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Portfolio of Doctorate in Health Psychology

Benchmarking and developing the role of Health Psychologist in IAPT

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For the qualification of

Professional Doctorate in Health Psychology

School of Health Sciences

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Appendices

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DECLARATION

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EDITORIAL STYLE

The contents of this doctorate programme will employ the editorial style of the American Psychological Association (APA) as detailed in the Publication Manual of the American Psychological Association (6th edition)

ABBREVIATIONS

ACT	Acceptance and Commitment Therapy
APT	Active Physical Treatment
BABCP	British Association for Behavioural and Cognitive Psychotherapies
BT	Behaviour Therapy
BCT	Behaviour Change Technique
BCW	Behaviour Change Wheel
CBT	Cognitive Behaviour Therapy
CT	Cognitive Therapy
DOH	Department of Health
GAD7	Generalised Anxiety Disorder Scale
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
PHC	Primary Health Care
PHQ9	Patient Health Questionnaire
PTSD	Post-Traumatic Stress Disorder
LTC	Long-Term Condition
PPS	Persistent Physical Symptoms
MBCT	Mindfulness-Based Cognitive Therapy
MBSR	Mindfulness-Based Stress Reduction
MUS	Medically Unexplained Symptoms
NCCP	Non-Cardiac Chest Pain
NICE	National Institute for Health & Care Excellence

NHS	National Health System
SCT	Social Cognitive Theory
TDF	Theoretical Domain Framework
SRT/CSM	Self-Regulatory Theory/Common Sense Model
WASAS	Work and Social Adjustment Scale

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Section A: Preface

Benchmarking and developing the role of a Health psychologist in IAPT

Health psychologists work as specialists in different settings in health with skills and knowledge in health psychology; accordingly, the roles and functions have expanded within these contexts in the NHS. One of these contexts is the IAPT (Improving Access to Psychological Therapies) which has expanded its services to include psychological therapies for people with physical health conditions, in particular long-term conditions, and persistent physical symptoms (LTC/PPS). This portfolio focuses on roles undertaken during benchmarking and service evaluation of LTC/PPS interventions and outlines how the role of health psychologist was developed in IAPT. Benchmarking is an innovative approach for quality improvement which requires multiple skills and competencies (Etu et al; 2019). This portfolio reflects on how the various competencies for the Health Psychology Doctorate were used to benchmark and develop psychological interventions to improve access for people with LTC/PPS. The work reflects on the context and roles in which these competencies were practised during health psychology training. The portfolio evolved with the role as Champion for Long-term Conditions during the placement. This role created opportunities for health psychology trainee to work autonomously and ethically while showing commitment to professional codes and standards. These health psychology competencies include research and publications, teaching and training, consultancy, and behavioural interventions, reflecting both research and practitioner practice. A brief discussion of how these competencies were used within these roles in IAPT including how there were interrelated to each other has been outlined below.

Consultancy Competency

In this portfolio, health psychology skills and knowledge of consultancy were expanded to use benchmarking process which was carried out to improve access to psychological therapies in IAPT for people with LTC/PPS. The objective of consultancy in this portfolio was to benchmark how the processes and interventions used within the organisation were meeting the needs of people with LTC/PPS against IAPT best practice standards.

This process relied heavily on knowledge of evidence-based practice used in IAPT as well as competencies of health psychologist particularly, research and service evaluation, including teaching and training. As part of disseminating results and sharing practice, workshops within the team and at a conference were presented on the role of a health psychologist in the benchmarking process at the 1st AHCP 2017 Practitioner Health Psychologist conference.

Behavioural intervention Competency

As part of the role as Health psychologist (HP) Trainee during placement as champion for long term conditions in IAPT, there were numerous opportunities for developing behaviour interventions in groups and individuals. The CBT group intervention adapted using health psychology theories (discussed in Chapter 2 of the research component in this portfolio) to improve for LTC/PPS is an example of this role in IAPT. During this placement, practice extended to working in primary health settings in GP's surgery with patients who suffer from both mental and physical health problems, encountering a range of patients with LTC/PPS.

The understanding of the bio-psychological and behaviour change techniques (BCT's) enables HP to work collaboratively with other professionals offering expertise (Michie et al; 2013). It is therefore against this backdrop that the clients who present with complex psychological and health issues in primary health care could be referred to HP (in training) especially if they are accredited Cognitive Behaviour Therapist as needed in this context. This work provides opportunities to use a range of assessment procedures, outcome measures, risk assessment, formulation including drawing on a range of health psychological models that are used to adapt CBT interventions in IAPT for groups and individuals. This contributes towards developing psychological skills including utilising and reflecting on existing therapy skills while integrating health psychology knowledge. In this portfolio a case study involving an individual client who presented with both physical and mental health condition has been presented to demonstrate this competence.

Teaching and Training competency

This role involved numerous activities of teaching and training, including workshops for both health professionals and clients. Within the role as Champion of LTC in IAPT there were responsibilities for mentoring, supervising, and supporting psychological therapists in behaviour change interventions for people with LTC/PPS. The role involved teaching at City University on the MSc Health Psychology behavioural and medicine programme on topics like HIV/AIDS and Pain Management, which are both long-term conditions. In the teaching and training role the HP competencies contributes towards helping other psychological therapists in using behaviour change techniques and in applying health psychology models sensitively when working in different contexts. In this portfolio, I have reflected on one of my teaching experiences with MSc students at City University on the topic of pain management. For my training case study, I have reflected on the workshop on improving assessment and referral pathways for people with LTC/PPS in IAPT. This workshop was designed to improve the competencies of the IAPT psychological therapies for working with people with both physical and mental health difficulties, particularly anxiety and depression

Systematic Review

This review was motivated by collaborative working with other physical health teams which included COPD and Cardiac Rehabilitation teams and GP's. During the benchmarking I noted that among the people with LTC/PPS there were also patients with Non-Cardiac Chest Pain (NCCP) who presented in IAPT with low mood and other anxiety disorders which included panic. Recent reviews had revealed a modest to moderate effectiveness for psychological interventions for NCCP and identified pragmatic complexities in implementing these psychological interventions in E/D and other primary health care centre (PHC) Kisley et al, 2015; Campbell et al., 2017). For this competency, a systematic review of randomised controlled studies (RCT's) which investigated the effectiveness of cognitive behaviour therapy interventions for reducing non-cardiac chest pain (NCCP) in primary health care (PHC) was conducted. The objective of the systematic review was to identify CBT content and designs of interventions that has been effectiveness for NCCP to add value to the existing evidence, and to consider how IAPT could also contribute in delivering these CBT interventions alongside Cardiac teams.

Research competency

Overview

The study was implemented as part of a benchmarking process, which included evaluation and quality improvement as well as the validation of existing psychological interventions and protocols used in IAPT for people with comorbid mental and physical health conditions. A few months before methodology and methods for the present study were selected, an extensive review of literature to support the project, was undertaken from both quantitative and qualitative studies. This literature review was synthesised to frame the topic and to identify gaps in the studies as presented in Chapter 1.

As part of quality improvement and implementation, Chapter 2 describes the psychological interventions that were attended by the participants in the study and presents the theoretical framework for the adapted CBT intervention. To the best of our knowledge, the adapted CBT model described in this chapter introduces an original contribution to health psychology knowledge. The model was used to make adaptations to the CBT interventions for people with LTC/PPS with anxiety and depression in IAPT. The IAPT has been criticised for lacking a service user perspective in its conceptualisations of outcomes of therapy and recovery; the research component in this portfolio contributed towards bridging this gap by exploring these views.

Chapter 3 discusses the epistemological position and methodology including justification of qualitative approach used in this study for exploring lived experiences following attendance at psychological interventions. Chapter 4 continues with the description of methodology and present step by step methods and procedures employed during the study, these include: sampling, the number of participants recruited to take part in the service evaluation, how the interview guide was developed and ethical considerations. Chapter 5 presents in line with IPA's idiographic approach a case by case analysis and results and the analytic strategy used in the study. Finally, Chapter 6 discusses the themes in relation to existing evidence and previous research. The themes are mapped and contextualised to the theoretical framework discussed in Chapter 2. The implications for practice and limitations of study are discussed and the chapter ends with reflections and conclusions.

Main thesis

A qualitative analysis of participants' experiences of illness and recovery following attendance of a Cognitive Behaviour Therapy (CBT) group programme adapted using health psychology theories (CSM and SCT) for (LTC/PPS), followed by an eight-week course of Mindfulness-Based Cognitive Therapy (MBCT) in IAPT

ABSTRACT

Aims and objectives: IAPT has been criticised for its focus on quantifying outcomes of therapy, rather than focusing on recovery as a lived experience. To bridge this gap, this qualitative study aims to explore the lived experiences of participants following an adapted CBT intervention programme and MBCT course. During a benchmarking and quality development project two health psychology theories, namely CSM and SCT, were used to adapt CBT group interventions for people with LTC/PPS with anxiety and depression in IAPT. After attending this adapted CBT group, participants entered the MBCT course to augment therapeutic gains and prevent reoccurrence.

Methods: Ten semi-structured interviews were conducted to explore the lived experiences and recovery journeys of people following both these interventions. A qualitative interpretive phenomenological approach (IPA) was used to analyse the data.

Results: Four superordinate themes and their subordinate themes that captured the lived experiences of illness and recovery of the participants emerged from the analysis. These included 'losing myself', 'the emergence of new understandings', 'changing representations of illnesses' and 'finding myself'.

Conclusions: Relevant clinical implications for psychological therapies in Primary Health Care (PHC) are shared, including the use of health psychology theories in adapting and improving the quality of CBT interventions for people with LTC/PPS in IAPT.

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Section B: Research

Chapter 1: The landscape of comorbid long-term conditions with anxiety and depression in IAPT

1.1. Overview

Following a through literature review from both quantitative and qualitative studies, Chapter1 outlines and traces the background and context of long-term conditions and medically unexplained syndromes (MUS) also referred to in this study as persistent physical symptoms (PPS) with comorbid anxiety and depression in IAPT. Additionally, the chapter expands on the conceptualisation of recovery in IAPT and a critical analysis of debates around these understandings is presented. In order to understand the lived experiences of people with LTC/PPS a review of qualitative studies has been synthesised. Finally, gaps in studies were identified and the position including contribution of this study is presented.

1.2. Context

In 2007, the Department of Health launched the programme for the national initiative for Improving Access to Psychological Therapies (IAPT) for people with mild to moderate depression and anxiety (Roth &Pilling, 2007). CBT, alongside other models, which include counselling, interpersonal psychotherapy, and couples therapy, was chosen to be used in IAPT. This choice was supported by the vigorous and robust evidence showing the effectiveness of CBT in the treatment of these disorders, as well as the recommendation by the National Institute for Clinical Excellence (NICE, 2009) of evidence-based psychological therapies (Clark et al., 2009).

This initiative adopted a stepped-care approach (Bower & Gilbody, 2005), consisting of pathways for low and high-intensity CBT interventions delivered by trained CBT therapists, counsellors, and psychologists in group and individual therapy. In the stepped-care approach, low-intensity interventions are delivered at Step 2 by psychological wellbeing practitioners (PWP) trained in CBT. These interventions include guided self-help and psycho-educational groups.

Similarly, at Step 3, high-intensity interventions are delivered by high-intensity CBT practitioners who are health professionals, including psychologists trained in CBT. These interventions are evidence-based and recommended by NICE (Bower & Gilbody, 2005; Roth &Pilling, 2007). This initiative is also associated with the economic debate that highlights how the successful reduction of these common mental-health issues could cut spending on welfare benefits and healthcare by increasing the number of people returning to work, which, in turn, enhances economic productivity (Clark, et al; 2009).

IAPT expanded its remit to other clinical disorders, including people with long-term physical health conditions (LTC) and those with persistent physical symptoms (PPS). Recognition of comorbidity between LTC/PPS and common mental-health issues, which include anxiety and depression, has been a pertinent topic of discussion. This has come alongside the pledge to reduce inequalities, integrate mental and physical health services, and increase accessibility for all. The World Health Organisation's (WHO) initiative, also adopted by the UK Department of Health, states a policy of 'No health without mental health,' which has been a driving force behind these initiatives (DoH, 2011).

These initiatives are also consistent with the five-year plan of improving and integrating mental and physical health services to improve health outcomes for people with comorbid physical and mental health issues (NHS, England, 2016). This strengthens the commitment of IAPT in reducing inequalities and traditional divisions in the care of both mental and physical well-being, which have a history of reinforcing stigma. IAPT accepts self-referrals and those from a variety of sources such as health professionals in the community and other health services including GPs and employment centres.

1.3. Long term conditions and medically unexplained symptoms (MUS) in IAPT

1.3.1. Long term conditions (LTC)

Long-term conditions (LTC), commonly termed ‘chronic illnesses’, refer to those medical conditions that cannot be completely cured, but that can be managed to improve people’s health and quality of life (Leventhal & Ian, 2012). It has been found that 40% of people with LTC also suffer from mental health problems, particularly anxiety and depression (NHS, England, 2016). This comorbidity of anxiety and depression has been found to have an impact on quality of life and self-management for people suffering from long term conditions (Walters et al; 2014). The most common long-term conditions seen in IAPT include cardiovascular diseases, diabetes mellitus, and chronic obstructive pulmonary disease (COPD) (IAPT, 2014, 2018). Studies have shown that anxiety and depression can increase a person’s vulnerability to and progression of their LTC, such as heart conditions (Haddad, et al; 2013; Cohen, et al; 2015).

1.3.2. Medically unexplained symptoms (persistent physical symptoms) (PPS)

Within the IAPT, self-referrals for persistent physical symptoms with comorbid anxiety and depression have increased the contextual understanding of long-term conditions. This increased understanding extended the recognition of chronic medical conditions to include disorders that impair functioning and those known as medically unexplained symptoms (MUS) (Goodman, et al; 2013). Examples of the latter are Fibromyalgia and chronic fatigue (IAPT, 2014). The definitions and explanations of medically unexplained symptoms (MUS) have been debated and contested. It has been argued that medical professionals assign this label when they have failed to legitimise an individual's persistent symptoms, which increases distress for the sufferer (Byng & Gask, 2009; IAPT, 2014; Chalder &Willis, 2017). The term has been identified and highlighted as a barrier to improving access to psychological therapies for people with long term conditions (Salkovskis, et al; 2016).

It has been contended that the use of 'medically unexplained symptoms' and being referred for psychological assessment, often with no adequate understanding of a person's condition/experience can be both frustrating and confusing for people, especially where physical illness is seen as a predominantly medical problem. A person in this situation is described as experiencing persistent physical symptoms and distress (PPS) (like LTC) in which a medical diagnosis has not been made due to a lack of observable biological pathology. It has been argued that the use of such disempowering language ignores (MUS) people's lived experiences by defining illness by what it is not and therefore creating an idea that it does not exist (Byng & Gask, 2009; IAPT, 2014).

PPS can be experienced as physical symptoms, including persistent pain and fatigue, and often involve psychological distress (Chalder & Willis, 2017). The symptoms may affect several areas of functioning for the individual, including social interactions, diminished roles at home, work, and mood (IAPT, 2008; 2014). While persistent pain and fatigue is frequent with MUS it is also associated with other musculoskeletal conditions and arthritis which present regularly in IAPT. Other persistent physical symptoms include breathlessness which often accompanies COPD or cardiovascular disease (IAPT/LTC, 2018). Breathlessness is also seen in people who present with non-cardiac chest pain (NCCP) comorbid anxiety and low mood. It is common for people with breathlessness to suffer from anxiety disorders, which include panic attacks and generalised anxiety disorder (GAD), often characterised by worry and fear of uncertainty.

LTC's are also frequently characterised by persistent and distressing physical symptoms. Furthermore, it is usual for people to suffer from more than one long-term condition, which increases their experience of persistent physical symptoms (Salkovskis et al., 2016).

The common physical health conditions described above and those classified under PPS share some systemic similarities, thus affecting many areas of physical and social functioning, including mental wellbeing (IAPT,2014). At times these are marked by episodes of flare-ups and progression which have adverse implications on careers, social roles, and employment (Chalder & Willis, 2017). Both LTC and MUS are associated with high health-service utilisation, long-term sickness absence from work and long-term unemployment (Deary, et al; 2007; IAPT, 2008, 2014; Nimmo, 2015; Salkovskis, et al, 2016).

As stated, the use of the term 'persistent physical symptoms' (PPS) has proven to be more engaging and acceptable to patients as it is less invalidating to their lived experiences. In contrast, the term 'medically unexplained syndromes (MUS) has been described as supporting 'dualistic thinking' with connotations of illness as either biological or psychological and therefore dismissive of people's embodied experiences. The term also contradicts the common understanding of people's experience of illness and persistent physical symptoms (Chalder &Willis, 2017). Furthermore, Chalder & Willis, (2017) contend that the use of this term (PPS) has some acceptability, as it increases shared understandings between practitioner and client. In addition, they assert that this terminology is consistent with the DSM-5 categorisation, which provides a more biopsychosocial conceptualisation of these conditions.

The policy of self-referral to improve acceptability and access to psychological therapies for people with LTC in IAPT made these conditions familiar to IAPT services, and therefore broadened conceptualisations of long-term conditions in this context. In this study, the commonly known chronic physical health conditions listed above and those referred to as MUS or functional syndromes will be collectively referred to as LTC/PPS.

1.4. CBT for LTC/PPS in IAPT: evidence from quantitative studies

Evidence from quantitative studies has contributed to our understanding of the impact of LTC/PPS on mental health and vice versa, as well as to our knowledge of what successfully reduces this impact. The most noteworthy evidence showed how the access to psychological therapies effectively reduced the impact of anxiety and depression on LTC/PPS (Coventry, et al; 2015; Wroe et al; 2015; Farrand & Woodford, 2015; Tan et al; 2015; Myers et al; 2016; Kellett et al; 2016; Delgadillo et al; 2017; Liu et al; 2019). Some of these studies focused on evaluating and benchmarking psychological therapies for LTC/PPS in IAPT. For instance, in a systemic review, Farrand & Woodford (2015) reported small, inconclusive effect sizes for the effectiveness of CBT self-help interventions for people with comorbid LTC and anxiety and depression. The review analysed 14 randomised controlled trials (RCTs) conducted between 1990 and 2014. However, with reference to the current study, the report, which is based on strong evidence from RCT's, has relevance for IAPT as it used CBT self – help interventions despite some of the studies being conducted before IAPT service and training. The other limitation of the review was its use of studies with small samples including use of self-repots as mentioned by authors. The systematic review also concluded that sub-clinical levels of anxiety and depression at enrolment to the interventions may have contributed to these findings (Farrand & Woodford, 2015).

Similar modest findings were reported in a cluster randomised controlled trial (RCT) that involved 387 patients with LTC including cardiac conditions and diabetes with comorbid anxiety and depression. The patients were from primary care and the Step 2 CBT interventions were carried out by PWP's from IAPT in collaborative care alongside nurses (Coventry et al;

2015). Despite the strong evidence from RCT, which involved the recruitment of patients from a large number (19) of doctor's surgeries; the patients received low-intensity CBT interventions which may have contributed to the findings as patients with LTC/PPS tend to have complex presentations. The collaborative working alongside nurses was, however, described as helpful. In a related study, it was found that CBT in low-intensity interventions was effective in improving mood and self-management for people with Type 2 diabetes, but had challenges that needed adaptations (Wroe et al., 2015). The study involved 95 patients from IAPT who had Type 2 diabetes with comorbid anxiety and depression. The psychological intervention was run in stages. The authors reported challenges with the low-intensity CBT interventions in the first stage and adapted subsequent stages accordingly. The study also used CBT low intensity interventions which focused on anxiety and depression, these included goal setting, behavioural interventions, and cognitive restructuring. The authors reported weak commitment, as clients did not find the interventions useful for their LTC and reported difficulty in engaging with content. However, when adaptations were made, which included enlisting the help of clinical health psychologist, an improvement was reported. The authors recommended collaborative working with other professionals and stressed the importance of good engagement skills with the client group. Although these findings are informative and have implications for planning CBT interventions in IAPT, it is worth noting some of the methodological challenges that may have affected the study. For instance, there was no random allocation of patients and therefore findings are based on a small sample including reliance on self-reports during service development and the follow up evaluation process. Collaborative working, including adapting CBT interventions to reflect co-occurrence of LTC/PPS, has also been recommended by Myers et al, (2016) following their pilot study which involved 161 referrals from GPs of people with LTC and comorbid anxiety and depression in an IAPT. Through their adapted Step 2 interventions and working alongside practitioner nurses with expert knowledge in LTC, a 59 % recovery rate was achieved.

Another pertinent study, involving 28,498 IAPT patients presenting with LTC and comorbid mental health issues, assessed the effectiveness of psychological therapies in IAPT for people with LTC/PPS. In the study Delgadillo et al., (2017) concluded that the IAPT stepped care psychological therapies were inadequate when offered alone to people with LTC, especially diabetes, persistent pain, and COPD. The authors further stated that these types of interventions do not adequately reduce the distress in LTC. The post-treatment PHQ9 and GAD7 scores from the study showed that at the end of therapy, patients with LTC remained more likely to have higher levels of both anxiety and depression than those in control groups. However, different socio-economic and demographic factors, including types of LTC, were also noted as moderators of recovery. The findings from this study have relevance for the planning and delivery of CBT interventions for LTC/PPS. It is important to note that although self-reports were taken from a large sample, this was from one IAPT site and therefore caution should be exercised when generalising findings. The findings recommended working collaboratively with other healthcare professionals, as their expert knowledge of these LTC would add value in improving self-management (Delgadillo et al., 2017). In addition to these recommendations and implications for delivery, another systematic review, involving 15 RCTs and 1,671 patients with MUS, found that when longer sessions were used with suitable skills and knowledge, CBT was effective in reducing physical symptoms with comorbid anxiety and depression (Liu, et al; 2019). An earlier study, that evaluated the provision of IAPT interventions for LTC/PPS, found no difference between clients who were labelled as having MUS and those with LTC; however, the recovery rates were much lower than those without LTC/PPS. The study involved 1293 patients with LTC/PPS who were treated at both Step 2 and Step 3 with most patients (81.8%) receiving low intensity CBT interventions at Step 2 (Kellet et al; 2016). This therefore implies that, more time and proper training for practitioners delivering the interventions should be given. In summary, despite substantial evidence for the efficacy of cognitive behaviour therapy (CBT) in treating anxiety and depression, studies have reported small effect sizes that are inconclusive for anxiety and depression with comorbid LTC/PPS. In addition, there are other challenges related to the use of the traditional CBT approach for LTC/PPS which affect recovery. Furthermore, as noted in Kellet et al; (2016), practitioners working with LTC/PPS are not always comfortable with the IAPT understandings of recovery when used in the LTC/PPS client group.

1.5. Conceptualising recovery in IAPT

Progress and therapy outcomes are monitored every session in IAPT using validated questionnaires for anxiety and depression which include; Patient Health Questionnaires (PHQ9) (Löwe et al; 2004); Generalised Anxiety Disorder Assessment (GAD7) for anxiety (Spitzer et al; 2006); Work and Social Adjustment Scale (WASAS) (Mundt et al; 2002) and social phobia scales (IAPT, Data Handbook, 2011). Both the PHQ9 and GAD7 are extensively used in primary healthcare and recommended in the screening for depression and anxiety disorders and in IAPT, these are used as benchmarks for recovery (IAPT/LTC, 2018). The IAPT also uses Patient Experience Questionnaires (PEQ) to allow service users to give feedback about their experience; however, the PEQ is used anonymously and therefore does not contribute towards sharing individual processes of change and recovery from psychotherapy (Omylinsika-Thurston et al; 2019).

The term ‘caseness’ is used to refer to the severity of symptoms of depression and anxiety that meet criteria for IAPT interventions when measured using validated IAPT outcome measures. Recovery in IAPT is defined using a formula for calculating reliable improvement (IAPT, 2017). In this formula, improvement or change by a reduction of 6 on the score for PHQ9 (or a score below 9) or 4 to the GAD7 (or a score below 7) is seen as a reliable improvement (Jacobson &Truax, 1991). It is possible for clients to deteriorate during therapy and the level of deterioration is also calculated reliably (Jacobson &Truax, 1991). This formula has suggested the recovery rates in IAPT to be as high as 50% (IAPT, 2017).

1.6. Criticisms of IAPT

The IAPT definitions of recovery has been criticised and debated on many levels (Rizq, 2011; 2012; Williams, 2015; Scotts, 2018; Binnie, 2018; Marks, 2018; Geharghty & Scott, 2020). IAPT has been severely criticised and seen as a cheap way of providing mental health in compliance with both economic and ideological pressures. Rizq (2011) criticises IAPT from a psychoanalytic perspective, questioning the 'unconscious dynamics' that operate in this context. The author describes the demanding processes which entail regular quantitative outcomes measures with inadequate user feedback, including what she refers to as 'well–being work' for dealing with depression and anxiety, as minimally helpful for both patients and staff. She also warns that the rigid protocols and high caseloads could undermine empathy, hinder the ability to care and cause burnout in the IAPT staff (Rizq, 2012).

IAPT has also been criticised for its focus on quantifying outcomes of therapy, rather than focusing on recovery experience and for limiting therapy choices by allowing for the dominance of CBT which espouses individual-centred practice (Williams, 2015). The criticisms extend to the practitioners of CBT who provide psychological therapies. The IAPT was further criticised in a report that involved 90 patients from GP surgeries whose problems were trauma related. Arguing from a psychiatric discourse, Scott (2018) claimed that the recovery rates in IAPT were much lower than the suggested 50% and estimated them to be below 10%. Scott's criticism extended to IAPT's protocols and assessment procedures including the therapists who employ these methods. He further criticised IAPT for their focus on conducting workshops and not providing enough training around group facilitation. While some of these criticisms maybe useful, particularly in planning services for people with LTC /PPS; Scott's criticisms on recovery, which implied that IAPT interventions were ineffective, were, however, based on a very small sample whereas stronger supportive evidence from systematic reviews and meta-analysis exist. For instance, 60 studies involving 636,734 patients, found that IAPT interventions were, in fact, effective (Wakefield et al; 2021). Likewise, evidence collected from more than 100 IAPT sites between 2012 and 2019, showed that recovery rates have been gradually improving and in 2018 data collected from 512,942 cases recorded a recovery rate of 50.8 percent (NHS England, 2019).

More relevant to the current study Geraghty & Scott (2020) highlighted limitations in how people with MUS symptoms are managed in IAPT. For instance, the authors criticised the IAPT for not being specific about MUS diagnoses and instead focusing on treating anxiety and depression and commented that IAPT's therapists were not adequately trained to treat people with LTC/PPS. Their paper echoed the criticisms of exaggerated recovery rates. These authors concur with other researchers, such as Williams (2015), in their recommendations regarding new understandings of recovery, with a focus on service user perspective in IAPT.

Despite these criticisms, others have identified strengths in IAPT stating that the approach offers new methods of engaging and progressive ways to break down barriers and stigma. Furthermore, some criticisms have been described as unhelpful, undermining both the multiplicity and contextual ways of knowing and working that characterise the current practice in IAPT (Binnie, 2018; Turner, et al; 2018). These critical views have been accused of undermining the different ways in which psychology can be used to benefit individuals in a variety of contexts and situations where non-judgemental and collaborative approaches are prioritised. As contended, the IAPT model of working offers alternative and less stigmatising engagement with psychological services (Binnie, 2018) thereby increasing accessibility and acceptability, offering flexibility especially for people suffering from LTC/PPS (Turner, et al; 2018).

Likewise, the overall benefits of using CBT in IAPT are highlighted and supported in more recent research. For instance, De Lusignan et al; (2013), found that referrals for psychological therapies for LTC were beneficial in the reduction of cases attended to by the Accident and Emergency Department (A/D). As well as increasing medication adherence, the study also found that people with LTC reduced their higher health service utilisation following referral to IAPT (De Lusignan et al; 2013). These benefits to the health care system further support the assertion that the referral to psychological therapies outweighs the challenges. In addition, Wroe et al., (2015) highlighted other benefits of psychological therapies, such as an increasing awareness of choices, and adherence to other medical procedures and medication plans that improve health outcomes.

1.7. Recovery as lived experience

IAPT is also criticised for lacking a service-user perspective in its definition of recovery, including a lack in focus on more long-term outcomes of recovery (Marks, 2018). In contrast, the concept of recovery, understood as an individual holistic lived experience (Levitt, et al ; 2016), has been debated and is differentiated from clinical recovery, a process usually predetermined using set criteria and outcome measures of symptoms as understood in IAPT.

Recovery as lived experience has been explored, for instance, a systematic review by Leamy et al; (2011); identified the five processes associated with personal recovery, namely;(1) sense of connectedness; (2) optimism and a sense of hope about the future; (3) sense of identity; (4) attaching meaning and (5) purpose to life including a sense of empowerment (Leamy, et al.

2011.p.448). Recovery has been viewed as an idiosyncratic non-linear process (Leamy, et al.2011; Slade et al; 2014; Levitt et al; 2016). A similar view is supported in the systematic review, which explored patients' experience following psychotherapy. Findings revealed that individuals viewed their experience of change as a 'holistic lived experience' rather than linear single patterns of information (Levitt et al; 2016). The understandings of recovery have originated from both mental health and addiction studies (Ashford et al; 2019). These understandings might, therefore, not fit with common understandings of recovery within the medical model context from which patients view LTC/PPS. Equally, these might also contradict the experience of persistent symptoms. The understanding of recovery from LTC/PPS therefore seems to be a complex process which might vary and be experienced differently by individuals depending on multiple factors such as their illness narrative (including impact on their quality of life and identity). It might be that some novel approaches are needed to allow the process of recovery to unfold and be viewed from the patient's perspective rather than imposed. More useful to this debate is how practitioners working with LTC/PPS can contribute towards helping the unfolding of this lived experience for patients. Levitt et al (2016) contended that drawing on multiple models during psychotherapy can allow for a range of change mechanisms to develop during psychotherapy, and therefore encourage psychotherapists to learn to practice in a more integrated way.

In criticisms as to how recovery is conceptualised in IAPT, debates inevitably shift towards the importance of lived experienced of illness, including experience-based understanding of recovery. In doing so, the critics argue for a paradigm shift in exploring recovery towards methodologies that permit service users to voice their interpretations of this lived experience (Williams, 2015).

1.8. Lived experience of illness and recovery: qualitative evidence

The focus of this study is exploring lived experience and recovery of participants following attendance at two psychological interventions, namely CBT adapted for LTC/PPS followed by MBCT. It has been found that patient's views following psychological therapy are not always consistent with their experience and initial expectations (Westra et al; 2010). Therefore, exploring the views of service users in IAPT has been described as important in planning and improving the quality of mental health services thereby enhancing the engagement between clients and therapists (Rizq, 2012; Delgadillo et al., 2017; Rousmaniere al., 2019).

Likewise, a qualitative meta-analysis (Levitt et al, 2016) of 67 studies that examined the lived experiences of individuals following face to face psychotherapy argue for an agenda in which psychological interventions are informed by the client's views and perspectives. Furthermore, the analysis contended that collating this information can help structure future psychological interventions. However, there is still a gap in studies exploring the lived experiences following recovery from psychotherapy in IAPT (Williams, 2015; Binnie, 2018). Importantly, there is limited information on these views from people with LTC/PPS and comorbid anxiety and depression following their attendance at IAPT interventions. To identify studies on this topic, a review of literature from qualitative studies focusing on lived experience of illness and recovery in the last ten years was undertaken and synthesised to identify themes from studies. The databases used included Google search; EBSCO; PubMed and ScienceDirect using key terms as follows: lived experience; long term conditions; qualitative research; IAPT; persistent physical symptoms and recovery. This was also followed up by searches from references identified in the studies and papers retrieved during the search.

