepted the participant’s practice of therapeutic interventions and therefore supported the participants in their training. Likewise there was a similar overlap in the emergent theme ‘academic training experience within a non-specialist area,’ and ‘clinical practice experience in a non-specialist area.’ In this case the participants both trained and worked in areas that did not specialise in PSIs and therefore they did not experience the support of a specialist service.

Emergent theme 3: clinical training experience within an area specialising in PSIs

The accounts of clinical training were seen as being more potent than those of academic training; they were afforded greater significance by the participants, as determined by the length of the discussion and the expressed emotion in the descriptions of their experiences. The five participants who reported prior clinical training in areas that implemented PSIs used positive language and spoke with energy about their enjoyment of working therapeutically with people, and the interest generated by these experiences.

Jamie discusses a variety of therapeutic interventions and supervision with senior clinicians:

“We had a number of cases that we had to do that were short therapy cases. So traditionally they’re 10 to 16 week cases and I think we had a requirement of at least 6, of which we had to do some CBT and we had to do other therapies like IPT. And we were supervised by a consultant psychiatrist familiar in those areas, or a clinical psychologist who was working in those areas. We would tape record and make notes and then weekly or fortnightly have supervision to map the process and to get the guidance. So that happened and we also had to do what we call a psychodynamic long case, so we had to follow someone in therapy for at least 40 weeks. Again we did a similar sort of scenario in terms of taping, making notes and that. But that was a different process and usually the frame works which we were working to were not short focused structured therapies so they were more dynamic and analytical in approach.”

p. 2 Jamie

Avery spoke with enthusiasm about early experiences of clinical training in a therapeutic environment that provided a sound foundation for later training and clinical practice.

“Well I suppose we go back to nursing, I mean I think nursing gave me a really good base, a base for working with people within an IPT framework. So I think it was those people skills, those skills that you learn within your training... I spent I think about six weeks in a residential alcohol and drug treatment place and that really introduced me to the whole area I think. More of around counselling and mental health, and I really enjoyed it. So there I really got quite involved in the programme and spent a lot of time talking to people, a lot of residents in a therapeutic way. So I think out of all the whole of my training that was the time where I actually worked with people in a more therapeutic way...a lot of it did really focus on the psychological interventions, yeah I would say it would probably be a good 80-90%.”

p. 3 Avery

Avery also reflected on the support of the psychiatrist on the team:

“I had quite a lot of supervision with (Dr B), so that I honed my skills too. Yes, it was very much a supervisory role but also a bit of tuition tossed in.”

p. 5 Avery

Reece also talks with energy and enthusiasm about clinical training and in this extract describes the training as being well supported by the whole team. Therapy training was seen as being of value because PSIs were offered by all disciplines as the first line treatment for all patients in the service. This level of support is seen as being a significant factor in the development of role perception and personal motivation to practice.

“So before I did the post grad certificate in CBT I did a brief course in REBT so it was like maybe 6 weeks or something like that. And I was quite interested in that because by that time I was working at (Service W) and some of the therapists there were using CBT. It wasn't a service wide practice, but it was kind of heading that way and so I went and did the short course. And that was fine because the psychiatrist working there at the time was quite happy to support things like that. Mainly because there was any, there are no medications that work in eating disorders and no treatments really that worked. So they were always quite accommodating really for things like CBT and stuff. Um and so I did the course and that went really well and it was really interesting, the guy that did the course also told us that he ran a year-long course a post graduate certificate course in Napier. Which I was really interested in, and I was especially interested in because the way it was funded meant that they would sort of pay the (Service W) for when I wasn't at work, so they could pay for someone to sort of replace me. So of course that went down really well with the manager and I was quite enthusiastic about doing it.”

p. 5 Reece

Alex describes the value of supervision and personal therapy when completing clinical training. Surprisingly this is the only account of the use of personal therapy, but Alex considered this training requirement to have been ‘one of my best tools.’

“With Gestalt you are required to have personal therapy and I had personal therapy for five years. So I actually thought that was one of my best tools to learn you know how to be a counsellor... I had a Gestalt supervisor, a psychiatrist in (City 1). It was a requirement that you had to have a Gestalt trained supervisor, and I think I met with her once a fortnight in a group of three.

p. 4 Alex

A striking characteristic of the accounts in this theme is the positive phrasing, energy and enthusiasm in the participants as they relate to their experiences. It is notable that all of the participants mention their supervision with a senior clinician as a supportive aspect of the training.

Emergent theme 4: clinical training experience within a non-specialist area

The polarization of reported experience between the last emergent theme, clinical training experience within an area specialising in PSIs and this one was immediately evident. There is also an overlap across the emergent themes ‘clinical training experience within non-specialist areas’ and the third superordinate theme which looks at ‘clinical practice experiences of team involvement in delivery of PSIs,’ because clinical training is reliant on the involvement of the team.

The first extract is defined by a feeling of being isolated by the lack of support from other clinicians and does not have reference to patient contact. In this case neither the environment nor the training provided a focus on therapeutic interventions:

“There was a lot of practical ward based general nursing and I remember having a mental health placement in um the ICU of mental health in (City 2). I don’t remember a lot of it... I don’t remember being mentored in any way. I remember feeling really out of place and spending a lot of time going through filing cabinets and reading books and things like that and feeling kind of detached from what was going on... I didn’t know what was going on, I couldn’t see what was going on and I don’t remember getting a mentor at all actually... At that time that was very nurse-y you know.

p. 4 Bailey

This extract from Jamie’s narrative stood out as interesting because it provided an account of the juxtaposition of a specialist training that took place in a non-specialist area, and showed that there were some issues for the participant and for the team.

“Well I was lucky because I was part of a training programme where there was a requirement that I had to do this. So they had to squeeze to accommodate it. So it did happen. And then I was very lucky because then we had the opportunities to have time set aside to actually have supervision during normal working hours and the like, so I think we were probably very fortunate from that point of view.”

p. 3 Jamie

The specialist training was specific to the discipline and not to the mental health area and there was a disparity in the expectations for training and the treatments offered routinely by the team. This is expressed in Jamie's acknowledgement of the team adjusting normal practice to 'squeeze to accommodate' the training process.

Jamie continued by discussing MDT review for therapy cases:

"No. I did not (take therapy cases to MDT for review). The MDT process probably wouldn't have been the most desirable forum to do that cos a: I was a trainee and so scrutiny by others and discussion about it perhaps wouldn't have been very valuable and b: we were so busy talking about people of concern and difficult cases there was never the opportunity or was I never invited to have discussed it. But then we had our own supervision elsewhere so we were lucky from that.

p. 5 Jamie

This extract suggests therapy work was tolerated as a training exercise rather than valued as a treatment, and regarded as separate from the day to day core business of the team. Across both extracts there was a repeated use of the word 'lucky' suggesting an understanding of being in a fortunate or favoured position not accessible to all disciplines.

Sam's experience was also unusual because a new therapy treatment was being introduced into a service that had not previously endorsed therapy as a routine treatment, and the specific clinical training took place in the clinical practice area. Sam describes the excitement at the prospect of the training 'this is brilliant' but then goes on to describe difficulties in implementing the training and feeling unsupported. This description was lengthy and extracts have been shortened to protect confidentiality. The researcher did not provide an interpretative analysis for this account, because the participant gave such an in depth description of the experience that shows the profoundly negative impact the experience had on the participant's confidence to practice PSIs.

“The three day course was great, got into it and thought actually this is brilliant; I am going to get the grounding and the training I am going to need. No one ever told me how to conduct a therapy session, just the basics. And when I’ve asked people they’ve always said, oh its ok you just do it. Its fine you just sit there, but just give me some details you know?”

(So you wanted some foundations stuff, there was a bit missing?)

“Totally...I’d been doing it informally for so long and looking back I was doing alright informally, but all of a sudden there was this weight feeling on my shoulders, of this was actually formal now... and I don’t know if I’m going to be doing it right. So I needed that support and some sessions to look at you know, and unfortunately we got nothing so that when I went into it and we were all getting taped it was just awful... so first time in my career I was turned off any form of therapy.”

p. 10 Sam

There was clear expression of lack of confidence and a feeling of being unsupported for this participant. As the narrative continued Sam reflected further on the negative experience of supervision with one of the senior clinicians:

“I ended up in tears because of ongoing supervision with (clinician I) because he was so awful and so demeaning and seemed to be having this power struggle, just the body language and everything was so awful that I didn’t know where to put myself. I didn’t want to go near therapy. The only good part about that time is I loved the group work that was happening and worked a lot with (clinician II) and he was great.”

p. 10 Sam

These three accounts of therapeutic practice in clinical training, in non-specialist areas demonstrate the diversity of experiences of the participants. Each of the experiences took place in dedicated psychiatric services, one was an experience of a primary training that offered no training in therapeutic interventions, one was primary training that incorporated therapeutic interventions, and one was specialist training as part of a new model of clinical practise. There were two areas of commonality across the three experiences, the first being that they all took place in areas of clinical practices where PSIs were not the accepted practice of all disciplines and the philosophy was one of a medical model. The second commonality was the influence of the team in defining the experience for the participants. All three participants described feeling detached from

the team in some way, and this seemed to have been generated by the lack of facility for the teams to offer support and guidance to clinicians in clinical training.

Summary of theme A: Focus on experience of therapeutic practice in prior training

The accounts were interpreted as being deeply personal, and across the four emergent themes extracts show the participants lived experience of the training could be remarkably different dependant on what focus was given to PSIs during the training, and the culture and characteristics of the service where the clinical placement took place. When different disciplines undertook different training in similar services, their experiences were reported in a similar manner. But even when participants were of the same discipline working towards the same qualification, if they undertook training in contrasting services, they reported different training experiences, and placed different values on that training, dependant on the service where clinical placement was.

A further commonality in the individual participant's experiences was that most clinicians placed significance on the influence of senior clinicians and the impact positive or negative experiences could have on the participants' confidence to practice therapeutically.

Table 5.1 is the first in a series of four master tables that provide an overview of the themes across the group. Viewed in conjunction with the other three master tables, it also demonstrates the ideographic patterns for the participants, mapping each participants training and clinical experiences, to be discussed in a later section of the findings.

Master Table of Themes for the Group		
<i>Emergent Themes</i>		
Participant	Key words	Interview/Page No.
<i>Academic training experience in an area specialising in PSIs</i>		
Avery:	<i>heavily focussed on working with people and the interpersonal dynamics</i>	2/1
Reece:	<i>I remember doing those classes much more vividly</i>	3/4
Jamie:	<i>important fundamental understanding of science, clinical application more so</i>	4/2
Alex:	<i>It was all very evidence based... very much more structured</i>	6/1
<i>Academic training experience in a non-specialist area</i>		
Bailey:	<i>Theory didn't actually assist me in any way shape or form</i>	1/2
Avery:	<i>It was still quite medicalised...so limited, definitely limited</i>	
Sam:	<i>Risks and everything else in there but it was definitely not prevalent</i>	5/4
Alex:	<i>Formulations were like learning new dance steps...</i>	6/3
Leigh:	<i>The main problem is ...we didn't learn one on one with the person</i>	7/1
Chris:	<i>cognitive, perception psychology, so nothing much with mental health really</i>	8/1
<i>Clinical training experience in an area specialising in PSIs</i>		
Avery:	<i>It did focus on psychological interventions; I would say...80 to 90%...</i>	
Reece:	<i>Case studies that we worked on, and had to do sound recordings</i>	3/4
Jamie:	<i>IPT...self-psychology, dynamic, analytical work...we were very fortunate</i>	4/2
Sam:	<i>More supervised cases, where a member of staff would sit in</i>	5/1
Alex:	<i>Gestalt you are required to have personal therapy...was one of my best tools</i>	6/3
<i>Clinical training experience in a non-specialist area</i>		
Bailey:	<i>All very task orientated, at that time it was all very nursely you know</i>	1/2
Avery:	<i>but mental health was very limited and medicalised</i>	2/2
Jamie:	<i>The focus of treatment I would have to say is very medically based...</i>	4/2
Alex:	<i>Nursing didn't train me for that...it was very practical the one I did</i>	6/1
Leigh:	<i>I would say it was 90% theory</i>	7/1
Chris:	<i>Nothing in undergrad</i>	8/2

Table 5.1 Master Table of Themes for the Group

Superordinate Theme A. Focus on Therapeutic Practice in Prior Training

Superordinate Theme B. Focus on Therapeutic Practice in Prior Clinical Experience

Enquiries about focus on therapeutic practice in clinical experience prior to IPT training were phrased as open questions that encouraged the participants to discuss clinical practice experience over the length of their careers. An assumption was made that the experiences selected by the participants would be those they considered to be important or significant in some way. Prompts were used to elicit additional information about, the extent to which PSIs were a focus of treatment, use of biopsychosocial formulations, opportunities to implement talking therapies, involvement of peers and the multi-disciplinary team with therapy patients, supervision, and any other factors that the participants considered may have been influential in the practice of IPT.

