The Experience and Meaning of Hope for Clinicians and Clients in Psychological Therapy, in Relation to Waiting Times

Being a Thesis submitted in partial fulfilment of the requirements for the degree of
Doctor of Clinical Psychology in the University of Hull

By Johanna Gledhill, BSc (Hons) Psychology, University of York

June 2018
I wouldn’t have been able to complete this thesis without a number of people, and I would like to take a moment to thank them. Firstly Dr Tim Alexander and Dr Chris Clarke, for all of their support and good advice throughout the process.

I would also like to thank my family. Mum for always, always being there when I needed you (even when I swore that I didn’t), Dad for always listening to my ramblings about my research and reassuring me that they make more sense than I think they do. My brother Robin for his ever calming, caring presence, and my cousin Becky for her much needed and much-loved phone calls.

Finally I’d like to thank my wonderful friends, who have been such an important support network throughout the six years of training. To my peers, this has been an amazing experience and I’m so privileged to have shared it with such brilliant, thoughtful, and supportive people. Lastly to my university ‘family’ who have been there for all six years, through all the twists and turns and ‘I can’t do it’ moments. Thank you for all the home cooked meals, welcome distractions, early mornings at the library, late nights debriefing from exams, and supportive ‘you can do this’ texts. I genuinely wouldn’t have been able to do this without you, so thank you so much.
Overview

This portfolio thesis consists of three parts: a systematic literature review, an empirical paper and a set of appendices. The thesis as a whole considers the meaning and experience of hope for clinicians and clients in psychological therapy, with emphasis on the context of waiting times.

The first section is a systematic literature review that explores the role, experience and effect of client hope in psychological therapy. The review also considers the methodological quality of the evidence in this area. Thirteen papers were included and synthesised using a narrative approach. The findings are discussed within the context of the wider literature, including existing theoretical models of hope. The clinical and research implications for these findings are also considered.

The second section is an empirical study that explores the meaning and experience of hopeful therapeutic relationships for clinical and counselling psychologists, in relation to long waiting times for therapy. The research used a qualitative method, gathering data using semi-structured interviews, and analysed the data using interpretive phenomenological analysis. Four superordinate and twelve subordinate themes emerged from the data. The results of this analysis are linked to literature relating to client hope and systemic models. The clinical and research implications for these findings are also discussed.

The third section consists of a set of appendices which relate to both the systematic literature review and empirical paper. Included in these appendices are a reflective and epistemological statement, describing the primary researcher’s reflections on the research journey, and the philosophical position and underlying assumptions of the research.

Total word count: 25985 (including tables, appendices and references)
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Part One: Systematic Literature Review
The Role, Experience, and Effect of Client Hope in Psychological Therapy

*Short Title: The Role of Client Hope in Therapy*

*Key words: Hope, therapy, psychology, clients, mental health*

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This paper is written in the format ready for submission to the Journal of Clinical Psychology. Please see Appendix A for submission guidelines.

Word Count: 7560 (excluding references and tables)
Abstract

Objectives: This review aimed to investigate the role of client hope in psychological therapy, including the experience of hope and its effect on psychological outcomes.

Design: PsycInfo, PsycArticles, Academic Search Premier and Cinahl Complete were searched for academic articles investigating links between client hope and psychological therapy outcomes. The quality of included studies was assessed using the MMAT and narrative synthesis was used to summarise results.

Results: The findings from included studies were synthesised into the following themes: the relationship between client hope and therapeutic outcomes, experiencing hope-pathways to goals, the role of agency in client hope, and the clinician’s influence on client hope.

Conclusions: Client hope has a relationship with therapy outcomes. Whilst clients vary in their baseline hope, clinicians can influence the degree to which clients experience hope during therapy. Finally, this review suggests that Snyder’s hope theory can be applied to client experiences of hope.
Introduction

Hope has long been considered to play a role in counteracting mental health problems (Frank, 1978). However, the context within which hope in therapy has been viewed has changed over time. When the pathology model of mental health difficulties was more commonly used by psychologists, hopeful therapy involved ‘fixing’ the person. However, more recent positive psychology approaches focus on client strengths (such as hope) rather than weaknesses, changing the way in which hope is perceived within therapy (Cheavens et al, 2006; Johnson & Wood, 2017). This shift towards emphasising client strengths (‘buffers’ against life stressors) has increased the interest of researchers and clinicians in client hope, and its value in therapy (Valle, Huebno, & Suldo, 2006).

Defining Hope

There have been several different definitions of hope described in the literature. These definitions have been categorised as either emotion-based or cognition-based (Lopez, Snyder, & Pedrotti, 2003). Averill, Catlin, and Chon’s social constructionist position on hope goes some way towards integrating these positions in asserting that hope is an emotion governed by cognitions, with the individual’s environment affecting the development of their hope (Averill, Catlin, & Chon, 1990). Hope can also be defined as relating to particular and generalised goals (Park & Chen, 2016). The research of Snyder and colleagues has been influential in this field, according to whom hope is ‘the perceived capability to derive pathways to desired goals and motivate oneself via agency thinking to use those pathways’ (Snyder, 2002, page 251). This definition of hope, which has been reconceptualised and updated several times since it’s conception in 1989 (Snyder et al, 2003), incorporates emotion, cognition, and goal orientated thinking and regards hope as dispositional whilst recognising ways in which interventions and the environment can change an individual’s level of hope (Valle,
Huebno, & Suldo, 2006). However it is worth noting that Snyder’s hope theory can be critiqued for putting a lot of emphasis on the role of the individual’s cognitive processes and neglecting the role of wider context variables such as culture, despite research suggesting that culture ‘influences the way humans select, interpret, process, and use information’ (Kluckhohn, 1954, as cited in Triandis, 1994). It can be argued that familial and cultural dynamics play a major role in hope, and that, by focussing on the cognitive aspects of hope and neglecting the role of these wider social contexts, Snyder’s theory may lack refinement in its description of the theoretical mechanisms underlying hope (Elliot & Sherwin, 1997).

Hope as a protective factor in mental health

A number of authors view hope as a valuable strength for individuals with mental health difficulties (Schrank & Slade, 2007). Luo, Wang, Wang, and Cai (2016) found that levels of hope had a significant effect on suicidal ideation in adults with depression and were also predictive of whether suicidal ideation transitioned into suicide attempts. Furthermore, studies of adolescents and young adults have found that high levels of personal hope appear to be a protective factor for mental health, linked to increased self-esteem, lower psychological distress, and increased life satisfaction (Dowling & Rickwood, 2016; Halama & Dedova, 2007). Snyder’s hope theory outlines the process by which hope may act as a buffer to mental health difficulties and life stressors; individuals with high levels of hope have higher levels of adaptability in terms of generating and switching pathways to their desired goals (Snyder, 2002).

Hope in Psychological Therapy

Psychological interventions specifically focussed on instilling and utilising hope have been developed, for example by Cheavens, Feldman, Gum, Michael, & Snyder (2006),
which was found to increase psychological strengths and reduce some symptoms of psychopathology. Furthermore, a growing body of literature is highlighting the role of client hope in psychological therapies generally (Dowling & Rickwood, 2016; Halama & Dedova, 2007). However, whilst client hope has been researched with respect to specific therapy styles, settings, presenting problems, and client groups, an integration of research findings in this area has yet to be developed. This means that commonalities and divergences in themes and findings relating to the experience and effects of client hope in psychological therapy across the literature are not yet fully understood. There is also a need to understand the relative methodological quality and overarching findings of this literature in order to inform clinical practice and further research. Therefore, this literature review will help summarise the common and differential findings in this field of research. This review will also give a critique of the literature and highlight areas in which further research is necessary. The literature base that this review aims to bring together is very diverse (for example in terms of the therapy type implemented, client group studied, and definition of hope used). This has potential benefits and negative consequences. It may mean that this current review has to take a ‘broad brush stroke’ approach in order to synthesise very varied literature, and therefore some of the rich details may be lost. However it may allow for a better understanding of the underlying commonalities (or indeed lack thereof) between studies that are not dependent on methodology or therapeutic approach utilised, and help to frame future review questions or research ideas that can better capture the rich details of elements of this literature (e.g. studies of a specific therapeutic approach) once the ‘bigger picture’ has been framed by this review.

Questions and aims

Research aims:
To investigate the role of client hope in psychological therapy including the experience and effect of client hope.

Research Questions:

- To what extent is client hope associated with outcomes of psychological therapies?
- How does client hope relate to experiences of psychological therapy?

Methods

Search strategy

Electronic databases (PsycInfo, PsycArticles, Academic Search Premier and Cinahl Complete) were searched on the 18th of February 2018 for published academic articles investigating links between client hope and psychological therapy outcomes. Searches were conducted using the following search terms (*indicates truncation, N3 indicates that these phrases should be no more than 3 words away from each other): (psycholo* or cbt or cognitive or behavioural or counselling or therapy) AND ( (client or patient or service user) N3 (hope or hopefulness or optimism) ) NOT ( health or palliative or cancer or "physical therapy" or "physical health" or paediatric or cardiac). These terms were generated in consultation with individuals who have lectured on and practiced psychological therapy to ensure that no important term variations were left out, as well as the clinical literature pertaining to the construct of hope and psychological therapies. Initially studies relating specifically to optimism (rather than hope and optimism) were included. The researcher initially thought that this was justified due to the relationship between the constructs of hope and optimism, as they both share the core elements of expectancies and focus on an individual’s valued goals (Magaletta & Oliver, 1999). However on reflection the researcher decided that, although hope and optimism are
related, they are different constructs and therefore studies related solely to optimism were also excluded.

The following additional limiters were added:

- Written in the English language (as no funding was available for translation)
- Published in or after 1989
- Published in an academic journal

Study selection

Studies were included if they met the following criteria: 1) published in a peer reviewed journal in English, 2) the study focussed on clients undertaking psychological therapy of any kind, 3) explicitly measured or explored the theme of client hope (quantitatively or qualitatively), either as part of the stated study aims specifically or if using measures designed to specifically measure hope within the context of the broader study.

Studies were excluded if they met any of the following exclusion criteria: 1) published prior to 1989, 2) Focused on therapy for physical health conditions/palliative care, 3) Focused on the hope of professionals providing / involved with therapy or care, 4) did not investigate hope within the context of psychological therapy, 5) were assessing a scale measuring hope.

The rationale for these exclusion criteria is shown in table 1.

Table 1. Exclusion criteria and associated rationales

<table>
<thead>
<tr>
<th>Exclusion criteria</th>
<th>Rationale</th>
</tr>
</thead>
</table>

Published prior to 1989

This was when the seminal book outlining Snyder’s theory of hope was published (Snyder, 1989). Although there was some research interest in hope prior to this date, interest in the construct of hope within therapy (and an increase in the ways to measure it, e.g.: through various hope scales) increased from approximately this time, and therefore this date allows for the inclusion of the relevant literature (Herth, 1992; Snyder et al, 1996). Furthermore the use of this date may help ensure that the therapeutic approaches used in included studies are more in line with the therapeutic practices currently utilised in practice (for example cognitive behavioural therapy) (Beck, 1979).

Focus on therapy for physical health conditions/palliative care

Whilst developing the final search criteria, a large number of such studies were present in the initial searches. However, when reading these studies it they exclusively focussed on hope related to progress of positive outcomes in their physical health (e.g. going into remission) rather than hope related to
improved mental health through psychological therapy. It was decided that investigating links between hope and physical health was beyond the scope of this review and would be better investigated in a review specifically on this topic.

| Focuses on the hope of the professionals involved with care | These studies do not investigate the first-hand experience of hope for clients, as they focus on the hope of professionals and only comment on the professionals’ perceptions of client hope (which may not accurately reflect the experiences of the client). |
| Investigating hope in a context other than psychological therapy | The information gathered from studies of hope in other contexts (e.g.: of substance users receiving vocational training) may not have been applicable to the context of psychological therapy. |
| Assessing a scale measuring hope | The focus of these studies is on the usability of the scale, rather than the expression of client hope and what this may mean for therapy. |

Study Quality Assessment
The quality of all studies meeting the inclusion criteria was assessed using the Mixed Methods Appraisal Tool (MMAT; Crowe and Sheppard, 2011; Appendix C). This tool has been specifically designed to assess the methodological quality of studies using qualitative, quantitative, and mixed methods designs, making it appropriate for use in a review seeking to integrate findings of studies using different methodological approaches. The MMAT has 21 criteria, each of which have the possible answers of ‘yes’, ‘no’, and ‘can’t tell’. The papers were rated by the lead researcher, and the overall quality of each included study was calculated and is shown in Table 3. The quality rating informed the researcher when considering the overall quality of the literature as well as differences in methodological quality across the literature base, and is discussed within the results. Please see Appendix D for a summary of the methodological quality of all included studies.

Data extraction

Relevant information about the study authors, research aims, research design, measures used, research participants, and key research findings related to the review question were collected from the included studies using a data extraction form (see Appendix B).

Data synthesis

Due to the heterogeneity of the measures and the inclusion of qualitative, quantitative and mixed methods studies, a meta-analysis was not appropriate. Data were therefore synthesised using a narrative synthesis approach (Popay et al, 2006). This method of synthesis was chosen as it can integrate qualitative and quantitative research findings to understand commonalities across a heterogeneous literature base and generate hypotheses for future research, which is one of the reasons that this literature review is being carried out. The data extracted from included studies (based on the current
review’s questions) were summarised with a descriptive summary paragraph produced for each included study. Then a preliminary synthesis was created based on the results of the included studies. This synthesis organised the data based on emerging patterns in the processes and factors related to client hope in therapy. Following this further information that had been extracted from studies (e.g. relating to the method used) were integrated in order to ensure that the synthesis was robust and adequately described how and why the patterns outlined in the synthesis were found (Popay et al, 2006).

**Results**

The electronic searches generated 555 results. A summary of the numbers and papers included/excluded is shown in Figure 1 below. Common reasons for exclusion were that the paper focused on hope related to health issues (265 papers based on their title), the paper focussed on neurological or psychiatric issues (43 papers based on their title), and that the paper focussed on the hope of professionals rather than clients (19 papers based on their title). One included study focussed on hopelessness rather than hope (Kuyken, 2004). This study was included because, when read, the authors of the paper made it clear that they subscribed to the view that hopelessness is part of the continuum of hope (a common, although not unanimous, view in the literature) (Grewal & Porter, 2007). Furthermore the study drew conclusions from its results that related to clients with varying degrees of hope (Kuyken, 2004). 13 papers were included in the review, the details of which are included in Table 3.
Database search (Web of Science, CINAHL complete, Psychinfo, Psycharticles, Academic Search Premier)  
N= 555

Duplicate Articles  
N= 80  
Articles excluded on the basis of title  
N=334

Abstracts read to determine relevance  
N= 141

Articles excluded  
N=85

Full articles read to determine relevance  
N= 56

Articles excluded  
N=43

Articles included in the review  
N=13

*Figure 1. Summary of the article selection process*
Studies comprised 7 qualitative, 1 mixed methods, and 5 quantitative studies. 9 studies recruited only therapy clients (including 2 by the same research team in which the clients were a couple dyad; Egeli, Brar, Larsen,Yohani, 2014; Egeli, Brar, Larsen, and Yohani, 2014) and 4 recruited both clinicians and therapy clients. Qualitative data were collected via semi structured interviews in three studies (Chamodraka, Fitzpatrick, & Janzen, 2017; Bartholomew, Gundel, & Scheel, 2017; Koehn & Cutlcliffe, 2012), unstructured interviews in one study (Cutliffe, 2004), and interpersonal process recall interviews in four studies (Egeli, Brar, Larsen,Yohani, 2014; Egeli, Brar, Larsen,Yohani, 2014; Larsen & Stege, 2010; Larsen & Stege, 2010). In the mixed methods study (Bartholomew, Gundel, & Scheel, 2017), quantitative data about therapeutic rupture experiences was collected using an adapted rupture assessment measure (Muran et al, 2009, as cited in Bartholomew, Gundel and Scheel, 2017) to identify participants for qualitative semi structured interviews. In terms of quantitative studies, one was a randomised controlled trial of CBT as an adjunct to pharmacotherapy (Abel, Hayes, Henley, & Kuyken, 2016), one compared participants allocated to either waiting list or a motivational orientation group throughout therapy (Irving et al, 2004), and 3 were quantitative descriptive studies (Littrell, Herth, & Hinte, 1996; Westburg & Boyer, 1999; Kuyken, 2004). Hope specifically was measured in numerous ways, and the quantitative measures of hope and number of studies using them are shown in Table 2.

