Clinical psychologists' usage and experiences of psychoanalysis and psychoanalytically-informed approaches within the NHS.

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ABSTRACT

Background

Psychoanalytic approaches have decreased in use as a therapy in the UK. After an initial growth in Britain post World War One, the subsequent emphasis on using empirically supported treatments resulted in cognitive and behavioural approaches being prioritized. Neoliberalism and austerity measures have led to an emphasis on short-term, low cost treatments, and the further marginalization of psychoanalytic approaches. There is no research exploring its use within clinical psychology in the NHS, despite increased research supporting its utility and a policy emphasis on patient choice.

Aims

This research will aim to explore how clinical psychologists use the psychoanalytic approach within the NHS and their experience of the approach.

Methods

A mixed methods approach was used. A quantitative online survey of clinical psychologists working within the NHS in the UK (N=189) collected demographic data as well as information about modalities used and their services, clients and training characteristics. An interview was used to explore the experiences of clinical psychologists of using the psychoanalytic approach within the NHS.

Results

It was found that a higher percentage of participants (18%) used the psychoanalytic approach than expected from previous research. A greater majority used CBT and third wave approaches. Most participants using psychoanalytic approaches worked with adults with severe and enduring difficulties in secondary care settings. From the interviews, participants spoke about having little space and practical time to use psychoanalytic approaches within services. Participants spoke about how the approach was useful to provide space for clinicians and clients to reflect and build a therapeutic relationship. However, some participants expressed concern that it could be regarded as elitist and inaccessible to some client groups. There was debate about the future of psychoanalytic approaches within the NHS.

Conclusions

Some clinical psychologists use psychoanalytic approaches in practice and find it useful, although there are service barriers that constrain its use within the NHS that should be addressed. Strengths and limitations of the study are discussed and recommendations made for future research.

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1. CHAPTER ONE: INTRODUCTION

1.1 Chapter Overview

This chapter provides an overview of the status of psychoanalytic approaches and how they are used within clinical psychology in Britain. It traces the history of these approaches from their introduction to the UK to their current use within the NHS by clinical psychologists. The empirical evidence for this approach will be briefly reviewed, as well as clinician and service user experiences of the approach. The chapter closes by presenting an argument about why research regarding the use of these approaches within clinical psychology is important.

1.2 Identifying Relevant Literature for this Research

The broad nature of this research topic means that there is a large amount of literature that could inform it. A scoping review was initially considered because it can be used to address subjects that have not been extensively reviewed and that are likely to be informed by research using a broad range of methodologies (Arksey & O'Malley, 2005). However, the pilot scoping review generated an unmanageably large body of literature, most of which had low immediate relevance (see Appendix A for details). Additionally, from the search results, it was not possible to map relevant research because most

areas that would inform the background of the topic were not represented in sufficient detail.

These are common difficulties when trying to apply a systematic method to a broad research subject (Ferrari, 2015). Instead, a narrative review was used. A narrative review aims to summarize previous research, identify gaps in the literature and provide a rationale for the research (Ferrari, 2015). However, it allows for a broader scope than other methodologies, because inclusion criteria are not as rigidly defined and more than one research question can be reviewed (Ferrari, 2015). It can also provide a cohesive account of the historical development of concepts, also advantageous for introducing this study (Ferrari, 2015).

However, narrative reviews have the disadvantage of being regarded as being prone to bias (Green, Johnson, & Adams, 2006). This will be guarded against where possible by using the Scale for the Assessment of Narrative Review Articles (SANRA) (Baethge, Goldbeck-Wood, & Mertens, 2019) as a guide throughout. As advised by the SANRA scale, the aims and importance of the research will be elaborated, all key statements will be supported by references and any evidence will be presented appropriately. Additionally, results from the pilot scoping review will be taken into account, reference lists of relevant articles will be explored, and reviews of a variety of subtopics will be included. These are represented as numbered paragraphs within the introduction. Information about the search strategy of each subparagraph is included in Appendix B.

1.3 Defining Psychoanalytic and Psychodynamic Approaches

The definition of psychoanalysis has long been debated (Stern, 2009). One definition suggests that what defines psychoanalysis as a therapy is how a psychoanalytically-trained clinician processes clinical data and transforms it into therapeutic action, based on knowledge of psychoanalytic theory (Stern, 2009). Psychoanalytic theory suggests that both early experiences and 'unconscious' thoughts impact mental state (Bateman & Holmes, 1995). The theory suggests that children can have unconscious conflicts, for example between theorized primal impulses, internalized social norms and external reality. This conflict can be resolved in ways that are maladaptive for the adult, such as depressive symptoms or other difficulties, or in ways that are more adaptive, which can be facilitated through therapy (Bateman & Holmes, 1995). Psychoanalytic theory is regarded as a developmental perspective because of its focus on child development and how it can influence functioning in later life (Bateman & Holmes, 1995).

It has been suggested that the therapeutic process has two fundamental mechanisms; relational and interpretative (Blatt & Shahar, 2004). Relational aspects involve the development of a dependable and supportive therapeutic relationship with the therapist, and interpretative aspects lead to increased insight and self-knowledge (Blatt & Shahar, 2004). Transference (attributing qualities of previous relationships onto the therapist), countertransference (subjective experiences of the therapist triggered by patient material) and

working through ‘resistance’ are processes that take place within the therapeutic relationship that facilitate therapy (Bateman & Holmes, 1995). Sessions are usually held three or more times per week, sometimes a couch is used and the therapy is regarded as producing structural changes in personality and functioning (Stern, 2009). Psychoanalysis usually takes place within the “therapeutic frame”. This is the framework for the therapy that the therapist and client agree to, and is usually comprised of an agreement about the setting, time and duration of sessions and confidentiality (Gray, 2013).

There is a large body of literature examining the difference between psychoanalysis and psychodynamic psychotherapy (Pilgrim, 2017; Stern, 2009). Psychodynamic psychotherapy is an umbrella term used to refer to a range of interventions informed by psychoanalytic ideas. It is partially distinct from psychotherapy, which can refer to a broader range of therapies from other traditions, such as client-centred therapy (Rous & Clark, 2009). Sessions are usually once per week, the therapist is more active, offering more emotional support and direction and therapy is generally shorter-term (Sripada, 2015). However, the importance of each of those elements to the outcome of therapy is contested (Blatt & Shahar, 2004). For example, some regard psychodynamic psychotherapy as producing less long-lasting and structural change. To explore this, the Psychotherapy Research Project run by the Menninger Foundation followed the outcomes of 42 patients engaged in psychoanalysis or psychodynamic psychotherapy over 30 years (Wallerstein, 1986; Widlöcher, 2010). It was suggested that structural and enduring change was achieved by both, as measured by clinician ratings of

functioning in life domains such as work and relationships, and measures that reflect the content of interpersonal schemas (Shahar & Blatt, 2005).

Psychodynamic psychotherapy offers both a short-term format (STPP) typically from 16-30 sessions (Leichsenring, Rabung, & Leibing, 2004), or long-term format (LTPP) which typically lasts one year or 50 sessions plus (Leichsenring & Rabung, 2008). Additionally, short-term manualised approaches such as Dynamic Interpersonal Therapy (DIT) (Lemma, Target, & Fonagy, 2010) and Mentalisation-Based Therapy (MBT) (Bateman & Fonagy, 2010) have also been developed. For brevity in this thesis, I will refer to psychoanalysis and all forms of psychodynamic therapy as psychoanalytic approaches.

1.4 History of Psychoanalysis and its Relation to Clinical Psychology in Britain

When presenting the history of psychoanalysis and its growth within clinical psychology in the UK, it was necessary to be selective in order to provide a concise and relevant background for this topic. Other aspects of its history has not been focused on, such as its growth in other countries, use in private practice and within psychiatry, or within certain groups such as children or those with learning disabilities. It is also necessary to clarify that here UK will refer to England, Wales, Scotland and Northern Ireland. It is acknowledged that Wales, Scotland and Northern Ireland have distinctive histories that might impact on this topic; their training courses were established at different times,

and internal politics and cultural histories can impact the development of therapies (Hall, Pilgrim, & Turpin, 2015). However, England, Scotland, Wales and Northern Ireland are included in this introduction because they share some core legislation, and the NHS operates in each of them (Hall et al., 2015).

1.4.1 The Early Years of Psychoanalysis

Psychoanalysis was founded by Sigmund Freud (1856-1939), a Viennese neurologist. After graduating from medical school, Freud was awarded a fellowship to work with Jean Charcot, a prominent neurologist who predominantly worked with those with 'hysteria'. Freud initially adopted Charcot's methods of using hypnosis with patients (Hall et al., 2015). However, over time he began to draw upon the cathartic method of Breuer, a Viennese neurophysiologist (1842-1925). This involved allowing patients to "free associate", or speak freely about whatever came to mind (Bateman & Holmes, 1995). This method seemed to temporarily relieve the symptoms of 'hysteria' of patients, such as Anna O., about whom Freud published a case study (Freud & Breuer, 1895). Freud hypothesized that this might bring 'unconscious material' into awareness, allowing it to be managed rationally (Bateman & Holmes, 1995). This could be regarded as the foundation of modern talking cures, many now developed and used by clinical psychology and other professions (Boswell et al., 2011). In 1902, a group of Viennese physicians who expressed interest in Freud's work came to meet on Wednesday afternoons and this group developed into the Vienna Psychoanalytic Society.

1.4.2 The Further Growth of Psychoanalysis

In 1908, the first formal international meeting of Freud's followers was held, and was regarded retrospectively as the first International Psychoanalytic Congress (Boswell et al., 2011). Here, action was taken towards advancing Freud's work. A journal was established, and, significantly for the advancement of psychoanalysis in Britain, Ernest Jones (1879-1958), a Welsh neurologist and psychoanalyst, attended this conference. He was tasked with promoting Freud's work abroad, which he did first in the US, helping to found the American Psychoanalytic Association in 1911, before returning to London.

In London, he founded the London Psychoanalytic Society in 1913 (Bateman & Holmes, 1995) and later the British Psychoanalytical Society in 1919. This organization mediated the propagation of psychoanalytic knowledge; the aims of the profession were identified, the label psychoanalyst was protected and the profession differentiated itself from psychotherapy (Alexander, 1998). From the 1920s onwards, there was a core group of psychoanalysts in Britain. This included the object relations school, based on the teachings of Melanie Klein, who settled in Britain in 1926, about the importance of early relationships, followers of Anna Freud, who settled in London with her father in 1938, and the independents (Richards, 2000). All three were powerful influences in British psychoanalysis (Bateman & Holmes, 1995).

The decades following World War One were regarded as a heyday for

psychoanalysts; the large numbers of soldiers returning from war allowed for psychoanalysts to establish training and treatment centres such as the Brunswick Square Clinic, as the numbers of practicing psychiatrists were insufficient to treat the number of those requiring treatment (Richards, 2000). The Brunswick Square Clinic was open between 1913 and 1922 and became the first psychoanalytic training programme in Britain (Raitt, 2004).

Psychoanalysis was concurrently establishing societies and institutes in other countries such as France, Italy and the US, albeit with variations in teachings and methods, dependent on the cultural and psychological traditions already present (Wallerstein, 1989).

1.4.3 The Growth of Clinical Psychology and the Experimental Method

The profession of psychology grew in tangent, and at times in opposition to, the psychoanalytic tradition (Hall et al., 2015). Various traditions from philosophy to medical thought, and in particular the experimental method, contributed to psychology as a discipline (Hall et al., 2015).The establishment of an experimental psychology lab by Wilhelm Wundt (1832-1920) in 1879 at the University of Leipzig is a noteworthy point in that journey (Hall et al., 2015). Wundt separated psychology from philosophy by emphasizing the importance of objective measurement and experimentation when examining the mind (Hall et al., 2015).

An International Congress of Physiological Psychology was held in Paris in 1889 (Rosenzweig, Holtzman, Sabourin, & Bélanger, 2000). This conference

reflected the dominance of the physiological and scientific approach to psychology at the time (Rosenzweig et al., 2000). For instance, physiology was present in the title of the conference and many sessions focused on sensation, perception and experimental research.

1.4.4 The Growth of the Behaviourist Movement

The behaviourist movement drew on the experimental approach of Wundt and attempted to understand and treat difficulties using experimental and scientific methods (Bateman & Holmes, 1995). It had a profound effect on the development of psychoanalysis. The beginning of the behaviourist movement is regarded as stemming from the publication of *Psychology as the Behaviourist Views it* (Boswell et al., 2011; Watson, 1913). In this, Watson suggests that all behaviour is learned and that only observable behaviour should be studied, and done so scientifically. This directly challenged psychoanalysis, in terms of both what it studied and the methods used for doing so.

The empirical support for behaviourism grew, as did the threat to psychoanalysis. The first behaviourist conference was held in Charlottesville, Virginia, in 1962 and the first journal, *Behaviour Research and Therapy,* emerged in 1963 (Thoma, Pilecki, & McKay, 2015). Behaviourist concepts such as classical conditioning (Pavlov, 1927) and operant conditioning (Skinner, 1938; Thorndike, 1905) which were eventually successfully incorporated into psychological treatments such as systematic desensitization for phobias and social anxiety, relaxation training and exposure and response

prevention for obsessive compulsive disorder (Thoma et al., 2015).

1.4.5 Behaviourism and Experimental Psychology in Britain

Hans Eysenck (1916-1997) was one of the early and foremost clinical psychologists in the UK. He was a professor in the psychology department in the Institute of Psychiatry, Maudsley Hospital, in the 1950s. He was research-oriented and believed that psychological research and therapy should be based on quantitative and experimental findings. In 1952, he published a paper that questioned the positive effects of psychoanalysis, claiming that it could not be shown to be effective as there was no systematic research done on the approach using behavioural outcomes (Eysenck, 1952). He believed that psychologists should have a minimal therapeutic role, especially regarding psychoanalysis, which he regarded as ‘unscientific and unclear’ (Eysenck, 1952). This was a considerable criticism of psychoanalysis, and particularly noteworthy, given that Eysenck was in a position of influence and he had a role in establishing one of the early clinical psychology training courses in the UK, at the Maudsley in 1947 (Yule, 2015). Clinical psychologists in the UK at this point mainly carried out clinical assessments, and therapies often drew on behaviourist approaches.

Behaviourism continued to grow in clinical psychology in the UK in the next few decades. Psychologists such as Stanley Rachman and others (Parry, 2000) in the Institute of Psychiatry built on techniques such as systematic desensitization, developed by Wolpe (1958), and trained UK clinical psychologists in these approaches. The British Association for Behaviour

Psychotherapy (BABP) was established in 1972 (Parry, 2015). It has grown in membership and breadth to becoming an accrediting body of behaviourist and cognitive therapists (Parry, 2015).

1.4.6 The Growth of Empiricism Versus Psychoanalysis

During the 1950s and 1960s, behaviourism and the experimental method continued to grow in the UK. The popularity of the experimental method built on a historically strong and long emphasis in Britain from the 17th century. British philosopher Francis Bacon was regarded as the founder of empiricism and argued that scientific knowledge could only be gained through inductive reasoning and observation (Stewart, 2015). Similarly, philosophers John Locke and David Hume (English and Scottish respectively), agreed that knowledge comes from experience and observation (Stewart, 2015). In 1963, another direct challenge to psychoanalysis was made by British philosopher, Karl Popper (1902-1994). Popper supported the empiricist tradition and directly criticized psychoanalysis, calling it a 'pseudo-science' as its theories could not be verified by refuting or falsifying them (Popper, 1963).

Evidently, the growth of the experimental method in Britain was a threat to psychoanalysis. Although Freud regarded psychoanalysis as a biological science (Winograd & Davidovich, 2014), he never linked it to any requirement for systematic research, beyond the case study method, which is generally required by the scientific approach (Wallerstein, 2009). Freud's single case designs, such as in *Studies in Hysteria* (Freud & Breuer, 1895) considered the therapeutic method as inseparable from research, as both utilized inductive

methods to produce data (Lees, 2005). This has remained the dominant method of research within psychoanalysis over the last hundred years (Lees, 2005).

Proponents of the experimental movement in psychology, such as Eysenck (Eysenck, 1952), alleged that these approaches lacked rigor and were based on unvalidated claims of truth. It was suggested that because outcome measurements are not used, there is no way of evidencing effectiveness, and any evidence that is presented is based on non-observable and subjective knowledge, and therefore cannot be verified or refuted (Lees, 2005).

There have been various responses to these criticisms by psychoanalysts. Some suggest that empirical approaches are reductionist (Lees, 2005) because psychoanalysis aims to produce ‘deep-seated’ change through the collaborative creation of meaning, rather than changes in observable behaviours or symptom improvement (McWilliams, 2013).

However, others have started to apply scientific methods, in order to try and increase the evidence base of these approaches. There has been some effectiveness research done on long- and short-term psychoanalysis (Abbass et al., 2014; De Maat et al., 2013; Shedler, 2010), which will be presented later, but this is often difficult and based on small sample sizes and heterogeneous populations (Paris, 2017).

Other psychoanalysts take a hermeneutic approach, removing psychoanalysis from the world of science altogether and allying it with more qualitative and exploratory 'human' sciences, such as history and the social sciences (Lees, 2005). They suggest that investigating what is true in terms of the history of the patient is less important than the co-creation of an understanding of the client's life that is meaningful for them (Lees, 2005). This implies that traditional methods of measuring outcomes and the certainties of RCT research are incompatible with psychoanalytic methods (Hinshelwood, 2010).

1.4.7 Medical Model and Psychoanalysis

The empirical approach within psychology was facilitated by the rise of the medical model of mental illness (Strupp, 2001). Medicalization involves understanding distress using a medical framework and treating it using a medical solution (D. T. Smith, 2014). This is exemplified in the use of manuals such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Mental and Behavioural Disorders (ICD). The medical approach to understanding diagnosis has its roots in the work of Emil Kraeplin (1856-1926), Freud's contemporary, whose work laid the foundation for diagnoses of mental illness (Hall et al., 2015).

Initially, the DSM manuals, from DSM (I-II), had a psychodynamic and social focus (Clegg, 2012). However, by the third iteration of the DSM (III) the psychoanalytic approach was in decline, partly due to its lack of empirical foundation. Hence, the DSM III removed psychoanalytic explanations, became more categorical and reframed distress in terms of observable

symptoms (Clegg, 2012). There had been a growing dissatisfaction with psychoanalytic concepts, given the need for well-defined entities within scientific research, and the medical model supplied this (Galatzer-Levy, Galatzer-Levy, & Sachs, 2007). However, this was not to everyone's satisfaction. Psychoanalysts such as Thomas Szasz argued that applying the medical model and empiricism to mental illness was inappropriate because mental illness is a metaphor for distress and was a form of scientism (Szasz, 1961).

Subsequently, various social, economic and political factors have consolidated the role of diagnosis (Clegg, 2012). For instance, pharmaceutical companies rely on DSM classifications for research (McWilliams, 2013) and hospitals and educational systems often require practitioners to assign a diagnosis (Galatzer-Levy et al., 2007). The primacy of this medical model has persisted, in contrast to the more non-diagnostic approach of psychoanalysis.

1.4.8 The Growth of the Cognitive Movement

The growth of cognitive-behavioural therapy (CBT) emerged from behavioural roots and was in contention with psychoanalysis.

Aaron T. Beck is regarded as the main founder of CBT. He began his career as a psychoanalyst, graduating from the Philadelphia Psychoanalytic Institute in 1956. He became disillusioned with psychoanalysis, regarding it as having dubious theoretical foundations (Boswell et al., 2011). Beck first established a cognitive model of depression suggesting that symptoms were underpinned

and maintained by negative cognitions that were produced by internal schemas, internal cognitive structures that influence thinking and behaviour (Milton, 2001). The therapy builds on this idea and the client is taught to recognize and modify these thoughts through challenging and reality testing (Milton, 2001). Beck integrated behavioural techniques such as exposure and relaxation into his approach, which he called cognitive-behavioural therapy (CBT) (A. T. Beck, 1967). The growth of CBT could be traced to a few factors, such as the development of outcome measures such as the Beck Depression Inventory (Thoma et al., 2015), the amenability of CBT to randomized controlled trials (RCTs) and the focus on treating specific disorders with manualised approaches (A. T. Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). It has become widely practiced by psychologists in the UK and other countries such as the US (Thoma et al., 2015); over one third of clinical psychologists in the UK use CBT as their primary approach (Nel, Pezzolesi, & Stott, 2012) and it has become the dominant therapy in the National Health Service (NHS) in the UK (Richardson, 2015).

1.4.9 Psychoanalysis, Clinical Psychology and the NHS

The National Health Service (NHS) is the dominant employer of clinical psychologists and provider of mental health services in Britain (Hall et al., 2015). Therefore, its structures have a major influence on how clinical psychology and therapies are shaped (Hall et al., 2015). Before World War II, there was no co-ordination between state-funded and local or voluntary health services (Hall et al., 2015). After the war, the National Health Service Act (1946) and the NHS was established on July 5th, 1948. The aim was to

improve mental and physical health, prevent illness and provide free healthcare (Hall et al., 2015). The establishment of the NHS led to criteria being developed for the training and appointment of clinical psychologists (Stewart, 2015). There have been several reorganizations of the NHS from the 1970s onwards, and in the context of this history, one of the key changes was the publication of *A First Class Service* in July 1998 (Hall et al., 2015). This set out the vision as to how quality would be assured and led to the establishment of the NICE (National Institute for Health and Care Excellence) guidelines in 1999, to evaluate the effectiveness of treatments and guide how they should be delivered (Hall et al., 2015).

1.4.10 NICE Guidelines and Psychoanalysis

The NICE guidelines provide guidance about health and social care services (NICE, 2020) and advise how psychological therapies should be used in clinical practice, based on research and evaluations of cost-effectiveness (Guy, Loewenthal, Thomas, & Stephenson, 2012). However, NICE tends to prioritize certain types of evidence such as RCTs, meta-analyses and systematic reviews, to which psychoanalytic approaches are not as easily amenable as CBT (J. Smith, 2007). As a consequence, the NHS and training institutions train therapists predominantly in NICE-approved treatments, meaning that psychoanalytic approaches are somewhat side-lined within therapy and the NHS (Guy et al., 2012; Richardson, 2015). Therefore, as discussed, the prevailing ideologies of empiricism and the medical model have contributed towards the relative marginalization of psychoanalytic approaches in the NHS. Neoliberalism, a political ideology introduced in the

next section is another current political ideology that has contributed to this process.

1.4.11 Psychoanalytic Therapies and Neoliberalism

Neoliberalism is a set of political and economic practices that proposes that human well-being can best be advanced in a society that supports free market and free trade (Harvey, 2007). This has become the dominant Western political ideology in the last 30 years (Dudley, 2017). Its impact can be seen on therapy, therapists and services in the UK, and on the provision of psychoanalytic approaches (Layton, 2014). Manualised therapies that can be offered on a short-term basis have been prioritized by government initiatives such as the Increasing Access to Psychological Therapies (IAPT) programme (Knight & Thomas, 2019). IAPT was set up over ten years ago, based on the work of an economist, Richard Layard, who argued that setting up a population-based service to treat depression and anxiety with evidence based therapies would be cost-effective; the expense of setting it up would be offset by the increased taxes gathered from those who returned to work (Centre for Economic Performance's Mental Health Policy Group, 2006). Although there are aspects to this that are beneficial to therapies in general - the need for wider provision of talking therapies, for example, (Shaw, 2014), there are some disadvantages for psychoanalytic approaches. The report relies on the evidence and findings of the NICE guidelines to come to these conclusions, and so CBT and empirical approaches are prioritized (Dudley, 2017).

Neoliberalism has led to the marketization and commodification of psychological services; there is an emphasis on productivity and achieving measurable outcomes as evidenced by the tendering of services to private companies and payment by quantifiable results (Gezgin, 2019; Rizq, 2014b). This leaves little room for psychoanalytic approaches (Layton, 2014). However, efforts are being made by the psychoanalytic profession to fit into a new framework for therapies which emphasize short-term, manualised approaches such as Dynamic Interpersonal Therapy (DIT) (Lemma, Target, & Fonagy, 2011). With the introduction of competency-based training, efforts have been made to develop competencies for psychoanalytic approaches (Lemma, Roth, & Pilling, 2008; Poston & Bland, 2019; UCL CORE, 2014).

1.5 Empirical Support for Psychoanalytic Approaches

Given the current context that prioritizes empiricism, the medical model and cost-effective approaches, there has been an increase of efficacy and effectiveness research (Boswell et al., 2011). Efficacy determines whether an intervention produces an expected result under trial conditions, whereas effectiveness trials measure the degree of beneficial effect in clinical settings (Gartlehner, Hansen, Nissman, Lohr, & Carey, 2006). This research is still relatively difficult to undertake for psychoanalytic approaches, given that the treatments are often of considerable length, an appropriate control is difficult to choose, the number of patients is often limited and it is difficult to capture outcomes that are regarded as relevant to psychoanalysis (De Maat et al., 2013). However, resulting problems with research such as small sample

sizes, heterogeneous clinical populations with high co-morbidity, lack of standardization and crude outcome measures are not problems unique to psychoanalytic research (De Maat et al., 2013). Research will be presented supporting psychoanalysis, long-term psychoanalytic psychotherapy (LTPP), short-term psychoanalytic psychotherapy (STPP) and manualised approaches. Systematic reviews and meta-analyses of research will be presented where possible, being mindful that these approaches are not preferred by some psychoanalytic researchers, but are the best means of testing relative effectiveness by the majority of studies in the current climate prioritizing empiricism and positivism (Rous & Clark, 2009).

1.5.1 Evidence for Psychoanalytic Approaches

Within the last ten years, a systematic review (De Maat, De Jonghe, Schoevers, & Dekker, 2009) and meta-analysis (De Maat et al., 2013) has provided support for the use of psychoanalysis with complex mental health issues. The systematic review found substantial evidence of symptom reduction for those with varied difficulties (De Maat et al., 2009) which was maintained at follow up, which ranged from 2 years to 5 years post-treatment (De Maat et al., 2009). Limited evidence was also found for pervasive personality change, measured through structured interview or scales such as the Inventory of Interpersonal Problems (IIP) or the Minnesota Multiphasic Personality Inventory (MMPI-2) (De Maat et al., 2009). The more recent meta-analysis (De Maat et al., 2013) included 603 adult patients who received between 234 and 921 hours of therapy whose diagnoses included depression, anxiety, issues classed as personality disorder, eating disorders, relational

problems, work problems and substance use. The majority achieved clinically significant change (pre-post effect size was 1.52 for symptom improvement and 1.08 for personality characteristics, both measured by standardized scales such as the Symptom Checklist 90 Revised (SCL-90-R) or IIP (De Maat et al., 2013). Additionally it was found that changes were either stable, or further positive changes were observed at follow up which was up to 4.5 years post-treatment (De Maat et al., 2013). Criticisms of this study point to a lack of control treatments in the majority of studies reviewed and the study did not account for those who dropped out (Gerber et al., 2011). However, this is the case for many reviews of RCTs (Gerber et al., 2011).

1.5.2 Evidence for Long-Term Psychoanalytic Psychotherapy (LTPP)

As discussed, a LTPP is defined as drawing on psychoanalytic ideas and principles and generally lasts 50 sessions or more over one year or more (Leichsenring & Rabung, 2008). A recent systematic review (De Maat et al., 2009) and a meta-analysis of randomized controlled trials (RCTs) (Smit et al., 2012) reached different conclusions on the effectiveness of LTPP. The systematic review was based on 27 studies of over 3500 patients and concluded that there were large improvements pre- and post-treatment for patients with issues such as depression, anxiety, relational issues and personality disorders (effect size was 1.03 for symptom reduction and 0.54 for personality change) (De Maat et al., 2009). These results also suggested that this improvement was independent of age, sex, diagnosis or therapist experience (De Maat et al., 2009). The meta-analysis questioned this finding on the basis that there were no control groups and so compared the

effectiveness of LTPP in comparison to other treatments or no treatment. Through 11 RCTs on patients with diagnoses of personality disorder, anxiety, depression, it concluded that LTPP was equivalent to other therapies such as Dialectical Behaviour Therapy or cognitive therapies, and superior to no treatment (Smit et al., 2012). Another study found that long-term psychoanalytic therapy was found to have equivalent effects on symptoms of depression to long-term CBT; there was a significant decrease in symptoms of depression over three years measured by the Beck Depression Inventory II (BDI-II) with an effect size of 1.83, and no significant difference between the groups receiving each type of treatment (Leuzinger-Bohleber et al., 2019). However, a further study comparing psychoanalysis and CBT found that at three year follow up, the group receiving psychoanalysis has significantly lower depression scores on the BDI-II and experienced enhanced social-interpersonal functioning and an improved self-schema as measured by self-report scales (Huber, Zimmermann, Henrich, & Klug, 2012). This was suggested to be related to the longer treatment time of psychoanalysis (average number of sessions was 234 for psychoanalysis compared to 45 sessions for CBT, despite both being classed as long-term treatments) and the broader focus of psychoanalysis on interpersonal and psychological functioning in contrast to CBT (Huber et al., 2012).

1.5.3 Evidence for Short-Term Psychoanalytic Psychotherapy (STPP)

There are fewer RCTs on the effectiveness of STPP in comparison to LTPP. A review of studies found that psychodynamic therapy, which was short-term and less than 40 hours, relieved symptoms of anxiety, depression and

somatic disorders with a mean effect size of 0.97 which increased to 1.51 at 9 month follow up (Shedler, 2010). Other outcomes such as healthcare utilization were also reduced, and the results tended to improve on follow-up, suggesting on-going change (Shedler, 2010). This was supported by a Cochrane review of RCTs that included 33 studies involving 2173 participants. Results again showed significant improvements in symptoms of depression and anxiety, reduced self-injury and improved interpersonal and occupational adjustment (Abbass et al., 2014). Again gains increased over time (Abbass et al., 2014). Another study of 5613 patients in the NHS with a variety of psychological problems found that psychodynamic therapy had an equivalent effectiveness to CBT and person-centred therapy in terms of improvements in scores on the CORE outcome measure of subjective wellbeing, with effect sizes of 1.29, 1.38 and 1.39 respectively (Stiles, Barkham, Mellor-Clark, & Connell, 2008). Other studies have investigated the use of STPP for specific disorders. A meta-analysis of 54 studies of depression found that STPP was more effective than control conditions which included waitlist control, treatment as usual and placebo with a mean effect size of 1.15 (Driessen et al., 2015). These improvements increased at 6 month follow up, with an increase in effect size of 0.13 (Driessen et al., 2015). STPP has also been associated with improvements in social, work and personal functioning (Taylor, 2008). An RCT showed that there were no significant differences between post-treatment outcomes of depression on the Hamilton Depression Rating Scale (HAM-D) between psychodynamic therapy and CBT, with an average remission rate of 22.7% post-treatment (Driessen et al., 2013). There is also evidence that psychoanalytic therapy is effective for various types of

anxiety disorder such as panic disorder (Milrod et al., 2007), social anxiety disorder (Leichsenring, Salzer, et al., 2013) and generalized anxiety disorder (Salzer, Winkelbach, Leweke, Leibing, & Leichsenring, 2011). In terms of personality disorder, a meta-analysis of studies published between 1974 and 2001 found that both CBT and STPP were effective in reducing scores related to personality disorder on measures such as the SCL-90-R, with an overall effect size of 1.46 (Leichsenring, 2005). A subsequent review of RCTs found that and that improvements were significant and were sustained at follow up, which was up to two years (Town, Abbass, & Hardy, 2011).

1.5.4 Evidence for Manualised Approaches

Some manualised treatments have been developed based on psychoanalytic principles, such as dynamic interpersonal therapy (DIT) and mentalisation-based therapy (MBT). DIT is a short-term, manualised therapy that utilizes the core competencies of psychoanalytic treatment such as the ability to make dynamic interpretations, and work within the transference, counter-transference and defenses of the client (Lemma et al., 2010; UCL CORE, 2014) and has been shown to be effective in reducing symptoms of depression and anxiety and patients found it acceptable and relevant to their problems (Lemma et al., 2011). Preliminary research also indicates that it could be effective for patients with medically unexplained symptoms (Selders, Visser, van Rooij, Delfstra, & Koelen, 2015).

MBT is a longer-term therapy based on psychoanalytic approaches that works on one's ability to differentiate one's own mental state from that of others, and

considering how it influences behaviour. It has been shown to be effective for borderline personality disorder in terms of reducing hospitalization and self-harm and improving social and interpersonal functioning (Bateman & Fonagy, 1999; Vogt & Norman, 2019).

1.5.5 Summary of Evidence for Psychoanalytic Approaches

From the evidence presented above, it seems there is evidence for psychoanalytic approaches being used with various difficulties. Although most of the research above is based on adults, there is some preliminary evidence that psychoanalytic approaches can be used effectively with children and adolescents with anxiety, depression and behaviour difficulties (Midgley, O'Keeffe, French, & Kennedy, 2017), older adults (Roseborough, Luptak, McLeod, & Bradshaw, 2013), groups (Blackmore, Tantam, Parry, & Chambers, 2012) and with those with learning disabilities, to reduce psychological distress, improve interpersonal functioning and increase self-esteem (Shepherd & Beail, 2017). Further research is also required to investigate differences between psychoanalysis, LTPP and STPP and how they compare across similar difficulties.

A ten year follow up study seems to indicate that the gains in psychoanalysis were greater, but given that this seems to happen over a longer time-frame than the other interventions, this may be a confounding factor (Lindfors et al., 2019). It may be difficult to justify, given the increased time-frame, but a cost-benefit analysis suggests that quality of life is sufficiently improved to justify

the higher cost, as individuals are less likely to require auxiliary treatments (Berghout, Zevalkink, & Hakkaart-Van Roijen, 2010).

1.6 Service User and Clinician Views of Psychoanalytic Approaches

1.6.1 Service User Views of the Psychoanalytic Approach

When assessing efficacy and effectiveness, it is important that therapeutic approaches used are helpful and well received by service users. Offering service users a choice in terms of therapies offered is critical, given that research shows that different forms of therapy work for different presentations and individuals (A. Roth & Fonagy, 2006) and the current emphasis on service user choice in policy (Department of Health, 2011b, 2011a, 2020).

There is little qualitative research into the ways service users experience the psychoanalytic approach, but research that has been done indicates that service users have found this approach helpful, although some research indicates some ambivalence towards the process of therapy (Fellows, Watters, & Gatherer, 2003). For instance, adults using psychodynamic approaches in the NHS valued being listened to, contained and having space to talk, and they reported this as leading to increased understanding and positive behaviour change (Fellows et al., 2003). Some felt ambivalent about the process of therapy, however, and found that not being ‘given answers’ was challenging (Fellows et al., 2003). This pattern was mirrored in other studies. When the approach was used with adults with bulimia, most clients benefited in terms of interpersonal relations and emotional regulation, but

again some felt challenged by the non-directive approach (Poulsen, Lunn, & Sandros, 2010). Similarly, teenagers who took part in psychodynamic psychotherapy valued the connection with the therapist and space to talk, but experienced stress and ambivalence during sessions when initially opening up about problems and establishing a therapeutic relationship (Bury, Raval, & Lyon, 2007).