Demographic data showed that all the participants had extensive mental health experience. The participants reported on a wide range of clinical practice in a variety of services, including research programmes, acute and rehabilitation services for adult mental health patients in both inpatient and community settings, forensic services, respite and community youth programmes, specialist services including residential and outpatients for alcohol and drug and eating disorders, and therapy and counselling services. The service providers were equally diverse, they were based across the South Island of New Zealand, and included non-government organisations, district health boards, private practice and university based services.

Despite the diverse nature of the participant's clinical experiences, the resultant data showed that the participant's accounts were sharply polarized and resulted in just two main emergent themes. The first group of participants described experience of working with people in a therapeutic environment where PSI were accepted as part of routine practice. This was categorized as the emergent theme 'experience within a care setting specialising in PSIs.' The second group of participants described the experience of working with people in clinical areas that did not generally use PSIs as part of routine practice. This was categorised as the emergent theme 'experience within a non-specialist area.'

Emergent theme 5: clinical experiences within a care setting specialising in PSIs.

Avery talks about moving from general nursing into a specialist mental health service that practiced PSIs and becoming ‘immersed’ in the therapy aspect, and being supported by the manager to recognise the need to do more training.

“I enjoyed working with people (In general nursing) but there was no, no real psychological interventions... and then clinical, clinically working in different areas over the years, and particularly I suppose in Alcohol and Drug services, where I had a case load of patients, including a methadone case load, and where I worked with people, with not just with addictions, but with a load of other mental health conditions, it was quite a leap in that respect I mean there I was quite immersed in the whole thing.”

p. 1 Avery

“Oh I mean people would have a lot of co-morbidity so you know for instance liver problems...but also mental health, so a lot of it did really focus on the psychological interventions, yeah. Yeah I would say it would probably be a good 80-90 percent. I mean I went to work there with no skills whatsoever, I mean I landed on the doorstep as a nurse working in A&E. So that is when I saw, and that is where the boss also saw there was a gap in my knowledge, that is when I went and did some training.”

p. 11 Avery

Reece also discussed the percentage of clinical work that focussed on psychological interventions using a biopsychosocial model and also the support of senior staff:

“For me I did have some responsibility for the physical health of patients as well, but I would probably say 80% of it was (PSIs). Yeah and I mean lots of support for that as well. You know, psychiatrist gave me clinical supervision so I could undertake training in these different psychotherapies, which is really good...Previous to using IPT yes that was, all the time I did (use a BPS model),... and I think the thing that encouraged me to do both the CBT and the IPT is was being at that stage the lone nurse in a team of psychiatrists and psychologists. Who you know had done training in CBT and things like that and I didn’t want to be mucking around with it, you know fooling around with it and not doing it properly. You know and I wanted to be respected by my peers for the work I was doing. And I felt that that would be really helped by having a qualification in CBT and IPT yeah definitely.”

p. 8 Reece

Reece's description was of an experience of working in a functional and supportive team and acknowledged the need to do some additional training in order to be able to offer the same evidence based treatments as peers within the team. It was important to Reece to be respected by the team as a lone nurse. Role perception emerged as a theme for a number of participants and is discussed in a later section of this chapter.

Alex described the eclectic use of therapies working in a therapy service. There was energy and enthusiasm in the narrative, and the sense of enjoyment in the work shone through as Alex used the metaphor of a family when describing the team having fun.

“Well everyone is allowed to use, everyone, they can be self-directed... some people use solution focussed and some people use self-psychology and some people use transactional analysis. But once they are on their own they all just use the model that fits them... So it's actually quite good, it is like you are living in your parent's home, but you have your own room and they respect your opinions and you generally behave, but have fun together. So we get a lot of support you know we have a tea room and we are fussy about boundaries but we are there if anyone needs support.”

p. 20 Alex

In common with the emergent theme experience of clinical training within a care setting specialising in PSIs, the participants all spoke positively about the experiences. There was a sense of enjoyment in the work and they all appreciated the support of the team.

Emergent theme 6: clinical experiences in a non-specialist care setting

The accounts of experiences of clinical practice in non-specialist care settings were in contrast to those who gave accounts of clinical practice in areas specialising in PSIs. Bailey begins by describing a significant experience early in mental health practice that left questions about mental health practice 'there had to be more'.

“I think the thing that influenced me the most was my absolute horror at (Unit C) itself, and the way it was staffed and the tone of the nursing. I thought I had gone into the asylum, the back-wards and I was absolutely horrified at what I found. I was in culture shock for a very long time and I was quite verbal about it and from there I saw what I didn't want to be. And what I clearly identified was that it was the conversation that made a difference to people and there had to be more than just “There there dear.”

And that it confounded me that we called ourselves mental health nurses but we had no informed ways; methods, techniques, of moving people forward. And I actually didn't see any of that happening around me. I didn't see any nurses with any advanced tools and techniques with which to do that. I guess I saw techniques that were learned in the bin, and were hiding out in the back ward, and that astounded me."

p. 8 Bailey

The participant's description was a cause of concern to the researcher who followed with enquiry about supports available in such a working environment. Bailey discussed a supportive relationship with an external supervisor, and the following extract demonstrated that dealing with difficulties in the environment and team dynamic became a priority over clinical intervention:

"Yes supervision has been really useful for me. I had someone called (clinician VIII) at that time and I found that really useful. I found her almost filling a mentor role."

(She was mentoring you, were you able to talk to her about those opportunistic moments when you might have used therapeutic interventions?)

"No we didn't, it wasn't the focus of our practice really. The focus of our practise was just in enabling me to cope with my shock and horror at the environment I was working and ways and means to identify my roles, because it was role theory so it was looking at the transference issues and how I might have done things differently, or to reframe them. Invariably yes, seeing things that I was really horrified about and didn't know whether I needed to act on them and what the consequences would be if I did."

p. 11 Bailey

Avery's account of early nursing practice was not in mental health but the experience was significant because it influenced a change in direction for Avery who then moved to practice in a specialised mental health service that had a therapeutic treatment philosophy.

"I think certainly, what the big thing that influenced me after working in A&E, before I went to alcohol and drug services was I started to think a lot about the people I was working with, as in the patients, and I got very, I realised I was tired of not being able to work with them in a way that I felt was actually helping them, to the degree that, it was like being on a - processing them. I found I realised I was really interested in was helping people making sustained change, and in all of my nursing career, there were patches of it but especially in A&E it just wasn't there."

p. 13 Avery

Jamie discussed the issues of both the medical model adopted by services, and the limited resources in terms of time and suitably qualified clinicians, and illustrates some of the difficulties in implementing PSIs.

“If we stick to general adult and we go community vs. inpatient really and that’s where I spent the bulk of my time and subsequently do, although it’s more community focussed now. The focus of treatment I would have to say is very medical based and its very medicine based using psychotropics there was very little psychological treatment that was available. It was usually limited by the availability of people to be able to do that. In the community it wasn’t uncommon for there to be no clinical psychologist or anybody else on the team that had a special interest or training.”

p. 5 Jamie

and

“In (unit C) and (service Z) I was allowed to have one patient so that was encouraged but out of training, no very limited time allotted for those sorts of things.”

p. 13 Jamie

Sam looked at how a move in practice area re-awakened an interest in PSIs that was reminiscent of early training experiences at a therapeutic service for patients with alcohol and drug problems. Sam talked about enjoying the work, but also feeling unsupported by the team, using the word ‘fear’ to describe real concerns about working with people without having the training or support to practice safely with confidence.

“That’s when I noticed my own personality probably coming through more so because I was able to sit and engage in that one on one time... remembering it back to training times, and I did a motivational course as well and that was good cos it gave me a baseline, but it didn’t feel like it was enough. I was working more and more with people with borderline personality disorder and feeling incredibly unsupported by the team, and it was becoming more and more difficult. ‘What do I do with these people that turn up and what can I formulate for them, what I do with them?’ So that was a big influence...that became another area where I thought I enjoy this, I find it challenging but I don’t know enough. Yes and almost that fear, cos we didn’t have a psychologist in those days at the (Service Y,) so I would talk to the doctors about it but it would leave me in a feeling of like I was opening a can of worms and have no concept of how to deal with it...I felt

like I was walking on a tight rope. But that was my main influence I think of working in that area.

p. 7 Sam

Similar to Bailey's recollection of experiences, Sam's reporting of negative experiences prompted further enquiry from the researcher, as to whether support was available, in Sam's case by using the multi-disciplinary team as a forum to discuss important concerns about the implementation of therapeutic interventions. The resulting narrative describes a feeling of lack of confidence in the team and apprehension about professional safety:

"I did, but I didn't frame it in that way, thinking about it there would've been a reluctance for me to verbalise it in those ways... no but I think my reluctance around that would've been the team dynamics, I would've got shot down. And in my mind, management knew what I was doing, psychiatrist knew what I was doing and it wasn't like I didn't tell the MDT, it would've been like how I formulated it for them so I'd be reluctant to use the words you know."

p. 8 Sam

Leigh relates clinical experiences as a journey, learning and moving forward and a realisation that it is the work with people that is most enjoyable:

"About just over three years ago I started working in the community team here and I feel like that really helped me move a lot more forward. The residential programme was good I learnt how to engage well with clients to de-escalate, talk through stresses but some of it was kind of everyday sort of house hold stuff that I was helping them with. Whereas here I had a lot more autonomy... so I would just really love talking to them and using a bit of CBT and really improve my counselling skills, micro counselling skills and I think that really did help it made me realise that going into that field would be really enjoyable."

p. 3 Leigh

Leigh also talked about the opportunities available to use PSIs in clinical practice prior to IPT training. The researcher interpretation of this extract was an indication that for Leigh the work was not fully satisfying and that the social work model did not fit well with Leigh's psychology background.

"With each client it's different but in general I will talk to them about how their mood or their mental health has been in the week, and that will often

morph into some sort of psychological intervention... also it was a very practical sort of job, so often it's doing sort of things like WINZ or advocacy so it's not using therapy...it's quite a social worky sort of job. I'd say more that I'm in a minority having a psychology background and there's a lot of people, my colleagues probably don't sit and talk quite as much as I would and try and unpack things and help them see triggers and give them bits of homework to do. They wouldn't do that, just because I come from my theoretical background."

p. 4 Leigh

As the narrative progressed the researcher interpreted that it had been both the mismatch of role and dissatisfaction with the limitations on therapy opportunities that had led Leigh to make a decision to leave and do more training to allow therapy practice.

"I am about to apply for a counselling psychology programme in Auckland so leading to registration as a psychologist so then I can be connected to that body and do talking therapies to my heart's content, because I think I've realised... actually I do love psychology."

p. 18 Leigh

Summary of theme B: focus on therapeutic practice in prior clinical experience

There is a sense that all the participants in non-specialist care settings were somewhat dissatisfied with their working environments and for most participants when reflecting back to these environments they saw the experience as being a catalyst in career change. Within the narrative they all established that meaningful work with people was important to them and they expressed frustration at not being able to offer evidence based psychological treatments. Much of the language and expressed emotion in these extracts was negative.

