ORIGINAL ARTICLE

WILEY

Exploring which aspects of a low-intensity CBT intervention were found to contribute to a successful outcome from the service user point of view: A mixed methods study

Miles Thompson[1] 🆔 | Holly Parker[2] | Jodie Cave[2]

[1]Psychological Sciences Research Group (PSRG), Department of Social Sciences, University of the West of England (UWE Bristol), Bristol, UK

[2]Department of Social Sciences, University of the West of England (UWE Bristol), Bristol, UK

Correspondence
Dr Miles Thompson, Address: Room 3A028. University of the West of England (UWE), Frenchay Campus, Coldharbour Lane, BRISTOL, BS16 1QY, UK.
Email: miles@mvdct.co.uk

Abstract

The broad area of psychotherapy research is sometimes subdivided into that which focuses on outcome and that which focuses on process. Research into the active processes of psychotherapy can sometimes be occupied with debates around common versus specific factors. At the same time, within the process literature there has been increasing focus on the qualitative accounts of the service user in therapy and what they found to be significant or useful to them. The aim of this mixed methods study was twofold: first, to identify what elements of a relatively brief CBT intervention contributed to a successful outcome from the point of view of the service user. Participants were recruited at a low-intensity Improving Access to Psychological Therapy (IAPT) service in the UK; and second, to attempt to frame those results within the common versus specific factor framework. Eight participants (5 males and 3 females) took part in this mixed methods research, which used semi-structured interviews analysed using thematic analysis and brief quantitative questionnaire completion. Five overarching qualitative themes were identified in the data: three relating to common factors ('Insight', 'Talking' and 'Therapist qualities'); and two relating to specific factors ('Responding differently to thoughts and feelings' and 'Tasks/activities'). Importantly, all participants spoke about the importance of both common and specific factors. The discussion relates the findings back to existing research, highlighting the relative importance of insight within the data set and the participant led focus on talking. Future directions are discussed.

KEYWORDS
common and specific factors, Improving Access to Psychological Therapy (IAPT), low-intensity CBT, mixed methods, process research

1 | INTRODUCTION

The aim of this mixed methods study was to explore what elements of a brief, low-intensity therapy clients, who had a positive experience of that therapy, perceive as contributing to their therapeutic outcome. The reason for conducting this study stems from two distinct but related areas in the psychotherapy literature: i. outcome v. process research; and ii. common v. specific factors. Both areas will be briefly outlined below before returning to the specific participants and research question associated with this research.

1.1 | Outcome v. process research

'Outcome research' typically examines 'if' interventions work. Often, research of this kind uses outcome measures, such as questionnaires, to identify whether significant improvements have taken place pre and post the intervention (Knobloch-Fedders et al., 2015). Sometimes, outcome research seeks to add rigour by randomising individuals to treatment arms and by comparing treatment groups with other active interventions or to control groups, such as those on a waiting list (i.e. randomised control trials, RCTs).

'Process research', on the other hand, examines 'how' interventions work. It is interested in 'what' about an intervention contributes to its success. In other words, what is the active ingredient or ingredients that contribute to successful experiences. The aim in process research is to pinpoint or explore the critical processes of change that occur during interventions.

Of course, outcome research and process research are related. With its focus on what enables or drives therapeutic change, one aim of process research is to improve the quality of therapy (Hardy & Llewelyn, 2015). By understanding what aspects are most important in facilitating change, we can then emphasise or develop these aspects to improve treatment outcomes. In other words, process research has the potential to help researchers improve the experience and outcomes of psychological interventions for service users.

1.2 | Common v. specific factors

A debate within process research is between 'common' and 'specific' factors. Common factors are argued to be variables found commonly across all psychotherapies (Wampold, 1997, 2015) and include factors such as the patient-provider (Vowles & Thompson, 2012) or therapeutic relationship. Since at least Rosenzweig in 1936, there has been the suggestion that core ingredients such as these are responsible for positive outcome (Ahn & Wampold, 2001; Messer & Wampold, 2002; Tschacher et al., 2014). On the other hand, some argue for the importance of specific factors, that is those that are unique to certain approaches (Chambless & Ollendick, 2001), for example techniques that are only found in cognitive behavioural therapy (CBT).

Implications for practice and policy

- The paper details mixed methods process-focused research examining which aspects of a low-intensity CBT intervention were found to contribute to a successful outcome from the service user point of view.
- The study was guided by the common and specific factor framework. All participants highlighted both common and specific factors, suggesting the importance of both to service users.
- 'Common' qualitative themes emphasised the importance of 'Talking' - service users being able to talk things through. Simple as this sounds, having the space to do this may be limited within some IAPT services.
- This research suggests the continued value of undertaking process research, including within low-intensity CBT services that are currently commonplace in the UK.

Taking CBT as an example, numerous RCTs and other studies have found CBT techniques to be an efficacious treatment (effect sizes of 0.75 and 0.85; Butler et al., 2006; Lambert & Ogles, 2004). But, at the same time, some studies suggest that improvements in CBT seem relatively unrelated to the application of CBT techniques or changing cognitions (Jacobson et al., 1996; Jones & Pulos, 1993; Longmore & Worrell, 2007). Indeed, Kazdin (2007, 2009) has noted: 'perhaps we can state more confidently now than before that whatever may be the basis of changes with CT [Cognitive Therapy], it does not seem to be the cognitions as originally proposed' (Kazdin, 2007, p. 7).

Debate and research around common v. specific factors has been 'long-standing and heated' (Levitt et al., 2016, p. 801). Arguably, it has also produced mixed results. While some researchers have cast doubt on the role of specific factors (Ahn & Wampold, 2001; Luborsky et al., 2002), others have argued that common factors, such as the therapeutic alliance, cannot be asserted to be the primary cause of therapeutic change (Blackledge et al., 2009).

Looking at the potential role of one common factor, the patient-provider relationship, there have been at least three meta-analyses that have explored the influence of this relationship on outcomes (i.e. Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000). Effect size values from these meta-analyses have been remarkably consistent with their range from $r = 0.22$ to 0.28. At the same time, the magnitude of these effect sizes only lies at the upper range of a small effect size (0.1 = small, 0.3 = medium and 0.5 = large) and so explains only between about 5% and 8% of the variance in treatment outcome (Vowles & Thompson, 2012). This leaves many areas unexplored or less explored.

It should also be noted that some have argued that the common v. specific factor debate is based on a false distinction. Specifically, specific ingredients cannot be delivered without common factors such as the patient-provider relationship (Wampold & Budge, 2012).