Interestingly, one study compared the experiences of service users who utilized either psychoanalytic or CBT approaches; a similar proportion felt satisfied or dissatisfied, and those who were dissatisfied with psychoanalytic approaches felt ambivalent, which contrasted with more disappointment in CBT (Nilsson, Svensson, Sandell, & Clinton, 2007). More research is needed to explore experiences while undergoing therapy; much of this research was done retrospectively after treatment finished, and longitudinal follow ups would be helpful (Fellows et al., 2003).

1.6.2 Clinician Views of the Psychoanalytic Approach

Clinician views of operating within this approach would also be helpful, in order to explore how the approach is received within services. However, there is very little research exploring these experiences. One study explored how practitioners viewed key elements of psychodynamic approaches such as the stance of the therapist and the emphasis on interpersonal relationships and past experience in contrast to CBT and schema therapy, but did not focus on how practitioners felt working within their service context utilizing these approaches (Boterhoven De Haan & Lee, 2014). Another study qualitatively

explored the how varied therapeutic settings, such as GP surgeries, impacted on the provision of therapy by psychodynamic psychotherapists in the NHS (Price & Paley, 2008). It was found that working in settings that were not primarily established for therapy was challenging because they might be noisy, unwelcoming and inconsistently available, making it difficult to hold therapeutic frame (Price & Paley, 2008). However, neither study included clinical psychologists, who may practice differently given the different training pathways and job role requirements. Both studies had a more specific focus in contrast to the aim of this study to broadly explore the experience of clinical psychologists of practicing psychoanalytically within the NHS.

1.7 Current Context of Use of Psychoanalysis by Clinical Psychologists in the NHS

Despite the challenges of empiricism, NICE guidelines, the medical model and manualised approaches, some psychoanalytically-informed work has been retained within the NHS. However, often this has been in an altered form; demands of the neoliberal market and pressures from austerity budgets have put economic and time constraints on therapy and have reduced session frequency from five sessions per week to three sessions per week (Stern, 2009). These same pressures have caused vacated psychoanalytic posts not to be replaced and some newly funded posts not to be filled (Rous & Clark, 2009).

1.7.1 Surveys of the Theoretical Orientation of Clinical Psychologists

There is no current research that indicates the number of clinical psychologists who use psychoanalytic approaches in contrast to other modalities in the UK. However, there is some longitudinal research that examines trends in choice of theoretical orientation of clinical psychologists over time in the US. A series of studies carried out on members of the American Psychological Association's (APA) Division of Clinical Psychology shows that the number of psychoanalytically-informed clinical psychologists has decreased from 35% in 1960 to 18% in 2010, whereas the numbers with cognitive-behavioural leanings have increased from 2% in 1973 to 31% in 2010 (Norcross & Karpiak, 2012). It is useful to keep in mind, however, that there are some differences in the US and UK samples. US clinical psychologists are more likely to work on an outpatient basis and carry out research in addition to clinical work, and they work within a different healthcare system (Norcross, Brust, & Dryden, 1992).

There is a relative lack of longitudinal data tracking choice of theoretical orientation over time in the UK. However, two studies suggest that this trend towards an increase in use of CBT and a decrease in psychoanalytic approaches is also apparent in the UK. One survey carried out in 2012 of over 350 clinical psychologists in the NHS found that a minority (5.6%) identified themselves as psychodynamic (Nel et al., 2012). In contrast, 33.6% identified as cognitive-behavioural (Nel et al., 2012). A survey carried out twenty years earlier of over 1000 clinical psychologists in the UK found a similar pattern; a minority (11%) identified their primary theoretical orientation as psychoanalytic

whereas behavioural or cognitive approaches were endorsed by 48% (Norcross et al., 1992).

However, another survey carried out in the early 1990s in the South-East of London found that 21% of clinical psychologists considered themselves to have a primarily psychodynamic orientation (O'Sullivan & Dryden, 1990). However, in contrast to the previous UK-based studies, this is a regional sample and differences in the regional and national samples could be due to greater opportunities to train in psychodynamic approaches in the south-east of Britain (Norcross et al., 1992). As a result, the national samples will be used for comparison throughout this thesis.

Previous surveys of clinical psychologists in the US show that 94.5% use their theoretical orientation always or often (Norcross & Prochaska, 1983). However, this research was carried out almost forty years ago, and there is no such data for clinical psychologists working in the UK (Nel et al., 2012; Norcross et al., 1992). Given the competing influences on choice of modality (Norcross & Prochaska, 1983), it is important to know how often clinician's choice of modality can be utilized.

1.7.2 Surveys of the Theoretical Orientation of Faculty Members of Clinical Psychology Departments

Another strand of research that illustrates the current level of practice of psychoanalytic approaches within clinical psychology focuses on modalities used by staff members of clinical psychology university departments. This

informs how often modalities are used, given the influence of training on future theoretical orientation and the fact that many staff are also practitioners (Lucock, Hall, & Noble, 2006). Most of this research, however, has taken place in the US. In the most recent survey, 21% staff members of clinical psychology departments identified as having a psychoanalytic orientation compared to 56% as having a cognitive-behavioural approach (Heatherington et al., 2012). In addition, the number of staff using the psychoanalytic approach has decreased and the number of CBT-endorsing staff has increased over the last twenty years (Levy & Anderson, 2013).

1.7.3 Service, Client and Professional Training Characteristics of Clinical Psychologists Using Psychoanalytic Approaches

There is little current research about the characteristics of services within which clinical psychologists who use psychoanalytic approaches work, what client groups they are most used with, and the training characteristics of these clinical psychologists. It is critical to gather more information about how the approach is being used and characteristics surrounding its use given that it has been suggested through research to be effective (De Maat et al., 2013, 2009; Shedler, 2010), has been experienced as useful by service users (Fellows et al., 2003) and has been marginalized by the dominance of empiricism and medical models (Busch & Milrod, 2010).

1.7.3.1 Service characteristics

Service characteristics that will be referred to based on previous surveys (Norcross et al., 1992; Norcross & Prochaska, 1983) are service setting (e.g.

hospital, outpatient clinic), professional activities (e.g. therapy, assessment etc.), number of clients worked with (e.g. therapy in an individual or group format) and preferences of services of modality and how clinician preferences fit within this.

A previous UK survey indicated that general and psychiatric hospitals were the most common work setting and that clinicians mainly spent their time doing individual therapy (Norcross et al., 1992). However, this survey was carried out over thirty years ago, giving little indication of the current UK context. Additionally, there is no information presented to indicate whether this varies according to modality used, or whether service or clinician preferences have an influence on modality used.

1.7.3.2 Client characteristics

It is unclear what client groups with whom clinical psychologists most commonly use psychoanalytic approaches in the UK. Reviews of effectiveness research suggest that it has been retained in child, learning disability and various adult services (A. Roth & Fonagy, 2006), but it is unclear at what rates. Some research suggests that psychoanalysis is used particularly when the goals of the therapy are related to personality growth and reorganization (Gabbard, Gunderson, & Fonagy, 2002), although other cognitive approaches such as schema focused therapy are offered for these presentations too (Jacob & Arntz, 2013; Young, 1999).

1.7.3.3 Professional training characteristics

Drawing on previous surveys, post-qualification training in psychoanalytic modalities and the availability of this training will be explored. Given that training has an influence on modality used (Lucock et al., 2006), and UK clinical psychologists are required to engage in future training (BPS, 2012), there is little information on how much clinicians engage in further training in different approaches, or how available they are.

1.8 Justification for Research

There is little research investigating the current proportion of clinical psychologists who use psychoanalytic approaches or psychoanalytically-informed within the NHS, relative to other approaches, or their experiences of using them. This research is critical for several reasons.

- Firstly, clinical psychologists are committed to offering a diversity of approaches, as laid out in regulatory guidelines (HCPC, 2015) and this is supported by governmental policy (Department of Health, 2010).
- Secondly, offering service users a choice in terms of therapies offered is critical, given that research shows that different forms of therapy work for different presentations (A. Roth & Fonagy, 2006) and service users have found this approach helpful, as discussed earlier (Bury et al., 2007; Fellows et al., 2003; Merriman & Beail, 2009; Poulsen et al., 2010). This view is reflected in policy, which recommends an increase in service user choice (Department of Health, 2011a, 2011b, 2020).

- Thirdly, the approach has been found to be effective, and therefore should be offered to patients among other options. Meta-analysis and reviews of psychoanalysis (De Maat et al., 2013), LTPP (Leichsenring & Rabung, 2011) and STPP (Abbass et al., 2014; Shedler, 2010) have found symptom improvements and changes in behavioural goals of patients across a range of issues, and these gains were often retained or improved over time.
- There has been an emphasis on the empirical approach, which has increased the focus on evaluating therapies in a manner which has been difficult to reconcile with the psychoanalytic approach (Busch & Milrod, 2010). This may contribute to a monoculture of ideas about what useful therapy looks like (Heatherington et al., 2012). This is problematic, because it may make people less open to different approaches, and we need to be creative in order to meet the needs of changing times, issues and populations (Heatherington et al., 2012). Additionally, exposing clinical psychology students and trainees to different approaches, enhances their ability to understand service user experiences and tailor treatments (Messer, 2004).
- Additionally, the current context of neoliberal ideologies emphasizes low-cost, high-turnover treatments (Rizq, 2014b), a trend which is reflected in the time-limited therapy recommendations made by the NICE guidelines (Salkovskis & Wolpert, 2012) and the introduction of the IAPT model (Knight & Thomas, 2019). Psychoanalytic approaches are often seen as being in conflict with this. It is questionable whether an approach should be prioritized because of its cost-effectiveness

rather than therapeutic effectiveness. It is critical to research what it is like to offer these therapies within current contexts, in order to discover what might facilitate wider provision and available help, given environmental stressors now including a global pandemic in COVID-19.

1.9 Research Aims and Research Question

With those above points in mind, this research aims to explore how clinical psychologists utilize psychoanalytic approaches within the NHS and their experiences of the approach. To do this, the below research questions will be addressed. Research questions one to three will be explored using a quantitative survey, and research question four will be explored using a qualitative interviews.

1. Is the number of clinical psychologists who use psychoanalytic approaches less than those who use other modalities?
2. How often do clinical psychologists use their preferred modality in their work?
3. What are the service, client and professional training characteristics of clinical psychologists using psychoanalytic approaches?
4. How do clinicians describe working within a psychoanalytic approach?

2. CHAPTER TWO: METHOD

2.1 Overview

This chapter describes the epistemological positioning of the research. It discusses relevant ethical considerations and describes the research design, procedure and analysis. Finally, researcher reflexivity is explored.

2.2 Epistemology

This research adopts a critical-realist stance, which proposes that there is a world that exists externally, but our appraisal of this external reality is influenced by other factors such as time, culture and social context (Bhaskar, 1979). This position differs from a realist stance, which assumes there is an objective reality that exists independently of the mind, and is akin to a moderate constructionist perspective, that acknowledges that our perspective of reality is mediated by context, culture and language (Maxwell & Mittapalli, 2010).

A critical realist epistemology was chosen because it is regarded as a useful stance for mixed methods research; it maintains an ontological realism, while accepting some epistemological relativism (Maxwell & Mittapalli, 2010). This is in contrast to some widespread views that the appropriate philosophical stance for quantitative methods is positivist, and qualitative is constructivist

(Maxwell & Mittapalli, 2010). A pragmatist viewpoint builds on the critical realist stance, and additionally suggests that the way we study phenomena should be informed by the needs of the research question (D. Morgan, 2014). There have been several frameworks developed to distinguish various purposes for combining methods which avoid "methodological eclecticism" (Hammersley & Atkinson, 1995). Here the framework of sequential contributions of Morgan (2014) will be drawn upon, which aims to use one method to enhance the other. This allowed quantitative and qualitative elements to be used to answer different research questions in the study in an integrated way (Bryman, 2006). The quantitative survey was used to provide a broader context around national use of psychoanalytic approaches (D. Morgan, 2014). The qualitative interview was used to explore the experiences of using the psychoanalytic approaches in more depth (Willig, 2013).

In addition, critical realism informed the method of analysis; it acknowledges that participants may not be fully aware of all contextual factors influencing their experience, and so advocates drawing from the literature to explore social structures and ideologies that may shape these experiences (McEvoy & Richards, 2006). This involves a move from reporting observations and experiences towards postulating the structures and mechanisms that account for the phenomena involved, which is done in the discussion chapter (McEvoy & Richards, 2006). This move is consistent with both the aims of the study and the method of analysis (thematic analysis) of the interviews (Braun & Clarke, 2006). In addition, this position acknowledges the existence of multiple realities and so a reflexive review will be carried out in this chapter

(see section 2.9) and in the discussion chapter (see section 4.12) (Mingers, 2006).

2.3 Ethical Considerations

The following issues have been addressed in order to ensure ethical practice, as laid out in the British Psychological Society (BPS) Code of Research Ethics and Conduct (BPS, 2009).

2.3.1 Ethical Approval

Ethical approval was granted by the University of East London Ethics Committee subject to minor amendments, which were acted upon (see Appendix C, D and E). Participants were not recruited through NHS services, and so no additional approval was required.

2.3.2 Informed Consent

Participants were presented with a Participant Information Sheet (PIS) (see Appendix D) after clicking on the survey link. This provided information to participants about the research purpose, what is involved in participation, how data will be stored and used, their right to withdraw by discontinuing the survey and confidentiality. Contact details of the researcher and supervisor were provided. Participants were then required to accept four statements of consent to participate (see Appendix G) to access the survey.

At the end of the survey, as described in the PIS, participants were provided

with the option to opt in to be interviewed. They were emailed a separate PIS (see Appendix H) and consent form (see Appendix I) before the interview, and again asked for verbal consent at the beginning of the interview. Participants were free to withdraw at any time, could decline to answer any questions and could take breaks or reschedule. Participants were given one week after the interview to ask for their information to be withdrawn. After this, their transcript would have been included in the analysis and write up, with identifying information removed. Questions about participation were welcomed at any stage.

2.3.3 Confidentiality and Anonymity

Participant information was kept confidential. Data from the survey was anonymised by storing it separately from names and contact details of participants. Names and identifying details were removed or altered in the transcripts.

2.3.4 Further Support

Although it was not anticipated that the interview would be upsetting, information about potential support services was given on the both PIS and on the debriefing sheet (Appendix J), provided after the survey and interview. This gave a reminder of how data would be processed and stored, their right to withdraw and contact details of the researcher, supervisor and support services.

2.3.5 Data Protection

Survey data, recorded interviews, consent forms and transcripts were saved in a password-protected folder on the computer of the researcher. All files were backed up on a secure server of the University of East London (UEL), again password protected. Only the researcher, supervisors and examiner would have access to data and transcripts.

2.4 Design

A cross-sectional mixed-methods design employing quantitative and qualitative methods was used. Participants completed an online questionnaire and could opt-in to participate in a semi-structured interview. Findings were integrated at the interpretation stage (Creswell et al., 2003).

2.4.1 Survey Design

The survey (see Appendix K) aimed to collect demographic data of clinical psychologists working within the NHS in the UK, who were using psychoanalytic approaches, as well obtaining contextual information about their services, client groups and modalities used. The questions were based on a previous survey carried out on clinical psychologists (Norcross et al., 1992) because this previous research surveyed similar characteristics of clinical psychologists in the UK (Norcross et al., 1992). However, some questions were updated to reflect a changing social context. For example, separate questions were asked about sex and gender (The GenIUSS Group, 2014; Westbrook & Saperstein, 2015) and recent UK recommendations for

collecting data regarding nationality and ethnicity were used (Office of National Statistics, 2019). Closed questions were used, with forced answer options and rating scales (Boynton & Greenhalgh, 2004).

2.4.2 Qualitative Interview Questions

A semi-structured interview schedule was used (see Appendix L) to explore the experiences of clinical psychologists of using or not using psychoanalytic approaches in the NHS. They were designed to be deliberately broad in order to allow for open elaboration by participants, rather than determining or constraining discussion topics (Willig, 2013). Prompt questions were included to elicit further information (Willig, 2013). Participants were invited to add anything at the end of the interview.

2.5 Participants

2.5.1 Inclusion Criteria

Participants were required to be clinical psychologists currently practicing within NHS services in the UK, where the UK was defined as being England, Scotland, Wales and Northern Ireland. Broad inclusion criteria were used to allow a breadth of experience and a large potential participant pool. Twelve self-selected clinicians were interviewed.

2.5.2 Recruitment and Sampling

The questionnaire was posted to various online forums for clinical psychologists of different clinical specialities, services and orientations

throughout the UK, and through connections of the researcher. Criterion sampling was used (Patton, 2002). For interview, participants had to choose to opt-in for interview at the end of the survey, there was no requirement to have a particular viewpoint on the use of psychoanalytic approaches.

2.6 Procedure

2.6.1 Pilot

The pilot was used to review the content and length of questionnaires. A convenience sample of three people working as mental health professionals were asked to review the questionnaire. Adjustments were made to the questionnaire based on feedback (see Appendix K).

2.6.2 Online Survey

The survey link was posted to various social media forums and professional networks for clinical psychologists. Participants clicked on the link, and were presented with the PIS and consent form. Participants had to read the PIS and indicate informed consent before progressing. The questionnaire took 5-10 minutes to complete. Participants could opt in to be interviewed at the end of the survey, and if they did, were asked to provide their name and contact details. All participants were presented with the debrief sheet. Data was downloaded and interviewee contact details and responses were stored separately and securely.

2.6.3 Interviews

Participants who opted in to be contacted for interview were contacted by the researcher to arrange a time to be interviewed. Twelve interviews were conducted, eight by phone, one face-to-face and three by Skype. Participants were emailed the PIS and consent form, and asked to return it by email before the interview. Participants were also asked to re-iterate their consent verbally at the beginning of the interview. The interviews lasted between 40 minutes and an hour and 25 minutes, with an average of 56 minutes. Interviews were recorded using a voice recorder or Skype record. Skype videos are deleted automatically after 30 days, and were deleted manually by the researcher from the voice recorder. Copies used for transcription were stored securely. As required for thematic analysis, the transcript involved a verbatim account of all verbal and some non-verbal utterances (Braun & Clarke, 2006) (see Appendix M for transcript annotations).

2.7 Analysis

2.7.1 Quantitative Analysis

Survey data was analysed using IBM SPSS Statistics for Mac, version 26. Descriptive statistics were used to describe the service, client and training characteristics of participants. A chi-square statistic was used to investigate whether the number of participants endorsing each modality as their primary modality was different to what would be expected by chance. Results are presented in Chapter 3.

2.7.2 Qualitative Analysis

Thematic analysis was used to analyse qualitative data because it can be used across a range of epistemological approaches, including critical realism, to describe the experiences of participants, while acknowledging the effects of social context on these experiences (Braun & Clarke, 2006). It identifies, analyses and describes repeating themes across a dataset, and allows some interpretation (Braun & Clarke, 2006). An inductive approach was mainly used; i.e. themes were identified from participant interviews, and deductive strategies were used to further interpret the themes by drawing on literature and previous research (Braun & Clarke, 2012). The following phases were implemented during the data analysis (Braun & Clarke, 2006).

1. Familiarisation with the Data

The process of immersion involved listening to interviews, transcribing and re-reading transcripts, noting initial ideas for codes.

2. Generating Codes

Data was coded systematically using NVivo 12 software. Data was coded inclusively, retaining relevant contextual content (see Appendix N and O).

3. Searching for Themes

Codes were sorted into potential over-arching themes *that related to the research question* using visual mind maps (see Appendix P). Themes were decided upon using both prevalence within dataset in terms of the number of participants mentioned the theme, and also in terms of how well they captured

an element of the experience of interviewees (Braun & Clarke, 2006).

4. Reviewing Themes

Potential themes were checked to ensure they fit with the coded extracts and dataset as a whole. The data was re-read to ensure that the themes reflected the dataset and identify any missing themes.

5. Defining and Naming Themes

Themes were further refined and named, and subthemes identified. It was ensured that the themes created a coherent narrative of the data and reflected the research question.

6. Producing the Report

The themes were presented as a coherent narrative with examples of data extracts that described the data in relation to the literature and research question.

2.8 Data Quality

The concept of trustworthiness (Lincoln & Guba, 1985) was used to assess the quality of this study because it is a widely used method, and has been operationalized in relation to thematic analysis (Nowell, Norris, White, & Moules, 2017). The trustworthiness of the data reflects its worth in relation to four criteria (Lincoln & Guba, 1985). Credibility refers to the fit between the views of the interviewees and the researcher's representations of them

(Nowell et al., 2017). This was addressed in this study though triangulation; themes represented the views of more than one participant, data was collected from multiple participants and research was used to support themes. In addition, peer debriefing was used to enhance credibility; interpretations were checked with my supervisor and amendments regarding the structure of themes were made (see Appendix P). A reflexive review was carried out to help the researcher recognise their influence in the research (see section 2.9 below).

An audit trail document was kept where decision rationales were described to enhance the dependability of the results. Decisions about the transferability of the research were facilitated by providing a detailed description of the study and context (Nowell et al., 2017). Finally, the confirmability of study is the ability to establish that the findings are derived from the data (Nowell et al., 2017). This was determined by meeting the standards for credibility, dependability and transferability, and through ensuring that quotes map onto identified themes (Nowell et al., 2017). A table is included in Appendix Q detailing the methods used to ensure trustworthiness at each stage.

2.9 Reflexive Review

Reflexivity involves reflecting on how the experiences, interests, beliefs, values and identities of the researcher shape the research (Willig, 2013), and is an important aspect of thematic analysis (Braun & Clarke, 2006). These are elaborated below and were kept in mind throughout.

I was aware that I believe that psychoanalytic approaches are valuable and useful for clients and clinicians. I was also aware that I am a white female from a middle-class background, and this may reflect how I engage with the approach, as historically it has been regarded as a preserve of middle-class therapists and clients (Ryan, 2017).

I was also conscious that my job as a trainee clinical psychologist may give me a particular view on how it is used in the NHS. At present, I believe that psychoanalytic approaches tend to be undervalued. Throughout my placements and job roles, I have not worked in any departments psychoanalytic approaches are used. A clinician of another background, discipline or set of experiences may have another viewpoint.

Holding these elements in mind, I tried to ensure that I did not lead participants, asked open questions, and did not share my views on the research topic. I also welcomed participants with any viewpoints.

I will return to retrospectively reflect on how these aspects of my identity and experience may have shaped the research in the discussion chapter (see section 4.12).

3. CHAPTER THREE: ANALYSIS

3.1 Chapter Overview

This chapter describes the results of the analyses relating to each research question. First the results of the survey are presented which correspond to research questions one, two and three, as laid out in the introduction chapter (see section 1.9). Descriptive statistics were performed to analyse the data, and a frequency count of text box answers was conducted (Field, 2013; Sandelowski, Voils, & Knafl, 2009).

Following this, the themes generated from the qualitative interviews, which addressed research question four, are presented.

3.2 Survey Sample Characteristics

3.2.1 Survey Respondents

Three hundred and fourteen individuals accessed the online survey. However, 115 (36%) did not complete the survey. A listwise deletion approach (P. L. Roth, 1994) was used, restricting analysis to complete cases only. This approach was taken for ethical reasons because non-completion was listed as an indicator of study withdrawal on the consent sheet. Additionally, 10 participants (3%) indicated that they did not currently work in the NHS, and so

were excluded from the analysis. Therefore the total number of participants was 189 (60% of those who initially accessed the survey).

3.2.2 Representativeness of Survey

It is estimated that this survey accessed approximately 2% of clinical psychologists in the UK. The closest estimate of the number of clinical psychologists in the UK was in a review of figures of the Health and Care Professions Council (HCPC) (Hall et al., 2015). They reported that 9324 individuals were registered as clinical psychologists in the UK in 2015 (Hall et al., 2015).

3.2.3 Participant Characteristics

The majority of participants were aged 30-39 years (59.8%), were female (85.2%) and/or identified as female (85.7%). The majority identified their nationality as English (35.4%) or British (37.6%) and identified as White or White-British (90.5%) (see Table 1).

Table 1: Demographics of sample

Demographics	N	%
Age		
20-29	15	7.9
30-39	113	59.8
40-49	49	25.9
50-59	9	4.8
60-69	3	1.6
Sex		
Male	28	14.8
Female	161	85.2
Gender		
Male	26	13.8
Female	162	85.7
Transgender	0	0
Prefer not to disclose	0	0
Other	1	0.5
Nationality		
English	67	35.4
Welsh	6	3.2
Scottish	11	5.8
Northern Irish	5	2.6
British	71	37.6
Other	29	15.3
Ethnicity		
White/White British	171	90.5
Black/Black British	0	0.0
Mixed/Multiple ethnicities	5	2.6
Asian/Asian British	4	2.1
Other	9	4.8

Note. Total N=189

In terms of training (see Table 2), the majority trained in the UK (97.4%) and completed their training between 2010 and 2019 (73.5%). There was a wide spread of representation across universities, although UCL (7.4%) and Lancaster (8.5%) had marginally higher representation.

Table 2: Training characteristics of sample

Training Characteristics	N	%
Country of Clinical Training		
UK	184	97.4
Other	5	2.6
Year Training Completed		
1970-1979	2	0.5
1980-1989	2	1.1
1990-1999	9	4.8
2000-2009	38	20.1
2010-2019	139	73.5
University of Clinical Training		
Lancaster	16	8.5
UCL	14	7.4
Edinburgh	10	5.3
Royal Holloway	9	4.8
Surrey		
Salomon's		
Hull	8	4.2
Newcastle		
Exeter	7	3.7
Birmingham		
Glasgow	6	3.2
Staffordshire		
Sheffield		
Leeds	5	2.6
Leicester		
Liverpool		
Manchester		
Teeside		
Trent (Nottingham & Lincoln)		
Essex		
Bath	4	2.1
East London		
Hertfordshire		
Oxford		
Plymouth		
Cardiff		
Bangor	3	1.6
Belfast (Queen's)	2	1.1
East Anglia		
IOPP		
Coventry and Warwick	1	0.5
Southampton	0	0.0

Note. Total N=189

In terms of current work (see Table 3), the majority work in England (84.1%) and have between 1 and 9 years of post-qualification experience (72%).

Table 3: Characteristics of clinical psychology work of participants

Characteristics of Clinical Psychology Work	**N**	**%**
Country of Work		
England	159	84.1
Wales	8	4.2
Scotland	19	10.1
Northern Ireland	3	1.6
Other	0	0
Years of Post-Qualification Experience		
1-9	136	72.0
10-19	41	21.7
20-29	9	4.8
30-39	2	1.1
40-49	1	0.5

Note. Total N=189

3.3 Research Question One: Is the number of clinical psychologists who use psychoanalytic approaches less than those who use other modalities?

3.3.1 Descriptive Statistics

It was found that only a small percentage of the sample rated humanistic (0.5%) and behavioural (4.2%) as their primary modality (see Appendix R, Table 1 for exact number and percentages of participants endorsing each approach). For this reason, those rating humanistic approaches as their primary modality were excluded from the rest of the quantitative analysis. Those endorsing behavioural approaches as their primary modality were

included in the numbers with those endorsing cognitive and behavioural approaches. This was believed to be justified given that behavioural principles are used within cognitive-behavioural therapy (J. S. Beck, 2011) and both behavioural and cognitive-behavioural competencies are listed within the same competency framework for practitioners (UCL CORE, 2007).

Psychoanalytic approaches were used as the primary modality by 18% of participants. CBT and third wave approaches were used by a greater majority (32.4% and 23.4% respectively) (see Figure 1). Other modalities were used by 11.2% as a primary modality. Other approaches used by participants are listed in Table 4 (see Appendix R, Table 2 for all text box answers given by participants). The modal response was EMDR therapy (16 participants) followed by Cognitive Analytic Therapy (CAT) (12 participants).

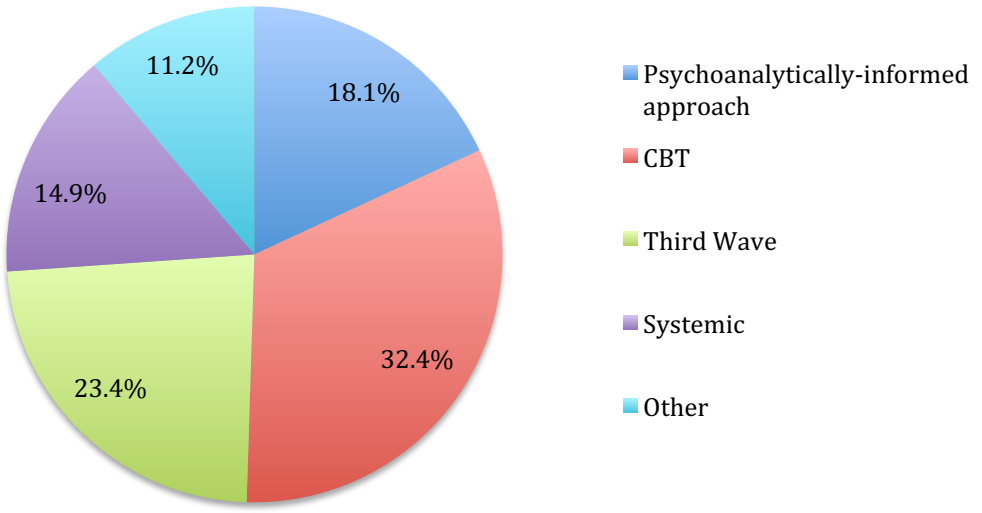

Figure 1: Percentage of clinical psychologists who use each modality as their primary modality

Table 4: Frequency count of other modalities used by participants

Other Modality Used	N	%
EMDR	16	8.5%
Cognitive Analytic Therapy (CAT)	12	6.4%

3.3.2 Chi-Square Statistic

A chi-square goodness of fit test is a single-sample non-parametric test. It was used to determine whether the number of participants endorsing each modality as their primary modality was different to what would be expected by chance. In this analysis, those endorsing “other” approaches were excluded as they were a heterogeneous group and so they could not be meaningfully compared with the other groups (see Table 5 for numbers and percentages of this subsample endorsing each modality). The percentage of this subsample endorsing each approach roughly reflects the percentages of the full sample endorsing each approach (see Figure 1).

Table 5: Frequency and percentage of participants endorsing each modality as their primary approach

Other Primary Modality	N	%
Psychoanalytic	34	20.4%
CBT	61	36.5%
Third Wave	44	26.3%
Systemic	28	16.8%

Note: Total N=167

The data meet the assumptions required for a chi-square test. The variable is a nominal categorical variable. There is independence of observations; there is no relationship between the cases, and the categorical variables are mutually exclusive. The number of observations in each category was above five.

The chi-square statistic suggested that the modalities were not equally endorsed by participants as their primary modality; $\chi^2(3)=14.964$, p=.002. (See Appendix R, Figure 1 for SPSS Output).

To explore this further, it is useful to look at the frequencies of participants endorsing each approach (see Table 5 above) and the difference between the observed scores and expected scores (See Appendix R, Figure 1). More endorsed CBT and less endorsed systemic and psychoanalytic approaches than might be expected.

3.4 Research Question Two: How often do clinical psychologists use their preferred modality in their work?

The majority of clinical psychologists use their preferred approach either often (56.1%) or repeatedly (34.4%) (see Figure 2).

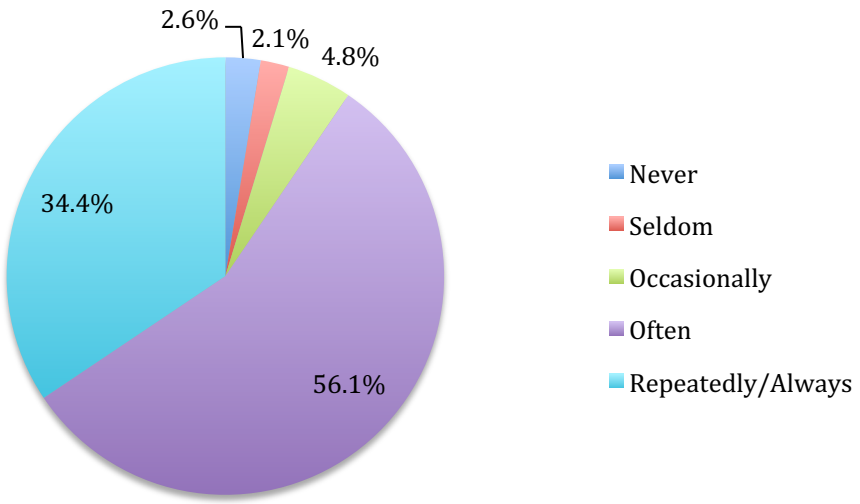

Figure 2: Frequency of use of the primary modality used by participants

3.5 Research Question Three: What are the service, client and professional training characteristics of clinical psychologists using psychoanalytic approaches?

3.5.1 Service Characteristics

3.5.1.1 Service setting

The majority of participants all modalities worked in secondary care community teams (see Table 6 below and Appendix R, Table 3 for full figures). This includes those primarily working with psychoanalytic (50%), cognitive-behavioural (54.1%), third wave (38.6%) and systemic (50%) approaches. Other services worked in by participants were mainly clinical health settings (16 participants), varied child and family settings including social care and paediatrics (10 participants) and forensic services (7 participants) (see Table 7 below and Appendix R, Table 4 for full figures).

Table 6: Percentage of participants working in each service setting according to their primary modalities

	Psychoanalytic	**Cognitive-Behavioural**	**Third Wave**	**Systemic**
Secondary Care Community Team	17 (50%)	33 (54.1%)	17 (38.6%)	14 (50%)
Other	8 (23.5%)	14 (23%)	14 (31.8%)	10 (35.7%)

Note. Shortened table, full results in Appendices

Table 7: Frequency count of other service settings worked in by participants

Other Service Settings	**N**
Hospital/Clinical health	15
Neuropsychology/Brain injury/Memory service	5
Children and families/CAMHS	4
Social care	2
Paediatrics	3
Perinatal	1

3.5.1.2 Professional activities

Therapy is the main professional activity of those using all the different modalities; psychoanalytic approaches (55.9%), cognitive-behavioural (59%) and third wave (40.9%) approaches (see Figure 3).

It is noteworthy that the second most common professional activity of participants using the psychoanalytic approach was consultation (20.6%). Assessment was the second most common activity for those primarily using cognitive-behavioural (23%), third wave (36.4%) and systemic (32.1%) approaches. The percentage of professional time spent during supervision and administration was relatively low across the modalities. Research was listed as an activity for those primarily using cognitive-behavioural (1.6%) and third wave (2.3%) only.