Table 2. Quantitative measures of hope and their use in the included studies.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Developed by</th>
<th>Number of studies using scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Hope Scale</td>
<td>Snyder et al, 1996</td>
<td>2</td>
</tr>
</tbody>
</table>
Hope for change through counselling style
Bartholomew, Scheel, & Cole, 2015

Herth Hope Index
Rustoen, 2014

The Beck Hopelessness Scale
Beck & Steer, 1988

One quantitative study also rated audio recordings of therapy sessions for hope, emotional processing, and therapist competence in case-conceptualization (Abel et al, 2016), and three studies developed scales (e.g. likert scales) specifically for the study (Chamodraka, Fitzpatrick, & Janzen, 2017; Irving et al, 2004; Bartholomew, Gundel, & Scheel, 2017). Data analysis approaches used included constant comparative methodology, open, axial and selective coding, recursive analysis, phenomenological analysis, and thematic analysis.

Research context

Eleven of the studies were based in America and Canada with the remaining two located in England. The number of participants recruited by studies ranged from 156 to 6 (see Table 3). Studies recruited participants from community services, residential services, or recruited participants who had received some form of therapeutic input (inpatient or community not specified) in the past. Six studies investigated hope in clients with a wide range of presenting problems, and seven studies investigated hope in patients receiving therapy for specific diagnoses such as depression, bereavement, substance abuse, schizophrenia with and without suicide attempts, panic disorder/agoraphobia, and hope within couples receiving couple’s counselling.

Methodological quality
All included studies met minimum quality criteria for evaluation using the MMAT; the aims and research questions were clearly stated and the collected data was appropriate to investigate these aims and questions. The range of methodological quality of included studies varied from 25% to 100%, with 1 included study receiving a rating of 25% (Irving et al, 2004), 7 included studies receiving a rating of 100%, and 5 studies receiving a rating of 75%.

In qualitative studies, researchers gave in depth descriptions and considerations of the sources of qualitative data, the process of analysing the data, and the setting of the study (e.g. population under study and sampling techniques). Strengths of two studies were the fact that participants fed back on findings and stated that the interpretations rang true for them (Koehn and Cutcliffe, 2012; Bartholomew, Gundel, & Scheel, 2017). One area that a number of qualitative studies overlooked was the role of the researcher in the findings of the research, e.g.: the role of the researcher’s personal values, power and influence, and their interactions with participants had an influence on their research results. A further area that was somewhat underreported in qualitative studies was the researcher’s epistemological stance, which is an important part of qualitative research as it can play a large role in shaping findings (Willig, 2013). A number of researchers drew on Snyder’s hope theory, and linked their findings to this theory.

Of the included quantitative studies, there was variation in the information given regarding response rates, and some that did include this information suggested high attrition rates. One quantitative study received a low quality rating, due to giving very little description of the randomisation approach used, completeness of outcome data, and the drop out rate of participants (Irving et al, 2004). However this does not necessarily mean that the researchers did not use an appropriate methodology.
Table 3. Summary of included studies

<table>
<thead>
<tr>
<th>Study Number</th>
<th>Author(s)</th>
<th>Aims</th>
<th>Design/method</th>
<th>Measures/Data collection</th>
<th>Participants/therapeutic setting</th>
<th>Key findings (relevant to the review)</th>
<th>Quality assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Abel, A., Hayes, A., M., Henley, W., &amp; Kuyken, W.</td>
<td>To examine client and therapist processes in sessions proximal to sudden gains, to better understand the antecedents of sudden gains</td>
<td>Quantitative Randomized controlled trial</td>
<td>Beck, Depression Inventory-II</td>
<td>156 adults with treatment resistant depression in primary care</td>
<td>More hope expressed in sessions preceding sudden gains, suggesting hope for change may predispose clients towards experiencing gains in therapy</td>
<td>100%</td>
</tr>
</tbody>
</table>

In a subsample of 50 clients, audio-recordings of therapy were rated for hope, emotional processing, and receiving an ‘adequate’ dose of medication. Receiving an adequate dose of antidepressant medication was associated with more client hope.
and potential mechanisms linking them to outcomes. And potential mechanisms linking them to outcomes.

| 2 | Chamodraka, M., Fitzpatrick, M. R., & Janzen, J. I. | To examine the trajectory of hope in psychotherapy in 2017 | Qualitative | State Hope Scale | Seventeen clients who had demonstrated a significant increase in hope over the course of therapy. Recruited from an urban counselling center. | Hope involves: increased sense of control (self-efficacy), increased sense of direction, and increased faith in counselling. | 100% |

Hope involves: increased sense of control (self-efficacy), increased sense of direction, and increased faith in counselling. Structural directiveness of hope-inspiring strategies used by clinicians.
<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Objective</th>
<th>Methodology</th>
<th>Sample Description</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Larsen and Stege 2012</td>
<td>To examine client accounts of hope during counselling.</td>
<td>Qualitative (case study)</td>
<td>10 clients (paired with 5 counsellors), all adults with treatment issues including grief, depression, illness, disability, substance misuse</td>
<td>Counselling relationship offers hope through safety, acceptance, understanding, and signs of counsellor commitment.</td>
</tr>
<tr>
<td>4</td>
<td>Larsen and Stege (2010)</td>
<td>To investigate how hope is translated into specific practices by psychotherapists during</td>
<td>Qualitative interpretative study</td>
<td>IPR interviews</td>
<td>5 psychologists. Three were Registered Psychologists with 5-16 years experience. Two were completing doctoral internships.</td>
</tr>
<tr>
<td>psychotherapy sessions</td>
<td>11 clients (5 men, 6 women) ranging in age from early 30s to 60s. Treatment issues included: long-standing depression, grief, cancer, family relationships, physical disability, substance use, separation/divorce, and employment concerns.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Objective</td>
<td>Design</td>
<td>Instruments</td>
<td>Participants</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-----------</td>
<td>--------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>2004</td>
<td>Irving, Snyder, Cheavens, Gravel, Hanke, Hillberg, and Nelson</td>
<td>To investigate the relationships between hope and outcomes at the pretreatment, beginning, and later phases of psychotherapy</td>
<td>Quantitative.</td>
<td>State hope scale, The regulation of emotional distress scale, The COPE Symptom distress check list, Subjective well being and level of functioning measured using likert scales</td>
<td>Adults of both genders being seen as outpatients for a range of presenting problems (with depression as the most common)</td>
</tr>
</tbody>
</table>
Bartholomew, Gundel, and Scheel. (2017) To explore how alliance ruptures are related to hope for change through counselling. Mixed methods. Participants who experienced ruptures in the quantitative phase were identified as participants for the qualitative interview phase. Rupture assessment measure adapted from Muran et al. (2009) for this study Quantitative phase: 105 adult university educated participants who reported that they had received psychotherapy services in the past four years. Hope for change through counselling scale. Individuals who experienced ruptures reported less hope for change through counselling. Ruptures lead clients to feel less hopeful about therapy being an effective pathway to change. The frequency of ruptures and their resolution in therapy significantly...
<p>| 7 | Koehn and Cutcliffe 2012 | To explore how counsellors inspire hope in clients struggling with substance abuse. | Qualitative (grounded theory) | Semi-structured interviews | 7 counsellors who provided substance abuse counselling. | Hope inspiration a collaborative process consisting of: Forming a non-judgemental bond, helping clients to change self-perceptions, interpersonal connections, and view of the future. Reviewing pathways to hope and identifying steps after therapy. | Two semi-structured interviews with each participant. | 3 adult clients who had received substance abuse counselling at some point in their lives. | 100% |</p>
<table>
<thead>
<tr>
<th>8</th>
<th>Littrell, Herth, and Hinte (1996)</th>
<th>To explore the combined effects of psychosocial treatment and clozapine on the levels of hope in patients with schizophrenia and historical suicidal attempts.</th>
<th>Quantitative, The Herth Hope Index assessed several times throughout treatment.</th>
<th>44 adult patients with a diagnosis of schizophrenia, accessing outpatient treatment.</th>
<th>Treatment led to marked increase in hope in all subjects.</th>
<th>Increased levels of hope in individuals with schizophrenia may be associated with improvements in symptoms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Westburg and Boyer</td>
<td>To evaluate whether hope assessed before State Hope Scale 22 adult student participants, accessing Individual counselling associated with increases.</td>
<td>Quantitative, State Hope Scale</td>
<td>22 adult student participants, accessing Individual counselling</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>
improves over the course of counselling and after counselling and to identify issues that can be explored in further studies.

<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Methodology</th>
<th>Sample Size</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>Egeli, Brar, Larsen, and Yohani</td>
<td>Qualitative (hermeneutic theoretical approach)</td>
<td>3 heterosexual adult couples participating in a reflecting team process at a university counselling clinic.</td>
<td>The intervention was perceived as an opportunity to gain new perspective.</td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td>Interviews (interpersonal process recall)</td>
<td></td>
<td>When encountering hope and vulnerability,</td>
</tr>
<tr>
<td>couple’s therapy.</td>
<td>participants weighed up pros and cons of participating/acknowledging both hope and vulnerability.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>Supportive positive team feedback diminished vulnerability and enhanced hope, however comments highlighting possibilities without providing clear pathways elicited hope and vulnerability.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Kuyken</td>
<td>To examine the effect of hopelessness on outcome in cognitive therapy.</td>
<td>Quantitative naturalistic outcome study.</td>
<td>The Beck Hopelessness Scale, Structured Clinical Interview for DSM IV, Beck Depression Inventory II</td>
</tr>
<tr>
<td>12</td>
<td>Egeli, Brar, Larsen, Yoha</td>
<td>To explore couples’ experiences of hope during participation in a reflecting team process</td>
<td>Explorative case study Thematic analysis</td>
<td>IPR interviews</td>
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<tr>
<td>13</td>
<td>Cutcliffe, JR</td>
<td>To explore whether bereavement</td>
<td>Qualitative modified grounded theory approach</td>
<td>Unstructured interviews</td>
</tr>
</tbody>
</table>
Counsellors inspire hope in their clients, and if so, how? 

Counsellors (who had a varied background and worked using a variety of different approaches) and ex-clients who had received bereavement counselling (recruited from a variety of counselling centres) were involved. Hope inspiration is a subtle process bound up with the counsellor’s qualities and the projection of these to the client. 

Hope inspiration involves compromising three sub core variables: forging the relationship; facilitating cathartic release; and experiencing a good ending.
Synthesis of Findings

The findings of the included studies were synthesised into four overarching themes:

- The relationship between client hope and therapeutic outcomes
- Experiencing hope-pathways to goals
- The role of agency in client hope
- The clinician’s influence on client hope.

Despite variety in therapeutic settings, client groups, and methodologies, the findings of studies were fairly consistent in terms of the positive influence of client hope on therapy and the means by which client hope is maintained/developed. Discrepancies in findings, and the potential moderating role of methodological quality, are incorporated in the discussion of each theme.

The relationship between hope and therapeutic outcomes

The methodological quality of the studies included in this section ranged from 25% (Irving et al, 2004) to 100% (Abel et al, 2004). The majority of studies in this section received a quality rating of 75%, suggesting a reasonable strength of findings of the included studies and, by extension, this theme.

This theme related to the first review question: ‘To what extent is client hope associated with therapeutic outcomes?’. All the included quantitative studies indicated that client hope has a positive association with therapeutic outcomes, although the direction of causation reported by researchers differed between studies. A number of studies suggested that higher levels of client hope positively affect therapeutic outcomes. For example, two studies (Abel et al, 2004; Irving et al, 2004) suggested that higher baseline hope predisposes clients towards gains in therapy, and is associated with greater
wellbeing, coping, emotional regulation, and fewer symptoms. As well as the finding that high client hope is predictive of positive outcomes, included studies also suggested that low client hope was predictive of negative therapeutic outcomes. For example, client hopelessness was found to predict therapeutic outcome (Kuyken, 2004), and low levels of hope were associated with depression at follow up (Abel et al, 2004).

Some researchers found that progress in therapy leads to increased client hope. In a study specifically investigating the hope of individuals with a diagnosis of schizophrenia, it was found that increases in client hope were associated with improvements in symptoms (Littrell, Herth & Hinte, 1996). However, it is important to note that, although an association was found by Littrell, Herth, and Hinte’s research, the design of the research cannot imply a causal link. In another correlational study Westburg and Boyer (1999) found that individual counselling was associated with increases in client hope. However, this research also recognised the role of client hope at intake as they recommended that assessing hope before counselling may be useful as a form of diagnostic information.

**Experiencing hope - pathways to goals**

The methodological quality of the studies included in this section ranged from 25% to 100%. The majority of the studies in this section received a quality rating of 100%, suggesting a reasonable strength of findings of the included studies and by extension this theme.

This theme linked to the second review question: ‘How does client hope relate to experiences of psychological therapy?’. Six of the included studies (both qualitative and quantitative) described client hope in therapy (at various different stages during the intervention) as related to the ability to see pathways to change. This theme reflects the presence of ‘pathways thinking’ in the findings of a number of the included studies, a
construct originally introduced into the hope literature by Snyder and colleagues in their theory of hope (Snyder, 2002). This theme was represented in three ways in the included studies: expanding possibilities, offering new perspectives, and providing direction.

Larsen and Stege’s (2012) qualitative research with clients with a range of presentations found that the experience of client hope during counselling was related to clinicians expanding client possibilities and fostering hope through perspective change. In couple’s counselling research by Egeli, Brar, Larsen, Yohani (2014) couples participating in a reflecting team process described experiences of the reflecting team presenting inspiring possibilities to them as related to their experience of hope within counselling. A further study by Egeli, Brar, Larsen, and Yohani (2014) also found that couples considered the counselling intervention to be a chance to try something new and gain new perspective (for example about what they needed from their partners). Research with clients who experienced a quantitatively significant increase in hope during therapy found that these clients reported an increased sense of direction and sense of control following the increase in their hope, with the clinical presenting problem moving from being experienced as all-powerful to containable and manageable (Chamodraka, Fitzpatrick, & Janzen, 2017). The role of direction as well as increased possibilities was also described in Egeli, Brar, Larsen, and Yohani (2014), which found that clinician comments suggesting possibilities, without describing a clear pathway to these possibilities, elicited hope but also elicited vulnerability in clients.