This literature review revealed how qualitative research in this field has contributed towards our understanding of the sociological impact of illness. This has been widely studied with specific relevance placed on the meaning and legitimisation of symptoms which directly impact identity (e.g., Bury, 1982; Crossley, 2000; Kralik, et al; 2010; Taylor & Bury, 2007;). This impact of illness and persistent symptoms on one's identity has been referred to as 'biographical disruption' and has been studied and expanded on since it was coined by Bury (1982). The concept was extended to acknowledge both the challenges and psychological processes of change to one's sense of self. It described how people adjust and adapt to the changes brought about by the impact of living with an illness. While recognising the interruption to the sense of self, other studies built on the concept to recognise and describe how people adjust and move towards a state of 'biographical restoration and repair' as they move towards acceptance of their illness (Lockock et al; 2009; Nanton, et al ; 2016, Brown, 2018; Bigony & Keitel 2020)

In a recent study, that explored the lived experiences of women with fibromyalgia using IPA, Brown (2018) further extended these understandings of identity during illness and warns against the uncritical use of the concept of a 'disrupted identity' by adding that 'illness is not always seen as disruptive by others'. In addition to this debate on changing identity due to illness, Nanton et al; (2016) conducted an ethnographic and narrative analysis involving a population of people with long term conditions over a period of 12 months. The study explored the changing presentation of selfhood observed in changing contexts and time in the face of fluctuating impact of persistent symptoms and progressing illness. The researchers were able to describe social and healthcare forces shaping identities of the sufferers through the trajectory of illness, illustrating that practitioners could contribute towards helping patients achieve their preferred identities to improve the damaging effects of illness on the sense of self (Nanton et al; 2016).

In IAPT, a more relevant study, explored the views, and experiences of patients with medically unexplained symptoms (PPS) following attendance at CBT or MBSR interventions were using a thematic analysis. The stepped-care CBT interventions included Step 2 (GSH) and Step 3 (High Intensity) or MBSR group interventions (Gerskowitch et al; 2015). The sample from this study was very small and the difference was that participants attended either CBT or MBSR and not both, as in the current study. There were four important themes that emerged in the analysis, namely; participants identified that a change was needed and they felt understood; participants were able to make links between their physical symptoms and mood and were able to reflect on their therapy experience. The results supported acceptability of CBT interventions and MBSR in IAPT and authors recommended further research in this area, including a focus on training group interventions for IAPT therapists (Gerskowitch et al; 2015).

Furthermore, LTC's are frequently characterised by persistent and distressing physical symptoms. It is also usual for people to suffer from more than one long-term condition, which increases their experience of persistent physical symptoms (Salkovskis et al., 2016). Other studies have contributed towards our understanding of lived experiences of chronic illness and other persistent symptoms and their impact on an individual's condition (e.g., Berglund & Källerwald, 2012; Dennis, et al ; 2013; Diviney & Dowling, 2015 ; Egan, et al ; 2017; Finlay, et al; 2018 ; Gerskowitch, et al; 2015; Maguire, et al; 2014; Marks et al , 2019). Smith & Osborn, 2015; Smith & Shaw, 2016).

Smith & Osborn (2015) used an interpretative phenomenological approach to explore the lived experiences of nine women who suffered from persistent back pain during their attendance at a pain management clinic. The authors state that exploring lived experience led to deeper understandings and construction of psychological meanings. The study, therefore, adds insights into the mental wellbeing and needs of people who suffer from persistent symptoms and highlights the types of psychosocial interventions needed. Likewise, Diviney & Dowling (2015) also adopted IPA to analyse information collected from emails and interviews in which both history and diagnosis were included for people with fibromyalgia (FM). Of relevance to the lived experience of participants in the current study, is how FM consists of persistent pain and fatigue, including psychological and cognitive factors, which include mood and memory. The multiplicity of these persistent symptoms showed both the complexity and subjectivity of FM, which therefore needs understanding from a patient’s perspective. In their analysis, Diviney & Dowling (2015) concluded that there was a lack of understanding from healthcare professionals and identified a need for responsiveness in planning services. The exploration of the PPS as lived experience helps to gain shared understandings between healthcare professionals and patients. The findings from this study spiked a need for psychological interventions that can be helpful and acceptable for people with LTC/PPS, while also adding value towards a shared understanding between health practitioners and service users. Maguire et al; (2014) also used IPA to explore the lived experiences of people with multiple physical symptoms of cancer. The most experienced, persistent symptoms in this study, were breathlessness, cough, fatigue and pain including distress related to meaning and experience. These physical symptoms and distress are also common in many others with LTC/PPS. This study contributes towards the understanding of the impact of multiple symptoms as well as the importance of the meanings attached to the experience.

In addition to this theme, Marks et al. (2019) studied the experience of people living with tinnitus to understand the impact of stress and how these symptoms become persistent. This study investigated living with tinnitus before and after attending MBCT. The participants described how difficult it was to live with tinnitus and how participants experienced other persistent psychosocial symptoms, including unhelpful reassurance-seeking behaviours and catastrophic thinking. The results implied the importance of prompt interventions including helpful content to effectively aid sufferers to prevent the psychological distress.

Another important theme in these qualitative studies is the phenomenology of learning to live with, and accept a long-term condition as also mentioned by Brown (2018) in describing the gains and losses with the women who lived with fibromyalgia. A different qualitative approach using a reflective lifeworld approach, by Berglund & Källerwald (2012) defined the phenomenology of learning to live with illness as a shift in understanding that comes because of trying to adjust to changing situations. This process was described as leading to acceptance, resulting in learning to be more resourceful when living with illness and persistent symptoms. It also recognised the experiences of people with LTC/PPS and their difficulty in manipulating their world due to the impact of persistent symptoms in their bodies. Smith & Shaw (2016), interviewed people with their partners in exploring the impact of living with Parkinson's disease and added further to the scope of evidence. Their findings revealed that it is not just individuals living with long term illness that are affected, but that significant others experienced the impact as unsettling with life-long consequences (Smith & Shaw, 2016). In another study, Egan et al. (2017) explored the perceptions of participants following a pain management programme (PMP) in which CBT was used and found that the PMP produced long-term gains in pain management over a 13-year time period (2001 to 2014). The researchers recommended follow-up sessions to maintain these gains and the qualitative reports of participants' experiences built on the existing evidence of positive outcomes.

Importantly, other studies have revealed clients' perspectives on psychological processes, such as in the results from Levitt et al; (2016) which found how clients developed new understandings of their thoughts and behaviours following therapy. Central themes in this meta-analysis included the conclusion that clients were appreciative of the support and guidance they received during treatment and experienced the benefits of the treatment beyond the therapeutic process. Another central theme, that was equally relevant to the current study, is how the clients positively viewed the experience of working with thoughts (Levitt et al., 2016). In a similar vein, Finlay et al; (2018) used IPA in the examination of mechanisms and practices inherent to supporting people with persistent pain. This study also offered insights into the processes and structures pertinent to the development and implementation of psychotherapy groups for people with LTC/PPS.

1.9. **Positioning and relevance of current study**

1.9.1. Lack of qualitative studies of recovery experiences in IAPT

The current literature from studies points to a lack of focus on service-user experiences of psychological interventions and recovery from IAPT. The studies exploring the outcomes of interventions for people with LTC/PPS have contributed towards our understanding of the impact of long-term conditions (LTC) including living with persistent physical symptoms in IAPT (Coventry et al; 2015; Delgadillo et al; 2017; Farrand &Woodford, 2015; 2016; Kellett et al ; 2016; ; Liu et al; 2019; Myers et al;2017; Tan et al; 2015; Wroe et al ; 2015). Research in this area has also identified a need for responsiveness in the planning of future services based on service-user perspectives', making this an important area of research. While the contributions of the quantitative studies discussed above are useful in planning healthcare and psychological interventions, there has been limited qualitative studies particularly in IAPT into how service users experience psychological interventions and their subsequent perspectives on recovery.

There are supportive arguments for more research focusing on patients' lived experiences of psychotherapy (Williams, 2015; Levitt et al; 2016). The current gaps in the reviewed studies show that more focus should be given to service users in IAPT to provide descriptions of their experiences of illness, therapy, and recovery. Considering this gap in the shared understanding of recovery, the current study contributes to the argument by considering how clients conceptualise their process of recovery. It also adds to an understanding of how psychological interventions work, and how they are experienced by service users in real-life situations. In addition, the project builds upon the understandings of both illness and recovery in people with LTC/PPS. This will help to fill the gap in this sphere of research as, to date, no study has been conducted on the experiences of those with LTC/PPS who have attended both adapted CBT for LTC/PPS and MBCT in IAPT. This is despite both interventions being used in IAPT and recommended for people with LTC/PPS and comorbidities of anxiety and/or depression (IAPT, 2018).However, it is more pertinent to this study that patients with LTC/PPS are unlikely to achieve the IAPT recovery following psychological therapies, as pointed out by Keller et al; (2016). This also stresses the importance of not relying solely on quantitative approaches for measuring recovery, but to also explore subjective client experiences (Williams, 2015).

1.9.2. Challenges with CBT (for anxiety and depression) for LTC/PPS in IAPT

As identified earlier in the literature review, there are challenges related to the use of the traditional CBT approach in patients with LTC/PPS, which may affect recovery. These include both types of CBT interventions and content (Hardet, 2013; Wroe et al; 2015). It was also identified that when adaptations were implemented, including the collaborations with other professionals with expert knowledge, such as professional nurses and clinical health psychologists, gains were observed. (Delgadillo, et al; 2016; Farrand & Woodford, 2015; Myers, et al, 2016; Wroe, et al; 2015). Despite acknowledging these adaptations, a gap remains in the transparent use of theories in adapting CBT interventions for LTC/PPS. This gap therefore creates a challenge for psychologists to effectively use their skills and knowledge.

The importance of developing effective evidence-based psychological interventions has been stressed. In health psychology interventions, behaviour theories and their constructs have been used for understanding and describing the processes involved in behaviour change. This use of psychological theories is important in both designing and evaluating the effectiveness of the psychological interventions as it highlights both ‘moderators and mediators of change’ (Davis et al; 2015).

1.9.3. Lack of focus on group interventions in IAPT

Due to the focus of most studies being on the lived experience of individual psychotherapy, less is known about the group experience of intervention. The literature review has also identified a lack of use of CBT group interventions (Scott, 2018) and qualitative studies that focus on recovery-oriented practices in IAPT.

1.10. Objectives of the study

The study is consistent with both the aims and objectives of IAPT and NICE guidelines which emphasise; “Improving access and engagement…as well as evaluating the role of specific psychological and psychosocial interventions in the treatment of adults with depression and chronic physical health problems” (NICE, 2016, p.13). Within this context, this study can be considered as part of implementation research in which an adapted CBT model was used followed by a service-user feedback process where their lived experiences were explored. As stated, the objective of implementation research in a health setting is to; “…grasp why, what, and how interventions work in real health contexts as well as investigate ways of improving these” (Peters, et al; 2013, p. 1). The project was implemented as part of a benchmarking process, which included evaluation and quality improvement as well as the validation of existing psychological interventions and protocols used in IAPT for people with comorbid mental and physical health conditions. Of relevance to the current service evaluation, was my role as a psychologist working with LTC/PPS in IAPT in ensuring that psychological interventions for LTC/PPS and comorbid mental health are implemented in IAPT to help people cope and adjust with diagnosis and management of these conditions (NHS England, 2018). As stated, one of the vital competencies for psychological therapists and psychologists working with LTC/PPS in IAPT is; "To be able to make appropriate adaptations to standard CBT intervention techniques to help clients who present with anxiety and depression in the context of long-term health" (NHS England, 2017. p10).

This study aims to explore the experience of the participants following their attendance to an adapted CBT intervention for people with LTC/PPS, which was followed by an 8-week attendance to MBCT programme. The psychological intervention employed in this study was a 10-week CBT programme which was adapted using both social cognitive theory (SCT) (Bandura, 2004) and self-regulatory theory (SRT), also referred to as the common-sense model (CSM) (Leventhal et al ; 1998).

CHAPTER 2: Implementation: Developing an integrated CBT programme for people with long-term conditions: an integrated model for quality improvement.

2.1 Overview

This chapter describes the adaptation of the model and includes discussion of the health psychology theories that were used to adapt the CBT interventions for people with LTC/PPS. The rationale for introducing two new theories into the content of the traditional CBT model has been identified and the need for bridging this gap was discussed in the previous section. Respectively, the chapter also discusses the relevance of these theories to the CBT interventions and how their constructs were developed during the programme. The chapter outlines and describes how the various facets of the model, including CBT interventions and behaviour change techniques were used in each session. Throughout this description of the sessions there is reference to the role of the facilitator and how group processes were facilitated during the programme.

2.2. Health psychology theories

In this psychological intervention, both the Common-Sense Model (CSM) (Leventhal et al;1998) and Social Cognitive Theory (SCT) (Bandura, 2004) were chosen because of the reliable evidence showing their effectiveness in promoting health and self-management (Munro et al., 2007). It has been shown that the use of theory when planning interventions encourages behaviour change (Davis et al; 2015; Michie, et al; 2011; Michie et al; 2013; Munro et al., 2007; Reid &Aiken, 2011). This is particularly vital when designing and implementing interventions for people with LTC/PPS where lifestyle changes are often needed. The CSM has been widely researched and the application of its constructs in health management has been investigated in various studies, including systematic reviews (Breland, et al; 2020; Dempster et al; 2015; Lau-Waker,2004; Leventhal, 2004; McAndrew et al; 2018).

The CSM has been useful in informing interventions in various long-term conditions to improve coping in people with LTC, for example Hill et al; (2007), in their study of people with musculoskeletal disease. Similarly, in another study the CSM was applied in improving CBT interventions for people with diabetes to help understand how individuals cope with physical illness and how anxiety and depression might have an impact on long-term conditions (Hudson et al; 2014). Importantly, the results of a systematic review involving 31 articles examining the constructs of the CSM, found that there is a relationship between illness representations and the use of coping strategies, and concluded that these constructs played an important role in understanding the distress experienced by patients with long term conditions (Dempster et al; 2015).

More recently, it has been suggested that the CSM could be used alongside any theoretical approach to enhance psychotherapy and self-management in mental health illness (McAndrew et al; 2018). Interestingly, extending the model to also reflect the impact of socio-cultural issues and ethnicity on coping, has also been proposed (Hagger &Orbell, 2021). Of even more significance to people with LTC/PPS, is a systematic review consisting of 25 studies of participants with a range of long-term conditions. This review revealed that when the constructs of both SCT and CSM were used in the same model, they improved both self-management and health outcomes for people with long term conditions (Breland, et al; 2020).

In addition, the SCT has been successfully used alongside behaviour change techniques (BCT's) including; self-monitoring, intention, formation, self-re-evaluation, modelling and social support which are needed in the adjustment and self-management of long-term conditions (Luszczynska & Schwarzer, 2020; Michie et al; 2011). Michie et al; (2013) stresses the importance of making explicit the behaviour change techniques used especially when conducting complex intervention sothat they can be easily replicated. To help with implementation and choice of theories and techniques for facilitation, the behaviour change wheel (BCW) and theoretical domain framework (TDF) were developed by behavioural scientist. Located at the centre of the BCW is the COM-model, which helps practitioners in making the initial assessment of Capability, Opportunities and Motivation before implementing behaviour change and more importantly the outer wheel consists of behaviour change techniques to choose from (Michie et al; 2011).In this adapted model these behaviour change technique were used alongside the constructs of the CSM and SCT theories to facilitate behaviour change.

Similarly, the use of SCT in interventions for people with LTC has been explored in past studies and used effectively in achieving both behavioural and cognitive changes (Luszczynska & Schwarzer, 2020). The theory is also useful in helping to observe and cultivate group processes which facilitate learning from others (Gustavsson, 2011; Rhee et al; 2018; Cameron et al., 2018). Gustavsson (2011) used SCT alongside CBT interventions in group therapeutic processes to cultivate the highlighted benefits, which included role-modelling and learning through observing others in a safe environment. Their study reported both cognitive and behavioural therapeutic gains in people with neck pain in primary care. Cameron et al; (2018) echoed similar findings, adding that self-efficacy, in turn, was associated with goal planning and achievement, thereby increasing self-management for people with LTC. In a more recent study, 213 participants with LTC attended a self-management group programme in which self–efficacy measures were used before and after interventions. The findings supported existing evidence that group interventions facilitate the development of self-efficacy through modelling and role identification. (Cameron et al; 2018). Further benefits have been observed in the application of SCT with relation to cognitive factors and self-efficacy, such as in Rhee et al;

(2018) who found that perceptions of barriers and expectations about outcomes predicted medication adherence.

Experts in in the field LTC/PPS have stressed the importance of cultivating self-efficacy and a sense of competency in managing LTC/PPS. CBT interventions that include a focus on self-efficacy have also been used for chronic fatigue syndrome (CFS) alongside graded exercise and specialist medical care for people with CFS. The authors also support the importance of focusing on self-efficacy when planning interventions to improve self-management and activity (Chalder et al; 2015). A gap has been identified in the use of health psychology theories for adapting both Step 2 and Step 3 interventions, to reflect the needs of people with LTC/PPS, as identified in the literature review.

It was therefore essential to choose theories that could mediate and strengthen the CBT interventions allowing participants in the programme to improve their adjustment and manage difficulties related to LTC/PPS. Both the SCT (Bandura, 2004) and the CSM (Leventhal et al.,1998) stress that individuals have capabilities and can self-regulate their lives. The purpose of using both theories in the intervention was to facilitate the development of helpful behaviours, including intentions for self-management, as observed in previous studies using SCT (Gustavsson, 2011; Hill et al., 2015; Cameron et al., 2018). Given this firm evidence base for both CSM and SCT, the adaptation provided a credible theoretical context for the CBT psychological intervention.

Psychoeducation based on cognitive behaviour therapy, that guided behaviour interventions in this study, adopts both behavioural and cognitive perspectives, which are inherent in SCT. The rootedness in social learning theory made the SCT more applicable to a CBT group format (Bandura, 2004). Likewise, the CSM was chosen for its emphasis on individuals' common beliefs and knowledge about illness, including how they feel and act on this (Leventhal, 2004;

Hill et al, 2015). Consistent with SCT, the psychological intervention followed a group format so that it could provide a supportive environment and context for learning from others (Cameron et al, 2018; Gustavsson, 2011).

As found by Breland et al, (2020) the two models are complementary, and the relationship between its constructs, such as ‘illness representations’ and ‘self-efficacy’ (Lau-Walker,2004), is well established in enhancing behaviour interventions. The CSM is useful in assisting the appraisal of prior learning, such as exploring the impact on coping behaviours, while the constructs of SCT contribute towards building confidence in performing helpful behaviours and improving the self-management of long-term conditions (Lau-Walker,2004; Breland et al, 2020).

2.3. Social Cognitive Theory (SCT)

Social cognitive theory contends that a person’s behaviour is motivated by self-efficacy; outcome expectations, including the ability to overcome what an individual experiences as barriers and the ability to effectively use what they consider to be facilitators of behaviour change (Bandura, 2004; Luszczynska & Schwarzer, 2020). In this adapted CBT model, it was more useful to apply the whole theory rather than just self-efficacy, as its constructs were used in the facilitation and observation of group processes. In addition, the theory considers the role of social support and motivation, including contextual factors, which are influential in learning and self-regulation in groups. In this intervention, the group provided an important environment for learning (Cameron et al, 2018; Gustavsson, 2011). The SCT focuses on the relationship of multiple interacting factors in influencing human behaviour. These factors could either be personal, such as cognitive and behavioural, or environmental in nature (Bandura,2004). In this theory, the ‘environment’ is conceived in a broader context to also include the care systems and where people live, learn, and entertain themselves (Bandura, 2004; Schunk & DiBenedetto, 2020). This has expanded to include social media platforms such as Facebook, and WhattsApp. The SCT is rooted in social learning theory, the constructs of which are used to cultivate ‘human agency’ which is explained as, “acts done intentionally” (Bandura, 2001, p.6). Intentional actions are relevant to behaviour change, particularly when lifestyle changes are needed, as is the often the case in with LTC/PPS. The image below provides a diagrammatic representation for the aspects of the theory.

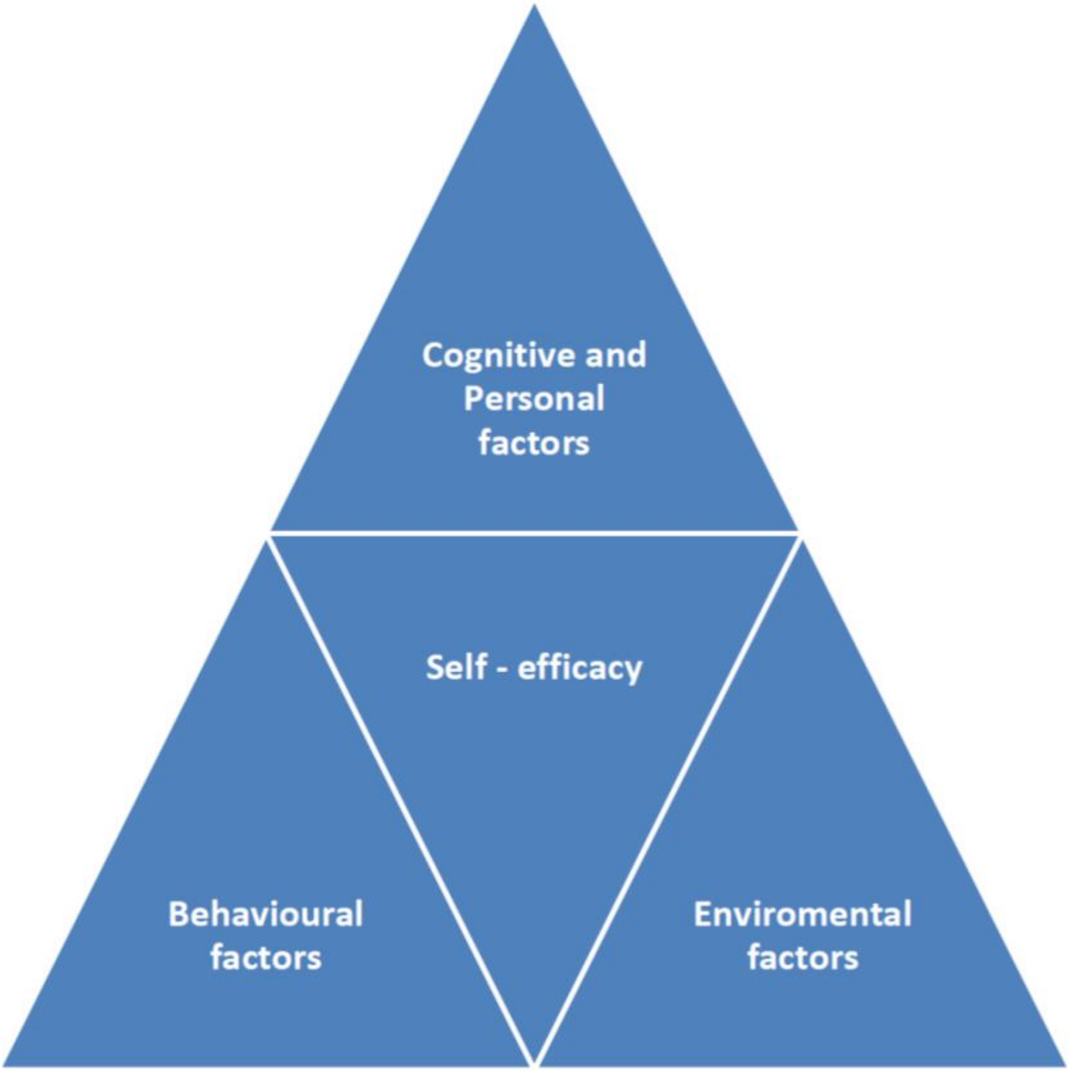


Figure 2.1. ***A graphical representation of SCT, adapted from Bandura (2004)***

2.4. The Common-sense Model (CSM)

The common-sense model (CSM) (Leventhal et al; 1998), illustrated in figure 2, was appropriate to and consistent with both CBT and SCT. The CSM has been used to understand the links between illness cognitions and emotional health. This model describes the common-sense understandings of a person's ability to self-regulate by using five domains namely, cause, identity, consequences, controllability, and timeline (Leventhal et al., 2004). CSM is utilised for its ability to explore participant's subjective experience of LTC/PPS. From what is understood using CSM, long term conditions are often perceived by people as a threat to which individuals actively develop strategies for self-care and protection against their impact (Hagger &Orbell, 2021; McAndrew et al; 2018). The theory further proposes that when an illness is triggered, cognitive representations of the specific illness are formed, which are linked to emotional and coping responses. These cognitive representations add to an individual's past experiences, influencing their conclusions and decisions about coping with the illness (Hagger &Orbell; Leventhal et al, 2004). According to this theory, these unique meanings lead to personal common-sense understandings of experience and adapting to illness. It is this individual, characteristic understanding which influences how a person learns to cope and adapt to their illness. Correspondingly, coherence is achieved when people can make sense of why their coping is working (Leventhal, 2004; Dempster et al., 2015). During our work in CBT, we observe these illness representations reflected in thoughts and other illness cognitions expressed in therapy or group discussions.

Likewise, the model focuses on a person's strengths and abilities as it proposes that people can regulate their lives as well as solve their problems. CSM, therefore, stresses an individual's agency in self-monitoring and self-regulating their lives (Leventhal,2004). It was, therefore, seen as more appropriate than solely CBT in exploring the impact of LTC/PPS and how participants cope with the impact as well as in identifying interventions as appropriate.

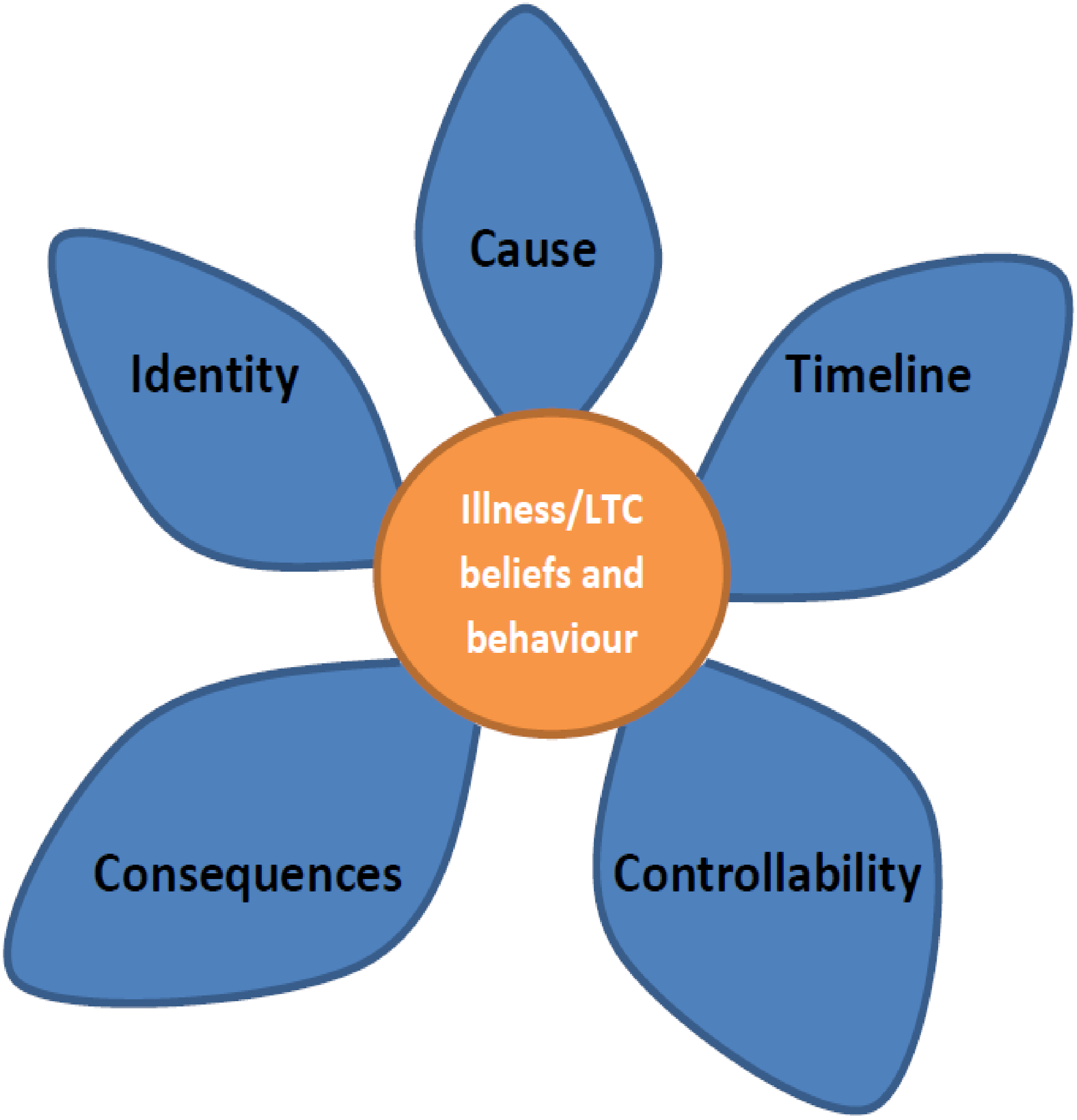


Figure 2.2 *A graphical representation of the CSM adapted (Leventhal et al 1998)*

2.5. Cognitive behaviour therapy for LTC/PPS

The history of cognitive behaviour therapy originated with Beck in the 1970s as a therapy for depression and has been extensively described in other studies which track how it has evolved into third-wave psychotherapies such as; acceptance and commitment therapies and mindfulness (ACT). Others have described CBT as an approach drawing on post-modern ideas which emphasise collaborative relationships rather than patriarchal and prescriptive therapy (Eagle, 2004; Freeman, 2006). Such approaches emphasise contextualised, social practices, in which individuals show common sense understandings and coping with their illness. At the heart of this, is a shift towards more collaborative relationships with practitioners that can facilitate growth and behaviour change by utilising a variety of CBT interventions (Salkovskis et al., 2016). It is within this context that CBT in IAPT has to be practised to improve self-management in people with LTC/PPS.