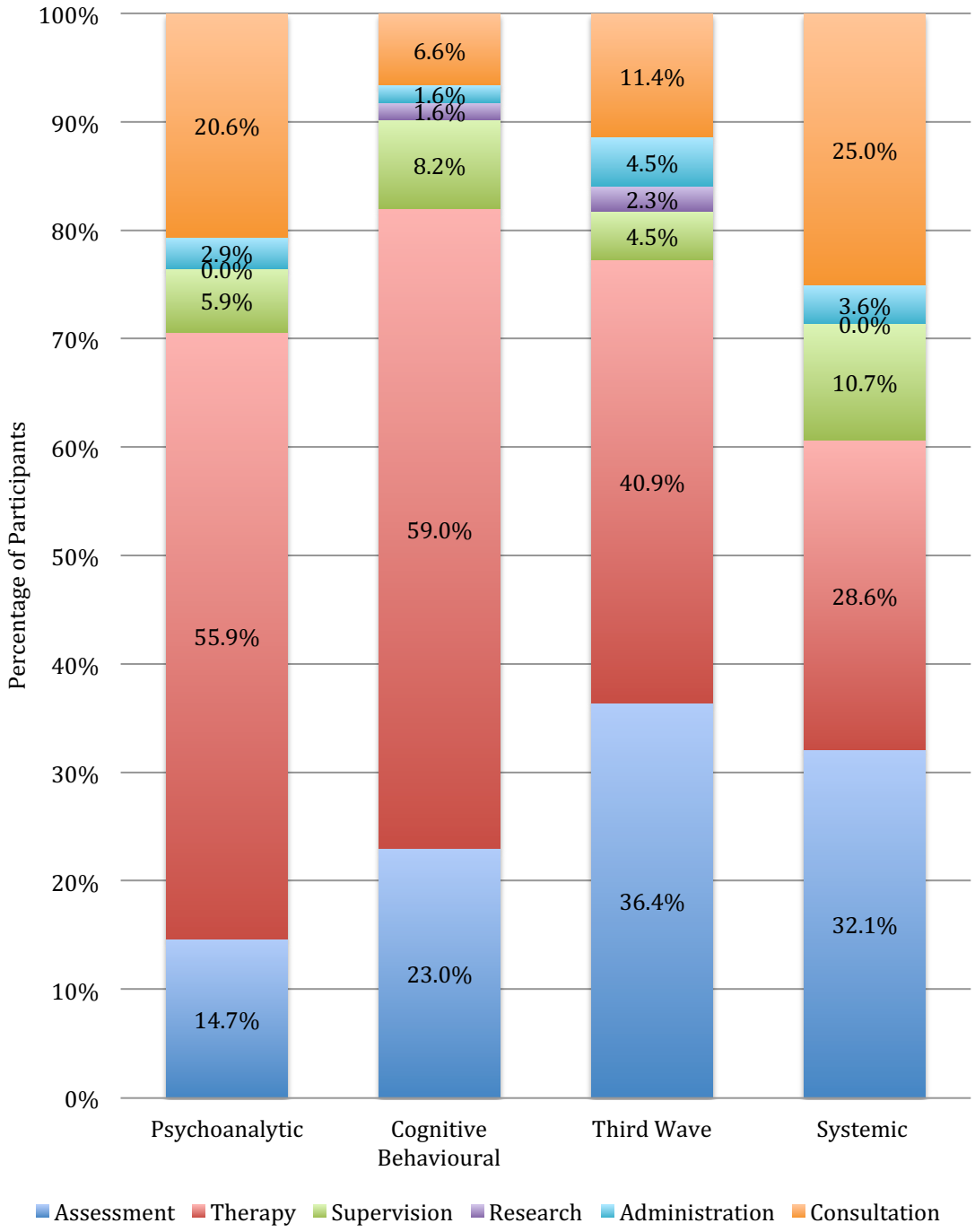

Figure 3: Percentage of participants that primarily spend their time doing each professional activity according to primary modality used

3.5.1.3 Range of numbers of clients worked with simultaneously

The majority of participants, regardless of modality used, mainly engaged in therapy with individuals (see Figure 4). This was consistent for participants

primarily using psychoanalytic (91.2%), cognitive-behavioural (88.5%), third wave (86.4%) and systemic (57.1%) approaches.

The use of other means of meeting clients was relatively low across the modalities, although those using systemic approaches tended to meet with families (21.4%) or use other formats of therapy (14.3%). Other formats of therapy used included meeting with systems around the child (5 participants), or working with organizational systems (2 participants) (see Table 8).

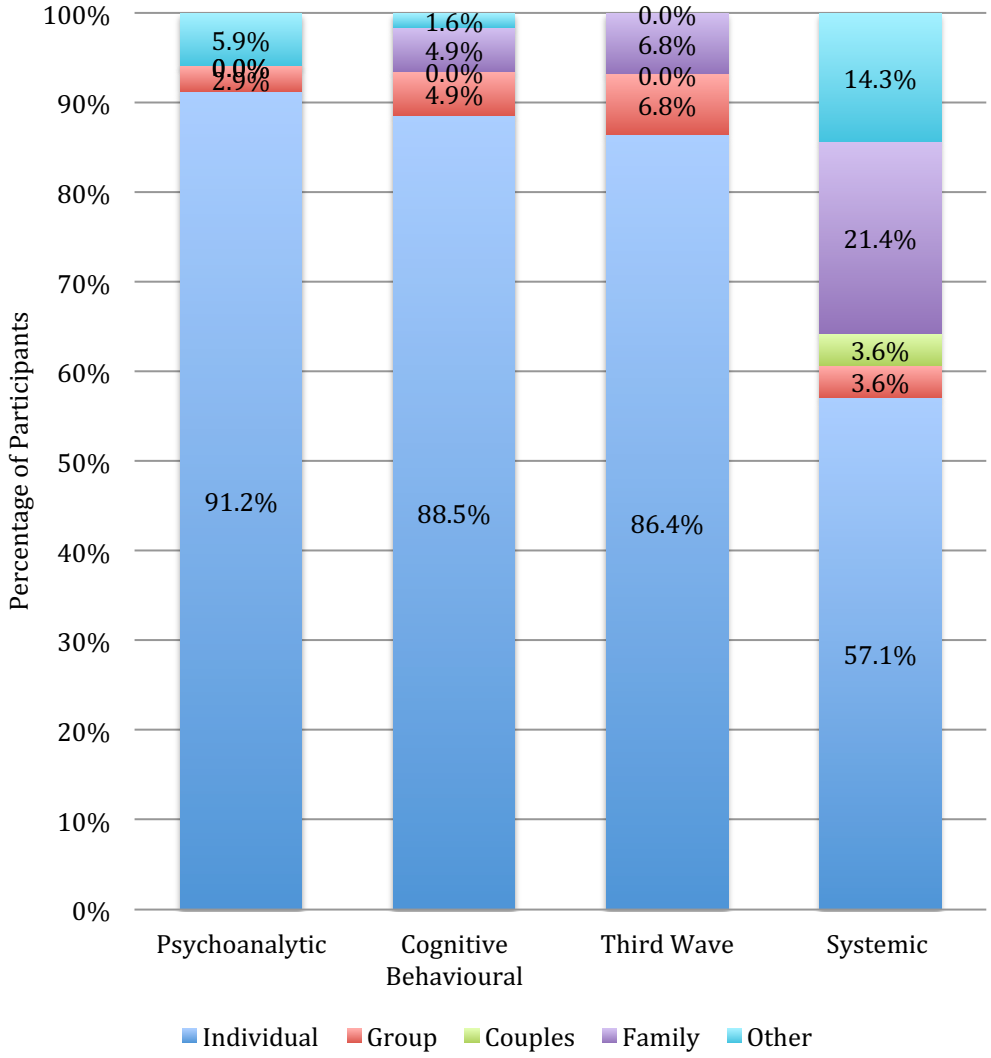

Figure 4: Percentage of participants using each primarily modality that meet with various numbers of clients simultaneously

Table 8: Frequency count of various other formats of therapy used

Other Formats of Therapy	N
Working with parents/carers/systems around the child	5
Working with organizational systems	2

3.5.1.4 Clinician and service preferences of modality

The majority of participants (60.8%) indicated that they chose the modality they worked within. Twenty per cent indicated that it was service requirements, 6.3% indicated that it was service user preference and 12.7% indicated that it was other factors that determined their use of modality. Other factors included the evidence base (13 participants), formulation (7 participants), service user need (4 participants) and a combination of factors (5 participants) (see Table 9).

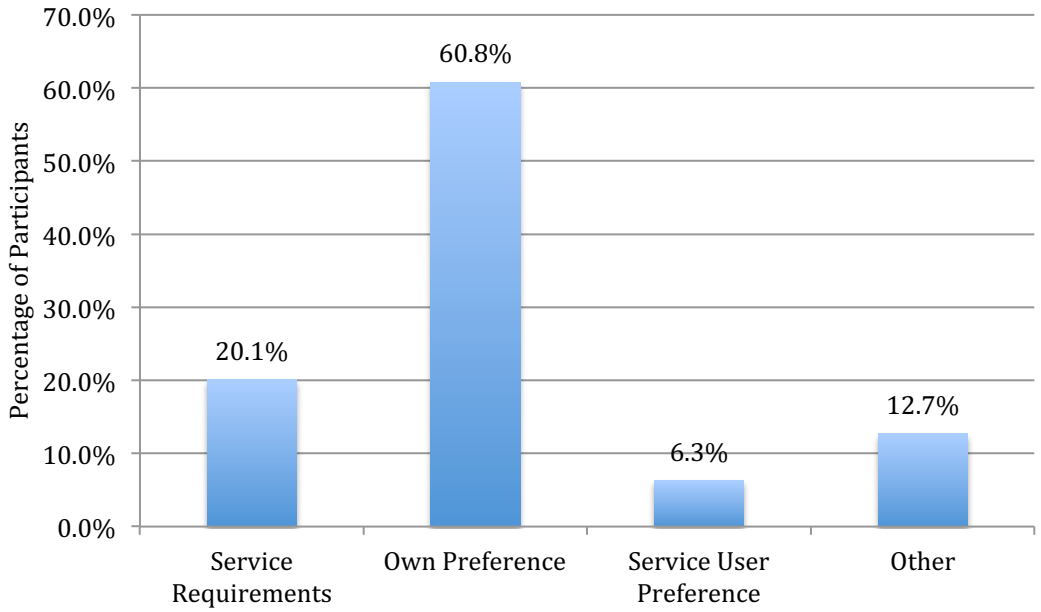

Figure 5: Primary factor influencing choice of modality of participants

Table 9: Frequency count of other factors that influence choice of modality

Other Factors Influencing Modality	N
Evidence base/Research/NICE	13
Formulation	7
Service user need	4
Combination of factors	5

When asked if their service had a preferred or recommended treatment modality, 36% said yes, and 64% said no (see Figure 6).

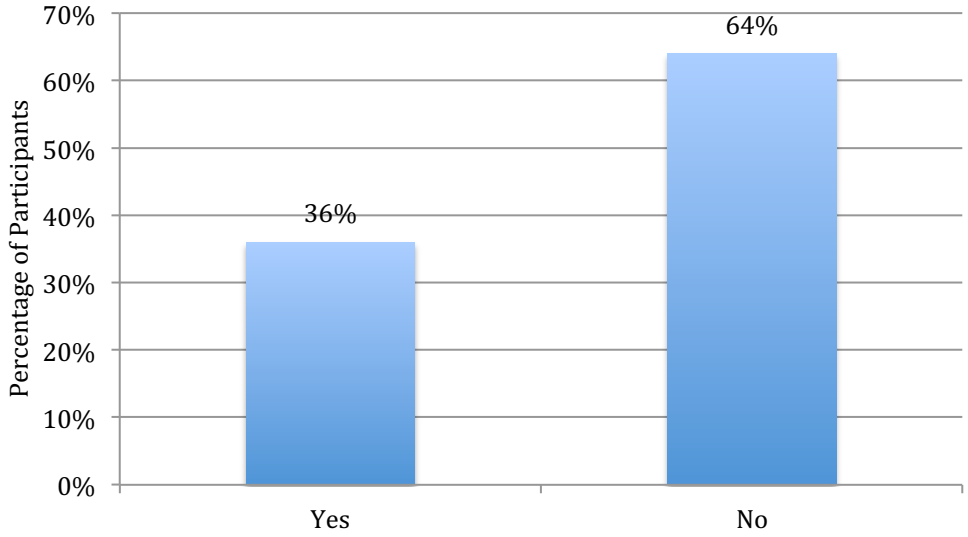

Figure 6: Percentage indicating their service as having a preferred or recommended treatment modality

If participants answered yes to the previous question, they were asked what was the preferred treatment modality of their service. The majority (67.7%) indicated cognitive-behavioural approaches were the treatment of choice (see Figure 7). Third wave and systemic were rated by 7.4% as the service treatment of choice, and psychoanalysis by 5.9%. Other approaches were prioritized by 11.1% of services. Other approaches included evidence-based approaches recommended by NICE (2 participants), a combination of approaches (2 participants) (see Table 10, see Appendix R, Table 5 for all text box answers).

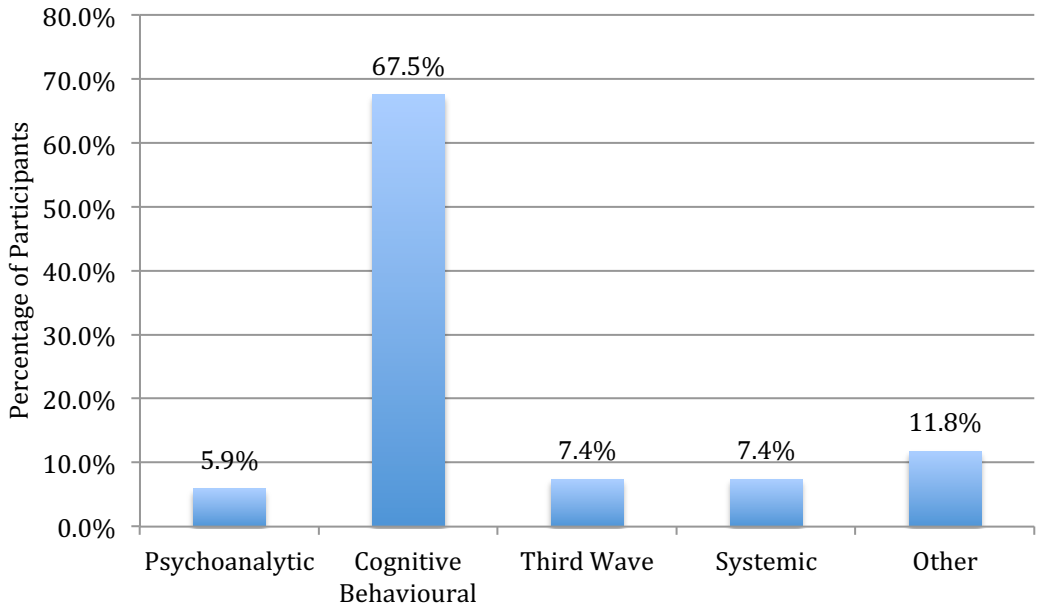

Figure 7: Preferred or recommended treatment modality of the services of participants

Table 10: Frequency count of other modalities preferred or recommended by services

Other Modalities Preferred by Services	**N**
Use evidence based approach/NICE guidelines	2
Combination of approaches	2

Participants were also asked what was their own preferred choice of modality. The majority said third wave (28%), followed by psychoanalytic (20.6%) approaches (see Figure 8). This was closely followed by systemic (18%) and other approaches (18.5%). Cognitive behavioural approaches were preferred by 13.2%. Humanistic (1.1%) and behavioural (0.5%) were preferred by the smallest percentage of the sample. Other preferred approaches included an integration of approaches dependent on need (15 participants), CAT (11 participants), and EMDR (5 participants) (see Table 11) (see Appendix R, Table 6 for all text box answers given).

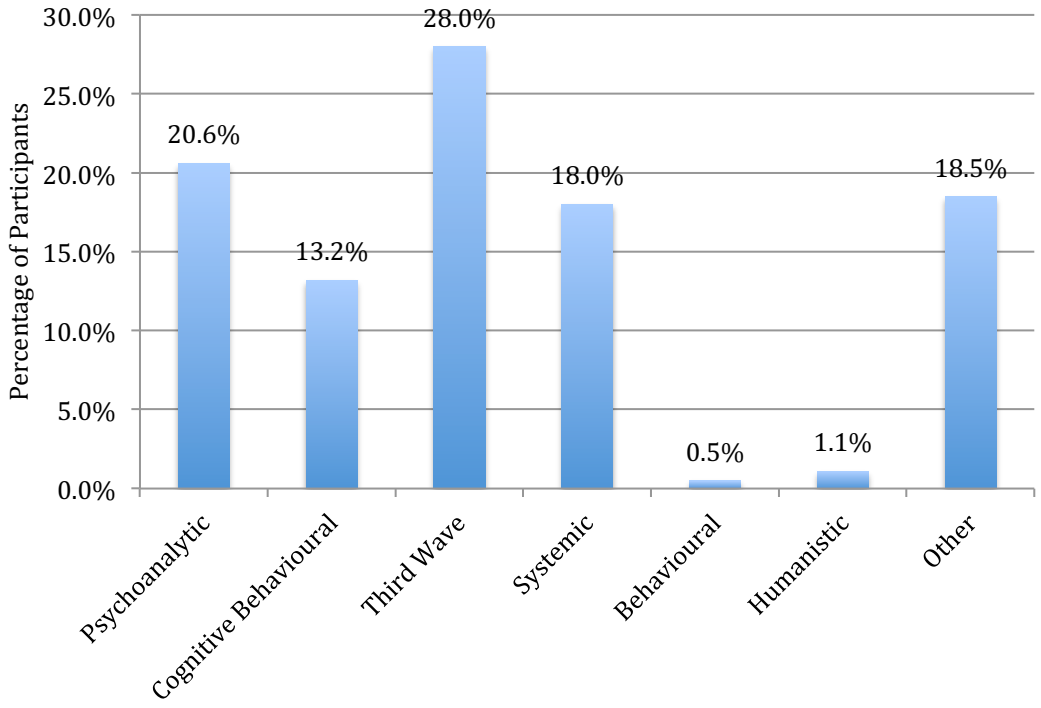

Figure 8: Preferred choice of treatment modality of participants

Table 11: Frequency count of participants other preferred choice of modality

Other Choice of Modality	**N**
Integration of approaches depending on need/Formulation	15
Cognitive Analytic Therapy (CAT)	11

3.5.2 Client Characteristics

3.5.2.1 Client age group

The majority of participants worked in adult services, including participants working primarily with a psychoanalytic (82.4%), cognitive-behavioural (70.5%), third wave (77.3%) and other approaches (71.4%). In contrast, the number of psychoanalytically-informed clinical psychologists working with children (14.7%) was less than the number using systemic (60.7%) or cognitive-behavioural approaches (19.7%).

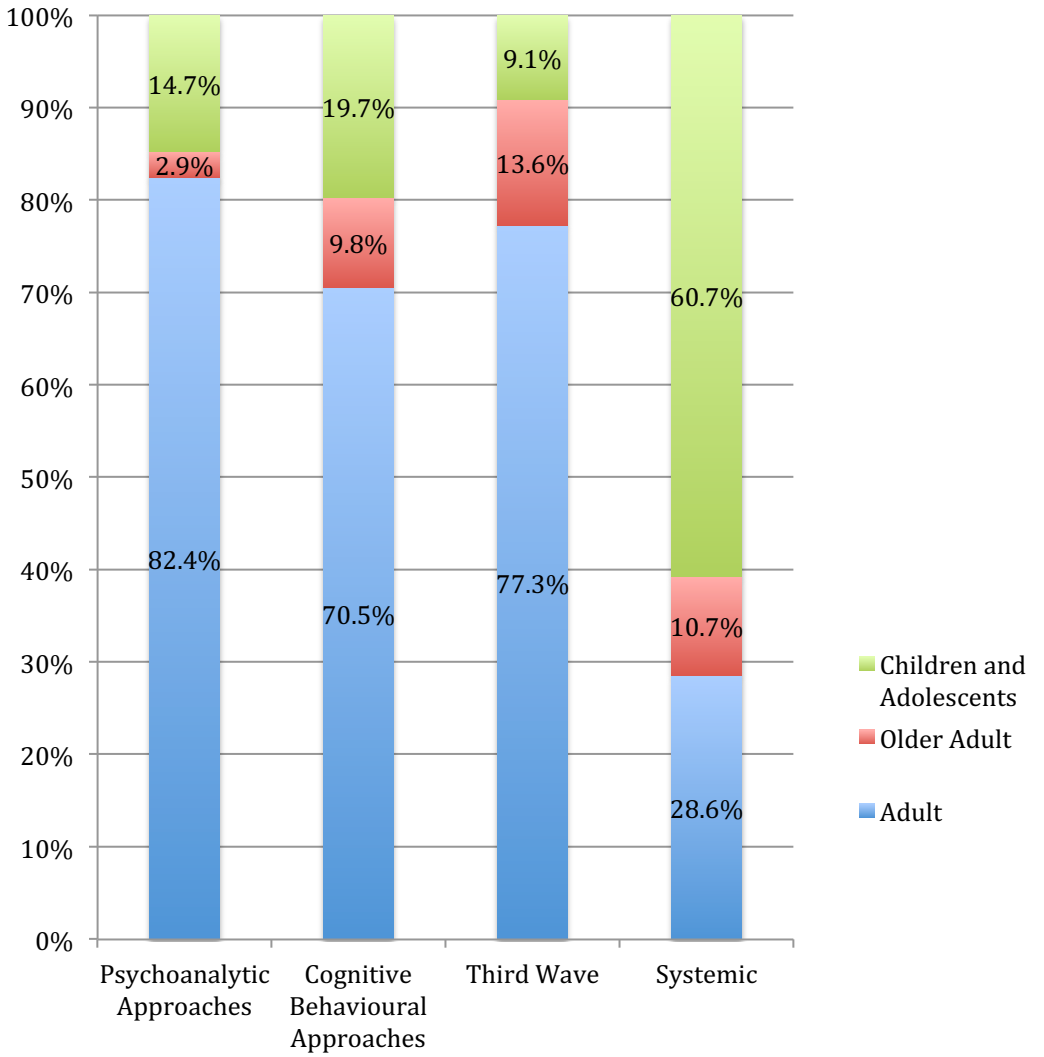

Figure 9: Type of service worked in by participants according to primary modality used

3.5.2.2 Presenting difficulties of clients

The majority of participants who work primarily with psychoanalytic approaches work mainly with clients with severe and enduring mental health problems (41.2%) and clients with personality disorder (13.1%). Participants using CBT approaches work mainly with clients with common mental health problems (26.4%) and with clients with severe and enduring mental health problems (15.1%). The majority of participants using third wave approaches work with clients with severe and enduring mental health issues (34.1%) and

health-related problems (25%). Participants using systemic approaches mainly used these with clients with learning disabilities and other difficulties (28.6%) (see Table 12, see Appendix R, Table 7 for full figures).

Table 12: Percentage of participants using different primary modalities who work with clients of each particular need

	Psychoanalytic	Cognitive-Behavioural	Third Wave	Systemic
Common Mental Health Problems	3 (8.8%)	16 (26.2%)	2 (4.5%)	3 (10.7%)
Learning Disability	3 (8.8%)	7 (11.5%)	3 (6.8%)	7 (25%)
Serious and Enduring Difficulties	14 (41.2%)	8 (13.1%)	15 (34.1%)	1 (3.6%)
Health-Related Problems	1 (2.9%)	6 (9.8%)	11 (25%)	3 (10.7%)
Personality Disorders	5 (14.7%)	1 (1.6%)	3 (6.8%)	
Other	4 (11.8%)	5 (8.2%)	4 (9.1%)	8 (28.6%)

Note. Total N=188

3.5.3 Professional Training Characteristics

3.5.3.1 Further training completion

The majority (79.9%) of participants have completed further training in a modality (see Table 13). Of these, the majority (38.6%) completed training in third wave approaches (see Figure 6). This was followed by other approaches (27%) and cognitive-behavioural approaches (25.9%). Psychoanalytic training was next most common (21.2%), followed by systemic (19%) approaches. The most common other approaches that participants completed training in

was EMDR (27 participants) and CAT (8 Participants) (see Table 14 and Appendix R, Table 8 for all text box answers).

Table 13: Number and percentage of participants who completed further training

Further Training Completed	N	%
Yes	151	79.9
No	38	20.1

Note. Total N=188

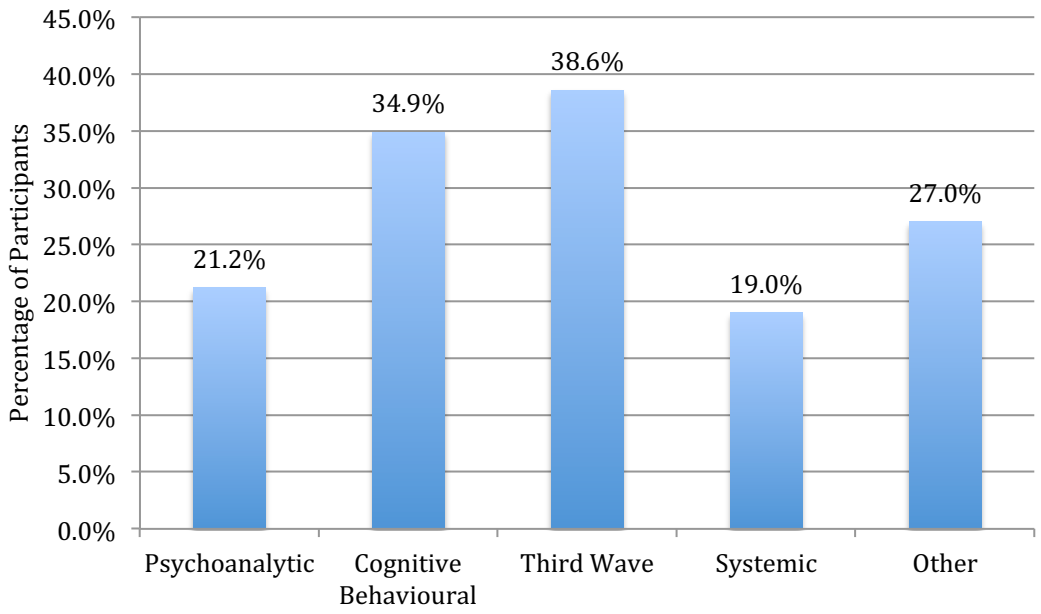

Figure 10: Percentage of participants who completed extra training in listed modalities

Note. Percentages do not add up as some participants completed training in more than one modality

Table 14: Frequency count of other modalities of training completed

Other modalities of training	N
EMDR	27
Cognitive Analytic Therapy (CAT)	8

3.5.3.2 Further training availability

Participants who had completed extra training (N=151) ranked availability of each modality for extra training.

The majority (56.7%) ranked cognitive-behavioural approaches as most available (see Table 15), followed by third wave (32%) approaches. Psychoanalytic and systemic approaches were regarded as least available, with only 5.3% and 6% regarding them as most available respectively.

Table 15: Percentage of participants that ranked each modality as most available

Modality	**N**	**%**
Psychoanalytic	8	5.3
Cognitive-behavioural	85	56.7
Third wave	48	32
Systemic	9	6

Note. Total N=150

3.6 Research Question Four: How do clinicians describe working within a psychoanalytic or psychoanalytically informed approach?

3.6.1 Approach to Analysis

Thematic analysis was used to analyse the transcripts as described in the Method Chapter. Quoted extracts below are taken verbatim from transcripts, with some non-verbal utterances omitted for clarity (Braun & Clarke, 2012). Phrases such as most, many, some or a few participants were used to describe the prevalence of themes in the data (Braun & Clarke, 2006).

3.6.2 Sample Size and Characteristics

The concept of data saturation was used to determine when to stop interviewing (Braun & Clarke, 2019; Nelson, 2017). Here, this is defined as conceptual density, where the researcher reaches a sufficient depth of understanding to elaborate on themes and relay them to external supervisors who were able to provide feedback (Braun & Clarke, 2019; Nelson, 2017). However, it is acknowledged that analysis is an iterative process that is never fully complete (Braun & Clarke, 2019). Pragmatic considerations were also a factor; it was thought that more than twelve interviews would be difficult to analyse in the time available.

Twelve interviews were conducted. The demographics of the subsample of interviewees reflected the larger sample. The majority were aged between 30-39 years (75%), were female (91.6%) and identified as female (91.6%). The majority identified as English (50%) or British (16.6%) and identified as White or White British (91.6%). All had completed their clinical training in the UK (100%) and the majority had between 1 and 9 years of post-qualification experience (83.3%). Full figures for the demographics are included in Appendix S, Table 1.

3.6.3 Thematic Map

From the codes generated from the interviews (see Appendix N and O), a thematic map was developed (see Appendix P). The final thematic map is depicted in Figure 11. The double-ended arrows in the diagram depict the interrelationship between the main themes. The connection between the

themes is implicit as they are all related to finding space and time for psychoanalysis within services, and this is further captured by having an overarching theme.

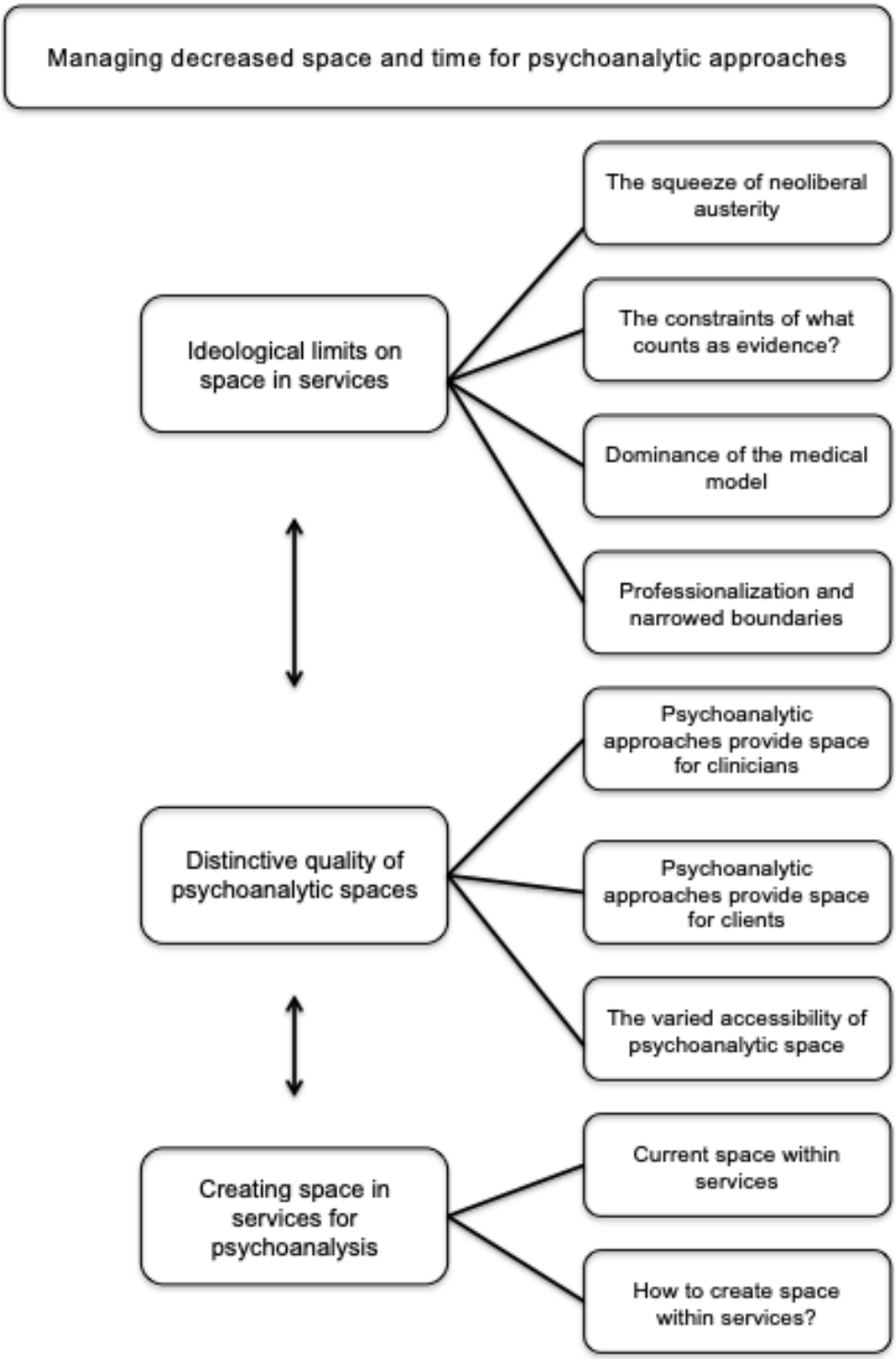

Figure 11: Final thematic map

3.6.4 Superordinate Theme: Managing Decreased Space and Time for Psychoanalytic Approaches

3.6.4.1 Theme One: Ideological Limits on Space in Services

Most interviewees spoke about the lack of space for the psychoanalytic approach within services due to the prevailing ideologies of neoliberalism, austerity, empiricism and medicalization. Some spoke about how occupations are professionalized has an impact on whether clinical psychologists feel they have the space to engage in psychoanalytic approaches.

3.6.4.1.1 Subtheme one: The squeeze of neoliberal austerity

Most participants spoke about the impact of neoliberalism on the provision of therapy. Some felt that the emphasis on outcomes and targets reduced clients to *"objects and commodities that can be put through something and come out the other side different". (Participant Four)*

> *"I think the NHS has become industrialised to the point where it is all about numbers and outcomes and money and efficacy and evidence." (Participant Two)*

These concerns impacted on the space and time many clinicians felt that they had to do clinical work, and to work in a psychoanalytic way and access the core issues of the client.

"it's not that I don't think psychodynamic is amazing, it's more that we don't have the time and space to do that within the [NHS] model, at the moment". (Participant One)

"I'm not sure the work that we do in the NHS allows us enough time to get to the…core problem." (Participant Five)

Some believed that austerity measures added to this pressure due to under-staffing and funding cuts.

"I think it is because [of]…austerity measures…everything is being cut, everyone is being asked to do more with less people, austerity measures, I think is completely political". (Participant Five)

Services use short-term intervention models to increase turnover. This means higher caseloads and an expectation to discharge quickly. This creates difficulties when using psychoanalytic approaches that require more time.

"I don't think [psychoanalytic approaches] would necessarily be given much time because we are so short staffed, we have so many people on our caseload, we have a supposedly six to ten session model and we're also under pressure for turnover". (Participant Five)

To manage long waiting lists, targets are set for services to see clients in a certain amount of time. This means long-term, more open-ended

interventions, such as psychoanalytic approaches are more difficult to justify and use.

> *"you are constantly expected to take on new cases….so it's very difficult to have more open-ended interventions." (Participant Eight)*

For example, some interviewees spoke about it being difficult to offer weekly appointments at the same time in the same room, which is key to maintaining the therapeutic frame.