Echoing these findings, Irving et al. (2004) report that pathway scores on the State Hope Scale (indicating participants’ ability to see ways to reach their goals and get past obstacles) are associated with positive changes later on in the course of therapy, although this research received a low quality rating due to high attrition rates leading to incomplete outcome data. However, Westburg and Boyer (1999) also found that both
hope and ability to find multiple ways to goals increased during counselling, which was framed by the study as pathway thinking. This theme links into the theme of the clinician role in client hope, as a number of studies found evidence of a clinician role in increasing hope via the creation and review of pathways to desired outcomes and fostering client perspective change (Koehn, & Cutcliffe, 2012; Larsen & Stege, 2010).

The role of agency in client hope

The methodological quality of the studies included in this section ranged from 25% to 100%. One study had a rating of 25% (Irving et al, 2004), two had a rating of 75% (Egeli et al, 2014; Westburg & Boyer, 1999), and two had a rating of 100% (Chamodraka, Fitzpatrick and Janzen, 2017; Larsen & Stege, 2012).

This theme linked to the second review question: ‘How does client hope relate to experiences of psychological therapy?’. Six studies converged on the theme that agency (defined in Snyder’s hope theory as the perceived capacity and motivation to use pathways to reach goals) plays a role in client experiences of hope and therapy (Snyder, 2002). Three studies explicitly linked their findings to hope theory (Irving et al, 2004; Westburg & Boyer, 1999; Chamodraka, Fitzpatrick, & Janzen, 2017). Quantitative research suggests that agency has an observable effect on therapeutic outcomes that can be separated from that of pathways thinking. For example Irving et al (2004) found that client agency was related to changes in outcome variables early in therapy, in contrast to pathways ratings which were associated with changes later in therapy. Westburg and Boyer (1999) found that individual counselling was associated with increased hope, including participants’ agency (defined in this study as their determination to pursue their goals). Research by Chamodraka, Fitzpatrick and Janzen (2017) described higher client hope as an increased sense of control and perceived sense of self-efficacy, described by one of their participants as ‘I had the power to, I had the ability to affect
how much this would affect me’. Chamodraka et al linked their hope as empowerment model to Snyder’s hope theory and the ways in which both agency and pathways thinking linked into it.

Although three studies included in this section did not explicitly couch their findings in hope theory, the themes extracted from these studies described client experiences linking to perceived capacity and motivational elements of hope and therapy. Creating a separate theme for these findings would therefore make an erroneous distinction between them and other findings relating to agency. Egeli, Brar, Larsen, and Yohani (2014) found qualitative evidence of agency thinking in couples’ experiences of couples counselling, which was described by participants as strengthened resolve and therapeutic processes maintaining their momentum. Further research by Egeli et al (2014) suggest that client perceptions of vulnerability may have a relationship with motivation. They found that counselling could lead to concurrent feelings of hope and vulnerability, and that when these were experienced together clients weighed up the pros and cons of participating further in therapy (sometimes leading them to react by denying hope to decrease vulnerability). This was the only study to explicitly discuss the interplay between feelings of hope and feelings of vulnerability, and it did not frame this discussion in terms of agency. The potential role of vulnerability in diminishing motivation and, by extension, hope for therapy will be discussed further in the discussion. Furthermore Larsen and Stege (2012) found that client understandings of hope during therapy were tied to understandings of the self and self-appraisal.

Clinician influence on client hope

The methodological quality of the studies included in this section ranged from 75% to 100%. The majority of studies in this section received a quality rating of 100%,
suggesting a reasonable strength of findings of the included studies and by extension this theme.

This theme linked to the second review question: ‘How does client hope relate to experiences of psychological therapy’. Seven studies found that client hope can be influenced by the actions and responses of clinicians or therapists. Chamodraka, Fitzpatrick, and Jansen found that compatibility between the clinician and client as well as clinician directiveness of hope inspiring strategies impacted upon client hope, and that faith in the therapist acted as a step before clients developing a sense of control over their presenting problem (agency thinking) (Chamodraka, Fitzpatrick & Janzen, 2017). Furthermore, therapeutic ruptures were found to lead to less hope for change, and the frequency and resolution of ruptures predicted agency and pathway thinking, according to Bartholomew, Gundel, & Scheel, 2017.

A number of studies described maintaining hope in therapy as being an active process, with techniques that therapists could use to engender and increase client hope (Koehn & Cutcliffe, 2012; Chamodraka, Fitzpatrick and Janzen, 2017; Larsen & Stege, 2012, Larsen & Stege, 2010, and Egeli, Brar, Larsen, and Yohani, 2014). These could be implicit clinician led processes, such as fostering client perspective change, allowing cathartic release, and ensuring good endings (Larsen & Stege, 2010; Cutcliffe, 2004). The most commonly found implicit hope engendering strategies involved development of a strong therapeutic relationship, which could be formed through safety, acceptance, understanding, commitment, and being non-judgemental (Larsen & Stege, 2010, Cutcliffe, 2004, Larsen & Stege, 2012; Koehn, & Cutcliffe, 2012). A number of studies also described more explicit hope engendering clinician practices such as giving supportive feedback and reviewing pathways to hope (Koehn, & Cutcliffe, 2012, Egali et al 2014). Clinician directiveness was an explicit part of the therapeutic process that seemed to have an interaction with client hope. Chamodraka, Fitzpatrick and Janzen
(2017) report that client hope varied as a result of clinician directiveness, and that when clients considered their actions to be the main reason for progress and clinicians were mainly non-directive, their sense of control was strongest. However, on the other hand, with clients who were more receptive in nature, directive clinician interventions could also elicit a sense of client control. Egali et al found that, when clinicians described possibilities for clients without highlighting clear pathways to these possibilities, clients felt hope but also vulnerability (which was found in this study to sometimes have a negative impact on hope) (Egali et al, 2014). Therefore, it appears that, whilst clinician directiveness can interact with client hope, this relationship is not always simple and may be affected by client factors such as their receptiveness or levels of vulnerability.

Discussion

The aim of the current review was to answer the following questions:

- To what extent is client hope associated with outcomes of psychological therapies?
- How does client hope relate to experiences of psychological therapy?

The findings from the studies fell into the following themes: the relationship between client hope and therapeutic outcomes, experiencing hope-possible pathways to goals, the role of agency in client hope, and the clinician’s influence on client hope.

There was a consistent pattern of findings regarding hope and outcomes in that included studies indicate a positive relationship between client hope and varied therapeutic outcomes. Furthermore, this relationship appears to be bidirectional, with higher client scores on measures of hope being linked to better therapeutic outcomes, and progress in therapy also linked to increases in levels of hope. Indeed one study stated that it may be useful to assess client hope prior to therapy as a form of diagnostic information,
implying an important role of hope within therapy (Westburg & Boyer, 1999). Overall, methodological quality did not impact on the relative findings of included studies, as all studies met the minimum criteria suggested by the MMAT, and, with the exception of one paper, all studies had a quality rating of 75% or higher (Irving et al, 2004).

The sub theme of hope as agency and the experience of hope as possible pathways reflected Snyder’s hope theory (even in studies that did not explicitly intend to use this model), suggesting that this theory is valid and links well to client experiences in therapy. The role of agency could be summarised as motivation and client self-appraisal as being able to follow pathways to change. Experiencing hope-possible pathways to goals could be summarised as the ability to see possible other ways of being and the actions necessary to achieve desired outcomes (Irving et al, 2004).

The role of clinicians in client hope linked into the other three themes (e.g. influencing agency and pathways thinking) and could be split into implicit approaches and explicit approaches. The most salient implicit approach involved utilising the therapeutic relationship (Larsen & Stege, 2012). Clinician directiveness could also have an impact on client hope, although the relationship between clinician directiveness and client hope was not simple and was impacted by client factors (Chamodraka, Fitzpatrick and Janzen, 2017).

Strengths and limitations

This literature review has several strengths. One of these is the scope of the review, as it consolidates a wide range of research investigating a number of different therapeutic settings, techniques, and therapies with clients with a wide range of diagnoses. Due to this wide scope, and the similar findings across studies with different research contexts,
it is probable that the conclusions of this literature review are applicable to a wide range of real world therapeutic contexts. A further strength was the inclusion of quantitative, qualitative, and mixed methods studies, as this allowed for a better picture to be formed of both the objective, measurable role of client hope, and the subjective experience of hope so as to provide context and a richer understanding of the processes involved in client hope.

The included research also had several limitations. For example, there were two pairs of studies (4 studies in total) that were performed by the same research group, using similar research methodologies but with slightly different research questions (Egali et al, 2014; Egali et al, 2014; Larsen & Stege, 2010; Larsen & Stege 2012). These studies were qualitative, and therefore the research would have been affected by the same researcher factors (e.g. researcher epistemological view) each time, possibly leading to more convergent findings in this literature review and a false view of the literature as homogenous. Another limitation was the fact that several of the qualitative studies included in this review overlooked the influence of the researcher on the findings (e.g. in their interactions with participants during interviews and whilst interpreting the data). Therefore, it is difficult to comment on the ways in which participants may have been influenced by the researchers, and consequently hard to tell whether the findings and themes discussed in the included studies were valid interpretations of what the participants had experienced.

This literature review itself also had limitations. Prior to synthesis, the researcher was aware of Snyder’s hope theory, having read much of the literature on this theory. Therefore, although the researcher did not intend to organise the findings based on Snyder’s theory and felt that this organisation came from the data extracted from the included studies (many of which used Snyder’s theory to guide their research aims and discussed findings explicitly in relation to Snyder’s theory), it is possible that the
researcher was primed towards organising the findings in a way that fitted with this theory and there may have been other ways to organise the research into themes (Snyder, 2002).

Bearing the strengths and limitations of the included studies in mind, the literature suggests a number of conclusions. Firstly, that client hope (before and throughout therapy) can have a positive impact on therapeutic outcomes. Secondly, whilst clients may vary in their baseline hope, clinicians can actively influence the amount of hope that clients experience during therapy, and progress in therapy itself can also positively impact on experiences of client hope. One clear way that clinicians can implicitly impact client hope is by developing a strong, safe, and non-judgemental therapeutic relationship with clients. Finally, this literature review suggests that Snyder’s hope theory (2002) can be applied to client experiences of hope within therapy. This review suggests that clinicians should attend to client hope, both by having an understanding of client hope for therapy, and by using the techniques mentioned within this review to engender hope.

Areas for future research

This literature review was undertaken with the view to inform future research hypotheses, and a strength of narrative synthesis is its utility for this purpose. This review has suggested that using Snyder’s hope theory to inform research into client hope is appropriate, and that client hope and therapeutic outcomes appear to be related. One interesting finding was the potential role of vulnerability in hope for therapy (Egali et al, 2014). This was only found in one of the studies, which outlined a complex relationship between hope and vulnerability in which the two were balanced against each other. This is a potential area for further research and clinical practice, as further investigation and addressing of feelings of vulnerability could increase and maintain
hope in therapy. Future research should also endeavour to investigate client hope within an increasingly wide range of settings. Finally, regarding qualitative research on this topic, it may be beneficial for the literature if a larger range of researchers begin to investigate this area, as there are a number of dominant research teams in this area, and different research teams may interpret results differently.
Acknowledgements

The researcher would like to acknowledge the supervisors and clinicians who were consulted in the process of writing this literature review.
References


Part two: Empirical paper
The Meaning and Experience of Hopeful Therapeutic Relationships for Clinical and Counselling Psychologists, in Relation to Waiting Times

Short title: Clinician Hope in Relation to Waiting Times

Key words: Hope, psychology, mental health, therapeutic relationship, waiting times, waiting list

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This paper is written in the format ready for submission to the Journal of Clinical Psychology. Please see Appendix A for submission guidelines.

Word Count: 10132 (excluding references and tables)
Abstract

Objectives: The study aimed to investigate the meaning and experience of cultivating hopeful therapeutic relationships when there are long waiting times for therapy for clinical and counselling psychologists.

Method: Six clinical and counselling psychologists working in services with waiting times longer than 28 days were recruited via volunteer and snowball sampling, and were interviewed using a semi-structured interview schedule. An interpretative phenomenological approach was used to analyse interview transcripts.

Results: Four superordinate themes emerged, these were: Hopeful therapeutic relationships as relationships within relationships, needing to take time but feeling pressured, client dependent reactions to waiting for therapy, and hopeful therapeutic relationships as a journey taken together.

Conclusions: Participants emphasised the importance of wider systemic and team-related factors that interacted with waiting lists. They named a number of ways in which hopeful therapeutic relationships could be constructed in the context of long waiting lists, and the collaborative nature of hopeful therapeutic relationships.
Introduction

Negative experiences such as prolonged emotional distress, victimization, risk to self or others, feelings of hopelessness, treatment disengagement, and incarceration, have been associated with waiting for therapy for a prolonged period of time (Brown, Parker, & Godding, 2002; Carter et al, 2012). Studies of individuals waiting for extended periods of time for substance misuse treatment have highlighted themes of severe symptom loads, significant interpersonal problems, increasing levels of criminal justice involvement over time spent waiting, feelings of hopelessness regarding waiting for treatment, and failure to engage in treatment once it’s offered (Brown, Hickey, Chung, Craig, & Jaffe, 1989; Nordfjærn, 2013; Wenger & Rosenbaum, 1994). Research has also found that time spent waiting for therapy is a significant predictor of therapy dropout for individuals with eating disorders waiting for cognitive behavioural therapy (CBT) (Carter et al, 2012). These researchers suggested that this finding was due to the fact that the motivation to engage in therapy, present at referral, may diminish over time (Carter et al, 2012).

Other research suggests that waiting times have benefits for practitioners and services in terms of caseload management. Dalziel and Kerr (1987) suggested that waiting times can help clinicians manage patients with problems that improve over time. However, these authors focussed on physical health problems, and acknowledged that the utility of waiting times is dependent on the condition being treated. There is evidence that some individuals waiting for mental health services spontaneously improve to the point where psychological input is no longer necessary (May, 1990; May, 1991; Beck, Burdett & Lewis, 2015). However, although a significant proportion of waiting list clients report problem resolution as their reason for attrition, negative effects of waiting for therapy
are found for clients with more urgent or severe problems (May, 1991). The literature is inconclusive on the effect of waiting times on client perceptions of mental health services. Wenger & Rosenbaum (1994) found that substance users awaiting treatment reported feelings of frustration and belittlement related to being placed on the waiting list, whereas May (1991) found that waiting for therapy does not influence client satisfaction.

There are several hypothesised effects and meanings of waiting times for clients. However, the research base is currently relatively sparse and inconclusive. The psychological construct of hope appears to be relevant to the experience of waiting for therapy. Wenger & Rosenbaum (1994) found that individuals waiting for treatment for substance use might experience feelings of hopelessness related to their placement on a waiting list. Furthermore, as previously mentioned, a number of studies have suggested that waiting for therapy can have a negative effect on motivation to change (Furukawa et al, 2014; Carter et al, 2012). According to hope theory, the ability to conceptualise goals, develop strategies to reach these goals, and initiate and maintain motivation to use these strategies, are the three reciprocal and necessary components of hope (Snyder, Lopez, Shorey, Rand, & Feldman, 2003). Consequently, a reduction in motivation to engage in therapy caused by placement on a waiting list could interact with hope for positive therapy outcomes.