Master Table of Themes for the Group		
B Focus on clinical practice prior to IPT training		
Theme		Interview/Page No.
Participant		
<i>In Area routinely implementing PSIs</i>		
Avery:	<i>It was quite a leap in that respect... I was quite immersed in the whole thing</i>	2/11
Reece:	<i>adopted Fairburn Oxford model and part of that model has an IPT component</i>	3/5
Jamie:	<i>I had the opportunity to continue picking up one IPT patient</i>	4/7
Alex:	<i>solution focussed, some people use self-Psychology, and some people use TA</i>	6/11
<i>In Areas not routinely implementing PSIs</i>		
Bailey:	<i>I thought I had gone into the asylum, the back-wards. I was in culture shock</i>	1/8
Avery:	<i>I worked there for about nine months, and it sort of put me off nursing</i>	2/8
Jamie:	<i>there was very little psychological treatment available</i>	
Sam:	<i>feeling incredibly unsupported by the team...So that was a big influence</i>	5/7
Alex:	<i>but basically we were more, the cleanliness of the patient</i>	6/8
Leigh:	<i>I learnt how to engage well...but it was kind everyday sort of household stuff</i>	7/3
Chris:	<i>crisis intervention, in the way that it is more a support role than risk assessment</i>	8/3

Table 5.2 Master Table of Themes for the Group

Superordinate Theme B. Focus on Therapeutic Practice in Prior Clinical Experience

Superordinate Theme C: Focus on Experience of Team Involvement of Delivery of PSIs

The participants were asked to turn their attention to clinical practice following IPT training, and their experience of team involvement in the delivery of PSIs. As with the two previous superordinate themes there was a definite divergence in reporting of experiences dependent upon whether the participant experience was in a team that embraced the use of PSIs, or a team that did not use PSIs as part of routine practice. This was reflected in the following two emergent themes:

- Experience of team involvement within an area specialising in PSIs.
- Experience of team involvement within a non-specialist area.

Emergent theme 7: experience of team involvement within an area specialising in PSIs.

The enquiry revealed a number of issues the participants considered important that related to the resources and philosophy of the service where they worked, and the impact of these factors on their ability to practice IPT, and are best described under the following three headings:

- team receptiveness to introducing IPT
- team supports that enable the practise of IPT, e.g. peer support, supervision
- logistics of implementing IPT, e.g. resources, time, funding, room availability

Avery worked in a therapy service where IPT was one of the therapies being used, and found because all supports were in place and resources were no object there were no issues with regard to introducing IPT:

Team receptiveness to introducing IPT

“Yes it is fully accepted, it’s recognised and it’s embraced so to speak, so in all aspects so there is no problem introducing it.”

p. 15 Avery

Team supports that enable the practice of IPT

“All of those are in place. They are intrinsic again to (Service U), so we have supervision once a week and also we have on going peer support, so at any time we have access to our psychiatrist and colleagues also working on the same study obviously are really available. We do group supervision but there is always the option that um I could see one of the other therapists, or (Dr A) for instance.

p. 15 Avery

Logistics of implementing IPT

Avery was working in a therapy service with purpose built facilities, therefore when logistics were discussed Avery’s focus was on the access of external supports to assist with case management, rather than resources directly related to the practice of IPT:

“Um if they need medication each one of them is assigned a psychiatrist... If they are say needing say they get a flu or hypertension or something like that we would obviously refer them to their GP so we would work in with the GP. If they need respite care, then we can organise that.”

p. 17 Avery

Reece also worked in a service where the treatment of choice was therapy and spoke about the ease with which IPT ‘fitted in.’ There was no apprehension about providing ‘a couple of education sessions’ for the team, it seemed the natural thing to do and there was an expectation that IPT would be accepted and embraced by all of the team:

Team receptiveness to introducing IPT

“Yes because the whole service used therapy, it was a therapy based service primarily so the structure is there for that anyway and it didn’t really change. I mean IPT fitted into that, I didn’t really have to do anything differently. I did do a couple of education sessions on IPT, just so people sort of understood the model of it, just to give a bit of background for what I was talking about what I was doing with my patients.”

p. 9 Reece

Team supports that enable the practice of IPT

“I had supervision with the psychiatrist who was also the clinical head, we would discuss ideas that I had and thoughts that I would like to do, and so there was always a sort of a tersest agreement in there, then it was just to get the manager to cough up and as long as the team were, (Dr D) was in agreement, it was easy enough to do. So yeah there was never any resistance to doing IPT or CBT.”

p. 12 Reece

Logistics of implementing IPT

“I had my own room yeah. So I wasn’t ever an issue.”

p. 12 Reece

Jamie reported that in private practice team involvement and resources supported the practice of IPT. However because of Jamie’s personal lifestyle choices, and because the higher cost of therapy with a psychiatrist was a consideration for many private patients, the preference was to refer on to other experienced therapists:

“In private, I’m very fortunate because whilst I have a good breadth of understanding and can practise it, I choose not to because of my timing and the amount of hours that I want to do in the private work, and I refer on to very very experienced therapists, clinical psychologists and I feel very comfortable with that, and the patients are going to do very well if they choose to engage in that”.

p.12 Jamie

Alex also worked in a service dedicated to counselling and psychotherapy where no changes were needed to implement IPT. The feeling of support Alex enjoyed from the team came across clearly with an analogy of feeling like an adult member of a family within the team:

Team receptiveness to introducing IPT

“So we don’t challenge each other, like when we are at clinical meetings it’s a different approach, we would often say to each other what would you do with this, people just come at it from their model and people just accept that everyone’s model’s right for them.”

p. 19 Alex

Team supports that enable practice of IPT

“We get regular supervision and regular team meetings. And the clinical leader is very, she only sees three clients so she is always available or generally available for us. So we get a lot of support, our manager too is available a lot...So um yeah it’s actually quite good, it is like being you are living in your parent’s home, but you have your own room and they respect your opinions and you generally behave.”

p. 19 Alex

Logistics of implementing IPT

“Yes. It feels like you are an adult member of a family you know, you are not the parent, you have basically got your own room, they have got a check and balance with the CDRI and which clients turn up, and you are expected to be there for a number of sessions. Basically you are self-managed.”

p. 19 Alex

The four clinicians who reported on experience of team involvement in the delivery of PSI’s within an area specialising in PSIs were the same group of four clinicians who had practiced IPT following training at some point. As with the findings in the two previous themes, this group of participants used positive language throughout their reporting. Similarly it was notable that all of these clinicians spoke respectfully about their colleagues, and seemed to hold them in high regard. The researcher interpreted these phenomena as an indication of the participant’s satisfaction with their clinical environment.

Emergent theme 8: experience of team involvement within a non-specialist area

Bailey was working in an inpatient unit where the use of PSIs was not normal practice outside of short term therapies with the ward psychologist when available, and found there were interdisciplinary barriers to the practice of IPT:

Team receptiveness to introducing IPT

“I think you have to consider the history of (Unit A). The nurse consultant was very supportive and had been wanting for a long time for the nurses to be offering more informed interventions. However, the history of (Unit A), the psychologists have been very very adamant that it is actually not nurse’s work. Yep, (Clinician VI) has never been able to facilitate it happening because of the politics involved with it all I think, and um a nurse is a nurse.”

p. 12 Bailey

Bailey also found difficulties of staff rostering to be an obstacle to implementing PSIs:

Team supports that enable practice of IPT

“The nature of my work environment is I can’t be guaranteed to be working with the same patients two days in a row. They may be moved on or I may get a more acute patient load.”

p. 14 Bailey

A further issue for Bailey was a feeling of guilt when spending a length of time with a patient as illustrated in the following extract. It was the interpretation of the researcher that Bailey’s guilt stemmed from a perception of the nursing role as being task orientated, therefore time spent talking could be seen as dereliction of duties. This issue is discussed further in theme D.

“There is certainly no funding for me to do it in a formalised manner and I have this thing were I feel guilty. Look I mean I provide supervision to people and you know I am already aware that I have two clients at the moment that I am regularly off the ward for those periods of time. You know it is a big ask really.”

p. 22 Bailey

Logistics of implementing IPT

In the following extract Bailey looked creatively at how strategies of IPT could be implemented in a clinical environment that was not receptive to PSIs. After exploring a

number of factors Bailey concludes that it would be ‘a big ask’, and on further reflection makes a decision to move on to a new service.

“It could be part of the treatment plan except for the fact that there is no guarantee that I would be working with the patient again. And I am setting up other nurses to feel alienated and to feel less than, because they don’t have the knowledge that I do? I have thought in the past that what I could do is to do brief psychotherapeutic interventions and have rationales for techniques and keep them in the filing cabinet. So that if it was written into a treatment plan then they could do that rationale and they could do a bit of self-education, and they could come to me. So I guess it could be, if it was approved, but I mean I have never taken that step. It seems a big ask.”

p. 16 Bailey

“I need to change my clinical setting. I am ready to move on now to use some other skills. Because what I have realised recently is that my ability to use my talking therapy skills is minimised by my environment, and by my role within the ward...So yes time for a change. Woo hoo!”

p. 23 Bailey

Prior to private practice Jamie had worked in a number of mental health services that allowed therapy as part of registrar training, and allowed for psychiatrists who wished to, to retain one case to ensure they did not lose their skills, but the service did not offer therapy routinely as a treatment.

Team receptiveness to introducing IPT

“(Service Z) different kettle of fish again, there’s a culture there where I don’t think it would have gone down well if I had dished out prescribing psychological treatments on a lot of people. I think there was always that pressure of time and that it wasn’t “with it,” and again how many people would’ve been sufficiently trained to be able to that, a couple.”

p. 9 Jamie

“(Unit C) very much from a training perspective, fine, but don’t pick up to many cases. If I was a consultant, again, I would be allowed to have one particular patient to keep my skills in. But I think it would’ve been frowned upon if I spend more time in therapy.”

p. 11 Jamie

Jamie was one of a number of participants who perceived that it would be frowned on if more time were to be spent on therapy. This is an interesting point, and it may be speculated that where services that have no data with which to measure outcomes of

therapy treatments, for example, length of care, improvement in functioning and number of crisis contacts, an assumption is made by clinicians that spending an hour each week or fortnight is excessive, because the value of therapy is being measured in time alone. Further enquiry would be worthwhile and could provide some insight into how this barrier may be tackled, but is beyond the limitations of this study.

Having a number of experiences across more than one health board, and a number of mental health inpatient units and outpatient services, afforded Jamie a greater insight into the issues for both individual team and health board divisional perspectives:

“It can be all summarised I guess for the (Health Board) as the emphasis is on service provision in terms of assessment in medication treatment, there wasn't a lot of emphasis or support for psychological interventions. Allegedly because of the work volume and the severity of the patients and whilst you might talk about evidence based practise and best practise when looking at guidelines that support those interventions often it would be stated that's in mild to moderate cases and were dealing with the severe 3% and whilst it's important for your training and understanding in knowledge of the role of psychological treatments the (Health Boards) weren't really interested in pursuing that.”

p.12 Jamie

Team supports that enable practice of IPT

Because in Jamie's experience, therapy was accepted as a tool to train and enhance skills for a particular discipline rather than as a treatment of choice, supports to enable practice did not come from within the MDT. None the less supports were available in a forum designed to assist professional development:

“Time pressures, and usually I was working on people that were relatively stable, so it wouldn't have needed to be brought up as such, and I had another forum by which I could discuss things, so I didn't think it was necessarily appropriate to do that in an MDT... perhaps not the best forum...”

p. 16 Jamie

Logistics of implementing IPT

As a doctor Jamie found the practicalities of offering psychotherapy were not a problem:

“Yeah it was usually pretty good. Either at (Unit C) people would see me, they’d just travel to the hospital and we’d find a room. (At Service Z) I had a room issued permanently to me and it wasn’t problem for people to get to the place from a logistics point of view, it was not a problem.”

p. 15 Jamie

For Sam after initial negative experiences of implementing therapy, as discussed in theme B, a more recent move to a service where there was potential for the introduction of PSIs seemed to assist Sam to view the possibilities with renewed enthusiasm.

Team receptiveness to introducing IPT

“Definitely it’s a totally different ball game because at (Service X) I’d be able to freely discuss it in the MDT and have no qualms about it...I believe they’d be on board.”

p. 16 Jamie

Team supports that enable practice of IPT

Sam had put forward some suggestions for the implementation of IPT and had experienced a positive reception to ideas. However, despite this encouragement, throughout this section of the interview Sam commented on a need for more experience.