> *"I think those things like maintaining the therapeutic frame can be really difficult when you are working in a service that is massively over subscribed, it can be hard to offer consistent appointments with the level of frequency that you might need in a more psychodynamic approach, certainly in our service it can be really hard to have the same room each time you have somebody". (Participant Eight)*

Psychoanalytic approaches emphasize the need for reflective spaces, which one participant described as being difficult to access in such a pressurized environment.

> *"I think people are open to psychodynamic ideas but…there's something about the space that is available to do that in terms of actual physical time and mental space, I think often people are so full up that it is hard to be reflective". (Participant Eight)*

One participant also spoke about it being difficult to get space to reflect during team meetings, because of the number of clients that needed to be discussed.

> *"…the service is under such pressure, when you are in team meetings where you have multiple cases to get through, making space for that more reflective thought can be really challenging". (Participant Eight)*

Some participants felt that the lack of space for reflection could be attributed to this not being prioritized by management, who decide how time and resources are used.

> *"I suppose if the time isn't made by the management then people can't really sit around for an hour and stop and think about the unconscious, even though they might want to, there's no time to, and I think it's a shame…because I think it should be integral to working in mental health". (Participant Four)*

Some participants reinforced the importance of management support and felt that a psychoanalytic approach was not welcomed by the service *"it's not really been something that has been encouraged" (Participant Eleven).* Some commented that although their experience varied between services, generally the response was somewhat negative.

"I mean I have worked in some services where psychodynamic approaches are welcomed in the NHS…but…generally …it has been maybe less welcomed…if you say you are working psychodynamically with someone, how are you working that long, how come, it seems to initiate more questions". (Participant Four)

A few thought this was because of the view of it being a long-term, and more 'costly' approach.

"I think a lot of it is that people have this sort of probably out-dated view that it's this like really long-term approach that takes years…and that's expensive, you know we're not going to pay for them to be on the couch two times a week". (Participant Six)

As a result, some clinicians found that they were "*doing it under the radar" (Participant Twelve).* In order to use the approach with clients, they were *"bringing it in the back door, under the guise of another approach" (Participant Four).*

A few felt that it would be risky or unsafe to use if that way of working was not supported by the service. Accessing deeper emotions might be difficult if the service could not support consistent and on-going appointments, for example.

"you can make use of psychodynamic understandings, but…I think sometimes that can be a risk if you work in a service that…is not able

to support an intervention that requires that kind of consistency and containment". (Participant Eight)

However, some said that psychoanalytic ideas were welcomed by colleagues and staff. For example, staff such as *"the care co-ordinators…and the community manager, they really value it, because they can see…the benefit to the clients" (Participant Twelve).* In certain forums, it also seems to be more welcomed, one participant commented *"it also seems to be more welcomed in formulation, or in team chats about patients" (Participant Four).*

3.6.4.1.2 Subtheme two: The constraints of what counts as evidence?

Most interviewees commented on the current emphasis of providing evidence-based approaches, which is exhibited by the adherence of services to the NICE guidelines, and the Matrix in Scotland. A few participants commented that the NICE guidelines tend to *"prioritize certain types of knowledge and evidence and lots of evidence is excluded" (Participant Four).* This leads to a lack of space for psychoanalytic approaches and therapies that lend themselves to being tested within these empirical frameworks, such as CBT, are more likely to be recommended.

"we use the Matrix, which is a range of skills drawn from the evidence based practice, and …psychodynamic approaches are represented there, they are very, very much marginal compared to CBT". (Participant Eleven)

Some participants commented that the psychoanalytic approach *"doesn't lend itself to being tested" (Participant One)* within these empirical frameworks. One participant felt that this wasn't the type of research that was generally endorsed by the psychoanalytic field and so there shouldn't be a need to produce that type of evidence.

> *"I almost want the field to say we don't believe in that, but look at all this other evidence we've got that shows it helps and works". (Participant Four)*

A few others also felt that psychoanalytic approaches should not be tested empirically. They felt that it was based on an alternative epistemology and way of understanding the world that was more aligned with the arts than with sciences.

> *"I think psychoanalysis does have an evidence base, but if you are coming at it from a different type of epistemology and different type of understanding about what it is to be human and what science is". (Participant Four)*

However, some others discussed how the evidence base for psychoanalytic approaches was growing, that "*psychoanalysts and other professionals are getting quite savvy as to how to demonstrate its efficacy"* (Participant Two). As a result, another participant suggested that there was *"more research into*

psychodynamic approaches and the effectiveness of them, and I think that's really positive" (Participant Eleven).

One participant commented that psychoanalytic research often relies on alternative types of evidence such as case series. However, some participants felt that these types of evidence were held in less esteem than from other methodologies.

> *"I don't believe RCTs are the be all and end all, but people pay attention…in a way that they don't pay attention to case series". (Participant Ten)*

A few interviewees said that those in positions of decision-making power such as service managers and commissioners often use the NICE guidelines to guide their decisions about treatment. One commented that *"those who manage services are just looking at certain reports which have prioritized certain knowledge and evidence" (Participant Four).* This means that CBT may often be offered as a first line treatment.

> *"I guess some of the people that are involved in this higher up from NHS England or whatever, they're not clinicians necessarily so they interpret it in this kind of rigid way which is well it says CBT cures so do CBT with people". (Participant Twelve)*

Interviewees wondered whether certain treatments had become institutionalized so that they had created *"a dominant narrative of certain interventions or talking treatments that don't allow for any other conversations" (Participant Ten).* A few interviewees spoke about the emphasis on CBT being institutionalized into service structures. For example, CBT is sometimes the only named option to choose when recording what type of therapy was used with a client after a session.

> *"there was a service that I worked in once where the only option to record the session was as CBT on the outcome form". (Participant Four)*

Some services required targets to be met for CBT provision and *"a lot of our funding is dependent on us meeting these targets" (Participant Twelve).*

> *"we have targets for how much CBT we're delivering, so we have to be evidencing that we're offering CBT to as many people as we can". (Participant Ten)*

Some felt that they were not given the space they could be as clinicians to make these judgments.

> *"I've felt really demoralised at times about the pressures to do CBT… because you are not free to practice as you wish or how you feel would be best for your clients". (Participant Twelve)*

However, a few participants shared the view that *"the research evidence base behind [psychoanalytic approaches] is not as robust as others". (Participant Three)*. They felt that it was based on assumptions, lacked veracity and reliability. As a result they *"don't feel confident to offer that" (Participant Nine).*

> *"You've got to just say that in order for this to be true, then I have to accept that this is true and there isn't any evidence for this being true". (Participant One)*

However, some interviewees felt that it was effective, based on their clinical experience. They said they had witnessed clients benefiting from the approach, and experiencing positive changes as a result.

> *"I wouldn't use it if I didn't think it was successful and I've worked with a lot of people who have had really significant problems…for whom it has made a massive difference". (Participant Twelve)*

3.6.4.1.3 Subtheme three: Dominance of the medical model

Some interviewees spoke about how the medical model informs how mental health services operate and how they conceptualize distress. One commented on how this analogy of treating mental health like physical health is no longer working, especially because of austerity, where services are even more under pressure for resources and time.

> *"The field of mental health is a broad experience, you can't treat it like a broken ankle, I know that's the analogy that is used, you know if you have a broken ankle you get it to the doctor, but I think that analogy has started to crumble now that we are on such as shoe-string because it's not possible to treat it by bandaging it, casting it and being done in five weeks". (Participant Two)*

A few other interviewees suggested that the symptom-focused approach cannot always support people with more complex problems in the long term. They could benefit from more in-depth work that is associated with psychoanalytic approaches.

> *"I always think there is going to be a need for looking under the problems that people present, I don't think the approaches that are purely focused on reducing symptoms in the long term are going to help all people". (Participant Eight)*

Some participants spoke about there being a lack of space in clinical psychology for long-term approaches addressing long-standing difficulties. One described *"clinical psychology work as sort of symptom focused" (Participant Five).* Another participant said that this is reflected in the training that is offered to clinical psychologists; they are often symptom- and treatment-specific.

"…being a psychologist who has been practicing for a long time, the type of CPD days or workshops I go to are more treatment specific…and it ends up being very model based so…it's not treatment using a psychodynamic approach to be honest". (Participant Seven)

3.6.4.1.4 Subtheme four: Professionalization and narrowed boundaries

Some participants reflected that leads to a tendency of clinical psychologists not to use psychoanalytic approaches.

"…there does tend to be a specialist psychotherapy service [and] they tend to use those models more and we then, the rest of the psychology services, clinical psychology and other therapists, tend not to use them". (Participant Seven)

Some felt that psychologists had become more associated with using CBT, although clinical psychology training encourages using multiple therapies.

"there seems to be this pressure to offer a…CBT based intervention, and the part that's frustrating about this is that as clinical psychologists…we're taught to use a broader range of ideas". (Participant Eleven)

Some participants felt that clinical psychologists had become *a "jack of all trades" (Participant Five).* This led to a difficulty in protecting the space

required to practice psychoanalytically, which was perceived to be in contrast to how psychotherapists practiced.

> *"the culture is much more that psychologists do everything…whereas the psychotherapist would specifically protect her time to do psychotherapy, which I think…helps her protect space for those ideas". (Participant Eight)*

A few felt that the tendency to split the professions was about the *"survival of professions" (Participant Three)*, and a protectiveness about who should do what tasks and roles.

3.6.4.2 Theme Two: Distinctive Quality of Psychoanalytic Spaces

3.6.4.2.1 Subtheme one: Psychoanalytic approaches provide space for clinicians

Many participants spoke about psychoanalytic approaches providing them with space and time to reflect, although this can be difficult while working in pressurized services.

> *"I think people are under such pressure that it can be hard to have the space to be reflective in that way". (Participant Eight)*

The longer amount of time associated with psychoanalytic approaches gave the clinician and client more time to think about goals, reflect and make progress in a relatively non pressurized way.

> *"It's because we could do year long, so I think I saw the real difference…it does free you up…there wasn't any pressure, we didn't have to fix, or address goals really quickly". (Participant Four)*

One interviewee suggested that the rate of therapeutic change expected to happen within the NHS may be unrealistic.

> *"in the NHS I feel we're under pressure to do things quickly, to get results, to make a difference far too fast than is actually possible". (Participant Four)*

Many participants felt the particular quality of space associated with psychoanalytic approaches allows the clinician space to consider how relational patterns might be enacted within therapy and how to respond.

> *"…having a psychodynamic hat on sometimes helps make sense of that, rather than acting on instinct, you have a moment to respond, rather than playing the same patterns that they may…have experienced so many times". (Participant Ten)*

Participants said that psychoanalytic approaches created space within the language for aspects of therapy that are not as easy to name with other approaches, such as the process within the therapeutic relationship.

"CBT doesn't have the words for understanding what goes on between the two of you in the room…I don't know how I'd make sense of that if I didn't have the words and the way of thinking about it that psychoanalytic approaches bring". (Participant Ten)

Psychoanalytic approaches also provided space for some of the clinicians to be aware of what they brought to the therapeutic relationship, in terms of past experiences and their own emotions. This ensured clinicians were not being *"driven by a lot of unconscious material" (Participant Ten)* and could more easily 'facilitate change'

"that's important for clinicians in general to be aware of what happens in the room, how much of that is linked with our own history and what we bring in….if we don't think about these things, there's lots of barriers to change". (Participant Eleven)

One individual regarded the space afforded to clinicians by psychoanalytic approaches as being helpful to contain their own and clients' emotions, in a way that supported the clinician to look after themselves.

"we hold so much for people, and to be able to deal with that, we need to have enough space in our own head to manage and contain that, so having an approach that creates more space, you can hold really overwhelming things, whilst looking after yourself". (Participant Ten)

Some participants spoke about how psychoanalytic ideas helped them reflect upon the patterns that staff teams and services can get stuck in and how *"psychoanalytic approaches give you some words for that" (Participant Ten).* Without this, some felt that patient care was affected. Staff wellbeing could also be affected as they purportedly carried 'unresolved issues', and this could cause more difficulties within the system.

> *"the system remains stuck and the patients' care remains stuck…and then it can I suppose lead to all sorts of problems like exhaustion for staff who are carrying certain problems on their own…so they get taken home or they get acted out, or they lead to more problems".*
> *(Participant Four)*

3.6.4.2.2 Subtheme two: Psychoanalysis provided space for clients

An emergent theme was around potential benefits of psychoanalytic spaces for clients.

> *"there's definitely clients that I see that would benefit from a psychodynamic approach". (Participant Nine)*

For example, when working with those with trauma, the space afforded by psychoanalytic approaches was deemed useful by a few participants, given that *"often to build that [therapeutic] relationship does take time and space" (Participant One)*. The longer relationship may help the client feel safe, to

disclose difficult information, in order for an accurate formulation to be formed and meaningful change to occur.

> *"I think it's really helpful to have extra time because you build a relationship with people…in secondary care we come across very complex histories, it takes time for people to build up a therapeutic rapport, for people to be able to feel safe to disclose, to build up a formulation and then to make meaningful changes in line with their goals". (Participant Nine)*

A few participants also deemed the long-term nature of the intervention useful, particularly if the client had many issues to work through.

> *"the nature of the cases that we see do have a high level of complexity and often maybe do require longer term interventions". (Participant Eight)*

It seemed that the space provided by psychoanalytic therapies was noted to be of a particular 'quality'. It contained the emotions of the client; it had *"ways of holding quite a lot of difficult material and what might feel like overwhelming material" (Participant Ten).* The space provided by the model also allowed clients to have an experience of being in a relationship with another person, that was potentially different to other relationships they had been in before.

> *“a lot of my clients who have been abused and neglected, just being in a room with me could be really hard, especially if they are …feeling suspicious and paranoid because they have been let down by everyone possible that’s been around, so just having an experience of being with someone, the psychodynamic approach has ways of understanding that, being with and the reciprocity that the client may not have had before”. (Participant Ten)*

One participant said that working in this way helped clients get to the ‘root and core’ cause of problems, that might have lasted for a long time.

> “*we’re talking in a way that helps them develop reflective space in a way that touches something deeper than many other approaches do”. (Participant Ten)*

Interviewees mostly felt that clients valued the space provided by psychoanalytic approaches. One said clients *“felt heard or understood” (Participant Four).* A few others said that clients tend to stay engaged in the work and had positive outcomes.

> *“they stay engaged, and…they find positive benefit”. (Participant Three)*

A few participants also talked about how this type of space might not be suitable for all, and even be difficult for some clients to tolerate. For example,

clients who might be more anxious or uneasy within therapy. One participant said they *"wouldn't necessarily leave [the client] in that sort of silence that might be experienced as very threatening" (Participant Four).* The psychoanalytic space can be different to other therapeutic modalities, as it requires the person to *"tolerate distress for a bit longer" (Participant Three).*

Additionally, a few suggested that the space might not be suited to working with the goals that clients would like to achieve. Sometimes the goals of the client involved *"relieving symptoms and they perhaps want to work at a more surface level" (Participant Eight),* which the psychodynamic approach is not necessarily suited to. The client might not *"want that level of fundamental change" (Participant Eight).*

3.6.4.2.3 Subtheme three: The varied accessibility of psychoanalytic space

Some participants talked about how accessible psychoanalysis was for themselves and their clients. Some participants felt they had an 'inner space' or an initial 'openness' to the approach. These participants said that the way that psychoanalytic ideas conceptualised problems *"made sense" (Participant Six)* and seemed 'true' to them. They experienced a moment of illumination when something was described in a helpful way.

> *"I think there is a sense of them being seen or true….I think there's often an "O yeah" moment when you start talking in those terms". (Participant Two)*

One suggested that that an inner affinity to the approach might depend on individual characteristics or "individual style and thinking" (Participant One). Whereas another said that it may be because the model tried to make sense of universal experiences, such as being born and having a caregiver.

> *"it's such universal things that psychodynamic approaches try and make sense of…we've all been born, we've all had exposure to some kind of caregiver, so…there's a universality about it". (Participant Ten)*

There was a tendency for reactions to be polarized, however. Psychoanalytic approaches tended to lead to a strong reaction in most participants, even if this started out as ambivalence.

> *"when I was training I think I was a bit ambivalent about psychodynamic approaches [but] generally this developed to feeling strongly one way or another" (Participant Eight)*

A few participants felt that they did not have an 'inner space' for the approach, and had a reluctance to use associated ideas. One reason for this was because they felt that they did not understand the theory.

> *"I just didn't get it, I just didn't understand it at all". (Participant Five)*

Some felt that the language was inaccessible and that one would need a *"certain standard of education and intelligence to grasp these things"*

(Participant One). One interviewee said that the 'difficult' language lead to there being a perceived *"cloud of mystery around psychodynamic techniques" (Participant One)* which made the model less accessible.

> *"I can sometimes sit there and look at my colleagues and just go, what did you just say, can you repeat that in English please, and so it can be…a little bit mysterious, dense". (Participant Three)*

The uncertainty around experienced 'dense' language was reflected in the difficulty that many of the participants experienced in how to define psychoanalysis and psychodynamic psychotherapy.

> *"it's really hard to explain, and put your finger on what you mean by psychodynamic and psychoanalytic". (Participant Ten)*

A few participants suggested that they did not feel an affinity to the approach because they regarded it as elitist. These participants felt that it was mainly associated with therapists who were wealthy, white and middle-class. One suggested *"psychology should be accessible for all" (Participant One).*

> *"I think it's a bit elitist, when I think of psychotherapists I think of rich, white, middle class people". (Participant Five)*

One participant suggested the therapy felt elitist, because of the use of interpretations. They suggested that interpretations involved using prior

theoretical knowledge that the client was not privy to, and made assumptions about the person.

> *"always just think people always come across a little bit snooty, like we know better than you, kind of all knowing, that we can guess these things about people and just say them as assumptions rather than being tentative". (Participant Five)*

One participant suggested that it felt elitist because only those who are better off financially had the time and financial resources to engage in it.

> *"that's how I feel about psychodynamic, and definitely psychoanalysis, that it's the preserve of the rich and idle frankly who have … the time and inclination to go in for these things". (Participant One)*

A few interviewees also talked about the difficulty clients might have in accessing this type of therapeutic space. One interviewee suggested the clinical psychologist who works psychodynamically was perceived as often the *"second point of call for someone who has tried CBT and it hasn't worked and then they come to me for something else" (Participant Twelve).* This participant and another expressed concern that this might have a detrimental impact on clients. They felt that accessing a new and different therapy for clients after a perceived initial failure of therapy might exacerbate issues of engagement and commitment.

> *"I worry about that… if people don't get a good experience of therapy for some reason, only because it's not the most appropriate approach for them, then does that put them off". (Participant Twelve)*

One participant talked about psychoanalytic space being hard to access by clients of non-European cultures. A few said they felt that *"other approaches feel like they are more cross-cultural" (Participant Seven)* and they were unsure how this approach *"might fit with other cultures and societies" (Participant Ten).* One talked about how it could be the predominance of white, middle-class demographics within the therapy, that might result in others from other backgrounds not *"recognising themselves within the demographic of the psychotherapy team and therapist" (Participant Three).* However, a few other interviewees felt that the approach might be a good fit for other cultures, *"particularly cultures that communicate in narrative" (Participant Three).* However, one acknowledged the difficulty she would have in assessing if this were the case, due to her own social demographics.

> *"I'm a white woman, in her mid-thirties with a middle class ish background so I've come at it from one particular cultural perspective so I don't know how that might fit with other cultures or societies". (Participant Ten)*

3.6.4.3 Theme Three: Creating Space in Services for Psychoanalysis

This theme captures where space has been found in services currently and then discusses how space could be expanded for psychoanalytic approaches in the future.

3.6.4.3.1 Subtheme one: Current space within services

Some participants were unsure about whether there was space for psychoanalytic approaches in services currently. They felt that the model had developed at a particular place and time and that there was no space for it in 'modern' services.

> *"I feel it's a bit, it's a bit, I don't know, a bit of a historical perspective really that doesn't have much place in the modern NHS". (Participant One)*

However, a few participants spoke about how they found space for the model by using it as part of an integrative intervention. They said that they might *"draw on other models alongside that" (Participant Eight),* and psychoanalytic ideas could be used to *"inform my thinking" (Participant One).*

> *"I wouldn't say that I use psychodynamic approaches in a pure form, more as a part of an integrative intervention". (Participant Eight)*

A few other participants felt that it had been retained in child and adolescent services due to its developmental perspective.

"there is very clearly a role for it in the NHS, in particular with children and young people, one of the things that I find useful about psychodynamic approach is the developmental perspective". (Participant Eight)

A few participants spoke about using psychoanalytic ideas to inform the formulation. One said to be *"able to draw from multiple approaches, including psychodynamic…to enable you to reach a much more meaningful understanding" (Participant Eleven).* Another said that the role and training of a clinical psychologist meant "*we can integrate different models" (Participant Nine).*

One of the reasons that a few participants felt that they did not use the approach in a 'pure way', was because of the barriers to using psychoanalytic interventions within the service, as discussed in theme one.

"I'm a bit eclectic in how I use it and I've just had to be in terms of the service". (Participant Six)

A few participants said that they tried to find services that were open to psychoanalytic approaches, in order to find space to practice in that way.

"I've always been searching for services where I can work in that way". (Participant Four)

3.6.4.3.2 Subtheme two: How to create spaces within services?

Interviewees were divided about whether the future for psychoanalysis within the NHS was hopeful or not, although many thought it might be positive. Some felt that there was hope because it was being offered in several places, such as DIT in IAPT, and that "people seem to be a bit more interested in it again" (Participant Four).

> *"I think it's getting brighter, especially with… IAPT taking on DIT". (Participant Six)*

A few felt that it was unlikely to be offered within the NHS, because of the *"lack of evidence and…the fact that it is one of the longer treatments out there" (Participant One).* This was particularly given that within the current NHS the emphasis was on evidence-based approaches, goal-directed outcomes and symptom reduction.

> *"I don't necessarily see it being any more used than it is…because so much focus is put on goals and do symptoms get better, and while symptoms do get better in terms of psychodynamic principles, I'm not sure, that's a focus for the work". (Participant Five)*

A few participants suggested that increasing teaching in psychoanalysis in clinical psychology training courses would be beneficial. One participant said that it was currently quite *"marginalised within the course structure"*

(Participant Eleven). Another suggested that if clinical psychologists do not have much experience of it, then it would be difficult to retain as one of the therapies offered in the NHS.

> *"if you're producing…psychologists who don't have a lot of experience of it, then it's hard to promote it in the NHS". (Participant Six)*

A few participants suggested that placements drawing on the psychoanalytic approach during training would be useful. These participants felt that exposure to the approach through placements, *"motivated and inspired" (Participant Ten)* them to use it.

> *"when I was training…there was only one person who had a psychodynamic placement and that made a huge difference…she uses psychodynamic ideas frequently in her work". (Participant One)*

A few other participants said that having a psychoanalytically-informed supervisor on placement was useful to help them use psychoanalytic theory in practice.

> *"you can learn about [the psychoanalytic approach] dry but particularly as a trainee I think you need to have a really good supervisor". (Participant One)*

In terms of post-qualification training, a few participants found *"there is a lack of training that is directed at psychologists… unless you want to actually train as a psychoanalytic psychotherapist" (Participant Eight).* They found that *"there are some significant hoops to jump" (Participant Three).* According to one participant, part of this is to do with *"the entry requirements" (Participant Eight)* and another said that the cost is significant; *"it does cost a lot" (Participant Three).* Even shorter, more manualised approaches such as DIT had similar barriers to training.

> *"I like DIT, it's definitely a modern, forward-thinking approach but you still have to jump through all the old-fashioned hoops to get onto it". (Participant Three)*

Some participants spoke about the NHS being currently *"more focused on more branded therapies" (Participant Eight).* Some said that there had been short-term, psychoanalytically-informed, "branded" approaches that had been developed such as *"Dynamic Interpersonal Therapy (DIT), it is quite a brief intervention but uses these ideas in quite a different focused way" (Participant Two).* These therapies had been marketed as having a certain number of sessions and had outcomes that might appeal to commissioners, such as reducing inpatient stays.

> *"there are some short term psychodynamic approaches that have a particular number of sessions, that probably do have evidence that*

they are helpful and reduce inpatient stays or lost days of income". (Participant Ten)

Participants were divided about whether this creation of "branded" approaches would be beneficial for the future of psychoanalytic approaches in the NHS. Some felt that it was good to adapt to the modern NHS.

"some services have tried to adapt and create therapies that meet both demands, they…can work short term, and still hold onto something of the psychodynamic approach". (Participant Four)

However, a few participants felt that psychoanalytic approaches should not be adapted. Historically, there *"has been an emphasis on keeping the model very pure" (Participant Two)* and they felt that becoming manualised and short-term pushed away from the traditional format.

"I have a conflict between whether to adapt and get more psychodynamic approaches into services or whether to resist and to say this is what we offer and it can't be changed". (Participant Four)

A few others raised concerns about trying to adapt to the current service model within the NHS were because it then followed 'neoliberal' values. One participant suggested that the current focus on symptom reduction was in the service of getting people back to work, and that this is not always a goal of the client.

> *"when we are looking at recovery, are we looking at getting rid of symptoms, are we talking about people going back to work, that's all tied in to neoliberal politics". (Participant Twelve)*

To retain psychoanalytic approaches in the NHS, some participants felt that it was important to communicate the advantages of the approach, in an accessible way to individuals who commission and design services.

> *"we need to effectively take in complex ideas so that the people who are holding the purse strings, who may not be clinicians can actually understand the importance of it". (Participant Eleven)*

Many participants felt that another way to communicate the usefulness of the approach to commissioners was to engage in research *"to get the word out" (Participant Ten).*

> *"if we want to get these approaches funded in a mainstream way then we have to engage with research departments". (Participant Twelve)*

A few participants spoke about the role of psychologists in facilitating these changes. They felt that there was a need for clinical psychologists to take more of a lead in this.

“I feel like we are brought up to be politicians and leaders, and I think that is good because we need to be in the CCGs and we need to be informing policy”. (Participant Five)

They felt that there was a need to mobilise and coordinate to facilitate these changes. However, a few participants spoke about the difficulties in doing this, given the divided views about the way forward.

“Finding a way of…mobilising somehow, but that only happens if you have a network of people who are all singing from the same hymn sheet”. (Participant Ten)

4. CHAPTER FOUR: DISCUSSION

4.1 Overview

This chapter reviews the aim of the research and discusses the results. The quantitative and qualitative findings are presented in relation to each research question, contextualized in research literature. The strengths, limitations and proposals for future research will be highlighted. This will be followed by implications of the research and a reflexive review of the research process, before final conclusions made.

4.2 Aims of Research

This research aimed to address a gap in the literature and explore how clinical psychologists utilize the psychoanalytic approach within the NHS, and their experiences of the approach.

4.3 Survey Sample Characteristics

4.3.1 Representativeness in Terms of National Numbers

The final survey sample consisted of 189 individuals. It is difficult to comment on the representativeness of the survey because it is difficult to estimate the number of clinical psychologists in the UK. Official figures often include England and Wales and omit Scotland and Northern Ireland. Additionally,

figures could be variously quoted as number of people or full time equivalents or based on BPS membership or NHS employees. As mentioned in the analysis chapter, it is estimated that the survey accessed 2% of clinical psychologists in the UK. The other national surveys mentioned in the introduction had higher response rates, however the sample sizes were smaller so a similar number of respondents results in a larger response rate. For instance, the most recent study carried out in the UK had a response rate of 19% which equated to 357 responses, which is similar to this study where 314 initially responded (Nel et al., 2012). Therefore, it could be suggested that the response rate is similar to previous studies.

4.3.2 Representativeness in Terms of Participant Characteristics

It could be suggested that the participants in this study are representative of UK clinical psychologists in terms of participant characteristics. The majority of survey participants were female and aged between 30-39 years (59.8%), which corresponds to earlier national surveys (Nel et al., 2012; Norcross et al., 1992). The majority in this sample was white or white British and identified as English. These figures on diversity unfortunately correlate with official figures. In 2014 it was reported that that 87.9% of clinical psychologists in England identify as white (Health and Social Care Information Centre, 2014).

As would be expected from a UK sample, the majority trained in the UK. There was representation from almost all UK universities, excepting Southampton. There were marginally more representatives from UCL and Lancaster, which could be attributed to their larger cohort sizes (BPS, 2018).

Most participants trained between 2010 and 2019, which is expected from this age group, as most trainees tend to be between the ages of 25 and 29 when they begin training (BPS, 2018).

Most of the sample had between 1 and 9 years of post-qualification work experience. This is reflective of the majority of the sample being aged between 30 and 39 years old, and the average age of trainees being between 25 and 29 (BPS, 2018). The majority worked in England, with smaller proportions working in Scotland, Wales and Northern Ireland. It could be suggested that the sample is more representative of respondents working in England.

4.4 Research Question One: Is the number of clinical psychologists who use psychoanalytic approaches less than those who use other modalities?

The number using psychoanalytic approaches as their primary modality is higher than would be expected (18%) from previous research, although CBT (32.4%) and third wave approaches (23.4%) were still used as a primary approach by a higher percentage. A previous survey of clinical psychologists in the UK showed that a minority (5.6%) identified as primarily using the psychoanalytic approach (Nel et al., 2012). This number had decreased in the twenty years previously from 11% in the early 1990s (Norcross et al., 1992). This trend can also been seen in the US; numbers of psychoanalytically-

informed clinical psychologists have decreased from 35% in 1960 to 18% in 2010 (Norcross & Karpiak, 2012).

There could be a few reasons for the higher than expected use of psychoanalytic approaches as the primary approach. It is likely that those who took part in the survey were likely to have an interest in psychoanalysis, leading to a self-selection bias (K. B. Wright, 2005). The researcher was aware that this may happen and took steps to try and manage this. For example, the survey was posted on general clinical psychology social media forums rather than psychoanalytic approaches specifically and it was specified that *all* views were welcome. Alternatively, there could be an increased use due to more short-term, "branded" psychoanalytic therapies becoming available, such as DIT in IAPT services (Lemma et al., 2010).

It is also noteworthy that the majority endorsed CBT as their primary modality (32.4%), which is consistent with previous surveys. The numbers primarily using cognitive approaches in the UK has increased from 21% in 1992 (Norcross et al., 1992) to 33.6% in 2012 (Nel et al., 2012). This increase was also seen in the US; the numbers primarily using cognitive-behavioural approaches increased from 2% in 1973 to 31% in 2010 (Norcross & Karpiak, 2012). As discussed in the introduction, the rise of CBT could be linked to amenability to being used with outcome measures and suitability for RCTs, which fits with the current emphasis on empirically validated treatments (A. T. Beck et al., 1961; Thoma et al., 2015). CBT is also easily manualised, which meant that it is seen as a short-term cost-effective approach (Strupp, 2001).

4.5 Research Question Two: How often do clinical psychologists use their preferred modality in their work?

The results indicate that 90.5% of participants use their chosen modality often or repeatedly/always. Previous surveys of clinical psychologists in the US showed that 94.5% use their preferred modality always or often (Norcross & Prochaska, 1983), but we have no such data for clinical psychologists working in the UK (Nel et al., 2012; Norcross et al., 1992). It was seen to be important to gain an idea about how often participants used their primary modalities in order to provide a context for the rest of the survey results, given that often competing demands aside from clinician choice - such as orientation of supervisors, training and presenting difficulties of clients - can influence use of modality (Norcross & Prochaska, 1983). The high percentage of clinical psychologists who can use their preferred approach often or always is noteworthy because it indicates that participants could use their chosen modality despite the constraints mentioned in the interviews, and discussed below.

4.6 Research Question Three: What are the service, client and professional training characteristics of clinical psychologists using psychoanalytic approaches?

4.6.1 Service Characteristics

4.6.1.1 Service setting

Most participants, including those primarily using psychoanalytic approaches, worked in secondary care community teams, with a tertiary service (national or specialist team) or a hospital/clinical health setting next most common.

This is in contrast to the UK-based survey of clinical psychologists carried out thirty years ago where general and psychiatric hospitals were the primary employment site, followed by outpatient clinics (Norcross et al., 1992). This may be explained by the increasing shift towards community care (Malone, Marriott, Newton-Howes, Simmonds, & Tyrer, 2007). There has been little research on how increased community care has impacted psychoanalytic approaches. Previous papers published at the time this shift towards community care started suggest that this may allow more individuals avail of it who may not have the resources to access psychoanalysis privately, although increased client numbers might increase the pressure on therapists (Wallerstein, 1968). The qualitative results, discussed later, suggest that clinicians are under pressure, however, there are still difficulties regarding the accessibility of therapy.

4.6.1.2 Professional activities

The majority of participants using psychoanalytic approaches (55.9%), as well as CBT and third wave approaches indicated that they spent most time doing therapy, which was in accordance with previous surveys of clinical psychologists in the UK (Norcross et al., 1992). Consultation was the next most common activity by those using psychoanalytic and systemic approaches. Specific comparative data is not available because previous surveys do not divide time spent consulting by modality. However, previously it was found that a substantial number (81%) are involved in consulting, but only for a small percentage of their time overall (12%) (Norcross et al., 1992). Consultation may have particularly developed within psychoanalytic and systemic approaches. Consultation models have developed within psychoanalytic thinking since the 1960s (de Swarte, 1998) and have merged with systems perspectives which bring an understanding of the organization in context (Gould, 2018). Consultation has developed into a professional practice that requires specific knowledge and skills (Falender & Shafranske, 2020) and is now a required competency for clinical psychologists (BPS, 2019).

Cognitive-behavioural, systemic and third wave approaches tended to rate assessment as the second most common professional activity. This reflected previous surveys of clinical psychologists in the UK (Norcross et al., 1992).

Only those using third wave or CBT approaches spent time doing research, which is noteworthy. In the past, more psychologists (71%) were involved in

research, although these past surveys did not analyse results according to modalities (Norcross et al., 1992). This is in accordance with literature which speaks about the low rates of research among psychoanalytic therapists relative to clinicians using other modalities (Busch & Milrod, 2010).

4.6.1.3 Range of numbers of clients worked with simultaneously

The majority of participants using psychoanalytic approaches, and all other approaches surveyed, primarily carried out therapy with individuals (91.2%). Those using psychoanalytic approaches used groups to a similar extent to systemic, but less than participants using third wave or cognitive-behavioural approaches. They did not tend to meet with couples or families. This is in accordance with a previous survey of UK psychologists which suggested that individual therapy was the most common therapy format, with almost twice the number of clinicians involved in individual therapy in contrast to group, couples and family therapy (Norcross et al., 1992).

4.6.1.4 Clinician and service preferences of modality

Participants were asked what determined their preference of approach, and the majority (60.8%) specified that it was their own preference, which was characterized as their values, training and clinical experience (Norcross & Prochaska, 1983). This echoes previous research which suggested that personal factors such as values, life, clinical experience and training were major factors in choosing theoretical orientation (Norcross & Prochaska, 1983). The next most popular choice was service requirements (20.1%), followed by “other” (12.7%), where the evidence base was the most

commonly mentioned other factor. This may reflect the current emphasis on evidence-based therapies (Boswell et al., 2011). Service user preference was the least endorsed (6.3%) as a factor influencing therapy choice. This is noteworthy given the recent emphasis on client choice in services (Department of Health, 2011b, 2011a, 2020). It could be suggested that there should be more of an emphasis on providing useful information for clients on the range of options available to them to enhance their ability to choose.