CBT has developed and evolved and is used in therapy for a range of mental-health issues, including anxiety and depression, and it has been proven to reduce relapse and assist in the reduction of symptoms (Beck, 1979; Paykel, 2007; Knaap & Beck, 2008). This effectiveness of CBT lies in the psycho-educational aspect of the process, in which clients can acquire skills and knowledge around illness, identify triggers to the associated distress as well as maintenance factors such as the role of negative cognition and compensatory strategies. There is also a significant focus on developing coping strategies to deal with illness. CBT has continued to evolve and be adapted in many forms and is now used for LTC/PPS in a variety of adaptations (Salkovskis et al., 2016). These developments have proved beneficial to the advancement of therapies for long-term conditions, as shown in the study on the management of chronic pain (e.g. Williams et al ; 2012) and in different forms of MUS (Deary et al ,2007; Escobar, et al 2007; Chalder & Willis, 2017). In its application to therapy, CBT uses a five-model approach that acknowledges the relationship between cognitive, affective, physical, behavioural and environmental factors (IAPT, 2014; Salkovskis et al., 2016). The basic principles underpinning CBT assert that how we think about the world; others; events, including our circumstances; influences our emotions or reactions, such as bodily sensations, behavioural or cognitive responses (Beck, 1979). These principles still apply to CBT for LTC/PPS. The significant contribution of applying CBT in the context of LTC/PPS comes from the acknowledgement of the complex interactions between the physical symptoms of illness and distress and how the unhelpful patterns are perpetuated and maintained through behavioural responses and cognitive interpretations (Salkovskis et al., 2016). The role of therapy in CBT is for clients to identify when these patterns and maintenance factors interfere with their daily lives. Psychological interventions based on CBT focus on changing and finding helpful alternatives for these unhelpful patterns of thoughts and behaviours (Roth & Pilling, 2007).

Correspondingly, an increasing number of research studies, including systematic reviews and meta-analyses, have found that CBT offers a useful explanation for the understanding and management of long-term conditions and persistent physical symptoms, including in the absence of pathology. CBT models have been used for people with persistent physical symptoms, including chronic fatigue syndrome (CFS) and irritable bowel syndrome (IBS) (Dearyet al; 2007; Chalder et al; 2015; Chalder & Willis, 2017). The importance of focusing on self-efficacy when planning interventions to improve self-management and activity has also been expressed in these CBT interventions (Chalder et al; 2015). As identified in previous studies, challenges remain in the use of standard CBT and its content and delivery for LTC/PPS in IAPT (Hardet, 2013; Wroe, 2015; Delgadillo, 2017) and therefore, in this study, health psychology theories were used to adapt the CBT intervention as was discussed earlier in this chapter. The Five Area CBT model is shown below in figure 3.

2.6. How the integrated model was used in practice

In this adapted model, the constructs of both SCT and CSM were used to make the impact of LTC/PPS with comorbid anxiety and depression more explicit and understandable to participants. The model, as it was applied in this intervention, provided a coherent explanation of how the constructs were used in the process. The adapted model from models of working with people with persistent physical symptoms (PPS) (Dreary et al; 2007; Chalder &Willis,2017) and Five area CBT model, (Becks,1979) is graphically represented in Figure 3 below.

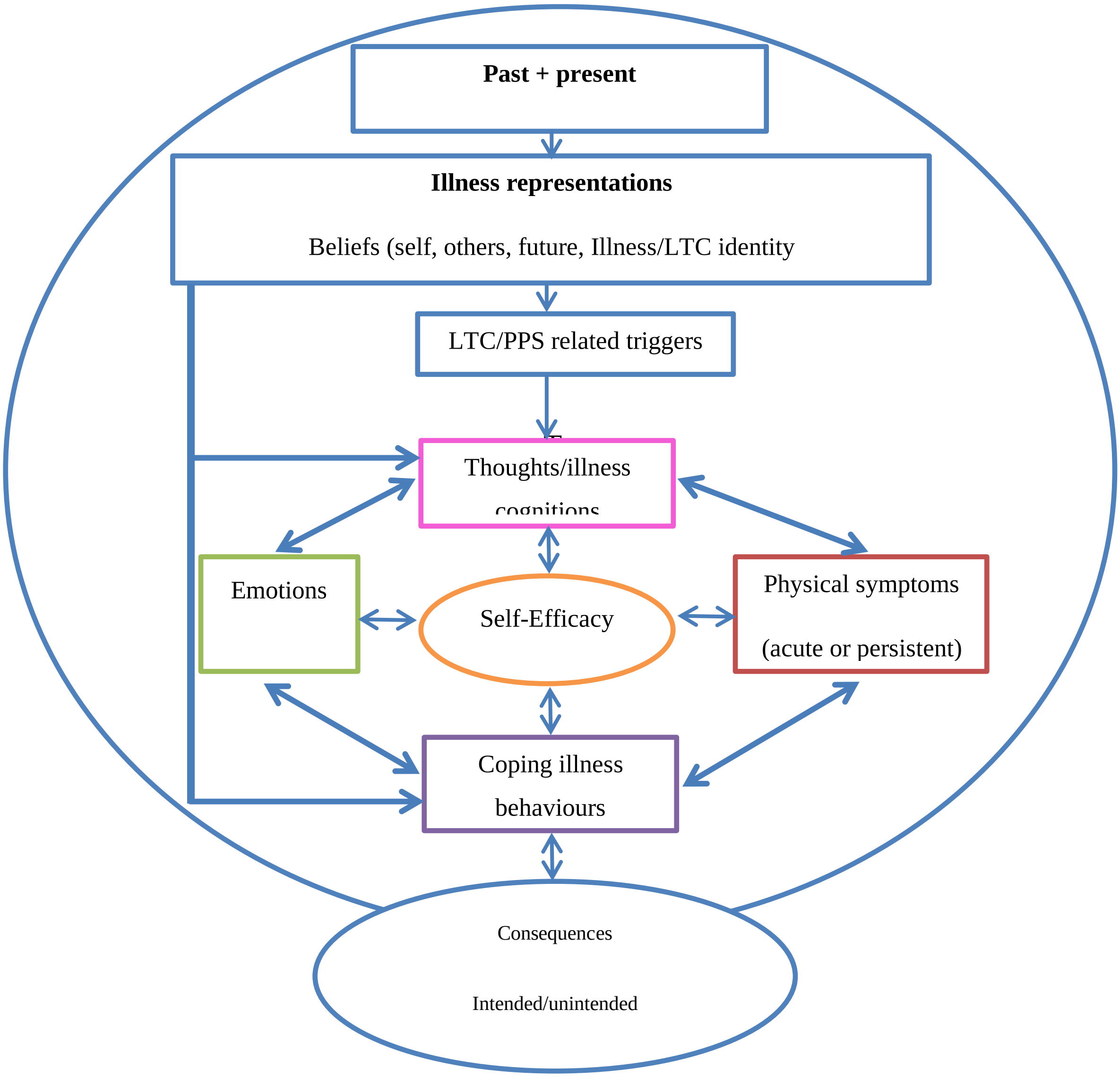


Figure 2.3. ***A proposed adapted cognitive-behavioural model for LTC/PPS***

2.7 Integrated Model: A session by session description

Session 1: Past, present (personal and environmental)

The first session commenced with introductions, a setting of ground rules, and a discussion of expectations. This part of the model explored how the impacting factors could be related to both past and present. The aim of the session was to facilitate and encourage group cohesion between participants and provide a collaborative and shared understanding of the impact of LTC/PPS deriving from past and present experiences of the participants. This led to a compilation of a group formulation where needs and expectations were identified. The model recognises the multiple factors interacting in LTC/PPS across life trajectories, as used in other models of working with PPS (Dreary et al; 2007; Chalder & Willis, 2017).

During the CBT intervention, psycho-education was conducted to help participants understand the impact of early experiences and on-going challenges. In this session there were opportunities for identifying gaps in understandings and identifying CBT content for interventions. This included information-giving on precipitating and predisposing factors which account for life events in one's environment and how they contribute towards the development of LTC/PPS (Dreary et al; 2007; Chalder & Willis, 2017).

While the discussions of early experiences are easily explored during assessment in individual therapy, the adapted group intervention was slightly different as the focus was on shared understandings of these aspects and therefore, less personal. Through group facilitation the following questions were asked:

'What has been people's experience of living LTC/PPS?'; 'What has been the impact of living with LTC/PPS', physically, psychologically and socially?'; 'How would you like things to be different?'

Group facilitators responded to questions asked and used prompts for further discussion, including psycho-education and more information around other important factors at play in LTC/PPS. During the group intervention, participants drew on common sense understandings of LTC/PPS about their early past and present experiences. Modifiable, lifestyle-related factors; and non-modifiable factors like ethnicity and age, which can predispose people to illness; were discussed (Tan et al; 2019).Themes that show the impact of LTC/PPS were presented on a flipchart or white board for the group participants to reflect upon. The impact of LTC/PPS, as described by participants, usually reflects a bio-psychosocial impact and some illness representations are identified. The sharing of themes to the group served as a good introduction and socialisation to a much broader bio-psychosocial model of dealing with physical illness and CBT. In this session the CBT model was briefly introduced during this session and continued throughout the programme.

Session 2: Mapping illness representations: LTC /PPS triggers and maintenance factors

As part of the continuing exploration and group formulation during the second two sessions, a debate was facilitated to identify and map illness representations. As the CSM proposes, when illness and symptoms have been triggered, people develop cognitive and emotional responses (Leventhal, 2004). Consequently, in this integrated model, group participants were encouraged to explore and share their thoughts about their experience of LTC/PPS, including their interpretations of and reactions to their conditions.

Exploring illness representation is a good way of evaluating the group understandings, feelings, and thoughts, including ‘expert’ knowledge of coping with LTC/PPS. In a group where the cultivation of self-management is crucial, prior learned management methods have relevance for coping with LTC/PPS. Implicit in the CSM, is the acknowledgement of the participant’s prior knowledge of dealing with their LTC/PPS, thereby identifying individual strengths and capabilities (Leventhal, 2004, Breland et al, 2020).

As proposed by Leventhal (2004), when illness symptoms are triggered, people want to know what caused them. Often questions and theories about the cause of illness are drawn from; opinions and facts gathered from experiences; social media (Whatsapp and Facebook groups) and internet searches; family; community and environment. In mapping and making these explicit, facilitators apply CSM constructs which take identity, timelines, cause, controllability and consequences into consideration alongside the CBT model. Each aspect of the 5 CBT area model is explained with examples from the group participants. For example, the model is drawn on the flip chart and questions are asked from participants who sometimes share similar or different experiences. Alongside the two health psychology theories, the CBT model is introduced to help map the illness representation. Using the CBT model within CSM made explicit not only concrete, experienced physical aspects of illness representations, but also abstract aspects such as emotions/feelings and thoughts/beliefs about the illness (Breland et al, 2020). In this model, the CBT contributes towards collaborative and shared formulation. (See figure 2.4 below).

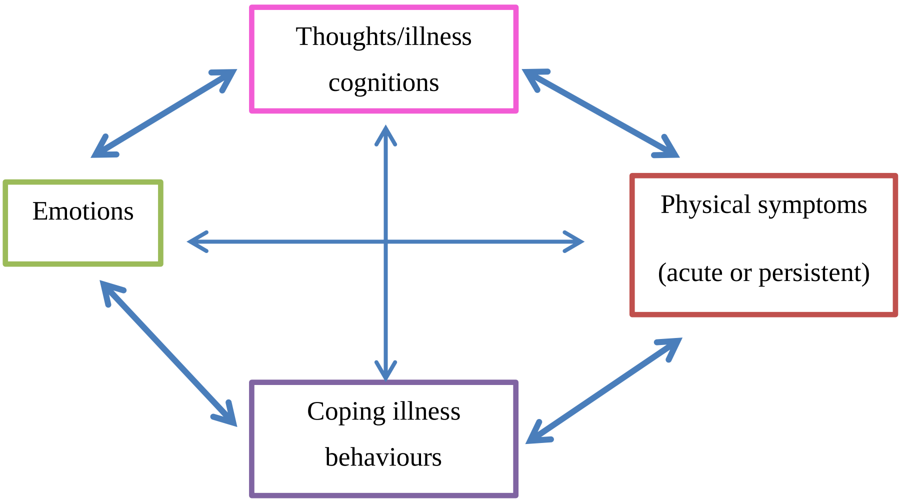


Figure 2. 4. *The five-area CBT model (adapted from Beck, 1979)*

Identity: These illness representations are reflected in people's (*beliefs about self and, others, future)*. These beliefs and thoughts are usually embedded in people's lived experiences and might reflect contextual issues which include the broader environment and culture (McAndrew et al, 2019). As noted by Leventhal et al. (2004), the development of symptoms of illness, triggers some personal questions about the meaning of observed symptoms and what they represent to the person. As contended in the CSM; questions such as the following may emerge:

'What are these symptoms?',' Why am I having them?', 'What do they mean?',' What does this say about me?', 'What is the name of this illness?', ' How is this going to affect others at home and work?', 'What does the future hold for me'

In facilitating the group, it was important to have a clear understanding of these constructs.

Timeline: Leventhal et al (2004) also noted that people might have an acute understanding of illness, which becomes a challenge for LTC/PPS with long-term conditions and symptoms persisting over several months and years, despite both treatment and investigation. Similar questions are asked or implied by participants with LTC/PPS:

'Why is this not going away?', 'Why is my pain and fatigue not going away?', 'How long will I be suffering?', 'Will this ever go away?', 'What will happen to me? Is this terminal? Will I die?', 'What does the future look like for me if I have to live with these persistent symptoms?'

The role of the facilitator is to ask questions such as:

'How have you been affected LTC/PPS?', 'What does this mean for you?'

The facilitators also used psychoeducation to answer questions and correct misconceptions related to the understanding of LTC/PPS. This also presented opportunities for psycho-education to describe the difference between acute and persistent conditions. This information is useful for the group intervention as people often have notions of illness as acute and possibly curable with medical treatment (Leventhal, 2004).

Controllability: With concerns about persistence and long-term consequences of persistent symptoms, as contended by the CSM, people might have questions about treatability of the illness and ability to exert control over this. Thus, questions like the following may be asked:

'Can this be cured?', 'How will I be able to control these symptoms?', 'Will they get worse with time?',

To prompt these understandings the facilitator asked questions that allowed the participants to examine their taken-for-granted knowledge about their LTC/PPS: *What does this means for you?* The facilitators used prompts to explore the contextual understandings. For instance: *Where does that come from?* Questions and answers about controllability provide an indication of a person's perceived efficacy or confidence in dealing with their LTC/PPS.

How confident are you that you could manage your LTC/PPS now? This question is usually asked in a group with every participant rating themself on a scale of 0-100 and this score is reviewed midway and at the end of the group session.

Consequences

As illustrated by the CSM, there are questions about the consequences of LTC /PPS as threatening, which leads to certain methods of managing. For people with LTC/PPS, such questions may lead to thoughts about the consequences for the individual and for significant others with reference to the impact on relationships. For example:

'What will become of me', 'How will this affect my family and work?', 'How will this impact on my relationships?'

It is important for participants to have a realistic perception of consequences as this could lead to helpful behaviour change and intended health outcomes (Leventhal, 2004).The appraisal of consequences, as observed in other studies, helps people acknowledge the impact on the quality of life as well as future prospects if things do not change (Leventhal, 2004; Breland et al, 2020). This part of the model refers to the appraisal of consequences of coping actions. In the integrated model, a discussion of both intended and unintended consequences of coping, created opportunities for group participants to challenge their taken- for-granted ways of coping with LTC/PPS. As represented in the model, alongside its use with the CSM constructs, the CBT model (positioned in the middle of the diagram) illustrates how these persistent symptoms can worsen through stress responses such as anxiety and depression. How a person copes is related to how he/she evaluates the consequences of a health threat. Similarly, coping actions do not always result in the intended outcomes. Therefore, as applied in this psychological intervention, the model was adapted to help the participants reinforce some helpful coping strategies and re-evaluate the unintended consequences of coping.

Session 3: Physical symptoms, acute and persistent

Following the introduction of the CBT model, this session was designed for assessing participants' coping behaviours and responses to the experience of acute and persistent physical symptoms. During facilitation, there was frequent referencing to the CBT model to assist participants to become aware of links and identify maintaining and perpetuating factors. Questions and concerns about timelines of symptom experience were further clarified, to support participants to differentiate between acute and persistent physical symptoms and sensations.

The other objective of this session was to provide coherence in the mechanism of pain and fatigue. This includes supporting participants in understanding how physiological, cognitive and psychological factors interact in the experience of pain and fatigue. To deliver this session, facilitators present information using diagrams, around the complex motivating and cognitive factors which contribute to mood when individuals experience pain. The CBT model is used to support the understanding of vicious cycles and factors that maintain pain. A similar approach has been described in the MBSR approach (Kabat-Zinn, 1982) in improving individuals' understanding of pain. During facilitation and psycho-education, information is presented about the differences between acute and persistent long-term pain as well as sensitization and the role of the brain (Stahl and Goldstein, 2009; Woolf, 2011).

Session 4: Self-efficacy (development)

The SCT stresses the importance of self-efficacy development in building confidence around the performance of activities. Likewise, the CSM focuses on developing 'intention actions' for improving health and illness (Leventhal et al., 2004). Therefore, this adapted CBT intervention aims to support participants' in cultivating self-efficacy and confidence in the management of LTC/PPS. To reinforce this cultivation, participants were encouraged to practice action-planning and goal setting during the session thereby improving these self-regulatory actions. The SCT theory, identifies and highlights both personal and group factors, such as; self-reflection, peer comparison and group influence; in the cultivation of self-efficacy (Bandura, 2004, Schunk & DiBenneditto, 2020) and participants were encouraged to set small, realistic and measurable (SMART) goals which were individualised to help them re-engage in valued activities. These were practised as home tasks during the week and feedback was facilitated in the group to allow for both peer evaluation and support (Chalder &Willis, 2017).

Behavioural-activation principles were also implemented by encouraging a choice of pleasurable and meaningful activities during goal setting. This was used to target avoidance and to improve engagement in meaningful and pleasurable activities (Veale, 2008). An additional objective of this session, is to maintain physical activity without over-activity or under- activity, often referred to as 'boom and bust.' The 'boom and bust' is often caused by difficulties in understanding and dealing with gaps between being asymptomatic and having flare-ups. The principles of pacing are taught and practised alongside participants' chosen activities (Chalder & Willis, 2017). There is evidence that shows that balancing activity levels is useful in maintaining both mental and physical health functioning, while reducing LTC symptoms. Therefore, in these sessions, pacing was used as a process of balancing and maintaining activity levels rather than slowing down completely (Chalder & Willis, 2017).

Session 5 and 6: Coping /illness/behaviours/thoughts

Following the mapping of illness representations, this part of the model was designed for working with thoughts and cognitions that interfere with tasks and behaviour change on a day-to-day basis. In-between home tasks are encouraged to create opportunities for participants to become aware of illness beliefs and thoughts that act as barriers to improving activity levels. As participants continued with their action plans and in-between session home tasks and behavioural experiments, thoughts and other illness cognitions were identified, particularly during group feedback. Through psycho-education, participants were supported in recognising 'thinking traps' common in people with LTCs, particularly where symptoms like pain and fatigue persist (Chalder & Willis, 2017; Salkovskis et al., 2016). As negative thoughts about illness are known to contribute towards disability and mental wellbeing, extra focus was given in both individual and group exercises using a variety of strategies, such as, practising the mindfulness of thoughts. Psycho-education and individual help with thought records as tools to use at home provided information on recognising common thinking traps related to illness Chalder et al., 2015; Salkovskis et al., 2016).

This session contributed towards the fostering and development of self-efficacy through becoming aware of thoughts as barriers or facilitators in coping with LTC/PPS. Group activities were used to encourage the participants' continued use of action plans and thought records, sharing with others and gaining peer feedback and developing group problem solving. Opportunities for the application of behaviour change techniques, which include intention formation and prompting both barriers and facilitators of behaviour change (Abraham & Michie, 2009) were identified and used effectively with individual participants in the session.

Session 7: Consequences: Exploring and reinforcing helpful coping and challenging unhelpful responses

This session's aim was for participants to develop awareness of both the intended and unintended consequences of individual coping with LTC/PPS. Group activities were organised so that participants can explore their coping actions and be supported in reinforcing helpful actions while challenging unhelpful responses. The introduction of the CBT model to the group provides opportunities for understanding the stress response, as it facilitates awareness of links between thoughts and emotional responses, including corresponding physical symptoms and coping behaviours. It also introduced the development of awareness of emotions in the body as well as the management of stress and anxiety. The session offered insight into the 'fight or flight' mechanisms including misinterpretations of physical symptoms and therefore provided a coherent explanation of anxiety and related physical symptoms (Stahl & Goldstein, 2009).Improving coherence is particularly important, as it reduces fear and threat perception and is associated with improved outcomes for LTC/PPS (Hagger &Orbell, 2021; McAndrew et al; 2018) .

Previous evidence has shown that targeting stress for people with LTC, particularly those with heart conditions, is an effective intervention for the prevention of a condition as well as the prevention of reoccurrence for those with an existing diagnosis (Cohen et al., 2015) This session included; practising skills on problem-solving; working with worry, using cost-benefit analysis and intolerance of uncertainty. Consistent with CSM, problem solving is an important aspect of self-regulation (Leventhal;2004). During the group process, common sense understandings of; the intolerance of uncertainty; worry, including positive and negative beliefs around the concept; are explored using the constructs of CSM. Facilitators created a debate by asking questions regarding the controllability causes, and consequences of worry. These debates help participants challenge misconceptions and inherent beliefs that maintain worry, while facilitators use psycho-education to offer CBT skills to support participants to deal with worry in their lives. The session included activities which cultivate problem-solving skills and adapted an individualised version of the analysis and application of Strengths, Weaknesses ,Opportunities , and Threats (SWOT) analysis including, use of the ‘worry tree’ and other worry strategies and cost-benefit analysis used in CBT (common examples of the adaptations of the SWOT included how to deal with housing or employment problems). These were all tailored for improving general abilities that enhance self-management abilities and problem-solving skills for improving mental and physical wellbeing in LTC/PPS, using CBT models that assist in dealing with worry (Wells,1997; Dugas ,1998).

Session 8: (a) Exploring and reinforcing helpful coping by improving communication

This session aims(ed) to improve and enhance effective communication with others including families and health professionals. During facilitation, we drew on participants’ examples of experiencing the feeling of being misunderstood in interactions. In the group facilitation, we used questions that prompted the identification of barriers and facilitators of communication with others, which included family members, partners, health professionals and colleagues. The session included psycho-education and sharing insight on communication styles and responding to criticism using examples and role-play activities. During these role plays, group participants provided feedback in a safe environment with the facilitators guiding the process.

Session 9: (b) Exploring and reinforcing helpful coping: Dealing with sleep difficulties

This session dealt with sleep difficulties as experienced by people with LTC/PPS. The session included exploring the experience of sleep difficulties and existing beliefs and current knowledge about sleep. A group activity, involving the brainstorming of helpful and unhelpful strategies of dealing with sleep difficulties, was facilitated which allowed the participants to appraise and challenge their coping strategies. Through psycho-education, the CBT model of sleeplessness/sleep cycles and sleep hygiene were presented including helpful dietary advice and relaxation exercises.

Session 10: Relapse prevention

The objective of this session is to maintain gains and prevent reoccurrence: Relapse prevention is an important step in CBT and during this session, we reviewed both individual goals and group objectives. We looked at how to maintain progress on a daily, weekly and monthly basis. Participants were given time to reflect on their goals individually and evaluate themselves on a scale of 0-100 with regards to how they manage their LTC/PPS. The session also entailed the drawing up of individual plans for maintaining progress and implementing new learning. In small groups, participants discussed the barriers that could prevent them from maintaining progress and brainstormed ideas on factors that could be facilitators of change. The participants were also given an opportunity to evaluate the content and the delivery of the group programme including the protocols of our IAPT service.

2.8. Below is a table summarising sessions and integration of theory and BCT's as used in the model.

Table 2.1

A summary of session and integration of theoretical constructs and BCT's

CBT interventions /session	Theory/constructs applied	Behaviour Change technique during facilitation
Session 1 Past, present shared understandings of living with LTC/PPS Exploring experiences of Living with LTC/PPS Impact of LTC/PPS Exploring shared understanding The landscape of LTC/PPS Viscous circle and impact based on Five area- CBT Model explained /how it fits in	SCT CSM CBT	Modelling respectful behaviours of listening and responding during facilitation Provide encouragement and supportive environment for sharing information on – past, present bio psychosocial influence Prompt and mapping of– identifying illness representations – identity, cause, timelines, controllability, and consequences Provide information /identify gaps information Provide feedback respectfully
Session 2 LTC /PPS triggers and maintenance factors Exploring illness representation, impact and coping, controllability triggers, thoughts, emotions, behaviours	CBT – Five area model, to make links explicit CSM – constructs - identity, cause, timelines, controllability and consequences	Prompt thoughts and beliefs about illness, meaning and impact to self and others Explore meanings and understandings

		Prompt understandings about control /beliefs / positive and negative consequences Explore feelings /make links using CBT Information on biopsychosocial model understandings Identify/ needs/expectations/gaps Information giving to provide coherence
Session 3 Physical symptoms, acute and persistent Exploring coping behaviours with acute and persistent physical symptoms Understanding science of pain and fatigue	CBT – making links and identify maintaining factors Explaining links and science of pain CSM – Construct of timelines /acute /chronic CSM - coherence CSM – consequences/outcomes	Information giving /science of pain Psychoeducation / Explore gaps in understanding Exploring gaps in coping/illness behaviours Prompt outcome expectancies / negative and positive consequences
Session 4 Self-efficacy (development) Identifying existing strengths and abilities – as a group exercise Science of pain and fatigue Goal planning and Smart goals Group activity – identifying activity cycling /boom and	SCT – Developing self-efficacy, Identifying barriers and facilitators CSM – Identifying self-regulation abilities /strengths and abilities	Goal planning and Setting graded tasks activity pacing To encourage some intention formation /goal planning behaviour changes Barrier identification / identifying facilitators Encourage problem solving of barriers

bust/over activity/under activity cycles Pacing /planning/problem solving to reduce activity cycling Homework – Action planning activity over the week	CBT – psycho-education -, information giving to balance activities	Prompt experiences of mastery and success
Session 5 Thoughts, illness cognitions Becoming aware of thoughts Developing self-efficacy by becoming aware of thoughts as barriers or facilitators in coping Relating better with task interfering cognitions/thoughts Working with illness cognitions Reviewing thoughts records Group activities – exploring thoughts that interfere with tasks and activities Developing new relationship and motivation for tasks and activities Paired exercises Homework – Action planning /activity usually difficult to do -Continue with thought record	CSM – Mapping illness representations CBT – identify thought patterns SCT	Action planning /problem solving Prompt self-monitoring of thoughts using thought diaries Prompt awareness of thoughts as barriers /facilitators in coping and behaviour change Teach mindfulness of thoughts Mindfulness thought exercise – Leaves on the stream /Thought distancing
Session 6: Coping /illness/behaviours	. SCT – barriers and facilitators	exploring barriers and facilitators of behaviour change /problem-solving in a group/

Working with difficult thoughts emotions /mood/worry Group tasks - Worry strategies, worry tree, worry time, problem-solving, and SWOT Working with intolerance and uncertainty	CSM – outcomes of illness representations CBT – techniques and strategies	facilitate peer support/challenging Group - Exploring positive and negative beliefs about worry/ prompt positive and negative consequences Prompting individualised problem solving/modelling
Session 7: Consequences Exploring and reinforcing helpful coping and help to challenge unhelpful Improving stress management and understanding stress response /fight-flight and bodily physical symptoms Reviewing homework Action plans and problem-solving- group feedback Exploring group knowledge and understanding and identification of stress and impact (behaviours, thoughts, emotions) Fight flight stress response and impact on body/	CSM – consequences SCT – group dynamics of role identification /feedback CBT – psychoeducation	Exploring social, physical and psychological expected outcomes Explore /positive and negative consequences Encourage record of consequences Provide information on consequences correcting possible misinterpretations
Session 8 **Improving and facilitating effective communication with others including families and health professions**	SCT – group tasks, role modelling	Provide information Use role play Provide role modelling and support

Review homework/problem solving Exploring barriers and facilitators of communications with others Feeling misunderstood Understanding communication styles and responding to criticism Expressing needs/emotions and feelings effectively Understanding different communication styles, confronting effectively Take home message - Be prepared for appointments, express what you want		Psycho – education, information giving Modelling effective communication responses
Session 9 **Managing and improving sleep**	CSM – exploring illness beliefs impacting on sleep /consequences	Information giving Prompt exploration of helpful and unhelpful Prompt exploration of positive and negative beliefs
Reviewing homework Exploring experience of sleep difficulties Exploring existing beliefs and current knowledge about sleep Exploring helpful and unhelpful strategies CBT model of sleeplessness /sleep cycles Sleep hygiene	SCT – facilitators and barriers CBT – psychoeducation and information giving	

Helpful dietary advice Relaxation exercises Progressive muscle relaxation		
Session 10: Maintaining gains Relapse prevention Reviewed last session /reviewed course objectives and group progress Looking at how to maintain progress Looking at barriers that could prevent maintaining progress	CBT – relapse prevention	Barrier identification / identifying facilitators Drawing up individual plans for maintaining progress and learning

Chapter 3: Epistemological position and methodology

3.1. Overview

This chapter discusses the epistemological position of the study in detail. In doing so, a justification for its qualitative approach is provided. It further outlines the reason for employing an interpretative phemenological approach (IPA), and describes the epistemological assumptions which guided the investigation. This section also provides a rationale for the use of theoretical concepts as well as the choice of the respective research methods employed. Finally, the chapter describes the methods that were used for data collection, as well as those used for the data analysis.

3.2. Justifying IPA as a qualitative approach for this study

In this project, the aim was to investigate the lived experiences and recovery of participants who attended an adapted 10-week CBT programme designed for people with LTC/PPS. This was followed by an MBCT programme, used for augmenting therapeutic gains and relapse prevention. To the best of our knowledge, the adapted programme was the first of its kind in the context of IAPT. In this study, the use of a qualitative approach marked an essential shift from relying solely on quantitative approaches in IAPT; and served as a response to the gap that was noted in previous research (Williams, 2015). The aim was to ‘give a voice’ to participants and to focus on the uniqueness and idiosyncrasies of meaning derived from their lived experience following the attendance at these programmes. In this study, IPA signified a movement away from quantified views to more personalised accounts of how people experienced the unfolding of persistent illness and recovery following their attendance at the IAPT LTC/PPS interventions (Smith, et al; 2015). IPA, like other qualitative approaches, aims to capture detailed descriptions of relevant information about the phenomenon being explored.

Therefore, a qualitative approach was more appropriate in producing the relevant psychological knowledge in a field dominated by quantitative methods.

IPA has been increasingly used in health psychology and is regarded as more relevant in exploring health and illness (Brocki &Wearden, 2006; Smith, 1996; Smith, 2011) Chapman & Smith, 2002; 2007). IPA is now used in multiple studies that explore the lived experiences of various health conditions and contexts (Osborn & Smith, 1998, 2015; Eatough &Smith, 2006; Larkin, et al; 2006; Dennis, Larkin and Deryshire, 2013; Smith, &Shaw, 2016; Finlay et al; 2018). These studies are further explored in the literature review.

IPA's stance differs from discourse analysis; an approach which highlights linguistic factors attached to experience, in aspects such as, 'deconstruction of cognitive dimensions' (Larkin et al., 2006; Smith et al; 2015). Unlike discourse analysis, IPA focuses on all cognitive dimensions of a lived experience, including how language is used (Larkin et al., 2006; Smith, 2015). However, there are fundamental similarities between these two approaches, including the attention given to linguistic aspects. Therefore, the participants' use of language formed an important component of the data analysis, as it did in previous studies (Eatough &Smith, 2006; Murray &Holmes, 2014).