Moreover, it seems possible that some of the inconsistent findings reported in the literature simply indicate that the common and specific factors have a reciprocal relationship (Owen et al., 2013).

The brief survey of the literature above highlights the continuing ambiguity around which factors or processes contribute to positive outcomes. With the above literature in mind, this research aims to do two things:

i. To move beyond one side or the other of the common versus specific factor debate, and to collect open process data where contributions from both sides can be freely gathered.

ii. To gather these data in a way that is led by the clients themselves, rather than bounded by the interests of researchers.

The research agenda just described is not entirely new, just new in comparison with the wider research pathways described above (outcome v. process, common v. specific factors). Researchers are increasingly beginning to look at how clients experience therapy. For example, Timulak first conducted a review in 2007 of seven qualitative studies focused on 'helpful processes' in therapy. Then, in 2010, Timulak reviewed 41 studies focused on 'significant moments in therapy'. Following this, in 2013, Timulak and McElvaney reviewed seven studies that explored clients' views of insight events in therapy. Even more recently, Levitt et al. (2016) conducted a meta-syntheses of 109 qualitative studies examining clients' experiences of psychotherapy. In that review, they note both how the client has been forgotten in the past and how 'it is time for a new agenda' (p. 824), which focuses on the client voice. Of course, adopting this client-centred approach reflects some of the contemporary values of NHS research, where one focus is on the clients' experiences and their perceptions of treatment (Mockford et al., 2012). In response to this background literature, the current mixed methods study aims to collect data from service users, which explores their perceptions of the reasons for their successful experience of, in this instance, a brief, low-intensity IAPT CBT treatment programme.

The English Improving Access to Psychological Therapies (IAPT) scheme seeks to make cost-efficient, evidence-based mental health services more available within the NHS (National Health Service; see Clark, 2011; Layard, 2006; Layard et al., 2007). IAPT divides into high-intensity and low-intensity pathways, with low-intensity services tending to work with service users with mental health issues such as anxiety and depression, not those who are in crisis or experiencing suicidal thoughts or behaviour. Low-intensity interventions tend to be manualised, CBT-based and are often delivered by psychological wellbeing practitioners individually by phone or face to face in group formats. Evidence of patient satisfaction from the early demonstration IAPT sites exists (Hamilton et al., 2011; Hann et al., 2015; de Lusignan et al., 2013; Parry et al., 2011). However, IAPT is also widely criticised for multiple reasons, including offering only a limited number of, often short, sessions and those sessions having a tendency to be manualised (Binnie, 2015; Hamilton et al., 2011; Turner et al., 2018; Williams, 2015). These criticisms notwithstanding, locating this research within an IAPT service allows us to understand participant perceptions of what contributed to successful interventions even within low-intensity settings.

In sum, this process-focused research will explore service user perceptions of the factors which contributed to the success of their interventions. Very deliberately, the research will focus on initially being as open as possible so as not to lead or direct the participants' responses. Related to the literature above, we will try to frame the results within the common v. specific factor framework.

2 | METHOD

2.1 | Design

This study adopts a mixed methods approach, utilising predominantly qualitative techniques. Applying mixed methods terminology, this study can be described as an explanatory sequential design (Qual → Quant → Qual; Tembo, 2014). In other words, sequential data collection (Creamer, 2018) was performed in three stages: qualitative data was collected first (stage 1), then quantitative data providing a space to check on those results (stage 2), before concluding with more qualitative data to allow participants to expand on their responses (stage 3). More specifically, semi-structured interviews were performed in stage 1, followed by questionnaire completion (stage 2), before concluding with further semi-structured interview questions (stage 3). The integration of these results will take place within the discussion, not the results section (i.e. 'independent' not 'interactive' strands; Tembo, 2014).

2.2 | Ethics, study location, participants and procedure

The faculty research and ethics committee at the host institution provided ethical approval for this study. Participants were recruited from a local low-intensity IAPT service in Bristol delivering CBT where JC was volunteering. Only former clients of the service who had both successfully completed eight or more weeks of individual CBT and granted permission to be contacted again were initially approached with an information sheet. For the purposes of this study, 'successful completion' was determined by expressing satisfaction with an end of service questionnaire and low scores on the Generalised Anxiety Disorder (GAD-7; Spitzer et al., 2006) and Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001). These measures were administered in advance by the service and did not form part of this study; however, participants would have initially had scores at least above 10/27 on the PHQ-9 and/or 8/21 on the GAD-7 in order to have been seen by the service (National Collaborating Centre for Mental Health, 2020).

The sample includes eight former patients (5 males and 3 females) aged between 24 and 65 years. Three participants completed the stages of the study in a private office at the service; five over the telephone. In the results below, all participants are referred to using pseudonyms.

In terms of the main data collection procedure, there were three stages. In stage 1, open-ended interview questions asked about why

the participant attended therapy, what positive changes the participant had noticed, and (the focus for this research) i. from their point of view, what aspects of therapy helped the participant make these positive changes and ii. which specific aspect they felt was most important. In stage 2, participants rated 19 potential contributors to psychological interventions, such as the therapeutic relationship and homework, in terms of the contribution they felt each had made to their improvements. From this list of 19 potential contributors, participants were then asked to select the item or items that they felt contributed the most to any positive changes. Finally, in stage 3, participants answered further semi-structured questions regarding what single items on the questionnaire they felt were most important to them and whether these were the same as they had highlighted in stage 1. Very simply, stages 2 and 3 allowed participants to consider a potentially wider range of topics and contrast those with their initial open responses from stage 1.

The qualitative data were analysed using thematic analysis (TA; Braun & Clarke, 2006). TA involves 'searching across a data set… to find repeated patterns of meaning' (p. 86). The six phases of TA were followed, namely (a) transcribing the data set, (b) familiarising oneself with the data set, (c) initial coding, (d) searching for themes, (e) reviewing and refining themes and (f) reporting the analysis (Braun & Clarke, 2006). Inductive analysis (led by the data) with semantic themes (explicit rather than interpretative) will be used (p. 83–84), although, as noted, we will explicitly be trying to place the themes within a common v. specific context. The quantitative data are presented using simple descriptive statistics.

3 | RESULTS

In stage 1, participants spoke about a range of interrelated factors playing a role in their recovery as they saw it. As noted, we will discuss them below in relation to the common and specific framework. Basic descriptive statistics provide information about the prevalence of themes and theme components (i.e. count). Themes will generally be discussed starting with the most prominent based on number of participants and comments. Due to word constraints, any theme commented on by fewer than four participants (50% of the sample) will not be discussed in detail, but can still be seen in the Table 1 below. [Corrections made on 21 June 2021, after first online publication: Table 1 is now cited in the preceding statement.]