One third of participants said that their service had a preference (36%). This was interesting, given that many of the interviewees had experienced difficulties using psychoanalytic approaches within service constraints (discussed below in section 4.7). It may perhaps be that the service constraints are implicit in the service structure, rather than explicitly specified.

The majority who said their service had a preference specified that it was cognitive-behavioural approaches (67.5%), reflecting the dominance of CBT documented in the literature (Thoma et al., 2015). In contrast, the lowest number of participants (5.9%) said psychoanalytic approaches were the preferred modality of their service. This is noteworthy in context of the finding previously discussed which showed the second most popular preference of participants was for psychoanalytic approaches. This suggests that service demands may be at odds with the working preferences of clinicians. More freedom for clinicians to choose the appropriate modality could be warranted, given that this is a required competency of qualified psychologists (BPS, 2019).

4.6.2 Client Characteristics

4.6.2.1 Client age group

The majority of the sample worked in adult services. However, those whose primary approach was psychoanalytic had the highest percentage of clinicians who worked mainly with adults (82.4%). In contrast, the number of psychoanalytically-informed clinical psychologists working with children (14.7%) was less than the number using systemic or cognitive-behavioural approaches.

This may be because psychoanalytic work tends to be carried out by psychotherapists rather than clinical psychologists in the NHS (Abbass, Rabung, Leichsenring, Refseth, & Midgley, 2013; Rous & Clark, 2009). Alternatively, it could reflect the importance the NHS puts on empirical evidence for treatments (Goldbeck-Wood & Fonagy, 2004). Evidence base is a strong factor to use when commissioning services (Lucock et al., 2006) and at present psychoanalytic approaches do not have as strong an evidence base for children, as they do for adults (Midgley & Kennedy, 2011; Midgley et al., 2017).

4.6.2.2 Presenting difficulties of clients

Psychoanalytic approaches were mainly used with client groups with long-term mental health issues, such as clients with severe and enduring problems (41.2%) and ‘personality disorder’ (13.1%). This reflects literature that suggests that psychoanalytic approaches are helpful for those with severe

and enduring mental health issues (De Maat et al., 2013, 2009) and NICE guidelines which recommend psychoanalysis often focus on those with complex and more long-term conditions, such as adults and children with refractory depression (NICE, 2009, 2019). In contrast, survey participants using third wave approaches also worked with clients with severe and enduring problems, but at a marginally lower rate and were more likely to additionally work with those with health-related conditions (25%). Clinicians using CBT approaches primarily worked with clients with common mental health problems (26.4%) such as anxiety and depression and systemic approaches were more likely to be used with clients with learning difficulties (28.6%). It could be suggested that different therapies are used for clients with different presenting difficulties because they differ in relative efficacy and in the profile of their evidence base (A. Roth & Fonagy, 2006).

4.6.3 Professional Training Characteristics

4.6.3.1 Further training completion

The majority had completed further training (79.9%). Psychoanalytic was the fourth most popular modality within which to engage in extra training (21.2%). A number of participants training in the "other" approaches specified that they attended cognitive analytic therapy (CAT) training, raising the overall number that completed training in psychoanalytic approaches, given that CAT draws on psychoanalytic ideas (Young, 1999). It is somewhat surprising that a relatively high percentage had completed training within psychoanalytic approaches, given a lower percentage in this sample primarily use this approach, and with previous surveys indicating that it has been declining in

popularity (Nel et al., 2012; Norcross et al., 1992). This again may be due to the self-selection bias in survey respondents (K. B. Wright, 2005).

4.6.3.2 Further training availability

Psychoanalytic approaches were rated as less available than the other cognitive-behavioural, systemic and third wave approaches. This may again reflect a self-selection bias in the respondents (K. B. Wright, 2005) or it may reflect an increase in short-term, "branded" psychoanalytic therapies becoming available within which to train (Lemma et al., 2010).

4.7 Research Question Four: How do clinicians describe working within psychoanalytic approaches?

When describing their experiences, the themes of limits of ideological space for psychoanalytic models, and time to practice within them encapsulated many of the experiences described by participants. Space was defined as being dependent on context, and referring to material spaces, as well as metaphorical, social, personal and/or intrapsychic space (Harvey, 2005). Participants spoke about how the current ideologies of neoliberalism, evidence-based practice, medicalization and the professionalization of occupations left little space for psychoanalytic approaches in services.

Time has also been linked to psychoanalytic approaches in the literature; session length and frequency are key parts of the therapeutic frame and past experience is thought to be important for current functioning (Sabbadini,

2018). Participants described how the use of psychoanalytic approaches has changed over time in NHS services, and speculated as to what the approach might evolve into in the future.

4.7.1 The Squeeze of Neoliberal Austerity

Neoliberalism, as mentioned in the introduction, is an economic and political worldview that prioritizes the free market, individualism and deregulation (Layton, 2014). According to some participants, neoliberal values could be identified in the way services emphasized effectiveness and how they evaluated services. Service quality indicators often focus on number of clients seen and in what time frame, rather than quality of therapy. In addition, to increase turnover, participants felt that short-term therapies such as CBT had been prioritized, rather than psychoanalytic approaches that require more space and time with clients. This echoes views in the literature that the NHS functions under a business framework that prioritizes targets and outcomes over measures of patient care (Rizq, 2014a). This is despite research showing that long term treatments are shown to be more effective than shorter interventions for complex mental disorders, as they can potentially address longer standing issues (Leichsenring, Abbass, Luyten, Hilsenroth, & Rabung, 2013; Taylor, 2008).

Participants felt that austerity measures accentuated the difficulties of using psychoanalytic approaches within this service model. For example, staff shortages and a lack of resources in terms of supervision and therapy rooms

made it difficult to adhere to basic tenets of psychoanalytic approach, such as the therapeutic frame (Gray, 2013).

4.7.2 Professionalization and Narrowed Boundaries

Neoliberalism, although it advocates for less government involvement in health services, supports considerable governance (Bondi, 2005; Dudley, 2017). Participants spoke about how they felt this regulation in the form of the professionalization of their occupations, and how it influenced how much space was available to use the psychoanalytic approach. Clinical psychology training courses now are required to train trainees in CBT plus one other modality (BPS, 2019; Dudley, 2017). In addition, some participants suggested that clinical psychology was now more associated with CBT and psychotherapy was associated with psychoanalytic approaches. It could be suggested that this delineation has become necessary for different professions to survive and maintain funding in a culture that requires high levels of regulation and specification of job roles (Dudley, 2017).

4.7.3 The Constraints of What Counts as Evidence?

Participants spoke about the evidence-based culture that has grown within neoliberal ideology (Bondi, 2005) and how this has affected the presence of psychoanalytic approaches in the NHS. They described how the principles of evidence-based research often do not fit psychoanalytic approaches as easily as other modalities such as CBT. For example, the evidence base for psychoanalytic approaches is often based on case series and naturalistic follow up, rather than RCTs which tend to be accorded less weight in the

NICE guidelines (Summers & Barber, 2009). As a result, they said psychoanalysis is often overlooked by commissioners, who tend to draw on the NICE guidelines (Lucock et al., 2006), leading to a dearth of psychoanalytic approaches in services. A few participants however suggested that the evidence base for psychoanalytic approaches was not up to 'standard', and so they should not be offered in the NHS.

Participants were divided about how psychoanalytic approaches should respond to the requirement for empirical research. Some participants spoke about the growing empirical evidence base for psychoanalysis, some of which was reviewed in the introduction (De Maat et al., 2013, 2009; Shedler, 2010). Other participants felt that psychoanalytic approaches adhered to a more hermeneutic epistemological framework that did not lend itself to being tested empirically (Wallerstein, 2009). This approach argues that there can be no absolute certainties, which are a key assumption of empirical (positivist) research, arguing 'truth' is uniquely constructed within a certain context, such as that between the therapist and client (Lees, 2005). Given this, methods such as qualitative methods or case studies would be more appropriate because they focus on the experience of individuals within a particular context (Wallerstein, 2009).

Other participants emphasized the role for practice-based evidence. This is research that integrates individual clinical expertise and service parameters with rigorous research activity (Barkham, Hardy, & Mellor-Clark, 2010). This method would allow more room for intuitive clinical judgment in deciding

treatments, which they felt was lacking currently. However, practice-based evidence is less valued in comparison to more 'scientific' methods (Lees, 2005). It is critical when examining the relative worth of these approaches to consider to whom power is distributed and withheld using this framework (Winograd & Davidovich, 2014). For example, qualitative research is usually less valued, and this is generally the most direct method of hearing the views and preferences of service users.

4.7.4 The Value of Intuitive Clinical Judgment

Participants were divided as to how much they valued intuitive clinical judgment in making treatment decisions, versus those who prioritized evidence-based practice, albeit used alongside clinical judgment. Some clinicians said they felt the psychoanalytic approach might be risky or unsafe to use due to the lack of evidence base. However, interestingly intuitive clinical judgment was rated as more influential on practice than research and evidence based guidelines in a previous survey of clinical psychologists (Lucock et al., 2006). Perhaps the epistemological framework one adheres to corresponds to the modality one uses, given that in that survey those who primarily used CBT were more likely to rate evidence as an important influence on their practice than analytic clinicians, who rated intuition more highly (Lucock et al., 2006).

4.7.5 The Dominance of the Medical Model

Participants also spoke about the medical model as leaving little space for psychoanalysis. Medicalization is compatible with neoliberalism as both

approaches treat the individual as self-contained agents and downplay the role of social context on behaviour (Esposito & Perez, 2014). Psychoanalysis is not an easy fit with a symptom-focused approach because it tends not to differentiate ‘pathologies’ or distress in the same way as the current medical model (Busch et al., 2001). Psychoanalytic theory suggests that every person has unconscious conflict and defenses, and it is the way that this is resolved that leads to difficulties (Bateman & Holmes, 1995), meaning that other approaches such as CBT are an easier fit within services (Cushman, 2015).

4.7.6 Psychoanalytic Approaches and Reflective Space for Clinicians

Within the NHS, participants spoke about key features of the psychoanalytic approach, such as having space to reflect, being difficult to realize. Reflection is important in psychoanalysis; the model suggests that the client can be helped through the thoughtfulness of the therapist, informed by clinical experience and self-reflexivity (Mollon, 1989).

Schön (1983) suggests reflection is the cultivation of the capacity to reflect while doing therapy, as well as retrospectively. This was evident in how participants said that they could spend more time when using psychoanalytic approaches reflecting on the therapeutic relationship, and how the model gave them space to consider their responses. Qualitative research suggests that this type of reflection can help increase understanding between the client and therapist, aid the development of the therapeutic relationship and help overcome impasses in therapy (Fisher, Chew, & Leow, 2015; O’Loughlin, 2003).

Participants also felt that it was useful for them to be able to reflect about patterns in which staff teams could get stuck. This corresponds to literature that has applied psychoanalytic thinking to public healthcare settings to enhance functioning and well-being of staff (Gabriel & Carr, 2002; Hoggett, 2006). It has been used to help staff teams manage challenges such as demanding jobs and service restructuring using reflective groups (Menzies-Lyth, 1988; Morante, 2005).

The importance of reflection is also recognized in clinical psychology; given reflection is identified as a core competency (BPS, 2019) and training courses routinely incorporate personal and professional development (PPD) groups to enhance the reflective capacities of trainees (Gillmer & Marckus, 2003). However, reflection is not currently valued in services; neoliberal ideas dissuade individuals from introspecting and promote a view towards doing, thinking ahead and setting goals (Layton, 2014).

4.7.7 Psychoanalytic Approaches and Relational Space for Clients

Some participants said psychoanalytic approaches afforded more space and time to work on the therapeutic relationship than other modalities. Some added that the psychoanalytic approach gave them a language to talk about concepts such as transference, countertransference and containment, all of which were felt key to the therapeutic relationship and distinct to psychoanalytic therapy (Sripada, 2015). This is important, given that much literature suggests that a strong therapeutic relationship is associated with a

good outcome (Martin, Garske, & Davis, 2000; Nilsson et al., 2007), in particular for those with complex histories and difficulties relating to others. Research suggests that a strong therapeutic alliance might facilitate changes in functioning and 'personality' structure (Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007).

However, some participants mentioned that some clients might find this difficult to tolerate. Service user research with those who took part in psychoanalytic therapy suggest that service users often found the process of therapy difficult, and sometimes painful, although most valued the space and benefited in terms of improved interpersonal relations, affect regulation and greater understanding of difficulties (Fellows et al., 2003; Nilsson et al., 2007; Poulsen et al., 2010).

4.7.8 Varied Accessibility of Psychoanalytic Space

Some participants felt that the approach was inaccessible to themselves as therapists and their clients. They felt that the language was difficult to understand. A few said the therapy was mainly for middle-class white therapists and clients, given the high costs associated with training and attendance (Ryan, 2017; Spiegel, 1970). Research has shown that those from working class backgrounds are less likely to be referred for psychoanalysis, and a recent study showed that therapists showed discrimination against working class or black inquirers when evaluating referrals (Ryan, 2017). Although it is available within the NHS which removes the monetary cost, the issue of accessibility remains, due to the differences in who is referred (Ryan,

2017). Neoliberalism may exacerbate this process, as it focuses on the individuals, not context, which exacerbates structural inequalities (Ryan, 2017).

Some felt that it might be inappropriate to use with black or minority ethnic cultures although others felt that the psychoanalytic analytic narrative basis might make it accessible, akin to other narrative-based therapies. Psychoanalysis has come under criticism for not addressing the issue of 'race' (H. Morgan, 2008). Therapeutic concepts such as object relations and assumed potential therapeutic goals are culture bound, often in unacknowledged ways (Bucci, 2002). Additionally, there are proportionally few black trainees and black patients (H. Morgan, 2008). Issues of racism are also prevalent within clinical psychology in the UK, the vast majority of psychologists are white, and many of the models and research used are deemed to be Eurocentric (Wood & Patel, 2019).

However, psychoanalysis has advanced in its exploration of race through practice and consultation with diverse psychologists and communities (Tummala-Narra, 2013). There has been an emphasis on understanding one's representations of race, whiteness and different cultural values (Dalal, 2001; Suchet, 2014) and how it operates to support a Eurocentric view of the world (Hook, 2004). This is important in order to acknowledge and validate racial trauma and understand and explore how power and race manifest in transference and countertransference within the therapeutic relationship (Tummala-Narra, 2015). The Tavistock, a prominent UK training institution,

has increased training, research, conferences and discussion forums dedicated to diversity, race and culture (A. Cooper, 2010; Lowe, 2014).

4.7.9 Current Space for Psychoanalysis within Services

Participants spoke about how they attempted to find space for psychoanalysis, through formulation or integrative approaches, given constraining service contexts. Formulation within clinical psychology is a working explanation of the difficulties of a client, informed by theories and research that forms the basis of ensuing treatment (Johnstone & Dallos, 2006). Psychoanalytic concepts such as defenses, inner conflict, early experience and unconscious thoughts and processes are commonly used to construct formulations (Leiper, 2014).

Integrative approaches have become more common within clinical psychology; a survey of clinical psychologists in the UK indicates that the majority of clinical psychologists in the UK regard themselves as integrative (Nel et al., 2012). The current use of psychoanalytic approaches in an integrative manner reflects pressure from the current context to offer more short term therapies (Milton, 2001).

However, there is minimal research on how clinicians integrate different modalities or how common this is in practice (Norcross, Karpiak, & Lister, 2005). Cognitive analytic therapy (CAT) (Ryle, Poynton, & Brockman, 1990) is an example of technical integration, where aspects of psychoanalytic approaches such as transference and the focus on the relationship are

integrated with aspects of traditional CBT (Ryle, Kellett, Hepple, & Calvert, 2014).

4.7.10 How to Create Space Within Services

In terms of looking towards the future of psychoanalysis in services, some participants were hopeful. For example, short-term branded psychoanalytic models are being accepted into the NHS, such as DIT into IAPT (Lemma et al., 2010). However, others suggested that by stripping therapies down to a manualised time-limited series of techniques, therapy is at risk of becoming a mechanical allocation of techniques to a client (Dudley, 2017).

Some participants felt less hopeful about the future and felt that the traditional long-term format of psychoanalysis and lack of empirical evidence would prevent it becoming part of the modern NHS. These are criticisms echoed in the literature (Salkovskis & Wolpert, 2012). However, a few of the participants felt that the therapy should not adapt anyway, because it may lose some of its 'essence'.

Some participants suggested psychoanalysis should be routinely incorporated into clinical psychology training because it is not currently prioritized in many courses. Some participants felt that increasing diversity of modalities taught was important in order to reduce a loss of innovation and the possibility of 'group think' (Levy & Anderson, 2013) and widen the rage of potentially helpful therapies to clients (Fonagy & Lemma, 2012). Participants suggested that psychoanalytic placements and supervisors could also be helpful, and

supervision has been suggested to improve the transmission of therapeutic knowledge (Levy & Anderson, 2013).

Participants thought that research was key to increasing the use of psychoanalysis within services. This is corroborated by literature suggesting that research such as meta-analyses and neuroimaging are key to increasing model prominence (Bornstein, 2005).

Communicating the advantages of the approach to service commissioners was also seen as potentially helpful which could be done by taking more positions informing policy or doing research (Bornstein, 2001).
A few participants felt that clinical psychologists should take a more prominent role in leadership, which would fit with the new leadership agenda developed for clinical psychologists within the BPS (BPS, 2010). Many participants felt that taking up leadership roles by psychoanalytically-informed psychologists may help counter neoliberal values and practices (Layton, 2014).

4.7.11 Effects of These Spaces on Clients

Neoliberalism suggests it is supportive of consumer choice and portrays individuals as being autonomous and unconstrained consumers (Bondi, 2005). However, choice is constrained by the limited options of therapy that are currently available and offering different types of support is not the same as providing what clients need or want (Glynos, 2014). In addition, patients usually have less power in mental health to make decisions, whether this is

explicit when they are under treatment orders, or less more implicit, in terms of not having knowledge of therapy choices available (Lewis, 2014).

There was also a concern among some participants that the focus on neoliberal values might have a negative impact on therapy. Literature suggests that the word ‘recovery’ has been redefined by neoliberal outcomes such as returning to work (Dudley, 2017). It is critical that therapy does not collude with these ideologies by failing to recognize how these narratives are implicated in patients distress (Layton, 2014). Therapies are often individualizing and depoliticizing and fail to give adequate attention to social factors in distress. Psychologists need to address this and their role in upholding these dominant narratives (Bondi, 2005)

4.8 Implications of the Research

Given that the experiences of participants of using psychoanalytic approaches in services were shaped strongly by contextual and political factors, many of the implications of the research operate on this level.

4.8.1 Accessibility

Most participants valued the psychoanalytic approach and thought it is helpful for themselves as clinicians and for clients. Participants spoke about how psychoanalytic approaches are not initially offered to clients. Often they complete what is deemed as the “first line” treatment (Taylor, 2008) in the NICE guidelines before they are referred, despite suitability for a more long-

term approach. With this in mind, participants suggested that it would be useful to make the therapy more accessible.

In addition, more research could be done on cross-cultural suitability of psychoanalytic models. There is little research on how minority ethnic communities or how cultures other than Western cultures experience therapy, how it could be adapted or whether this would be suitable. This is critical given that it has been suggested that psychoanalysis fails to address issues such as colonialism and racism adequately (Frosh, 2013).

In addition, it would be useful to make the training more accessible to clinical psychologists. Participants spoke about the cost and time involved in training as prohibitive in accessing training. It would be useful for training institutions such as the Tavistock to offer shorter and more cost-sensitive post-graduate courses that clinical psychologists could attend while working. Additional CPD opportunities may also be useful. Because some participants perceived the approach to be specifically for more privileged, white, middle-class therapists, it would be useful to consider making training courses more accessible to minority ethnic communities. Although the Race Relations (Amendment) Act (2000) implies that training organizations need to address the reasons for any disparity between the numbers of white and minority ethnic members (H. Morgan, 2008), often experiences of black and minority ethnic trainees suggest a reluctance of training courses to address these issues (Wood & Patel, 2019).

4.8.2 Increasing Awareness of Impact of Prevailing Ideologies on Therapy

From the interviews, participants perceived services as not encouraging the use of psychoanalytic approaches. Despite only one-third answering that their service had an overt preference, which was mainly for CBT, it seemed that this preference was expressed in subtle ways. For example, it was expressed by only having outcome options for CBT therapies and having service models specifying a short number of sessions. It would be useful for services to consider making changes that would be less prohibitive against using psychoanalytic approaches, such as allowing a longer intervention time when it was assessed to be beneficial to the patient.

This, however, would involve more widespread change in the prioritization of neoliberal values. More research could be done and communicated by clinical psychologists on how values that emphasize efficiency over care impact on therapy. More attention needs to be paid to how funding cuts affect care and how prioritizing certain types of evidence limits what therapies can be offered. These pressures have curtailed patient choice of therapy. We are obliged to explain and offer a variety of different therapies if we are to offer true patient choice.

4.8.3 Response of Psychoanalysis

There is little consensus on how psychoanalysis should respond to the changing context of the NHS. Some suggest that it should adapt and produce empirical evidence and brief manualised therapies. Others believe this context is unhelpful in itself, so analytic models should *not* adapt. They suggest that

adapting would mean losing some of the model's 'essence', i.e. as a long-term approach that focuses on relational experiences.

Other participants have adapted to the restraints of context by using psychoanalytic ideas in an integrative way, or in formulations. All these approaches have merit and could be potentially helpful. It has been remarked that those who practice psychoanalytic approaches are not always the most involved in policy development (Bornstein, 2004). Engaging in this way may help communicate the value of the approach. A medium for clinicians to communicate and compare ideas and ways forward would be useful to facilitate this, such as social media forums, online webinars and discussion groups, for example.

4.8.4 Increase in Research within Psychoanalytic Approaches

Given that rates of research are low within those using the psychoanalytic approach (Busch & Milrod, 2010), more psychoanalytically-focused research output could be helpful. This research could involve communicating relative uses of different approaches, rather than a 'one size fits all' approach. If psychoanalysis could harness synergies between qualitative and quantitative approaches, they may help strengthen both their research base and institutional acceptability.

4.9 Strengths of the Research

4.9.1 Addresses a Gap in the Literature

There has been no previous research that explores the usage and experiences of clinical psychologists using or considering analytic approaches in the NHS. Research that addresses clinician experiences of using the approach is key to exploring whether analysis should be retained within the NHS. This research has considered the barriers and service constraints, as well as possible advantages to using analytic models, which have for various outlined reasons, fallen largely out of favour in many settings.

4.9.2 Accessed an Interest in the Area

When the questionnaire was released on various social media sites, it sparked a significant amount of responses and reactions within a small space of time. Additionally, many who completed the survey volunteered to be interviewed. This was taken by the researcher to indicate good interest in the research area.

4.9.3 Mixed Methods

The use of both qualitative and quantitative methods was regarded as a strength of the research. The quantitative survey was used to provide a broader illustration of the national usage of psychoanalytic approaches. The qualitative interviews were used to explore the use of psychodynamic approaches in more depth (D. Morgan, 2014).

4.9.4 Use of an Online Anonymous Questionnaire

Using an online questionnaire was useful. Designing the survey so that participants had to answer each question before moving on to the next one reduced the amount of missing data in the final sample. Options such as “other” or “not applicable” were included to increase the number of questions that each person could answer. The questionnaire was also anonymous, unless the participants chose to leave their details. This hopefully allowed more people to respond freely and reduce social desirability bias in responding (Joinson, 1999). There were limited open-ended questions included, however, interviews were used to address this gap.

4.10 Limitations of the Research

4.10.1 Pilot Study

It would have been useful to carry out a more complete pilot study of the questionnaire (Hazzi & Maldaon, 2015). Three mental health professionals were initially asked and their feedback was useful and taken into account (see Appendix H for details). The researcher had been reluctant to dip into the pool of potential participants because reduced numbers may limit the generalizability of the study. However, the final number was substantial, so a pilot could have been carried out. It would have been useful to discover if there were any issues with the statements, scales or questionnaire length, because one-third of the participants did not complete the survey after they started it.

4.10.2 Sample

Given the number of respondents who used psychoanalytic approaches was larger than expected, it could be that there was some self-selecting bias in the responses (K. B. Wright, 2005). However, although the sample may be skewed towards those who are interested in the approach, significant numbers of clinical psychologists still took part whose views cannot be disregarded. Additionally, a proportion of those who were interviewed did not use psychoanalytic approaches or ideas, and so many views were represented.

As discussed, it is difficult to comment on the generalizability of the results as it is unclear how representative the survey is in terms of the number of participants. It is likely from the demographics collected that the sample is more representative of English respondents. However, the other basic demographics (such as number of women, the age range and ethnicity) seem to tally with previous surveys (Nel et al., 2012; Norcross et al., 1992) and official figures (BPS, 2016, 2018; Health and Social Care Information Centre, 2014) so it could be suggested that the survey is somewhat representative of the population.

It is acknowledged that there is a lack of participants in the sample who identify as male (14.8%). However, this unfortunately corresponds to official figures which show that clinical psychologists are in the majority women (81.5%) (Health and Social Care Information Centre, 2014). Additionally, national surveys show that the number of men in the profession has been

decreasing from 45% of psychologists in 1992 (Norcross et al., 1992), to 29% twenty years later (Nel et al., 2012).

There is limited research exploring why this is happening, although some suggest it is due to socialization of individuals to associate caring professions with being 'female' careers (Addis & Mahalik, 2003). The lack of male representation in psychology is slowly being addressed. An Equality, Diversity and Inclusion Policy has been developed, and a Male Psychology Network has been established within the BPS which coordinates conferences and research. This is important because men have high rates of suicide, substance abuse and treatment dropout (Addis & Mahalik, 2003). Having a male perspective on treatment (Kiselica & Englar-Carlson, 2010) and accommodating preferences for a male or female therapist was associated with greater engagement and treatment outcomes (Swift, Callahan, Cooper, & Parkin, 2018).

4.10.3 Focus on Adult Psychology

It is acknowledged that the focus in this piece of work has been on the psychoanalytic approach as used with adults. For instance, much of the literature in the introduction covers how the approach was developed historically in adult services and evidence presented focused on studies conducted with adults. Its applicability to adult services was focused on because the majority of the sample worked in adult services and spoke about its applicability in relation to adults. Some mentioned how the developmental

perspective of the approach is useful when working with children and adolescents; however, these participants were in the minority.

4.10.4 Lack of Data on the Primary Modality of Interviewees

It is acknowledged that it would be useful to know the primary modality used by interviewees when interpreting qualitative results to illustrate the extent to which interviewees use the approach in their work. This information was not included because it was stipulated in the ethics application and consent form that the survey data and interview data would not be connected to retain participant anonymity and confidentiality.

4.11 Future Research

4.11.1 Longitudinal Research

It would be useful to carry out longitudinal research on the use of different modalities over time in the UK, similar to the series of studies discussed in the introduction that have been carried out in the US (Norcross & Karpiak, 2012). There have been some previous studies done which explored the use of various modalities in the UK (Nel et al., 2012; Norcross et al., 1992). However, they are difficult to use for comparative purposes because both studies explore uses of slightly different modalities, were carried out twenty years apart and may be subject to contextual cohort effects.

4.11.2 Choice of Theoretical Orientation

More detailed research on which factors influence choice of theoretical orientation would be useful. There has been some research exploring this but

it was carried out almost forty years ago (Norcross & Prochaska, 1983). Additionally, the factors explored in the studies were quite different so no consistent conclusions can be made (Norcross & Prochaska, 1983). For example, orientations of lecturers and clients difficulties were factors that were included in some surveys but not others (Norcross & Prochaska, 1983). If psychoanalytic approaches were going to be supported or retained in the NHS, it would be important to attend to factors that might influence this. Preliminary research suggests that training, supervision and placements are regarded to be important, however, further research needs to be done (Lucock et al., 2006).

4.11.3 Experiences of Clients of the Approach

Given that therapies are developed for the benefit of clients, it is important to ensure that clients perceive the therapies as helpful. There has been some qualitative research carried out (Bury et al., 2007; Fellows et al., 2003). However, more research would be useful to explore how clients of minority ethnic backgrounds and ages experience the model.

4.11.4 Child Psychotherapy Services

A similar study could be carried out exploring the use of psychoanalytic approaches in child psychotherapy services. Research has suggested that the approach is useful (Edlund & Carlberg, 2016; Midgley & Kennedy, 2011), so a study exploring current use and experiences of therapists would be useful.

4.12 Reflexive Review

It is critical for researchers to engage with how their beliefs, experiences and interests shape the research and how the research in turn influences us (Willig, 2013), which I will do retrospectively here.

I am interested in psychoanalytic understandings of how early experiences and the unconscious effects individuals, and how psychological issues can often be relational, and hence be 'worked out' in the context of a therapeutic relationship. Therefore, I had to be aware of my view that the approach and its ideas can be helpful, and that others do not share these views. To ensure that the research was not overly influenced by my beliefs, I did not disclose to participants before they participated in the research study that I was sympathetic to the approach. I hoped that as a result, participants would feel free to talk about their opinions. Additionally, I welcomed the views of participants who did not use the approach, in order to gain a range of perspectives. I tried to maintain a balanced approach throughout, for example, when I presented effectiveness and efficacy research in the introduction, I spoke about the weaknesses of the research.

I noticed when I was writing the thesis that I was having a similar debate about research to participants and the literature. I found that some of the studies that I found had not been carried out within an empirical framework. I found myself questioning their validity; it seemed that I have an implicit awareness of the value that the profession puts on empirical findings. Due to

the scope of the literature review, it was just possible to cite the largest studies, such as reviews and meta-analyses, but again I reflected that this privileges a certain type of research.

Additionally, I reflected that this study in itself reflects the dichotomy between empirical and more hermeneutic approaches because it is a mixed methods study, and how method would be more usefully driven by research aims and appropriateness to the topic rather than privileging one over the other. The research made me appreciate more the different methods of research, and the importance of ensuring that there is a coherent epistemological framework and set of assumptions underlying it.

Also, because I read a lot of literature produced by psychoanalytic researchers, I read about the psychoanalytic understandings of neoliberalism. Some of these suggested that the function of audits, performance indicators and adherence to evidence-based procedures functioned as unconscious containment, restraining anxieties about not being able to “solve” psychological distress or vulnerability in society (Rizq, 2014a). However, I was aware that my value of psychoanalytic viewpoints might increase my appreciation of these ideas and they may not have the same appeal for everyone, particularly those who endorse a more evidence-based approach. As a result, I did not include them in the discussion, because I feared that the subjective content would detract, for some, the power of the research findings. I reflected again how this mirrors the split between the value of the objective

and subjective and how this can be unhelpful when aiming to gain a fuller understanding of experience.

I also reflected on how difficult it is to break free from the neoliberal, empirical and medical model informed context that the NHS operates within. For instance, the words client and service user both come from a consumer and business-informed model, and patient is informed by the medical model. Survivor is another alternative, but that again is informed by a discourse of the survivor movement that not all who have passed through the NHS identify with (Dillon, 2013). This made me reflect that it is difficult to move out of this context and envision an alternative if there is a scarcity of words that we can use to refer to this alternative (Dillon, 2013).

Given how important contexts have been to this study, I have reflected on how the current coronavirus pandemic might affect the NHS and the provision of psychoanalytic approaches. I wondered whether the push to remote working might force even the purist of psychoanalysts to consider different ways of working. I also wondered whether the deaths of so many in society, and the threat to so many more might put the current emphasis on efficiency and cost into perspective relative to patient care.

4.13 Conclusion

This study found that a higher percentage of clinical psychologists in the sample used the psychoanalytic approach than expected from previous

research (Nel et al., 2012; Norcross et al., 1992). A greater majority primarily used CBT and third wave, whereas less endorsed systemic and humanistic approaches. Most of the sample that used psychoanalytic approaches worked with adults with severe and enduring difficulties in secondary care settings. They mainly carried out individual therapy and consultation. The majority of the sample worked with their preferred choice of orientation and approximately one third specified that their service had a preference, which was mainly CBT.

From the interviews, participants spoke about having little space and time within services to use the approach. They attributed this to a neoliberal and austerity context that prioritizes efficiency, reaching targets and reducing costs over patient choice of therapy and care. This service context, in conjunction with an emphasis on evidence-based practiced informed by an empirical model and medical framework, is associated with an increase in short-term, cost-effective approaches such as CBT. This has left little space for psychoanalytic approaches that generally have a different epistemology and longer treatment length.

Participants spoke about how they found the approach helpful, in terms of providing them with space to reflect, which enhanced their clinical work. However, some felt it was outmoded and unsafe, given the relative lack of evidence base. They also spoke about how clients found the space containing and therapeutic. However, participants felt that this space was not always accessible, to them as clinicians in terms of cost and training required, and to

clients of different social backgrounds and cultures, and as a first line treatment.

Some participants found space within services to use psychoanalytic ideas within formulations and integrative approaches. Participant views were divided on what the future looked like for psychoanalysis. Some participants felt that there was no future in the NHS for a historical approach that felt out of date. Some felt that psychoanalytic ideas should continue to try to adapt to the current climate by conducting empirical research and producing brief, manualised models. Others felt that the approach retained value, but should *not* adapt, as it would lose its essence. Improving teaching, training opportunities and increasing, research volume was seen as helpful to retain the interests of clinical psychologists in the approach.

From this research, it could be suggested that analytic approaches could be useful for clients and therapists to provide space and time to reflect and develop a strong therapeutic relationship that is the foundation of therapy. Psychoanalytic understandings could be useful to illuminate how the neoliberalist and empirical ideologies that guide our current health system serve a purpose of anxiety containment. However, it is difficult for these views to be valued and prioritized in a world that may be divided into two modes of thinking.

One side prioritizes objective, measurable and quantifiable phenomenon and the other side values subjectivity and relational therapy. It is proposed that the

way forward may involve the creation of a new ideological space through collaboration between psychoanalytic proponents that might accommodate the strengths of each viewpoint and create a new theoretical and therapeutic position that keeps client care as the focus at its heart.