Grounded theory could have been chosen if the purpose was to only study the processes involved in theory development, as this approach focuses predominantly on the theory of a phenomenon (Willig, 2013). This study's focus extended beyond theory development to the exploration of the lived experiences of the participants following the two psychological interventions. There are also differences in sampling methodology between IPA and grounded theory. Grounded theory sampling is conducted on theoretical grounds in which large samples are needed to reach saturation. Grounded theory is also often used within a scientific realist framework (Willig, 2013) which contrasts to the critical realist approach that was adopted in this study. IPA's focus on experience, alongside the validation of subjectivity, aligns it with other qualitative approaches and like other qualitative research, follows a rigorous plan of methodology and processes in an endeavour to develop rich descriptions (Carter & Little, 2007, Smith, 2015).

In contrast to the sampling approaches used in grounded theory, the idiographic nature of IPA focuses on specifics rather than generalisation, and therefore small samples are appropriate (Larkin et al., 2006). These small samples are purposively defined and chosen to explore vital questions in unique situations (Smith, 2015) as experienced by the participants who suffered from comorbid LTC and anxiety and depression and who attended both CBT and MBCT. The occurrence of these psychological programmes are rare and relevant within the IAPT context, which encourages access to psychological therapies for people with LTC/PPS and mental health difficulties.

To conclude this argument, IPA's theoretical and philosophical assumptions, which include its use of idiographic samples and double hermeneutic interpretations, differentiate it from other qualitative approaches (Smith et al., 2015). This epistemological positioning and assumptions, as were applied in this study, are discussed below.

3.3. Epistemological positioning of the study

Epistemology refers to how we know or contemplate about what we know and in its purest form; it is referred to as the 'theory of knowledge' and how knowledge is justified (Carter & Little, 2007). Epistemology influences methodology, which, in turn, has an impact on how methods and procedures are chosen to produce knowledge in a study. Equally relevant in this section is the researchers' perspective; referred to as 'ontology'; which describes how reality is interpreted, understood and talked about; either tacitly or explicitly (van Vlaenderen & Neves, 2004).

As others have asserted, it is also my contention that knowledge is not a fixed entity, but can rather be understood as, ‘conditional, situation-bound and local’ and therefore may vary from one context to another (Madill et al., 2000). In addition, a critical realist approach is applied in the analysis of the findings in this study to recognise both the social and contextual understandings of knowledge (Bhaskar, 2008). In its appreciation of the worth of all knowledge, this approach acknowledges that human experiences lie in both history and language, depending on context (Niall, 2012). This invites the researcher to be contextually sensitive in their understanding of participants and their experiences (Madill et al., 2000). Both the critical realist and contextualist approaches are consistent with my values and assumptions as a practitioner and researcher. Critical realism, as explained by Fletcher, is, “…about events as experienced…events can be measured empirically but are often explained using common sense understandings…equally; these events cannot escape the human interpretative activity” (Fletcher, 2016, p.183).

3.4. Epistemological assumptions adopted by IPA

3.4.1 Overview

IPA’s theoretical foundation and its exponential use in health psychology and other fields; mostly as an experiential qualitative approach; is attributed to Jonathan Smith (1996). Tracing of IPA’s theoretical and philosophical foundation is beyond the scope of this study. IPA’s philosophical origins are traced back to Husserl’s work (1971) which studied the philosophy and phenomenology of human consciousness and the theory’s hermeneutic stance stems from Heidegger’s (1962) study on existential phenomenology. IPA is ideographic in nature, focusing on individual case analysis and is, therefore, well suited for exploring rich descriptions of lived experiences where subjective meanings are prioritised (Larkin et al; 2006; Smith & Shaw, 2016; Miller et al; 2018).

3.4.2. The assumptions of compassion and responsiveness

Consistent with the values that motivated this study; namely ‘respecting user feedback’ and ‘responding to lived experiences during the implementation of the respective interventions’; IPA was chosen for its unique epistemological position that adopts phenomenological attitudes of compassion, curiosity, and self-reflexivity (Smith, 1996). I aimed to adopt an empowering and compassionate stance towards the participants in the psychological interventions throughout the implementation, including the evaluation process. This epistemological position was observed throughout the engagement with the participants in this study and is evident in the choice of semi-structured interviews; which allow for freedom of expression; thereby encouraging human agency. In the empathetic hearing of these lived experiences and through the employment of epistemological principles of inductiveness, participants have been given a voice to prioritise their understandings of experience (Smith & Osborn, 2015).

3.4.3. Idiographic approach

IPA adopts an epistemological standpoint in its sampling methodology that differs to more positivistic methods, such as RCTs, which require considerable large sample sizes to make generalisations about their claims. The idiographic nature of IPA, which focuses on the study of specific individuals who are in unique situations and life events, deems it appropriate to this study as it deals with individuals with LTC/PPS. In this study, both similarities and differences amongst the participants are of equal importance (Larkin et al., 2006). In this approach, there is a commitment to the acknowledgement of specific contextual accounts. The latter is evident in the small sample of participants (N = 10) in primary care, who were interviewed about their lived experiences, following the implementation of two psychological interventions in IAPT.

3.4.4. The person in context

Like other qualitative methods, IPA is guided by some important qualitative features, including the recognition of contextual factors, such as political influences. In recognising these external influences, IPA ensures that socio-cultural factors cannot be stripped away from people's experience and meaning making (Smith, 2009; Miller et al; 2018). IPA aligns with other postmodernist qualitative approaches in recognising that events and experience derive their meaning from both social and personal worlds (Smith, 2015).In this study the context in which both LTC/PPS and recovery are understood has been described to allow the reader to understand the background of the participants who's lived experiences were explored following psychological interventions.

3.4.5. Dual hermeneutic approach

Another epistemological assumption, that separates IPA from other qualitative research methodologies, is its use of the double hermeneutic approach. This means that it recognises that the researcher brings their own interpretation of the participants' interpretation of experience (Smith, 1996; Larkin et al., 2006; Tuffour, 2017). Therefore, IPA acknowledges the double interpretative action by both the researcher and the participants in the understanding of the participants' lived experiences, making the role of the researcher in the interpretative activity explicit (Eatough & Smith, 2006; Smith & Osborn, 2015).

This approach also stresses the dynamic relationship between the researcher and participants and acknowledges the difficulty of 'directly accessing participants' lived experiences (Smith, 1996; Brocki & Wearden, 2006; Smith et al., 2018). By virtue of its nature, IPA recognises that different contexts and background from both the researchers and participants might affect how data is interpreted (Finlay, 2018).

3.5. Personal and Professional reflexivity

Qualitative methods endorse the importance of reflexivity in the research process. Implicit in the IPA methodology are issues of transparency and openness about the role of the researcher (Larkin et al., 2006). IPA also acknowledges the dynamic interaction between the participants and researcher. In writing about researcher reflexivity, Macleod (2004) warns against ‘expert positioning’ of the researcher in relation to the participants and emphasises an awareness of relational power dynamics in these interactions. During this study I was aware of this privileged position, including the inherent power imbalance associated with it. This include the power of language, as the study investigator, I also believe that language is an important aspect of investigation and analysis. As asserted by Anderson (2007), “…language is fluid, creative and transformative… and therefore gains meaning and value to its use” (Anderson, 2007, pp. 8–9). In accordance with these notions, I was aware of using language accessible to participants and refrained from using health and psychology jargons. The use of IPA is consistent with these notions through its emphasis on prioritising the participants and valuing them as experts in their lived experiences (Smith, 2015). During the semi – structured interviews, an attitude of phenomenological reduction was observed to allow the participants to speak freely about their lived experience before and after IAPT interventions. It is also the nature of implementation research for the researcher to be involved in all the stages of the research, rather than taking an objective stance and being the dispenser of knowledge (Peters et al ;2013). In this study, the lead investigator (LT) was involved in all the phases, co-facilitated both groups and was also responsible for the content and adaptation of the CBT model. It is acknowledged that these activities could affect how participant responded including the interpretation of the themes, but careful attention was given to prioritising the accounts of the participants in order to maintain the authenticity and trustworthiness of the investigation. This openness and transparency is shown by using quotes throughout the analysis. Furthermore, to achieve this rigour and quality, themes were also checked by two other psychologists who include the supervisor (CE) and (AM).

Working with people with comorbid mental and physical health conditions draws heavily on the knowledge and competencies of those involved in implementing care and planning. LT is a counselling psychologist trained in high-intensity CBT and practised CBT in IAPT, while also studying health psychology. LT is also trained as an instructor for MBCT/MBSR. Through various types of training, her practice has broadened and shifted over the years informed by multiple influences, including her work with others. All these aspects are considered in the interpretation of results.

Chapter 4: Methods

4.1. Overview

This chapter describes the methods and procedures used for selection and recruitment of participants to the study, including methods used for collection and analysis of data.

4.2. Design

The current study adopted a qualitative approach, using an interpretative phenomenological approach to explore the lived experiences of illness and the recovery of people with LTC/PPS following two psychological interventions used in IAPT.

4.3. Participants: inclusion/exclusion criteria

Participants were recruited to the study if they had attended both the 10-week adapted CBT programme for LTC/PPS and the eight-week mindfulness-based cognitive therapy programme (MBCT), which was used to augment gains, prevent reoccurrence and relapse. The participants were adult clients of 18 years and over with no upper limits. The participants met the criteria if they attended 4 or more sessions in both groups. Participants were excluded if they attended only one of the group programmes. Participants were also excluded if they attended fewer than four sessions in any one of the group programmes. As contended with IPA these boundaries were set to allow participants for whom the exploration of the lived experiences would be significant in line with the goal of service evaluation (Smith,2011).

4. 4. Sample

A criterion sampling method was employed purposely to include only participants who had attended CBT /LTC group and MBCT. The objective of criterion sampling was to gather rich insights from the shared experiences rather than achieve statistical generalisability. The criterion sampling was also in line with the service evaluation of the implemented evidence-based psychological interventions (Palinkas et al; 2015). In this study, the small idiographic sample was deemed adequate for the purposes of IPA to capture unique, in-depth understandings of the lived experiences of the participants (Smith, 1996; Larkin et al., 2006).

The participants were identified from the records of attendance from IAPT to the adapted CBT and MBCT programmes which took place between 2015 May and March 2017. As not all group participants attended both groups, (27) participants who met the criteria were identified and approached through telephone contact by LT. After (13) participants agreed following these telephone calls, the number was considered adequate for conducting the study. Out of (13) participants who agreed to take part, (3) participants were not available for the interview at the arranged times, (2) participants decided to withdraw from the project due to ill health, and (1)participant was travelling abroad during the interview period, so was subsequently interviewed much later than the others; (1) participant was not available to attend on the day of the interview due to a doctor's appointment and decided to withdraw. In all, N=10 participants were interviewed for the service evaluation.

4.5. Ethical considerations and confidentiality

Application for NHS ethical approval was received from [redacted] (see **IRAS** in **Appendix A**). The project was carried out as part of a service evaluation for benchmarking and quality improvement of psychological interventions for people with LTC/PPS in IAPT. Ethics of confidentiality, anonymity, and use of data adhered to NHS and IAPT protocols to make sure that participants were protected.

4. 6. Informed consent

Following the identification of participants who attended both IAPT interventions the individuals were informed about the service evaluation and quality improvement and invited to take part by LT through telephone contact (see **Appendix B** for information sheet). Participants, who were willing to take part in the service evaluation and quality improvement project, were invited for face-to-face interviews which took place in IAPT offices between June and October 2017. Participants were supplied with consent forms (see **Appendix C**), that included an information leaflet detailing the nature and purpose of the service evaluation and quality improvement in order for them to make informed choices about taking part. Likewise, they were informed of their right to withdraw from the study without being penalised. To alleviate the risk of participants being emotionally affected, measures were taken to debrief individuals after the interviews and information for support and counselling was provided.

4.7. Interventions

4.7.1. Adapted CBT group

The CBT interventions in this service evaluation were carried out between May 2015 and March 2017. During this period, (176) individuals, who met the criteria for IAPT LTC/PPS with comorbid anxiety and depression, were approved to receive CBT interventions. There were 11 groups and each group ranged from 12-16 participants in size. This programme involved 10 weekly, 2-hour sessions which were conducted Fridays in the IAPT group/conference room. This programme was conducted as a Step 3 intervention which meant that interventions were delivered by professionals with a high intensity CBT qualification. The adapted CBT model is discussed in the session-by-session outline in Chapter 2.

4 .7.2. MBCT

Following attendance at the CBT interventions, participants were recruited to the MBCT group to enhance the therapeutic gains and prevent re-occurrence. The numbers in these groups ranged between 8-12 people and were also conducted between March 2015 and July 2017. In total, there were (72) people who took part in the programme during this period. The structure of the programme was based on the MBCT programme model for relapse prevention designed by Segal, (2012). Before starting the MBCT programme, the recruited participants were invited to a one-hour introductory session. This introduction was followed by eight weeks of two-hour sessions of facilitated meditation practice, including in-between session home-practice. Each two-hour session consisted of different content and meditation practices. During the sessions, participants were encouraged to reflect on their experiences of the ‘here and now practice’, followed by reviews and reflections from the in-between session home-practices (Segal et al., 2012). The MBCT class was also conducted by two high intensity trained psychological therapists, who were also trained in instructing both MBCT and MBSR. The therapists received monthly supervision and engaged in peer supervision. The therapists met every week to plan the content and structure of each session.

Table 4.1. Summary of interventions session by session

Adapted CBT programme	MBCT
Session 1: Past, present shared understandings of living with LTC/PPS	Session 0: Introduction to MBSR
Session 2: LTC /PPS triggers and maintenance factors	Session 1: Autopilot
Session 3: Physical symptoms, acute and persistent	Session 2: Introducing mindfulness of breath
Session 4: Self-efficacy (development) Goal planning and activity pacing	Session 3: Guided sitting meditation
Session 5: Thoughts, illness cognitions	Session 4: Allowing, Accepting, Letting be
Session 6: Coping /illness/behaviours	Session 5: Thoughts are not facts
Session 7**:** Consequences Exploring and reinforcing helpful coping and help to challenge unhelpful	Session 6: Self-care
Session 8; Improving and facilitating effective communication with others including families and health professions	Session 7: Using the learning
Session 9: Managing and improving sleep	Session 8: Relapse prevention: Maintaining and extending gains
Session 10 Maintaining therapeutic gains and progress	

4.8. Data collection

4.8.1. Setting of data collection

The interviews were carried out in the IAPT interview rooms, including the conference room where these programmes took place between June 2017 and October 2017. A further tenth interview was conducted in June 2019 of a participant who was not available at the time of the other interviews. Data saturation was achieved as no new themes emerged following the 10th interview. The interviews were between approximately 50-90 minutes, as some participants had less or more to say than others. These were face-to-face meetings involving only the interviewer (LT) and the respective participant being interviewed. These interviews were audio-taped and transcribed verbatim before they were analysed.

4.8.2. Developing interview guide

A month (May 2017) before the collection of the data, a pilot interview was conducted in preparation for the service evaluation and to pre-test using one broad question: The participant met the criteria for the study. In line with the IPA, there was one broad open – ended question:

What has been your experience following your attendance at both the CBT and Mindfulness courses?

Following the pilot interview and discussions with the study supervisor, some changes were made to the interview schedule in order to allow some information, which was in line with the aims of the study and service evaluation, to be captured during the interview. The revised schedule is described in the following section. Prompts were included to explore the impact of the programmes and observations of recovery.

4.8.3. Interview guide

The interview guide was developed by the researcher (LT) with questions consistent with the phemenological approach used in the study to allow the participants to speak freely about their experiences (Hefferon & Gil- Rodriguez, 2011, Smith, 2011). In line with the aforementioned aims of this study and service evaluation, the two main questions were broad and open-ended, allowing the participants to speak freely about their experiences before and after their attendance at both the adapted CBT and MBCT. As noted, prioritising the broad open-ended questions allows the interview not to be biased towards the investigator's concerns and interest (Smith,2011). Consistent with IPA and other phemenological approaches the interviewer is allowed to use prompts to ensure that interesting areas are covered during semi-structured interviewed. These prompts can be prepared in advance, and they are also used to elaborate and explain during the interview (Smith, 2011). In this study prompts were included to explore impact of programmes and observations of recovery as this was a service evaluation for quality development.

4.8.4. Interview questions

Question 1: To explore experience of living with LTCPPS

What was your experience of living with LTC/PPS before your attendance at both CBT 10-week programme and mindfulness?'

Question 2: To explore lived experience following attendance at both courses:

Now, thinking back, what has been your experience following your attendance at both the CBT and mindfulness course?'

Prompts

What changes did you notice following your attendance at the CBT group?

Is there anything else to add?

What did you find helpful?

Was there anything unhelpful?

'What changes did you experience in your wellbeing?'

'What additional benefits did you notice following your attendance at the mindfulness course?

'Is there anything else you would like to add?'

What did you find helpful?

Was there anything unhelpful?

4.8.5. Semi-structured interview

To collect data, in-depth, semi-structured interviews were carried out with N=10 participants, who had attended both the CBT and MBCT groups, to explore their lived experiences of illness and recovery. Semi-structured interviews were used to capture, verbatim, the lived experiences and recovery process of the participants. In qualitative research, semi-structured interviews are a powerful strategy for collecting data (Smith,2011). During this project, the one-on-one interaction offered by interviews presented a flexible and useful opportunity for the study investigator to demonstrate compassionate and empathic listening to the participants, consistent with epistemological assumptions of IPA (Eatough &Smith, 2006). The interviews were carried out by LT (investigator), a CBT therapist and health psychologist (in training), responsible for the service evaluation and quality development. Inherent in this approach is the valuing and respect of the participants' shared experiences. There was recognition that the interviews might trigger some affective memories and the participants were given information about what to do if this should occur. An information leaflet, that addressed this potential adverse effect, was read and explained. This all shows that an attitude of care and compassion for the wellbeing of the participants was central to the process.

4.10. Analytic Strategy

To analyse the data, IPA method used by Eatough & Smith (2006) was utilised. Following the IPA analysis, the emerging themes were mapped to the theoretical framework used in the Adapted CBT model as discussed in Chapter 2.

4.10.1. Getting familiar with the data and making notes

To familiarise myself with the narratives, I (LT) listened to the recorded interviews and made initial comments of interesting ideas as they emerged, and these were then written to produce a transcript of the first interview. There was a focus on single-case analysis with more transcripts being produced, as I continued to listen to the interviews and reading them numerous times and highlighting key facts directly expressed by the participants (Eatough & Smith, 2006, Miller et al; 2018). In the first stage of the analysis, in order to stay authentic and true to the participants voices, the words they used to describe their experience of living with LTC/PPS following their attendance of both the CBT and MBCT, were transcribed verbatim and sometimes the audio was replayed more than once. In doing so, the transcription process enhanced familiarity with the data. It was important that the analysis was firmly grounded in the participants' words as they were expressed, capturing the context in which their understandings were grounded as well as noting both cognitions and affective tones in the participants' narratives. At this stage, an inductive approach was used, allowing the themes to emerge from the participants' narratives (Eatough & Smith, 2006, Miller et al; 2018). The emotional tones and expressions were noted and highlighted in the quotations.

4.10.2. Looking for themes

Following the highlighting of notes which outlined emerging patterns, the re-reading of the transcripts continued. There was a continuation of listening to the recordings numerous times to check and validate the accuracy of information. In stage two of the analysis, there was more exploration of the content, noting how language was used to describe the experiences and noting comments around the meaning of this language use. From these comments and meaning analysis, an initial interpretation emerged, and psychological concepts and models of explanation were noted and highlighted. Interesting processes and initial themes that emerged from the participants' use of metaphors and language were noted including the differences and similarities of their accounts. The use of both inductive and deductive methods was seen as appropriate at this stage of the analysis, as more themes unfolded from the use of prompts in line with the study questions (Smith,2011). These included unanticipated descriptions of their lived experience before and after attending the adapted CBT and MBCT programmes with some emerging processes observed (Eatough & Smith, 2006).

4.10.3. Connecting and clustering themes

The next level of analysis was connecting and establishing links to cluster themes together. A word document was used to type and collate these emergent themes and the analysis continued to add developing themes from participants' narratives. The themes were explored and connections between them made in order to link higher-order themes into a more coherent story (Smith, 1996; Eatough & Smith, 2006). Themes which appeared less relevant and not well supported by a participant’s narrative were removed. Initially, 8 themes and 16 subthemes were identified, and these were worded, named and merged to the participants’ narratives. The themes were collapsed together several times and renamed, and certain ones emerged as master themes with subordinate themes, captured by relevant text. Ultimately, 4 higher-order themes and 10 subordinate themes were produced. Information that linked themes to individuals was removed and pseudonyms were used to protect participants’ privacy and to maintain authenticity, direct words and grammar have not been changed. In line with transcription convention and to shorten quotes in this study, silences are indicated by using dots […]; dotted lines in brackets (…) replace omitted words and in order to improve readability, words like “mmm” and “er” have also been removed (Bannister et al; 2011).

4.10.4. Drawing up a table of themes

The final stage entailed drawing up a table to show the main higher-order themes and their sub-themes respectively (see Figure 3). The themes attempt to present a coherent narrative produced by the interpretative activity which is embedded in participants’ accounts.

4.10.5. Writing up: application of the double hermeneutic approach in the discussion of themes

This final stage is concerned with the reporting and writing up of the themes. Inherent in this approach, researchers do not have direct access to participants’ lived experience and therefore the researcher’s active role in the interpretations is made transparent. In the continuation of interpreting and writing up in IPA style, it is acknowledged that the ‘researcher cannot avoid the process of interpretation’ (Smith, 1996; Brocki &Wearden, 2006; Eatough & Smith, 2006). While the writing up is a continuous process, the double hermeneutic approach broadens and expands the process of analysis from the themes (Smith & Osborn, 2004). In this dual interpretative activity, the researcher attempts to contextualise the common-sense understandings from a psychological viewpoint (Larkin et al., 2006).

4.10.6. Mapping themes to theoretical framework

Following the IPA analysis (Eatough & Smith ,2006) the emerging themes were mapped to the theoretical framework used in the Adapted CBT model. To be consistent with the goals of the study analytical pluralism as used by Gerskowitch & Tribe (2021) was adopted by initially using IPA and then mapping the themes to the theoretical framework used for adapting CBT programme attended by the participants. As described by Clarke (2015) analytic pluralism in its simplest form means using more than one method for analysing data in qualitative research. This strategy has been used creatively and differently by researchers; Spier & Riley (2019) demonstrated skilful use of this analytical pluralism in exploring the distress of general practitioners (GP's) by applying two qualitative research methods namely Thematic Analysis (TA) (Braun & Clarke (2006) and Interpretive Phenomenological Approach (Smith ,1996). Using this method, the single data set was able to reveal both experiential and existential meanings through IPA as well as more practical goals for the investigation, derived from TA. More recently Gerskowitch & Tribe (2021) used this strategy differently in analysing the therapy experiences of working with interpreters, in adopting analytic pluralism, the authors used the IPA approach to analyse their data and subsequently used a psychoanalytic theory to contextualise themes.

4.11. Quality in qualitative research

Like all other qualitative research approaches, IPA is subjected to scrutiny to ensure the production of credible findings. Notwithstanding the importance of these trustworthy findings, however, reliability and validity are established differently in qualitative research (Madill, et al; 2000). Several criteria have been used for ensuring quality and trustworthiness including ensuring authenticity of findings in this qualitative study. These include, pilot testing interview, transcribing the interviews verbatim; coherence; ensuring that the arguments presented in the study were consistently justified and supported by the data grounded in participants' voices (Eatough & Smith ,2006).

In this study, triangulation has been adopted through the use of multiple researchers to guarantee the credibility of the data. The two researchers, who were asked to review the transcripts and recorded data, included a co-facilitator in the adapted CBT intervention involved in working with LTC/PPS (KD). Equally, the themes were checked and discussed with the research supervisor (CE) and another colleague (AM) and consistency of meaning was reported (Madill et al; 2000).

Chapter 5: Analysis and Results

5.1. Overview

This chapter summarises the analysis and results of the study. This study explored the lived experience of participants following their attendance at two related psychological interventions; namely the CBT programme adapted using CSM and SCT health psychology theories for LTC/PPS and MBCT used to augment gains and to prevent re-occurrence. The interpretative phenomenological analysis of 10, semi-structured interviews yielded four superordinate themes and their subordinate themes. These themes and their subordinate themes were interrelated and are discussed below using IPA (Larkin et al., 2006; Smith et al., 2015). In keeping with the ideographic approach, the themes are grounded directly on participants' accounts made evident in the use of a range of quotations throughout the analysis. (Smith et al, 2013). The superordinate themes and their subthemes are plotted in Table 3; illustrating the interrelationship and emergent processes of change; to provide a coherent meaning of findings.

5.2. Demographics

Demographic information: which included age, gender, marital status, employment status is recorded below and no specific LTC/PPS; was not reported to avoid participants being identifiable and pseudonyms were used to protect their identities. This information is presented in Table 5.1.

Table 2. *Summary of participant demographics*

Participant	Age	Gender	Status	Employment Status
1. Lindsay	49	F	Single	Employed
2. Ruby	49	F	Single	Unemployed
3. Bobby	33	F	Married	Employed
4. Fred	62	M	Married	Unemployed
5. Sue	53	F	Married	Unemployed
6. Jamie	58	M	Unmarried	Unemployed
7. Zoe	26	F	Single	Employed
8. Diddy	54	F	Married	Employed
9. Kenny	37	M	Married	Employed
10. Francis	61	F	Married	Employed

5.3 Theme 1: ‘Losing myself’

When participants spoke of their lived experience and gains following attendance at the two psychological interventions, a common theme in their accounts was a reflection on the lived experience of illness before their attendance at IAPT. The interview that explored the lived experience provided an opportunity for their stories of living with LTC/PPS; prior to the interventions; to be heard. In this first theme, some participants revealed living with diagnosed long term conditions accompanied by pain, fatigue and other cognitive symptoms and distress; while some revealed living with persistent physical symptoms with no medical diagnosis. In this theme, some participants expressed concerns about the persistence of their physical symptoms for many years without explanations, while others were newly diagnosed. The interviews revealed that, at times, the persistent symptoms and distress created confusion with regards to the continuation of everyday life and normal roles.

In this first theme, participants described living with LTC/PPS as a threat to their sense of self and how their condition interfered in all areas of their lives. Equally, the experience affected the dynamics of relating to significant others; including health professionals; creating a perception of communication barriers and a feeling of being misunderstood. Complicated relationships with friends and family seemed to be an inevitable factor in this embodied experience, leading to distress and hopelessness about the future. The impact on participants’ sense of identity was revealed in their narratives as well as conflicts and ambivalence with regard to life roles. There was a recurring theme of ‘life taken away’ and a feeling of being misunderstood. The referral to IAPT for psychological interventions was viewed with scepticism and experienced as part of this perception of being misunderstood that was revealed in subtheme 2.

The analysis highlighted both similarities and differences in their lived experiences and concerns derived from in-depth single case analysis (Larkin et al., 2006; Miller et al, 2018). The superordinate theme of 'losing myself' was expressed in two interrelated subthemes namely, 1.1 'life taken away' and 1.2. 'feeling misunderstood'.

Sub-theme 1.1 'life taken away'

In the quote below, Diddy described her experience of living with persistent pain before she attended the psychological interventions.

"(….) it was extremely painful not just in the sense of bodily hurting but because I felt as if everything in my life had been taken away [….] so I found that extremely difficult to deal with to the point of not wanting to be here a lot of the times, my life was hurting so much .[…] I find every sort of life situation difficult to deal with […] I was in a very deep hole and could not climb back up and(…) what was not helping everywhere in my body I was experiencing many kinds of pain… [….]… I was worrying […] and everything" (Diddy, 4–44).

In this account, Diddy used the phrase, ''not just bodily painful'' to symbolise the embodied experience, both literally and metaphorically. Her use of language and emphasis appeared to show an attempt to demonstrate both the severity and the persistence of the physical symptoms, primarily pain and the emotional impact. Seen together, these descriptions captured the embodiment of co-occurring mental health and physical health issues' including the negative effects these had on her life. In this quotation, the use of the verbal statement, "…extremely painful…" constructed an emotional tone which expressed the relentlessness of her experience with LTC/PPS. Equally, a sense of loss was articulated, as she described how she had felt like giving up on life and felt as if it had already been taken away.

A similar experience of feeling as if life was taken away was also expressed by Ruby:

"I was so sad (...) I did not think I had a life anymore" (Ruby,147-161)

Similarly, below Bobby described her experience before she attended:

"I had recently been diagnosed with fibromyalgia, and initially I tried to ignore it [...] but I was crying every day, the pain was getting worse, and I could not concentrate, it was beginning to affect my work. I felt like my options were closed, I could not do the things I wanted to do, I felt overwhelmed, and I was anxious about small things [...]" (Bobby, 45–78).

As shown in the narratives, both Diddy's and Bobby's lived experiences with LTC/PPS; before attendance at the psychological interventions; involved distress, which affected their self-identity in the trajectory from illness to IAPT. Bobby also named her diagnosis of fibromyalgia in her experience before she attended the psychological interventions. She clearly explained the impact of the LTC on her cognitive functioning and how this affected her ability to make decisions, thereby affecting her work. A sense of 'life unsettled by the illness', as well as descriptions of 'loss and hopelessness for the future' were expressed; seemingly due to the severity of the pain; which interfered with all aspects of life.

In the following interview Lindsay described a differing experience and raised additional concerns to this debate as she described being stressed by not knowing what her symptoms meant, including their persistence over a long time:

"I have had this pain for a long time [...] I was getting pain everywhere, and the doctors would not tell me what I had [...] I kept asking them [....] I used to worry and stress all the time at work and home [...]. I started asking is this why people kill themselves? I had no life. I thought, it must be something terminal and the doctors just don't want to tell me. Why am I in so much pain? [...] (Lindsay, 79 –115).

In this narrative, Lindsay added concerns with regards to uncertainties and timelines. Lindsay also highlights the reality of the participants' involvement with medical professionals and the need for clarification in understanding long-term conditions and persistent physical symptoms. This lack of clarity made the persistence of symptoms harder to accept and comprehend. In their accounts, both Bobby and Lindsay described the difficult emotions experienced following them finding out or living with LTC/PPS. In the narrative, the theme is developed and illuminated by a description of the difficulties they experienced physically, along with the cognitive and behavioural responses following a diagnosis.

In Bobby's account, the sense of unclear timelines and threat was expressed as she spoke about 'options closed'. In this context, options were about time and possibilities in the future. Bobby also expressed pessimistic projections about the future based on what she felt and the lack of clarity about the expected timelines related to the illness.

Similarly, the significance and impact of these lived experiences on the personal and socioeconomic contexts was revealed in how the experiences were described. For instance, in the narratives below, all three women; Diddy, Bobby and Lindsay; described how work and family were affected as they tried to cope and continue to function as normal, despite their physical symptoms getting worse. In this theme, participants described tendencies to carry on with life despite their suffering as noted in Bobby's narrative: *"I tried to ignore it [...] but I was crying every day, the pain was getting worse, and I could not concentrate, it was beginning to affect my work. I felt like my options were closed"* (Bobby, 45-78). In this narrative, Bobby described the impact of living with the effects of both physical and cognitive symptoms of fibromyalgia following a diagnosis. From her distress and lack of hope about future options, it seems that Bobby did not have enough knowledge about the newly diagnosed condition before she attended the interventions.

