



# Working Knowledge

*Working Together*

## Collaborations Between Academics and Clinicians

by  
Hearing the Voice



**'Collaborations Between Academics  
and Clinicians'  
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# Collaborations Between Academics and Clinicians

## A case study of working together to produce new therapeutic methods

Given its focus on an aspect of human experience that is usually seen as a symptom of psychiatric disorder, Hearing the Voice presents distinctive opportunities for collaboration with mental health professionals. As part of our focus on applying research findings in ways that make a difference to individuals who hear voices, we have engaged with clinicians in many different contexts, including in our monthly psychosis special interest group, translational events we have run in collaboration with a partner NHS trust, planning research studies and clinical trials, training workshops and public engagement activities. In this Project Short, we focus on one particular aspect of our work that has involved close collaboration with mental health professionals. Beginning with an overview of the collaboration, we consider some of the challenges that faced us at the outset and then describe how we set about addressing them.

### **Brief CBT for voice-hearing: A treatment manual**

Clinicians working in the field of mental health work to alleviate distress caused by unusual experiences and behaviours by drawing on a range of resources, such as cognitive behaviour therapy (CBT). CBT is grounded in individuals' interpretation and attribution of their experiences and is currently recommended (in National Institute of Clinical Excellence guidelines) as a treatment for psychosis. However, CBT for voice-hearing has shown mixed results, partly because existing packages are nonspecific, not targeted at voice-hearing and not sensitive to the diversity of voice-hearing experiences.

In 2012 we began collaborating with Dr Guy Dodgson, a consultant clinical psychologist in the Northumberland, Tyne and Wear (NTW) NHS Foundation Trust. Guy had been developing a CBT manual for helping clients with psychosis to deal with distressing voices. The aim of the manual was to tailor CBT specifically to voice-hearing, including recognising the heterogeneity of auditory verbal hallucinations (AVHs) and the fact that

treatments targeted at specific subtypes of experience would likely be more effective than a 'one size fits all' approach.

We worked with Guy and his team to develop the existing treatment manual (that is, information on basic psychological concepts) on inner speech and voice-hearing, by improving and updating the theoretical background used to explain hyper-vigilance AVHs, and adding a module on memory-based AVHs. We also used feedback from local clinicians to streamline the manual so that it is easier to use in therapy sessions. The new manual is specifically tailored for voice-hearing, addressing heterogeneity of AVHs with targeted treatments and providing improved psychoeducation on the phenomenology, causes and development of voice-hearing, inner speech, attention and memory.

In addition to working with Guy in developing the manual, we have pioneered the use of new technologies for the use of the manual in the consulting room. Clinicians' confidence in adopting new treatment programmes can be limited by the extent and complexity of the information concerned, and referring to paper manuals in a therapeutic session is not ideal. With this in mind, we developed a tablet version of the manual that runs on a smart tablet (iPad) and includes embedded video clips and other attractive functionality. We began by consulting with clinicians about the feasibility and desirability of this use of technology, and found that there was considerable enthusiasm. We have now provided five iPads loaded with the manual to clinicians in the Tees, Esk and Wear Valleys (TEWV) and NTW NHS Foundation Trusts for use in their clinical work.

At present, around a dozen local clinicians have used the manual. We are beginning a study formally to evaluate how often clinicians use the manual during routine CBT and which parts of the manual they typically use. In addition, we will examine whether the manual is acceptable to service-users, in terms of whether they find the subtyping approach and the use of an iPad during therapy sessions useful and appropriate. By the end of this acceptability study, around

20 clinicians will have used the manual to some extent. Ultimately we hope that we will be able to demonstrate the effectiveness and acceptability of the manual and pursue wider national roll-out of the CBT package.

## Issues before the start of the collaboration

At the start of the collaboration we understood that we shared a common desire to improve treatment options for individuals with distressing voices. On both sides there was a strong feeling that the heterogeneity of voice-hearing experiences was under-recognised and potentially highly clinically relevant, so there was genuine enthusiasm for pursuing this translation from academic to clinical work. Despite this **positive approach to the partnership**, we had several concerns at the outset about how a collaboration between academic researchers and clinicians might go.

One issue was a perception that clinicians might be less receptive than academics to **multidisciplinary working**. Given the profoundly interdisciplinary nature of our project, this was a concern before the collaboration commenced.

**Time** was expected to be a limiting factor on both sides. Resource limitations in the public sector (specifically the NHS) mean that even those clinicians who are keen to do research have only limited time allocated for it, and that can often get eaten up by other demands.

Another issue relates to **career demands** in clinical vs academic roles. Academia in the UK is driven by the Research Excellence Framework (REF): the bottom line is that people have to publish well and reasonably frequently. The same does not apply for clinicians (although publishing is of course seen as a good thing). One difficulty for academics is understanding what *does* count, career-wise, for a clinician. Any proposal for collaboration requires some understanding of what it offers to partners, which in turn requires an understanding of career and operational constraints for individuals from the partner organisation. It can be difficult for academics to get a true insight into what 'counts' for someone with a clinical background, beyond the obvious motivation to help people in distress. What is 'good' about this kind of collaboration from their point of view? What do they

get 'points' for? What does a clinician need to get promoted? What counts as success for a clinical team or organisation? Personal progression is of course not the be-all and end-all, but it naturally figures in how collaborators work out how to make such partnerships work.