“I talked to (Clinician VII) who’s our psychologist about when I have more experience I’d like to do more formalised IPT and he’s really keen for it. It all helps so I don’t have any blocks there. Our new manager (Manager B) she’s got no blocks with it. The team itself they really are very psychologically minded for a team as a whole.”

p. 14 Sam

Logistics of implementing IPT

Barriers for Sam seemed to be minor practicalities that could be overcome:

“It’s never happened a lot in the old (Service X) building before we moved because we didn’t have the space, now we have more space so able to actually bring people into the (service X) building itself, we’ve got a room I

can book out and do a bit of therapy work with people. We have a room available it's not ideal, it's got windows on two sides so there's a lot of distractions. There may be another room out the back I can use, depending on the day, but then it's often cold. Lately we've had a few mice issues, very off putting, but we can get around that."

p. 21 Sam

It also seemed that for Sam other more personal factors were at play,

"I like it I wish I could do more of it but the timing's not right. I'm doing my masters, shared care project and I'm part of the whole direction for change of our service I'm involved in all these meetings and all that stuff so it just doesn't feel like, I haven't got enough head space."

p. 23 Sam,

including the personal nature of the negative experience of supervision at the previous service:

"Because of that whole fear factor of sitting next to someone and opening up about things that form some reason the transference from (clinician I), it was really hard for me..."

p. 24 Sam

Although negative experiences within teams are experienced as personal issues, such experiences may also be a reflection on the supportive nature of team environments.

Leigh described a feeling of discontent at being unable to practice IPT following formal training:

Team receptiveness to introducing IPT

"I wouldn't be able to say "well I'm just going to start doing IPT" purely IPT with my clients because my contract says we have to be doing all these wide varieties of things so I can't just start doing that it has to be kind of even if they think that it's a good idea they have to go to the (health board) and say can we actually use the spare money that we have to do it? Which is quite laborious if you think...I had to fight really hard to get the funding to actually do IPT (training)...but definitely to try and do anything, talking therapy wise, it's quite difficult to recognition for it, even in its evidence based therapy, it shouldn't be as difficult as it is. And it all comes down to, I can get frustrated with management, but it all comes down to the (Health Board) because they fund us and they give us the criteria of where our money should go."

p. 12 Leigh

Team supports that enable practice of IPT

For Leigh role perception amongst the disciplines was an issue and is illustrated here. After talking about the role of social workers and their prescribed model, it appeared finding a description for a personal place in the team was a struggle for Leigh: ‘yeah I am a little bit in, not.....’ and then Leigh voice trails off. Role perception is examined in more depth in theme D.

“I would say that I’m one of the few that would have therapy in mind when they’re doing, there’s maybe 3 or 4 of us that, 5 maybe, that in terms of talking therapy. We’ve got social workers that will be using social work structure but in terms of talking therapies there’s, yeah I am a little bit in, not.....”

p. 12 Leigh

Logistics of implementing IPT

Leigh looks towards future implementation of IPT and works through how the logistics may work. Leigh also looks at how some previous brief psychological interventions have worked and as plans for IPT begin to emerge Leigh’s language and demeanour become more positive.

“Yeah we haven’t really got that far. This room is often used when I need a room. Well that’s the other thing, we did, I did a couple of people at home and I did a couple of people here and I very much liked here, I decided I didn’t like going to people’s houses cos of the distractions and getting there and they’d either be finishing feeding their chickens...so I’ve used this room and it’s not ideal but I’ve arranged the seats so it’s a lot closer and cosier and so it would probably be this room or (clinician V’s) room, cos it’s quite a nice size and it would probably weekly, trying to do it as pure as possible for 50 minutes, 12 – 16 sessions.

p. 16 Leigh

Chris looks forward to the planned implementation of IPT in the service:

Team receptiveness to introducing IPT

“Well I got into IPT, at first our CEO is interested in doing this therapy service and this option came up, so basically when me and (Clinician III) did IPT (training) there was an expectation that we would use it in (Service V)...They already have the, you know, expectation that something will happen in the future.”

p. 6 Chris

Team supports that enable practice of IPT

“I don’t know what the background is, the funding and all that sort of thing. I think it is funding and opportunities to get it going with some credibility in practising that so yeah.”

p. 7 Chris

Logistics

“Yes but what I would like though, to see it happening more in (Service V), make it more available...If we can do that, but the problem is at the moment that we don’t have the (therapy) service and we can’t just say this is something we could do, because we don’t have the time and we don’t have the funding, so we can’t actually just say yes and see the person as part of our work.”

p. 11 Chris

The findings showed that the participants who experienced a care setting that regularly used PSIs described a positive and nurturing work environment. They all found their team receptive to the implementation of IPT, there were no challenges, and no changes were necessary to accommodate its integration into the service because PSIs were fully accepted, recognised and embraced. Team supports were already in place and included peer support, group supervision or supervision with the psychiatrist on the team was viewed as normal practice, and all the participants reported positively about the support received from management. Logistically all of the clinicians had their own room, time to practice and supports for patients, such as medication reviews were in place.

In stark contrast, the participants describing team involvement in care settings that did not routinely offer formal psychological interventions, described team cultures that were not receptive to the introduction of PSIs. The teams operated in a medical model with rigidly defined roles, and one discipline that created barriers for the implementation of PSIs, and it was felt other disciplines would frown upon clinicians taking time to practice IPT. Participants described feeling unsupported, and at times undermined by colleagues when they attempted to introduce evidence based PSIs into practice and supervision was used to deal with interpersonal team dynamics rather than clinician interventions. The lack of support was also seen to apply at other levels including managers and funders. Logistically barriers to practice included; limited resources of time, rooms, and staff availability, roles that were defined to prioritize the needs of the

organisation and management of the environment, such as paperwork, supervision of junior staff and rostering issues that prevented patient continuity needed to practice therapeutically. Participants also described feeling guilty and feared alienation when spending time working therapeutically.

Master Table of Themes for the Group		
C Focus on experience of team involvement in delivery of PSI		
Theme		Interview/Page No.
Participant		
<i>In areas regularly using PSIs</i>		
Avery:	<i>It is fully accepted, it's recognised and it's embraced so to speak</i>	2/15
Reece:	<i>the whole service used therapy, it was a therapy based service primarily</i>	3/9
Jamie:	<i>I refer on to very very experienced therapist, clinical psychologists</i>	4/12
Alex:	<i>It feels like you are an adult member of a family, ...so we get a lot of support</i>	6/19
<i>In areas not regularly using PSIs</i>		
Bailey:	<i>I didn't feel confident enough to put myself out there like a red flag</i>	1/18
Jamie:	<i>emphasis is on service provision in terms of assessment in medication treatment</i>	4/12
Sam:	<i>I like it, I wish I could do more of it but the timing's not right...</i>	5/22
Leigh:	<i>Talking therapy wise it is quite difficult to get recognition for it, even EBT</i>	7/12
Chris:	<i>So we follow the plan that is drawn up by their doctor or case</i>	

Table 5.3 Master Table of Themes for the Group

Superordinate Theme C. Focus on Team Involvement in Delivery of PSIs

Superordinate Theme D: Focus on Role Perception

As participants described their experiences of training and clinical practice there was frequent reference made to how they or others saw their role, and how they perceived the roles of other disciplines.

Emergent theme 9: role perception in a specialist care setting

When participants described training and clinical experiences in specialist areas, role perception was not found to be an issue. Participants described being part of a team, and generally roles were defined by the type of therapy a clinician offered rather than

discipline. This is illustrated by Reece's experience of working in a team where all clinician's adopted a therapy role and Reece looked for an IPT clinical supervisor who was a nurse in order to assist in maintaining some nursing focus to the delivery of IPT treatment, which was otherwise difficult to achieve:

"I really liked the clinical supervision that I had with the psychiatrist in many ways... I just didn't want to lose sense... that I am a nurse and I kind of thought if there was a nurse who had got that kind of background (IPT) and could give me the support that might kind of help me keep the nursing in it as well."

p. 14 Reece

When Avery discussed team interactions (other than with the psychiatrist) no mention was made of roles; other clinicians were simply called peers or colleagues.

"Also we have on going peer support, so at any time we have access to our psychiatrist and colleagues also working on the same (Service U) obviously are really available. We do group supervision but there is always the option that um I could see one of the other therapists, or (clinician A) for instance. That I need to park up and talk about this and I have done that on one or two occasions."

p. 15 Avery

Alex worked in a team that offered therapy as routine practice, experiences of the team did not include role definition.

"So we don't challenge each other, like when we are at clinical meetings, a different approach, we would often say to each other what would you do with this, people just come at it from their model and people just accept that everyone's model's right for them. Everyone tend to work with their favourite sorts of patients or clients they like to work with that suit their model."

p. 19 Alex

Emergent theme 10: role perception in a non-specialist care setting

Some of the nurses, particularly nurses who had completed comprehensive training, related to a task orientated perception of the nursing role. Although they had moved to mental health nursing, and they were no longer practicing in this way, their perception of how they saw themselves at some point in their careers, and how they expected others to perceive them, seemed to hang in the shadows, not quite shaken free.

Bailey remembers back to comprehensive nurse training with a joke about it being ‘very nursesey’:

“Oh yeah, there was lots of ward placement, surgical ward, medical ward placements, all very task orientated. At the time that was very nursesey you know.”

p. 4 Bailey

The linguistics of Avery’s comment were also be interpreted as being somewhat self-deprecating with phrases like, ‘no skills whatsoever’ and the metaphoric image of ‘landing on the doorstep as a nurse working in A&E’ which was said with laughter and an element of self-mockery.

“However, that was I mean I went to work there with no skills whatsoever, I mean I landed on the doorstep as a nurse working in A& E.”

p. 11 Avery

Alex described early nursing as task orientated and the suggestion that nurses who talked were lazy suggests an attitude that the nurse role was to offer physical comfort, but to spend time on spiritual or emotional wellbeing was wasting time:

“Basically we were more, the cleanliness of the patient doing the medicines and dressings, no not talking therapies; no I think the nurses that talked were a bit frowned upon. They were thought of as lazy.”

p. 8 Alex

When Alex talks about personal motivation there is a sense that with nothing better to do, nursing was a default or fall-back choice:

“I think I um, I probably didn’t have a lot of sense of self so I did, we had nurses in the family so I’d just copy of my older sisters, and I enjoyed it but I wasn’t, I mean I would do this this (therapy) even if I didn’t get paid, whereas no way would I do nursing for that.”

p. 7 Alex

These perceptions may have been typical of comprehensive nursing of the time, and the findings from emergent theme one, suggest that many nurses who had completed comprehensive nurse training felt that they were not adequately trained in therapeutic interventions. Some participants described perceptions of their professional role that included a normalisation of the handing over of interventions that required therapeutic

engagement to other disciplines such as social workers. Avery describes this phenomenon in the following extract:

“Not really, it was very much a sort of, if someone had, if your patient was depressed you’d sit and talk to them or listen to them. But you’d definitely; you’d refer to the social worker on the ward. You were very much focussed on the doing.”

p. 9 Avery

Sam reports a similar experience in a non-specialist area of mental health in the early 2000’s:

“Because when I came here, the therapy side of things in forensics was pretty much non-existent. I mean it was but from a nursing perspective it wasn’t our role, it was seen as more of a psychologist role.”

p. 2 Sam

Although these participant’s comments about role were historical there was evidence that role perception remained a current issue. The following account is of a nursing experience in a psychiatric ward at the time of the interviews. This account highlights the continuing focus on task orientated practice, with the key nurse role being defined as a ‘paperwork role.’

“Yes there is a key nurse role...The idea is you admit this patient and you are the key nurse. I admit this patient and then the next day I get moved through to the other ward, and I have got to stay there for the next two weeks. So I am responsible for the paperwork. So the key nurse role is a paperwork role really. Unless you are able to facilitate staying working with that patient, which is difficult to do at times...”

(So your key nurse role isn’t to do with a therapeutic engagement?)

“No it doesn’t work really. Individual nurses do the best they can but...no you can’t really because you may be working on the B wing for the next two weeks, and then they get transferred through to the B wing and you are on the A wing, or they get transferred through to an open ward. You’ve just got to make sure the paperwork is up to date.”

Pg. 16 Bailey

Bailey acknowledged the historical aspect of the nursing role perception in the following extract, but also notes one of the current day limitations for the role of mental health nurses as the limited number of nurses in the workforce who are trained in PSIs or therapies such as IPT or CBT. In Bailey’s experience following formal IPT training, the perception of role continued to define which of the mental health professional

disciplines could engage in therapeutic interventions, and this was seen as a barrier to the implementation of PSIs. In this extract Bailey reported that it is accepted practice for one discipline to take ownership of therapeutic interventions, and to block PSIs from being offered by suitably qualified staff of any other discipline.

“I think you have to consider the history of (Unit A). The nurse consultant was very supportive and had been wanting for a long time for the nurses to be offering more informed interventions. However, in the history of (Unit A), the psychologists have been very very adamant that it is actually not nurse’s work. Yep, (Clinician VI) has never been able to facilitate it happening because of the politics involved with it all I think, and um a nurse is a nurse is a nurse.”