6. REFERENCES

Abbass, A. A., Kisely, S. R., Town, J. M., Leichsenring, F., Driessen, E., De Maat, S., … Rusalovska, S. (2014). Short-term psychodynamic psychotherapies for common mental disorders. *Cochrane Database of Systematic Reviews*, *2014*(7), 1–105. https://doi.org/10.1002/14651858.CD004687.pub4

Abbass, A. A., Rabung, S., Leichsenring, F., Refseth, J. S., & Midgley, N. (2013). Psychodynamic psychotherapy for children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*(8), 863–875. https://doi.org/10.1016/j.jaac.2013.05.014

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, *58*(1), 5–14. https://doi.org/10.1037/0003-066X.58.1.5

Alexander, S. (1998). Psychoanalysis in Britain in the early twentieth century: An introductory note. *History Workshop Journal*, *45*(1), 135–143. https://doi.org/10.2307/4289553

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Baethge, C., Goldbeck-Wood, S., & Mertens, S. (2019). SANRA—a scale for the quality assessment of narrative review articles. *Research Integrity and Peer Review*, *4*(1), 2–8. https://doi.org/10.1186/s41073-019-0064-8

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence: A guide for the psychological*

therapies. New Jersey: John Wiley & Sons.

Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry*, *156*(10), 1563–1569. https://doi.org/10.1176/ajp.156.10.1563

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, *9*(1), 11–15. https://doi.org/10.1002/j.2051-5545.2010.tb00255.x

Bateman, A., & Holmes, J. (1995). *Introduction to Psychoanalysis*. New York: Routledge.

Beck, A. T. (1967). *Depression: Causes and treatment*. Philadelphia, PA: University of Pennsylvania Press.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*, 561–571. https://doi.org/10.1001/archpsyc.1961.01710120031004

Beck, J. S. (2011). *Cognitive Behavior Therapy: Basics and beyond*. New York: Guilford Press.

Berghout, C. C., Zevalkink, J., & Hakkaart-Van Roijen, L. (2010). A cost-utility analysis of psychoanalysis versus psychoanalytic psychotherapy. *International Journal of Technology Assessment in Health Care*, *26*(1), 3–10. https://doi.org/10.1017/S0266462309990791

Bhaskar, R. (1979). *The possibility of naturalism: A philosophical critique of the contemporary human sciences.* Brighton: Harvester.

Blackmore, C., Tantam, D., Parry, G., & Chambers, E. (2012). Report on a

systematic review of the efficacy and clinical effectiveness of group analysis and analytic/dynamic group psychotherapy. *Group Analysis*, *45*(1), 46–69. https://doi.org/10.1177/0533316411424356

Blatt, S. J., & Shahar, G. (2004). Psychoanalysis - With whom, for what, and how? Comparisons with psychotherapy. *Journal of the American Psychoanalytic Association*, *52*(2), 393–447. https://doi.org/10.1177/00030651040520020401

Bondi, L. (2005). Working the spaces of neoliberal subjectivity: Psychotherapeutic technologies, professionalisation and counselling. *Antipode*, *37*(3), 497–514. https://doi.org/10.1111/j.0066-4812.2005.00508.x

Bornstein, R. F. (2001). The impending death of psychoanalysis. *Psychoanalytic Psychology*, *18*(1), 3. https://doi.org/10.1037/0736-9735.18.1.2

Bornstein, R. F. (2004). Reconnecting psychoanalysis to mainstream psychology: An agenda for the 21st century. In J. Reppen, J. Tucker, & M. A. Schulman (Eds.), *Way beyond Freud: Postmodern psychoanalysis observed.* (pp. 1–19). London: Open Gate Press.

Bornstein, R. F. (2005). Reconnecting psychoanalysis to mainstream psychology: Challenges and opportunities. *Psychoanalytic Psychology*, *22*(3), 323. https://doi.org/10.1037/0736-9735.22.3.323

Boswell, J. F., Sharpless, B. A., Greenberg, L. F., Heatherington, L., Huppert, J. D., Barber, J. P., … Castonguay, L. G. (2011). Schools of psychotherapy and the beginnings of a scientific approach. In D. H. Barlow (Ed.), *The oxford handbook of clinical psychology* (pp. 98–127).

Oxford: Oxford University Press.

Boterhoven De Haan, K. L., & Lee, C. W. (2014). Therapists' thoughts on therapy: Clinicians' perceptions of the therapy processes that distinguish schema, cognitive behavioural and psychodynamic approaches. *Psychotherapy Research*, *24*(5), 538–549. https://doi.org/10.1080/10503307.2013.861092

Boynton, P. M., & Greenhalgh, T. (2004). Selecting, designing, and developing your questionnaire. *British Medical Journal*, *328*(7451), 1312–1315. https://doi.org/10.1136/bmj.328.7451.1312

BPS. (2009). *Code of ethics and conduct*. Leicester: British Psychological Society.

BPS. (2010). Clinical Psychology Leadership Development Framework. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Member Networks/Faculties/Leadership/Clinical Psychology Leadership Development Framework - BPS %282010%29.pdf

BPS. (2012). Continuing Professional Development Policy. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Professional Development/CPD Policy.pdf

BPS. (2016). *HCPC Registered Psychologists in the UK*. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy - Files/HCPC Registered Psychologists in the UK.pdf

BPS. (2018). *The Alternative Handbook 2018*. London: British Psychological Society.

BPS. (2019). Standards for the accreditation of doctoral programmes in

clinical psychology. Retrieved from https://www.bps.org.uk/sites/bps.org.uk/files/Accreditation/Undergraduate Accreditation Handbook 2019.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological.* (Vol. 2, pp. 57–71).

Braun, V., & Clarke, V. (2019). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, 1–16. https://doi.org/10.1080/2159676X.2019.1704846

Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research*, *6*(1), 97–113. https://doi.org/10.1177/1468794106058877

Bucci, W. (2002). The challenge of diversity in modern psychoanalysis. *Psychoanalytic Psychology*, *19*(1), 216. https://doi.org/10.1037/0736-9735.19.1.216

Bury, C., Raval, H., & Lyon, L. (2007). Young people's experiences of individual psychoanalytic psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *80*(1), 79–96. https://doi.org/10.1348/147608306X109654

Busch, F. N., & Milrod, B. L. (2010). The ongoing struggle for psychoanalytic

research: Some steps forward. *Psychoanalytic Psychotherapy*, *24*(4), 306–314. https://doi.org/10.1080/02668734.2010.519234

Busch, F. N., Milrod, B. L., Rudden, M., Shapiro, T., Roiphe, J., Singer, M., & Aronson, A. (2001). How treating psychoanalysts respond to psychotherapy research constraints. *Journal of the American Psychoanalytic Association*, *49*(3), 981–984. https://doi.org/10.1177/00030651010490030601

Centre for Economic Performance's Mental Health Policy Group. (2006). *The depression report: A new deal for depression and anxiety disorders*. London: London School of Economics.

Clegg, J. W. (2012). Teaching about mental health and illness through the history of the DSM. *History of Psychology*, *15*(4), 364–370. https://doi.org/10.1037/a0027249

Cooper, A. (2010). Institutional racism: Can psychotherapy change? *British Jounal of Psychotherapy*, *26*(4), 486–501. https://doi.org/10.1111/j.1752-0118.2010.01211.x

Creswell, J. W., Clark, J., Gutmann, V., Hanson, W., Clark, V., & Creswell, J. (2003). An expanded typology for classifying mixed methods research into designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 209–240). Thousand Oaks, CA: Sage.

Cushman, P. (2015). Relational psychoanalysis as political resistance. *Contemporary Psychoanalysis*, *51*(3), 423–459. https://doi.org/10.1080/00107530.2015.1056076

Dalal, F. (2001). Insides and Outsides: A review of psychoanalytic renderings

of difference, racism and prejudice. *Psychoanalytic Studies*, *3*(1), 43–66. https://doi.org/10.1080/14608950020026845

De Maat, S., De Jonghe, F., De Kraker, R., Leichsenring, F., Abbass, A. A., Luyten, P., … Dekker, J. (2013). The current state of the empirical evidence for psychoanalysis: A meta-analytic approach. *Harvard Review of Psychiatry*, *21*(3), 107–137. https://doi.org/10.1097/HRP.0b013e318294f5fd

De Maat, S., De Jonghe, F., Schoevers, R., & Dekker, J. (2009). The effectiveness of long-term psychoanalytic therapy: A systematic review of empirical studies. *Harvard Review of Psychiatry*, *17*(1), 1–23. https://doi.org/10.1080/10673220902742476

de Swarte, T. (1998). Psychoanalysis and management: The strange meeting of two concepts. *Journal of Managerial Psychology*, *13*(7), 459–468. https://doi.org/10.1108/02683949810239231

Department of Health. (2010). *Equity and excellence: Liberating the NHS*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

Department of Health. (2011a). *No health without mental health*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Department of Health. (2011b). *Talking therapies: A four year plan*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uplo

ads/attachment_data/file/213765/dh_123985.pdf

Department of Health. (2020). *NHS Choice Framework*. Retrieved from https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs

Dillon, J. (2013). Just saying it as it is: Names matter; language matters; truth matters. *Clinical Psychology Forum*, *243*, 15–19.

Driessen, E., Hegelmaier, L. M., Abbass, A. A., Barber, J. P., Dekker, J. J. M., Van, H. L., … Cuijpers, P. (2015). The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis update. *Clinical Psychology Review*, *42*, 1–15. https://doi.org/10.1016/j.cpr.2015.07.004

Driessen, E., Van, H. L., Don, F. J., Peen, J., Kool, S., Westra, D., … Twisk, J. W. R. (2013). The efficacy of cognitive-behavioral therapy and psychodynamic therapy in the outpatient treatment of major depression: A randomized clinical trial. *American Journal of Psychiatry*, *170*(9), 1041–1050. https://doi.org/10.1176/appi.ajp.2013.12070899

Dudley, J. (2017). Clinical psychology training in neoliberal times. *Clinical Psychology Forum*, (298), 30–34.

Edlund, J. N., & Carlberg, G. (2016). Psychodynamic psychotherapy with adolescents and young adults: Outcome in routine practice. *Clinical Child Psychology & Psychiatry*, *21*(1), 66–80. https://doi.org/10.1177/1359104514554311

Esposito, L., & Perez, F. M. (2014). Neoliberalism and the commodification of mental health. *Humanity & Society*, *38*(4), 414–442.

https://doi.org/10.1177/0160597614544958

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, *16*(5), 319–324. https://doi.org/10.1037/h0063633

Falender, C. A., & Shafranske, E. P. (2020). Consultation in psychology: A distinct professional practice. In C. A. Falender & E. P. Shafranske (Eds.), *Consultation in psychology: A competency-based approach* (pp. 11–35). Washington, DC: American Psychological Association.

Fellows, J. L., Watters, C., & Gatherer, A. (2003). Clients ' experiences of psychodynamic therapies : A phenomenological study. *European Journal for Qualitative Research in Psychotherapy*, *6*, 8–19.

Ferrari, R. (2015). Writing narrative style literature reviews. *Medical Writing*, *24*(4), 230–235. https://doi.org/10.1179/2047480615z.000000000329

Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. New York: Sage.

Fisher, P., Chew, K., & Leow, Y. J. (2015). Clinical psychologists' use of reflection and reflective practice within clinical work. *Reflective Practice*, *16*(6), 731–743. https://doi.org/10.1080/14623943.2015.1095724

Fonagy, P., & Lemma, A. (2012). Psychoanalysis: Does it have a valuable place in modern mental health services? YES. *BMJ: British Medical Journal (Overseas & Retired Doctors Edition)*, *344*(7845), 18–19. https://doi.org/10.1136/bmj.e1211

Freud, S., & Breuer, J. (1895). *Studies in Hysteria*. Vienna: Deuticke.

Frosh, S. (2013). Psychoanalysis, colonialism, racism. *Journal of Theoretical and Philosophical Psychology*, *33*(3), 141.

https://doi.org/10.1037/a0033398

Gabbard, G. O., Gunderson, J. G., & Fonagy, P. (2002). The place of psychoanalytic treatments within psychiatry. *Archives of General Psychiatry*, *59*(6), 505–510. https://doi.org/10.1001/archpsyc.59.6.505

Gabriel, Y., & Carr, A. (2002). Organizations, management and psychoanalysis: An overview. *Journal of Managerial Psychology*, *17*(5), 348–365. https://doi.org/10.1108/02683940210432600

Galatzer-Levy, I. R., Galatzer-Levy, R. M., & Sachs, D. M. (2007). The revolution in psychiatric diagnosis: Problems of the foundations. *Perspectives in Biology and Medicine*, *50*(2), 161–180. https://doi.org/10.1353/pbm.2007.0016

Gartlehner, G., Hansen, R. A., Nissman, D., Lohr, K. N., & Carey, T. S. (2006). *Criteria for distinguishing effectiveness from efficacy trials in systematic reviews*. Rockville (MD): Agency for Healthcare Research and Quality (US).

Gerber, A. J., Kocsis, J. H., Milrod, B. L., Roose, S. P., Barber, J. P., Thase, M. E., … Leon, A. C. (2011). A quality-based review of randomized controlled trials of psychodynamic psychotherapy. *American Journal of Psychiatry*, *168*(1), 19–28.

Gezgin, U. B. (2019). 20 theses on psychology and neoliberalism: from mainstream psychology to critical psychology. *Eurasian Journal of Anthropology*, *10*(2), 46–55.

Gillmer, B., & Marckus, R. (2003). Personal professional development in clinical psychology training: Surveying reflective practice. *Clinical Psychology*, *27*, 20–23.

Glynos, J. (2014). Neoliberalism, markets, fantasy: The case of health and social care. *Psychoanalysis, Culture and Society*, *19*(1), 5–12. https://doi.org/10.1057/pcs.2013.23

Goldbeck-Wood, S., & Fonagy, P. (2004). The future of psychotherapy in the NHS. *British Medical Journal*, *329*(7460), 245–246. https://doi.org/10.1192/pb.13.8.432

Gould, L. J. (2018). *The systems psychodynamics of organizations: Integrating the group relations approach, psychoanalytic, and open systems perspectives*. London: Routledge.

Gray, A. (2013). *An introduction to the therapeutic frame*. New York: Routledge.

Green, B. N., Johnson, C. D., & Adams, A. (2006). Writing narrative literature reviews for peer-reviewed journals: secrets of the trade. *Journal of Chiropractic Medicine*, *5*(3), 101–117. https://doi.org/10.1016/S0899-3467(07)60142-6

Guy, A., Loewenthal, D., Thomas, R., & Stephenson, S. (2012). Scrutinising NICE: The impact of the National Institute for Health and Clinical Excellence Guidelines on the provision of counselling and psychotherapy in primary care in the UK. *Psychodynamic Practice*, *18*(1), 25–50. https://doi.org/10.1080/14753634.2012.640153

Hall, J., Pilgrim, D., & Turpin, G. (2015). Introduction. In J. Hall, D. Pilgrim, & G. Turpin (Eds.), *Clinical psychology in Britain: Historical Perspectives* (pp. 3–19). London: British Psychological Society.

Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in Practice*. New York: Routledge.

Harvey, D. (2005). Space as a key word. In D. Harvey (Ed.), *Spaces of neoliberalization: Towards a theory of uneven geographical development* (pp. 93–118). Germany: Franz Steiner Verlag.

Harvey, D. (2007). *A brief history of neoliberalism*. Oxford University Press, USA.

Hazzi, O., & Maldaon, I. (2015). A pilot study: Vital methodological issues. *Business: Theory and Practice*, *16*(1), 53–62. https://doi.org/10.3846/btp.2015.437

HCPC. (2015). *Standards of proficiency for practitioner psychologists*. London: Health and Care Professions Council.

Health and Social Care Information Centre. (2014). *NHS Workforce statistics in England, Non- medical staff 2004-2014*. Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics-non-medical-staff

Heatherington, L., Messer, S. B., Angus, L., Strauman, T. J., Friedlander, M. L., & Kolden, G. G. (2012). The narrowing of theoretical orientations in clinical psychology doctoral training. *Clinical Psychology: Science and Practice*, *19*(4), 364–374. https://doi.org/10.1111/cpsp.12012

Hinshelwood, R. D. (2010). Psychoanalytic research: Is clinical material any use? *Psychoanalytic Psychotherapy*, *24*(4), 362–379. https://doi.org/10.1080/02668734.2010.513541

Hoggett, P. (2006). Conflict, ambivalence, and the contested purpose of public organizations. *Human Relations*, *59*(2), 175–194. https://doi.org/10.1177/0018726706062731

Hook, D. (2004). Fanon and the psychoanalysis of racism. In D. Hook (Ed.),

Critical Psychology (pp. 114–137). South Africa: Juta Academic Publishing.

Huber, D., Zimmermann, J., Henrich, G., & Klug, G. (2012). Comparison of cognitive-behaviour therapy with psychoanalytic and psychodynamic therapy for depressed patients–a three-year follow-up study. *Zeitschrift Für Psychosomatische Medizin Und Psychotherapie*, *58*(3), 299–316.

Jacob, G. A., & Arntz, A. (2013). Schema therapy for personality disorders—A review. *International Journal of Cognitive Therapy*, *6*(2), 171–185. https://doi.org/doi.org/10.1521/ijct.2013.6.2.171

Johnstone, L., & Dallos, R. (2006). *Formulation in psychology and psychotherapy: Making sense of people's problems*. New York: Routledge.

Joinson, A. (1999). Social desirability, anonymity, and internet-based questionnaires. *Behavior Research Methods, Instruments, & Computers*, *31*(3), 433–438. https://doi.org/10.3758/BF03200723

Kiselica, M. S., & Englar-Carlson, M. (2010). Identifying, affirming, and building upon male strengths: The positive psychology/positive masculinity model of psychotherapy with boys and men. *Psychotherapy*, *47*(3), 276–287. https://doi.org/10.1037/a0021159

Knight, T., & Thomas, P. (2019). Anxiety and depression in the age of austerity: Public health's problems with IAPT. *Perspectives in Public Health*, *139*(3), 128–130. https://doi.org/10.1177/1757913919839004

Layton, L. (2014). Some psychic effects of neoliberalism: Narcissism, disavowal, perversion. *Psychoanalysis, Culture & Society*, *19*(2), 161–178. https://doi.org/10.1057/pcs.2014.5

Lees, J. (2005). A history of psychoanalytic research. *Psychodynamic Practice*, *11*(2), 117–131. https://doi.org/10.1080/14753630500108042

Leichsenring, F. (2005). Are psychodynamic and psychoanalytic therapies effective? A review of empirical data. *International Journal of Psychoanalysis*, *86*(3), 841–868. https://doi.org/10.1516/RFEE-LKPN-B7TF-KPDU

Leichsenring, F., Abbass, A. A., Luyten, P., Hilsenroth, M., & Rabung, S. (2013). The emerging evidence for long-term psychodynamic therapy. *Psychodynamic Psychiatry*, *41*(3), 361–384. https://doi.org/10.1521/pdps.2013.41.3.361

Leichsenring, F., & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *Journal of the American Medical Association*, *300*(13), 1551–1565. https://doi.org/10.1001/jama.300.13.1551

Leichsenring, F., & Rabung, S. (2011). Long-term psychodynamic psychotherapy in complex mental disorders: Update of a meta-analysis. *British Journal of Psychiatry*, *199*(1), 15–22. https://doi.org/10.1192/bjp.bp.110.082776

Leichsenring, F., Rabung, S., & Leibing, E. (2004). The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: A meta-analysis. *Archives of General Psychiatry*, *61*(12), 1208–1216. https://doi.org/10.1001/archpsyc.61.12.1208

Leichsenring, F., Salzer, S., Beutel, M. E., Herpertz, S., HiDer, W., Hoyer, J., … Leibing, E. (2013). Psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder: A multicenter randomized controlled

trial. *American Journal of Psychiatry*, *170*(7), 759–767. Retrieved from http://10.0.4.152/appi.ajp.2013.12081125

Leiper, R. (2014). Psychodynamic formulation: Looking beneath the surface. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy: Making sense of people's problems (2nd Ed.)* (pp. 45–66). New York: Routledge.

Lemma, A., Roth, A., & Pilling, S. (2008). The competencies required to deliver effective psychoanalytic/psychodynamic therapy. Retrieved from https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-6

Lemma, A., Target, M., & Fonagy, P. (2010). The development of a brief psychodynamic protocol for depression: Dynamic Interpersonal Therapy (DIT). *Psychoanalytic Psychotherapy*, *24*(4), 329–346. https://doi.org/10.1080/02668734.2010.513547

Lemma, A., Target, M., & Fonagy, P. (2011). The development of a brief psychodynamic intervention (Dynamic Interpersonal Therapy) and its application to depression: A pilot study. *Psychiatry: Interpersonal & Biological Processes*, *74*(1), 41–48. https://doi.org/10.1521/psyc.2011.74.1.41

Leuzinger-Bohleber, M., Hautzinger, M., Fiedler, G., Keller, W., Bahrke, U., Kallenbach, L., … Schoett, M. (2019). Outcome of psychoanalytic and cognitive-behavioural long-term therapy with chronically depressed patients: A controlled trial with preferential and randomized allocation. *The Canadian Journal of Psychiatry*, *64*(1), 47–58. https://doi.org/10.1177/0706743718780340

Levy, K. N., & Anderson, T. (2013). Is clinical psychology doctoral training becoming less intellectually diverse? And if so, what can be done? *Clinical Psychology: Science and Practice*, *20*(2), 211–221. https://doi.org/10.1111/cpsp.12035

Lewis, L. (2014). User Involvement in mental health services: A case of power over discourse. *Sociological Research Online*, *19*(1), 6. https://doi.org/10.5153/sro.3265

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lindfors, O., Knekt, P., Lehtonen, J., Virtala, E., Maljanen, T., & Härkänen, T. (2019). Effectiveness of psychoanalysis and long-term psychodynamic psychotherapy on personality and social functioning 10 years after start of treatment. *Psychiatry Research*, *272*, 774–783. https://doi.org/10.1016/j.psychres.2018.12.082

Lowe, F. (2014). Thinking Space: The model. In F. Lowe (Ed.), *Thinking space: Promoting thinking about race, culture and diversity in psychotherapy and beyond* (pp. 11–35). London: Karnac Books.

Lucock, M. P., Hall, P., & Noble, R. (2006). A survey of influences on the practice of psychotherapists and clinical psychologists in training in the UK. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *13*(2), 123–130. https://doi.org/10.1002/cpp.483

Malone, D., Marriott, S., Newton-Howes, G., Simmonds, S., & Tyrer, P. (2007). Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. *Cochrane Database of Systematic Reviews*, *2007*(3).

https://doi.org/10.1002/14651858.CD000270.pub2

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

Maxwell, J. A., & Mittapalli, K. (2010). Realism as a stance for mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social & behavioral research* (pp. 145–168). Thousand Oaks, CA: Sage.

McEvoy, P., & Richards, D. (2006). A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing*, *11*(1), 66–78. https://doi.org/10.1177/1744987106060192

McWilliams, N. (2013). Psychoanalysis and research: Some reflections and opinions. *Psychoanalytic Review*, *100*(6), 919–945. https://doi.org/10.1521/prev.2013.100.6.919

Menzies-Lyth, I. (1988). The functioning of social systems as a defence against anxiety. In I. Menzies-Lyth (Ed.), *Containing Anxiety in Institutions: Selected Essays*. London: Free Association Books.

Merriman, C., & Beail, N. (2009). Service user views of long-term individual psychodynamic psychotherapy. *Advances in Mental Health and Learning Disabilities*, *3*(2), 42–47. https://doi.org/10.1108/17530180200900020

Messer, S. B. (2004). Evidence-based practice: Beyond empirically supported treatments. *Professional Psychology: Research and Practice*, *35*(6), 580–588. https://doi.org/10.1037/0735-7028.35.6.580

Midgley, N., & Kennedy, E. (2011). Psychodynamic psychotherapy for

children and adolescents: A critical review of the evidence base. *Journal of Child Psychotherapy*, *37*(3), 232–260. https://doi.org/10.1080/0075417X.2011.614738

Midgley, N., O'Keeffe, S., French, L., & Kennedy, E. (2017). Psychodynamic psychotherapy for children and adolescents: An updated narrative review of the evidence base. *Journal of Child Psychotherapy*, *43*(3), 307–329. https://doi.org/10.1080/0075417X.2017.1323945

Milrod, B., Leon, A. C., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J., … Shear, M. K. (2007). A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *American Journal of Psychiatry*, *164*(2), 265–272. https://doi.org/10.1176/ajp.2007.164.2.265

Milton, J. (2001). Psychoanalysis and cognitive behaviour therapy: Rival paradigms or common ground? *International Journal of Psychoanalysis*, *82*, 431–447. https://doi.org/10.1516/0020757011600957

Mingers, J. (2006). Philosophical Foundations: Critical Realism. In J. Mingers (Ed.), *Realising systems thinking: Knowledge and action in management science* (pp. 11–31). Boston, MA: Springer US.

Mollon, P. (1989). Anxiety, supervision and a space for thinking: Some narcissistic perils for clinical psychologists in learning psychotherapy. *British Journal of Medical Psychology*, *62*(2), 113–122. https://doi.org/10.1111/j.2044-8341.1989.tb02818

Morante, F. (2005). Applying psychoanalytic thinking in a staff support group to reflect on service change and clinical practice in a specialist psychiatric service. *Psychoanalytic Psychotherapy*, *19*(2), 103–120. https://doi.org/10.1080/02668730500114948

Morgan, D. (2014). *Integrating qualitative and quantitative methods: A pragmatic approach*. London: Sage Publications.

Morgan, H. (2008). Issues of “race” in clinical psychoanalytic psychotherapy: Whose problem is it anyway? *British Journal of Psychotherapy*, *24*(1), 34–49. https://doi.org/10.1111/j.1752-0118.2007.00062.x

Nel, P. W., Pezzolesi, C., & Stott, D. J. (2012). How did we learn best? A retrospective survey of clinical psychology training in the United Kingdom. *Journal of Clinical Psychology*, *68*(9), 1058–1073. https://doi.org/10.1002/jclp.21882

Nelson, J. (2017). Using conceptual depth criteria: Addressing the challenge of reaching saturation in qualitative research. *Qualitative Research*, *17*(5), 554–570. https://doi.org/10.1177/1468794116679873

NICE. (2009). Depression in adults: Recognition and management. Clinical Guideline [CG90]. Retrieved from https://www.nice.org.uk/guidance/cg90

NICE. (2019). Depression in children and young people: Identification and management. Clinical guideline [NG134]. Retrieved from https://www.nice.org.uk/guidance/ng134

NICE. (2020). National Institute for Health and Care Excellence (NICE): About. Retrieved from https://www.nice.org.uk/about

Nilsson, T., Svensson, M., Sandell, R., & Clinton, D. (2007). Patients’ experiences of change in cognitive-behavioral therapy and psychodynamic therapy: A qualitative comparative study. *Psychotherapy Research*, *17*(5), 553–566. https://doi.org/10.1080/10503300601139988

Norcross, J. C., Brust, A. M., & Dryden, W. (1992). British clinical psychologists: II. Survey findings and American comparison. *Clinical*

Psychology Forum, *40*, 25–29.

Norcross, J. C., & Karpiak, C. P. (2012). Clinical psychologists in the 2010s: 50 years of the APA division of clinical psychology. *Clinical Psychology: Science and Practice*, *19*(1), 1–12. https://doi.org/10.1111/j.1468-2850.2012.01269.x

Norcross, J. C., Karpiak, C. P., & Lister, K. M. (2005). What's an integrationist? A study of self-identified integrative and (occasionally) eclectic psychologists. *Journal of Clinical Psychology*, *61*(12), 1587–1594. https://doi.org/10.1002/jclp.20203

Norcross, J. C., & Prochaska, J. O. (1983). Clinicians' theoretical orientations: Selection, utilization, and efficacy. *Professional Psychology: Research and Practice*, *14*(2), 197–208. https://doi.org/10.1037/0735-7028.14.2.197

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1–13. https://doi.org/10.1177/1609406917733847

O'Loughlin, S. (2003). Attending to the patient within us. *Clinical Psychology*, *27*(7), 24–26.

O'Sullivan, K. R., & Dryden, W. (1990). A survey of clinical psychologists in the South East Thames Health Region: Activities, role and theoretical orientation. *Clinical Psychology Forum*, *29*, 21–26.

Office of National Statistics. (2019). *Measuring ethnic group, national identity and religion*. Retrieved from https://www.ons.gov.uk/methodology/classificationsandstandards/measur

ingequality/ethnicgroupnationalidentityandreligion

Paris, J. (2017). Is psychoanalysis still relevant to psychiatry? *Canadian Journal of Psychiatry*, *62*(5), 308–312. https://doi.org/10.1177/0706743717692306

Parry, G. (2000). Developing treatment choice guidelines in psychotherapy. *Journal of Mental Health*, *9*(3), 273–281. https://doi.org/10.1080/jmh.9.3.273.281

Parry, G. (2015). Psychologists as therapists: An overview. In *Clinical psychology in Britain: Historical Perspectives* (pp. 181–193). London: British Psychological Society.

Patton, M. Q. (2002). *Qualitative evaluation and research methods*. London: Sage.

Pavlov, I. P. (1927). *Conditioned reflexes: An investigation of the physiological activity of the cerebral cortex*. Oxford: Oxford University Press.

Pilgrim, D. (2017). Critical realism, psychology and the legacies of psychoanalysis. *Journal of Critical Realism*, *16*(5), 468–482. https://doi.org/10.1080/14767430.2017.1372668

Popper, K. (1963). *Conjectures and refutations: The growth of scientific knowledge*. London: Routledge.

Poston, J. M., & Bland, E. D. (2019). Not just anything goes: Psychoanalytic psychotherapy competencies in psychology doctoral programs. *Psychoanalytic Psychology*, *37*(1), 62–73. https://doi.org/10.1037/pap0000209

Poulsen, S., Lunn, S., & Sandros, C. (2010). Client experience of psychodynamic psychotherapy for bulimia nervosa: An interview study.

Psychotherapy, *47*(4), 469–483. https://doi.org/10.1037/a0021178

Price, J., & Paley, G. (2008). A grounded theory study on the effect of the therapeutic setting on NHS psychodynamic psychotherapy from the perspective of the therapist. *Psychodynamic Practice*, *14*(1), 5–25. https://doi.org/10.1080/14753630701768941

Race Relations (Amendment) Act. (2000). Retrieved from http://www.legislation.gov.uk/ukpga/2000/34/contents

Raitt, S. (2004). Early British psychoanalysis and the medico-psychological clinic. *History Workshop Journal*, *58*(1), 63–85. https://doi.org/10.1093/hwj/58.1.63

Richards, G. (2000). Britain on the couch: The popularization of psychoanalysis in Britain 1918—1940. *Science in Context*, *13*(2), 183–230. https://doi.org/10.1017/s0269889700003793

Richardson, A. (2015). The political and NHS context. In J. Hall, D. Pilgrim, & G. Turpin (Eds.), *Clinical psychology in Britain: Historical Perspectives*. London: British Psychological Society.

Rizq, R. (2014a). Perversion, neoliberalism and therapy: The audit culture in mental health services. *Psychoanalysis, Culture and Society*, *19*(2), 209–218. https://doi.org/10.1057/pcs.2014.15

Rizq, R. (2014b). Perverting the course of therapy: The fetishisation of governance in public sector mental health services. *Psychoanalytic Psychotherapy*, *28*(3), 249–266. https://doi.org/10.1080/02668734.2014.933034

Roseborough, D. J., Luptak, M., McLeod, J., & Bradshaw, W. (2013). Effectiveness of psychodynamic psychotherapy with older adults: A

longitudinal study. *Clinical Gerontologist*, *36*(1), 1–16. https://doi.org/10.1080/07317115.2012.731476

Rosenzweig, M., Holtzman, W., Sabourin, M., & Bélanger, D. (2000). *History of the International Union of Psychological Science*. UK: Psychology Press.

Roth, A., & Fonagy, P. (2006). *What works for whom? A critical review of psychotherapy research*. New York: Guilford Press.

Roth, P. L. (1994). Missing data: A conceptual review for applied psychologists. *Personnel Psychology*, *47*(3), 537–560. https://doi.org/10.1111/j.1744-6570.1994.tb01736.x

Rous, E., & Clark, A. (2009). Child psychoanalytic psychotherapy in the UK National Health Service: An historical analysis. *History of Psychiatry*, *20*(4), 442–456. https://doi.org/10.1177/0957154X08338338

Ryan, J. (2017). *Class and psychoanalysis: Landscapes of inequality*. New York: Taylor & Francis.

Ryle, A., Kellett, S., Hepple, J., & Calvert, R. (2014). Cognitive analytic therapy at 30. *Advances in Psychiatric Treatment*, *20*(4), 258–268. https://doi.org/10.1192/apt.bp.113.011817

Ryle, A., Poynton, A. M., & Brockman, B. J. (1990). *Cognitive-analytic therapy: Active participation in change: A new integration in brief psychotherapy.* New Jersey: John Wiley & Sons.

Sabbadini, A. (2018). *Boundaries and bridges: Perspectives on time and space in psychoanalysis*. New York: Routledge.

Salkovskis, P., & Wolpert, L. (2012). Does psychoanalysis have a valuable place in modern mental health services? No. *British Medical Journal*,

344(e1188). https://doi.org/10.1136/bmj.e1188

Salzer, S., Winkelbach, C., Leweke, F., Leibing, E., & Leichsenring, F. (2011). Long-term effects of short-term psychodynamic psychotherapy and cognitive-behavioural therapy in generalized anxiety disorder: 12-month follow-up. *The Canadian Journal of Psychiatry*, *56*(8), 503–508. https://doi.org/10.1177/070674371105600809

Sandelowski, M., Voils, C. I., & Knafl, G. (2009). On quantitizing. *Journal of Mixed Methods Research*, *3*(3), 208–222. https://doi.org/10.1177/1558689809334210

Schon, D. (1983). *The reflective practitioner: How practitioners think in practice*. New York: Basic Books.

Selders, M., Visser, R., van Rooij, W., Delfstra, G., & Koelen, J. A. (2015). The development of a brief group intervention (Dynamic Interpersonal Therapy) for patients with medically unexplained somatic symptoms: A pilot study. *Psychoanalytic Psychotherapy*, *29*(2), 182–198. https://doi.org/10.0.4.56/02668734.2015.1036106

Shahar, G., & Blatt, S. J. (2005). Benevolent interpersonal schemas facilitate therapeutic change: Further analysis of the Menninger Psychotherapy Research Project. *Psychotherapy Research*, *15*(3), 345–349. https://doi.org/10.1080/10503300500091488

Shaw, S. (2014). Layard, IAPT and current treatment for depression. *Psychoanalytic Psychotherapy*, *28*(4), 379–396.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *The American Psychologist*, *65*(2), 98–109. https://doi.org/10.1037/a0018378

Shepherd, C., & Beail, N. (2017). A systematic review of the effectiveness of

psychoanalysis, psychoanalytic and psychodynamic psychotherapy with adults with intellectual and developmental disabilities: Progress and challenges. *Psychoanalytic Psychotherapy*, *31*(1), 94–117. https://doi.org/10.1080/02668734.2017.1286610

Skinner, B. F. (1938). *The behavior of organisms: An experimental analysis*. New York: Appleton-Century-Crofts.