Diddy expressed a similar experience in her interview: "*I was overexerting myself, so I was making things worse… life was very miserable, one minute I was okay and I was living my life as normal […] I was at a battle with myself constantly."* The difference was that all three women Ruby, Diddy and Lindsay; did not have a diagnosis, despite experiencing persistent physical symptoms like Bobby.

In the following narrative, Fred expressed and described the impact differently while he also added descriptions around his experience with medical professionals:

"I did not trust myself […] what else can I do? What else is next? My body was not responding. It was not worth living, it was not so much the pain, but I was getting fatigued, I was not getting any answers from (...), it was very frustrating" (Fred, 117–132*).*

Fred described an experience of the body not responding due to persistent pain and fatigue. In this account, Fred seemed to separate himself from 'a body with pain', but also put himself in charge of regulating his body; hence he gets frustrated with himself for the inability to self-regulate. There was an experience of an overwhelming struggle with the body and an expectation of more difficulties to come as he loses trust in himself.

Sue expressed similar experiences in the narrative below:

"Before I came to the classes I felt low, I felt sad, I felt depressed until I went to my GP, he told me about this course [referring to the CBT interventions]. *I felt like I was the only one going through this pain, people did not want to understand […] I did not think I had a life anymore (...) I felt sad"* (Sue, 133–146).

In these narratives, both Sue and Fred described emotional struggles and a sense of disconnection between the self and the body, which created a lack of self-trust and, like others expressed, challenged future expectations and projected limited available options. These overwhelming experiences created doubts about the value of life. In this context, the narrative, *'I did not trust myself, what else can I do? What else is next?'* seemed to describe a sense of powerlessness and self-doubts and loss of control about what the future could bring. The experience of pain and fatigue generated loss of hope in one's abilities as well as a feeling of being let down by one's body. There seemed to be a lack of self-trust and diminished self-reliance in pursuing day-to-day life situations. There was also a sense of being let down by the health system in terms of providing meaningful, logical explanations for their persistent symptoms. The participants described the experiences of living with LTC/PPS as depressing and isolating. In this account, continuing to live was further questioned, as shown in the next narrative: *"I felt very depressed; it was as if I was the only one going through this and I was always thinking how I can continue to live like this?"* (Ruby, 147–161).

In these accounts, some participants expressed thoughts that life was not worth living due to the distress they were experiencing. In the following narrative, the experience of isolation and difficult emotions related to the impact of LTC/PPS, was described and illuminated further by Bobby: *"It was isolating like very isolating I felt like there was nobody to relate to, it was like [...] It was difficult to explain [...]* (Bobby,45 -78).

These overwhelming feelings of depression and anxiety were initially described by Diddy; who was not aware that she was depressed but was aware of her experience of anxiety; which she described as 'through the roof'. During her interview, it seemed to be much easier for participants to identify anxiety than depression, as it related to worries about life in the future which are usually normalised in everyday life. Diddy likened her experience of depression as being in a 'deep hole' and unable to climb back up. This described the feeling of helplessness associated with depression.

Both Ruby and Bobby described their experience as isolating and difficult to communicate this to others in understandable terms.

Sub-theme 1.2. 'feeling misunderstood'

In this subtheme, participants' narratives shifted as they reflected on their initial experiences of IAPT interventions. In the following accounts, the participants expressed difficulties in comprehending how psychological interventions could cure physical symptoms that medical experts had failed to alleviate. This expectation of physical symptoms particularly pain, being eliminated; created an extra barrier to their understanding and acceptance of psychological interventions. Lindsay echoed the sentiment in her account:

"(...) so, when I came there, I was one of the people who was very sceptical and then I thought, (...), maybe it will take the pain away. Is it going to be a waste of time and I was just really looking for this pain should go away, you know I just want this to go away but then when I started, (...), the first day I was (...) like everybody else I think most people of the group had never really gone through CBT before .... I thought give it a chance you know, and I started noticing a difference'' (Lindsay, 79-115).

The underlying common belief: that only medical interventions can treat physical symptoms; seemed to be the initial obstacle and their previous experiences fuelled these representations. The search for a cure for physical symptoms created confusion about the introduction to a psychology intervention. Participants expressed in their narratives that they were already feeling misunderstood by others, including their families and health professionals and therefore, for some, the referral to psychology seemed to perpetuate these feelings. This is noted in Bobby's narrative:

"When I started, I did not understand it, how could this take the pain away? […] I was a bit unsure in the first few weeks?" (Bobby, 45–78).

These doubts and scepticism seemed to be compounded by the stigma and meanings attached to psychological interventions, which was further expressed by Bobby in her account: "*It seemed as if things were in your head or your mind. I was not completely convinced but needed to do something for my stress"* (Bobby, 45– 78).

The benefits of psychological interventions for LTC/PPS were misunderstood during the first few sessions. In the narratives, Bobby; who elsewhere in the study described her difficulties of adjusting to persistent physical symptoms at work and home; explained her initial doubts about CBT's ability to remove her pain. As expressed in the interview, the scepticism was fuelled by the misunderstanding that an introduction to a psychological view meant that 'things were all in my head'. Like others, Bobby felt that this approach was dismissive of her real experience of persistent pain. Nevertheless, as Bobby explained in her account, she felt a need to engage to find a way of reducing stress. From her narrative, there seemed to be an initial understanding that a psychological approach could deal with the mind, for instance by reducing stress, but not with the body. The lack of awareness of the link between the brain and the body, fuelled by negative connotations of 'pain being in the mind' was evident in Bobby's account.

Equally, although participants described overwhelming feelings and distress, they were more concerned about the persistent physical symptoms, especially pain. There was a belief that if the physical symptoms and the diagnosed illness were cured, things would improve. Some participants, therefore, normalised their distress and frustrations associated with limitations, but did not seem to recognise the extent and impact on their mental well-being. For example, Diddy described this lack of recognition of her mental distress as follows: "*I did not realise that I was depressed until I came for an assessment […] I was not aware of that situation… I* *was finding every sort of life situation difficult to deal with... (....) extremely, I was in a very deep hole and felt I could not climb back up [...].*

However, like others in the CBT group, responses of scepticism were similarly expressed in the accounts of the perception of the MBCT as noted in the accounts below:

"At the beginning I thought (...) this is not going to be good for me [referring to MBCT] – especially because at the beginning I was finding difficult to relax that I kept sleeping at the beginning" (Diddy,4-44).

Similar comments about the MBCT were made by Sue:

"I thought it was not for me [MBCT], I was unable to switch off [...] I did not like it; the language was too difficult for me" (Sue, 133–146).

Correspondingly, some expectations of 'switching off and relaxing' during the mindfulness practice, also presented as obstacles to the understandings of psychological benefits. Like Diddy, Ruby was depressed and had suffered from persistent pain for a long time when she was referred by her GP. She too was sceptical about being referred for CBT as noted in her account:

"Before I came to the classes I felt low, I felt sad, I felt depressed until I went to my GP he told me about this [referring to the CBT interventions], I felt like I was the only one going through this pain, people did not want to understand [...] (Ruby,147-161).

These barriers to psychological therapies for participants appear to stem from experiences of feeling misheard or not believed, as expressed in the previous themes. There was an understanding of illness as an acute entity, which seemed to be different from the lived experience of persistent symptoms and distress. This is noted in Lindsay's previous narrative:

"I have had this pain for a long time […] I was getting pain everywhere, and the doctors would not tell me what I had… I kept asking them… do I have cancer? Why am I in so much pain? … is it terminal?"

Worries about the uncertainty and consequences of the persistent symptoms seemed to perpetuate the distress and doubts experienced by participants which they expressed in their accounts, particularly with regards to the first theme.

5.4. Theme 2: 'The emergence of new understandings'

The group interaction formed a safe space for hearing others and experiencing being heard and understood. In this sub-theme, as participants learned and became engaged in the group's activities, their doubts seemed to reduce, which cultivated a sense of being understood and understanding others. This differed from the emotions of grief, alienation and anger that were experienced and expressed in the previous theme. The interactions in the group encouraged acceptance, and participants felt believed by others who shared similar experiences of living with LTC/PPS. There was a relief in the shared experience with other sufferers of LTC/PPS. Likewise, the group provided a safe space in which participants felt heard and this experience cultivated empathy and compassion for others as relayed in their accounts. This theme is comprised of two subthemes namely, (2.1) a safe space for shared understanding and (2.2) embodying empathy and compassion. These are discussed below and supported by direct quotations from participants' accounts.

Sub Themes

Sub-theme 2.1. a safe space for shared understanding

In this subtheme, sharing their narratives with others in the group was described as a safe space and a liberating experience which led to shared understandings amongst the participants, as noted in their accounts.

In this sub-theme, a sense of 'shared relief' and a feeling of 'sameness' were expressed by participants. For example:

"It's interesting to listen and gain feedback from others [...] finding that other people are experiencing the same pressures" (Kenny, 162–170).

"There are a lot of people suffering from this pain [...] knowing that I am not the only one boost my confidence" (Ruby,147–161).

On a whole, the participants generally expressed an appreciation for their long suffering being shared and believing that it was understood. There was a shift from the problem-saturated stories of pain and isolation to a safer and more compassionate, empathic space in the group. From the words used in the personal statements of the participants a change could be seen in the emotional tones of their narratives. The change in tone was expressed as 'a sigh of relief' with feelings of enablement and hope. This was revealed in language used by the other participant Ruby:

"*knowing that I am not the only one boosts my confidence" (Ruby,147-161).*

In these accounts, the power of group therapy and being given a voice was apparent. Attendance in the group programme and sharing experiences seemed to have had a give-and-take effect, as participants felt at ease revealing their lived experiences, with the others providing an empathetic audience. It could be contended from these accounts that the group experience was the start of a re-making of their shattered world and sense of self.

Sub-theme 2.2. Embodying empathy and compassion

In the second subtheme, participants revealed experiences of embodied empathy and the development of compassion for others. The group experiences were associated with developing compassion for others through listening to their concerns and suffering and this was differentiated from being a recipient and expecting others to listen to one's own suffering.

Below Fred described this view of experiencing empathy:

"It's nice to be in a group where things are accepted [...] People could be empathetic from a position of knowing [...] it breaks the isolation because it is amazingly isolating [responding to prompt] "Just that basic human contact of hearing other people breath [...] [emphasising] just that basic human contact where there are no expectations." (Fred, 117–132).

In this sub-theme, the natural sense of empathy that was described involved understanding physical closeness, including thoughts and a range of emotions. Fred described the beneficial effect of the group interactions in dealing with isolation, plus the positive feeling of being in a safe space. There was therefore recognition of the benefits of being in a group.

In the following accounts, a change in the accounts was noted, as the group was experienced as being in a safe space and empathy and compassion from others was felt and experienced. In her account, Diddy expanded on the meaning of this felt experience, expressing the realisation of what it was like when others spoke about their distress and pain:

"*Sometimes you go into this situation thinking it's me [...] I am in pain, listen to me… that could be a powerful effect too just to listen to others and start realising that others have pain and distress too" (Diddy,4–44).*

In this reflection, Diddy appeared to show the emergence of new realisations as she engaged with others also suffering from LTC/PPS with accompanying distress. At other points in this interview, Diddy spoke about the impact the stress and misunderstandings between herself and family had on her. In this narrative, there was awareness that relationships disrupted by LTC/PPS could be restored through these new understandings of others' needs.

Bobby described these emerging understandings as life changing:

"CBT is life changing. I am back to work; it changed my focus [...] I learned skills that are good for everyone not just for somebody who is depressed. It is skills for life. (…) *I am more understanding and more empathetic of other people's feelings (*Bobby, 45–78*).*

In the narrative Bobby normalised CBT as skills for life and seemed to have developed empathy for others in her life.

The group formed a safe space where psychological benefits were understood, including those of being heard and hearing others. These understandings cultivated a sense of empathy and compassion. There was a change in the talk about empathy from the usual 'outsider perspective' of an objective feeling (as perceived in the health profession) towards an embodied 'insider perspective'. This was described by (Fred) as a 'felt sense of being understood' in a group 'where things were accepted and where others were empathetic from a position of knowing'. Elaborating on this experience, Fred described a 'felt sense, able to break the isolation' during group interactions. There was appreciation of the embodied sense and human contact; which included hearing other people breathe [during mindfulness]; with no expectations.

5.5. Theme 3: ‘changing representations of illness’

As noted in the previous theme, new understandings emerged and navigated a change in representations of illness through group interaction and facilitation. Alongside the experience of the group as a safe space for shared understandings and the experience of embodied empathy and compassion, further new understandings developed. In this third superordinate theme, changing representations of illness emerged from the narratives of participants. There were three interconnected, recurring subthemes in the participants narratives namely, (1) renewed sense of space and time, (2) awareness of body and activity and (3) stepping back and increased attentiveness.

Sub-theme 3.1. renewed sense of space and time

In this sub-theme, Bobby described how the programmes helped improve her health, both physically and psychologically. She described the mindfulness as helping to create a sense of space and time to apply the ideas learned earlier in the adapted CBT programme:

“CBT allowed me to be more open to the mindfulness. If I did mindfulness without the CBT, I think I would have given up whereas CBT taught me that you could do things bit by bit, you don’t have to do hundred percent. Courses helped both physical and mental well-being […] the mindfulness course helps you to create time to apply the CBT ideas.” (Bobby,45–78).

This sense of time and space, which included an appreciation of newly acquired skills, was expanded on in the following narrative by both Jamie and Kenny. They described how learning to pace helped them in coping with activities and reducing pain medication.

Below, Jamie describes how learning to pace had changed his sense of time and attitude to approaching activities.

(...) I pace myself more, I don't rush myself I minimize the chances of passing out ...It helped me mentally, I take time to think about things before I do them (Jamie,171-184).

As is evident from his account this changing sense of time and reduced reactivity to situations seemed to have lessened his panic.

"I am chilled (...) taking my time getting up trying not to take tablets, pacing [...] Taking time out when doing things, otherwise I would have done 'til I explode" (Kenny, 162–170).

For Kenny, the sense of time brought a state of calmness and other benefits, including pacing and reduced pain which led to decreased medication use. Kenny used the word 'chilled' to describe a state of calmness and adjustments to use his space and time differently leading to less pain and a decreased need for medication. The use of the phrase, *"I would have done until I explode."* seemed to describe an awareness of a feeling and body connection in this context meaning (being shattered or falling apart). Kenny reflected on his past behaviour of cyclical 'boom and bust' activity which maintained his persistent symptoms of pain and fatigue including the negative effect on his mood.

During the interview Kenny continued and expanded on this subtheme of renewed sense of space and time. He reflected on past experiences of his inner world using the metaphor, 'prison in my mind', to describe his inner experience of fearful cognitions and insecurities that prevented him from engaging with life as he would have liked to.

"It helps me mentally [...] I take time to think about things. I am outward looking and outgoing, I have got an outward view [...] the prison was in my mind. I am a happier person; it's given

me information and tools to go on; the mindfulness kick-started a new way of thinking. Without it I would still be the same person." (Kenny, 162–170).

The terms 'outward' and 'inward' in this context were used to explain the threat and fear of life and events experienced as uncontrollable in the context of illness. Kenny described how he experienced panic attacks alongside his inability to go out. In this account, he described explicitly how the CBT course gave him information and tools for living his life and how the extra gains and insights from mindfulness changed his thinking. He used the term 'kick-started' to explain new, emerging mechanisms and insights that made him a happier person following his attendance at both CBT and MBCT. In this sense, **'**kick-started' is a construction of life being pushed to move forward from being on hold due to illness, insecurities, and fears. Further in his interview he talked about how this experience had changed him, implicit in his reflection and the emotional tone of happiness.

Sub-theme 3.2. Awareness of body and activity

The changing illness representations led to increased body awareness and activity, increasing periods where participants experienced good days and lessening the need for pain tablets for some participants as expressed by participants below:

"I am definitely being more aware of what my body was doing." (Sue, 133-146).

"I learned that you don't have to do everything at once I don't take pain tablets as I use to do, I use to take 8 tablets a day" (Lindsay,79-115).

The changing illness representations had an impact on how time and space, including the body, were conceptualised as predicted time frames related to the illness were re-perceived in light of new understandings. In this narrative, the way the lived experiences had been changed by both CBT and MBCT were articulated and in Diddy's narrative there was differentiation on the impact of each intervention. Diddy's experience of emerging awareness of body and reactivity had reduced reactions to situations. Diddy also referred to CBT and MBCT as acquired skills and acknowledged a positive difference in her ability to cope with the unchanged condition.

"I think I don't react to situations like I use to do […] I sit back and allow the situations to take place [...] go back and I think I am willing to make more changes. I think I am different but am not better still have pain, but I do more […] but now using mindfulness and other skills from CBT I think I can cope" (Diddy,4–14).

These gains of awareness of body and activity were expanded on, as noted in the following sub-theme:

"*I learned that you don't have to do everything at once I don't take pain tablets as I use to do I use to take eight tablets a day […] I can postpone things and deal with them later more rationally I have more good days than bad days" (Francis, 196-216).*

Francis made similar comparisons in her description of the changing sense of time and space and she expanded on these gains to explain how her ability to pace and use time differently for activities had benefited her by reducing pain and therefore, using less medication Through learning to pace, increasing good days and lessening bad days, Francis indicated both physical and psychological gains.

Sub-theme 3.3. Stepping back and increased attentiveness

Shifting of illness representations included gaining the ability to recognise unhelpful thinking; increased attentiveness, stepping back, and re-perceiving timelines; which all resulted a reported reduction in anxiety. There was also a recurring theme in accounts which outlined how these changes led to a reduction in stress levels. These experiences were clearly described by both Jamie and Lindsay in the accounts below:

"It helped me mentally [referring to CBT] *[...] I take time to think about things I am outward-looking and outgoing, I have got an outward view [...] the prison was in my mind (...) I am a happier person; CBT gave me information and tools to go on; the mindfulness kick-started a new way of thinking. Without it I would still be the same person"* (Jamie, 171–184).

"I have been having this pain for more than twenty years if it killed (...), I would have been dead by now (...) stressful situations do not go away, the pain will come. I learned to detach myself from situations; I learned to deal with things differently" (Lindsay, 100–102).

In her account, Lindsay demonstrated gaining the ability of stepping back and re-perceiving timelines about her illness as she developed new understandings about the impact of stress and pain. This was different to her earlier accounts which included worries and uncertainties about having terminal illness escalating her fear and undermining her trust in her consultant.

Similarly, in the next sub-themes, participants became aware of tendencies towards unhelpful thinking which included 'all or nothing', 'catastrophising' and 'ruminations' which all maintained states of anxiety and depression. These had an impact on decision making; including ambivalence towards adopting the 'sick role' which was discussed in their previous themes.

"I think I learned to stop thoughts from cascading, I learned to be where I am rather than to be where I want to be (...)" (Fred, 117–132).

"I felt overwhelmed, and I was anxious about small things… everything was quite difficult… I could not make decisions […] to me; it was like things were right or wrong" (Bobby,45–78).

In the above accounts, both Fred and Bobby reflected on how they recognised and became aware of tendencies towards catastrophising and possible ruminations, as Fred used the word 'cascading' which, in this context, referred to uncontrollable negative thoughts. Bobby described other tendencies like *'all or nothing*', also referred to as 'black and white thinking', which made it hard for her to make decisions. In her earlier interview, these tendencies had caused her to ignore her physical symptoms and carry on with her activities, which became unhelpful.

In the following sub-theme, it is noted that the increased understanding of thought patterns and ability to step back helped participants to be more attentive and reduced stress levels, as noted below.

In the following account Lindsay expanded on her experience of increased awareness that seemed to have led to stress reduction.

"I started noticing things around me. I was like a robot, I used to tell people that you could blindfold me from my house, but I would still find my way to work just automatically; it's just being alert and being conscious; it's something I never come across before and it's connecting to my CBT (...)

In this narrative, Lindsay used the robot to describe her day-to-day activities and state before she attended the IAPT interventions. Lindsay made some generalisations about awareness and alertness to other life aspects while reflecting on her previous inability to recognise the limitations of engaging in activities. It was also clear from this narrative and elsewhere in the interview, that her strategies of coping became too problem-focused and exhaustive, negatively impacting her both emotionally and physically. Despite engaging in healthy activities, she reported that she was not getting relief from the troubling, persistent, physical symptoms. Instead, she had experienced these engagements as repetitive behaviours that maintained distress related to alertness and awareness, which she described as, '…being like a robot.' At other points in the interview, she reflected on how these activities were no longer helpful. In this narrative, Lindsay uses the terms 'alert' and 'conscious' to describe the positive shifts in her level of attention and awareness.

Like most people living with LTC/PPS, Lindsay described in her interview how she was bombarded with advice with regards to lifestyle change activities such as; joining gyms, doing Pilates, healthy eating, diets, and vitamin supplements; from both health professionals and media. Often people with LTC/PPS feel obliged to accept this help, which can sometimes induce more anxiety and blame, as it becomes yet another series of tasks to be performed. This was evident as she revealed:

"*I remember [...] I used to do everything, go to the gym, do Pilates, but I was not getting better. I was not stopping, and I was not aware, but now I have learned that stress won't stop, but it's just how you deal with it"* (Lindsay, 79–115).

In this account, Lindsay articulated a sense of awareness around the consequences of her relentless problem-focused and exhausting responses to her LTC/PPS.

In this subtheme, participants' situations had not changed. For instance, as noted in how both Jamie and Diddy spoke about their experience:

"Don't get me wrong, the pain is still there, but I learned other ways of dealing with my pain […] The course got me out of the house" (Jamie,171–184).

"But things have been different since I came to the course… you yourselves have put some structures in place for me which I use […] yes, I have got this disorder, but I can manage it […] I think I have gone through the grievance part; I am not saying it's brilliant, it isn't, but I have picked up different skills, different ways of dealing with things" (Diddy, 4–44).

In this sub-theme of awareness and subsequent reduced stress, there was a change in how persistent symptoms were perceived and spoken about with some noted flexibility in thinking. This was illuminated in Jamie's use of language, for example, in his description of his experience of how, '…mindfulness kick-started a new way of thinking' (Jamie).

5.6. Theme 4: 'Finding myself'

The progression of themes in this study showed that as illness representations evolved and altered, this coherence shaped new understandings about LTC/PPS. As observed, the new understandings challenged old perceptions and informed new ways of thinking and managing LTC/PPS including accepting one's own capabilities and limitations. These overall experiences seemed to have had a positive impact with the reshaping of previously shattered identities. Participants reported that these changes enhanced their quality of life by gaining more meaning and understanding about scheduling activities and dealing with the 'boom and bust' behaviours explored in the CBT programme. This final master theme of 'finding myself' is comprised of two subthemes namely 'acceptance' and 'regaining own expertise'; which were articulated by participants.

Sub-theme 4.1. Acceptance

In the following accounts, participants reflected on how attendance at these group programmes made them realise their potential to live a different life, despite having LTC/PPS. It was as if a projection into a future with options became possible. These accounts, noted below, mark a movement away from the expressions of anger, stress and a sense of 'life lost' seen in their earlier interviews:

"But things have been different since I came to the course… you yourselves have put some structures in place for me, which I use […] yes, I have got this disorder, but I can manage it [….] I think I have gone through the grievance part. I am not saying it's brilliant, it isn't, but I have picked up different skills, different ways of dealing with things. I gained hope, I realised there is hope at the end of the tunnel […] I gained a lot of understanding about myself" (Diddy,4–44).

In this narrative, the shifts from a state of biographical disruption to life after and during the interventions were revealed. For instance, Diddy referred to the experience as 'structures and skills' put in place to manage LTC/PPS. There was a sense of new connections which made life more manageable, despite the LTC/PPS. There were new understandings, which Diddy referred to as structures. In this account, she described how she has gone through the process of grieving for her loss of a life taken away, as expressed in the previous sub-theme, and how she had seemed to reclaim herself. Implicit in her account, was the shift from grieving to acceptance of being able to live with less suffering from LTC/PPS.

This realisation brought about improved self-awareness; stemming from the understood connections between one's body, thoughts and emotions as articulated in the next narrative account with Sue**.** *"I am no longer stressed; I appreciate things more; it made me think differently. I understand myself more; I understand my pain more, my thinking and feelings"* (Sue, 133–146).

There was an increased understanding of physical symptoms, while both the distancing and ownership of pain, were implicit in this account. The pain was talked about separately from the self, thoughts and feelings, which could symbolise both acceptance and detachment. These new understandings were accompanied by a general appreciation of things in life; in the same way as the sub-theme of acceptance and ability to use these skills and knowledge including new understandings in dealing with LTC/PPS. These developments are described by both Ruby and Francis below:

"Pain has not gone away, but I have learned how to deal with it and knowing that I am not the only one boosts my confidence" (Ruby,147-–161).

"Pain is there, but I do not focus on it that much" (Francis, 196-216).

In the accounts of Ruby and Frances, there was a reiteration that things were not perfect; often a reality for people living with LTC/PPS; but that the new understandings had made it easier to cope. The focus on persistent symptoms, such as pain, had lessened. The participants expressed how the persistent symptoms of LTC/PPS; including pain and fatigue; made the body a central focus detracting from the moment-by-moment awareness and interest in other activities. This lack of awareness extended into other areas of life; as articulated in earlier accounts; affecting social interactions at work and home. In the following narratives, both Zoe and Diddy also revealed a sense of finding themselves and hope for the future. In this theme, participants described how their identity was reclaimed following attendance at the two psychological interventions. The participants reflected on how they were more hopeful and confident in dealing with persistent physical symptoms and the impact thereof. There were comparisons of past and future identities that showed a reduction on how the impact of LTC/PPS was described and experienced.

The impact on emotional health, identities, and plans was evident in the participants' accounts. For example, in Zoe's interview, she made a direct reference to self-identity:

"I am more than fibro. I became more forgiving of myself regarding illness; I just don't let my illness define me; I am more than just fibro […] I don't sit around feeling sorry for myself […] Before the group. I lost my job […] after it helped [referring to the course]; *it helped me get off my feet. I got a placement and will get the job"* (Zoe, 185–193).

In this study, the participants reported that an understanding of CBT was able to help them engage with mindfulness which resulted in some learning taking place. Significant to this study were the comparisons around the therapeutic gains from the two psychological interventions. For instance, two participants concluded that they gained more from the first CBT intervention than from the MBCT. In the following accounts Diddy elaborates on this sentiment:

"It is beneficial to go to both groups; they overlap in places […] you learn skills and those skills come to play […] mindfulness teaches you to look at your situation and put your skills to the place; I think the two groups should follow each other" (Diddy,4–44).

Bobby also describes a similar experience: *"CBT allowed me to be more open to the mindfulness; if I did mindfulness without the CBT I think I would have given up whereas CBT taught me that you could do things bit by bit* [referring to activity scheduling and dealing with boom and bust]. *You don't have to do a hundred percent"* (Bobby, 45-78).

It is also worth noting how the participants in use common-sense interpretations to explain the psychological interventions.

Sub-theme 4.2. recognising one's own capability

In the following account, Zoe expressed her happiness in establishing that the benefits of the lifestyle change she had already made, before coming to the psychological interventions, were reaffirmed.

"The course reinforced things that you already know, things like drinking, sleep, exercising" (Zoe,185–193).

As well as reaffirming existing life skills and knowledge which improved coping; participants gained new information and adapted some difficulty-maintaining behaviours as noted in Lindsay's accounts:

"*I learned that you don't have to do everything at once. I don't take pain tablets as I used to do. I used to take eight tablets a day [...] I can postpone things and deal with them later more rationally. I have more good days than bad days"* (Lindsay, 79–115).

The participants seemed to have applied this newly acquired knowledge of pacing to other situations in their lives, which had positive effects on how they felt and spoke about themselves. In this sub-theme, the pacing was used to denote a common understanding of balancing and regulating activity levels.

In the following sub-theme, participants described their life-changing personal goals. This learning process was demonstrated in the following account:

"I learnt other ways of pacing at home and work" (Kenny, 162–170).

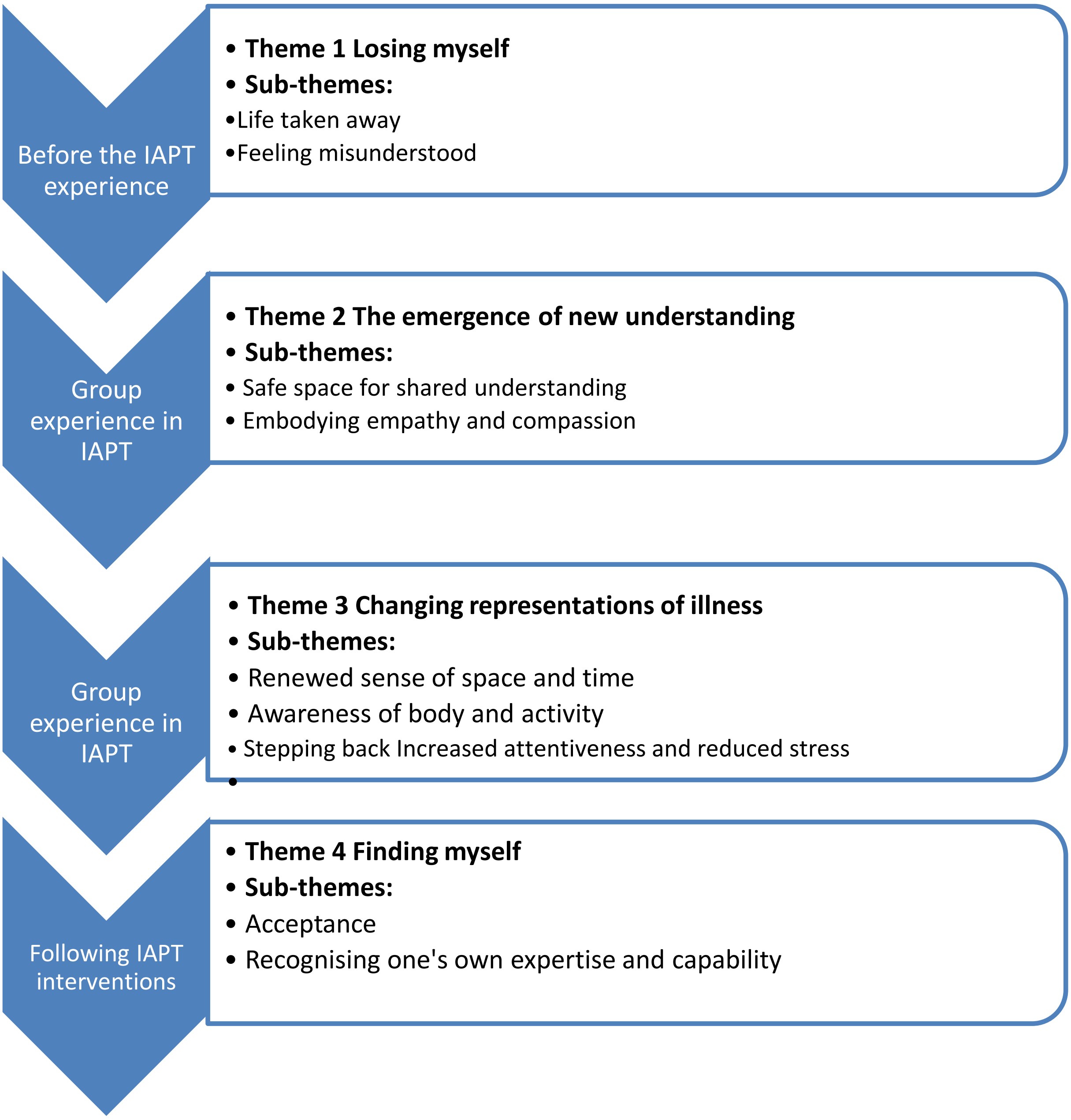
"I can postpone things and deal with them later more rationally [...] recognising that you cannot change everything" (Lindsay, 79–115).