(So your team includes one discipline who?)

“Maintain ownership of that psychotherapeutic intervention in any sort of formal capacity. Occasionally nurses will come along who have those IPT, CBT skills, but then we do them informally, and we might make reference to them, and reference doing some problem solving work, but we wouldn’t give voice to detail... I suppose it is opportunistic as well.”

p. 12 Bailey

It was not only the participants from a nursing background whose experience included an understanding that barriers to the implementation of IPT were imposed through role perception within their teams. Jamie was on a registrar programme and acknowledged being in a fortunate position because it was acceptable for the discipline only to offer IPT and take time out for supervision of cases:

“I think we were probably very fortunate from that point of view. I don’t think any other clinician would have that. On occasion you might have the occasional clinical psychologist that might be able to do that but then there was always pressure on them to case manage and to do psychometric evaluations.”

p. 4 Jamie

Jamie’s experience was of disciplines taking on a more generic role and in effect losing their specialities. The effect of role dilution was that none of the disciplines were able to formally offer PSIs as part of their role:

“(Service Z) that was a nice blend of psychiatrists, consultants, some very experienced nurses, also some very experienced allied health professionals, but in role of case managers rather than in their own specialty as such.”

p. 11 Jamie

Leigh described being isolated ‘in no man’s land.’ because training offered by the service was focussed on social work, but also because without affiliation to a professional body options to offer therapy were further limited.

“The major issue for me has been, that I’m not registered to a particular health body and I think if I was they would maybe see more point in training me, but I’m kind of in no man’s land with what I’ve done, and because it is a social worker sort of field they’re more likely to do more social worky seminars rather than specific talking therapy stuff, if that makes sense?”

p. 5 Leigh

With a psychology background Leigh experienced a working environment with a high ratio of clinicians with a social work background where the service had adopted a social work philosophy. Leigh had been encouraged by the team to complete a social work qualification but preferred to retain a psychology perspective.

“When I talked to them when I first came, I was like ‘Where should I go?’ and they were like ‘I think you should do your masters in social work,’ and I said ‘but I don’t want to be a social worker,’ and they were like ‘What? Well that is pretty much your only option.’ So I think it’s just a big gap because they do expect people to do eight years of study and there needs to be more opportunity for people with master levels, but that is not going to change quickly.”

p. 12 Leigh

“Yeah, I think it’s the (health board) they don’t seem to value the talking therapies as much as they should. So that would be probably, partly I think well I could’ve done social work and then I could be a registered and then I could do the talking therapies to my heart’s content but actually I do love psychology.”

p. 18 Leigh

The interview guide did not specifically target the area of clinician role definition. On reflection this may have been because the researcher fell into the category of clinicians who, had been able to practice IPT in a team, if not a service, that embraced and accepted PSIs, and therefore did not immediately recognise role as being an issue. The participants who practiced in teams that supported talking therapies as a recognised treatment made scant reference to role in their narratives. For this group of participants roles were seen in generic terms, and clinicians were more likely to be defined by the

model of therapy they offered than their affiliation to a professional discipline. The exception was that of psychiatrists on the teams, who were viewed as having a clinical leadership role for the team and often offered supervision and guidance for all disciplines.

The narratives of participants who worked in care settings that did not routinely offer PSIs provided a different view of role. For these participants role was seen as a barrier to offering PSIs regardless of the participant's qualification in IPT, CBT or other therapy modalities. For nurses, particularly nurses who were qualified as comprehensive nurses as opposed to the psychiatric nurse, role was a particular issue. The participants in this category defined their role as being task orientated, with the senior nurse being responsible for paperwork and monitoring of junior staff. Talking therapy was seen as outside of their role, however these nurses also spoke about using PSIs 'opportunistically and informally', but were reluctant to 'give voice' to what they were doing.

For psychiatrists, they also felt subject to the pressure of their colleagues to fulfil their duties of patient review and medical treatment, and the understanding they could offer one psychotherapy case was seen as being fortunate, and recognised as being a privileged position not afforded to other clinicians because of their designation.

For the participants with masters' level psychology backgrounds and a qualification in IPT, role was a particular issue. Their training did not include any clinical practice and they were not able to register with a professionally affiliated body. This was seen as a barrier to practice. For this group of participants, they found they were not funded to offer therapy, which in their organisation was seen as the role of social workers.

Master Table of Themes for the Group		
D Focus on role perception		
Theme		Interview/Page No.
Participant		
<i>Role perception within a non-specialist area</i>		
Bailey:	<i>at the time it was very nursey</i>	1/4
Avery:	<i>I went to work there with no skills whatsoever</i>	2/11
Jamie:	<i>case managers rather than in their own specialty as such</i>	4/4
Sam:	<i>a nursing perspective it wasn't our role... seen as more of a psychologist role</i>	5/2
Alex:	<i>nurses that talked were a bit frowned upon</i>	6/8
Leigh:	<i>no man's land with what I've done... because it is a social worker sort of field</i>	7/5
<i>Role perception within an area specialising in PSIs</i>		
Avery:	<i>you'd sit and talk with them but you'd definitely refer to the social worker</i>	2/9
Reece:	<i>I just didn't want to lose sense... that I am a nurse</i>	3/14
Alex:	<i>people just accept that everyone's model's right for them</i>	6/19

Table 5.4 Master Table of Themes for the Group

Superordinate Theme D. Focus on Role Perception

SUMMARY OF FINDINGS

It was found that all of the participants who went on to practice IPT had experienced academic and clinical training and clinical practice prior to IPT training, in services where PSIs were formally accepted for their discipline. Notwithstanding, many of this group of participants had also had experiences when PSIs were not part of the curriculum or accepted as routine clinical practice at some point.

In contrast, of all the participants who had been unable to practice the treatment of IPT after qualifying as an IPT therapist, only one had some prior training and clinical experience in a service that offered PSIs.

Three of the four participants who had practiced IPT following training had done so in an area where IPT was being offered as a treatment of choice. The third participant had used IPT in a team that accepted IPT as a treatment however, it was only acceptable if practiced by a doctor, and then the therapy was limited to only one case at a time.

The four participants who had not practiced IPT following training were practicing in teams that did not offer therapy as routine practice. In these teams a limited amount of PSIs were available to patients. However, the philosophy of the teams was to restrict the practice of therapy to one specific discipline. In two teams it was the psychologist who offered CBT, and in the other two teams social workers were able to offer therapy. In each team therapy was limited by the availability of qualified staff of the acceptable discipline.

CHAPTER 6: DISCUSSION OF FINDINGS

INTRODUCTION

This chapter will first provide a concise summary of three key areas from the findings and then follow with a discussion of findings and relevant research, and conclude with the limitations of the study and the possible implications for future research and practice.

Providing access to evidence based treatment is a focus of New Zealand mental health guidelines. Recommendations have been made for the dissemination and implementation of talking therapies, including IPT and CBT, throughout each of the sectors of New Zealand mental health care (Te Pou., 2007, 2009, 2012).

International studies show the uptake of evidence based treatments like IPT by frontline clinicians can be variable (Paley et al., 2003), (Reay et al., 2003), and (Sin & Scully, 2008). This issue was also considered by the National Centre of Mental Health Research, Information and Workforce Development, in their document ‘Talking Therapies: Where to next?’ (Te Pou., 2012). This report concluded that there is variability of access to talking therapies in New Zealand, and that this must be addressed to meet demand by 2020.

This study has examined the training and clinical practice experiences of a group of multi-disciplinary frontline mental health clinicians, both prior to, and following post graduate training in IPT to investigate factors that influence the uptake and continuing practice of IPT by frontline mental health clinicians following formal training. The research began with four broad questions to guide the enquiry:-

1. Is previous training a predictor for incorporating IPT into clinical practice
2. Does pre-training clinical experience influence the post training practice of IPT by clinicians?

3. What are the characteristics of services which operate to enhance talking therapy provision and enable clinical staff to practice their discipline?
4. What are the participants' positive and negative experiences of introducing IPT into clinical practice?

The findings suggest there are three primary factors that influence the uptake and continuing practice of IPT following formal training.

5. The therapist's experience of psychotherapeutic interventions (PSIs) in prior training
6. Team involvement and the role of senior clinicians in the implementation and dissemination of psychotherapeutic interventions in clinical practice
7. The perception and definition of roles across professional disciplines

An area of significant interest was the striking polarisation in the accounts of participants across all findings. The polarisation occurred between those who had experienced mental health training and clinical practice in settings that incorporated evidence based PSIs, and those who trained and practiced in mental health settings with a greater focus on a medical model of treatment.

DISCUSSION OF FINDINGS

1: Participants Experience of PSIs in Prior Training

Seminal research suggests that training manual approaches are most effective with therapists who are already skilful in therapy (Rounsaville et al., 1988; (Strupp, Butler and Rosser, 1988). This is acknowledged in the pre-requisites for acceptance into the IPT training programme: a professional qualification in mental health and two years prior clinical experience in a mental health setting. This part of the enquiry explored the focus on PSIs in the participant's mental health training and practice.

Academic training

With regard to academic training prior to IPT training, the narratives of all of the participants who had experienced mental health training in a biopsychosocial model were positively phrased, and conveyed energy and enthusiasm for their training. This group acknowledged that their academic training prior to IPT training had provided a relevant grounding for aspects of clinical practice for their discipline. However, participants from this group also concluded that academic training prior to IPT training was not *as* helpful for the delivery of PSIs, as was their experience of clinical training in settings where they were able to work therapeutically with clients, and access supervision with senior clinicians. All of the participants in this group had practiced IPT in a clinical setting following formal training.

The narratives of participants who had experienced academic training based on a medical model of mental health that did *not* include psychotherapeutic interventions described their training as having little relevance to the clinical practice of mental health care. All of these participants reported on their experiences in negative terms and described feeling disadvantaged or isolated by their lack of training in therapeutic engagement when they reached clinical practice. Furthermore, they reported similar experiences in their clinical practice training and this is discussed in more depth later in this section. None of the participants from this group had practiced IPT in a clinical setting after completing IPT training.

In summary the findings indicated that where academic mental health training is focused on a medical model there was a gap in learning psychotherapeutic interventions. More than half the participants described feeling inadequately trained to engage in psychotherapeutic interventions when they first entered clinical practice. International research shows that even brief training programmes in psychotherapeutic interventions can foster a culture of therapeutic engagement. For example Hosany et al., (2007) found that at three months follow up, after a two day course on Solution Focused Therapy, clinicians reported that

they had developed ‘skills of real value to patients’, that they were better able to structure one to one sessions, and had increased confidence to practice psychotherapeutic interventions. Similarly in a study that evaluated a new approach to clinical training, (Van Rijn et al., 2008) the researchers concluded that training and supervision methods linking emerging issues in clinical practice to theoretical training assisted in closing the gaps between clinical practice, supervision and formal training and facilitated the translation of theory into practice.

Clinical practice training

The participants’ experiences of clinical practice training were varied and the accounts were interpreted as being deeply personal to each individual participant. There was an overlap of this theme and the theme of ‘team involvement in the delivery of PSIs.’ Across the emergent themes, extracts showed the participants’ lived experience of their training could be remarkably different depending on:

- a. what focus was given to PSIs during the training,
- and
- b. the culture and characteristics of the service where the clinical placement took place.

Reports of positive and negative experiences were dependent upon whether the treatment model where clinical placement took place accepted and embraced the routine practice of PSIs, regardless of the training discipline. There were two commonalities across the individual reports of training experience: - first, the significance given to the influence of senior clinicians on their practice, and second, the positive or negative impact that working with multi-disciplinary team members could have on their confidence to practice therapeutically.

For those that had experienced clinical training in settings that routinely practiced PSIs, particular value was placed on both the easy access of informal day to day support of

the multidisciplinary team, and the mentoring role offered by senior staff. Participants training in these specialist settings saw supervision as being especially helpful, particularly when it was offered by psychiatrists on the team, and for these participants role definition was not raised as an issue. In contrast, others who had clinical training experiences in settings that operated under a medical model not routinely offering PSIs, reported feeling unsupported by their peers and reflected on experiences of working with other disciplines that had been invalidating of their attempts to practice therapeutically.