There have been several different definitions of hope described in the literature. The research of Snyder and colleagues has been influential in this field, defining hope as ‘the perceived capability to derive pathways to desired goals, and motivate oneself via agency thinking to use those pathways’ (Snyder, 2002). This definition of hope is useful as it incorporates emotion, cognition, and goal orientated thinking. Furthermore, Snyder’s hope theory suggests that individuals with high levels of hope have higher levels of adaptability in terms of generating and switching pathways to their desired
goals, positing ways in which hope can be protective in terms of mental health (Snyder, 2002). However it is important to note that Snyder’s perspective on hope is not the only valid way to view this construct. Hope can be viewed as a multi-dimensional construct, and therefore it is possible that people experience hope in different ways, whilst maintaining the same function in terms of motivation and well-being (Fitzgerald, 2007). One criticism of Snyder’s hope theory is that it puts a lot of emphasis on the role of the individual and their cognitive processes, and therefore somewhat neglects the role of wider systemic variables such as culture and life circumstances. These variables have been posited by other researchers as playing an important role in hope development and maintenance. For example Elliot and Sherwin (1997) outlined the ways in which culture might interact with personal hope. Furthermore Morse and Doberneck (1995) argue that the meaning and significance of hope depends on both life circumstances and personal philosophical stance on hope, thus recognising the role of systemic factors.

Personal levels of hope for both clinicians and clients are consistently viewed as a strength throughout the literature, helping to initiate and sustain recovery from mental health difficulties (Schrank & Slade, 2007). In studies of adolescents and young adults, high levels of personal hope appear to be a protective factor for mental health, linked to increased self-esteem, lower psychological distress, and increased life satisfaction (Dowling & Rickwood, 2016; Halama & Dedova, 2007). In addition to the importance of client hope, research suggests that it is helpful for mental health workers to elicit and encourage hope in clients. A study involving focus groups of service users highlighted the ability to convey hope as an important attribute of mental health workers (Rydon, 2005). Furthermore, Coppock, Owen, Zagarskas, and Schmidt (2010) investigated the relationship between therapist hope and therapy outcome. They found that client-rated hope increased significantly after a single therapy session, and that therapist hope for
clients after the first and final therapy session was significantly associated with client outcomes (Coppock, Owen, Zagarskas, & Schmidt, 2010). Some ways in which hope can be elicited by practitioners were outlined in a study in which bereavement counsellors and clients were interviewed. This study found that the therapeutic relationship could be used to implicitly project hope. Being ‘genuinely’ hopeful as a practitioner was also found to be important, suggesting that it is important to maintain practitioner levels of hope in order to foster these feelings in clients (Cutcliffe, 2004).

As there is evidence that the personal hope of mental health workers is an important resource for fostering hope in service users, research into the ways in which mental health workers can maintain their own hope is important. Although there is little research in this area, Larsen, Stege, and Flesaker (2013) examined the experiences of psychologists and how they maintain their personal hope when working with complex or demoralized clients. These researchers found that a useful way to maintain practitioner hope was by intentionally influencing conversations with service users in a hopeful direction. Some practitioners also used their confidence in the process of therapy in order to maintain their own levels of hope when working with complex clients, as well as envisioning the future direction of therapy. However, due to the fact that this study focussed on ‘in-session’ experiences of hope, it did not take into account contextual variables such as waiting times. (Larsen, Stege & Flesaker, 2013).

Furthermore, Niebiesczanski, Dent and McGowan (2016) interviewed mental health nurses and found that, although the process of maintaining hope can be challenging, supervision and a positive team atmosphere were helpful in fostering perspective and renewing hope. Therefore, although maintaining hope can be difficult for practitioners, there are a number of ways in which hope can be renewed.
Hope and the therapeutic relationship have been linked in the literature. Therapeutic relationships have been defined as comprising of a) an agreement on treatment goals, b) an agreement on the treatment tasks which must be completed for successful treatment, and c) bond development between the clinician and client (Bordin, 1979). For clients hope appears to be protective and is a useful feature of the therapeutic relationship (Cutcliffe, 2004). It has also been suggested that an important element of the therapeutic relationship is the ability of the clinician to foster hopeful expectations of treatment effectiveness in the client (Jensen & Kelley, 2016).

The literature suggests that long wait times for therapy can lead to client frustration at mental health services and feelings of hopelessness (Wenger & Rosenbaum, 1994; Brown et al, 1989). Furthermore, whilst working in a positive team with confidence in the process of therapy maintains practitioner hope (Niebieszczanski, Dent & McGowan, 2016), working in a service with a long waiting list may have a connection to these hope-instilling factors. Although no studies have investigated a potential link between long waiting times and clinician hope or ability to develop hopeful therapeutic relationships directly, Clemente, McGrath, Stevenson and Barnes (2006) evaluated a technique designed to shorten mental health service waiting lists and found that long waiting times can influence staff morale, and that the successful implementation of techniques to decrease service waiting times can increase staff morale. However, possible links between long waiting times, clinician and client hope, and maintaining hopeful therapeutic relationships have received little specific attention in the literature and therefore are not currently fully understood.

Within the United Kingdom, National Health Service waiting times for mental health services have been historically long. This led to the ‘We Need to Talk’ coalition which
called on the NHS to offer ‘a full range of evidence-based psychological therapies to all who need them within 28 days of requesting a referral’, citing evidence that one in five clients with mental health problems wait for over a year to receive treatment (We Need To Talk, 2010, page 1). In April 2015, waiting time standards for mental health services were introduced within the NHS. These standards state that 75% of people referred to the Improving Access to Psychological Therapies (IAPT) programme should be treated within six weeks of referral, with 95% treated within 18 weeks of referral (Parkin, 2016). However, the current focus of these standards and budget is on IAPT, child services and psychosis, suggesting that many services may continue to have long waiting times for treatment.

The literature has linked client and clinician hope with therapeutic relationship development, and client and clinician hope with waiting times for therapy, however no research exists that adequately brings together these constructs. Furthermore, the literature is especially sparse regarding clinician experiences of developing and maintaining hopeful therapeutic relationships, despite a wealth of research highlighting the importance of clinicians instilling hope in clients and being ‘genuinely’ hopeful (Coppock, Owen, Zagarskas, & Schmidt, 2010; Cutcliffe, 2004). Much of this research regarding instilling hope and the importance of client hope focusses on psychological therapy (suggesting an important role for psychologists). However there is a lack of research into the experiences of psychologists working in non-research/clinical trial settings, with existing ‘real world’ research investigating these experiences with mental health nurses (Niebiesczanski, Dent and McGowan, 2016). As studies (especially randomised controlled trials) tend to have more ideal conditions than ‘real life’ therapeutic settings (for example, participants in such studies may not have had to wait for the intervention), research into psychologists’ experiences in everyday clinical
practice is valuable. Furthermore within the NHS mental health clients may wait on the service waiting list, before being allocated to other mental health workers (e.g. mental health nurses), prior to being referred for psychological therapy, and therefore the wait to enter psychological therapy can be especially long. The existing research suggesting a link between client hope and waiting for therapy had a much broader focus (intending to highlight the relevant constructs for waiting times). As there is no existing literature on this subject, an explorative approach investigating the meaning and experience of developing hopeful therapeutic relationships in the context of long waiting times from the perspective of psychologists, would highlight relevant themes for future research. Therefore, this study could have clinically relevant findings by investigating how hopeful therapeutic relationships are experienced in the context of working in a service with long waiting times by clinicians. This research could highlight the ways in which clinical and counselling psychologists cope with issues around constructing a hopeful therapeutic relationship, and their own experiences of hope more generally, which could provide useful information for improving services with long waiting times. If we understand what the meaning and experience of hope in the context of waiting times is from the perspective of clinicians, we can better understand ways in which the effectiveness of therapeutic interventions work in real life settings.

The aim of this study was to investigate the meaning and experience of cultivating hopeful therapeutic relationships when there are long waiting times for therapy, by asking the following questions:

- What are clinicians’ experiences of forming hopeful therapeutic relationships in the context of long waiting times?
- How are hopeful therapeutic relationships maintained in services with long waiting times?
Method

Design
This exploratory study used semi-structured interviews to produce qualitative data, which was analysed using interpretative phenomenological analysis (IPA). It was decided that IPA was the most appropriate methodology, as this study is interested in the personal meaning and experience of waiting times for clinicians, a group who are likely to have a valuable perspective and personal feelings about this topic (Larkin & Thompson, 2012). As the lead researcher was a trainee clinical psychologist, this was a piece of insider research, and the lead researcher’s assumptions and epistemological position (outlined in Appendix M) were mitigated through supervision and reflection. Descriptive data, such as the length of service waiting times, was also collected in order to contextualise the qualitative data.

Recruitment
Participants were recruited via volunteer and snowball sampling. The following recruitment methods were used:

1. An information sheet (see Appendix H) and circular email outlining the research project was sent to the lead Psychologists within each participating NHS trust, who were identified by the lead researcher as having a number of psychology departments that would meet the study criteria (through informal conversations with psychologists working within the trusts) and approached via email as part of the ethical approval process. These lead psychologists in turn forwarded the email to the psychologists within their service.
2. An information sheet and paragraph (see Appendix G and H) detailing the research was included in the NHS trust’s weekly email (which is received by all employees of the trust).

3. Participants were able to take copies of the information sheet with them following the study and were encouraged to give these to any colleagues that they thought might be interested in participating (snowball sampling) as outlined and supported as an approach for qualitative research by Noy (2008).

If potential participants who had been made aware of the research through any of the above methods contacted the researcher, their eligibility for the study was then checked by asking whether they met the following inclusion/exclusion criteria:

Inclusion Criteria:

- Working in a service with a waiting list of greater than 28 days (based on the recommendations of the We Need To Talk Coalition, 2010). This was verified using self report by potential participants following initial contact with the lead researcher, and again using the demographic information sheet prior to interview. The researcher decided not to set an upper waiting list time limit as they decided that individuals working in services with longer waiting times would potentially have relevant and rich insights into the topic being researched.
- Hold a professional role as a counselling or clinical psychologist
- The researcher decided not to set any inclusion or exclusion criteria based on time since qualification, as it was felt that newly qualified psychologists may also have useful experiences (e.g. during their current work and whilst on placements as a trainee). Furthermore the researcher wanted a volunteer sample that was representative of the clinicians doing the therapeutic work within the trusts being recruited from (which included many reasonably newly qualified psychologists).
Exclusion Criteria

- Not having adequate supervision in order to be able to process any feelings elicited by the research (based on the BPS recommendations; British Psychological Society, 2014). This was verified by self-report by potential participants following initial contact with the lead researcher.

Participants

Six individuals participated; this sample size is in keeping with the size of sample deemed appropriate for IPA analysis (Smith, 2004). Two further potential participants who met the inclusion criteria volunteered to take part in the study but as an adequate sample size had been met and analysis had begun when these participants volunteered they were not recruited.

Measures

- Demographic information- information was collected about the type of therapy offered by the clinician, their service role, type of clients seen by their service, average wait time for their service, any service specific rules regarding how long clients can be on the waiting list for, and their number of years’ experience (see Appendix F for demographic information form).

- Semi Structured Interview- The interview schedule was designed for this piece of research, following consultation with a service user regarding their views on what questions the interview should incorporate in order to gather meaningful data. Interviews began with a general question in order to build rapport (Willig, 2013). The interview schedule was designed to enable participants to talk about their experiences of maintaining (or attempting to maintain) hopeful therapeutic
relationships with clients who have waiting a long time for therapy, and used open ended questions (see Appendix E for interview schedule).

**Procedure**

If potential participants who saw the research advertised were interested they could use the contact information provided to contact the researcher. The researcher then ensured that they had a copy of the information sheet and confirmed that they met the inclusion/exclusion criteria via email. Then a convenient date, time, and location were agreed upon for the interview. Before beginning the interview, the researcher checked that the participants understood the research and had read the information sheet. Following this a consent form was provided and completed by the participants (see Appendix I). The demographics and background information questionnaire (see Appendix E and F) was then completed. Following this the semi-structured interview was conducted. At the end of the interview several of the participants took copies of the information sheet, in order to show it to colleagues who may be interested in participating. Interviews were transcribed verbatim with pauses, laughter, and sighs included.

**Ethical Approval**

Ethical approval was obtained from the University of Hull faculty of Health and Social Care ethics committee on 16\textsuperscript{th} October 2017 and the HRA on 21\textsuperscript{st} December 2017 (see Appendix J).

**Data Analysis**

Data was analysed using interpretative phenomenological analysis (IPA). IPA was the most appropriate methodology, as this research is interested in the personal meaning and experience of waiting times for clinicians, a group who are likely to have a valuable perspective and personal feelings about this topic (Larkin & Thompson, 2012). The analysis was carried out in line with the methodology outlined in (Smith, 2004). The
interview transcripts were individually analysed and emergent themes were documented
(initially for individual cases, followed by analysis over multiple cases). A structure was
then developed, based on the data analysis and the lead researcher’s psychological
knowledge of NHS structures, and theories relating to hope, therapeutic relationships,
and systemic models, leading to a narrative interpretation of the data (Larkin &
Thompson, 2012). This interpretation of the data is not intended to be seen as the only
‘true’ reading of the data, and a full statement of the researcher’s epistemological stance
is provided (see Appendix M). A worked example of the coding of transcripts and how
this related to the generation of themes is provided in Appendix K).

Results

The transcripts were very consistent in the themes that emerged, despite variability in
the individual experiences of participants (e.g.: in the services that they have worked
in). The themes were organised into 4 super-ordinate themes, as outlined in Table 1.
Each theme is described using verbatim quotes drawn from the transcripts, with the
information anonymised.

In order to protect anonymity, the demographic information is presented as a whole in
Appendix L. All participants used an integrative therapeutic approach, drawing on a
number of different therapy styles. The number of years’ experience (qualified) of
participants ranged from 6 months to 9 years. The wait times of the services that
participants worked in ranged from 3 months to 14 months. When necessary small
amounts of demographic information may be discussed alongside individual quotes
within the results section, however this will be done in such a way that anonymity is
maintained.

Table 1. Super-ordinate and subordinate themes
<table>
<thead>
<tr>
<th>Hopeful therapeutic relationships as relationships within relationships</th>
<th>Needing to take time but feeling pressured</th>
<th>Client dependent reactions to waiting for therapy</th>
<th>Hopeful therapeutic relationships as a journey taken together</th>
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<tr>
<td>Impact of the wider NHS context</td>
<td>Importance of not rushing to ‘fix’ the problem/make hasty decisions</td>
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<td>Beginning the journey- clinician holding the hope ‘they don’t always have’</td>
</tr>
<tr>
<td>‘I feel like I have NHS bashed a bit and, erm, it’s no ones fault it’s just something needs to change’ (participant 5)</td>
<td>‘what’s maybe helped is not felt that I needed to rush in and fix things straight away’ (participant 3)</td>
<td>‘it bothers me that they have to wait that long. But at the same time I have some hope that they won’t need it, or that they’ll find some other way of coping’ (participant 1)</td>
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### Relationships with the rest of the MDT

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<th>Waiting lists leading to a sense of pressure</th>
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<tr>
<td>‘I think working in a hopeful team certainly has a big impact on me’ (participant 6)</td>
<td>‘you can feel really responsible for that process, I think I did initially feel really responsible for the fact that I have this waiting list’ (participant 4)</td>
<td>‘I suppose another thing about our psychology waiting list-like I said before is it potentially helps you think about whose motivated for therapy’ (participant 3)</td>
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<td>‘They’d be amazed at how you remember stuff about them…it’s usually those elements that are the most help-someone listening’ (participant 4)</td>
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### Importance of supervisory relationships

<table>
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<th>A continuum of hope building whilst waiting to hope eroding over time</th>
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<td>‘he still very much has this sense that, when the therapy</td>
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‘supervision’s helpful’ (participant 2)
she’d been waiting a long time to see someone I think and again I think that impacts on how people are when they come in, they might be like chomping at the bit ready to go or some people might be the other way kind of ‘uhhh, god, you know, I’ve been waiting this long, you know what’s the point of it’ (participant 5)

comes to an end what if I’m still struggling’ (participant 3)

Perceived Anger, Uncertainty and anxiety in clients
‘they might have a lot of angry feelings about having waited that long’
**Superordinate theme: Hopeful therapeutic relationships as relationships within relationships**

This theme was represented across all the transcripts, despite the semi structured interview schedule focussing somewhat on the 1:1 therapeutic relationships between clinicians and clients. It became very clear that, for clinicians, developing and maintaining hopeful therapeutic relationships with clients who have waited a long time for therapy is experienced within the context of relationships of the wider system. They described the 1:1 relationship as interacting with and being affected by a large number of other relationships. The sub-ordinate themes capture the other relationships that interplay with hopeful therapeutic relationship formation for both clinicians and clients.