Smit, Y., Huibers, M. J. H., Ioannidis, J. P. A., Van Dyck, R., Van Tilburg, W., & Arntz, A. (2012). The effectiveness of long-term psychoanalytic psychotherapy: A meta-analysis of randomized controlled trials. *Clinical Psychology Review*, *32*(2), 81–92. https://doi.org/10.1016/j.cpr.2011.11.003

Smith, D. T. (2014). The diminished resistance to medicalization in psychiatry: Psychoanalysis meets the medical model of mental illness. *Society and Mental Health*, *4*(2), 75–91. https://doi.org/10.1177/2156869313512211

Smith, J. (2007). From base evidence through to evidence base: A consideration of the nice guidelines. *Psychoanalytic Psychotherapy*, *21*(1), 40–60. https://doi.org/10.1080/02668730601181101

Spiegel, R. (1970). Psychoanalysis—for an elite? *Contemporary Psychoanalysis*, *7*(1), 48–63. https://doi.org/10.1080/00107530.1970.10745189

Spinhoven, P., Giesen-Bloo, J., van Dyck, R., Kooiman, K., & Arntz, A. (2007). The therapeutic alliance in schema-focused therapy and transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, *75*(1), 104. https://doi.org/10.1037/0022-006X.75.1.104.

Sripada, B. (2015). Essential psychoanalysis: Toward a re-appraisal of the relationship between psychoanalysis and dynamic psychotherapy. *Psychodynamic Psychiatry*, *43*(3), 396–422. https://doi.org/10.1521/pdps.2015.43.3.396

Stern, S. (2009). Session frequency and the definition of psychoanalysis. *The International Journal of Relational Perspectives*, *19*(6), 639–655. https://doi.org/10.1080/10481880903232058

Stewart, J. (2015). Psychology in context: From the first world war to the National Health Service. In J. Hall, D. Pilgrim, & G. Turpin (Eds.), *Clinical psychology in Britain: Historical Perspectives* (pp. 39–51). UK: British Psychological Society.

Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: Replication in a larger sample. *Psychological Medicine*, *38*(5), 677–688. https://doi.org/10.1017/S0033291707001511

Strupp, H. H. (2001). Implications of the empirically supported treatment movement for psychoanalysis. *Psychoanalytic Dialogues*, *11*(4), 605–619. https://doi.org/10.1080/10481881109348631

Suchet, M. (2014). Unraveling whiteness. *Relational Psychoanalysis: Expansion of Theory*, *4*(6), 199–220. https://doi.org/10.4324/9781315787008

Summers, R. F., & Barber, J. P. (2009). *Psychodynamic therapy: A guide to evidence-based practice*. New Jersey: Guilford Press.

Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2018). The impact of

accommodating client preference in psychotherapy: A meta-analysis. *Journal of Clinical Psychology*, *74*(11), 1924–1937. https://doi.org/10.1002/jclp.22680

Szasz, T. (1961). *The myth of mental illness*. US: Harper and Row.

Taylor, D. (2008). Psychoanalytic and psychodynamic therapies for depression: The evidence base. *Advances in Psychiatric Treatment*, *14*(6), 401–413. https://doi.org/10.1192/apt.bp.107.004382

The GenIUSS Group. (2014). Best Practices for asking questions to identify transgender and other gender minority respondents on population-based surveys. *The Williams Institute*, 1–68. https://doi.org/10.1016/j.physletb.2013.10.054

Thoma, N., Pilecki, B., & McKay, D. (2015). Contemporary cognitive behavior therapy: A review of theory, history, and evidence. *Psychodynamic Psychiatry*, *43*(3), 423–462. https://doi.org/10.1521/pdps.2015.43.3.423

Thorndike, E. L. (1905). *The elements of psychology*. New York: A. G. Seiler.

Town, J. M., Abbass, A. A., & Hardy, G. (2011). Short-term psychodynamic psychotherapy for personality disorders: A critical review of randomized controlled trials. *Journal of Personality Disorders*, *25*(6), 723–740. https://doi.org/10.1521/pedi.2011.25.6.723

Tummala-Narra, P. (2013). Psychoanalytic applications in a diverse society. *Psychoanalytic Psychology*, *30*(3), 471–487. https://doi.org/10.1037/a0031375

Tummala-Narra, P. (2015). Cultural competence as a core emphasis of psychoanalytic psychotherapy. *Psychoanalytic Psychology*, *32*(2), 275–292. https://doi.org/10.1037/a0034041

UCL CORE. (2007). *Cognitive and Behavioural Therapy Competence Framework*. Retrieved from https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-2

UCL CORE. (2014). *Psychoanalytic/psychodynamic competencies framework*. Retrieved from http://www.ucl.ac.uk/clinical-psychology/competency-maps/psychodynamic-map.html

Vogt, K. S., & Norman, P. (2019). Is mentalization-based therapy effective in treating the symptoms of borderline personality disorder? A systematic review. *Psychology and Psychotherapy: Theory, Research and Practice*, *92*(4), 441–464. https://doi.org/10.1111/papt.12194

Wallerstein, R. S. (1968). The challenge of the community mental health movement to psychoanalysis. *American Journal of Psychiatry*, *124*(8), 1049–1056.

Wallerstein, R. S. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy.* New York: Guilford Press.

Wallerstein, R. S. (1989). Psychoanalysis and psychotherapy: A historical perspective. *International Journal of Psycho-Analysis*, *70*(4), 563-591+589.

Wallerstein, R. S. (2009). What kind of research in psychoanalytic science? *International Journal of Psychoanalysis*, *90*(1), 109–133. https://doi.org/10.1111/j.1745-8315.2008.00107.x

Watson, J. B. (1913). Psychology as the behaviourist views it. *Psychological Review*, *20*(158–178).

Westbrook, L., & Saperstein, A. (2015). New categories are not enough:

Rethinking the measurement of sex and gender in social surveys. *Gender and Society*, *29*(4), 534–560. https://doi.org/10.1177/0891243215584758

Widlöcher, D. (2010). Distinguishing psychoanalysis from psychotherapy. *International Journal of Psychoanalysis*, *91*(1), 45–50. https://doi.org/10.1111/j.1745-8315.2009.00233.x

Willig, C. (2013). Introducing qualitative research in psychology. *Journal of Chemical Information and Modeling*, (9), 1689–1699. https://doi.org/10.1017/CBO9781107415324.004

Winograd, M., & Davidovich, M. (2014). Freudian psychoanalysis and epistemology. Political disputes. *Recherches en Psychanalyse*, *17*(1), 73–88. https://doi.org/10.3917/rep.017.0073

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.

Wood, N., & Patel, N. (2019). On addressing 'Whiteness' during clinical psychology training. *Clinical Psychology Forum*, *323*, 31–37.

Wright, D., & Abrahams, D. (2015). An investigation into the effectiveness of Dynamic Interpersonal Therapy (DIT) as a treatment for depression and anxiety in IAPT. *Psychoanalytic Psychotherapy*, *29*(2), 160–170. https://doi.org/10.1080/02668734.2015.1035740

Wright, K. B. (2005). Researching Internet-based populations: Advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services. *Journal of Computer-Mediated Communication*, *10*(3). https://doi.org/10.1111/j.1083-6101.2005.tb00259.x

Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-*

focused approach. US: Professional Resource Press/Professional Resource Exchange.

Yule, W. (2015). Clinical psychology at the Institute of Psychiatry and the Maudsley Hospital: The early years. In J. Hall, D. Pilgrim, & G. Turpin (Eds.), *Clinical psychology in Britain: Historical Perspectives*. UK: British Psychological Society.

7. APPENDICES

Appendix A – Results of Pilot Scoping Literature Search

The results of a pilot scoping review of the literature using terms such as (psychoanalysis OR psychotherapeutic techniques OR psychodynamic psychotherapy) AND clinical psychology* returns 53,926 articles from PsychInfo, CINAHL plus, Academic Search Complete and Psychoanalytic Electronic Publishing website together. Narrowing the search using NHS put in Britain/ UK narrows the search down to 8,709, most of which were of low relevance.

The search terms used in the pilot scoping review were informed by the research question and the subject terms of each database. It must be noted that the searches below were part of a pilot scoping search rather than a full and complete review in themselves.

		Number of search results
Database	PsychInfo	
Date of Search	31.01.2020	
Exclusion criteria	Full text not available	
Inclusion criteria	English language Human based	
Search terms	(psychoanalysis OR psychodynamic psychotherapy OR psychotherapeutic techniques) AND (clinical psycholog*)	5, 174
	(psychoanalysis OR psychodynamic	1,042

	psychotherapy OR psychotherapeutic techniques) AND (clinical psycholog*) AND (NHS OR Britain OR UK)	

		Number of search results
Database	Academic Search Complete	
Date of Search	31.01.2020	
Exclusion criteria	Full text not available	
Inclusion criteria	English language Human based	
Search terms	(psychoanalysis OR psychodynamic psychotherapy) AND (clinical psycholog*)	18,395
	(psychoanalysis OR psychodynamic psychotherapy) AND (clinical psycholog*) AND (NHS OR UK OR Britain)	4,390

		Number of search results
Database	CINAHL Plus	
Date of Search	31.01.2020	
Exclusion criteria	Full text not available	
Inclusion criteria	English language Human based	
Search terms	(psychoanalysis OR psychodynamic psychotherapy) AND (clinical psycholog*)	2,586
	(psychoanalysis OR psychodynamic psychotherapy) AND (clinical psycholog*) AND (NHS OR UK OR Britain)	1,058

		Number of search results
Database	Psychoanalytic Electronic Publishing	
Date of Search	31.01.2020	
Exclusion criteria	Full text not available	
Inclusion criteria	English language Human based	
Search terms	(psychoanalysis OR psychodynamic psychotherapy) AND (clinical psycholog*)	27,771
	(psychoanalysis OR psychodynamic psychotherapy) AND (clinical psycholog*) AND (NHS OR UK OR Britain)	2,219

Appendix B – Search Terms Used For or In the Narrative Review

Information about the search strategy used as part of the narrative review is presented below. The Scale for the Assessment of Narrative Review Articles (SANRA) guidelines (Baethage, Goldbeck-Wood & Mertens, 2019) suggests that a brief description of the search strategy of a narrative review is necessary to ensure a quality narrative review (Baethage et al., 2019). Below the search terms, databases and inclusion criteria of articles is listed.

Inclusion and exclusion criteria

The criteria are purposefully broad in order to capture as great a selection of papers as possible.

Inclusion criteria:

- Studies that included the search terms below

Exclusion criteria:

- Studies not written in English
- No abstract or full text available
- Poetry, fiction or artistic literature

Databases Used

In all of the following searches, the following databases were used:

- PsychInfo: For psychological literature
- Academic Search Complete: For multi-disciplinary scholarly research
- CINAHL: For allied health literature

- Psychoanalytic electronic publishing: For psychoanalytic literature and research
- Pubmed: For health and biomedical literature
- Google Scholar: Search engine and database for scholarly literature

Search terms used

The following list the search terms used for each subtopic covered in the introduction. In bold are the names of the subheading, and the following box includes the search terms used. The search terms were used together, linked by the Boolean operators 'AND' and 'OR'.

Defining psychoanalytic and psychodynamic approaches

Defin*, explain, explanation, clar*
Psychoanalys*, psychodynam*

History of psychoanalysis and clinical psychology in the UK

Psychoanalys*, psychodynam*
Clinical psycholog*
History, development, growth
UK, United Kingdom, Great Britain, Britain, G.B.

Psychoanalysis, clinical psychology and empiricism in the UK

Psychoanalys*, psychodynam*
Clinical psycholog*
UK, United Kingdom, Great Britain, Britain, G.B.
Empiric*, positiv*, experiment*, NICE, scienc*, research

Psychoanalysis, clinical psychology and behaviourism

Psychoanalys*, psychodynam*
Clinical psycholog*
Behaviouris*, behaviour*, behavioural therap*, behaviour therap*

Psychoanalysis, clinical psychology and cognitive psychology

Psychoanalys*, psychodynam*
Clinical psycholog*
Cognitiv*, cognitive-behaviour*, CBT, cognitive therap*

Psychoanalysis, clinical psychology and the NHS

Psychoanalys*, psychodynam*
Clinical psycholog*
NHS, National Health Service

Psychoanalysis and neoliberalism

Psychoanalys*, psychodynam*
Clinical psycholog*
Neoliberal*

Current use of psychoanalysis with clinical psychology in the NHS

Psychoanalys*, psychodynam*
Clinical psycholog*
NHS, National Health Service
Current*, present*, use, utility, today

Empirical support for psychoanalytic approaches

Psychoanalys*, psychodynam*, psychotherap*, long term, LTPP, short term, STPP, manual*
Efficacy, effective*, empiricial, RCT, randomized controlled trial, RCT, meta-analy*, review, systematic, overview, outcome, evaluat*, evidence, research

Service user and clinician views of psychoanalytic approaches

Psychoanalys*, psychodynam*
Clinical psycholog*, clinician, therap*, psychotherap*, psychoanalyst
View*, experience*, attitude*, qualitative, perspective, phenomenolog*

Service user views of psychoanalytic approaches

Psychoanalys*, psychodynam*
Service user*, client*, patient*, survivor*
View*, experience*, attitude*, qualitative, perspective, phenomenolog*

Appendix C – Ethics Application Form

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH
FOR MSc/MA RESEARCH
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

If you need to apply for ethical clearance from HRA (through IRIS) for research involving the NHS you DO NOT need to apply to the School of Psychology for ethical clearance also. Please see details on
https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/NHS-Research-Ethics-Committees.aspx

Among other things this site will tell you about UEL sponsorship

PLEASE NOTE that HRA approval for research involving NHS employees is not required when data collection will take place off NHS premises and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

If you are employed by the NHS and plan to recruit participants from the NHS Trust you work for, it please seek permission from an appropriate person at your place of work (and better to collect data off NHS premises).

PLEASE NOTE that the School Research Ethics Committee does not recommend BSc and MSc/MA students designing research that requires HRA approval for research involving the NHS as this can be a demanding and lengthy process.

Before completing this application please familiarise yourself with:

The *Code of Ethics and Conduct (2018)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website
https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

And please also see the UEL Code of Practice for Research Ethics (2015-16)
https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Documents/Ethics%2

0forms/UEL-Code-of-Practice-for-Research-Ethics-2015-16.pdf

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.

2. Type your name in the 'student's signature' section (5.1).

3. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc**

4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. Your supervisor will then look over your application.

5. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' (section 5) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

6. Your supervisor should let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See section 4)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the participant invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.
3. A copy of the debrief letter you intend to give participants.

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

- Example of the kinds of interview questions you intend to ask participants.

- Copies of the visual material(s) you intend showing participants.

- A copy of ethical clearance or permission from an external institution or organisation if you need it (e.g. a charity, school, local authority, workplace etc.). Permissions must be attached to this application. If you require ethical clearance from an external organisation your ethics application can be submitted to the School of Psychology before ethical

approval is obtained from another organisation (see Section 5).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. If you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice.

- DBS clearance is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 5 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

  If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Tim Lomas (Chair of the School Research Ethics Committee) at t.lomas@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see Section 5 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another for the duration of your studies in order to conduct research with vulnerable populations.

Please read all guidance notes in blue carefully to avoid incorrect or insufficient applications

If yours is an online study using Qualtrics please see the example ethics application in the Ethics folder in the Psychology Noticeboard

SECTION 1. Your details

1. **Your name**: Grainne Fleming

2. **Your supervisor's name**: Dr. Nick Wood

3. **Title of your programme**: Professional Doctorate in Clinical Psychology (DClinPsych)

4. **Submission date for your BSc/MSc/MA research:** May 2020

5. **Please tick if your application includes a copy of a DBS certificate (see page 3)** ☐

6. **Please tick if your research requires DBS clearance but you are a Prof Doc student and have applied for DBS clearance – or had existing clearance verified – when you registered on your programme (see page 3)** ☐

7. **Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Tim Lomas for confidentiality reasons (Chair of the School Research Ethics Committee) t.lomas@uel.ac.uk** ☐

8. **Please tick to confirm that you have read and understood the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics** (See links on page 1) ☑

SECTION 2. About your research

9. What your proposed research is about:

Title: Clinical psychologists' usage and experiences of psychoanalysis and psychoanalytically-informed approaches within the NHS.

There has been a reduction in the use of psychoanalytic and psychodynamic approaches over other modalities within clinical psychology, evidenced by the reduction in clinical psychology faculty members and clinicians primarily utilising this approach and publication rates of psychodynamic writings. This is significant given the commitment of clinical psychologists to offering a diversity of approaches, the research supporting its effectiveness and service user support for this model. This research will investigate the proportions that primarily use this approach relative to others within the UK, and the qualitative experiences of clinical psychologists within these contexts. The study will use an online questionnaire which will be distributed to clinical psychologists working within the NHS across the UK. There will be an option to opt-in to a voluntary interview, and from this, between 8 and 12 clinicians will be interviewed. Transcripts will be analysed using thematic analysis to identify themes. It is hoped this research will identify the proportion that use this approach relative to other models, and identify what might be useful about the approach as well as any service factors that influence its implementation if appropriate.

This research aims to address the following question, with the following subquestions;

- What is the current use of psychoanalytic or psychoanalytically- informed approaches within clinical psychology within the NHS and what are their experiences of working within this approach?
    - Is the proportion of clinical psychologists primarily using psychoanalytic or psychoanalytically-informed approaches within the NHS less than those using other modalities?
    - Do the characteristics of the clinical psychologists influence the type of approach used?
    - Do the characteristics of the service and client group influence the approach used?
    - How do clinicians describe working within a psychoanalytic or psychoanalytically informed psychodynamic approach?

10. Design of the research:

The study will use a mixed methods quantitative and qualitative approach. A survey will be constructed and sent to clinical psychologists working in the NHS through social and professional networks, such as online forums, other relevant online communities and professional organisations. Key figures in these communities (e.g. forum administrators) will be contacted prior to distribution

to gain the required permission to distribute the web link. In the survey, respondents will have the option to opt in to be contacted about an interview. As many clinical psychologists as possible will be recruited. Eight to twelve clinical psychologists will be interviewed. Interviews will be transcribed by the researcher. Thematic analysis will be used to analyse the data through identifying themes.

10. Recruitment and participants (Your sample):

The survey will be distributed through online social and professional networks, networks of the researcher and professional clinical psychology networks such as the BPS. There will be an option to opt in to an hour-long interview within the survey. Eight to twelve clinical psychologists who opt in will be interviewed. Participants will need to have completed a professional training course in clinical psychology. There are no other requirements in terms of age, gender or other demographics in order to ensure a potentially diverse pool of participants and experiences.

11. Measures, materials or equipment:

A survey and interview schedule will be constructed. Survey questions will ask about what modalities are primarily used by the clinician. Contextual information about the clinician and type of service will also be gathered. Interview questions will ask about the experiences of clinical psychologists using psychoanalytic or psychoanalytically-informed approaches within the NHS, potential barriers to practice, how their experience of working in this way has changed over time and the utility of the approach. A sample survey and interview schedule has been completed and attached. Interview recording equipment, online survey tools and transcribing equipment are all accessible to the researcher.

12. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

NA

13. Outline the data collection procedure involved in your research:

Firstly, relevant administrators of professional networks and online communities will be contacted to gain the required permission, as well as researching the respective policies on research of each network. The link to the survey (developed in the Qualitrics software package) will then be posted or sent through email through these networks, depending on the research policy of the network. Through clicking on the link, individuals will be able to access the information relating to the aims of the study, questions about consent, and the survey questions. The survey should take about 5 minutes to complete. There

will be an option to opt-in to be contacted about participating in an interview within the survey. Once sufficient data is collected, the survey will be closed, and data transferred to SPSS for subsequent coding and analysis. A request will be placed with Qualtrics for deletion of the survey data from their server. The interviews will be mainly be conducted by skype or telephone, on UEL campus, or at another time and place convenient to the participant which doesn't pose a risk to interviewer or interviewee. All potential participants will be provided with an information sheet that will give information about confidentiality, consent, how their data will be managed and their right to withdraw or not answer any questions they choose. They will be asked to sign a consent form.

SECTION 3. Ethical considerations

14. Fully informing participants about the research (and parents/guardians if necessary):

Participants will be fully informed about the research and what is involved through an online information sheet that will be available before completing the survey. Participants who opt in to be interviewed will be provided with a more detailed participant information sheet about the interview process. Questions about the interview and process will be invited at the time that the interviews are being arranged, and also before the interview takes place.

15. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

The study will use a consent sheet tailored towards an online study, which participants will be asked to complete before starting the survey. The form will be broken down into statements with a check box next to each statement, participants will simply add a tick/cross to each respective box to signal their consent. Consent forms will be written clearly, and will be provided to participants. All participants will be aged over 18 given the length of the qualifications necessary to be included within the research study and so consent is not required from parents or guardians.

16. Engaging in deception, if relevant:

There will be no deception required, and participants will be fully informed about the nature of the research before they take part.

17. Right of withdrawal:

Participants will be informed of their withdrawal rights on the online participant

information sheet and consent form, and on the participant information sheet given before the interview. Survey participants can exit the survey to withdraw at any time during it. Exiting from the survey still allows data up until that point to be stored, and participants will be notified of this. Once the survey data is submitted however, they may not be able to withdraw their data as the majority will be anonymised, unless they choose to leave their contact details. Regarding their interview data, they will be informed on the information sheet and verbally before the interview that they have a three-week window within which they can withdraw their interview information from the research study.

18. Will the data be gathered anonymously?

Some information in the survey will be anonymous as participants do not need to leave their name or contact details unless they wish to do so. However, there will be some information in the survey questions that might potentially identify participants, for example, the type of service that they work within, their training, and some demographic information. The interview will not be anonymous as it will be carried out face-to-face or over the phone.

19. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

Data collected for the survey will be anonymous, unless the participant chooses to leave their name and contact details at the end in order to participate in the interviews. The data received from the online study is stored on Qualtric's server within the EU, and thus is subject to the EU data protection act. Only the researcher has access to the final anonymised data set. When the study is completed all online measures will be promptly removed from the internet. Qualitrics will be contacted at the completion of the study to delete the survey data from its servers.

The anonymised survey results, and any names and the contact details of participants will be stored in a password-protected file on the hard drive of the researcher, and will be backed up on a password protected file on an external harddrive. The survey results will be kept in a separate file to the names and details of interviewees. Only the researcher will have access to these. Interviews will be recorded on a password-protected device, and transferred immediately to a password-protected file on the hard drive of the researcher, where the subsequent transcriptions will also be kept. At this point, the data on the recorder will be destroyed. All names and identifying information will be removed from the interview transcripts, and the transcripts will be coded. The participant codes will be linked to participant identities in a separate file. This file will be kept separately to the contact details of interviewees. Only the researcher, the supervisor and the examiner will have access to the transcriptions, and then only if necessary. The names and contact details of the participants will be destroyed at the end of the study. Raw data (coded survey responses and interview transcripts) will be kept on the password- protected hard drive and backed up again on a password protected hard drive for three years after completion of the study to allow for publication.

20. Will participants be paid or reimbursed?

NO

If YES, why is payment/reimbursement necessary and how much will the vouchers be worth?

N/A

SECTION 4. Other permissions and ethical clearances

21. Research involving the NHS in England

Is HRA approval for research involving the NHS required?

No, HRA approval is not required for this study. If it is difficult to recruit as planned through the means detailed in this ethics form, it will be considered whether to recruit through the NHS. In that case HRA approval will be applied for.

Will the research involve NHS employees who will not be directly recruited through the NHS and where data from NHS employees will not be collected on NHS premises?

YES

If you work for an NHS Trust and plan to recruit colleagues from the Trust will permission from an appropriate member of staff at the Trust be sought and is a copy of this permission (can be an email from the Trust) attached to this application?

NA

22. Permission(s) from an external institution/organisation (e.g. a school, charity, workplace, local authority, care home etc.)?

Is permission from an external institution/organisation/workplace required? NO

If YES please give the name and address of the institution/organisation/workplace:

COPIES OF PERMISSIONS (LETTER OR EMAIL) MUST BE ATTACHED TO THIS APPLICATION

In some cases you may be required to have formal ethical clearance from the external institution or organisation or workplace too.

23. Is ethical clearance required from any other ethics committee?

NO

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? N/A

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation confirming its ethical clearance is acceptable.

SECTION 5. Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible.

If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

24. Protection of participants:

There is no risk of physical harm coming to potential participants directly because of their participation. It is not expected that emotional or psychological harm will come to participants, but information about appropriate support services will be provided to participants should they feel they need extra support as a result of anything discussed during the interviews.

25. Protection of the researcher:

A third party will be told where and when the interviews are being held and the researcher will make contact before and after these times to ensure safety. There are no other health and safety risks to the researcher.

26. Debriefing participants:

The research does not involve deception. However, a debrief letter will be included at the end of the survey and interview.

27. Other: NO

28. Will your research involve working with children or vulnerable adults?* NO

If YES have you obtained and attached a DBS certificate?
N/A

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

N/A

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see:

https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/Research-involving-children.aspx

29 Will you be collecting data overseas? NO

If YES in what country or countries (and province if appropriate) will you be collecting data? N/A

Please click on this link https://www.gov.uk/foreign-travel-advice and note in the space below what the UK Government is recommending about travel to that country/province (Please note that you MUST NOT travel to a country/province/area that is deemed to be high risk or where essential travel only is recommended by the UK Government. If you are unsure it is essential that you speak to your supervisor or the UEL Travel Office – travelúel.ac.uk / (0)20 8223 6801).

SECTION 6. Declarations

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Grainne Fleming

Student's number: U1725779 Date: April 23rd, 2019

Supervisor's declaration of support is given upon their electronic submission of the application

YOU MUST ATTACH THESE ATTACHMENTS:

1. PARTICIPANT INVITATION LETTER(S)

See pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This can be adapted for your own use and must be adapted for use with parents/guardians and children if they are to be involved in your study.

Care should be taken when drafting a participant invitation letter. It is important that your participant invitation letter fully informs potential participants about what you are asking them to do and what participation in your study will involve – what data will be collected, how, where? What will happen to the data after the study is over? Will anonymised data be used in the write-up of the study, or at conferences or in possible publications etc.? Tell participants about how you will protect their anonymity and confidentiality and about their withdrawal rights.

Make sure that what you tell potential participants in this invitation letter matches up with what you have said in the application.

2. CONSENT FORM(S)

Use the pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This should be adapted for use with parents/guardians and children.

3. PARTICIPANT DEBRIEF SHEET

This can be one or two paragraphs thanking participants, reminding them what will happen to their data and, if relevant, should include the contact details of a relevant agency or organisation that participants can contact for support if necessary. Should include the true nature of the study if your research involved deception.

OTHER ATTACHMENTS YOU MAY NEED TO INCLUDE:

See notes on Page 2 about what other attachments you may need to include – Example interview questions? Copies of questionnaires? Visual stimuli? Ethical clearance or permission from another institution or organisation? Current DBS clearance certificate?)

SCANNED COPY OF CURRENT DBS CERTIFICATE
(If one is required. See notes on Page 3)

Appendix D – Ethical Approval Letter

UNIVERSITY OF EAST LONDON
School of Psychology

SCHOOL OF PSYCHOLOGY RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

REVIEWER: Sonya Dineva

SUPERVISOR: **Nicholas Wood**

STUDENT: Grainne Fleming

Course: Professional Doctorate in Clinical Psychology

Title of proposed study:

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments required *(for reviewer)*:

Please reconsider and amend or clarify the following:
- You will be aiming at recruiting as many participants for your survey as possible but what is the minimum number of participants that will be required from you to stop collecting data and start analysing it?
- The code used to identify the participants may pose threats to their anonymity so please think about applying another way to generate codes.
- Will the participants who complete the survey only be allowed to a 3-week window to withdraw their data or does it refer only to the ones participating in the interview and those completing the survey only will be able to withdraw the data at any time? Please also be very clear about that in the consent form and replace "the researcher reserves the right to use my anonymous data after analysis of the data has begun" with a specific deadline (e.g. 3 weeks after survey completion).
- Data storage – please consider storing participants' names and contact details separately from the research results (as you have mentioned in the information sheet in the appendices).
- Please see below for some recommendations related to your own safety and well-being as a researcher.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Gráinne Fleming
Student number: 1725779

Date: 29th August, 2019

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

Reviewer comments in relation to researcher risk (if any).

- Please reconsider the following statement "The interview will be conducted at a time and place convenient to the participant, or over telephone or skype call" as it may pose threats to your own safety should the participants ask you to hold the interviews at their homes or to participants' anonymity should they ask you to do the interviews in their workplaces.

- There may be some risks to your online identity as you will be in touch with many people so please think about using your UEL email address only and not revealing your personal contact details to your participants.

Reviewer *(Typed name to act as signature)*: Sonya Dineva

Date: 30 April 2019

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix E – Ethical Approval of Amendment Letter

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. t.lomas@uel.ac.uk).

HOW TO COMPLETE & SUBMIT THE REQUEST

7. Complete the request form electronically and accurately.
8. Type your name in the 'student's signature' section (page 2).
9. When submitting this request form, ensure that all necessary documents are attached (see below).
10. Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at t.lomas@uel.ac.uk
11. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
12. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

4. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
5. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
6. A copy of the approval of your initial ethics application.

Name of applicant:	Gráinne Fleming
Programme of study:	Professional Doctorate in Clinical Psychology (DClinPsych)
Title of research:	Clinical psychologists' usage and experiences of psychoanalysis and psychoanalytically-informed approaches within the NHS.
Name of supervisor:	Dr. Nick Wood

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	**Rationale**
Change of Title to: Clinical psychologists' usage and experiences of psychoanalysis and psychoanalytically-informed approaches within the NHS.	This title clarifies that the research study will explore the usage and experiences of clinical psychologists in both psychoanalysis and psychoanalytically-informed approaches. Additionally, the previous ethics form did not specify the title so an amendment is needed to ensure this is clear.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	Yes	

Student's signature (please type your name): Gráinne Fleming

Date: 17 February 2020

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Tim Lomas

Date: 18.2.20

Appendix F – Participant Information Sheet for Survey

PARTICIPANT INFORMATION SHEET

You are being invited to participate in a research study. Please read the following information before deciding to take part.

Who am I?

I am a trainee clinical psychologist in the University of East London and I am conducting this research as part of my studies.

What is the research?

I am conducting research into the use of psychoanalytic and psychoanalytically-informed approaches within the NHS by clinical psychologists. My research has been approved by the School of Psychology Research Ethics Committee, and so adheres to the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been asked to participate because I am interested in the experiences of clinical psychologists about using psychoanalytic and psychoanalytically-informed approaches who are currently working within the NHS. You are quite free to decide whether to participate.

What will your participation involve?

You will be asked to complete a short survey that takes about 5 minutes. Questions will ask about whether you use the psychodynamic approach and a little background information about you and the service you work within.

Within the survey, you can opt in to be contacted about a follow up interview to ask you more about your experiences of psychoanalytic and psychoanalytically-informed practice within the NHS. This is completely optional. The interview would take approximately one hour either face-to-face, or over telephone or Skype.

I unfortunately will not be able to pay you for your participation, although your time and contribution would be much appreciated and valued.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. The online version of this questionnaire has been constructed as an anonymous survey, meaning no emails, IP

addresses and/or geolocation data will be identified in the responses. HTTPS survey links (also known as secure survey links) have been used, giving Secure Sockets Layer (SSL) Encryption while a questionnaire is being completed. During the study data collected online will be stored on an EU-based server and will be subject to EU Data Protection acts.

However, the only time I may have to break this confidentiality, is if I think there is a risk of harm to you or others from what you have said. However, if I do need to notify someone, I will try to discuss this with you first.

What will happen to the information that you provide?

The information from the survey will be anonymous and I will ensure that this anonymised information is stored safely and securely in a password-protected file, which only I will have access to. If you choose to leave your name and contact details, this will be stored separately in a password-protected file which only I will have access to. This will be deleted when the study has been completed.

The anonymised data will be seen by myself, my supervisor and the examiners, and the data may also be used in subsequent publications. However, no one will be able to identify you from what will be written. I will keep coded survey responses and interview transcripts for three years until publication in a password-protected file.

What if you want to withdraw?

You are free to exit the survey at any time during it. After submitting your answers to the survey, they cannot be withdrawn as they will be anonymous. Regarding the interview, you are free to withdraw from the research study at any time up to three weeks after the interview has been completed.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me. If you feel distressed by any of the topics discussed, there is some information about support services that you are welcome to contact provided at the bottom of this page.

Grainne Fleming
Trainee Clinical Psychologist, University of East London
Email: u1725779@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr. Nick Wood, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: n.wood@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email: t.lomas@uel.ac.uk)

Support Services:

Samaritans
Website: https://www.samaritans.org
Tel: 116 123
Email: jo@samaritans.org

Mind
Website: www.mind.org.uk
Tel: 0300 123 3393 (9am-6pm Monday to Friday) or text 86463
Email: info@mind.org.uk

Rethink Mental Illness Advice Line
Website: http://www.rethink.org/about-us/our-mental-health-advice
Telephone: 0300 5000 927 (9.30am - 4pm Monday to Friday)
Email: online contact form

Appendix G – Consent Form for Survey

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Clinical psychologists' usage and experiences of psychoanalysis and psychoanalytically-informed approaches within the NHS.

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

Please tick box ☐

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

Please tick box ☐

I hereby freely and fully consent to participate in the study which has been fully explained to me.

Please tick box ☐

Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Please tick box ☐

By only ticking all of the above boxes can this be taken as consent to participant in the research study.

Appendix H – Participant Information Sheet for Interview

PARTICIPANT INFORMATION SHEET

You are being invited to participate in a research study. Please read the following information before deciding to take part.

Who am I?

I am a trainee clinical psychologist in the University of East London. I am conducting this research as part of my studies.

What is the research?

I am conducting research into the use of psychoanalytic and psychoanalytically-informed approaches within the NHS by clinical psychologists. My research has been approved by the School of Psychology Research Ethics Committee, and so adheres to the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate because I am interested in the experiences of clinical psychologists about using psychoanalytic and psychoanalytically-informed approaches who are currently working within the NHS. The interview aims to gain a deeper understanding of these experiences in addition to the survey data you previously provided. You are quite free to decide whether to participate.

What will your participation involve?

Participation will involve an interview lasting approximately one hour. This will take place either face-to-face, or by telephone or Skype. The interview will ask about your experiences of working as a psychoanalytic or psychoanalytically-informed clinical psychologist within the NHS. I will record the interviews with an audio recorder so that I can present what you said accurately in the research.

I unfortunately will not be able to pay you for your participation, although your time and contribution would be much appreciated and valued.

Your taking part will be safe and confidential

If you choose to take part in the interview, I will ensure that your name or any details that might identify you are not included in the write up after the interview, which includes the thesis or any resulting presentations, papers or publications.

However, the only time I may have to break this confidentiality, is if I think there is a risk of harm to you or others from what you have said. However, if I do need to notify someone, I will try to discuss this with you first.

If at any point you don't want to answer a question, that is fine, we can either move on, or you can withdraw from participating at any time.

What will happen to the information that you provide?