These findings are consistent with research that has examined core mental health training and post-qualification training, and recommended that such training should be offered in a model that encourages the sharing of information. Continuing interdisciplinary support and supervision by senior clinicians was seen as essential to the ongoing development of therapy practice. Trenchard et al. (2002) argued that discipline-specific training programmes created barriers to the sharing of knowledge between mental health professionals. This report found that training programmes for multi-disciplinary mental health professionals, with a focus on PSIs, developed in the UK, provided suitable support for clinicians implementing talking therapies into contemporary mental health practice.

Policies developed in of implementing and disseminating psychological interventions in mental health settings, have also acknowledged the need for multi-disciplinary training with more focus on the therapeutic relationship and psychological interventions. The concept of multi-disciplinary training was discussed in The Ministry of Health document 'Mental Health Nursing and its Future: A discussion framework' (2006). This document concluded that multidisciplinary programmes that focus on 'psycho-social' interventions, similar to education programmes developed in the UK, exemplified best practice. Hurley (2010) concluded that effective training for talking therapies is best conducted in formal educational settings *and* in work-based sites using effective mental health role models, and recognised the need to grow the interfaces between nursing, psychology, medicine and social work.

Other guidelines emerged from a Scottish study conducted by Chouliara et al. (2011) who investigated clinicians' perspectives on helpful and hindering experiences of therapeutic practice and the perceived satisfaction of needs in providing talking therapies. This study recommended placing greater emphasis on relational models in core mental health training, supervision and practice. Holloway et al., (1995) also concluded that supervision, as a training method, is considered 'critical' by educators, trainers and professional bodies to establish fitness to become 'a fully-fledged member of the profession.' Holloway et al., (1995) also found that although therapy skills may be acquired quickly in training, supervision may have a more substantive role in the longer term development of conceptualisation of cases and treatment decisions. This is reflected consistently in the participants' views that supervision and readily available peer support was a valuable contributing factor to the practice of PSIs.

The participants in this study had undertaken IPT training in a multi-disciplinary model that incorporated didactic training, supervised cases and workshops that encouraged feedback and dialogue. Ongoing supervision was made available to support students as they transitioned into clinical practice. Although the research enquiry did not specifically investigate participants' experiences of post-graduate IPT training itself, many participants reflected on the structure of IPT training as being particularly helpful because it 'made sense' of previous trainings, for example, drawing together academic teachings from the participant's early core training on attachment theory, and bringing it to life in their current therapeutic practice with patients. Furthermore the students reported that they felt supported in their supervision with both peers and a senior psychiatrist.

Although it is widely accepted that mental health practice is rooted in the quality of the therapeutic relationship, the findings of this study suggest the core training does not always adequately address an understanding of PSIs. When clinicians begin clinical practice they may encounter inter-disciplinary barriers to the dissemination and implementation of PSIs into routine practice. Clinicians who have on the other hand, experienced training that encourages a multi-disciplinary

interface and exchange of knowledge and support from both peers and senior clinicians, went on to practice IPT following formal training.

In summary academic and clinical practice training experienced prior to IPT training which focuses on PSIs, demonstrates functional and supportive interdisciplinary relationships, and features experiences of positive and encouraging ongoing supervision with senior clinicians, may be an important factor of influence in the uptake and continuing practice of IPT following formal training.

2: Team Involvement in the Implementation and Dissemination of Psychotherapeutic Interventions in Clinical Practice

There was significant overlap between the study findings and existing research in two areas: ‘focus on delivery of PSIs in prior clinical practice’ and ‘focus on team involvement in the implementations of PSIs’. The close relationship between these two areas was such that treating them separately would have added little to the discussion and resulted in repetition, therefore a brief summary of the findings is set out for each area and then relevant literature and implications are discussed together.

Focus on delivery of PSIs in prior clinical practice

Prior to IPT training half of the participants practiced in settings that supported the practice of PSIs. This group reported positive experiences and portrayed a sense of enjoyment and enthusiasm for their work. Further commonalities amongst this group of participants were their descriptions of functional interdisciplinary relationships within their teams, and their appreciation of the availability of peer support and supervision with senior clinicians. In common with the emergent theme ‘experience of clinical training within settings specialising in PSIs’, the participants used positive language in their narratives, and all went on to implement IPT into practice following training.

In contrast those who experienced training and clinical practice in settings prior to IPT training that did not offer PSIs as routine treatments expressed dissatisfaction with their working environments. Within the narratives of this group all established that meaningful work with people was important to them, and expressed frustration at not being able to offer evidence based PSIs. Three quarters of this group felt unsupported by their colleagues, and expressed negative emotions and used pessimistic language in their narratives. Half had experienced feelings of isolation and distress as a result of team involvement and supervision experiences when implementing therapeutic practice. When reflecting back to these environments, the participants saw their experiences as being a catalyst for a change of direction in their professional life. The findings from this study also showed that those who reported negative experiences during clinical training, clinical practice and supervision demonstrated less confidence in practicing IPT following formal training and had not practiced IPT at the time of the interview.

Focus on delivery of PSIs following IPT training

This area of enquiry investigated participants' experiences following IPT training. Narratives of participants who worked in a setting where PSIs were fully accepted recognised and embraced described a positive and nurturing work environment. All participants from this group found their teams receptive to the implementation of IPT, did not experience challenges, and no changes were necessary to accommodate its integration into the service. Team supports were already in place and management support, peer support, group supervision or supervision with the psychiatrist on the team were all expected normal practice. Logistically all of the clinicians had their own room, time to practice, and supports for patients such as medication reviews were in place.

With regard to literature in this area, Rounsaville et al. (1986) and Bradshaw et al. (2007) highlighted difficulties in accessing suitable structured clinical supervision as a barrier to the practice of PSIs. The findings of the present study showed that half the participants had experience of supervision of their therapy following formal training within their teams. All participants in this group reported that

both formal supervision with a senior clinician and easy access of more informal peer supervision was invaluable.

In common with previous superordinate themes there was a stark contrast in the participants' descriptions of team involvement in settings that did *not* routinely offer formal psychological interventions. This group of participants described team cultures that were not receptive to the introduction of PSIs. They reported that these teams operated in a medical model, and rigidly defined roles were seen to create barriers for the dissemination of PSIs. Work roles were designed to prioritize the needs of the organisation and management of the environment, such as paperwork, supervision of junior staff, and rostering issues which impacted on patient continuity of care required in order to practice therapeutically.

Participants felt guilty and feared alienation when spending time working therapeutically. They described feeling unsupported, and at times undermined by colleagues when they attempted to introduce evidence based PSIs into practice. Half the participants from this group used supervision to deal with the difficulties of interpersonal team dynamics rather than clinical interventions. This lack of support was seen to apply throughout the service including at managerial and organisational levels. Logistical barriers to practice included limited resources of time, rooms, and staff availability.

When summarising the two superordinate themes 'focus on delivery of PSIs experience of therapeutic practice in prior clinical experience' and 'focus on experience of team involvement in delivery of PSIs following IPT training' a strong overlap of themes and commonalities was identified when considering: a. Barriers to implementation and dissemination and b. Receptiveness of implementation and dissemination.

a. Barriers to implementation and dissemination

Barriers to implementation and dissemination of IPT into clinical practice only occurred in settings where PSIs were not routinely practiced. The findings from this study were similar to the findings of Doyle et al. (2007), who concluded that

lack of time, conflicting pressures, uncertainty regarding roles, weak infrastructure for workforce planning and therapist attrition all contributed to a lack of PSI approaches found in mental health care settings. A further area of 'diversity of interests' was also identified in Doyle's study that did not emerge in this research. Brooker and Repper, (2002) found that no matter how well trained or motivated, staff could not effectively implement PSIs into organisational systems without organisational support.

Fourie et al., (2005), also suggested that a defensive delivery model was applied when practice was driven by the needs of the organisation rather than the needs of the patient. Similarly a UK study into training in the delivery of PSIs in inpatient wards by McCann et al., (2005) concluded that effective leadership and management, sufficient and stable staffing of a ward were key, and where these elements were lacking the programme proved to be less successful. This research reflects similar findings in the reports of the participants who saw that when the more senior nurses in acute inpatient settings were involved in prioritising organisational efficiency and with less patient contact time, containment of the unit became a priority over therapeutic interventions.

Similar barriers were also seen in community mental health services. In the present study participants reported that service provision was designed to focus on assessment and medication treatment, rather than psychological treatment. They saw a lack of trained therapists, a medicalised culture where psychological treatments were seen as being 'not with it', (unfashionable) and time pressures as barriers to implementation. Paley et al., (2003) also reported a lack of supportive organisational and managerial culture, substantial evidence of a paucity of training, and inadequacies of the physical and professional environment within community mental health setting, as barriers to treatment. Paley and colleagues (2003) concluded that there was strong evidence to show consumers were in favour of the implementation of psychotherapeutic interventions as treatment, and that a high standard of training led to high levels of commitment from enthusiastic therapists who wanted to disseminate their knowledge to other nurses and patient groups. Paley and colleagues (2003) also reported their evidence based practice

could lead to practice based evidence as a way forward, but that questions still remained over whether organisations would allow dissemination.

A study by Crawford and colleagues in 2002 was seen as very relevant to this study because so many of the participants of this study had expressed dissatisfaction and disempowerment in their work environment and saw themselves as isolated in their desire to disseminate evidence based treatments. Crawford et al., (2002) suggested that resistance to evidence based practice may be a mechanism used by disempowered clinicians to retain some control as they attempted to manage overly complex roles. Recommendations from the Crawford study included rethinking how new initiatives are introduced to ensure clinicians who do not embrace evidence based practice to are not viewed as ‘ignorant luddites’, and concluded that the key to this was in addressing ideological and organisational factors for example work based cultures and roles. They suggest ‘practitioner activism’ to enable learning and sharing of knowledge as a tool to change work environments. This may be a strategies that may be worthy of discussion when attempting to introduce an evidence based practice such as IPT into clinical areas that have not previously used PSIs.

b. Receptiveness to implementation and dissemination

Consistent with previous literature, this study suggests that clinicians require the support of their organisation, senior clinicians and peers to break down barriers and empower them in the implementation and dissemination of evidence based PSIs into clinical practice. Participants reported that the teams who were receptive to the implementation of IPT were already practicing evidence base therapeutic interventions. The characteristics of these teams included the recognition and acceptance of evidence based practice, positive and functional interdisciplinary relationships, readily available peer support and therapy supervision with a senior clinician, usually a psychiatrist, and positive regard for peer education sessions in additional evidenced based models.

A good example of an IPT model which was successfully disseminated from clinical research into a community mental health setting is IPT for depressed adolescents (IPT-A). Mufson (2010) concluded that the success of implementing IPT-A was not simply a question of efficacy, but also rested on the buy in of stakeholders and the provision of a forum for decision making and problem solving within the organisational structure of the care setting.

Sin & Scully (2008) found that despite increased access to training, serious problems remain for the implementation of PSIs into routine service provision, and recommended identifying measures to facilitate the implementation of policies and protocols, protected practice time, assessment tools, managerial and strategic support for graduates to disseminate skills. An evaluation of the impact of PSIs by UK researchers Forrest et al. (2004), found that training in PSIs was a positive experience for participants but the dissemination of training into practice was a 'complex and context dependant process'.

3: The Perception and Definition of Roles for Professional Disciplines

The interview guide in the present study did not specifically target the area of 'clinician role definition' as a factor that may influence the uptake and continuing practice of IPT. On reflection this may have been because the researcher fell into the same category as the participants who had practiced PSIs throughout training and clinical practice. It was concluded that because of this 'role' was not recognised as being an issue until the data was analysed. This preconception that 'role' was not a defining factor in the implementation of PSIs was consistent with the attitudes of all of the participants that practiced in teams that supported talking therapies as a recognised treatment, who made scant reference to 'role' in their narratives. Participants from these settings all reported highly functional multi-disciplinary teams, which offered interdisciplinary supports and sharing of knowledge. Roles were seen as being generic, and clinicians were more likely to be defined by the model of therapy they offered rather than their affiliation to a particular professional discipline. The exception was the role of psychiatrists, who were seen as having a supportive clinical leadership role for the whole team,

and often offered supervision and guidance for all disciplines. In terms of efficacy Santor et al. (2001) found no significant difference in responses of adolescent patients treated with IPT by psychologists, psychiatric registrars, doctoral students, clinical nurses, social workers and occupational therapists.

The narratives of participants who worked in settings that did not routinely offer PSIs provided a different view of 'role'. For these participants 'role' was seen as a barrier to offering PSIs regardless of the participant's qualification and expertise in IPT, CBT or other therapy modalities.