In the above accounts, the aforementioned theme of a new sense of space and time was repeated and used in the context of performing activities, as expressed by Lindsay:

"I can postpone and deal with them more rationally"

In this account, there was a sense that more thinking and planning was given before an action was taken. Equally, there was also a recognition of and acceptance of things that cannot be changed. These themes and subthemes are represented in Figure 3 below.

Figure 3: *Lived experiences of illness and recovery*



Chapter 5: Discussion

6.1. Overview

In order to explore lived experience of both illness and recovery following attendance in IAPT, the interpretative phenomenological analysis of 10 participants was used and yielded four superordinate themes along with their respective subordinate themes. These interrelated themes are briefly outlined, justified and then further discussed in this chapter.

(1) “Losing myself”, the first theme which reflected on the lived experience before and therefore was an important aspect of their experience, adding an extra layer to the retrospective nature of the study. It elaborated on the impact of LTC/PPS on self-identity from the narratives of those suffering from these conditions, this theme highlighted the uncertainties, ambivalence and feelings of being misunderstood harboured by participants before attendance at IAPT.

(2) The second superordinate theme revealed processes and the emergence of new understandings during attendance at IAPT group interventions.

(3) The third superordinate theme revealed changing representations of illness.

(4) The fourth and final theme of “Finding Myself”, revealed processes of acceptance and regaining of self-identity following attendance at IAPT interventions.

These are discussed individually below in the context of the subtheme and connectedness and the interrelated meanings are made explicit. The themes are also discussed with reference to literature and previous research findings. Finally, in adopting Clarke’s analytic pluralism, the last section of this chapter contextualises the themes to the theoretical framework used in the adapted model for quality development, to make sense of the emergent themes from the participants, following their attendance at IAPT interventions.

(6.2) 'Losing myself'

This theme revealed loss of self-identity and existential concerns and it consists of two interconnecting subthemes namely, 'life taken away', and 'feeling misunderstood'. All participants began by reflecting on being overwhelmed by their experience of living with a long-term condition and persistent physical symptoms before they attended the IAPT interventions. This subtheme of 'life taken away' expressed a threat to meaning and purpose of life in the face of LTC/PPS with participants' narratives being characterised by explanations of limited abilities to self-regulate their bodies, including diminished self-reliance. The participants reflected on how they questioned the meaning and purpose of life. In a narrative describing difficult mood states, one participant used a metaphor of, "being in a deep hole" and sadly described a feeling of being "unable to come back up". Smith, (2019) noted that; similar to the fearful cognitions expressed by participants with LTC/PPS; the exploration of lived experiences can lead to engaging with difficult thoughts and emotions as people continue to search meaning when they have been confronted with difficult major events, regardless of how long they have suffered.

As noted in the rich accounts, instead of using medical language such as 'stress, anxiety or depression'; commonly used by health professionals; participants with LTC/PPS chose representations that seemed to have emotion and body connections to make sense of their embodied experience in this subtheme of 'life taken away'. To describe their lived experience, participants spoke about disconnection and the difficult relationship between the body and the self, as captured in their verbatim accounts which described; 'bodies unable to respond' and 'bodies doing things till they explode'. Using the IPA to explore these lived experiences gave participants the freedom to express their embodied experiences, including feelings and thoughts, using common-sense understandings. How the body and self were talked about separately seemed significant, as they described a struggle in regulating and managing their bodies, which impacted on their identity and led to ‘losing oneself’. In these narratives, through the use of their own language, participants differentiated between both subjective meanings about pain as medically understood, shared, and assumed by others, to express the personal embodiment of LTC/PPS as it affected their daily lives and identities.

In the same vein, in a study by Smith, & Osborn (2015), on women who suffered from persistent pain, it was contended that exploring lived experience led to deeper understandings and construction of psychological meanings. Likewise, in this study, these meaning-making, shared understandings of the mental wellbeing needs of people who suffered from LTC/PPS might highlight how psychological interventions should be planned and delivered. Their constructions of lived experiences contribute towards shared understandings of the significance and impact of LTC/PPS on the participants’ life and self-identity.

In addition, related to this factor ‘lost identity’, participants described the lack of information and difficulties in communication that impacted negatively on their relationships, social interactions and decision making; thereby increasing their frustration. In this theme, participants also revealed the difficulties of living with fear and uncertainty and described a range of associated emotions. In exploring the narratives of people with progressing chronic illness, Nanton et al; (2016), also noted how uncertainty could affect personal identities, adversely affecting mental health. The lived experiences, reported by people with LTC/PPS in this study, described a similar effect on families and those close to them, resembling findings from a study with people suffering from persistent symptoms of Parkinson’s (Smith & Shaw, 2016). Similarly, in exploring the lived experiences of people with IBS, who live with distressing persistent physical and emotional symptoms, Bigony & Keitel (2020) also noted the impact on the participants' sense of self and social relationships with significant others.

Previous studies in chronic illness have referred to this lived experience, which affects people's sense of self and social interactions, as 'biographical disruption' (Bury, 1982; Crossley, 2000; Brown, 2018). However, the difference in this study, is that these initial themes were reflections from the past as noted from the changing narratives as participants moved forward in 'finding themselves'. In this study, continuity and changing selfhood were observed in later themes. In the IPA analysis of narratives from people suffering from pain, Smith (2019) also noted that biographies were not static but can be reconstructed over time. While recognising the interruption that illness can cause to the sense of self, previous and recent studies have also recognised that people adjust and move from biographical disruption towards biographical restoration and repair, as they move towards acceptance of their LTC/PPS (Lockock et al ; 2009; Nanton et al ; 2016, Brown, 2018).

In this study, some participants reflected on their early diagnosis while others described suffering for longer. Similarly, Brown (2018) noted that early diagnosis of illness was associated with loss of abilities and future options in women with fibromyalgia. Although not all participants in this study were diagnosed with fibromyalgia, the findings revealed that people with LTC had similar experiences of distress with persistent pain and fatigue being the dominant reported experiences. Fibromyalgia, experienced by some of the participants (e.g., Bobby), is characterised by a multitude of both physical and cognitive symptoms which include; fatigue, persistent pain, poor sleep and cognitive fog, also referred to as 'brain fog' or 'fibro fog' in accounts. It has also been noted that fibromyalgia shares some similarities with other conditions which present with persistent physical symptoms, e.g., chronic fatigue syndrome (Glattacker et al, 2010). As asserted, IPA recognises that events and experience derive meaning from social and personal circumstances, thereby considering the person in context (Smith, 2015). It is therefore worth mentioning that participants in this study included people who had self-referred or who were referred by health professionals to IAPT. They suffered from a range of LTC's such as diabetes, arthritis, or pain and fatigue with no other diagnosed condition and were all experiencing anxiety and depression related to persistent physical symptoms associated with these conditions. As highlighted in the literature on LTC, it is common for patients to suffer from more than one long-term condition, which intensifies their experience and distress from LTC/PPS (Salkovskis et al., 2016). The negative impacts of persistent physical symptoms have also been reported in patients who suffered from cancer (Maguire et al., 2014). The participants in this study by Maguire et al., (2014), described obvious difficulties of functioning in their lives which made them lose trust in themselves; similar to the described experiences of the participants in current study. In line with this study, previous research found that difficulties and distress potentially created by the multiplicity of persistent symptoms, need understanding from the patient's perspective (Maguire et al., 2014; Diviney & Dowling, 2015). The exploration of the LTC/PPS as lived experience might, therefore, improve shared understandings between healthcare professionals and patients. To our knowledge, this study is the first to have explored the lived experience of LTC/PPS following attendance at the adapted CBT interventions (described in Chapter 2) and MBCT.

Also related to losing oneself, was a second subtheme of feeling misunderstood and scepticism to engage with psychological interventions, which was expressed by participants. The participants had suffered from persistent symptoms for a long period of time before they were referred to IAPT and, as revealed in the accounts, the journey of health-seeking exposed them to a variety of physical interventions such as medication and lifestyle changes. These experiences, coupled with medical understandings of illness management, created some scepticism about the referral to psychological services as was communicated in their accounts.

Furthermore, the implications and impact of feeling misunderstood and being disbelieved, seemed to be worrying and confusing for participants, leading to indecision with regards to continuity within their role expectations, which also impacted on their self-identity. There was consequently some evident ambivalence about adopting a sick role. The lack of clarity, with regard to illness timelines experienced by the participants with LTC/PPS, seemed to have challenged the common-sense understandings of the usual temporal sick role, usually achieved through the legitimization of the illness (Werner et al, 2004). The lived experience with LTC/PPS seemed to contrast to that of the sick role associated with the understanding of illness. Placed in this position and feeling misunderstood, participants therefore continued with social expectations, as reported in their narratives. In this way feeling misunderstood created more than just scepticism, but also maintained suffering caused by persistent symptoms through the behavioural patterns of 'boom and bust'; characterised by cycles of doing too much or too little in response to LTC/PPS and the anxiety of not knowing. In their exploration of narratives of recovery, Cheshire et al (2021) also identified these behavioural patterns and experiences of sick role resistance due to stigma and being doubted. Previously, Diviney & Dowling (2015) expanded on this phenomenon in studies on fibromyalgia patients, describing the difficulties created by living with an unseen illness and the impact on their daily roles and relationships.

The subtheme of 'feeling misunderstood', recurrent in the narratives, maintained frustrations, distress, and a continued search for meaning and an understanding of suffering. Similar themes of; 'not being believed' and the frustrating search for the legitimisation of symptoms; have been noted in previous studies. For example, in Smith & Osborne, (2015) who studied patients with persistent pain and Gerskowitch et al; (2015), who similarly conducted their study on IAPT services for people with persistent symptoms following attendance at either CBT or MBSR. While working with patients with tinnitus, Mark et al; (2019) highlighted the impact of distress which can lead to anxiety and depression when a disorder is not understood by sufferers. Mark et al; (2019) also noted that distress could perpetuate the symptoms of the illness, creating more confusion for the individual akin to what was observed in this current study.

Comparable themes were also reported in the Gerskowitch et al; (2015) study, in which the only three participants who attended the MBSR instead of the CBT, reported challenges about their experiences of meditation. The authors therefore stressed the importance of educating patients in managing their expectations with regards to mindfulness. In this study, there was a change in participants' narratives, as new understandings about psychological interventions emerged (as noted in theme 2). All participants reported benefiting from both CBT and MBCT, except two participants who reported challenges related predominantly to their expectations around MBCT. It is possible that the nature of CBT; which is goal and structure oriented (Becks,1979); was more acceptable for the participants in the current study. The findings around experiential challenges and expectations during group therapy; particularly with regards to MBCT; have implications for selection and recruitment of participants.

(6.3) 'The emergence of new understandings'

The accounts of participants related to this theme were marked by continuing self-reflexivity, including shifts from scepticism towards new meaning-making, as participants engaged in the psychological interventions. The new understandings emerged as participants grappled to make sense of their experience and its significance in the context of LTC/PPS. In laying out the position of IPA, Smith, (2019), contends that the role of the researcher is to 'make sense' of these understandings. In doing so, two subthemes were identified as the new emergent understandings namely, (1) safe space for shared understandings and (2) embodying empathy and compassion.

In this study, the group interventions were experienced as a safe space for shared understanding. The therapeutic relationships which emerged through group sharing authenticated and normalised the distress and impact of multi-faceted contextual issues related to the participants' lived experiences of LTC/PPS. In accordance with the findings in this study, Social Cognitive Theory has been successfully used as a theoretical framework, to implement group programmes where learning, and behaviour change were motivated (Gustavsson, 2011; Cameron et al; 2018).Previous qualitative research on CBT and mindfulness interventions used for people with LTC/PPS, identified comparable themes in which group interactions were experienced as validating and normalising of participants' experiences and therefore reported as beneficial by participants (for instance Griffith et al. 2009, Gerskowitch et al; 2015; William et al; 2019).

The second shared understanding to emerge was the embodying of empathy and compassion, experienced during the group interactions. Participants in this subtheme experienced sharing and listening to others with LTC/PPS as a powerful and liberating experience. The constructions of both empathy and compassion revealed how participants felt when their experiences of pain and discomfort were validated, including what it meant to be understood. In a phenomenological sense, 'empathy' involves the ability to be receptive or responsive to people's emotions including the ability to understand the significance and meaning of these emotions (Thwaites & Levy – Bennet 2007). Similarly, 'self-compassion' is associated with kindness towards self and a reduction in feelings of shame and self-criticism Gilbert & Tirch (2009). Similarly, according to this understanding, 'compassion' is associated with kindness and the understanding of others' suffering as well as refraining from 'isolating and shaming the sufferer'. Despite mindfulness being associated with the development of empathy and compassion, from these narratives it seemed that both groups were associated with these qualities. In this subtheme, group interactions provided opportunities to experience other people’s perspectives which lessened the focus on one’s own problems. This subtheme of embodying empathy and compassion, as conveyed by participants in this study, has not been identified although a previous study by Bermudez et al (2013) reported increased empathy following mindfulness practice.

The participants in this study had attended both the CBT adapted group and the MBCT. In addition to the therapeutic gains associated with being in groups, mindfulness is also associated with the development of both empathy and compassion. In this study, participants had an additional advantage of attending both CBT and MBCT. The narrative account of the ‘embodied sense and basic human contact of hearing other people breathe, with no expectations’, expressed by one of the participants also resembled the attitude of ‘non-striving and being mode’ as the state associated with reduced stress level, which is cultivated and encouraged in mindfulness (Kabat-Zinn, 1982; Segal et al., 2013).

(6.4) ‘Reflexivity’

During this write up, I reflected on this subtheme in my journal as follows:

In their own words, the group understood from a position of knowing (meaning being validated by somebody who has the same experience as yours who understood the physical pressures of pain and fatigue. The narrative accounts about empathy and compassion taught me a lot as a health professional, I started questioning my understanding of empathy and kept constantly checking my sense making of empathy which I had learned from early training as: ‘the ability to put oneself in somebody’s else’s shoes’ in order to remain objective, it seemed as if this definition may not always be adequate in expressing understanding of other people’s lived experiences.

In accordance with IPA's double hermeneutic interpretations, this unfolding theme was linked to these theoretical understandings and previous knowledge of what empathy meant as well as what I knew about the history of the participants, to construct meaning-making beyond the descriptions in the discussions (Larkin et al., 2006; Smith et al., 2015).

IPA, as a qualitative approach, makes allowance for the deployment of constructs and theoretical framework in the interpretative activity to help make sense of the participants' accounts (Larkin et al, 2006). I realised that drawing on the 'sameness of experience or suffering' was not always a common denominator for me as facilitator in our caring roles, but also wondered if this was important at all if we are able to keep this empathic attitude in mind. I could not find an answer, so I remain curious. During my roles in this study, I shifted between empathic and suspicious approaches to try and understand participants' sense making of their lived experiences (Larkin et al, 2006; Smith, 2004).

However, my previous understandings of empathy shifted with these new constructions characterised by sameness and a belief that one's lived experience had been understood from a position of the embodiment of pain and suffering. These constructions expressed an important experiential significance which added to both the 'everydayness' of empathy from friends and loved ones and different to the conceptualisations of the construct in health professions. This was a different kind of empathy from what I understood, and I became acutely aware of my position as an outsider in the group at times.

Making sense of these narrative accounts; however; required considering the historical context of the participants, including the initial narratives in the previous theme such as; 'life taken away and feeling misunderstood'' difficulties of communicating the suffering, sometimes wondering if life was worth living with persistent symptoms and how suffering from LTC/PPS was maintained through the pressures of role expectations. The opportunity to experience empathy and conveying compassion for others seemed like a sigh of relief for the participants. This process of bearing witness to other people's suffering appeared to be the beginning of regaining their own identity? for the participants. The group, therefore, expanded the audience of people who validated and believed the participants' lived experiences. The embodied sense of empathy, described above, involved understanding the physical pressures and to the related thoughts and a range of emotions, including grief and loss.

(6.5) 'Changing representations of illness'

In this third superordinate theme, shifting illness representations included perceptions of time, which comprised understandings about the persistence of illness and the outcomes and consequences thereof. In the participants' narratives these informed how time and space were used to cope. As noted in the accounts of participants, at times, attempts to cope led to protective behaviours, including avoidance and panic attacks. However, the aforementioned emergence of new understandings identified narratives that depicted changing illness representations. In this theme, the interpretative process is an attempt to make sense of how the participants, thought, felt and spoke about the impact of illness on their coping and functioning. Their narratives revealed changing illness representations comprised of three interconnected subthemes with related meanings namely, (1) renewed sense of space and time; (2) awareness of body and activity and (3) stepping back, with increased attentiveness.

The first shift in their illness representations was a renewed sense of space and time. In their narrative's participants described the CBT interventions as giving them tools, information, and structures to cope with LTC/PPS. Contrastingly in this subtheme, the MBCT was described as creating ability for time and space to apply these ideas and from their narrative's mindfulness seemed to be a way of perfecting this renewed sense of space and time. As contended, through the practice of mindfulness as suggested by Kabat- Zinn (1982,) participants are invited to ‘step outside their clock time’ during the practice. In this subtheme, the participants’ accounts seemed to suggest that they developed other meanings and significance about time and their use of space. Theoretically, through awareness and focus in the present moment; including self-awareness and self-regulatory abilities acquired through the practice of mindfulness; renewed time and space could be cultivated which was subjectively reported by participants in this study (Kabat-Zinn,1982; Segal et al ,2013). In describing the benefits of mindfulness, participants expanded their meaning and explained the significance of their understandings of the skills of pacing, to their journey in acceptance of self and limitations. This was evident in their assertions that by learning to pace, they realised that they did not have ‘to be hundred percent as a person’. In a similar vein, mindfulness was further described as accelerating this process of understanding and described as ‘kick-starting’ (meaning a propelling action to accelerate its speed) by one participant. In this study participants were taught pacing as a self-regulation activity, which involved time and speed in space in the context of LTC/PPS limitations. Through these new understandings of using time and space; skills learned from the CBT adapted intervention contributed towards cultivating self-regulatory abilities, facilitating goal-directed changes including cognitive control, which were further accelerated by MBCT. Previous studies using MBCT following CBT interventions found that it complemented therapeutic gains for instance, Key et al, (2017) discovered that mindfulness provided extra benefits to patients who suffered from OCD following the augmentation with MBCT. In elaborating on this new relationship between thought, body and emotion participants expressed how it seemed to have brought liberation and a renewed sense of space and time to use the body, space and time in a different way. This experience also bears some similarities to the process of ‘decentring’; a core skill of mindfulness; in which participants are trained to relate differently to thoughts, feelings, and body sensations (Segal et al, 2013). In expanding on this narrative, one participant, who in his earlier narrative described suffering from panic attacks, spoke about discovering ‘prison being in his mind’ and how he changed from being inward-focused to being more able and outward-focused. This noted shift from an imprisoned mind; in which thoughts and physical sensations of panic led to fearful misinterpretation; towards being more outward focused; does capture the essence of mindfulness. The latter refers to the ability of self-regulating both attention and emotions, allowing freedom for engaging capably within time and space (Brown & Cordon, 2009). The sub-theme of renewed space and time, which enabled increased awareness of body and activity, transcends previous findings. These shifts in the understandings and use of time and space, as reported by participants in this study, has not been reported although parallel themes that comprise of an increased sense of agency and improved activity levels have been reported in previous studies following mindfulness practice in people with physical health illnesses (Bermudez et al., 2013; Allen et al., 2009; Griffith et al. (2009).

The renewed experience of time and space, as understood from participants’ narratives, appears to have led to a state of psychological readiness and liberation for skilful actions. There was a noted reinterpretation of the inner world experiences, which seemed to have resulted from decoupling of thoughts, feelings and reactivity; consistent with the theory of MBCT (Segal et al, 2013). There was a change in emotional representations of threat and fearful cognitions, including self-critical thoughts, as new understandings emerged. Alongside other representations, participants reported improved activity levels. In this study the theme expanded to the awareness of body and activity, which appeared to have helped participants in recognising their existing strengths and expertise in dealing with LTC/PPS, as noted in their accounts. This had a positive impact on the reduction of stress and anxiety related to t activities as participants reported changes of calmness in their mood allowing them to change how they approached both their activities and use of pain medication. The improved self-regulatory abilities and how mindfulness practice improved well-being and behavioural functioning were consistent with the theoretical explanations of MBCT (Brown & Ryan, 2003, Segal et al, 2013). Also relevant to the current study is the use of the common-sense model; as identified by Hale (2007) in studies on people with osteoarthritis; as people learn more about their bodies and reactions, illness representations are modified. Following the attendance at the interventions, illness representations, as noted in participants' narratives, revealed new understandings related to improved awareness of body and activity; conceptualisations of space and time and abilities for stepping back from fearful and anxious thoughts. Smith & Osborne (2015) argue from a phenomenological view that 'illness representations are not fixed entities but can be reshaped'. The lived experience of participants, as expressed in this theme, supported these notions.

A third subtheme, in this theme of shifting illness representations, was the ability to 'step back' which led to increased attentiveness, as described by participants. In this subtheme, participants' narratives demonstrated an improved ability to observe and step back from thoughts allowing participants to describe re-perceived timelines associated with their illness, as they gained new meaning and understanding around the impact of stress and physical symptoms. In these narratives, participants revealed that, following CBT interventions, they noticed improved recognition of unhelpful thoughts, including a reduction in fearful cognitions. Their accounts showed that this contributed towards changing both cognitive and emotional illness representations. Through these new understandings, participants developed new relationships with their thoughts, which challenged their negative narrative of self. As noted in their narratives, through these understandings, gained from both CBT and MBCT, a different way of dealing with negative illness representations was cultivated (Kabat-Zinn, 1982; Segal et al, 2013). As contended by Brown & Cordon (2009), the mindfulness practice introduced participants to the experience of thoughts and emotions both as psychological and bodily occurrences, rather than conceptualised descriptions. This has been articulated by participants in their attempt to describe their subjective experiences of both CBT and mindfulness. In this study it appeared that the balancing of the conceptual and goal-orientated CBT and non-conceptual nature of mindfulness did benefit participants with LTC/PPS.

In this subtheme, participants acknowledged the black and white thinking which contributed towards indecisiveness and catastrophizing, described in their earlier narratives. Previous evidence in LTC has contended that unhelpful thinking styles contribute towards cognitive inflexibility. Consistent with the narratives of participants, this cognitive inflexibility limits problem-solving skills and weakens perspective taking, which impacts on ways of coping (Salkovskis et al., 2016). Similarly, previous studies involving people with LTC have associated unhelpful thinking with poor self-management, indecisiveness and stress, which negatively affects health outcomes in people with diabetes (Hudson et al., (2014)) and persistent pain (Gustavsson, (2011). These authors stressed the importance of targeting negative cognitions in interventions for LTC/PPS. In the psychological interventions used in this study, sessions dealing with illness cognitions and thoughts, including problem solving, were added to the adapted CBT programme.

Equivalent themes of, shifts in thought patterns identified in this study were reported in a meta-analysis of 67 studies that investigated psychotherapeutic work. Similarly, the researchers stated that this ability led to participants being more rational about options and future possibilities. Consistent with these findings, results showed that after therapy clients developed new understanding of thoughts and behaviours (Levitt et al., 2016). The accounts from participants demonstrated changes in previous illness representations towards new understandings and a skilful response to persistent symptoms, including better regulation of emotions and thoughts. Both CBT and mindfulness have been associated with improvement in cognitive flexibility (Segal et al, 2013).

(6.6) “Finding myself”

A marked shift in the lived experiences of the participants was the fourth superordinate theme of looking beyond illness and ‘finding myself’, which brought hope for the future, as expressed in their accounts. There was a recurring theme of gains and improved activity levels along with understanding one's limitations and acceptance of these. In this theme, there was a sense of appreciation and reinforcement of their previously existing skills and knowledge, which was experienced as empowering and reaffirming by participants. This was revealed in two subthemes: (4.1) acceptance and (4.2) regaining one’s own expertise**.** In these subthemes’ participants’ narratives shifted to talk about gains and a sense of hope in their ability to live with LTC/PPS

In this study, as noted in the changing narratives, adjustment and learning came with acceptance of situations that were unchanged. There was a revelation that persistent symptoms, especially pain, had not gone away, as noted in the interviews. Instead, participants had developed new, alternative explanations which were less threatening and less fearful through their engagement in the interventions as well as their continual regaining. The focus on suffering and LTC/PPS as a threat had lessened, as confidence to deal with the impact had improved. Participants also revealed new understandings which added value to the understanding of processes and constructs inherent in their lived experiences of illness and recovery.

The theme of looking beyond illness and ‘finding myself’ brought hope for the future, as expressed in the accounts of participants. Berglund & Källerwald (2012) described the phenomenology of adjusting towards acceptance of persistent symptoms as a shift towards new understandings that emerge from learning through lived experience. Likewise, as described in the context of the women with fibromyalgia, the experience of illness is multi-faceted;

triggered by life events, which can sometimes enhance and rebuild people's sense of self as they go through a process of growth, and psychological development, through their lived experiences (Brown, 2018). Nanton et al., (2016) observed a similar process of preserving selfhood with people suffering from chronic illness and comorbidities. As in this current study, Nanton et al; (2016) identified the changing experiences of patients through interviews. The study attributed the findings to creating contextual factors in people's environments that made it possible for them to engage with valued activities that maintained their pre-illness identities and provided continuity of the preferred sense of self, despite changes in illness. Through these findings Nanton et al; (2016) concluded that healthcare practitioners can intentionally contribute towards helping clients build preferred identities, rather than just engaging their patient identity.

As discussed, these previous studies confirmed the importance of acknowledging the beneficial skills and knowledge accumulated through lived experiences with LTC. Evidence from the current study; however, adds that due to the challenging impact of comorbid mental health problems, including anxiety and depression, patients might sometimes lose their confidence and be unable to recognise their existing strengths in dealing with their LTC. In the current study, participants attended two interventions to progress towards strength recognition, and reclaiming lives, as noted in their accounts. The change in narratives from 'life taken away' and having no life to a theme of 'regaining one's own expertise' and 'finding myself', showed both learning and recognition of existing expertise through lived experiences facilitated through the interventions for more than a year afterwards. Another important finding in this study was the changing illness representations. Egan et al; (2017) also reported long term cognitive shifts where participants focused on new, positive ways of defining themselves, including focusing more on self-management and the absence of disempowering use of pain language following CBT pain-management programmes.

In the current study, the sub-theme of recognising one's own expertise revealed a sense of self-appreciation as well as affirmation of prior existing skills and knowledge of dealing with LTCPPS. This was experienced as empowering and validating by participants and attendance at the programmes was ultimately perceived as significant and life-changing by the participants.

6.7. Contextualising and mapping themes to theoretical framework

In this study, the qualitative approach; IPA; was used to generate psychological knowledge about lived experiences, including processes and activities following attendance at IAPT interventions. Following the IPA analysis, themes revealed that attendance at both the adapted CBT intervention and MBCT had enhanced new understandings and given new meaning to the lived experiences of participants with LTCC/PPS, as noted in their accounts. In this journey, participants described a shift from 'losing themselves' to 'finding themselves' following the formation of these new understandings. After the IPA analysis, the themes were mapped against the theoretical model that was used for adapting the CBT programme. The epistemological tensions involved in mapping the emergent themes to the theoretical model, are worth acknowledging and reflecting upon. Throughout this project there was an attempt to adhere to the epistemological principles of compassion and responsiveness in the empathic hearing of the lived experiences of the participants. Both empathic and questioning hermeneutics; principles employed by IPA; were appropriate to this qualitative enquiry which involved both understanding and explaining (Smith & Osborn, 2015). This required shifting between empathic and suspicious approaches at times, to be able to explain some of the complexities and processes revealed by participants following their attendance at the interventions. This study was part of a benchmarking, service evaluation and quality improvement analysis of existing interventions for people with LTC/PPS in IAPT. The participants attended a CBT intervention, which was adapted using CSM and SCT models and the CBT-adapted programme was followed by a MBCT, which was used to augment gains and prevent the occurrence of depression and anxiety.

This contextualisation was important, as the model was used for quality improvement, to enhance group facilitation and interpersonal processes. The themes followed a progression of shifting understandings from the first superordinate theme, of "losing myself" to the fourth superordinate theme of "finding myself ". In theme 1, participants reflected on life before the IAPT experience. The first superordinate theme, as revealed in themes and subthemes, provided an opportunity for participants to be heard and understood and revealed existential and identity concerns which are consistent with the phenomenological approach. In mapping this theme; as understood from the CSM; LTC/PPS was experienced and described as a threat to well-being and living with capacities to self- regulate being hindered and participants experiencing a significant sense of loss, which impacted on their identity making it seem as if life was taken away. The subthemes highlighted illness representations and made explicit the impact of the lack of information and high levels of uncertainty, which had a disempowering effect on identity. For all participants this had contributed to a referral to IAPT for depression and anxiety related to LTC/PPS. In the subtheme of 'feeling misunderstood', the narratives demonstrated a lack of coherence created by a combination of several factors related to co-occurring mental and physical health conditions, including misunderstood timelines. Within the CSM coherence, sense making plays an important role in helping individuals understand the course of illness and their attempts to manage and cope and coherence is also positively associated with adjustment to illness (Hagger & Obell, 2021). As found in the systematic review, identifying illness representations for people with MUS (also referred to PPS in this study) can inform self-management programmes and enhance health outcomes. The review, which focused on studies using CSM, also found that threat-related and emotional illness representations, had a profound negative effect on managing and coping with PPS and affected overall health outcomes (McAndrew et al; 2018). These subthemes, therefore, might offer some insights into the use of the model to make explicit the illness representations and prior learning using the constructs of the CSM namely, (identity, time frames, consequences, and controllability (Leventhal, 2004, McAndrew et al; 2018; Hagger & Obell, 2021).