First, themes that relate most closely to common factors will be discussed, followed by themes that relate to specific factors. Under common factors, themes include *'Insight'*, *'Talking'* and *'Therapist qualities'*, and under specific factors, themes include *'Responding differently to thoughts and feelings'* and *'Tasks/activities'*. For each, quotes are used to expand on participant perspectives.

3.1 | Common factors

Common factors are not specific to any one psychotherapy (Wampold, 1997). Three overarching themes, *'Insight'*, *'Talking'* and *'Therapist qualities'*, were identified as being related to common factors.

3.2 | Overarching theme: Insight (7 participants, 25 comments)

The most mentioned theme across the entire data set was *'Insight'*. Here, participants discussed the importance of gaining new insight(s) as being an important part of their journey. These new understandings might be about their *'Condition'* (7 participants), for example in terms of psychoeducation about their presenting problem or the interrelationship between thoughts, feelings and actions. Another level of insight was related to *'Past-experience'* (2 participants), which is simply insight into how past experiences impacted on the present. As this theme was only highlighted by two participants, this theme will not be discussed below.

3.3 | Mid-level theme: Into condition (7 participants, 21 comments)

Participants stated that they found it helpful to gain knowledge, information or an explanation about what they were experiencing and why. Learning more about why things had or were happening seemed to help participants move forward.

> it was a very enlightening, revelatory experience for me because no one had ever taught me how – how the mind works, actually
>
> (Adam).

> she made me realise that I'm not on my own, that it's very common, and actually most people feel this way
>
> (Claire).

Through gaining an understanding of their condition, some participants recognised that some of their issues were relatively common and they were not at fault or unusual for experiencing them. Participants became more able to make sense of why they behaved and thought in particular ways, and being aware of this helped them move towards positive change.

3.4 | Overarching theme: Talking (5 participants, 18 comments)

Here, participants described the importance of talking through their issues. The overarching theme will be discussed in relation to two mid-level themes: *'The importance of talking'* (5 participants) and *'Aspects of the therapist enabling talking'* (4 participants).

3.5 | Mid-level theme: The importance of talking (5 participants, 9 comments)

Here, simply but frequently, participants noted the importance of talking through their issues - the necessity of talking. For example:

TABLE 1 Factor type, overarching and mid-level themes

Factor type	Overarching theme	Mid-level theme
Common factors (8p, 59c)	Insight (7p, 25c)	Into condition (7p, 21c)
		Into past experiences (2p, 3c)
	Talking (5p, 18c)	The importance of talking (5p, 9c)
		Aspects of the therapist enabling talking (5p, 9c)
	Therapist qualities (5p, 15c)	As a person (5p, 9c)
		As a professional (5p, 6c)
Specific factors (8p, 36c)	Responding differently to thoughts and feelings (8p, 22c)	Worry tree (4p, 13c)
	Tasks/activities (4p, 14c)	In session/homework (4p, 7c)
		Using mindfulness and relaxation techniques (4 p, 7c)

Note: p = participants, c = comments. Themes in italics refer to smaller subthemes, commented on by less than 50% of the sample. They are recorded in the table but not detailed in the main text.

> I think half of it is the fact that you've talked to somebody, because there was really no one who I could have talked to, and told my troubles to
>
> (Tony).

> I needed to talk out a lot of personal issues
>
> (Kate).

In short, understandably, participants reported that the process of being able to talk through their issues was important for them.

3.6 | Mid-level theme: Aspects of the therapist enabling talking (5 participants, 9 comments)

Of course, participants did not talk in isolation, to no one. Instead, multiple participants stressed the importance of how their therapist enabled their talking, for example making participants feel comfortable enough to explore personal information.

> it was lovely to sit and talk to somebody who was interested in me, and I could actually air all my fears and anxieties and feelings
>
> (Kate).

> that was the best thing of it, was feeling that I could talk about it to somebody and not – not have somebody sniggering behind their hands, or pointing, which if I had been talking to somebody else it probably would have been
>
> (Tony).

In addition, participants reported that things the therapist did, such as listening and asking questions, facilitated the talking process.

> she was very good at clarifying – clarifying and actually getting it right...but actually for me it was very important
>
> (Adam).

So, overall, participants reported that there were some specific things that the therapist did that enabled them to talk about their issues.

3.7 | Overarching theme: Therapist qualities (5 participants, 15 comments)

In addition, other qualities of the therapist were mentioned, not just in terms of enabling talking: first, their qualities as a person; and second, their skills and experience. So, two mid-level themes are included as follows: *'As a person'* (5 participants) and *'As a professional'* (5 participants).

3.8 | Mid-level theme: As a person (5 participants, 9 comments)

For example, in terms of qualities as a person:

> the most helpful thing was not what my counsellor or therapist did it's actually what she was like as a person
>
> (Adam).

> She was very warm, and made me feel relaxed almost straight away, so, then it became a very positive experience
>
> (Joe).

Participants noticed the importance of the therapist being empathetic, supportive and non-judgemental and how this was important in the therapy process generally.

3.9 | Mid-level theme: As a professional (5 participants, 6 comments)

In addition, participants also emphasised the importance of the therapist being experienced, for example having expertise in mental health and CBT.

> ...she was very equipped and skilled, I wouldn't have wanted someone less equipped... I think it's very important that psychologists are well trained before they are let loose on patients
>
> (Adam).

> you can try as much as you want, go online and try and find all the health advice, but without a professional, you're not going to get professionally better
>
> (Edward).

Experiencing the therapist as trained and professional seems to have been another key part of the story of success according to participants.

3.10 | Summary of common factors

Overall, under common factors, participants viewed both gaining insight into and talking about their issues as key aspects in their recovery. Both were facilitated by their therapist—who enabled talking to take place and more generally was empathetic and experienced enough to help provide them with new insights into their difficulties.

3.11 | Specific factors

As well as common factors, participants also consistently mentioned some more specific factors, which, in this case, are found under the broad CBT model. Two themes were identified: 'Responding differently to thoughts and feelings' (8 participants) and 'Tasks/activities' (4 participants).

3.12 | Overarching theme: Responding differently to thoughts and feelings (8 participants, 22 comments)

All participants noted the importance of being able to respond to thoughts and feelings differently. In their comments, participants reported being more able to identify their thoughts and emotional reactions and 'pause' before responding to them. By taking a step back to observe their thoughts and feelings, participants were able to assess the usefulness of their thinking and maybe respond differently to them.