**Impact of the wider NHS Context**

Clinicians described the impact of their relationship with the wider NHS as having a large impact on them, making it harder for them to hold hope for clients generally. Participants described this system as making them feel less supported, less well resourced, and more hopeless, with frustrating decisions being made by people with more power and them having to deal with the consequences:

Participant 4: “The financial situation isn’t down to me, the decisions that have been made to cut my colleagues wasn’t down to my decision making…but I’m the one that picks up the pieces”

Participant 2: “The policy kept changing so that wasn’t very…it wasn’t very easy for clinicians to kind of feel that they knew where they stood with making the decisions and that somebody would kind of back that up if they, if they did make a decision that somebody didn’t like”

**Relationships with the rest of the MDT**
All participants talked about the impact, positive and negative, of other healthcare professionals within their teams on client and clinician hope and relationships. This was especially relevant to care coordinators, from whom referrals to Psychology are often received and who are often the main point of contact with mental health services for the clients prior to Psychology. Several participants suggested that, as care coordinators tend to refer the clients that they are most stuck with rather than the clients who are most ready/motivated for therapy, a referral to psychology could be a very hopeless starting point, and that the way in which the case was referred and described to psychologists by care coordinators could play a role in the hope that clinicians felt for the client:

Participant 3: “There’s this dynamic where they refer the worst... and I think that’s the-that can be a bit of a problem because sometimes those are the people that are most stuck and actually don’t want to make a change...but the staff are really stuck...so you’re kind of seeing them for the staff rather than for the patient”

The psychological mindedness and hope of the team as a whole was something that participants were very mindful of and felt responsibility for managing (by using their relationships with other staff). Some respondents felt that if they could create more hope in the team, it could affect the hope of clients:

Participant 4: “I think if you can safely make the team feel a bit more hopeful in a hopeless time, then that might help to move onto clients as well on the client level”

Whereas two participants described elements of their team that helped them to develop hopeful therapeutic relationships, such as working in a hopeful and well-connected team:
Participant 6: “I think that makes a massive, massive difference…staff who are energetic and hopeful…that rubs off…on you and there’s a positive kind of vibe…and that makes a difference both for the client…but also, erm, with myself as well”

And working in a team where powerful members of the team were psychologically minded:

Participant 5: “it’s good when you can work with psychiatrists and doctors who are really on board with psychology…and really advocate for that…cos I think sometimes you come home feeling a bit beat by the system, erm, and thinking you know ‘what’s the point of trying to instil change, when you’ve got the system around you that’s not very supportive of that’”

The importance of supervisory relationships

All participants, regardless of time since qualification, stated that good supervision and supervisory relationships (both formal and informal) were important for maintaining hopeful therapeutic relationships with clients. These relationships were especially meaningful when supervisors/other colleagues shared their own similar experiences and confirmed that experiences of hopelessness within therapeutic relationships are normal for clinicians and could have positive outcomes. Supervision was also used for taking a step back when stuck and finding novel solutions. There was a sense that the experience of forming and maintaining hopeful therapeutic relationships with service users that had waited a long time for therapy was made more manageable and felt more contained due to supervision:

Participant 2: “I guess supervision but I guess like also kind of informal supervision with colleagues that will kind of say well ‘have you thought about this’ and or maybe
‘that bit sounds like this was going on’ or things like that... that’s quite helpful and I guess just the normal kind of theme that other people have been through that as well”

Super-ordinate theme: Needing to take time but feeling pressured

Throughout the transcripts there was a sense of the importance of space and time for hopeful therapeutic relationship development, and the sense that long waiting lists had several effects that led to clinicians feeling pressured and like they couldn’t take as much time as they wanted for therapeutic relationship development.

Importance of not rushing to ‘fix’ the problem/make hasty decisions

Throughout therapy, the importance of having time to make decisions was highlighted. This included whilst deciding who to take on for individual therapy, formulating and creating goals with clients, and deciding when to end therapy:

Participant 3: “I think it can be difficult in the complex history to sort of nail down exactly what that person wants to work on erm so I think having that slightly longer assessment is really useful”

Participant 3: “We’ve got plenty of time to...focus on the issues...but also to focus on just where that person is right now and build that relationship and I think, not having the pressure allows us to...develop more of a therapeutic relationship which can go on and feel more hopeful”

The analysis suggested that a longer-term relationship which takes time to understand their problems and behaviours is often more useful for clients than a quick fix strategy for their problem. Furthermore, one participant spoke about having time to help clients with issues that aren’t necessarily therapeutic, but are meaningful to the client and therefore help the development of a strong and hopeful therapeutic relationship:
Participant 3: “what’s maybe helped is I’ve not felt that I needed to rush in and fix things straight away”

Participant 2: “I’ve written letters for housing or benefits appointments, things like that...can help actually with the relationship with somebody... I guess it helps the person to feel...that you’ve kind of listened to the issues that they thought were important”

**Waiting lists leading to a sense of pressure**

As well as the need for time in order to develop therapeutic relationships, the data analysis also suggested a number of ways that long waiting times can increase the amount of pressure on clinicians. When waiting times for therapy are long, services may introduce new rules, for example one participant worked in a service in which rules were implemented about discharge after a certain number of sessions. Furthermore, participants described a sense of guilt about the length of the waiting list, which had a negative impact on the experience of hopeful therapeutic relationships for clinicians, and made them question whether they should discharge their current clients. There was agreement regarding this theme across participants with different waiting list lengths (3 months-14 months):

Participant 2: “I guess trying to be like a lot stricter about people not turning up or cancelling or not attending which I think was probably one of the most difficult things for me...in terms of kind of maintaining therapeutic relationship with somebody when you’re also having to if they ring in to say ‘oooh well, this is like number whatever cancellations’ is a bit tricky as well”

Participant 6: “it’s kind of like a tricky like moral dilemma really about erm, finding a good enough point to finish with people who are currently on your caseload but not
rushing it…but not carrying on much longer that then we can’t offer services to other people”

Superordinate theme: Client dependent reactions to waiting for therapy

All participants stated that they believed that waiting for therapy could change the experience (or necessity) of hopeful therapeutic relationship development for clients, but that this could be either a positive or a negative depending on the individual client. Whether the wait for therapy led to positive or negative changes were perceived by participants to be due to client factors, such as transference from previous relationships, changes in life circumstances or personality factors.

Opportunity to get ‘better’ whilst waiting vs changes in life circumstances

Three participants talked about having hope that clients would get better whilst waiting for therapy, leading to them never actually having therapy. This was generally considered to be better than clients receiving therapy straight away and therefore viewing themselves as only being able to recover with intervention from a professional:

Participant 1: “I guess to some extent in that I have hope that things will get better for them in the meantime and they don’t need to see me eventually”

However, the flip side of this coin appeared to be the possibility that things could get worse over time, especially if clients experienced negative changes in their circumstances. Three participants talked about it during the interview. For example, if a client were to lose a supportive and significant person in their life whilst waiting for therapy, entering therapy and developing a hopeful therapeutic relationship would be much harder:
Participant 3: “I think one of the difficulties of a waiting list, erm, is that we might feel that somebody is appropriate for therapy, we put them on the waiting list and then their life circumstances might change or, something else might come up for them that then means they’re not in a place to have therapy and then I suppose you could say that they’ve missed out potentially on that opportunity in those 9 months.”

One participant (whose service had the shortest wait time), talked about their services’ system that allowed clients to choose when they entered therapy (and encouraged clients to consider life events). This was deemed to be a positive and allowed for better, more hopeful therapeutic relationships once the client did enter therapy:

Participant 6: “In traditional services, you’d wait on a waiting list up until a point and then you’d get offered your, erm appointment… and if you don’t take it you get a kind of discharged whereas you might be waiting, totally ready for it when you agreed and then you’re waiting for three months and something totally changes… you’re really not in a good place where it’s hard to attend appointments… [whereas in their service] you say is now a good time for you to do it and kind of put the ball in their court to consider what’s going on… then they can get to a point that they feel that they’re more able to make the most of it”

**Ensuring motivation and preparedness for therapy**

This was another theme in which there was convergence across participants’ experiences, with five participants stating that they thought a positive effect of clients waiting for therapy was that it ensured motivation for therapy was present and that clients were fully prepared for therapy. For some participants this was linked to the client’s work with other members of the MDT, for example the benefits of continued stabilisation work with care coordinators whilst waiting for therapy. For other
participants this was more due to the clients looking forward to and getting ready for therapy:

Participant 3: “[waiting for therapy] can be a positive thing in some ways because I think...it helps you to sort of work out if somebody is motivated for therapy”

One participant described a client for whom a long wait for therapy had been highly useful and ultimately led to better therapy outcomes, as this time had been well utilised by the client themselves and their care coordinator:

Participant 4: “This man had been on the waiting list for 2 years, 3 years, but in that three years he’d come off cannabis, he’d stopped using any substances, he’d stopped drinking, he’d got himself a bit fitter with his care co so they’d done a lot of the prep work to get him to a better place and I guess that’s the advantage of having that waiting list in this situation, because it gave him opportunity to show that he was committed to do something”

A continuum of hope building whilst waiting to hope eroding over time

Throughout the transcripts there was a sense that changes in client hope were common during the wait for therapy. This appeared to exist on a continuum of hope increasing or decreasing over time. Clinicians believed that waiting for therapy could lead to increases in client hope, which could be positive if the hope was in line with reality. However, some of the participants talked about experiences of clients whose expectations for therapy had become unrealistic whilst waiting. This led to participants having to have conversations in which they managed and reframed these expectations early in therapy, reducing the client’s unrealistic hope for therapy:
Participant 3: “There’s the difficulty of managing expectations if people are on a waiting list for a really long time and they’ve sort of pinned all their hope on this being helpful to them”

In contrast, for some clients, it appears that hope can erode over time whilst waiting. This idea of hope eroding over time was discussed by participants working in services with very different waiting list times (between 3-5 months and 12-14 months):

Participant 4: “There’s another thing that actually readiness to change, if you are really ready and then you’re stuck on a waiting list for three years... does that erode hope as well?”

Participant 5: “Some people might be the other way kind of ‘uhhh, god, you know, I’ve been waiting this long, you know what’s the point of it’”

Part of this appeared to be due to the client’s trust and opinion of the NHS being affected by the wait, leading to reduced trust in the clinician by extension:

Participant 5: “I think people come in a bit miffed, bit angry a bit sceptical... I think people probably come in perceiving kind of NHS and NHS staff as kind of lacking competency or lacking efficiency you know ‘I’ve had to wait six months for this, you know come on then work your magic’”

One participant talked about a client whom had committed suicide, and the role that hope eroding over time, due to inadequate psychology input, had on this tragic outcome:

Participant 4: “I worked with another client... he died, he committed suicide and he should have been seen so much earlier... it got to the point where things were offered too late cos hope had already been completely eroded”

Perceived anger, uncertainty, and anxiety in clients
All participants discussed their perceptions of the emotional reactions to having to wait for input that they had experienced from clients. These responses could impact on relationship development if not addressed by clinicians. The most commonly described emotional response was anger, with all participants having experienced clients as angry in relation to waiting/having waited for therapy (despite the differences in participant’s waiting list times, which ranged from 3 months to 14 months). This appeared to be distressing for clinicians, as there was a sense that they empathised with the clients, however at the same time did not have the power to change the situation for the better. Clinicians felt that this anger could be addressed by validating the clients’ experience, and it was reported that this anger was perceived to be generally short lived and therefore did not change the experience of hopeful therapeutic relationships in the long run:

Participant 5: “Yeh it’s not fair on the patients but we’re the kind of messengers that have to deliver that news, and we deal with the anger when they come in”

Participant 2: “They might have a lot of angry feelings about having waited that long, erm, and I guess it is just about kind of acknowledging that and validating that as kind of a legitimate thing to feel rather than kind of pathologizing it in a way, so I think it, I think it, like most of the time people do build a good enough therapeutic relationships”

Participants also described how waiting for therapy appeared to make clients more anxious due to the uncertainty of when they were going to be seen, and having a long time to ruminate on what therapy would be like:

Participant 3: “I suppose it’s also actually quite anxiety provoking because people can feel quite ambivalent about ‘oh I want the support but I’m also worried about what it might bring up for me’, and I suppose if you’ve got people in that sort of anxiety state for a long period of time, worrying about that’s potentially detrimental”
Super-ordinate theme: Hopeful therapeutic relationships as a journey taken together

Throughout all the transcripts there was a clear message that hopeful therapeutic relationship maintenance relies on both the client and the clinician being hopeful. The client experience of hope and the clinician experience of hope interact, and a shared sense of hope is developed together within the therapeutic relationship:

Participant 1: “There’s some sort of interaction between the feedback you get from your client and your own level of hope which I suppose is equally the same for the other way isn’t it, so if I go in hopeful…. then that person is maybe more inclined to engage in that then things are more likely to change, and I suppose that then has an impact on me in that my hope is maintained and I become more hopeful”

Beginning the journey-clinician holding the hope at the beginning

Participants consistently suggested that clinicians consider it to be their role to introduce and ‘hold’ hope at the beginning of therapy:

Participant 1: “I guess they don’t always have hope themselves...I suppose trying to...hold their hope for them a little bit, in the sense that like things can be different even though it’s awful and it’s hard for it to be different”

This represents a balance between entering into the therapeutic relationship hopefully and conveying this to clients to help them feel that something can be different, whilst avoiding appearing so hopeful that the client perceives the clinician’s hope as unrealistic and unempathetic. Therefore, participants did not only feel that it was important for them to hold the hope initially, but that they had an important dilemma to consider in terms of how much hope to convey to clients:
Participant 6: “When [the client] would become really hopeless I suppose sometimes I would respond with… communicating that there was potential that things were gonna get better, …he’d often respond by being more hopeless and… from then [I]… not dropped the hope but didn’t take that kind of same, erm, approach in I was just kind of maybe more sat and really tried hard just to kind of empathise and understand the person’s experience”

Strategies for developing hopeful therapeutic relationships

A number of strategies that could be employed to develop hopeful therapeutic relationships in the context of clients who had waited a long time for therapy were named. Although there was a sense that these would be the same strategies used with clients who hadn’t waited a long time, the context of having waited was taken into consideration by clinicians (e.g. setting goals is always important, but if someone has waited a long time, they may have developed unrealistic goals over this period). Furthermore there was agreement between participants regarding the strategies that would be used to develop hopeful therapeutic relationships, despite the variation in waiting list times for participant’s services.