The intention for adapting the CBT model, using health psychology theories, was to observe and improve facilitation and group processes. The group processes employed, helped in encouraging shared understandings using participants' language of their lived experience, as shown in the quotes. As noted in theme 2, shared understandings were developed between the participants as a group as well as between the participants and facilitators. The subthemes revealed the benefits of group processes and made explicit the emergent understandings revealed by participants. Also highlighted in these themes, was how processes of change became explicit in the accounts of the participants as they engaged in the interventions. These accounts revealed that theories (SCT and CSM), which focused on observing group processes through flexible facilitation styles, increased their participation and engagement with learning. This was noted from their narratives in the theme 2 which highlighted shared understandings. In terms of therapeutic gains, benefits have been described as difficult to achieve in traditional CBT (Ehde, 2014) as facts are sometimes presented in a didactic manner, which might not be contextually sensitive and have no relevance for LTC/PPS. The adapted model was used intentionally, to maximise the effectiveness of the CBT interventions, through the mapping of illness representations and the facilitation and observation of group processes. The theoretical model adopted a group format during the CBT intervention and encouraged open discussions. Through facilitation, participants were able to explore their prior learned beliefs and coping skills, including feared and actual consequences, during the group discussions (Leventhal et al; 1998; Hagger & Obell, 2021). As contended in the CSM, illness representations are constructed through lived experiences and influence how people respond to illness. These; however, can be reconstructed and responses updated with new information, as noted in further accounts of the participants (Hagger & Obell, 2021). Furthermore, by observing group dynamics through SCT, including the intention to develop self-efficacy and reinforced confidence, seen in superordinate theme 2; participants felt confident to share personal information in the group. Therefore, through the application of these theories, the group emerged as a safe place in which social interactions and group facilitation led to the emergence of new shared understandings, thereby altering fearful illness representations and predictions. Through the emergent understandings within and between the participants, both compassion and empathy were experienced.

In the adapted CBT model, the 5-area model was integrated with the CSM constructs from the first session and, as reflected in the themes, led to improved learning and understanding. As highlighted in previous studies, working with LTC/PPS can be complex, as people might experience multiple symptoms which may be misinterpreted at times (Salkovskis et al; 2016). It can be hard for people experiencing persistent physical symptoms to differentiate when the persistent symptoms are triggered and intensified by emotional states or from existing LTC. Similarly, in Hudson et al; (2014) where CSM was used in people with LTC, it was found that lacking understanding, with regards to timelines, perpetuated fears and anxiety ultimately impacting on illness coherence. In response to these findings and to improve the quality of the CBT interventions, a session to support participants in differentiating between acute and persistent physical symptoms and sensations, was included in this adapted model. It was noted throughout the themes how this provided some coherence, which changed some of the threatening illness representations, including a better understanding of emotions.

In addition, as noted in participants' narrative accounts, CBT improved the understanding of the links that exist between thoughts, feelings, and behaviours. The employed model was able to embed these understandings into participants' contextual and personal circumstances (expressed during session debates), which made it possible for them to articulate how their lived experiences changed following attendance at the interventions.

In the adapted model, sessions 7.8, 9, which dealt with consequences, incorporated facilitated debates on coping skills exploring both helpful and unhelpful behaviours including interesting information from participants. Through the mapping of illness representations and prior knowledge/skills, both helpful and unhelpful ways of coping and consequences were made explicit and shared with others. The group was effectively facilitated to allow participants to safely debate and challenge each other, while also sharing good coping skills and knowledge. During these interactions, there were opportunities for participants to challenge some of the 'taken for granted' and sometimes unhelpful behaviours/thoughts that maintained difficulties, while new knowledge and capabilities emerged. Through this process of facilitation, participants found it easier to accept behaviour changes as their existing knowledge and common understandings were acknowledged. In line with CBT, guided self-discovery was used during facilitation. This facilitation helped in drawing on the existing strengths and expertise of the participants, which appeared to be reaffirming for participants, as noted in their accounts. Also consistent with both CBT and CSM, psychoeducation was used, and facts were presented to bridge information gaps. This was useful in encouraging and improving coherence and helped participants to update some of the consequences of their learned coping. This has been noted in the sub-theme of 'regaining own expertise'.

As shown in the adapted CBT model, there were efforts to include interventions associated with developing self-efficacy and intention formation to develop self-regulatory actions, which are imperative to self-management interventions. Throughout the delivery of interventions, theoretical constructs were constantly considered during the facilitation. In session 4, interventions associated with developing self-efficacy, such as goal- planning and identifying strengths and abilities for self-regulatory activities (CSM) (Leventhal et al ; 1998); identifying barriers and facilitators during goal planning (SCT) (Bandura, 2004), including CBT e.g. psychoeducation ,guided self-discovery to improve intention formation for setting smalls goals for valued activities were added to the programme. Through these processes of facilitation in Theme 4, participants recognised their own strengths and expertise, which seemed to have led to acceptance and finding themselves.

6.9. Limitations and strengths of the study

Strengths of the study

In this section factors that need to be considered in the evaluation of this study are discussed, including strengths and limitations such as methodological challenges. The strength of this study is that both therapist and participants were drawn from routine primary services. This increases the ecological validity of this study with regards to representativeness. The participants in this study were drawn from a variety of LTC/PPS and this heterogeneous nature of the participants' LTC/PPS is characteristic of primary-healthcare clients, including those in IAPT and its policy of self-referral. The themes and subthemes permit findings to be drawn from different long-term conditions and wider persistent physical symptoms which are treated in IAPT.

The study combined both research and practice-based evidence as it was carried out in an IAPT service as part of service evaluation and quality improvement of existing psychological interventions. This is a strong point for the study as the goal was to explore the lived experience of people who used psychological interventions in IAPT. This strength is significant as it elicits service-use feedback and collates information for responsiveness. In their accounts, the service users explained and described their experiences revealing understandings of how these psychological interventions work. The topic of the study did not pose a threat or cause distress to participants; instead it generated an interest and an opportunity to speak about lived experiences.

Although this study was conducted as a service evaluation its component of quality improvement can be viewed as implementation research (Peter's et al, 2013). It used a qualitative interpretative phenomenological approach to explore service-users' experiences following their use of an adapted CBT intervention. The implementation to improve quality involved use of health psychology theories. It has also highlighted how health psychology theories can contribute to evidence-based interventions. Throughout the study, there has been transparency about the methods used and reflexivity has clarified how the study investigators' own biases could have affected the interpretation of the themes.

The themes and subthemes in this study highlight directions for future research and theory building in the field of psychological interventions for improving access to psychological therapies for people with long-term conditions and comorbid mental health.

6.10. Limitations and methodological challenges

The study used a small sample (N=10) which was purposefully recruited as participants met criteria for an in-depth, idiographic exploration of subjective experiences of attending two psychological interventions in IAPT (Smith and Osborn, 2015). It would have been helpful to employ triangulation of the quantitative information from outcome measures generated during the psychological interventions; however, due to resource limitations; this was not possible.

Furthermore, despite self-efficacy being central in the adapted CBT model alongside evidence stressing the importance of its cultivation in self-management of LTC/PPS, it was not measured directly in this study. It would be helpful for future research and service evaluation studies to include this measure before and after to understand if the attempts to develop this ability in the adapted CBT interventions did produce quantifiable changes to this construct.

During the semi structured interviews, participants' narrative accounts involved levels of reflectivity on their journey prior to attendance and sometimes included their experience during their attendance and recovery, therefore potential recall biases should be considered in the interpretation of findings. In this project, the lead investigator (LT) was involved in all the phases and co-facilitated both groups and was also responsible for the content and adaptation of the CBT model. While this involvement, motivated by interest and experience and training in this area, was helpful for the success of the project, it also carries some potential biases to the interpretation of the findings. As the study investigator (LT) was known to the small, purposive sample, it should also be noted that the recruitment could have attracted group participants who were enthusiastic about being interviewed and had positive experiences to report. As the study investigator (LT) was also involved in the implementation of both psychological interventions, there was pressure to succeed as well as a driving curiosity to understand how the participants have experienced these psychological interventions. This background motivated the choice of methodology and the interpretative repertoires the investigator (LT) brought to these understandings and is equally noted in that context. Throughout the study process, these potential biases in social desirability and the influence of power, were considered. In order to offset these potential biases, all activities were always performed within professional and ethical guidelines, for instance, the interview guide and construction of questions and probes prepared by (LT) being discussed with supervisor (CE) and colleague (AM).

IPA is criticised for focusing more on meaning-making and less on embodied experience. In this study, attention was given to this experience and felt sense. This study has focused on both cognitions and embodied experiences as participants could talk about their lived experience, which involved living with long-term conditions and persistent physical symptoms, including anxiety and depression. One of the criticisms levelled at IPA is the lack of focus on language. In this study the latter was attempted and yielded added value in the analysis. For instance, this was seen in the discussion of the use of metaphors which showed how meaning-making was interwoven with used words and expressions (Touffor, 2017). In this study the discussions are grounded on the participants' accounts and there were several attempts to identify the nuances and emphasis present in the participants' descriptions of their experiences. The transparency by the researcher is communicated in the presentation of the epistemology and the reflections.

6.11. Implications for practice

1. **Use of qualitative research in service evaluation to highlight recovery gains for LTC/PPS in IAPT**: This study has highlighted the importance of using qualitative methods to elicit service-user feedback for responsive service planning. The themes have highlighted the importance of the agency of the participants in the therapeutic processes. In prioritising participants' voices, IPA was a useful approach in helping to elicit service user-feedback and in encouraging responsiveness when planning future interventions.

2.**Making explicit processes of change following psychological interventions:** Through the use of qualitative approach participants were able to describe their experience of illness, the impact on their identities including changes during and following the psychological interventions.

3. **Contribution to theory and practice-based evidence**: By using the health psychology theories namely; CSM and SCT; to adapt CBT interventions and make explicit how their constructs were used and applied as well as in how group processes were facilitated, this study contributes to both the theory and practice of health psychology. The adapted model discussed in Chapter 2 of this study is, to the best of our knowledge, the first of its kind and will contribute towards working with people with LTC/PPS in groups and face-to-face.

4. **Contribution towards gaining psychological benefits for LTC/PPS**: This study has implications for understanding how both theory and an ability to facilitate interventions contribute towards psychological benefits and recovery-oriented outcomes. The findings in this study, as shown in the superordinate themes of 'losing myself', 'finding myself' and 'changing illness representations', revealed some insights about the changes and processes involved in reclaiming identities.

5. **Responsiveness in planning relevant interventions for service-users and highlighting aspects of interventions:** It is important to note that this study was part of service evaluation and quality improvement and therefore contributes towards practice-based evidence. In the analysis of the participants' experiences, their engagement in psychological interventions has provided new insights for practitioners. It has helped identify the elements of the interventions as experienced by the participants and reported in themes. Also significant for practice is how the important components of CBT interventions have been reported in the adapted model used in this study. The key information which includes the training and experience of therapists that carried out both psychological interventions; the content of both CBT and MBCT interventions and participants' interactions during the implementation; is also reported. These reported insights and challenges will contribute towards planning better services in the future.

6. **Managing client expectations in group therapy:** Although this study was not about client expectations, it does highlight the importance of managing client expectations in psychotherapy, as pointed (Westra, et al, (2010; Gerskowitch et al; 2015). This study also highlights the importance of the therapist's understandings of patients' negative expectations and their responsibility in managing them to enhance therapeutic processes in therapy and group facilitation. This is particularly important for patients with LTC/PPS. The sub-theme of 'being misunderstood' and the associated reactions of scepticism, have relevance to explanations given and the language used when service users are referred to psychological therapies. Equally, socialisation and educating patients about what to expect during group interventions such as the MBCT and LTC groups, is important for maintaining engagement and preventing group dropouts.

7. **Using a non-diagnosis LTC/PPS model**: Using a generic, adapted CBT programme has benefits for people with a range of LTC/PPS, although more studies, with larger samples employing both qualitative and quantitative approaches, might be needed to gain more evidence about its use and efficacy.

8. **Contribution to group and facilitation skills for therapists**: The accounts of the participants also showed that the use of the theories and the group facilitation increased their participation in psychological interventions. This facilitation helped draw on existing strengths and expertise of the participants. The sharing and validation of expertise was found useful by participants and the peer support and reinforcement encouraged helpful behaviour changes. These findings have implications for the training of CBT therapists in the facilitation of groups with regards to being skilled in understanding group processes, including formation and maintaining engagement for participants. It is important, therefore, to always consider the

relevant theories and constructs, such as CSM in this study (Leventhal et al; 1998) and SCT (Bandura, 2004) including use of BCT in facilitation (Michie et al; 2013).

6.12. Conclusions

This study was part of a service evaluation, and quality improvement of existing interventions for people with LTC/PPS in IAPT. The participants attended a CBT intervention which was adapted using CSM and SCT models. The CBT-adapted programme was followed by an attendance at MBCT, used to augment gains and prevention of re-occurrence of depression and anxiety (Segal, et al, 2013). The IPA qualitative exploration revealed rich descriptions of the impact of their experience with personal accounts (Smith, 2019) of the emotional impact of living with LTC/PPS, which differed from previously criticised, objectively quantified, selected versions of facts (Williams, (2015). From the first theme, it became obvious that the qualitative interviews gave participants an opportunity to reflectively describe the impact and distress of living with LTC/PPS before attendance at the psychological interventions. The participants' use of common-sense language to describe their bio-psychological lived experiences made the impact on their identity explicit and understandable in their own terms. This incorporation of common-sense language helped in mapping illness representations, including processes of change. Themes and subthemes highlighted how group interactions played a role in normalising experiences and cultivating new shared understandings for the participants. Although some participants reported that the CBT intervention made them appreciate the mindfulness intervention more, it does seem that using the two interventions together had a beneficial effect on psychological flexibility, particularly on the ability to deal with thoughts and illness representations, as noted in Theme 3. In the participants' accounts, the use of MBCT seemed to have refined and added value to how participants understood and used the CBT gains through mindfulness practice. These were noted in Theme 3 with the subthemes of space and time relating to body and activity.

In these themes, positive outcomes seemed to develop with the emerging shifts in understanding and continued throughout the process and beyond the IAPT experience. Interpreted as therapeutic gains, themes and subthemes identified in this study, seem to resemble the processes that define personal recovery identified in previous studies and literature namely; (1) a sense of connectedness; (2) optimism and a sense of hope about the future; (4) sense of identity; (5) attaching meaning and purpose to life and (6) a sense of empowerment (Leamy et al., 2011; Slade et al; 2014). This study might therefore shed some light on the conceptualisation of recovery amongst healthcare practitioners and service users.

The interpretative approach used in this study builds on the knowledge of recovery experience while also highlighting ideographic variations in the experiences noted in the themes and subthemes. There was a consensus among participants around the acceptability and perceived value of both psychological interventions. All participants described attendance at the CBT programme as beneficial. While eight of the participants found the MBCT equally helpful, two had difficulty in engaging with mindfulness and became sceptical about its usefulness, as expressed in their interviews. Both participants reported gains which they attributed to the adapted CBT intervention. In reflecting about this experience, some participants referred to both CBT and MBCT as the whole experience without differentiating. Their accounts revealed that therapeutic gains were conceptualised as a product of the combined benefits. The themes from the participants' accounts showed that some experienced the two programmes as complementary to each other and therefore both necessary to achieving the reported gains. The shifts in understanding appeared to form long-term gains, including cognitive shifts and changed perceptions about illness that were observed more than a year after the interventions.

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Appendix A: Project approval form (Removed)

Appendix B: Consent form

CONSENT FORM

Title of Project:

Benchmarking the existing practices and interventions used in an IAPT service for

people with Long term conditions including pain and fatigue.

Date: 26/04/2017

Participant Identification Number for this Service Evaluation and quality improvement project.

Name of Principal Investigator: Lumka Tutani

Please initial box

1. I confirm that I have read the information sheet dated.................... For the above Service evaluation. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I understand that the information collected about me will be used to support and improve the quality of care for people with Long term Conditions a ☐ xiety and Depression in IAPT and may be shared anonymously with other health professionals.

☐

4. I agree to take part in the above Service Evaluation and quality improvement project.

______________________	______________________	______________________
Name of Participant	Date	Signature

______________________	______________________	______________________
Name of Person taking consent	Date	Signature

Appendix C: Information leaflet

Title of the Project

Benchmarking the existing practices and interventions used in an IAPT service for people with Long term conditions including pain and fatigue.

Date: 19/05/2017

Participant information

You have been invited to take part in our Service evaluation and quality improvement project. Please take time to read the following information carefully. Ask questions if you feel there are things that are not very clear.

Why have I been invited?

You may recall that you attended both our 10-week Cognitive Behaviour Therapy (CBT) group for Long-term conditions/Pain Management (LTC) as well the Mindfulness Based Stress Reduction (MBSR) 8 week course. You are one of the 10 participants chosen to share their experience following their attendance at these groups.

What is the purpose of this Project?

The purpose of this project is to evaluate the existing practices and interventions used in our IAPT service for people with Long term conditions with Depression and Anxiety. We aim to improve the quality of our services and offer more choices for people with LTC with Depression and Anxiety where possible. The information you share with us will add value in improving the quality of these services.

Do I have to take part?

Taking part in this project is voluntary. We will go through the information sheet with you. You can ask questions if there are aspects you want clarified. We will then ask you to sign a consent form which shows that you agreed to take part.

If you decide to take part you are still free to withdraw at any time you wish, and this will not affect your future care in any way.

What will happen to me if I get involved?

The plan is to meet once for an interview which should last for an hour, unless further clarification is needed. Should further information be needed a follow-up meeting would be arranged. The project is estimated to last for a minimum of 4 – 6 months.

The principal investigator will ask you some questions about your experience of the groups. This information will be audiotaped and kept securely. The information you share will be analysed along with information from others. All information will be stored securely and be kept confidential and only used for the purposes of this service evaluation. Information will be securely kept for about 5 years before it gets destroyed according to NHS regulations.

What are the advantages and benefits of taking part in this project?

The aim of this project is to improve the quality as well as expand choices of services that we offer for people who have Long term conditions with Depression and Anxiety. The information you share with us will benefit the people who use our services and other professionals who are involved in similar services as we would publish our findings for this purpose. There will be no identifiable information in the writing and reporting process. This information would also be given to you if you are interested.

Will there be any risks?

We do not expect you to experience any discomfort however should you feel distressed by talking about your experience support and counselling will be available for you. This information will be given to you if needed.

Approval for the Project

Permission for the Service Evaluation project was granted by the Research and Development Office of The Oxleas NHS Foundation Trust. The project complied with all local policies and procedures.

Contact details of Principal investigator

Lumka Tutani (Principal Investigator [redacted]

Email: lumka.tutani@nhs.net

Further information and contact details

Supervisors:

[redacted]

[redacted]

Dr Clare Eldred – Chartered Health Psychologist – City University, London

[redacted]

Appendix D – Supervisor Report

CITY UNIVERSITY
LONDON

Department of Psychology
City University
Northampton Square
London EC1V 0HB

Professional Doctorate in Health Psychology

Supervisor's Report

Trainee Details:

Name: Lumka Tutani
Supervisors: Dr Clare Eldred

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Declaration
I verify that the above named trainee has undertaken the above mentioned competence. I am of the opinion it has been completed to a satisfactory professional standard.

Signature: **Date: 24/12/2**

Appendix Supervision Plan – Research

Area of competence	Area of practice	Supporting evidence to complies	Changes
Research Competence	**Setting** Long-term Conditions Champion/Lead IAPT services (Improving Access to Psychological Therapies)	Supporting evidence 30,000 word bound thesis 10,000 word piece/journal articles submitted in a peer-reviewed journal(a minimum of two journal articles)	
2.1 Conduct Systematic Review .2 Design Psychological Research	A systematic review of effectiveness of CBT interventions ,in managing Non-Cardiac Chest pain (NCCP)	Please see Publications ,Paper1 and Paper2 6000 words systematic review	
2.3 Conduct Psychological Research 2.4 Analyse and Evaluate Psychological Research Data 2.5 Initiate and Develop Psychological Research	A qualitative exploration of lived experience and recovery of people with LTC/PPS following attendance at adapted CBT programme and Mindfulness Base Stress Reduction	30,000 words	

Section C: Publications

Publications and Presentations

Tutani, L (2017). Benchmarking and developing the role of a Health Psychologist in IAPT (2017). Oral presentation at the 1st AHCP 2017 Practitioner Health Psychologist.

Tutani, L (2018). A qualitative analysis of participants' experiences following attendance to both a Cognitive Behaviour Therapy (CBT) group programme adapted using Social Cognitive and Self-Regulatory theories followed by Mindfulness-Based Stress Reduction (MBSR) in IAPT for long-term conditions and medically unexplained symptoms (LTC/PPS). Oral presentation at the 6th Annual SHS Doctoral Research Conference.

Paper 1:(removed from thesis)

3. **Tutani, L, Eldred C and Sykes, C (2018).** Practitioners' experiences of working collaboratively with interpreters to provide CBT and guided self-help (GSH) in IAPT; a thematic analysis. In the Cognitive Behaviour Therapy Volume 11. [See practice log, paper previously published] DOI: https://doi.org/10.1017/S1754470X17000204

Paper 2: (removed from thesis)

4. Tutani, L and Eldred, C (2017). A critical review of Interpretive Phenomenological Analysis as a qualitative research method in the study of the experience of living with HIV/AIDS in South Africa: bridging the gap between research and professional practice in health psychology. In PINS: Journal of Psychology in Society. South Africa (under review). (See copy below (Copy removed) see Practice log and abstract below

Systematic Review

A systematic review of delivery and content of cognitive behaviour therapy (CBT) interventions that have been effective for reducing psychological distress for patients that attend the Emergency Department (ED) and other primary health care (PHC) services for non-cardiac chest pains (NCCP).

Abstract

Background: Non-cardiac chest pain (NCCP) is a common reason to attend the Emergency Department (ED) and other primary health care centres (PHC) including GP surgeries. Alongside common physical symptoms which include chest pain and breathlessness, NCCP can become persistent and distressing and is often associated with anxiety, panic and low mood. When sufferers are not reassured by explanations, re-occurrence of symptoms becomes distressing leading to frequent attendance at ED and other PHC services. To date, there is a paucity of studies that have investigated the efficacy of CBT in dealing with people with NCCP in this context.

Aim: To examine the effectiveness of the content and design of cognitive behaviour therapy (CBT) interventions for the management of NCCP in ED and PHC.

Methods: This systematic review was performed between 07/07/2018 and 30/08/2018, through searching English-language peer-reviewed studies and articles from databases as follows: Cochrane systematic review library, Google scholar, PsychInfo, CINAHL, PubMed, Embase, Ovid Medline, DARE and Campbell Library. The participants were adults who are 18 and above with no upper limit in age. The participants have attended an ED or PHC centre and include chest clinics and GP surgeries for chest pain and received a diagnosis of NCCP. Ten randomised controlled trials (RCT) were systematically reviewed. The review examined the differences in the design and content of the CBT interventions in studies identified for the management of NCCP.

Results: Following a thorough search of relevant articles and peer-reviewed journals 10 RCTs that met the criteria for CBT interventions used for the management of NCCP were reviewed. This review assessed the quality and content including delivery of CBT interventions that were effective in reducing persistent physical and psychological symptoms of NCCP. The review identified some common elements which improved the efficacy of CBT interventions. A narrative approach has been used to for reporting the results of this review.

Conclusions: This review has assessed the quality of the design and CBT content that have been effective in reducing both physical and psychological distress for NCCP. The important elements that enhance the effectiveness of cognitive behaviour therapies interventions have implications for both clinical context and practice, as identified in the studies.

Introduction

Non-cardiac chest pain (NCCP) is a common presentation in emergency department (ED) and other primary health care centres (PHC) that include chest pain clinics in the UK. Despite chest pain being associated with heart disease; between 40% and 60% of people attending ED and PHC are not diagnosed with any heart condition (Jonsbu et al; 2011; Webster et al; 2017). It is also estimated that 75% of referrals to chest clinics in the UK are discharged with NCCP (Chambers et al; 2015). NCCP is more common in adults although increasing statistics for younger adults, below the age of 40 with low risk of cardiac diseases, have been reported (Myle & Greensburg, 2016).

Consistent with other persistent physical symptoms, also known as medically unexplained symptoms (MUS), NCCP is defined by the absence of a cardiac diagnosis (Chambers et al; 2015). Chest pain is a prominent feature of most heart conditions and therefore is experienced with fear, and prompts emergency attention for sufferers and medical practitioners alike (Fleet et al; 1996). When patients present with chest pain at ED, there is more attention on excluding acute cardiac conditions rather than the management of these distressing, persistent physical symptoms (McDevitt et al; 2017). Following a differential diagnosis and exclusion of cardiac causes of chest pain from ED and PHC, patients are discharged with NCCP. Patients with NCCP are known to have low cardiac events despite their constant presentation to ED and other PHC for chest pain alongside psychological distress. Both physical and psychological causes are implicated in NCCP; these may include various cardiac symptom explanations including anxiety (Mayou et al; 1997).

Psychological causes could include panic, and both depression and anxiety disorders (Campbell et al., 2017). In most cases of NCCP breathlessness and panic present simultaneously leading to psychological distress for most sufferers. These psychological factors influence the perception of both breathlessness and the experience of NCCP. Previous reviews have identified that patients with NCCP had the same levels of anxiety and depression including poor quality of life as those diagnosed with heart conditions (Webster et al; 2011). Similarly, a recent study investigating anxiety levels of chest patients who were discharged from ED discovered that NCCP patients were found to have high levels of anxiety (Basara et al; 2016). Interestingly it has been suggested that a significant proportion of patients attending for NCCP at ED also suffer from panic attacks. Fear of death due to a heart attack is common both in people who have panic attacks and those who present with NCCP. Due to these psychological stressors that usually occur concurrently, both NCCP and panic are associated with distress that leads to physical and psychological problems disability and regular attendance to ED and other PHC (Salkovskis, 1992; Foldes-Busque, et al; 2017).

As postulated in individuals susceptible to NCCP, physical sensations experienced in the chest area are easily misconstrued as a heart condition, most commonly a heart attack. It is for this reason that recent research recommends the identification of panic attacks for patients with NCCP visiting ED (Myles & Greensburg, 2016). The misinterpretation of physical sensations for NCCP sufferers leads to a vicious cycle of fearful cognitions, which can increase other anxiety symptoms and lead to safety actions including visits to ED and other PHC centres to be cleared of the feared threat (Salkovskis, 1992). Alongside this psychological distress it is common for sufferers to engage in other safety measures which include limitation of their activity levels for fear of recurring symptoms (Ockene et al; 1980; Salkovskis, 1992). Consequently, it is this influence that leads to regular consultations for some sufferers of this condition at ED. This tendency adversely affects the quality of life particularly for people with persistent NCCPs, that presents with a cycle of further symptoms and chest pain. Hence NCCP is associated with increased cost and consultations in ED and other PHC centres (Chambers et al., 2015; Tyrer et al., 2017). These costs include the use of ambulance services and various tests for acute cardiac syndromes. Despite these findings, most reviews do not include the element of cost-effectiveness in their evaluations (Tyrer et al., 2017).

Research has found that no psychological follow-up interventions or unanimity exist for treating patients with NCCP (Jonsbu et al., 2011), but the National Institute for Health and Care Excellence (NICE) Guidelines do recommend that reassurance and information should be given to patients with NCCP (NICE, 2010). For some patients with NCCP, the information that they are not having an acute cardiac condition at the time is not reassuring (Esler, 2004). Therefore, despite NICE guidelines recommending this reassurance, most patients with NCCP do not feel reassured and continue to engage in emergency medical seeking actions. This reassurance-seeking behaviour is often motivated by persistent physical symptoms and misinterpretation of bodily sensations which perpetuate fears of developing a heart condition (Salkovskis, 1992; Kisley et al., 2012; Hadlandsmyth et al; 2012).

From previous reviews and RCTs, it is therefore already known that CBT is effective in the management of NCCP (Salkovskis, 1992; Mayou, 1997; Jonsbu et al., 2011; Kisley et al., 2015). CBT has also been found to be effective in improving physical functioning in other similar MUS/PPS especially where interventions target the common cognitive and behavioural responses, for instance fear and avoidance beliefs (Chalder et al; 2015; Chalder & Willis, 2017).

More importantly, as highlighted by previous studies, a recent qualitative study (Miley & Greensburg, 2016; Webster et al., 2017) concluded that CBT interventions are acceptable for NCCP sufferers, but it has been proposed to be difficult to implement in contexts like ED. These findings are relevant to the current review.

Cognitive behaviour therapy defined in this review

CBT has developed and evolved from being used to deal with thinking in depression. The initial focus was on cognitive restructuring to challenge negative thinking (Beck, 1979; 1995) but CBT has evolved and is now used for anxiety and other conditions with behavioural strategies included in the interventions. In this review, interventions will be described as CBT if they have elements of cognitive restructuring, behavioural strategies and psycho-educational properties to allow for an understanding of the interactions between thoughts, physical sensations and emotions (Beck, 1995; Fennel, 2009). In this context, CBT interventions should allow an ability to appreciate alternative explanations and close gaps in information where there are difficulties that maintain unhelpful cycles due to misunderstanding (Salkovskis, 1992).

Objectives for the review

As highlighted in a review by Anorld et al; (2009), there is generally not enough evidence for the effectiveness of cognitive behaviour therapy in the management of most medically unexplained symptoms, referred to in this paper as persistent physical symptoms (PPS). These PPS include NCCP in PHC. Equally, a review pointed out that interventions used in secondary care are not always easily extrapolated to primary health due to a variety of issues which include delivery, resources, and patients (Raine et al., 2002). To date, there is a scarcity of studies that have investigated the efficacy of CBT in dealing with people with NCCP (Marchand et al; 2012). A recent review assessed the value of the current management and treatment of the existing models for treating NCCP. The review included different types of modalities. These interventions encompassed medical, surgical, pharmacological, and psychological therapy which incorporated CBT (George et al., 2016). Equally, Olde Hartman et al; (2017) also pointed out that there are difficulties in the implementation of CBT in primary health and recommends research CBT techniques that could improve efficacy for PPS.

Similarly, another review revealed a modest to moderate effectiveness of psychological interventions for NCCP, CBT. The review included all psychotherapy studies incorporating CBT. The review also identified existing pragmatic complexities in implementing these psychological interventions. The findings suggest a need to improve the efficacy of interventions for managing NCCP in primary health care services (Kisley et al., 2015).What the current review adds is to investigate which aspects of the CBT interventions are more effective and how they function to improve NCCP symptoms. It is hoped that by examining the design and content of the CBT interventions, the review will add more value to previous studies. It is also hoped that by identifying these aspects the current review might shed light onto the current difficulties of implementing CBT interventions for NCCP in primary health care settings and ED. This need has been identified in previous studies and advocated for more research to determine the most effective way of managing NCCP (Potts et al; 1999; Kisley et al, 2015; Campbell et al., 2017, Olde Hartman et al., 2017). Therefore, the aims of this systematic review are:

- To investigate the effectiveness of cognitive behaviour therapy (CBT) interventions
- To examine the differences in the design and content of the CBT interventions in studies identified for the management of NCCP.

Method

Search Strategy

The search was conducted systematically to identify all relevant and appropriate randomised controlled trials for the review. The searches were done between 07/07/2018 and 30/08/2018, using guidelines from the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) statement (Moher et al; 2009). The study selection was performed by screening all the abstracts and articles that met the inclusion criteria as suggested. A diagram of a flowchart detailing this process is shown in **Figure 3. 1.** This search included published peer-reviewed studies and systematic reviews on the current topic including citation searching of relevant papers. The following electronic databases were searched systematically: Scopus, and Science direct, Cochrane systematic review library, Google scholar, PsychInfo, CINAHL, PubMed, Embase, Ovid Medline, DARE and Campbell Library.