> I think what it helped me to understand is... That I might react in a very strong way emotionally, I might become overwhelmed very quickly, but it gave me the ability to, sort of, pause, and to think, you know, I can manage this
>
> (Joe).

> It's thinking through, why do I feel this way? And to what extent is that a legitimate way of thinking about it? I suppose – like, am I being unreasonable or unfair on me or others, thinking this way?
>
> (Adam).

Participants seemed more able to identify and alter the relationship between unhelpful thoughts, feelings and their resulting behaviours. Participants appear to acknowledge they may not always be able to change their initial thoughts and emotional reactions to events, but they may have more control of how they later respond.

3.13 | Mid-level theme: Worry tree (4 participants, 13 comments)

Participants reported that a specific method, 'The Worry Tree', helped them to respond differently to thoughts and feelings. 'The Worry tree' is a concept within CBT that encourages participants to step back and identify whether a worry relates to a current problem towards which action can be taken or a hypothetical situation about which nothing can be done (Hancock, 2019).

> ...letting things go, talking about the worry tree, "is it something you can deal with now?" I can see things that are a problem and aren't a problem
>
> (Amy).

> I talked through this worrying tree, and the thought process, and whether I need to worry about that, I can completely go...I don't need to worry about this
>
> (Edward).

This method seemed to help participants and was regularly recalled. It is also a specific task and activity and so relates to the next theme.

3.14 | Overarching theme: Tasks/activities (4 participants, 14 comments)

Half of participants discussed the importance of completing different tasks and activities. Participants discussed how both tasks completed 'In session and as homework' (4 participants) contributed to their recovery, as did 'Using mindfulness and relaxation exercises' specifically (4 participants).

3.15 | Mid-level theme: In session/homework (4 participants, 7 comments)

Participants reported the tasks they completed both in sessions (in-session tasks) and between sessions (homework tasks) were useful to them.

> she'd say, "Go away and try this thing, fill out this form", and, you know, there was always something to do that I could really focus myself on for that next week
>
> (James).

> I still look at the sheets and think, like, oh, I thought like this, there was no need to think like that. So, it's just like a helpful reference to have
>
> (Adam).

Participants found that these tasks helped them try out the techniques both inside and outside of sessions, providing active and structured steps towards positive change.

3.16 | Mid-level theme: Using mindfulness and relaxation techniques (4 participants, 7 comments)

Finally, participants also reported that mindfulness and relaxation techniques were a useful aspect of their recovery. Participants reported they were more aware of their stress response and more able to let go of worrying thoughts and feelings.

> if you do feel like your heart beat starts elevating, or you do feel like you're getting a little bit stressed, um, learning to bring your breathing back down from your chest to your stomach, um, and some breathing exercises
>
> (Amy).

> to close my eyes and relax, and try and clear my mind of thoughts and that, and try and concentrate on one thing, like what I feel through my feet, and just let everything else go.....if I feel myself getting wound up, that does get rid of things, it, sort of, takes it out of my mind
>
> (Tony).

Through using these skills outside of the sessions, participants seemed more able to maintain or resume a more relaxed or mindful state.

3.17 | Summary of specific factors

In terms of specific factors, participants found techniques specific to CBT helpful during their therapy. Participants were more able to take a different view of their thoughts and feelings, enabling them to respond differently: perhaps in more helpful ways. Participants reported that mindfulness and relaxation techniques enabled them to feel more able to let go of difficult thoughts and feelings. Finally, participants reported that the above was facilitated by tasks and activities completed both in and between therapy sessions.

3.18 | Both common and specific factors as helpful aspects of therapy

Above, we have explored themes related to both common and specific factors that participants identified as being important in their recovery. However, so far, we have only looked at the data across all participants. As useful as this is, cohort-wide interpretation potentially ignores differences in the accounts from individual participants. It cannot highlight whether a single participant spoke exclusively about common factors or specific factors. Mapping the data out in Table 2, we see that all participants made comments related to both common and specific factors in their responses. This suggests that all participants viewed factors relating to both common and specific factors as playing an important part of their recovery. In addition, Table 2 also highlights the single or several most important aspect or aspects of therapy participants identified during stage 1 of the interview.

3.19 | Stages 2 and 3

The results discussed above refer only to the first stage of the research (stage 1). Later stages encouraged participants to consider other factors they may not have thought about as playing a role in their recovery (stage 2 questionnaire), followed by participants reflecting on stage 1 responses in the light of their questionnaire results (stage 3). Below, the responses to stages 2 and 3 will briefly be presented.

In stage 2, participants were given a list of items, identified from previous literature, and therapist experiences as possible contributors to therapeutic change. The questionnaire simply functioned as a prompt to encourage participants to consider factors they may not have otherwise thought of. Participants were asked to rate each item on a scale from 1 (not at all important) to 7 (extremely important). Participants generally rated most items around 6 (very important) or above. The three lowest rated items referred to 'others'. Participants, on average, seemed to feel these items less relevant to the success of their therapy journey. Importantly, it is unlikely that the lowest ranking item (17) could have scored highly as participants had received

TABLE 2 Factor type, overarching and mid-level theme structures related to individual participant responses

Factor Type	Overarching theme	Mid-level theme	Participant number							
			1	2	3	4	5	6	7	8
Common	Insight	Into condition	**X**	x	**X**		**X**	x	x	x
Common	Insight	Into past experiences	x				x			
Common	Talking	The importance of talking	x			**X**	x		**X**	
Common	Talking	Aspects of the therapist enabling talking	x			**X**	x		x	x
Common	Therapist qualities	As a person	x	x	x				x	x
Common	Therapist qualities	As a professional	x	x	x				x	x
Specific	Responding to thoughts and feelings differently		x	x	x	x	x	x	x	**X**
Specific	Responding to thoughts and feelings differently	Worry tree		x	x			**X**	**X**	
Specific	Tasks/activities	In session/homework	x	**X**	x				x	x
Specific	Tasks/activities	Using mindfulness and relaxation techniques				x	x		**X**	x

Note: x = At least one comment from the participant related to this theme/subtheme. Larger Xs in bold were identified as being the most important aspect of therapy by participants.

individual and not group therapy (see Table 3 for items and their mean rating score). What Table 3 also shows is how it appears relatively easy to map many, but not all, of the overarching factors from stage 1 onto specific items from stage 2. This is not something that was shared with participants or anticipated when the study was designed, but perhaps provides some small post hoc validity to the stage 1 results.