An important part of initial hopeful therapeutic relationship development appeared to be deciding on shared goals and contracting the relationship. Whilst clear goals were deemed to be important, the participants also described the necessity of reviewing these regularly and allowing flexibility too. This appeared to help initiate hopeful relationships and keep the relationship hopeful:

Participant 5: “I think often people can come in with unrealistic goals for therapy saying I want to be happy and I-what what does that mean, does that mean you’re never feeling sad then? So always coming back to those smart goals, erm reviewing often”
Participant 3: “When therapy drifts for whatever reason, I think for clients again that can make them question ‘is this gonna be something that’s helpful for me, am I going to be able to change’, whereas if we’re regularly reviewing... that can again provide a sense of hope that their needs are being taken into account and they’re being listened to and we’re able to develop something that’s fluid it’s not fixed... and that for me feels quite hopeful in providing helpful-guiding hope”

There was also a sense that both the clinician and client needed to feel able to be open and honest, and trust the other person to also be open and honest:

Participant 5:“I think it’s all about mutual trust...I put trust in my clients to be honest with me about how they’re feeling as well as them trusting in me that I will, you know, keep everything confidential within the boundaries and, erm, create a safe space so yeh I think it is about mutual honesty and respect for each other”

In the context of long waiting times, this often involved the clinician openly talking about the wait time not being good enough and the reasons for this wait:

Participant 5: “I come in and I say ‘yeh, it’s beauracracy and I can only apologise, erm, about the wait, erm’ and I’ll say you know ‘it’s no individual’s kind of fault, it’s it’s just government and systems at the moment it’s really incredibly difficult’”

Another aspect that was important for the client’s hope and the strength of the therapeutic relationship was the clinician acting in a way that allowed the client to feel listened to and understood:

Participant 4: “They’d be amazed at how you remember stuff about them...it’s usually those elements that are the most help-someone listening”

Participant 3: “I think hope is really strongly linked to feeling understood and it’s not necessarily about, this is, you know I can teach you this strategy or I can provide this
for you I think it is more linked-in my experience of working with people-it’s more linked to being understood”

Finally, all bar one of the transcripts mentioned the importance of acknowledging and celebrating small but significant client acts for hopeful therapeutic relationships. These small but significant acts could include coming to therapy every week or disclosing difficult information. These small but significant client acts were described as incredibly meaningful and hope inducing for clinicians as well as clients:

Participant 5: “Even just small achievements, you know I used to work with a man with really big anger issues and even just the fact that he went one week without having a physical fight with someone, and just making a really big deal about that gave him hope”

Ending the journey with hope

Following hopeful therapy, it appears to be important to end in a hopeful way, to allow clients to continue to be hopeful past the end of therapy. The context of long waiting times is pertinent here as this can lead to clinicians feeling pressured to end therapy with current clients and having to balance not wanting to rush endings whilst also wanting people on the waiting list to have access to therapy (linking to the ‘waiting lists leading to a sense of pressure’ sub-theme). There was agreement on this theme from participants who had substantially different waiting list times (3 months-14 months):

Participant 6: “I think sometimes if it is a…premature ending I think sometimes people…become more distressed and kind of communicate that in a certain…way”

Another part of hopeful endings was the importance of clinicians reflecting on cases at the end of therapy and learning from their experiences. This was generally positive, as
many clients had made more progress than the clinicians had hoped for at the beginning of therapy, and therefore thinking about experiences with previous clients was a useful way to maintain hopeful therapeutic relationships with similar current clients:

Participant 4: “I think it was really powerful for the team to actually see the progress and to see actually he’s made a difference and done something different so I think it started to reignite hope in the team that even those people who’ve been around a long time, something can be different”

Ending with hope was described similarly by participants with a range of years’ experience. However one participant wondered whether being relatively newly qualified may interact with this ability to draw on previous hopeful experiences, as they did not have as many previous experiences with other clients (good or bad) to draw on as someone who was more experienced. They believed that having this ‘back catalogue’ could effect hope for current clients positively or negatively:

Participant 1: “I do think there’s something about…how new I am…I don’t particularly have a whole back catalogue of clients in my head…that effect how hopeful I am for a particular one”.

Discussion

This study explored the meaning and experience of hopeful therapeutic relationships in the context of long waiting times. This study was performed as there is a gap in the literature regarding the experience of hopeful therapeutic relationships in the context of long waiting times, despite research linking waiting for therapy with hope and hope with therapeutic relationships. Participants’ responses were grouped into 4 overarching
themes; hopeful therapeutic relationships as relationships within relationships, needing to take time but feeling pressured, client dependent reactions to waiting for therapy, and hopeful therapeutic relationships as a journey taken together. These themes gave a sense of the active and two-way process of forming hopeful 1:1 therapeutic relationships, but also the importance of considering wider systemic influences and pressures on this relationship, including but not limited to factors relating directly to long waiting times for therapy.

The influence of the wider system on both the client and clinician’s hope and ability to form therapeutic relationships, as captured by the theme ‘hopeful therapeutic relationships as a relationships within relationships’, was talked about at length by all participants. For all bar one participants the focus was on the ways in which external factors had a negative impact or made it harder to have positive hopeful 1:1 therapeutic relationships with clients. Although these factors were discussed in the specific context of clients who had waited a long time for therapy, it is possible that some of these factors may have an influence in settings without a long waiting list as well (although this was not explored by the current study). The benefits of having a more connected, hopeful and well-resourced team who are psychologically minded, and the impact of this on individual therapeutic relationships was strongly felt. Also, the need for clinicians to feel supported by and hear stories of hope from individuals who they identify as having had similar experiences to them (via supervision) was very clear throughout the data.

It should be noted that the questions on the semi structured interview schedule were worded in a way that would imply answers focussing on 1:1 therapeutic relationships and waiting times specifically, and therefore it is of interest that many of the interviews focussed a considerable amount of time on the wider systemic context, as this was clearly important to all the participants. This theme links to research regarding systemic
approaches to development and mental health. For example Bronfenbrenner’s bioecological perspective emphasises that it is important, when considering human development and potential for change, to take into account context. This model conceptualises context as the microsystem (the setting in which the individual is behaving in the given moment), the mesosystem (a set of microsystems that make up the individual’s developmental niche), the exosystem (contexts that, whilst not directly involving the person, have an influence on the person’s development and behaviour), and the macrosystem (the superordinate level involving culture and macro institutions such as the government) (Bronfenbrenner, 2005). In line with this theory the relationship between the therapist and client does not exist without being influenced by the therapist and client’s mesosystem (e.g. the relationship with the rest of the client’s care team), exosystem (the clinician’s relationship with other members of the team), and macrosystem (wider factors effecting the NHS such as policy changes and pervasive lack of resources).

The second super-ordinate theme, that hopeful therapeutic relationships needed time but the context of waiting lists added pressure, was strongly linked to the first. The finding that time is needed in order to develop a positive hopeful therapeutic relationship is in line with the findings of Shattell, Starr, and Thomas (2007). Their qualitative phenomenological study focussing on the experiences of mental health care recipients’ experiences of therapeutic relationships found that, even if a mental health practitioner is skilled, if they to not take time to get to know the client or appear rushed, a therapeutic relationship will not develop. Therefore it appears that both clients and clinicians view the ability to take time/not be rushed as important for therapeutic relationship development.
The third super-ordinate theme focussed on the client dependent reactions to waiting for therapy. The subordinate themes included in this were reasonably in line with previous research findings. For example, the themes found in this study are in line with findings stating that waiting for a long time for therapy can increase client feelings of hopelessness, motivation to engage decreasing over time whilst waiting, and a negative opinion of the mental health services as a whole (Brown, Parker, & Godding, 2002; Carter et al, 2012; Wenger & Rosenbaum, 1994). However the current study found more positives of waiting for therapy than previous research has, possibly because of the qualitative and open ended nature of the interview used. This complements and adds to the research of Dalziel and Kerr (1987) focussed on physical health problems, which argued that waiting lists could help manage caseloads due to some clients spontaneously getting better whilst waiting for treatment. There was a sense throughout the transcripts that individual factors such as personality and developmental history of relationships were perceived to be predictive of whether clients would be negatively affected by waiting or not. This client dependent nature of the reaction to waiting led to a sense of uncertainty for clinicians in the first session, as it could ‘go either way’.

The final super-ordinate theme described hopeful therapeutic relationships as a shared journey for the clinician and the client. This theme described hope in an active way, with the clinicians purposefully creating and renewing hope using a number of techniques. The ways in which hopeful therapeutic relationships were described by participants aligns with Snyder’s hope theory. The subordinate theme of creating congruent goals in order to develop a hopeful therapeutic relationship concurs with Snyder’s definition of hope as the perceived capability to derive pathways to desired goals and motivate oneself via agency thinking to use those pathways’ (Snyder, 2002). Creating realistic and shared goals with clients allows both clinician and client to understand what they are hopeful for and see a path for therapy. Furthermore, the
importance of agency for hope was highlighted by this theme, as clinicians reported feeling responsible for holding hope, but equally felt that the client had a role to play in generating hope within the therapeutic relationship and named ways in which client-clinician pairs could actively motivate themselves towards their shared goals. Overall there was a sense that, although it can be hard to develop and maintain hopeful therapeutic relationships in pressured services with long waiting times, all participants had positive stories regarding experiences of hopeful therapeutic relationships with clients and felt some sense of agency in terms of their ability to develop and maintain hopeful therapeutic relationships in these contexts. These findings may have implications for therapeutic practice of individual clinicians, as it suggests that hopeful therapy is possible in these difficult situations and names some ways in which hopeful therapeutic relationships may be best developed in these contexts.

The convergence in themes suggests that this research reached data saturation. For all super-ordinate themes that emerged in this research, there was convergence across transcripts, and several occasions in which different participants produced almost exactly the same quotes. One participant (participant 6) was notably different due to the fact that they considered themselves to work in a very hopeful service. Whilst this may have been evidence of divergence, analysis of participant six’s transcript suggested that they were highlighting the opposite end of the continuum in terms of what clinician’s need to feel hopeful. For example, unlike the other interviewees, participant 6 considered their service to be well resourced and to have more flexibility in terms of allowing clients to enter therapy at the point that they felt most ready for therapy, whereas other participants highlighted that their services did not allow this flexibility or were not well resourced, which negatively influenced their hope. Therefore, this may suggest that there are a number of feasible ways in which services can adapt to encourage more hopeful therapeutic relationships between psychologists and clients.
Further research investigating particularly hopeful services may be useful, in order to better understand the processes that make services hopeful and ways in which other services can adapt to be more hopeful.

Whilst analysing the transcripts, the researcher felt that the data was very rich, and whilst this is positive, this piece of research is necessarily a broad brush stroke piece of work in order to summarise all of the most pertinent themes raised by the participants, meaning that some of the detail and depth of the initial analysis has been lost. Future research specifically investigating individual super-ordinate themes, especially regarding the meaning of wider context variables on development of hopeful therapeutic relationships, would be beneficial to gain a more in depth understanding of these specific processes.

A limitation of this research is that the researcher was a trainee clinical psychologist, and therefore this was a piece of ‘insider research’. This may have led to the participants responding in a way that was biased towards social desirability. As part of the process of gaining informed consent, participants were informed that the researcher would follow the NHS whistleblowing policy if they disclosed information that constituted a safeguarding issue. Although this was a necessary part of gaining informed consent, it is possible that they may have changed some of their responses due to feeling anxious about saying something ‘bad’ that would be reported. Furthermore, the researcher reflected on the fact that participants used a lot of psychologist ‘jargon’, and that during interviews there was a sense of participants sharing experiences with someone whom they expected had similar experiences. This may have in some ways been an advantage, in that they may have felt more at ease. Furthermore it is possible that the fact that the researcher was an insider may have led participants to spend less time explaining the context of their service or therapeutic approach (as they may have assumed a level of understanding on the part of the researcher). There could have been benefits to this, as it
may have allowed them to use more of the interview time for what they deemed important. However there is also the risk that the researcher may have a different understanding of these factors, leading to an interpretation that may not have rung as true for the participant as if they had gone into more detail explaining these factors. Furthermore some of this information may have valuable for analysis. These potential benefits and risks were discussed in supervision, and the researcher was aware of this whilst asking questions and made a concerted effort to keep questions as open and unbiased as possible, as well as asking follow up questions to ensure that the understanding of what was being discussed was shared.

A further potential limitation is that, as previously mentioned, the semi structured interview schedule was worded in a way that would imply answers focussing on 1:1 relationships with clients, however it was clear in the interviews that wider systemic factors were relevant to hope for clinicians. This 1:1 focus of the schedule may have been due to the fact that the interview schedule construction was informed by the researcher’s reading regarding hope, and therefore may have been influenced by Snyder’s hope theory (Snyder, 2003). However this hope theory can be criticised for under-emphasising the role of wider systemic variables in the meaning, development and maintenance of hope (Elliot and Sherwin, 1997). Although the researcher believes that this interview schedule captured the information most relevant to the participants, and there was flexibility in interviews due to their semi-structured nature, this potential limitation is worth consideration.

**Conclusions**

In conclusion this study found that hopeful therapeutic relationships are maintained in contexts where clients have waited a long time for therapy, although contextual factors (including but not limited to waiting list length) interact and can have an impact on
clinician experiences of developing and maintaining hopeful therapeutic relationships. Therapeutic relationships do not happen in a vacuum, and hopeful, well resourced, flexible, and unpressured services are the optimum condition for hopeful therapeutic relationship formation. Furthermore, the process of developing and maintaining hopeful therapeutic relationships is collaborative and goal orientated. Clinicians initially feel responsible for holding the hope, however hopeful therapeutic relationships are an active and two-way journey, with client and clinician hope interacting and influencing each other.
Acknowledgements

The author would like to acknowledge the contributions of the clinicians involved with recruitment and supervisors for their input.
References


Parkin, E., NHS maximum waiting times standards and patient choice policies, May 2016


We Need To Talk Coalition, We Need To Talk; Getting the right therapy at the right time, 2010


Part Three: Appendices
Appendix A: Journal Submission Guidelines for the Journal of Clinical Psychology

Author Guidelines

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Author Guidelines

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3. Register (if you have not done so already).
4. Go to the Author Center and follow the instructions to submit your paper.
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6. Please note that this journal's workflow is double-blinded. Authors must prepare and submit files for the body of the manuscript that are anonymous for review (containing no name or institutional information that may reveal author identity).
7. All related files will be concatenated automatically into a single .PDF file by the system during upload. This is the file that will be used for review. Please scan your files for virus(es) before you send them, and keep a copy of what you send in a safe place in case any of the files need to be replaced.