A related issue is that **research impact** is becoming more important, at least in the UK. Academic

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researchers will want to propose collaborations that are meaningful to both sides and are not just seen as a grasp at impact, which is in turn again driven by the REF. Here the challenge of understanding becomes flipped around, and the issue becomes about clinicians' understanding of the motivations of academics. An obvious danger is that academics are seen to be grasping at impact in a cynical way, rather than being driven by genuine motivations to improve understanding and reduce suffering. Ideally, clinicians will recognise that impact is important for academics and that they are in a uniquely powerful position to help effect it.

In terms of **personal roles**, it is quite rare that a person holds both a clinical and an academic post. There are good reasons for this: salaries for clinicians are higher in the UK than for academics, and universities usually feel that they cannot afford them. This makes it difficult to propose interesting posts that cross the boundary. Another downside for a university appointing a clinician is that they are less likely to be 'REFable': that is, to have the necessary number of top-flight publications that can count towards the REF. All in all, this can make it difficult for academics to find potential collaborators who have a foot in both worlds.

Academics may also experience issues in relation to **seniority**. Much of the time, the clinicians involved in academic projects are relatively senior (e.g., consultants), for a variety of reasons (e.g., they are better able to negotiate research time than are junior staff). But most of their contact with the academic project will involve working

with relatively junior academic staff (e.g., post-docs). This can create some unbalanced working relationships. It can be difficult, for example, for a junior academic to stand their ground against a consultant psychologist/psychiatrist even when their argument/idea is the best way to progress a particular project. Rank-pulling by more senior partners is another danger in this respect.

It can be tricky to understand the **economics** of an NHS trust including the perennial 'resource implications'. These are primarily time costs; there is rarely any actual money available. But there are other, less predictable resource implications, such as room availability (very limited in NHS properties). One of the advantages for academics in this respect is that universities are usually not short of bookable meeting space.

Another issue is the way that **treatment is evaluated** (for example, through patient treatment databases such as PARIS and Rio). Anything that counts as 'treatment' will inevitably contribute to treatment statistics, limiting the range of activities that academics and clinicians can do together.

Finally, the NHS is set up to treat patients rather than to conduct research, meaning that **organisational structures** can be barriers to research collaboration. Many academics, for example, find that NHS ethics and R&D approval systems can seem unnecessarily restrictive.

## Our experience of the collaboration

Generally speaking, we have found that **clinicians are happy to get involved with other disciplines**. Clinicians are either pro-interdisciplinarity (perhaps because they are used to working in multidisciplinary teams), or are unaware that they are doing it and so get on board with minimal fuss. For example, the new CBT manual includes a section on the 'predictive processing framework' (PPF), which has its roots (in part) in computational neuroscience and philosophy of mind. We therefore asked the project's philosophy postdoc to explain the PPF to a room of clinical psychologists. This was a great success: engaging for the clinicians, extremely helpful for our postdoc (presumably not many philosophy postdocs do training with clinical psychologists) and so on.

We did not encounter any difficulties in relation to **seniority** and status imbalances. Guy has worked closely with our PDRFs and respected their

expertise throughout. In other circumstances, perhaps when the clinician collaborators are less well known to the academic team in advance, it would be advisable to draw up clear plans and understandings about respecting expertise before the collaboration begins.

With regard to **time**, the partnership allowed a partial solution to the problem we had anticipated. Guy's collaboration with Hearing the Voice gave him additional support in applying for funded buyout. In April 2014 Guy received funding from NTW's Research Capability Funding initiative to allow him to spend one day a week for a year with Hearing the Voice to work on the manual.

Other **structural** issues are unlikely to be resolved easily. Working closely with clinicians is certainly an advantage in dealing with NHS research bureaucracy, and Guy's input was extremely helpful in securing ethical and R&D approval for our project.

Several **unexpected benefits** arose from the collaboration. The treatment manual draws connections between the personification of heard voices and the process of a novelist creating a fictional character. This issue has subsequently been investigated in Hearing the Voice's Writers' Inner Voices' study examining these processes in professional writers, findings from which will feed back into future iterations of the manual.

New **academic collaborations** have arisen from the partnership, including a proposed review article by Guy and our philosophy postdoc linking hypervigilance hallucinations to the PPF.

Finally, this kind of partnership can allow academics to get **closer than would otherwise be possible to the experiences that they are interested in**. As a researcher in this kind of collaboration, you feel that you are talking to people who really understand and have experience of the issues. In the case of Hearing the Voice, this is no substitute for talking to voice-hearers, but in many ways it is the next best thing. It is endlessly interesting, especially if you are something of a clinician *manqué* yourself.

**W**orking Knowledge is a collection of accessible and user-friendly resources dedicated to the practical ins and outs of interdisciplinary research.

Covering everything from managing a research project's social media presence to conducting experimental design 'hackathons', the series is a must-read for anyone considering funding or embarking on interdisciplinary research.

**Series editors:** Charles Fernyhough, Angela Woods and Victoria Patton.