In stage 3, following the completion of the questionnaire, participants were invited to reflect on whether their answers to stage 1 had changed at all following the stage 2 questionnaire. Participants did not change their answers from the first stage of the interview and felt their initial responses still reflected what they viewed as the most helpful aspects of therapy. There were no significant changes; however, some participants expanded or clarified their initial answers.

4 | DISCUSSION

This study sought to explore what elements of therapy clients who had a successful experience of a low-intensity CBT IAPT programme perceive as contributing to their positive outcomes. The results provide some initial, limited but specific insights into which elements service users viewed as positive in relation to the common and specific factor framework. This discussion: i. provides an overview of the results before ii. relating its findings back to both the literature and iii. the common and specific framework. Before concluding, it: iv. discusses limitations and future research possibilities.

In terms of a brief overview of the results, five overarching themes were identified: three relating to common factors— *'Insight'*, *'Talking'* and *'Therapist qualities'*; and two relating to specific factors— *'Responding differently to thoughts and feelings'* and *'Tasks/activities'*. The first common theme, *'Insight'*, included a range of examples of how patients gained new understandings around their condition,

for example a greater understanding of how past experiences impacted on the present or on the interrelationship between thoughts, feelings and actions. The second theme, *'Talking'*, highlighted the importance of talking through their issues. The third common theme, *'Therapist qualities'*, describes other ways in which participants felt the therapist contributed to their positive outcome. In terms of specific themes, *'Responding differently to thoughts and feelings'* included details on how participants felt able to identify and/or alter the relationship between unhelpful thoughts, feelings and behaviours. The final specific theme, *'Tasks/activities'*, described how activities including mindfulness, relaxation and other tasks such as homework were beneficial for them in terms of making positive changes.

One of the main aims of this study was its focus on being initially led by the participant voice. By deliberately asking participants to freely explore any helpful aspects of their experiences from their point of view, we found both a wide range of material and consistent patterns across accounts.

It seems important to begin by highlighting what ended up being the most mentioned theme across the data set: *'Insight'*. The theme includes different aspects of participants coming to understand more about their condition (e.g. the inter-connectedness of thoughts, feelings and actions; learning about the impact of past experiences on the present). This seems to fit both other definitions of insight (e.g. a new understanding of a connection between past and present experiences, or between thoughts, feelings, desires or behaviours, that has not previously been recognised [quoting from Connolly Gibbons et al., 2007, p. 144]) and previous reviews that have found small but positive effects from psychoeducation (Van Daele et al., 2012). Of course, it must be noted that this research took place within a low-intensity IAPT setting where perhaps there was more of a focus on psychoeducation.

We spent a lot of time considering whether *'Insight'* should fall under common factors. But we were reassured that it sits within a

TABLE 3 Item importance mean score and standard deviation, presented in rank order

Questionnaire items in order of rating (highest–lowest)	Mapping overarching themes from stage 1	Mean	Std. deviation
14. Share concerns/get things off chest	C. Talking	6.75	0.70
6. New knowledge about condition	C. Insight	6.62	0.74
18. Understood and supported by therapist	C. Therapist qualities	6.62	0.51
11. Change thoughts and/or feelings	S. Responding differently to thoughts and feelings	6.50	0.75
12. Even though still have similar thoughts and/or feelings, do not bother as much anymore	S. Responding differently to thoughts and feelings	6.50	0.53
1. Problem clarification	C. Insight	6.50	1.06
15. Feel more positive about myself	-	6.37	0.91
10. Understand how thoughts and/or feelings can hinder actions	C. Insight	6.37	0.74
3. Confident about ability to change	-	6.12	0.83
19. Working on homework	S. Tasks/activities	6.00	1.31
7. New knowledge about behaviour	C. Insight	6.00	1.19
4. Overcome barriers and move towards change	-	6.00	1.06
9. New knowledge about thoughts and/or feelings	C. Insight	6.00	1.06
13. Overcome gap between intentions to change and actually making changes	-	6.00	0.92
2. Clear plan	-	5.62	1.84
5. Move towards challenging situations	-	5.62	0.92
8. New knowledge about others' behaviour	C. Insight	5.14	1.06
16. Feel more positive about others	-	4.87	0.83
17. Gained from being in environment with others who've had similar experiences	-	2.75	2.71

Note: C. = common factor, S. = specific factor

published expert survey of 'common' factors within psychotherapy (Tschacher et al., 2014). Moreover, a study that explores how insights can span modalities was carried out by Elliott et al. (1994). Here, insight events of three clients in CBT and three in psychodynamic-interpersonal therapy were compared. They identified commonalities across both therapies where insight involved a 'meaning bridge' (linking the client's reaction to its context; from Rice & Sapiera, 1984). However, there are also differences, with some CBT insights being more re-attributional in nature (e.g. considering alternative causes of events) and psychodynamic insights involving the 'cross-session linking of core interpersonal conflict themes' (p. 460). To us, this appears to further confirm the common nature of insights within CBT (Grosse Holtforth et al., 2007) and across therapy generally.

It seems striking how *'Talking'* emerged as a stand-alone theme in its own right, not just talking as something that takes place as part of the therapeutic relationship or therapeutic journey, but talking as being a key process on its own. We wonder whether this is because we did not constrain or guide what participants spoke about. Of course, previous literature has highlighted that clients find talking with a therapist provides emotional relief (e.g. Grencavage & Norcross, 1990; Messari & Hallam, 2003; Straarup & Poulsen, 2015) so the overarching theme is perhaps not surprising. Moreover, our findings break the theme down further into both *'The importance of talking'* and *'Aspects of the therapist enabling talking'*. Participants reported both that talking needed to happen and that there were things that the therapist did which facilitated this. Again, the focus on the simple need to talk feels like an interesting insight from this data set.

In a similar way, the *'Therapist qualities'* theme subdivides into *'As a person'* and *'As a professional'*, again providing some nuance as it does. Previous research suggests that therapists who deliver techniques more skilfully achieve better outcomes (Baldwin & Imel, 2013). This

is not in dispute, but our research also provides evidence of what many therapists would also attest, that other qualities such as being supportive and empathetic are also an important aspect of therapy. And, of course, part of this will no doubt facilitate talking, as mentioned in the previous paragraph.

Of course, there is extensive research demonstrating the importance of the therapeutic relationship in terms of positive outcome (Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000) and even data which involve clients speaking to the centrality of the therapeutic relationship in therapy (Hodgetts & Wright, 2007). But the term 'therapeutic relationship' is not quite what we got back from participants themselves, perhaps because it was not the term we got them to speak to. Instead, by collecting process data in this open way from participants, we seem to gain small insights into the participants' perspectives that support findings from previous research while also adding new detail.