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**Format.** Number all pages of the manuscript sequentially. Manuscripts should contain each of the following elements in sequence: 1) Title page 2) Abstract 3) Text 4) Acknowledgments 5) References 6) Tables 7) Figures 8) Figure Legends 9) Permissions. Start each element on a new page. Because the *Journal of Clinical Psychology* utilizes an anonymous peer-review process, authors’ names and affiliations should appear only on the title page of the manuscript. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

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- **Objective(s):** Succinctly state the reason, aims or hypotheses of the study.
- **Method (or Design):** Describe the sample (including size, gender and average age), setting, and research design of the study.
- **Results:** Succinctly report the results that pertain to the expressed objective(s).
- **Conclusions:** State the important conclusions and implications of the findings.
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Appendix B: Data extraction form

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**Therapeutic setting**

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**Participants**

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<td>Salient discussion points (e.g. implications)</td>
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Appendix C: Quality Assessment Tool (MMAT)

Mixed Methods Appraisal Tool (MMAT) – Version 2011

For dissemination, application, and feedback: Please contact pierre.phaye@mcgill.ca, Department of Family Medicine, McGill University, Canada.

The MMAT is comprised of two parts (see below): criteria (Part I) and tutorial (Part II). While the content validity and the reliability of the pilot version of the MMAT have been examined, this critical appraisal tool is still in development. Thus, the MMAT must be used with caution, and users’ feedback is appreciated. Cite the present version as follows:


Purpose: The MMAT has been designed for the appraisal stage of complex systematic literature reviews that include qualitative, quantitative and mixed methods studies (mixed studies reviews). The MMAT permits to consecutively appraise and describe the methodological quality for three methodological domains: mixed, quantitative and qualitative (subdivided into three sub-domains: randomized controlled, non-randomized, and descriptive). Therefore, using the MMAT requires experience or training in these domains. E.g., MMAT users may be helped by colleagues with specific expertise when needed. The MMAT allows the appraisal of most common types of study methodology and design. For appraising a qualitative study, use section 1 of the MMAT. For a quantitative study, use section 2 or 3 or 4. For randomized controlled, non-randomized, and descriptive studies, respectively. For a mixed methods study, use section 1 for appraising the qualitative component, the appropriate section for the quantitative component (2 or 3 or 4), and section 5 for the mixed methods component. For each relevant study selected for a systematic mixed studies review, the methodological quality can then be described using the corresponding criteria. This may lead to exclude studies with lowest quality from the synthesis, or to consider the quality of studies for contrasting their results (e.g., low quality vs. high).

Scoring metrics: For each retained study, an overall quality score may be not informative (in comparison to a descriptive summary using MMAT criteria), but might be calculated using the MMAT. Since there is only a few criteria for each domain, the score can be presented using descriptors such as *, **, *** and ****. For qualitative studies, the score can be calculated by summing the number of criteria met divided by four (scores varying from 25% (*) - one criterion met - to 100% (****) – all criteria met). For mixed methods research studies, this score is the overall quality score is the lowest score of the study component. The score is 25% (*) when QUAL=1 or QUAN=1 or MM=0, it is 50% (**) when QUAL>=2 or QUAN=2 or MM=1; it is 75% (***) when QUAL=3 or QUAN=3 or MM=2; and it is 100% (****) when QUAL=4 and QUAN=4 and MM=3 (QUAL being the score of the qualitative component, QUAN the score of the quantitative component, and MM the score of the mixed methods component).

Ratifications: There are general criteria for planning, designing and reporting mixed methods research (Creswell and Plano Clark, 2010), but there is no consensus on key specific criteria for appraising the methodological quality of mixed methods studies (O’Cathain, Murphy and Nicholl, 2008). Based on a critical examination of 17 health-related systematic mixed studies reviews, an initial 15-criteria version of MMAT was proposed (Phaye, Gagnon, Griffiths and Johnson-Lafeur) in 2003. This was pilot tested in 2009. Two raters assessed 29 studies using the pilot MMAT criteria and tutorial (Phaye, 2010; Phaye, Bartlett, Macaulay et al., 2010). Based on this pilot exercise, it is anticipated that applying MMAT may take on average 15 minutes per study (hence reliable), and that the Intraclass Correlation might be around 0.8 (hence reliable). The present 2011 revision is based on feedback from four workshops, and a comprehensive framework for assessing the quality of mixed methods research (O’Cathain, 2010).

Conclusion: The MMAT has been designed to appraise the methodological quality of the studies retained for a systematic mixed studies review, not the quality of their reporting (writing). This distinction is important, as good research may not be ‘well’ reported. If reviewers want to accurately assess the former, companion papers and research reports should be collected when some criteria are not met, and authors of the corresponding publications should be contacted for additional information. Collecting additional data is usually necessary to appraise qualitative research and mixed methods studies, as there are no uniform standards for reporting study characteristics in these domains (www.equator-network.org). In contrast, e.g., to the CONSORT statement for reporting randomized controlled trials (www.consort-statement.org).

Authors and contributors: Pierre Phaye, Marie-Pierre Gagnon, Frances Griffiths and Janice Johnson-Lafeur proposed an initial version of MMAT criteria (Phaye et al., 2009). Romina Facei and Pierre Phaye led the pilot test; Gillian Bartlett, Belinda Nicolae, Robby Selle, Justin Jagoal, Jan Salberg and Ann MacAnally contributed to the pilot work (Face et al., 2010). Pierre Phaye, Emmanuelle Robert, Marguerite Cargo, Alain O'Ciadhain, Frances Griffiths, Felicity Boardman, Marie-Pierre Gagnon, Gillian Bartlett, and Marie-Claude Rousseau contributed to the present 2011 version.

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## PART I MMAT criteria & one-page template (to be included in appraisal forms)

<table>
<thead>
<tr>
<th>Types of mixed methods study components or primary studies</th>
<th>Methodological quality criteria (see tutorial for definitions and examples)</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening questions (for all types)</td>
<td>• Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?</td>
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<tr>
<td></td>
<td>• Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).</td>
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<tr>
<td></td>
<td><strong>Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions</strong></td>
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</tbody>
</table>

### 1. Qualitative

1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?

1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?

1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?

1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?

### 2. Quantitative randomized controlled trials

2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?

2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?

2.3. Are the complete outcome data (80% or above)?

2.4. Is there low withdrawal/drop-out (below 20%)?

### 3. Quantitative non-randomized

3.1. Are participants (organizations) recruited in a way that minimizes selection bias?

3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument, and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?

3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?

3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?

### 4. Quantitative descriptive

4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?

4.2. Is the sample representative of the population under study?

4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?

### 5. Mixed methods

5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?

5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?

5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?

**Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied**

*These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated.
## Appendix D: Methodological Quality Summary Table

<table>
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<tr>
<th>Types of study components of primary studies</th>
<th>Methodological Quality criteria</th>
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<td>Is the sampling representative?</td>
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</tr>
<tr>
<td>Are measurements appropriate?</td>
<td></td>
</tr>
<tr>
<td>Is there an acceptable response rate (&gt;60%)?</td>
<td></td>
</tr>
<tr>
<td><strong>Mixed Methods</strong></td>
<td></td>
</tr>
<tr>
<td>Is the mixed methods design relevant to address the qual and quan research questions?</td>
<td></td>
</tr>
<tr>
<td>Is the integration of results relevant to the research question?</td>
<td></td>
</tr>
<tr>
<td>Is appropriate consideration given to limitations with the integration?</td>
<td></td>
</tr>
</tbody>
</table>

**Key**

Score of 1 = Yes
Score of 0 = No or unsure
Appendix E: Semi Structured Interview Schedule

Questions to settle someone in

• How are you today?

• Perhaps we could start with you telling me a bit about why you became a Psychologist?

Questions about hopeful therapeutic relationships

• What does the term ‘therapeutic relationship’ mean to you?

• What is the meaning of ‘hope’ within your therapeutic relationships? Prompts: Do you experience hope within your therapeutic relationships?

• What are your experiences of maintaining hopeful therapeutic relationships with clients? Prompts: Are there any experiences of maintaining hopeful therapeutic relationships that come to mind? What was this experience feel like for you?

• Have you ever experienced difficulties maintaining a hopeful therapeutic relationship? Prompts: What was this experience like for you? What do you think the experience was like for your client? Did your feelings about this relationship change over time? Tell me a little bit more about how the relationship changed over time, and what the experience of the change was like for you?

Questions about experiences of waiting times

• Could you tell me what your experiences of services with long waiting times for therapy have been like? Prompts: Approximately how long were the waiting times for the service? Tell me a bit about the experience of giving therapy/constructing therapeutic relationships in a service with a long waiting time?
• Could you tell me about your experiences of constructing hopeful therapeutic relationships with clients who have waited a long time for therapy?

Questions about service user experiences

• Could you tell me a bit about how you believe that service users experience hopeful therapeutic relationships? *Prompts: have you ever had any feedback about this topic from service users?*

• What do you think that the experience of hopeful therapeutic relationships is like for service users who have waited a long time for therapy?
Appendix F: Background Information Questionnaire

Before the interview begins I would like to ask some background questions about you, in order to put the interview in context. You are not obliged to answer these questions. If you do provide answers you are free to withdraw the information at any point during the research. These questions are designed to keep the interview confidential and your data unidentifiable, however if you are worried that an answer will make you identifiable, you do not have to respond.

Section 1. Demographic Information

How many years’ experience do you have as a qualified Clinical Psychologist? Please tick one of the following:

- 1-3 years
- 4-6 years
- 6-9 years
- 10 years or over

Briefly, what is your role in your service (e.g.: service lead, mainly consultation, mainly individual therapy)?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

What type of clients are seen by service (e.g.: children, clients with long term health conditions, older adults)?
What type(s) of therapy do you offer?

Section 2. Service Information

Approximately, what is the average wait time for your service? Please tick one of the following:

- [ ] 0-2 months
- [ ] 3-5 months
- [ ] 6-8 months
- [ ] 9-11 months
- [ ] 12-14 months
- [ ] 15-17 months
- [ ] 18 months or over
In your service, are there any service specific rules regarding how long clients can be on the waiting list for? If so please briefly outline these rules below:

..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................
Appendix G: Circular Email Sent to Potential Participants

To whom it may concern,

I am currently conducting my thesis research project, and I am investigating the meaning and experience of forming hopeful therapeutic relationships with clients who have waited a long time for therapy.

For this research I am looking to recruit Clinical or Counselling Psychologists who meet the following inclusion criteria:

- Working in a service with a waiting list of greater than 28 days (based on the recommendations of the We Need To Talk Coalition, 2010).
- Employed as a counselling or clinical psychologist
- Receives supervision in line with BPS and DCP recommendations (BPS, 2014).

A link to the supervision policy is included here:


This research comprises of a semi-structured interview (which will take approximately 1 hour). For more information please find attached an information sheet.

If you are interested in participating, and meet the inclusion criteria, then please contact me using the following email address or telephone number:

Email address: Johanna.gledhill@nhs.net

Telephone Number : 0787969576

Kind Regards

Jo Gledhill
Appendix H: Information Sheet

Participant Information Sheet

Title of the study: How do therapists maintain hopeful therapeutic relationships when there are long wait times for therapy?

Many mental health services within the NHS have long waiting times, and there is currently very little research investigating the experience and meaning of long waiting times for clinicians. Furthermore hopeful therapeutic relationships have been found by research to be an important part of the therapeutic process. Therefore this study aims to investigate the meaning and experience of long waiting times in relation to cultivating hopeful therapeutic relationships using a semi-structured interview with between 6 and 10 Clinical and Counselling Psychologists working in services with wait lists of more than 28 days.

What is the purpose of the study?

To investigate the meaning and experience of hopeful therapeutic relationships in the context of long waiting times.

Why have I been invited?
You have been invited as you have a role as a Clinical or Counselling Psychologist, and have worked within a service with a waiting list of over 28 days. Therefore it is believed that you meet this study’s inclusion criteria.

Do I have to take part?

This study is voluntary, and therefore you do not have to take part.

What will happen if I decide to take part?

If you would like to take part, please contact the chief investigator using the contact details outlined in this information sheet. The investigator will then contact via email in order to ensure that you meet the inclusion criteria and provide further information regarding the study. If you are still willing to take part in the study and meet the inclusion criteria, then the investigator will arrange a time to conduct the semi-structured interview. This interview will be undertaken at a time and place that is convenient for you. At the beginning of the interview the investigator will answer any questions you have regarding the study and obtain informed consent. The semi-structured interview will take approximately one hour. Following completion of the interview, you will have a chance to ask the interviewer any questions that you have. Some examples of topic areas which you may be asked about include:

1. Personal feelings about working in services with long waiting times

2. Your experiences of maintaining hopeful therapeutic relationships with clients

What are the possible disadvantages and risks of taking part?
Although no disadvantages are expected and this study will not involve a level of risk greater than that encountered in daily life, it is possible that you may find that the interview has been distressing. If this happens then you should address any negative feelings that may have been brought up by this research with your supervisor.

If you disclose information that constitutes a safeguarding risk (e.g.: to clients), then the Chief Investigator’s response will be in line with the NHS Whistleblowing policy, which may include disclosing the information shared with the relevant authorities if it is believed that harm may be done to clients or members of the public if the information is not shared. However, all other information shared will be kept confidential.

**What are the possible benefits of taking part?**

This research provides an opportunity to reflect on your experiences of long waiting times.

**What will happen if I decide I no longer wish to take part?**

You can withdraw from this study at any point up to data analysis.

**Will my taking part in this study be kept confidential?**

Yes, your taking part and results will be kept confidential, unless information is shared during the interview that constitutes a safeguarding risk in which case the NHS Whistleblowing Policy will be followed.
What will happen to the results of the study?

The results of this study will be included in the chief investigator’s Thesis. The data will be recorded on a Dictaphone, before being onto a password protected encrypted laptop immediately following the interview. This data (along with electronic copies of interview transcripts) will then be encrypted and stored on a network drive within the University of Hull (where it will be held for 10 years before being destroyed). Furthermore, identifiable information will be separated from transcripts and each participant will be identified using only a code number. No hard copies of interview transcripts or participant information will be kept, as the information from these records will be immediately transferred into electronic records and the hard copies shredded.

Who is organising and funding the research?

This research is being undertaken as part of the Chief Investigators Doctorate from the University of Hull, and is funded by the Humber NHS trust.

Who has reviewed the study?

This study has been independently reviewed by the research group within the University of Hull Department of Psychological Health and Wellbeing.

Further information and contact details

If you are interested in taking part in the study please contact the Chief Investigator using the contact details below:
Thank you very much for your interest!
Appendix I: Consent Form

Consent form

Centre Number:

Study Number:

Patient Identification Number for this trial:

---

CONSENT FORM

Title of Project: **How are hopeful therapeutic relationships maintained when there are long wait times for therapy?**

Name of Researcher: **Ms Johanna Gledhill**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 15/05/2017 (version 01) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I understand that relevant sections of my data collected during the study, may be looked at by individuals from the University of Hull, regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my transcript from the interview.

4. I understand that there are limits to the confidentiality of the information that I share during this interview, and that if I share information that constitutes a safeguarding risk the researcher will follow the NHS Whistleblowing policy.

5. I agree to take part in the above study.

________________________  _________________  _______________
Name of Participant        Date                 Signature

giving consent.

________________________  _________________  _______________
Name of Person             Date                 Signature

Appendix J: Ethical Approval from the University of Hull and HRA

Health Research Authority

Ms Johanna Gledhill
Trainee Clinical Psychologist
University of Hull
Cottingham Road
HU6 7RX

21 December 2017

Dear Ms Gledhill

Letter of HRA Approval

Study title: How do clinical and counselling psychologists maintain hopeful therapeutic relationships when there are long waits for therapy?
IRAS project ID: 228478
Protocol number: 1.1 RP4
REC reference: 18/HRA/0363
Sponsor Humber NHS Foundation Trust

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England
The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read Appendix B carefully, in particular the following sections:

- Participating NHS organisations in England – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- Confirmation of capacity and capability - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.
It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from the HRA website.