Nurses in this group defined their 'role' as being complex, multiple and task orientated and included the organisational tasks of ward and patient management. Talking therapy was seen as outside of their role, however these nurses also spoke about using PSIs 'opportunistically and informally', but were reluctant to 'give voice' to what they were doing. Leading the researcher to suggest that in these environments the practice of PSIs had been driven underground with therapy being offered secretly, in effect they had become black market therapies.

The psychiatrist's role was defined as medical, and subject to pressure from colleagues to fulfil duties of patient review and medication treatment. An understanding that they could offer one patient psychotherapy was seen by the participant as being a fortunate position not afforded to other clinicians because of their designation.

For the participants with masters' level psychology backgrounds and a qualification in IPT, 'role' was a particular issue. Their psychology training had not included any clinical practice and they were not able to register with a professionally affiliated body. The lack of affiliation was seen as a barrier to practice and these participants found that they were not funded to offer PSIs rather the role of those trained in psychology was task defined and included goal planning and welfare benefit issues. Offering PSIs was seen as the role of social workers alone.

Across this group participants reported that some roles were perceived by other disciplines to be unsuited to therapy work, or their colleagues were concerned that therapy would take them away from the core tasks designated to their roles.

Mathers (2012) looked at roles within mental health inpatient units and found work defined roles created barriers to therapeutic involvement that included pressures of time, comprehensive and wide ranging roles, duties unrelated to therapeutic involvement with patients, and the perception that PSIs were hit and miss and seen as a luxury.

Smith (2010) completed an analysis of narratives of Solution Focused Therapy (SFT) students, and found that participants reported significant changes in relationships with clients and increased professional confidence and enthusiasm following training. Smith suggested that substantive training in SFT may enhance professional role and cultural identity of the therapist. Brooker et al. (1999) suggests good staff morale is critical for effective role functioning. Whilst it is accepted that training assists confidence and development of therapist identity, it is the implementation of this training into routine practice that has been a problem for participants working in areas where PSIs are not routinely offered.

The findings from this study suggest that IPT is most successfully implemented in care settings that operate with minimal role definition. This concept may be a step too far for care settings that have established very clear role definitions, particularly in inpatient settings. However some literature suggests an alternative approach, by defining an autonomous psychiatric nurse role that promotes the 'nurse therapist'. Littlejohn (2003) conducted a study to determine whether psychiatric nursing can exist autonomously. In this study Littlejohn describes the medical model of mental distress (the result of largely medical conditions), and the psychological model of mental distress (determining disorder as arising from a change in the normal brain, resulting from the way an individual thinks about an experience). In this debate Littlejohn called for a new paradigm for psychiatric nurses, conceptualising an autonomous discipline rather than being attached to, or aiding the disciplines of psychology and psychiatry. This recommendation appears to reach back to specialist psychiatric nurse training based on therapeutic interventions. Peplau's (1952) theory of interpersonal relations in nursing defined the purpose of nursing as being to help others identify their felt needs, and understand and integrate the meaning of their life into the here and now.

Hurley (2010) also calls for the promotion of nurses in the context of talking therapies in order to assist recognition of the value of nurse practice as an autonomous profession, rather than identifying with psychology or counselling professions. Hurley (2010) concluded that it is no longer a question of whether nurses should practice therapy, but rather one of how to best implement therapy in challenging environments, and that nurse leaders may need to consider how to respond to, and support mental health nurses who return to their care setting after specialist therapy training. Although the barriers created by role definition are not solely a problem reported by nurses, nurses constitute a high proportion of the mental health workforce, and a change in clinical practice roles for such a large body of clinicians could have implications for practice across mental health services.

CONCLUSION

Research both internationally and in New Zealand shows that IPT is an effective treatment for depression and other mental health issues. In line with international guidelines the Ministry of Health are calling for increased access to talking therapies and have been explicit that mental health clinicians are ideally placed to offer psychotherapeutic interventions. IPT is one of the few recommended evidence based talking therapies included in the guidelines for implementation throughout the New Zealand mental health system. However, this study concurs with international research pointing to the variable uptake of talking therapies following formal training.

The findings from this study suggest there are complex and overlapping factors that influence the uptake and continuing practice of IPT by frontline clinicians following formal training. Three factors were highlighted as: a. prior training, b. team involvement and c. interdisciplinary role definition:-

- a. It was established that the therapists who went on to implement IPT into clinical practice had completed core and post graduate clinical training in settings that incorporated a biopsychosocial model. Characteristics of

successful care settings for training were identified as those that supported evidence based psychological interventions as routine practice, had available of multi-disciplinary peer support available to trainees, and had clinical supervision offered by senior clinicians during and following training.

- b. The implementation and continuing practice of IPT was facilitated in care settings that routinely practiced a therapeutic treatment model and where there was evidence of a supportive functioning multi-disciplinary team committed to the practice of PSIs. The introduction of IPT was well received in a clinical environment that encouraged a sharing of knowledge, where there was dialogue across disciplines, where roles were only minimally defined and in settings where ongoing supervision with senior clinicians and peer support was readily available during day to day clinical practice.

- c. Continuing practice of IPT was successful in care settings where contemporary interdisciplinary role definition prioritised clinician's expertise, and the 'role' of therapists was embraced through peer support, and ongoing interdisciplinary supervision by senior clinicians offered credibility to clinicians practicing therapy. Barriers to implementation of IPT were identified in care settings that promoted a medical model of assessment and pharmaceutical treatment. Uncertainty of role was identified as a major limiting factor in these settings. Complex task orientated roles included workforce planning, and the prioritization of the organisational needs of the clinical environment. The perception that PSIs were a luxury was explained as being due to a lack of time. In these settings the provision of talking therapies was seen as being limited by disciplinary role rather than a lack of expertise.

LIMITATIONS OF THE RESEARCH

Limitations of the research include a lack of prior studies on the dissemination and implementation of IPT to specifically provide a New Zealand context with which to build upon and guide the enquiry. In addition the size of the study and the extent of enquiry were limited by the resources available to a master's level study. Acknowledging and working within these limitations, this study concentrated on four areas of enquiry: prior training, prior clinical experience, team involvement and role perception. Other variables of patient complexity, service provision and therapist competency were not considered and may be areas for future research.

The enquiry was developed out of the professional interest of the researcher as a practicing IPT therapist working in a mental health service that does not offer PSIs as part of routine treatment. The researcher completed IPT training at the same University, and worked for the same organisation as some of the participant's, and was therefore known to some of the participants prior to the commencement of the research study. Although the potential for bias was acknowledged and addressed throughout the study through the application of transparent and rigorous IPA processes and was identified as a focus in supervision, the issue of social desirability bias was not factored into the research process and the use of a social desirability scale (Stoeber, 2001) may have provided valuable data.

The researcher acknowledged that there was a propensity for her to fill pauses in the participants' narratives with personal opinions and assumptions particularly in the first two interviews. Supervision and reflection at the time of data analysis was used to improve the researcher's interview technique and identify data that may have been elicited by leading questions. However this is acknowledged as a limitation of the research conducted by a novice researcher.

POTENTIAL FOR FUTURE RESEARCH AND PRACTICE INITIATIVES

Training: The findings from the present study suggest that further development in the area of core multi-disciplinary training in the implementation of talking therapies into routine practice, may increase both individual and team confidence to practice.

Team Involvement: The researcher suggests that a forum of educators, service leaders, clinical leaders, and well trained and motivated clinicians may assist the development of initiatives to aid the implementation and dissemination of IPT for teams that do not routinely practice PSIs. An example of such an initiative would be a programme of short education sessions across mental health teams that demonstrates the potential for the training and routine practice of IPT.

Collaboration between the university providing IPT training, and the organisations that fund and release clinicians to attend training in PSIs would be ideally suited to instigate such a process.

Role definition: Care settings where role definition was not identified as a barrier were characterised by affirming multi-disciplinary teams, where the availability of senior clinicians to provide ongoing supervision was highlighted as an invaluable support. It is accepted that supervision is recognised as crucial to successful therapy training, however there may be potential for further role development through the implementation of formally recognised IPT supervision into routine practice. It is suggested that in addition to ongoing practice development, formally integrated IPT supervision may have the potential to increase confidence in clinicians as they adopt therapy roles. There may be potential for negotiation between an IPT training institution and mental health service planning and funding managers of to develop a training and supervision programme as a joint venture.

In clinical settings where PSIs were not routinely practiced nurses described a reluctance to 'give voice' to their use of IPT. This concept of IPT or IPT strategies being offered to clients without full knowledge and support of the MDT

was worthy of further investigation but was beyond the resources of this small study, however this is an area for potential future research.

This study has provided a unique perspective into the uptake and continuing practice of a short term evidenced based psychotherapy after formal training and provides insights into the experiences of clinicians before and after this process. The qualitative nature of the study encompassed a valuable breadth and depth of understanding. It brought together and supported the existing literature pertinent to the research questions. Regrettably the results suggest that despite Ministry of Health recommendations for promoting psychological treatments such as IPT and the clear availability of quality training, barriers to practice remain.

A collaborative multi-disciplinary approach to support training and the provision of supervision at a practice level may serve to increase the availability of IPT in the New Zealand mental health service. The question remains with regard to the attitudes, resources and support services that are available to advance this.

APPENDIX I : PATIENT HANDOUT - INTRODUCTION TO INTERPERSONAL PSYCHOTHERAPY

Introducing Interpersonal Psychotherapy (IPT)

Evidence from randomized controlled trials indicates that IPT is an effective treatment for depression. It can be used either as a stand-alone treatment, or alongside medication.

IPT works on the premise that the depression you are experiencing is linked to events and/or relationships within your interpersonal world. And that discovering more about your interpersonal relationships and how you might work to improve them or better cope within them, will improve your mood, reduce your symptoms, and help you to feel better.

The issues that IPT may examine fall into 4 categories:

1. Grief. Although grief can be the response to any form of loss, it often relates to the death of someone close to you.
2. Role disputes. This is as it sounds - arguments, communication problems and poor relationships with one or more significant people in your life.
3. Role transition. The experience of moving from one role in your life to another, e.g. retirement, childbirth, moving house, entering/leaving a relationship or changing jobs.
4. Social Isolation. This relates to feelings of isolation, limited social supports and difficulties in forming or maintaining relationships.

It is possible you may need to work on one or more of these areas.

The treatment is time limited. You are likely to require 12 -16 sessions of 50 minutes. The time and frequency of the sessions can be negotiated with your therapist. Towards end of this time it is expected that you will be beginning to recover. Follow up can then be arranged with three or six monthly sessions. Research has also shown that during this maintenance period symptoms often continue to improve.

IPT consists of 3 phases:

After explanation of treatment, the first phase, lasting three to four sessions will be an exploration of your interpersonal world, focusing on the here and now. Although some significant past events may require some examination, most of the work will be looking at your recent life and people who are important to you now. During this phase functioning within your interpersonal world will be related to the severity of your mood symptoms.

The second phase is a closer examination of your relationships, what changes you may wish to make to improve them. During this time you will have the opportunity to try out the things you have worked on in therapy. You will also have the opportunity to examine and recognise how these changes might affect your mood symptoms.

The third phase will be working towards concluding your therapy and reviewing your progress. At this time any necessary follow up sessions can be arranged.

Reference: Weissman, M, M., Markowitz, J, C., Klerman, G.L. (2000). *Comprehensive Guide to Interpersonal Psychotherapy*. New York: Basic Books.

APPENDIX II: LITERATURE REVIEW FRAMEWORK

Factors that influence the uptake and continuing practice of Interpersonal Psychotherapy by frontline mental health clinicians following formal training.

RESEARCH QUESTIONS

Questions Guiding Enquiry:

1. Is previous training a predictor for incorporating IPT into clinical practice?
2. Does pre-training clinical experience influence the post training practice of IPT by clinicians?
3. What are the characteristics of services which operate to enhance talking therapy provision and enable clinical staff to practice their discipline?
4. What are the participants' positive and negative experiences of introducing IPT into clinical practice?
5. Is role perception a factor in the implementation and dissemination of psychological interventions into mental health services?