Taken together then, in terms of common factors, there seems to be a picture of clients who find it important to get things out (talk), who equally value the insights they get back from their therapist. The successful therapist, then, seems to have qualities that facilitate both the participant talking and the expertise to provide useful insights. It seems possible to suggest that these different aspects working together are an encapsulation of what participants in this study see as being a successful therapeutic relationship.

4.1 | Common and specific factors

As previously discussed, common factors are argued to be variables found commonly across all psychotherapies (Wampold, 1997), while specific factors are argued to be aspects unique to certain approaches (Tschacher et al., 2014). Importantly, in this limited data set, all participants spoke about both common and specific factors as playing an important role in the success of their intervention. When considering the sometimes acrimonious debates in this area (therapy wars / dodo bird hypothesis; Marcus et al., 2014), it seems important to simply note that in this data set, all participants thought both common and specific factors played a role in their successful outcome, with participants offering both common and specific factors as being most important, when asked to pick one factor.

Of course, this does not negate quantitative work, which raises questions about the role of specific CBT techniques (e.g. Longmore & Worrell, 2007). Simply, as has been said before, this data set appears to suggest that multiple factors are 'necessary but not always sufficient' (after Rogers, 1957) in terms of not just providing the conditions for change – but achieving it. Or, from a different angle, simply, that specific factors cannot be delivered without the context of common factors (see Wampold & Budge, 2012). This study deliberately aimed to move away from finding a 'winner' in the common versus specific factor debate, and as all participants identified both common and specific factors as being important to them, perhaps these data support that position.

Of course, the specific factors themselves relate to the CBT model, and so tie to cognitive components and both in-session and post-session activities. The active role of the client both inside and outside of sessions is something long associated with CBT (Curwen et al., 2000; Curwen et al., 2018). Perhaps of more note is how a theme was labelled *'Responding to thoughts and feelings differently'* rather than 'changing thoughts' as might have been expected in a more traditional cognitive therapy framework (e.g. Beck, 1995). This perhaps suggests the influence of the third-generation behavioural and cognitive approaches such as ACT (acceptance and commitment therapy; Hayes et al., 2006, 2013) and, as specifically noted under tasks/activities, mindfulness (Kabat-Zinn, 1990). Here, changing the relationship with thoughts and feelings is the aim more so than changing the content of thoughts themselves.

4.2 | Limitations and future research

The final theme framework was reached through analyses and discussions between a limited number of researchers. Although reflexive checks were repeatedly carried out, there is the possibility the data may have been categorised differently by different researchers. Similarly, if different methods or versions of qualitative analysis were used, different conclusions about the data may have been reached.

It is also important to acknowledge that the arrangement and boundaries between themes in these results are nuanced, permeable, and other research groups might arrange them differently. For us, some interesting tension was found in applying the common v. specific framework. For example, with 'insight' as a common factor, this led to an interesting situation where learning about how thoughts can influence behaviour was a common factor, while 'responding to thoughts and feelings differently' was a specific factor. For us, this perhaps speaks to the further interconnected nature of common and specific factors, with both potentially being more related to each other.

This research took place not just within a CBT treatment modality, but within a time-limited low-intensity IAPT setting. As noted in the introduction, it is important to acknowledge that IAPT is not without its critics (Binnie, 2015; Hamilton et al., 2011; Turner et al., 2018; Williams, 2015), who have concerns over the limited number of sessions, short sessions and manualised interventions. This can make things difficult for those who work in these services, who may have to limit what clients talk about, and even the amount of time they can give their clients to talk (Amos et al., 2019; Turner et al., 2018; Watts, 2016). It is noteworthy that the participants in this study: i. had successful interventions, ii. spoke genuinely about the gains they had made and iii. highlighted the importance of talking and their therapist facilitating talking as playing key roles in their interventions being a success. In time-limited, target-driven services, allowing the client the freedom to talk may be threatened, and yet, the findings of this study see the clients themselves citing its importance in the success of treatment.

The above notwithstanding, there is no automatic expectation that the findings from this sample are generalisable to all IAPT

services or to different therapy modalities. Instead, it would be fascinating to explore whether similar themes emerge from replicated research conducted across other IAPT services, treatment modalities and intervention formats.

Also, in future work, it could be important to explore the fit, or not, of the thematic framework from these results. For example, it was noteworthy that many of the themes from the results mapped well onto many of the items in Table 3 - but not all of them. Items related to emotions being different (e.g. feeling more positive, confident about ability to change) were rated highly by participants in the questionnaire, but were not dominant in the initial qualitative data set. Future research could perhaps explore this potential gap - while still being led by participant accounts. Finally, especially if this research is replicated or extended in other IAPT services, it may be useful to gather brief background information from the service on the number of therapists involved across the sample and/or the years of experience held by them. It is possible that different therapists or differences in therapist experience may result in differences in the thematic content that comes from service users.

A further limitation of the study is its sample size ($n = 8$), which is likely to have restricted the range of possible client views. However, it should be noted that in the review by Levitt et al. (2016), the number of participants ranged from 3 to 77, with a mean of 13. However, examining the table of previous studies, it is noticeable just how many studies collected data from between 3 and 7 participants. The review also noted that previous research had been female-focused (>70%), whereas these data drew more from males.

5 | CONCLUSION

The expansion of process work by deliberately exploring service user perceptions of what has been helpful in therapy has been called for (e.g. Levitt et al., 2016). This study, in a low-intensity setting, specifically asked participants to freely explore what was helpful to them, and this backdrop may have drawn certain material to the surface (e.g. talking). Few qualitative studies have explored the mechanisms of change in CBT from the patient's perspective and fewer still in an IAPT setting. Perhaps a full understanding of how all therapies facilitate change cannot be achieved without spending more time asking patients about their experiences in different settings. By gaining a fuller understanding of participants' perceptions as to why their intervention was successful, this and future work may provide more evidence about what aspects of treatment are important in terms of process - increasing our understanding and also improving our outcomes. More research is needed that explores this area across different treatment modalities and intervention formats.

ORCID

Miles Thompson https://orcid.org/0000-0002-1358-1962

REFERENCES

Ahn, H., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology*, 48(3), 251–257. https://doi.org/10.1037/0022-0167.48.3.251

Amos, R., Morris, L., Mansell, W., & Edge, D. (2019). Clients' experiences of one-to-one low-intensity interventions for common mental health problems: An interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 92(4), 565–583. https://doi.org/10.1111/papt.12200

Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert, S. L. Garfield, & A. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (pp. 258–297). Wiley.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. Guildford Press.