Appendices
The HRA Approval letter contains the following appendices:
- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval
The attached document "After HRA Approval – guidance for sponsors and investigators" gives detailed guidance on reporting expectations for studies with HRA Approval, including:
- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope
HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through IRAS.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback
The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website.

HRA Training
We are pleased to welcome researchers and research management staff at our training days – see details on the HRA website.

Your IRAS project ID is 228478. Please quote this on all correspondence.
Yours sincerely

Alki Sifoneloudaki
Assessor

Email: hra.approval@nhs.net

Copy to: Mr Stephen Walker, Humber NHS Foundation Trust, Sponsor Contact and R&D contact
PRIVATE AND CONFIDENTIAL
Johanna Gledhill
Faculty of Health Sciences
University of Hull
Via email

16th October, 2017

Dear Johanna,

REF 293 - How are hopeful therapeutic relationships maintained in services with long waiting times?

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair’s action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of subsequent amendments to your study.

I wish you every success with your study.

Yours sincerely,

[Signature]

Professor Liz Walker
Chair, FHS Research Ethics Committee
**Appendix K: Worked example of interpretive phenomenological analysis-creation of themes**

To outline the process of IPA an example, using an excerpt of transcript 3, is used. In this transcript segment ‘P’ refers to the participant and ‘R’ to the researcher. This highlights each stage of the analysis. The transcript (middle column) was initially read through, sections that stood out as meaningful highlighted. Then the transcript was read again with the left-hand margin (left column) used to annotate points of interest. Then the text was read for a third time with the right-hand margin (right column) used to highlight emerging themes. Links were made to other transcripts (e.g. repeated patterns and comments) and theoretical constructs at this stage.

| Difference to other relationships | P-errmm, I think therapeutic relationship I suppose is diff-I guess it’s different in terms of other relationships, so I suppose when we have more personal relationships, friendships there’s not that same, err, sense that there’s maybe something to achieve or a goal or a, erm, I suppose a therapeutic relationship, that person has entered into potentially because |
| Therapeutic relationship linked to goal |
| Wanting help, link to goal |

Forming therapeutic relationship: intrinsically linked to goals/a purpose
<table>
<thead>
<tr>
<th>Therapeutic relationship defined by purpose</th>
<th>Forming therapeutic relationship: intrinsically linked to goals/a purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance between having a goal and being flexible/knowing person</td>
<td>Forming therapeutic relationship: flexibility/genuine knowing</td>
</tr>
<tr>
<td>Therapeutic relationship needs time and work</td>
<td>Necessity of time for therapeutic relationship development</td>
</tr>
<tr>
<td>they want some help with something R-mmm P-erm, and then you would’ve gone onto contract what it is that they wanted help with or what they wanted to explore, so I suppose there’s…maybe something about there being a purpose to it? Not quite sure how to explain it properly but yeh something about there being, erm, an aim I guess, so a rough aim in mind but at the same time it’s about being flexible and getting to know that person R-yeh P-so I suppose the therapeutic relationship is something for me that, erm, very much develops Forming therapeutic relationship: genuine knowing/communication</td>
<td></td>
</tr>
<tr>
<td>Getting to know each other</td>
<td>over time. Erm and I suppose like all relationships requires work</td>
</tr>
<tr>
<td>Adapting to each other’s styles of communication</td>
<td>R-mmm</td>
</tr>
<tr>
<td></td>
<td>P-erm, and getting to know that person getting to know erm their sort of preferred communication style- them getting to know you as well and your sort of way of communicating, erm, yeh I’m trying to think if there’s anything else that I would, that’s probably all that I’ve got in my head right now <em>laughs</em></td>
</tr>
<tr>
<td>Importance of hope when people have had long term mental health problems</td>
<td>R-erm, well what’s the mean-maybe you could tell me a bit about the meaning of hope within those therapeutic relationships</td>
</tr>
<tr>
<td>Long journey to therapy, doesn’t happen in a vacuum</td>
<td>P-mmm, OK erm I suppose hope is really Wider systemic factors: journey to therapy eroding hope over time</td>
</tr>
</tbody>
</table>
Long journey to therapy - this erodes hope

Clinician introducing hope at formation of relationship

Hope tied to expectations in therapy

Therapeutic relationship formation: Clinician holding hope

Hopeful therapeutic relationship: balancing hope for change with managing expectations/goals

- important particularly
- because the people I tend to see have severe and enduring mental health problems
- so quite often before they come to see me they’ve had a really long journey, they might have a long history of something, and I think because of that it can sometimes feel like their hope that things can get better has been eroded over time

- so there is something important about, *sighs* right at the start of therapy producing the idea of hope in terms of that things can change

- R-right
- P-right

R-right
| Maintaining hope for client | P-erm and **things can improve for that person**…erm I suppose *sighs* it’s difficult because-I don’t know whether I’m going off topic a little bit here but in **terms of hope** I suppose for me it’s really tied as well to expectations |
| Clinician holding hope in the beginning, actively introducing it at the start of therapy | R-right yeh |
| Introducing hope but on the other side managing expectations | P-and **expectations in therapy**, so although it’s really important to maintain a sense of hope for someone and to kind of, erm acknowledge with them right at the beginning of therapy that you think actually something can change so there is that positive element to it, but it’s also about **managing expectations** |
Level Three Analysis

Emerging themes and their corresponding quotes from the text of each transcript were organised and themes across transcripts were compared.

<table>
<thead>
<tr>
<th>Emerging Theme</th>
<th>Supporting Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forming therapeutic relationship: intrinsically linked to goals/a purpose</td>
<td>“sense that there’s maybe something to achieve or a goal or a, erm, I suppose a therapeutic relationship, that person has entered into potentially because they want some help with something…and then you would’ve gone onto contract what it is that they wanted help with or what they wanted to explore, so I suppose there’s...maybe something about there being a purpose to it?”</td>
</tr>
<tr>
<td>Forming therapeutic relationship: genuine knowing/communication</td>
<td>“getting to know that person getting to know erm their sort of preferred communication style- them getting to know you as well and your sort of way of communicating”</td>
</tr>
<tr>
<td>Necessity of time for therapeutic relationship development</td>
<td>“the therapeutic relationship is something for me that, erm, very much develops over time”</td>
</tr>
<tr>
<td>Wider systemic factors: journey to therapy eroding hope over time</td>
<td>“before they come to see me they’ve had a really long journey, they might have a...”</td>
</tr>
</tbody>
</table>
long history of something, and I think because of that it can sometimes feel like their hope that things can get better has been eroded over time”

<table>
<thead>
<tr>
<th>Therapeutic relationship formation: Clinician holding hope</th>
<th>“so there is something important about…right at the start of therapy producing the idea of hope in terms of that things can change”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hopeful therapeutic relationship: balancing hope for change with managing expectations/goals</td>
<td>“although it’s really important to maintain a sense of hope for someone and to kind of, erm acknowledge with them right at the beginning of therapy that you think actually something can change so there is that positive element to it, but it’s also about managing expectations”</td>
</tr>
</tbody>
</table>

**Level Four Analysis**

Emerging themes across transcripts were compared and organised into groupings of superordinate themes with subordinate themes within them. Themes that were not well represented across transcripts were discarded. Superordinate and subordinate themes (along with supporting quotes) were discussed with the trainee’s supervisor and reorganised in a way that was felt to better represent the text.
Appendix L: Demographic Information about Participants

All participants used an integrative approach to therapy comprising of several different models and types of therapeutic intervention (e.g. consultation, group and individual therapy).

Table 1. Clients seen by the participants’ services

<table>
<thead>
<tr>
<th>Type of client seen by service</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe and enduring mental health difficulties</td>
<td>4</td>
</tr>
<tr>
<td>Psychosis</td>
<td>1</td>
</tr>
<tr>
<td>Long term physical health conditions</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 1. Participants’ number of years’ experience as a qualified psychologist
Figure 2. Average wait time for therapy within the participants’ service
Appendix M: Epistemological Statement

The term ‘epistemology’ relates to the theory of knowledge, and focuses on the knowledge gathering process (Grix, 2002), or ‘how we know what we know’ (Crotty, 1998). As a range of views can be held about knowledge and the processes of gaining knowledge, an epistemological stance allows the researcher to outline their assumptions about knowledge (Tuli, 2010).

Most of my education and experiences have involved adopting a positivist approach (that there is an objective truth, which research should be able to uncover using testable and provable methodologies) (Guba & Lincoln, 2013). However, in the past two years I have begun to challenge this positivist viewpoint, mainly due to my role as a psychologist and my increasing knowledge of alternative positions such as social constructionism. My increased understanding of social constructionism has been influential in my clinical practice, day to day life, and research position. Social constructionism encourages researchers to take a critical stance to ‘taken for granted’ knowledge about the world, as our findings about what exists in the world what we perceive to exist, rather than perfectly reflecting the objective truth (Burr, 2006). I now hold an anti-positivist epistemological position, and therefore I believe that human experiences are not objective events, but rather consist of meanings and intentional participation and interpretation by each individual involved (Hayes, 2000).

This anti-positivist position informed the research approach chosen for this study (IPA), as this type of analysis explores how individuals interpret and give meaning to their experiences (Smith, Flowers & Larkin, 2009). However IPA also acknowledges ‘double hermeneutics’, or the influence of the researcher on data, as they are making sense of
what the participant is reporting whilst the participant is also concurrently making sense of their account (Smith, Flowers and Larkin, 2009). Therefore, it was very important to reflect on my own views on the research topic and the influence that these might have on data analysis throughout the research process. These reflections uncovered my own personal beliefs about this topic which are informed by my clinical experience working in services with long waiting times (with some of the service users waiting up to 2 years for therapy). I found these clinical experiences frustrating, as I personally felt that the clients’ presenting problems often changed considerably during their wait (often causing increased distress). I also personally felt that the long wait for therapy effected the client’s expectations for therapy, and this opinion was, on a number of occasions, expressed by clients. Therefore I feel that I have experienced waiting times effecting clients’ expectations and hope for therapy in a number of ways, for example increasing hopeful expectations for successful therapy (as these had built up over time), and decreasing hopeful expectations (as the wait had decreased confidence in the service). On reflection, I did expect the participants in my study to express similar viewpoints to my own, and therefore I managed these assumptions by being aware of them and actively challenging them (using both informal and formal supervision when necessary). These themes were indeed found in data analysis, and though I do believe the interpretation found in this study to be an adequate interpretation of the participants experiences, my role as researcher and predisposition to attach importance and meaning to these experiences should be considered.
References


Appendix N: Reflective Statement

Within this statement I endeavour to chronologically reflect on the research process. I have found the process of writing this thesis both challenging and stimulating, and it led to considerable reflection throughout.

When choosing my topic I was, on reflection, very used to framing research within a quantitative framework, and somewhat uncomfortable with the approach towards truth that was necessary for qualitative research. I think that this was due to previous training at undergraduate level, which had provided me with a research lexicon consisting of words such as ‘effect’ and ‘reliable’, and the subjective approach to knowledge and results interpretation was very daunting. However the support and gentle guidance of my supervisors, coupled with reading and discussion with other trainees, my comfort with this approach gradually increased and I saw it as a challenge to open my mind to the less definitive world of qualitative research.

This project was borne out of my experiences of working with clients who had waited a long time for therapy. Personally I had found working in an environment with a long waiting list very frustrating, and could not believe that it was considered acceptable for people to wait so long. It was therefore an active process to consider the possible positives of working in services with long waiting times, as I couldn’t imagine anything positive coming out of waiting for therapy. However I think this experience had a positive effect on my practice, as it taught me to always try and see the other side of the story. Despite my own negative view of long waiting times, I have an interest in the positive psychology movement, and I wanted my project to reflect the values of this movement. This led to the focus on hope in both my empirical study and SLR. Again, I already had an opinion on the role of hope within therapy, and therefore I had to actively open myself up to other viewpoints on this.
The process of getting ethical approval took longer than I expected it to, and I found this process highly frustrating. As I was interviewing clinicians who work with distressing cases regularly, I think that I did not initially give enough thought to the idea that the interviews would be distressing for participants. However I am, on reflection, glad that the process of ethics made me consider these issues more. This also gave me a chance to reflect on the stressors of being a clinician, and the fact that sometimes you cannot predict what elements of the job will be distressing. During the period of waiting for ethical approval, both the literature review and the empirical study felt like huge burdens that I was carrying, and I felt somewhat hopeless and helpless about my ability to write both of them (which, on reflection, parallels some of the themes found in my empirical study regarding the active process of waiting and it’s hopeless nature).

As it took significantly longer than I had anticipated to get ethical approval, I was relieved once I was able to begin interviews. Following my first interview I felt buoyed up and hopeful, and throughout data collection I was reminded of my original passionate rationale for the study. Each interview, whilst having common ground with others, had a different ‘feel’ and brought something new to my understanding of the data. Whilst conducting the interviews, I had to actively remind myself to remain as non-directive as possible. This was made more difficult by the fact that my participants and I share a profession, and therefore sometimes I felt a pull towards speaking in the way that I would with colleagues in the office (i.e. giving my opinion or offering my own stories).

Transcribing the data felt, at times, like an endless task. I was eager to begin analysis, and it felt frustrating to type up interesting sections of the data and have to leave it for later and continue the transcription. However, on reflection, this gave me an intimate understanding of the data and made the process of analysis itself feel less daunting, as I knew that there were multiple parts of the data that I had found inspiring. Analysis,
whilst time consuming, was an interesting process, and I became very engrossed in the process. As I share a profession with the participants, and they were necessarily more advanced in their career than me, I felt a sense of respect for each of the transcripts that I believe helped me stay motivated. Reducing my initial analysis into themes that could be outlined in my write up at first felt like an overwhelming task, and I initially felt like consolidating the data was in some way a betrayal of my participants and the many powerful things that they had said. However upon reflection, focusing on the most powerful and potent themes allows them to stand out and have more meaning (rather than getting lost in an overly convoluted results section), and I feel that my results section is an honest representation of what the participants said.

My systemic literature review felt somewhat secondary to the empirical research, and in hindsight I should have dedicated more time to this early on in the thesis writing process. This may have been because I felt that I was not contributing to the evidence base in any way, as I at times felt like I was only repeating what has already been said by others. Furthermore, I went through a stage of feeling that my literature review did not have any useful or interesting conclusions, as all of my findings felt in some way obvious to me. However on reflection bringing together the literature and consolidating and synthesising findings across the literature base is a necessary and worthy research task, and the findings of my literature review may not seem so obvious to others who have spent less time investigating this topic.

In summary, I have found this a difficult, frustrating, but enlightening experience. I was truly inspired by my participants and their reflectiveness, and I really hope that my research (both the literature review and empirical paper) reflects their resilience, adaptability, and care for their clients. If I were to do it again, I would endeavour to start the literature review earlier, and attempt to get less overwhelmed (or at least to react to feeling overwhelmed with less avoidance). Finally, the peer support from other trainees
conducting research at the same time has been invaluable, allowing a space for both frustrations and inspiration and hope. This experience would have been a lot harder without this support network, and, if I were to do research again, I would try and ensure that I had peers around me.