The interview will be transcribed and assigned a code or pseudonym. A document linking your name to the pseudonym will be stored separately and password protected, a file linking your name to your contact details will be stored separately again, and also password protected. Names and contact details will be deleted after the project has been completed.

The anonymised data will be seen by myself, my supervisor and the examiners, and the data may also be used in subsequent publications. However, no one will be able to identify you from what will be written. I will keep coded survey responses and interview transcripts for three years until publication in a password-protected file.

What if you want to withdraw?

You are free to withdraw your interview data from the research study at any time up to three weeks after the completion of the interview.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me. If you feel distressed by any of the topics discussed, there is some information about support services that you are welcome to contact provided at the bottom of this page.

Grainne Fleming
Trainee Clinical Psychologist, University of East London
Email: u1725779@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr. Nick Wood, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: n.wood@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.
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Email: jo@samaritans.org

Mind
Website: www.mind.org.uk
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Email: info@mind.org.uk

Rethink Mental Illness Advice Line
Website: http://www.rethink.org/about-us/our-mental-health-advice
Telephone: 0300 5000 927 (9.30am - 4pm Monday to Friday)
Email: online contact form

Appendix I – Consent Form for Interview

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Clinical psychologists' usage and experiences of psychoanalysis and psychoanalytically-informed approaches within the NHS.

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

Date: ……..……

Appendix J – Debriefing Form

UNIVERSITY OF EAST LONDON

Debriefing Sheet

Thank you for participating in this research. Your time and contribution is valued and appreciated.

I would like to remind you that your data will be stored safely and securely, and any information that you gave that will be written up either in the thesis or subsequent published work will be done anonymously. This means that your name or any identifying information will not be included. Also, if, for any reason you would like to withdraw from the study, you can do this within three weeks of the interview completion. After this, your data may be included in the final write up, although with all identifying information removed.

If you would like to discuss any of the issues that arose further, or if you feel distressed by any of the topics discussed, there is some information about support services that you are welcome to contact provided at the bottom of this page.

Thank you again for taking part in this research, it is much appreciated.

Grainne Fleming
Trainee Clinical Psychologist
University of East London
Email: u1725779@uel.ac.uk

Dr. Nick Wood
Research Supervisor
University of East London
Email: n.wood@uel.ac.uk

Support Services:

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Website: https://www.samaritans.org
Tel: 116 123
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Rethink Mental Illness Advice Line
Website: http://www.rethink.org/about-us/our-mental-health-advice
Telephone: 0300 5000 927 (9.30am - 4pm Monday to Friday)
Email: online contact form

Appendix K – Survey and Post-Pilot Adjustments Made

This is the final survey that was distributed to participants. Feedback from the pilot was used to construct it. Adjustments made as a result of the pilot are noted in the footnotes.

Q1 What age are you? Dropdown list: 21-100

Q2 What sex were you assigned at birth? Male, Female

Q3 What gender do you currently identify with? Male, Female, Transgender, Prefer not to disclose, other

Q4 How would you describe your national identity? English, Welsh, Scottish, Northern Irish, British, Other

Q5 What option best describes your ethnic group? White/White British, Black/African/Caribbean/Black British, Mixed/multiple ethnic groups, Asian/Asian British, Other ethnic group

Q6 Where did you complete your clinical psychology professional training course? UK, Other Country

If they answer UK to Question 6:

Q7 In what institution in the UK did you complete your clinical training? Bangor Bath, Belfast (Queen's) Birmingham Coventry and Warwick East Anglia East London Edinburgh Essex Exeter Glasgow Hertfordshire Hull Institute of Psychiatry, Pychology and Neuroscience Lancaster Leeds Leicester Liverpool Manchester Newcastle North Thames (UCL) Oxford Plymouth Royal Holloway Salomons (Canterbury) Sheffield Southampton South Wales (Cardiff)

Q8 What year did you complete your clinical psychology professional training course? Dropdown list of years: 1960-2019

Q9 How many years clinical experience do you have since completing your clinical training? Dropdown list 1-80

Q10 In what country do you currently work?

England/Wales/Scotland/Other

Q11 Are you currently employed in the NHS? Yes/No

Q12 Within what type of service setting do you work? Primary Care: GP Service, Primary Care: IAPT Service, Secondary Care: Inpatient Acute Ward, Secondary Care: Long Term Ward, Secondary Care: Community Team, Crisis Resolution or Home Treatment Team, Tertiary: National or Specialist Service, Other

Q13 What client group do you mainly work with? Child and Adolescent, Adult, Older Adult

Q14 What particular needs do your clients have? Common mental health problems (e.g. anxiety, depression), Learning Disability, Serious and enduring mental health problems, Health-related problems, Substance abuse, Neuropsychological problems, Early Intervention in Psychosis, Eating Disorders, Forensic, Personality Disorders, Looked After Children, Neurodevelopmental, Not applicable, Other

Q15 What theoretical approaches do you use in your work?[1] Please rank four of these seven options in the order that you most utilise them by putting the numbers 1 to 4 in the box adjacent to the relevant approach. Please do not enter the same number twice.

1 = most utilised approach

2 = second most utilised approach

[1] It was advised to include the above explanation underneath the question. It was also suggested to provide the numbers that participants should use and what these would indicate below the question.

3 = third most utilised approach

4 = fourth most utilised approach

_____**Psychoanalytic/psychodynamic approaches:** Therapies of any length and duration that draw on psychoanalytic ideas, including psychodynamically informed approaches. *Includes mentalisation based therapy, dynamic interpersonal therapy, transference focused psychotherapy, interpersonal group psychotherapy, panic focused psychodynamic psychotherapy, supportive-expressive therapy, psychodynamic interpersonal therapy.*

_____**Behavioural approaches:** Therapies based on learning principles that suggest more helpful patterns of behaviour can be learnt. *Includes exposure therapy and behavioural activation, functional analysis, applied behavioural analysis, functional analytic psychotherapy, integrative behavioural couples therapy.*

_____**Cognitive-Behavioural approaches:** Therapies directed towards solving current problems by modifying unhelpful thoughts and behaviours. *Includes rational emotive behaviour therapy, problem-solving therapy, cognitive behaviour modification, schema therapy, cognitive therapy, DBT.*

_____**Third Wave approaches:** Therapies which suggest distress is associated with how we relate to our thoughts and emotions and contain elements of mindfulness and acceptance. *Includes approaches such as ACT, MBCT, CFT,*[2] *meta-cognitive therapy, mindfulness.*

[2] It was advised to include CFT under third wave approaches.

_____**Systemic approaches:** Approaches that suggest that problems are interpersonal and works primarily with families and systems. *Includes family therapy, multidimensional family therapy, multisystemic therapy, brief strategic family therapy, systemic couples therapy, MRI brief therapy, solution-focused therapy, externalising approaches, narrative, open dialogue, attachment-based family therapy, attachment narrative therapy, multiple group family therapy, cognitive-behavioural family therapy.*

_____**Humanistic/Existential/Experiential approaches:** These approaches focus on human potential for growth and self-actualisation. *Includes gestalt, Rogerian, phenomenological and person-centred approaches.*

_____**Other approach** (please specify)

Q16 How frequently do you use this primary theoretical orientation in your work? Never, Seldom, Occasionally, Often, Repeatedly/Always

Q17 By what is your choice of theoretical orientation primarily driven?[3] Service requirements, Own preference (based on values, training, clinical experience etc), Service user preference, Other

[3] It was suggested to include this question to explore what primarily drives choice of theoretical orientation, and include an open-ended "other" option.

Q18 Does your service have a preferred or recommended treatment modality?[4] Yes, No

If answer yes to Q18:

Q19 What is the preferred or recommended treatment modality of your service? Psychoanalytic/psychodynamic approaches, Behavioural approach, Cognitive-behavioural approaches, Third Wave approaches, Systemic approaches, Humanistic/existential/experiential approaches, Other (please specify)

Q20 What is your own personal preferred choice of theoretical orientation? Psychoanalytic/psychodynamic approaches, Behavioural approach, Cognitive-behavioural approaches, Third Wave approaches, Systemic approaches, Humanistic/existential/experiential approaches, Other (please specify)

Q21 Please rank order these professional activities in the order of how much you engage in them by placing the numbers 1 to 6 in the box adjacent to the activity. Please do not enter the same number twice.

1 = you spend the most time at this activity

2

[4] It was suggested to include this question again to explore what primarily drives choice of theoretical orientation.

3

4

5

6 = you spend the least time at this activity

_____ Assessment

_____ Therapy

_____ Supervision

_____ Research/writing

_____ Administration

_____ Consultation

Q22 In what format do you mainly engage in therapy with clients?

Individual therapy, Group therapy, Couples therapy, Family therapy, Other

Q23 Have you done further training in any theoretical orientation? Yes, No

If Q23 Answer is Yes:

Q24 In which theoretical orientation have you undertaken further training? Please select all that apply[5]. Psychoanalytic/psychodynamic approaches, Behavioural approach, Cognitive-behavioural approaches,

[5] It was suggested to allow participants select all modalities within which they completed further training, as some people complete training in more than one modality.

Third Wave approaches, Systemic approaches, Humanistic/existential/experiential approaches, Other

Q25 Please rank order the different approaches in terms of how available further training is, in your experience, by placing the numbers 1 to 6 in the adjacent boxes. Please do not enter the same number twice.

1 = further training is most available in this approach

2

3

4

5

6 = further training is least available in this approach

_____ Psychoanalytic/psychodynamic approaches

_____ Behavioural approach

_____ Cognitive-behavioural approaches

_____ Third Wave approaches

_____ Systemic approaches

_____ Humanistic/existent

Appendix L – Semi-Structured Interview Schedule

Re-iterate consent, confidentiality and that the participant can withdraw, take a break or reschedule at any time. Discuss interview length.

Interview Questions

- Can you tell me about your experience of using, or not using, the psychoanalytic approach in the NHS?
- Were there any times you did use/did not use the approach?
- What is helpful about the psychoanalytic approach?
- What is more difficult about using the approach?
- Are there particular difficulties or client groups that it is more helpful for?
- What are client reactions to the approach?
- How do services respond to use of the approach?
- Do you use it when working in teams?
- What has sustained some practice of psychoanalytic approaches within the NHS?
- What has hindered the development of the approach within the NHS?
- Have you done further training in psychoanalytic approaches?
- What is the future of the psychoanalytic approach within the NHS?

Clarify:

- What do you mean by the psychodynamic/psychoanalytic approach?

Sample Prompts

Prompts will be used to encourage the participant to elaborate on their narrative, and will be based on what the participant says. For example, the following may be used;

- Could you tell me more about that?
- Could you expand on that for me?

Debriefing

How do you feel about the interview we just had? Is there anything else you might like to add? Do you have any questions? If you have any questions later on, you can contact me and there are contact details of support organisations if you feel like you would like to talk to someone.

Appendix M – Transcript Annotations

.. pause

… long pause

[ ] description of an external event

Appendix N – Codes and Initial Code Groupings for Thematic Analysis

All the phrases and headings below were initial codes. The words and phrases in bold were initial groupings and the words in italics were initial sub-codes. These were then sorted into over-arching themes, themes and codes, as depicted in Appendix P.

Definition

Psychoanalysis definition

Psychodynamic definition

Uncertainty about definition

Space

Historical in a modern NHS

NHS is evidence focused

- *Difficult to build evidence*
- *It's an Art*
- *There is evidence*

No physical space in NHS

Difference between professions

Received by clients

- *Containing*
- *Emotional release*
- *Understanding*
- *Validating*

Received by service

Received by staff

Space for clients

- *Cross cultural application*
- *Helpful for particular clients*
- *Mix with psychotherapy useful*
- *Not as helpful for some clients*

Space for clinicians

- *Language useful*
- *Luxury*
- *Reflect about service and systems*
- *Reflective space for self*
- *Rewarding*
- *Therapeutic Frame*
- *"Through the back door"*

- *Useful for clinical work*
- *Useful for therapeutic relationship*

Inclination

"Don't get it"

Elitist

Individualistic

Irrelevant

Lack of confidence

Mystery

Not truth

Placements useful

"Risky" or "unsafe"

Speaks to me

Supervision

Teaching

Truth

Uncertainty

Why elitist

Finding Space for Psychoanalysis

Barriers to training in psychoanalysis

Branded therapies useful

Change in language needed

"Change or Die"

Connecting with networks

Elements of psychoanalysis used in services

Extra training useful

Psychoanalytic ideas used in formulation

Future hopeful

Future not helpful

Marketing of psychoanalysis needed

Needs to be more accessible

Neoliberal climate

Training placements useful

Practitioner-Service fit

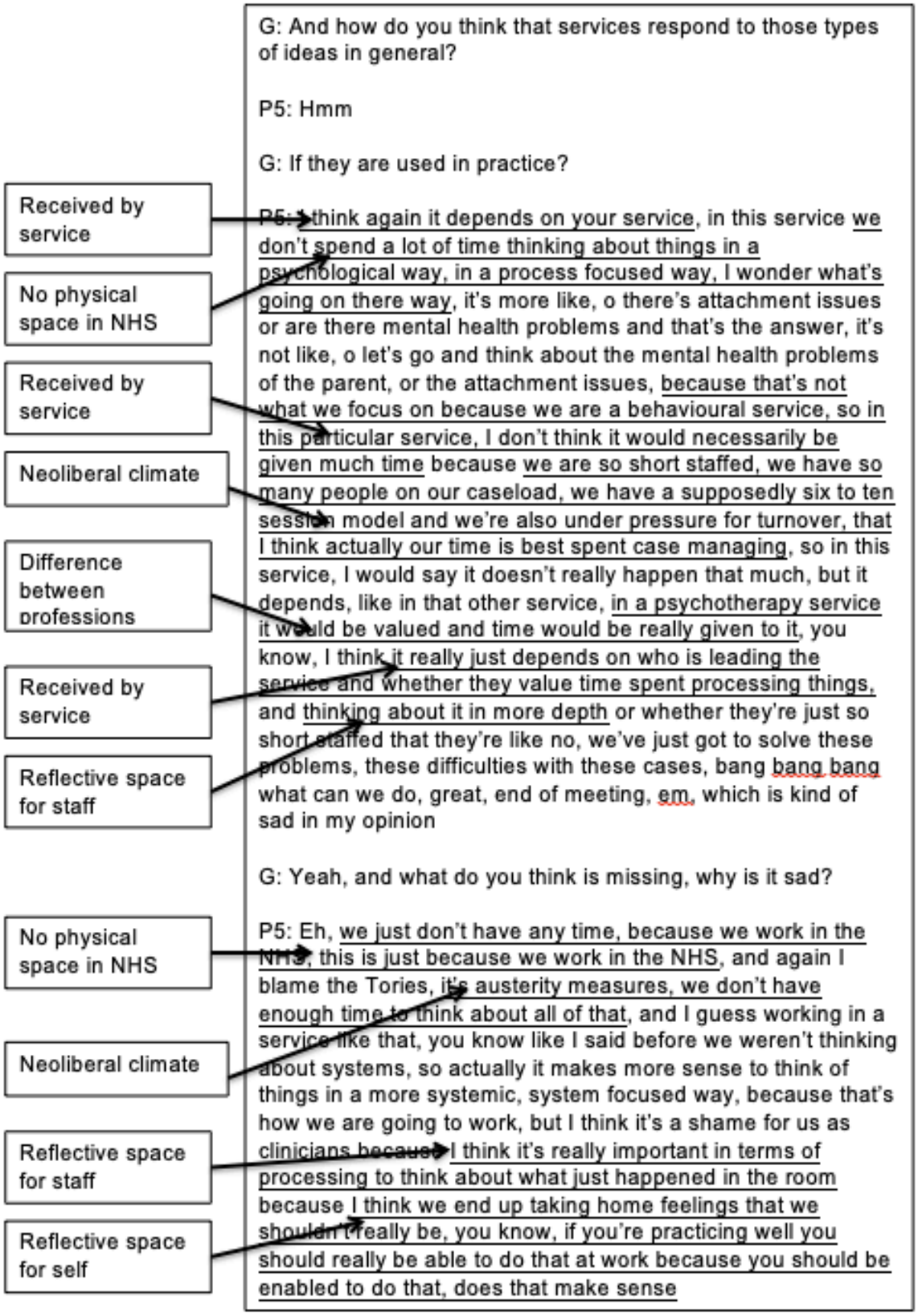
Research is key

Service support

Stigma

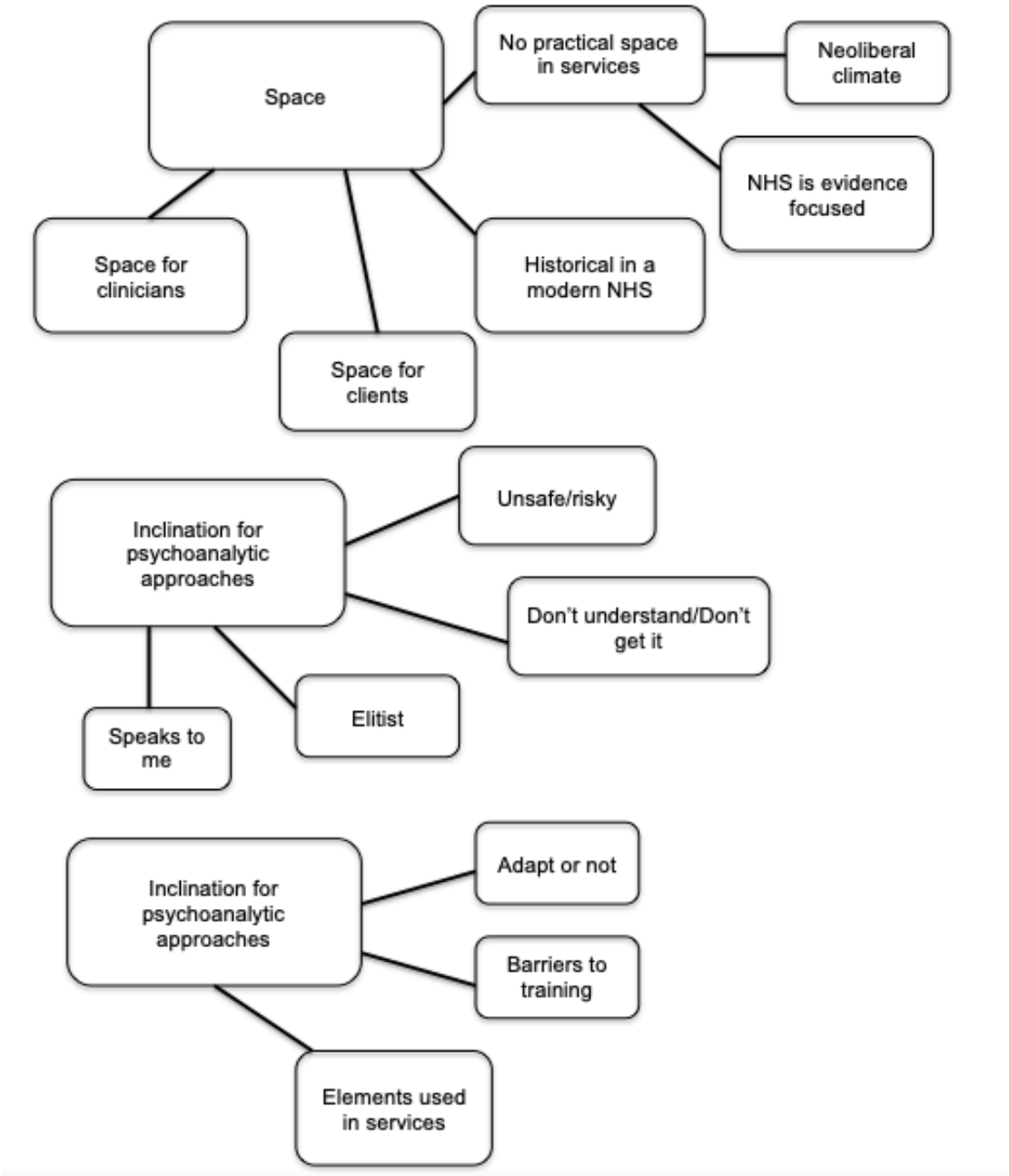
Supervision/Training

Appendix O – Example of Coded Transcript

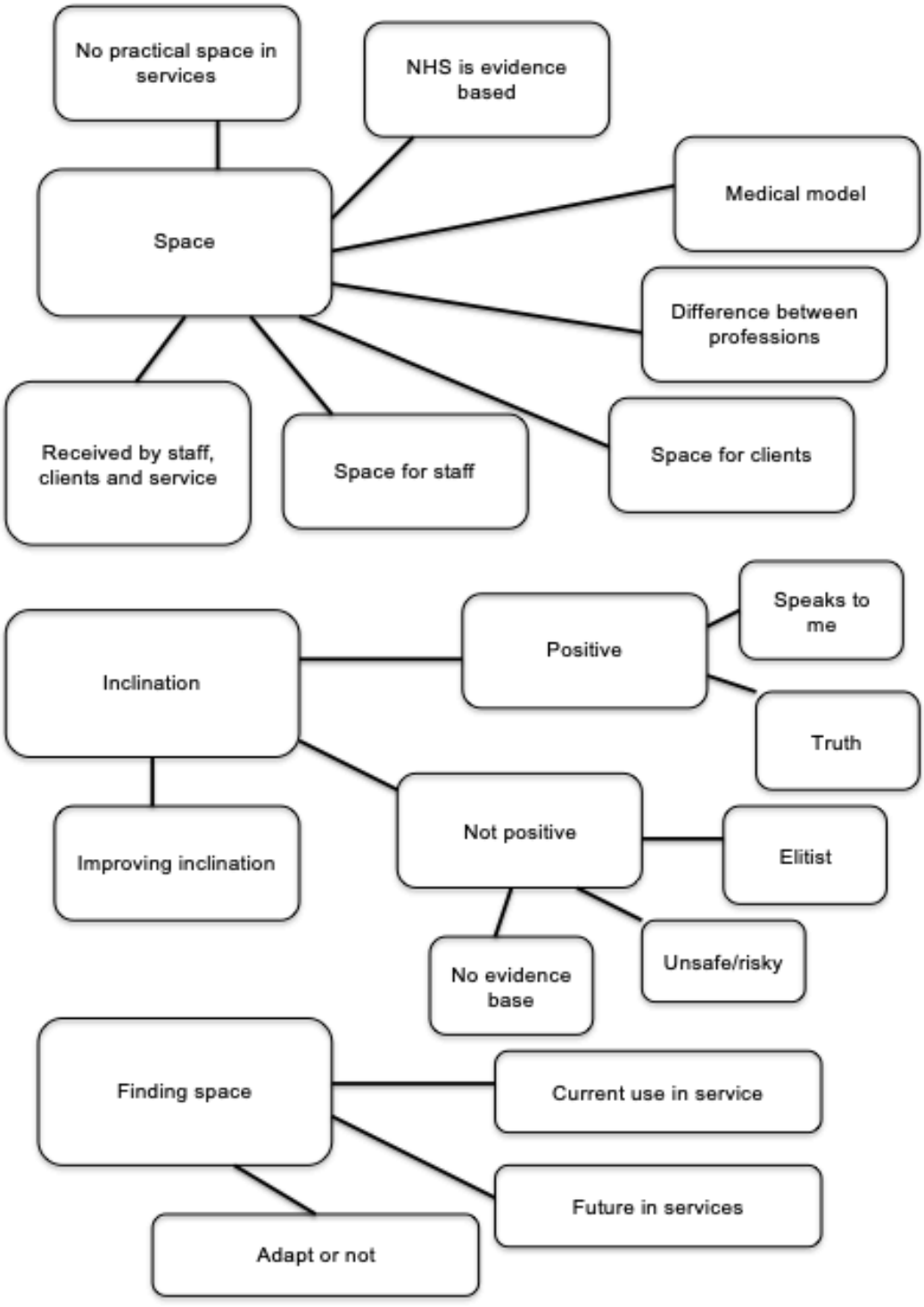


Appendix P – Theme Development

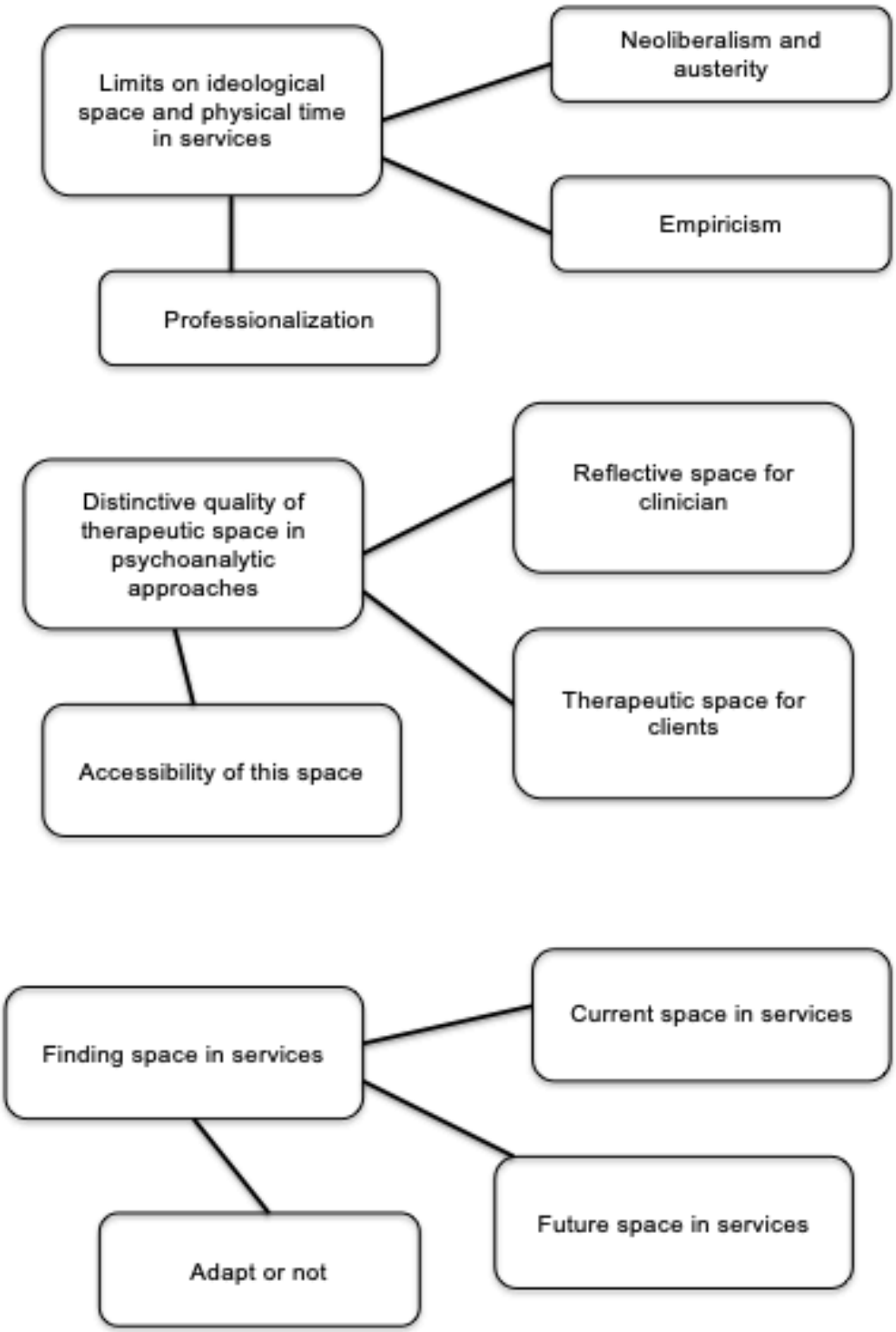
First draft of themes



Second draft of themes



Third draft of themes after peer debriefing



Appendix Q – Table of Methods Used to Enhance Trustworthiness

Table 1: Establishing trustworthiness at each phase of thematic analysis based on Nowell et al., 2017

Phases of Thematic Analysis	**Means of Establishing Trustworthiness**
Familiarising yourself with the data	Prolonged engagement with the data Documented reflective thoughts, ideas about codes and relevant theory Keep records of interviews, transcripts and notes
Generating initial codes	Record of code generation Reflexive journal Record kept of decisions made
Searching for themes	Retaining mind maps used to organise themes Triangulation of participant views Record kept of decisions made
Reviewing themes	Peer debriefing Potential themes were reviewed in relation to codes and whole data set Record kept of decisions made
Defining and naming themes	Peer debriefing Generated themes reviewed in relation to data Record kept of decisions made
Producing the report	Peer debriefing Triangulation with the literature Record kept of decisions made

Appendix R – Quantitative Analysis

Table 1: The number and percentage of clinical psychologists who use listed modalities as their first, second and third choice of modality

	Psychoanalytic	Behavioural	CBT	Third Wave	Systemic	Humanistic	Other
Primary	34 (18%)	8 (4.2%)	53 (28%)	44 (23.3%)	28 (14.8%)	1 (0.5%)	21 (11.1%)
Second	17 (9%)	32 (16.9%)	49 (25.9%)	48 (25.4%)	31 (16.4%)	6 (3.2%)	6 (3.2%)
Third	11 (5.8%)	45 (23.8%)	46 (24.3%)	38 (20.1%)	29 (15.3%)	11 (5.8%)	9 (4.8%)

Note. Total N=189

Table 2: Frequency count of other modality used by participants

Other Modality Used	**N**	**%**
EMDR	16	8.5%
Cognitive analytic therapy (CAT)	12	6.4%
Attachment/Attachment-informed	5	2.7%
Trauma-informed approaches	4	2.1%
Integrative approaches	4	2.1%
Narrative exposure therapy	2	1.7%
Sensorimotor psychotherapy	1	0.5%
Group psychotherapy	1	0.5%
Structural dissociation approaches	1	0.5%
Neuropsychological model	1	0.5%
Community psychology	1	0.5%
Hypnosis	1	0.5%

Figure 1: Chi-Square analysis SPSS output

PRIMARY_TO_COMBINED

	Observed N	Expected N	Residual
PP	34	41.8	-7.7
CBT	61	41.8	19.3
Third Wave	44	41.8	2.3
Systemic	28	41.8	-13.7
Total	167		

Test Statistics

	PRIMARY_TO_COMBINED
Chi-Square	14.964[a]
df	3
Asymp. Sig.	.002

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 41.8.

Table 3: Percentage of participants working in each service setting according to their primary modalities

	Psychoanalytic	Cognitive-Behavioural	Third Wave	Systemic	Other
Primary Care: GP Service	1 (2.9%)	1 (1.6%)	0 (0%)	0 (0%)	0 (0%)
Primary Care: IAPT Service	1 (2.9%)	1 (1.6%)	0 (0%)		1 (4.8%)
Secondary Care: Acute Inpatient Ward	0 (0%)	2 (3.3%)	1 (2.3%)	1 (3.6%)	1 (4.8%)
Secondary Care: Long Term Ward	0 (0%)	0 (0%)	3 (6.8%)	0 (0%)	0 (0%)
Secondary Care: Community Team	17 (50%)	33 (54.1%)	17 (38.6%)	14 (50%)	14 (66.7%)
Crisis Team	2 (5.9%)	1 (1.6%)	1 (2.3%)	0 (0%)	0 (0%)
Tertiary: National or Specialist Service	5 (14.7)	9 (14.8%)	18 (18.2%)	3 (10.7%)	2 (9.5%)
Other	8 (23.5%)	14 (23%)	14 (31.8%)	10 (35.7%)	3 (14.3%)

Note. Total N=188

Table 4: Frequency count of other services worked in by participants

Other service settings	Frequency
Hospital/Clinical health	15
Neuropsychology/Brain injury/Memory service	5
Children and families/CAMHS	4
Social care	2
Paediatrics	3
Perinatal	1
Forensics	7
Substance misuse	1
Early intervention	1
Eating disorders	1
Learning disability	1
Psychological therapies/Psychotherapy	3
Third sector	1

Table 5: Frequency count of other modalities preferred or recommended by services

Other modalities preferred by services	N
Use evidence based approach/NICE guidelines	2
Combination of approaches	2
DBT	1
Narrative therapies	1
Positive behavioural support	1
Trauma focused therapies	1
Compassion focused therapy	1
Mentalisation based therapy	1
Structured clinical management	1

Table 6: Frequency count of participants other preferred choice of modality

Other Choice of Modality	N
Integration of approaches depending on Need/Formulation	15
Cognitive analytic therapy (CAT)	11
EMDR	5
Trauma-informed therapy	3
Attachment focused	2
Compassion focused therapy	1
Mentalisation based therapy	1
Schema therapy	1

Table 7: Percentage of participants using different primary modalities who work with clients of each particular need

	Psychoanalytic	Cognitive-Behavioural	Third Wave	Systemic
Common Mental Health Problems	3 (8.8%)	16 (26.2%)	2 (4.5%)	3 (10.7%)
Learning Disability	3 (8.8%)	7 (11.5%)	3 (6.8%)	7 (25%)
Serious and Enduring Difficulties	14 (41.2%)	8 (13.1%)	15 (34.1%)	1 (3.6%)
Health-Related Problems	1 (2.9%)	6 (9.8%)	11 (25%)	3 (10.7%)
Substance Abuse	1 (2.9%)			
Neuropsychological Problems		5 (8.2%)	4 (9.1%)	1 (3.6%)
Early Intervention in Psychosis	1 (2.9%)	2 (3.3%)		
Eating Disorders		4 (6.6%)		1 (3.6%)
Forensic	2 (5.9%)	7 (11.5%)	1 (2.3%)	
Personality Disorders	5 (14.7%)	1 (1.6%)	3 (6.8%)	
Looked After Children			1 (2.3%)	1 (3.6%)
Neurodevelopmental				3 (10.7%)
Not Applicable				
Other	4 (11.8%)	5 (8.2%)	4 (9.1%)	8 (28.6%)

Note. Total N=188

Table 8: Frequency count of other modalities of training completed

Other modalities of training	**N**
EMDR	27
Cognitive analytic therapy (CAT)	8
Trauma-focused approaches	2
Family therapy/parenting	3
Schema therapy	3
Third wave (CFT, DBT)	3
Video interaction guidance	2
MBT	2
IPT	2
Hypnosis	2
Sensorimotor psychotherapy	2
Neuropsychology	1
Motivational interviewing	1
Narrative therapy	1
Community psychology	1

Appendix S – Demographics of Interviewees

Table 1: Demographics of interviewees

Demographics	N	%
Age		
20-29	1	8.3
30-39	9	75
40-49	2	16.6
Sex		
Male	1	8.3
Female	11	91.6
Gender		
Male	1	8.3
Female	11	91.6
Nationality		
English	6	50
Welsh	1	8.3
Scottish	1	8.3
British	2	16.6
Other	2	16.6
Ethnicity		
White/White British	11	91.6
Asian/Asian British	1	8.3
Country of Clinical Training		
UK	12	100
Years of Post-Qualification Experience		
1-9	10	83.3
10-19	2	16.6

Note. Total N=189