Binnie, J. (2015). Do you want therapy with that? A critical account of working within IAPT. *Mental Health Review Journal*, 20(2), 79–83. https://doi.org/10.1108/MHRJ-11-2014-0044

Blackledge, J. T., Moran, D. J., & Ellis, A. (2009). Bridging the divide: Linking basic science to applied psychotherapeutic interventions—a relational frame theory account of cognitive disputation in rational emotive behavior therapy. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 27(4), 232–248. https://doi.org/10.1007/s10942-007-0078-x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, 26(1), 17–31. https://doi.org/10.1016/j.cpr.2005.07.003

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, 52, 685–716. https://doi.org/10.1146/annurev.psych.52.1.685

Clark, D. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, 23(4), 318–327. https://doi.org/10.3109/09540261.2011.606803

Connolly Gibbons, M. B., Crits-Christoph, P., Barber, J. P., & Schamberger, M. (2007). Insight in psychotherapy: A review of empirical literature. In L. G. Castonguay, & C. Hill (Eds.), *Insight in psychotherapy* (pp. 143–165). American Psychological Association. https://doi.org/10.1037/11532-007

Creamer, E. G. (2018). *An introduction to fully integrated mixed methods research*. SAGE Publications, Inc. https://doi.org/10.4135/9781071802823

Curwen, B., Palmer, S., & Ruddell, P. (2000). *Brief Cognitive Behaviour Therapy* (1st edition). Sage Publications Ltd.

Curwen, B., Palmer, S., & Ruddell, P. (2018). *Brief Cognitive behaviour therapy* (2nd edition). SAGE Publications Ltd.

de Lusignan, S., Jones, S., McCrae, N., Cookson, G., & Chan, T. (2013). *An evaluation of a stepped-care model of psychological therapy for people with long-term conditions and medically-unexplained symptoms*. University of Surrey for IAPT. Retrieved from: http://epubs.surrey.ac.uk/804165/

Elliott, R., Shapiro, D. A., Firth-Cozens, J., Stiles, W. B., Hardy, G. E., Llewelyn, S. P., & Margison, F. R. (1994). *Comprehensive process analysis of insight events in cognitive-behavioral and psychodynamic-interpersonal psychotherapies* (pp 333). American Psychological Association. https://doi.org/10.1037/10412-019

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice*, 21(5), 372–378. https://doi.org/10.1037/0735-7028.21.5.372

Grosse Holtforth, M., Castonguay, L. G., Boswell, J. F., Wilson, L. A., Kakouros, A. A., & Borkovec, T. D. (2007). Insight in

cognitive-behavioral therapy. In L. G. Castonguay, & C. Hill (Eds.), *Insight in psychotherapy* (pp. 57–80). American Psychological Association. https://doi.org/10.1037/11532-003

Hamilton, S., Hicks, A., Sayers, R., Faulkner, A., Larsen, J., Patterson, S., & Pinfold, V. (2011). *A user-focused evaluation of IAPT services in London. Report for Commissioning Support for London.* Rethink, March 2011. Retrieved from: https://www.rethink.org/resources/a/a-user-focused-evaluation-of-iapt-services-in-london

Hancock, D. (2019). What mental health support is available for GPs? *Practice Management*, *29*(8), 18–24. https://doi.org/10.12968/prma.2019.29.8.18

Hann, A., Hemming, L., Billsborough, J., Couperthwaite, L., Hewis, E., Pinfold, V., & Hamilton, S. (2015). A *Service user evaluation of the IAPT for SMI demonstration sites*. McPin Foundation and NHS England. Retrieved from http://mcpin.org/wp-content/uploads/Full-report-from-service-user-evaluation-of-IAPT-for-SMI.pdf

Hardy, G. E., & Llewelyn, S. (2015). Introduction to psychotherapy process research. In O. C. G. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: Foundations*, *process*, *and outcome* (pp. 183–194). Springer-Verlag Publishing. https://doi.org/10.1007/978-3-7091-1382-0_9

Hayes, S. C., Levin, M. E., Plumb-Vilardaga, J., Villatte, J. L., & Pistorello, J. (2013). Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behavior Therapy*, *44*(2), 180–198. https://doi.org/10.1016/j.beth.2009.08.002

Hayes, S. C., Luoma, J. B., Bond, F., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes, and outcomes. *Behaviour Research and Therapy*, *44*(1), 1–25. https://doi.org/10.1016/j.brat.2005.06.006

Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology & Psychotherapy*, *14*(3), 157–163. https://doi.org/10.1002/cpp.527

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy (Chicago, Ill.)*, *48*(1), 9–16. https://doi.org/10.1037/a0022186

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*(2), 139–149. https://doi.org/10.1037/0022-0167.38.2.139

Jacobson, N. S., Dobson, K. S., Truax, P. A., Addis, M. E., Koerner, K., Gollan, J. K., Gortner, E., & Prince, S. E. (1996). A component analysis of cognitive-behavioral treatment for depression. *Journal of Consulting and Clinical Psychology*, *64*(2), 295–304. https://doi.org/10.1037/0022-006X.64.2.295

Jones, E. E., & Pulos, S. M. (1993). Comparing the process in psychodynamic and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology*, *61*(2), 306–316. https://doi.org/10.1037/0022-006X.61.2.306

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress*, *pain*, *and illness*. Delacorte Press.

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology*, *3*(1), 1–27. https://doi.org/10.1146/annurev.clinpsy.3.022806.091432

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research*, *19*(4–5), 418–428. https://doi.org/10.1080/10503300802448899

Knobloch-Fedders, L. M., Elkin, I., & Kiesler, D. J. (2015). Looking back, looking forward: A historical reflection on psychotherapy process research. *Psychotherapy Research*, *25*(4), 383–395. https://doi.org/10.1080/10503307.2014.906764

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert, S. L. Garfield, & A. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (pp. 139–193). Wiley.

Layard, R. (2006). *The depression report: A new deal for depression and anxiety disorders*, Vol. No. *15*. Centre for Economic Performance, LSE.