LITERATURE REVIEW METHOD

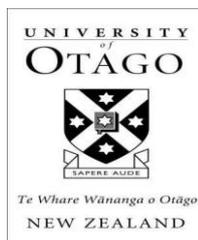
1. Develop framework to define questions/searches/exclusions
2. Search:
 - Journals from Otago University and Canterbury Medical Libraries
 - National and international health service websites
 - Collection of articles from researcher's library

- Collection of articles serendipitously acquired
 - Google scholar
3. Set up database alerts for newly published articles of interest
 4. Read abstracts of all resultant articles
 5. Select possible articles and scan read
 6. Print articles of interest - must be relevant
 7. Create article data base including all articles worthy of printing
 8. Create reference list, transferring all references as they are included into thesis
 9. Review of selected articles:
 - Search and review citations of interest from within each article
 - Mark areas of significance with colour coding system:
 10. Identify any unexpected themes
 11. Repeat searches as research progressed

LITERATURE REVIEW FRAMEWORK

Question	Search rationale	Keywords	Codes
Background to Research	To identify seminal works, theoretical underpinnings that inform professional standards, and national and international guidelines for practice. Search past and current research in this area, ministry of health guidelines and workforce development strategic planning	Interpersonal Psychotherapy Clinical practice Evidence based practice Talking therapies Patient outcomes Mental health Psychological interventions	Yellow
Is previous training a predictor for incorporating IPT into clinical practice?	To address this question search for studies that: outline training prerequisites and follow up clinician's in clinical practice. This may be included as a by-product in studies that train clinicians in IPT for : <ul style="list-style-type: none"> • A pilot introducing IPT into clinical practice • A pilot adaptation of IPT • A feasibility study where clinicians have trained and then incorporated training into practice. • A study of therapist training and competence. 	Interpersonal Psychotherapy Training Pilot Community Feasibility Therapist competence	Pink
Does pre-training clinical experience influence the post training practice of IPT by clinicians?	For this question relevant findings are likely to come from similar studies to above.	Interpersonal Psychotherapy Training Pilot Community Feasibility Therapist competence Clinician experience	Red
What are the characteristics of services which operate to enhance talking therapy provision and enable clinical staff to practice their discipline?	Successful introduction of IPT into service provision is likely to be highlighted in community pilot/feasibility studies and studies which investigate the efficacy and cost effectiveness of incorporating psychological interventions into routine practice.	Interpersonal Psychotherapy Training Pilot Community Feasibility Therapist competence Clinical experience Cost effectiveness	Blue
What are the trainee therapist's positive and negative experiences of introducing IPT into their clinical practice?	Narratives of the clinician's experiences are likely to be embedded into pilot/feasibility studies as noted above.	Interpersonal Psychotherapy Training Pilot Community Feasibility Therapist competence Clinical experience	Green
Is role perception a factor in the implementation/ dissemination of PSIs	An additional area of enquiry highlighted in the interview data	Interpersonal Psychotherapy PSIs Nurses/Social Workers Psychologists/Psychiatrists Occupational Therapists	Orange

APPENDIX III : INFORMATION SHEET FOR PARTICIPANTS



Factors that influence the uptake and continuing practice of Interpersonal Psychotherapy by frontline mental health clinicians following formal training

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

Aim of this study

To identify factors that influence the uptake and continuing practice of Interpersonal Psychotherapy by frontline mental health clinicians following formal training.

This qualitative study will collect demographic data for three cohorts of students who graduated from the Otago University Postgraduate Interpersonal Psychotherapy Certificate of Competence programme over the last six years, conduct a recorded interview with each of the students to determine the extent to which they use IPT in clinical practice, and investigate the factors which may influence the transfer of knowledge into practice.

This project is being undertaken as part of the requirements for the Master of Health Science course PSME5H.

What Type of Participants are being sought?

Past students from of Otago University IPT Certificate of Competence training programmes will be invited to participate. The initial approach to potential participants will be an invitation to participate, sent out by the university course administrator. Potential participants who agree to contact details being forwarded to the researcher will then complete a process of providing informed consent to participate in the study.

What will Participants be Asked to Do?

Participants who agree to take part in this project will be contacted by the research student by email or telephone to arrange a mutually convenient time and place to conduct the interview. At the agreed time the research student will make contact to conduct a recorded interview which will take approximately 60 minutes.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

What Data or Information will be Collected and What Use will be Made of it?

Participants will be asked some pre-determined questions and will also be encouraged with open ended questions to describe their prior training and clinical experience, the strengths and barriers of service management, and their own experience when introducing IPT into clinical practice. The interviewer will ask for specific examples or anecdotes illustrating their experience, to provide context to the interview and support to the emerging themes.

Questions will also be reframed as statements for participants to rate using a five-point Likert item and will be collated and presented in graph form to offer validation to the narrative.

One Note software will be used to identify key words from recorded interviews. The emerging themes will be tabled and coded, then re-read until all data is collected and a narrative of understanding of the participants experience is achieved. Data will be written as an interpretive narrative and will be illustrated by anecdotal examples.

The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. At the end of the project any personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project

depend will be retained in secure storage for five years, after which it will be destroyed.

The research student and her supervisors will be the only people to have access to raw data as described above.

The collated data will be used as part of a Master of Health Science Thesis. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

At the end of the research process participants will be invited to a presentation of the research with opportunity for discussion and a luncheon will be provided in the spirit of reciprocity.

This project involves an open-questioning technique. The general line of questioning includes:

1. Structured questions to gather demographic data describing clinician's professional discipline, prior experience and training.
2. Participants will be asked some pre-determined questions and will also be encouraged with open ended questions to describe their prior training and clinical experience; their own experience when introducing IPT into clinical practice and the strengths and barriers of service operation. The interviewer will ask for specific examples or anecdotes illustrating their experience, to provide context to the interview and support to the emerging themes.

Questions about:

3. Pre training education
4. Prior clinical experience
5. Introducing IPT into routine practice
6. Organisational systems

will also be reframed as statements for participants to rate using a five point Likert-style items to validate data obtained in the open ended interviews questions.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

This proposal has been reviewed and approved by the Department of Psychological Medicine Ethics, University of Otago.

Can Participants Change their Mind and Withdraw from the Project?

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Dawn Nolan	and/or	Sue Luty or Dave Carlyle
Department of Psychological Medicine		Department of Psychological Medicine

University Telephone No. 03 3720400

University Telephone No. 03 3720400

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Factors that influence the uptake and continuing practice of Interpersonal Psychotherapy by frontline mental health clinicians following formal training

This study has been approved by the Department stated above. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479-8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

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Te Whare Wānanga o Otago

Dear Colleague

Having been a past student of the PSMX Interpersonal Psychotherapy Course through the Department of Psychological Medicine, at the University of Otago, Christchurch, and then introducing Interpersonal Psychotherapy into my clinical work, I am now working on a research project to examine the experiences my fellow clinician's have had since completing the course.

I would like to invite you to participate in this research project and enclose an information to participants sheet.

Should you wish to take part, or know more about my project my contact details are below.

Kind regards

Dawn Nolan

Dawn Nolan

Home Telephone: 03 3133267

Work Telephone: 03 3391109

Email: nolda242@student.otago.ac.nz

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APPENDIX V: PARTICIPANTS CONSENT FORM

Factors that influence the uptake and continuing practice of Interpersonal Psychotherapy by frontline mental health clinicians following formal training

CONSENT FORM FOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information on audio tapes will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years.
4. This project involves an open-questioning technique. The general line of questioning includes: describing prior training and clinical experience; personal experiences when introducing IPT into clinical practice and the strengths and barriers of service operation. The interviewer will ask for specific examples or anecdotes illustrating experience, to provide context to the interview.

The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops and that in the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

7. The results of the project may be published and available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity.

I agree to take part in this project.

.....
(Signature of participant)

.....
(Date)

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APPENDIX VI: DEMOGRAPHIC QUESTIONNAIRE

Factors that influence the uptake and continuing practice of Interpersonal Psychotherapy by frontline mental health clinicians following formal training

Demographic Data

Gender	
Age range	
Location	
Discipline	
Primary Qualification Prior to completing IPT Training	
Primary Qualification Institution	
Additional Qualifications Prior to completing IPT Training	
Additional Qualifications Institutes	
Year IPT Certificate of Competence Completed	

APPENDIX VII: INTERVIEW SCHEDULE

Factors that influence the uptake and continuing practice of Interpersonal Psychotherapy by frontline mental health clinicians following formal training

Questions guiding enquiry:-

- Is previous training a predictor for incorporating IPT into clinical practice?
- Does pre-training clinical experience influence the post training practice of IPT by clinicians?
- What are the characteristics of services which operate to enhance talking therapy provision and enable clinical staff to practice their discipline?
- What are the trainee therapist's positive and negative experiences of introducing IPT into their clinical practice?

Questions to the research	Interview question guide	Notes
<p>Is previous training a predictor for incorporating IPT into clinical practice?</p>	<p>These questions relate to your training prior to commencing your IPT training:-</p> <p>Can you tell me about your training programme?</p> <p>During this training programme what training did you receive in:</p> <ul style="list-style-type: none"> • Assessment/developing a formulation within a biopsychosocial model • Advanced communication/therapy skills • What was the weighting given to theory and clinical practice component? • What was the arrangement for supervised cases? • Was there anything else about this training that may have influence your decision to practise IPT? <p>Can you tell me about your professional development following primary training but prior to commencing your IPT training?</p> <p>For each clinically relevant training programme undertaken I would like to repeat the discussion about your primary qualification</p>	

<p>Does pre-training clinical experience influence the post training practice of IPT by clinicians?</p>	<p>I would now like to talk about your clinical practice prior to commencing your IPT training:-</p> <p>How long were you in clinical practice prior to commencing IPT training? What were your areas of clinical practice prior to IPT training?</p> <p>In each of those clinical areas:-</p> <ul style="list-style-type: none"> • To what extent were psychological interventions a focus of treatment? • What experience did you have of using a biopsychosocial formulation model? • What opportunities were available to you to implement talking therapy as an intervention? • How did you use the MDT/Peer review process to review therapy patients? • What clinical supervision did you have to work specifically on you therapy cases? • Are there any other factors about your clinical experience that may have influenced your decision to practise IPT? 	
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<p>What are the characteristics of services which operate to enhance talking therapy provision and enable clinical staff to practice their discipline?</p>	<p>We are now going to talk about the team/work environments you have worked in since completing your IPT training.</p> <p>Where have you been working since completing your IPT training?</p> <p>I would like discuss each of the places you have worked:-</p> <ul style="list-style-type: none"> • What model does the team/service operate under i.e. counselling service, case management, or outreach? • What is the core business of that team/service i.e. client group/treatments/expected outcomes? • What is the philosophy of the clinical/service head in relation to treatment provision? • What is the culture/flexibility of the team in relation to implementing a treatment such as a talking therapy? • Is there an infrastructure/forum in place for workplace planning where you could introduce IPT? • How would you describe the peer support you might expect in relation to talking therapies? • What is the team mix: <ul style="list-style-type: none"> Disciplines? Level of practice? • How would you describe the support in terms of approval and encouragement, flexibility, and resources you might expect from: <ul style="list-style-type: none"> a. Managers? b. Clinical leaders? c. Team members? • What access do you have to professional leaders/mentors? • What access do you have to Clinical Supervision specific to IPT? • Did you attempt to introduce IPT/ipt into clinical practice? • And what happened? 	
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<p>What are the trainee therapist's positive and negative experiences of introducing IPT into their clinical practice?</p>	<p>I would like to discuss each of the workplaces where you attempted to introduce IPT into your practise:</p> <p>Looking at the availability of clients:</p> <ul style="list-style-type: none"> • Did service criteria allow for talking therapies? • What was the source and type of referral? • What was range of clinical diagnoses or problem areas? • What was level of unwellness, ie acute, functional gain, maintenance, none? • What was the suitability of clients for: <ul style="list-style-type: none"> a) The IPT model? b) The level therapist experience ie novice, intermediate or advanced? • What was the extent of your client's previous experiences of therapy? • How did they describe previous therapy in terms of positive or negative experiences? • How did you manage the introduction of IPT and the informed consent process? • What arrangements/logistics were available for therapy: <ul style="list-style-type: none"> Place? Frequency of sessions? Travel involved? Childcare etc? • As a therapist were you required to take on any dual roles i.e case management? • How would you describe your experience of: <ul style="list-style-type: none"> Supervision? MDT processes? • Did you use IPT or ipt and why? • Do you think this worked for you? • Why? And what if anything would you change? <p>To round up what changes would you like to see that may help you to use your IPT skills in your clinical setting?</p>	
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