Layard, R., Clark, D., Knapp, M., & Mayraz, G. (2007). Cost-benefit analysis of psychological therapy. *National Institute Economic Review*, *202*, 90–98. https://doi.org/10.1177/0027950107086171

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin*, *142*(8), 801–830. https://doi.org/10.1037/bul0000057

Longmore, R. J., & Worrell, M. (2007). Do we need to challenge thoughts in cognitive behavior therapy? *Clinical Psychology Review*, *27*(2), 173–187. https://doi.org/10.1016/j.cpr.2006.08.001

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T. P., Berman, J. S., Levitt, J. T., Seligman, D. A., & Krause, E. D. (2002). The Dodo bird verdict is alive and well—mostly. *Clinical Psychology: Science and Practice*, *9*(1), 2–12. https://doi.org/10.1093/clipsy.9.1.2

Marcus, D. K., O'Connell, D., Norris, A. L., & Sawaqdeh, A. (2014). Is the Dodo bird endangered in the 21st century? A meta-analysis of treatment comparison studies. *Clinical Psychology Review*, *34*(7), 519–530. https://doi.org/10.1016/j.cpr.2014.08.001

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*(3), 438–450. https://doi.org/10.1037/0022-006X.68.3.438

Messari, S., & Hallam, R. (2003). CBT for psychosis: A qualitative analysis of clients' experiences. *British Journal of Clinical Psychology*, *42*(2), 171–188. https://doi.org/10.1348/014466503321903580

Messer, S. B., & Wampold, B. E. (2002). Let's face facts: Common factors are more potent than specific therapy ingredients. *Clinical Psychology: Science and Practice*, *9*(1), 21–25. https://doi.org/10.1093/clipsy.9.1.21

Mockford, C., Staniszewska, S., Griffiths, F., & Herron-Marx, S. (2012). The impact of patient and public involvement on UK NHS health care: A systematic review. *International Journal for Quality in Health Care*, *24*(1), 28–38. https://doi.org/10.1093/intqhc/mzr066

National Collaborating Centre for Mental Health (2020). *The improving access to psychological therapies manual*. https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/iapt/the-iapt-manual-v4.pdf?sfvrsn=2575784_2

Owen, J., Hilsenroth, M. J., & Rodolfa, E. (2013). Interaction among alliance, psychodynamic-interpersonal and cognitive-behavioural techniques in the prediction of post-session change. *Clinical Psychology & Psychotherapy*, *20*(6), 513–522. https://doi.org/10.1002/cpp.1792

Parry, G., Barkham, M., Brazier, J., Dent-Brown, K., Hardy, G., Kendrick, T., Rick, J., Chambers, E., Chan, T., Connell, J., Hutten, R., de Luisgnan, S., Mukuria, C., Saxon, D., Bower, P., & Lovell, K. (2011). *An Evaluation of a New Service Model: Improving Access to Psychological Therapies Demonstration Sites 2006–2009*. HMSO. Retrieved from http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1610-154_V01.pdf

Rice, L. N., & Sapiera, E. P. (1984). Task analysis and the resolution of problematic reactions. In L. N. Rice, & L. S. Greenberg (Eds.), *Patterns of change* (pp. 29–66). Guilford Press.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95–103. https://doi.org/10.1037/h0045357

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Straarup, N. S., & Poulsen, S. (2015). Helpful aspects of metacognitive therapy and cognitive behaviour therapy for depression: A qualitative study. *The Cognitive Behaviour Therapist*, *8*, e22. 1–19. https://doi.org/10.1017/S1754470X15000574

Tembo, D. (2014). Mixed methods. In D. M. Walker (Ed) *An introduction to health services research* (pp. 115–126). SAGE Publications, Inc. https://doi.org/10.4135/9781473920514

Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research*, *17*(3), 305–314. https://doi.org/10.1080/10503300600608116

Timulak, L. (2010). Significant events in psychotherapy: An update of research findings. *Psychology and Psychotherapy*, *83*(4), 421–447. https://doi.org/10.1348/147608310X499404

Timulak, L., & McElvaney, R. (2013). Qualitative meta-analysis of insight events in psychotherapy. *Counselling Psychology Quarterly*, *26*(2), 131–150. https://doi.org/10.1080/09515070.2013.792997

Tschacher, W., Junghan, U. M., & Pfammatter, M. (2014). Towards a taxonomy of common factors in psychotherapy—results of an expert survey. *Clinical Psychology & Psychotherapy*, *21*(1), 82–96. https://doi.org/10.1002/cpp.1822

Turner, J., Brown, J. C., & Carpenter, D. T. (2018). Telephone-based CBT and the therapeutic relationship: The views and experiences of IAPT practitioners in a low-intensity service. *Journal of Psychiatric and Mental Health Nursing*, *25*(5–6), 285–296. https://doi.org/10.1111/jpm.12440

Van Daele, T., Hermans, D., Van Audenhove, C., & Van den Bergh, O. (2012). Stress reduction through psychoeducation: A meta- analytic review. *Health Education & Behavior*, *39*(4), 474–485. https://doi.org/10.1177/1090198111419202

Vowles, K. E., & Thompson, M. (2012). The patient-provider relationship in chronic pain. *Current Pain and Headache Reports*, *16*(2), 133–138. https://doi.org/10.1007/s11916-012-0244-4

Wampold, B. (1997). Methodological problems in identifying efficacious psychotherapies. *Psychotherapy Research*, *7*(1), 21–43. https://doi.org/10.1080/10503309712331331853

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277. https://doi.org/10.1002/wps.20238

Wampold, B. E., & Budge, S. L. (2012). The 2011 leona tyler award address: The relationship—and its relationship to the common and specific factors of psychotherapy. *The Counseling Psychologist*, *40*(4), 601–623. https://doi.org/10.1177/0011000011432709

Watts, J. (2016). IAPT and the ideal image. In J. Lees (Ed.), *The future of psychological therapy: From managed care to transformational practice* (pp. 84–101). Routledge.

Williams, C. H. J. (2015). Improving Access to Psychological Therapies (IAPT) and treatment outcomes: Epistemological assumptions and controversies. *Journal of Psychiatric and Mental Health Nursing*, *22*(5), 344–351. https://doi.org/10.1111/jpm.12181

AUTHOR BIOGRAPHIES

Miles Thompson is a Senior Lecturer in Psychology at UWE Bristol where he is the co-lead of the Psychological Sciences Research Group (PSRG) and the lead of the Promoting Psychological Health (PPH) theme. He is also Clinical Psychologist, registered with the HCPC (Health and Care Professions Council) and a Fellow of the Higher Education Academy. From 2005 to 2011, he worked full time in the NHS at the Bath Centre for Pain Services. Prior to working at UWE, he worked as Senior Lecturer in Psychology at Canterbury Christ Church University.

Holly Parker studied her BSc in Psychology at UWE Bristol. She currently works as Assistant Psychologist within the NHS.

Jodie Cave is Mental Health Professional with an MSc in Health Psychology from UWE Bristol. She has worked as Associate Lecturer for the Psychological Wellbeing Practitioner (PWP) course at Exeter University.