Search words

The search included both text words and medical terms (MeSH) using the following search terms:

“Cognitive Behavioural Therapy” OR “Behaviour Therapy” OR” Cognitive Therapy” OR “Behavior Therapy OR Psychological Therapy”

AND “non-cardiac chest pain” or “chest pain” or “chest tightness” or “non-specific chest pain” AND “ emergency department” or” primary care” or “primary health care” or” primary healthcare” or “family practice” or “community care “or “general practice.”

AND “Non-cardiac chest pain” “Accident and emergency department” “Benign palpitations” “hyperventilation” “Breathlessness.”

Study selection: Inclusion criteria

The inclusion guidelines followed the principles of the Centre for Reviews and Dissemination (CRD, 2008), referred to as PICOS, which focused on the important characteristics that included participants, interventions, comparator and study designs as used in this review. These criteria are depicted in **Table 1**.

Exclusion criteria

Studies that included participants with existing cardiac diagnoses were excluded. A flowchart detailing the process from search to selection is shown below in **Figure 3**.

Flow Chart

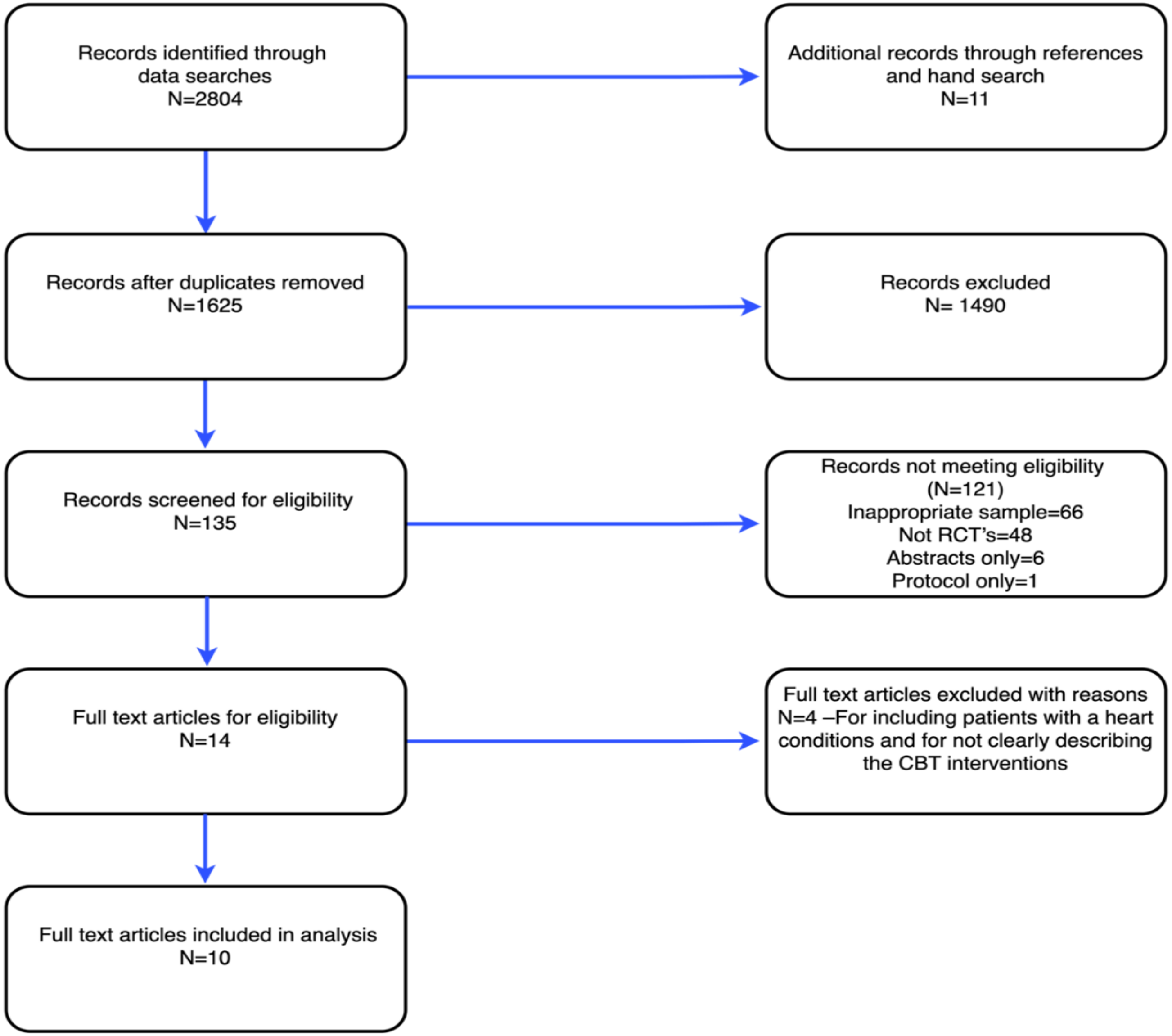
Records identified through data searches N=2804
Additional records through references and hand search N=11
Records after duplicates removed N=1625
Records excluded N= 1490
Records screened for eligibility N=135
Records not meeting eligibility (N=121)
Inappropriate sample=66
Not RCT's=48
Abstracts only=6
Protocol only=1
Full text articles for eligibility N=14
Full text articles excluded with reasons N=4 –For including patients with a heart conditions and for not clearly describing the CBT interventions
Full text articles included in analysis N=10

Table 1. Inclusion criteria per the PICOS framework

P - Participants: The participants in the studies attended the ED or PHC centre which included chest clinics and GP surgeries for chest pain and received a diagnosis of NCCP. The participants were medically examined, and their chest pain found to be of non-cardiac origin. The participants were adults from 18 and above with no upper limit in age.
I - Interventions: The review included studies that employed CBT interventions. The studies described their interventions as based on CBT principles or behaviour therapy or cognitive therapy.
C- Comparator: All studies had a comparator or control group or a waiting list or delayed treatment groups. Studies that used drugs as the comparator and a placebo group were included.
O- Outcomes: The studies used **v**alidated psychometric tools/outcome measures that measured changes in physical symptoms, psychological distress and changes in quality of life.
S- Study design: Randomised controlled trials (RCT) were chosen. Studies included were published in English from 1997–2017.

Data extraction

As described by the Centre for Reviews and Dissemination (2008) data extraction is an individualised process depending on the aims of the review. These guidelines were followed in the extraction of the data in this review. Due to limitations of time and resources, the author/reviewer (LT) extracted the data independently using a self-designed data extraction form. The process was later checked and verified by (CE) (academic supervisor). The data extracted included descriptions and context of studies, including allocation and randomisation of participants in line with the inclusion and exclusion criteria of the review. Search enquiries are detailed in **Table 2**, and data extracted is shown in Appendix A.

Table 2. Search enquiries employed in the literature search

- **The name of the authors and where and when the study or report was published**
- **The participant numbers and how they were allocated in CBT and comparator groups**
- **A summary of the content and delivery of the CBT intervention**
- **Both primary and secondary outcome measures used in the studies**
- **The comparator group and the number of participants in the group**
- **Follow-up intervals as specified in the study**
- **The outcomes as reported in the studies**

The data included interventions that were used in comparison to CBT, which included pharmacological, control waitlist or care as usual as defined in different studies. Included in the data is the content of CBT used together with information about the CBT intervention, e.g. its format and whether it was face to face, individual, or group or internet guided. The duration, number of sessions, time, and intervals between sessions are also included. The table also shows use of, training protocols, manuals, and homework where these were available. It included outcome measures and follow-up intervals. This information included outcomes and statistical tests used to analyse the data where these were provided. LT as the principal reviewer was responsible for collating this information which was validated by supervisor CE to offset subjectivity.

(Please see Appendix A for full details of data extracted.)

Summary of risk of bias

To assess the risks of bias in this review a tool was designed following guidance from the Cochrane Collaboration’s tool for assessing the risk of bias (Higgins et al., 2011). Studies were categorised as having low risk, unclear regarding risk or high risk as stated in the tool. The overall risk was assigned to studies based on all the assessed categories. The risk was assessed based on the following items as outlined in the tool:

- Selection bias which included information of methods used to allocate and randomise participants
- Performance bias which considered whether there was information on blinding of participants and practitioners during the intervention
- Attrition bias which assessed the completeness of reporting data outcomes, including the reporting of attritions and exclusions

- Reporting bias which assesses reporting of outcomes and findings, including what was investigated

In five studies selection bias that included information of methods used to allocate and randomise participants was low. The studies were: Mayou et al. (1997), Spinhoven et al., (2010), Jonsbu et al. (2011; 2013); Van Beek et al. (2013) and Tyrer et al. (2017). Four studies were unclear in their concealment; these are Sanders (1997), Potts (1999), Van Peski-Oosterban et al. (1999) and Esler et al. (2004). Only one study, Mourad et al. (2016), was rated as having a moderate selection bias.

In this review, performance bias was high due to the nature of the intervention, for instance, out of the 10 studies reviewed only one study (10%) reported blinding their researchers, i.e. Tyrer al. (2017). The other nine studies, representing 90% of the overall sample reviewed were unable to blind their researchers during the study interventions (Sanders, 1997; Mayou et al., 1997; Van Peski-Oosterbaan et al., 1999; Potts et al., 1999; Esler et al, 2004; Spinhoven et al., 2010; Jonsbu et al; 2011 and 2013; Van Beek, 2013; Mourad et al., 2016).

Attrition bias in this review is rated as high as up to six studies (Sanders et al., 1997; Potts et al., 1999; Van Peski-Oosterbaan et al., 1999, Esler et al., 2011, Van Beek, 2013; Spinhoven et al., 2010) reported high attrition rates and one as high as 43%, (e.g. Spinhoven et al; 2010). Four studies reported low attrition rates (Mayou et al., 1997; Jonsbu et al., 2011 and 2013; Mourad et al., 2016; Tyrer et al., 2017). However, the small samples alongside a lack of long-term follow-up reported in this review renders the attrition bias in this review as high.

Reporting bias in this review is judged as low. All studies were assessed as low risk. (Sanders, 1997; Mayou et al., 1997; Van Peski-Oosterbaan et al., 1999; Potts et al., 1999; Esler et al., 2004; Spinhoven et al., 2010; Jonsbu et al., 2011 and 2013; Van Beek, 2013; Mourad et al., 2016; Van

Beek, 2013; Tyrer et al., 2017) as all outcome measures in these 10 studies seem to have been reported, although in two studies it was unclear whether both primary and secondary outcomes were reported. These were Potts et al. (1999) which was the only study that used a group intervention in this review and Spinhoven et al. (2010). **Table 3** summarises the risk in this review.

Table 3. Summary of risk bias

Study	***Selection bias***	***Performance bias***	***Selective Reporting***	***Attrition bias***	***Overall risk bias***
Tyrer et al. (2017)	low	low	low	low	low
Mourad et al. (2016)	moderate	high	low	low	moderate
Van Beek (2013	low	high	low	high	moderate
Jonsbu et al. (2011 and 2013)	low	high	low	low	low
Esler and Bock (2004)	unclear	high	low	high	moderate

Spinhoven et al. (2010)	low	high	low	high	moderate
Van Peski-Oosterbaan et al. (1999)	unclear	high	low	high	moderate
Potts et al. (1999)	unclear	high	low	high	moderate
Mayou et al. (1997)	low	high	low	low	low
Sanders et al. (1997)	unclear	high	low	high	moderate

Excluded studies with reasons

Four studies were excluded from this review. The study by Cott et al; (1992) was excluded due to its inclusion of patients with a diagnosed heart condition of mitral valve prolapse in their sample. Keefe et al; (2014) was also excluded as their CST (Coping Skills Training) intervention was not clearly described as CBT although it contained some elements of CBT as detailed in their content and design. Pelland et al; 2011) delivered brief CBT interventions but was excluded as the study was a quasi-experimental design rather than an RCT. The fourth study was Klimes et al. (1990), also excluded for inclusion of participants who were already diagnosed with heart conditions.

Results

Synthesising data from studies

A narrative approach has been chosen for reporting the results as the focus was on evaluating the content of the CBT interventions and asking questions about how and whether interventions work. This approach is described, and guidance is given (Popay et al., 2006) and has been used successfully in other reviews (e.g., Olde Hartman, et al., 2017) in a review for MUS guidelines. Ten RCT studies were analysed in this review. The findings of this review show that CBT in both brief and longer interventions is more effective than treatment as usual (TAU) or placebo and drugs (paroxetine) even in brief interventions. Through examining the quality of CBT interventions used for managing NCCP in primary health care the review has identified elements that improve the efficacy of CBT interventions with implications for context and practice.

Comparative groups

Nine of the studies in this review used treatment as usual (TAU) as a comparator group to CBT (Sanders et al, 1997; Mayou et al; 1997; Van Peski-Oosterbaan,et al; 1999; Potts et al; 1999; Esler et al; 2004; Jonsbu et al., 2011 and 2013; Van Beek, 2013; Mourad et al., 2016; Tyrer et al., 2017). Following negative results from the cardiac investigations, TAU is individualised according to the patient's needs and includes information giving and reassurance. This review has identified that some clients with NCCP benefit from the reassurance that they do not have a heart condition. In eight out of the 10 RCT studies, CBT was found to be superior to TAU; (Mayou et al;1997; Van Peski-Oosterbaan, et al;1999; Potts et al;1999; Esler et al ,2004; Jonsbu et al; 2011 & 2013; Van Beek, 2013; Mourad et al; 2016; Van Beek,2013; Tyrer et al.,2017). In one study by Sanders et al., (1997) TAU group improved more than the CBT group.

One study (Spinhoven et al., 2010) used pharmacology and placebo groups as comparative groups with CBT. CBT was found to be superior to pharmacology and placebo in reducing NCCP symptoms at follow-up. Both CBT and paroxetine were superior to placebo, and interestingly both CBT and paroxetine reduced heart-focused anxiety and cognition. CBT reduced heart-focused anxiety and catastrophic thinking and improved activity. In this study, participants seemingly had a preference for talking therapy rather than drugs. The drug proved not to be more effective than placebo groups (Spinhoven et al., 2010).

Outcome measures used to evaluate the effectiveness of interventions

All 10 studies reviewed used reliable and validated psychometric measures; however, there was some variability regarding outcome measures used for evaluating physical symptoms in NCCP. Most studies evaluated the effectiveness of intervention by measuring changes in frequency, intensity, and duration of chest pain. Seven out of 10 studies used chest pain symptoms as an outcome measure. CBT was found to be superior to TAU in reducing chest pain symptoms in five of the studies (Mayou et al., 1997; Van Peski-Oosterbaan et al., 1999; Potts et al., 1999; Esler et al., 2004). In one study by Spinhoven et al; (2010) CBT was superior to both paroxetine and placebo. In the study by Mourad et al. (2016) there were no differences in the group post treatment. In an earlier study by Sanders et al. (1997) TAU was superior to CBT in reducing physical symptoms of NCCP.

Van Beek et al. (2013) used the Clinical Global Inventory (CGI) which assesses disease severity as their participants presented with comorbid panic and depression. Their results indicated superiority of CBT, as shown in the significant reduction of clinical severity, compared to TAU CGI. However, the frequency and intensity of chest pain were not measured.

Equally the study by Tyrer et al. (2017) used a Healthy Anxiety Index (HAI) tool which was adapted for NCCP as a primary outcome measure. Results showed superiority of TAU post-treatment; however, at 12-months follow-up CBT was superior to TAU. No other study used HAI as a primary or symptom measure in the analysed studies. Tyrer et al. (2017) also used visual analogues to measure changes in chest pain frequency and intensity as secondary outcomes which showed no significant differences between the groups, and it is the only study that assessed the impact of interventions on service utilisation.

Both studies by Jonsbu et al. (2011;2013) focused on fear of bodily sensations. In Jonsbu et al. (2011) the authors used a questionnaire which measures fear of bodily sensations (BSQ) as a primary outcome. In a second study Jonsbu et al. (2013) used the BIPQ (Brief Illness Perception Questionnaire) which measures changes in illness perceptions assessed in eight domains. In both studies, the aim of intervention seemed to have targeted avoidance behaviour and interpretation of bodily symptoms. Jonsbu et al; (2013) is the only study out of the 10 studies that assessed the effectiveness of interventions on health beliefs. Psychological outcome measures evaluated the effectiveness of interventions on symptoms that included anxiety, panic, and depression. Most of the studies used these as secondary outcome measures; these included the Hamilton Depression Scale (HADS), and State-Anxiety (STAI) to measure anxiety and depression. In all studies, CBT showed superiority in improving psychological symptoms especially at follow-up. In the Mourad et al.'s (2016) study there were no differences with changes in the group post post-treatment in any of the outcome measures. CBT showed more reduction in cardiac anxiety and depressive symptoms using the Patient Health Questionnaire (PHQ9) for measuring depression after four weeks. Most interestingly in the study by Spinhoven et al, (2010) both CBT and paroxetine reduced heart-focused anxiety and cognitions, and CBT impacted on heart-focused anxiety, catastrophic cognitions, and avoidance behaviours. The results in this study showed more acceptability for CBT than psychopharmacology in NCCP, and paroxetine was shown to be less effective than placebo. The individual results of the studies are shown in Appendix A.

Measures of quality of life

In this review, the results showed that CBT is superior in improving impairment and quality of life than TAU especially in interventions with a focus on targeting avoidance and interpretation of bodily symptoms as shown in some of these studies. Most of the studies assessed the impact of NCCP on quality of life using self-reports that measure social functioning and disability. In the study by Mayou et al. (1997) CBT was superior in improving activity levels by challenging avoidance and limitation of activity and therefore, improved social difficulty and overall impairment (P<0.05) and leisure (P<0.01). There were no other differences in other outcomes except that CBT showed significant differences in disease conviction after 6 months following exclusion of dropouts.

In the study by Van Peski-Oosterbaan et al. (1999) the outcome measure of social functioning (SF36) showed significant differences in physical limitation, in favour of CBT at 6 and 12 months. Most importantly, regarding functioning the participants' visits to the GP and PHC did not differ after 12 months for NCCP (P=0.69) and equally for other medical complaints (P=0.82). Interestingly, 19% of participants in the control group went on to use psychological services compared to none in the CBT group (P=0.02).

In Potts et al, (1999) participants in the intervention group improved disability and exercise tolerance significantly compared to TAU, with p <0.0001 for disability and p <0.05 for exercise tolerance. Equally, in the study by Mourad et al, (2016) the bicycle stress test led to conviction about participants' heart ability to tolerate physical activity and reduced avoidance after four weeks, this reduced avoidance. Tyrer et al. (2017) also measured social functioning using the Social Functioning Questionnaire (SFQ) which was superior for CBT than the control but not significant (p=0.435) at 12 months. This study also included an economic analysis that showed an improvement of cost-effectiveness in using emergency services for the intervention group.

Follow-up

Follow-ups in this review ranged between baseline and 12 months; none of the studies reported beyond 12 months. Mourad et al. (2016) had a follow-up of up to 4 weeks, and the other studies had follow-ups of 3 to 6 months; only three studies had longer follow up after 12 months to establish longer-term effects. These are Jonsbu et al. 2011; and Jonsbu et al. (2013); Van –Peski-Oosterbaan (1999) and Tyrer et al. (2016).

Content and delivery of CBT

This review assessed the quality and content including the delivery of CBT interventions which were effective in reducing persistent physical and psychological symptoms of NCCP. The quality of the content and its delivery were fairly consistent in using empirically validated CBT protocols based on tested models. For instance, five studies individualised and modified existing CBT models to fit the needs of clients with NCCP, e.g. Esler et al. (2004), Van Beek et al. (2013), Spinhoven et al. (2010), Van Peski-Oosterbaan (1999) and the panic model by Clark (1986). Tyrer et al. (2017) was the only study that modified the health anxiety model (Salkovskis & Warwick, 1986). In eight of the studies, the CBT intervention was carried out by practitioners trained in CBT and receiving supervision. One study (Mourad et al., 2016) used an internet-delivered programme by professionals who were not trained in CBT and the time contact with therapist was about 22 minutes. Equally, Sanders et al. (1997) used a professional not trained in CBT. In both of these studies CBT content was not adequately defined and lacked some important elements of CBT interventions like cognitive restructuring.

It is difficult to make conclusive differences in effectiveness between face to face and group CBT intervention as there was only one group intervention in the studies reviewed (Potts et al., 1999) which was shown to be superior to TAU. The length of the CBT interventions in seven out of 10 studies was brief and ranged from 1 to 6 sessions of between 45 and 90 minutes. Sanders et al. (1997) had one-hour sessions conducted immediately following negative cardiac results. This intervention was shown not to be effective and was not acceptable to participants. In this review it has been found that although some NCCP sufferers found the medical investigations reassuring, a large percentage continued to experience the persistent symptoms and continued to seek help as found in the studies reviewed.

Important elements that improve the efficacy of CBT interventions

Most of the successful interventions, both brief and longer, used elements of CBT that were able to target and achieve the following:

- Providing alternative explanations for chest pain symptoms
- Targeting misinterpretation of bodily symptoms
- Identifying and targeting the maintaining factors for the NCCP

- Identifying and targeting catastrophic cognitions that maintained NCCP in individuals
- Targeting heart-focused anxiety
- Targeting avoidance behaviours and cardiac protective behaviours through physical, behavioural experiments

Through its psycho-educational aspects, CBT fills the information gaps that create doubts and misinterpretation and offers helpful ways of responding (Salkovskis, 1992). These results are also consistent with the findings and literature which state that using interventions which target cognitive and behavioural responses mediate the effects of CBT (Chalder et al., 2015; Chalder & Willis, 2017).

Behavioural change addition

The review has identified some elements that seemed to improve the efficacy of CBT interventions. For instance, adding physical exercises was shown to be a mediating factor demonstrated in the CBT interventions with Jonsbu et al. (2011). As the authors explained, the participants were exposed to physical activities, and this experience showed to challenge their cardiac protective behaviours. The behaviour change showed that challenging health beliefs about heart functioning, as shown with treadmill exercises, reduced fear and anxiety about body sensations. As contended by the authors, targeting these factors seemed to be the mediating factor (Jonsbu et al., 2011; Jonsbu et al. 2013). These findings have confirmed earlier findings in which the addition of graded behavioural activity component in interventions increased the effectiveness of CBT (Mayou et al., 1997). Adding to this evidence Mourad et al. (2016) added a bicycle stress test which led to conviction about participants' heart ability to tolerate physical activity and reduced avoidance after four weeks. Therefore, in this review, the addition of behavioural experiments which could be an activity or exercise was an important aspect that was noted to improve the efficacy of CBT intervention.

Targeting misinterpretation of bodily symptoms

Other important findings include interventions that target misinterpretation of bodily symptoms; this seemed to be the mediating factor in the CBT interventions as seen in several of the studies analysed. This trend is also observed in studies that showed changes in BSQ, which measured changes in fear of bodily symptoms (e.g., Van Peski-Oosterbaan, 1999); Jonsbu et al., 2011 and 2013). The effectiveness of these CBT interventions supports the hypothesis that misinterpretation of bodily symptoms experienced in the chest area contributes to the recurrence of NCCP, as noted earlier in the literature (Salkovskis, 1992). There were also some benefits from receiving pharmacotherapy as shown in the reduction of cardiac anxiety which therefore could improve choices for sufferers of NCCP (Spinhoven et al., 2010).

Illness perceptions mediate the effects of CBT

In the follow-up study by (Jonsbu et al; 2013) there were significant differences between CBT and TAU in the BIPQ items (that measure personal control and illness perceptions). The authors report that a change in illness perceptions mediated for depression. Illness perceptions, therefore, mediate the effectiveness of CBT.

Discussion

Summary of findings

This review has assessed the quality of both the design and CBT content that had been effective in reducing both physical and psychological distress for people who visit ED and other PHC for NCCP. This review examined both qualities and identified the elements of CBT interventions that had been effective in reducing both physical and psychological symptoms of NCCP in the context of primary health care and emergency services.

The review found that many of the studies used CBT interventions that were standardised, validated protocols, and conformed to the delivery by using therapists who were trained and supervised. Both group and individual CBT interventions have been used for the management of NCCP although in this review only one study used CBT group intervention (i.e., Potts et al., 1999). Equally the review identified both long and shorter CBT interventions. These CBT interventions were found to be effective with modest to moderate effect sizes where these were reported. Both brief and longer sessions were effective although some longer sessions were associated with a higher rate of attrition; for example, Van-Peski-Osterbaan et al. (1999) who delivered 4–12 sessions in their CBT intervention and had a 43% attrition rate. Likewise, Spinhoven et al. (2010) who delivered 16 sessions reported a high attrition rate. Compared to these much longer CBT interventions, both Esler et al. (2004) who delivered only one brief CBT intervention and Van Beek et al. (2013) who delivered six sessions also reported high attrition rates. It appears as if it is not necessarily the length of sessions that enhance effectiveness but rather the content and the quality of the delivery of interventions. As noted in the study by Sanders et al. (1997) the timing and delivery including the content are important elements in mediating the effectiveness of CBT interventions.

The review also found that there were some modest gains in the TAU groups which in most studies consisted of reassurance and information giving; in most studies these gains were short lived compared to CBT. There was a reduction in symptom severity, e.g. frequency of chest pain and a reduction in cardiac anxiety following treatment as usual (TAU). There was a lot of variation in how care as usual and reassurance was delivered. This was mostly individualised, and the content and design depended on where and who was giving it.

The overall success of CBT compared to both pharmacology and TAU shows that CBT provides additional explanations about fears and anxiety and these learnings and understandings prepares the individual when persistent physical symptoms re-occur. As shown in this review these gains last much longer than TAU, as seen in follow up for up to 12 months in studies (e.g., Jonsbu, 2011 and 2013; Van Peski-Oosterbaan et al., 1999). These findings were shown even where there were no differences immediately after treatment, for instance in the study by Mourad et al. (2016) which had the shortest follow-up, the CBT groups showed some significant gains after four weeks. This review has identified how CBT interventions can be used flexibly in different forms which include internet programmes, face to face brief and long interventions including group CBT interventions. The important elements of CBT that mediated for treatment effects included changes in the misinterpretation of bodily misinterpretation. Other elements noted were improvement in avoidance of physical activity due to fear of a heart attack which is one of the key illness cognitions in NCCP (Jonsbu, 2011; 2013).

Implications for practice

The main focus of this review was around the content and method of delivery and some pertinent components were identified. The findings that even the one-off information session has modest gains including the effectiveness of brief CBT are an important discovery for primary health care (Sander, 1997; Elser, 2004; Morad, 2016).

This review has found that timing, content, and context, including the professionals delivering the CBT interventions for people with NCCP, need to be considered to improve effectiveness. As found in one study by Sanders et al. (1997) CBT interventions were implemented as soon as possible following the cardiology report by a practitioner not trained in CBT and this resulted in the TAU group being superior to the CBT group. Despite CBT interventions being found to be less effective, these findings have pragmatic implications for the success of both TAU and CBT interventions. This could mean that for certain patients the delivery of appropriate content in certain contexts for instance in ED in the presence of a healthcare professional might be more meaningful and convincing enough to allay a patient's anxieties. This finding supports collaborative approaches to working with and assessing NCCP sufferers who might be having some initial doubts about the benefits of psychological therapies. As noted by Olde Hartman et al. (2017) in their narrative review of MUS, some guidelines were based on the notion that patients responded better to biological explanations, as this seems to reduce self-blame; this could explain the success of the study by Sanders et al. (1997). Consistent with these findings Tyrer et al. (2017) advocate a need for a stepped-care approach and working collaboratively with the cardiology team. The stepped-care approach is already used in some Improving Access to Psychological Therapies (IAPT) services, where there is collaborative working with cardiac teams. Future reviews and research could identify who benefits from this content as well as examine other aspects of TAU that are effective. The success of the CBT interventions reviewed attests to the suggestion that some patients need a different way of understanding their lived experiences including a helpful way of responding and taking control. In this regard, CBT offers an alternative understanding of the persistent physical and psychological symptoms experienced in NCCP (Salkovskis 1992; Mayou, 1997).

Limitations

The current review provides useful information although with some limitations in the sample of studies used. Methodological shortcomings are worth mentioning in the studies reviewed; for instance, studies had small samples and some of the studies included were pilot studies with sample sizes well below 100, e.g., Mourad et al. (2016) who had the smallest sample of N=15. This lack of robust samples used reduced statistical power and might have increased type 2 errors, which therefore reduced the internal validity of the studies. Equally significant were the high attrition rates in six of the studies reviewed. The reasons for the high attrition rates shown in these studies need to be investigated further as both brief and longer CBT interventions were affected as mentioned. In this review only single coding of risk level was employed due to time constraints, therefore it is acknowledged that double coding could have increased the quality of evidence. There was also a high risk of performance bias in the studies as most of the studies in the review did not blind both researchers and participants due to the nature of the intervention. Both primary and secondary outcome measures used in studies were self-reports which therefore reduces the internal validity of the studies, and most of them did not report the effect sizes. Equally there was a lot of variability in the choice of outcome measures used in the studies. The other limitation in this review was the use of fewer studies as it focused only on RCTs in which CBT was used as the treatment intervention. Due to lack of RCT studies that have used CBT interventions in NCCP five of the studies in the current review were more than 10 years old. It is worth mentioning that publication bias in this review could have affected the results as CBT interventions reviewed were only from published studies and due to time constraints, there was not enough time to offset this bias. Due to time limitations the review was unable to include grey literature and other government documents, including unpublished theses and conferences on the topic, which could have improved the quality of the review.

Conclusion

The aim of this review was to examine the content and quality of CBT interventions that have been used in managing for patients with NCCP in primary health care services. Previous reviews identified a paucity of research in this area especially RCT's in CBT due to complexities of implementation which is created by unwillingness of both healthcare practitioners and patients (Kisley,et al., 2015; Tyrer & Tyrer, 2017), Therefore a strength of this study is that all 10 RCTs used CBT interventions, unlike the previous studies. This review provides important information on the content including suggesting contexts which could improve delivery of CBT interventions for NCCP. Some of the important preliminary findings in this review was that it is not the length of sessions that enhance effectiveness but rather the content and the quality of the delivery of interventions. The review provided some initial information that could be a solution to some of the pragmatic challenges for CBT interventions for NCCP in primary healthcare. In the context of this systematic review, the strength of IAPT services is its use of the stepped care model where clients have access to less invasive treatment protocols and could be stepped up accordingly depending on their needs.

Word Count -6244

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Data Extraction

Table Studies	Number of Participants	Summary of CBT content and delivery	Control	Outcome measures	Follow up	Outcomes as reported
Tyrer et al; (2017) England, UK	68 (CBT = 34; C = 34)	CBT content (flexible sessions 4-10 or even up to 15 depending on complexity) mean session 5.7; SD3.49. Modification of health anxiety model Formulation using recent episode of chest pain	TAU	Outcome measures- HAI- health anxiety inventory HADS – anxiety and depression SEPS – schedule for evaluating persistent symptoms, evaluates the quality of life. None of the outcomes was significant, but CBT showed superiority to care as usual. Reduction in anxiety, reduction in frequency and intensity of chest pain, depressive symptoms and attendance at A/E	6months and 12months None of the outcomes were significant, but CBT showed superiority to care as usual.	None of the outcomes was significant, but CBT showed superiority to care as usual. Reduction in anxiety, reduction in frequency and intensity of chest pain, depressive symptoms and attendance at A/E TAU (3.29,95%Cl-5.63-0.95) compared to CBT (2.3595%Cl,95%-4.58-.012) however after 12months CBT was superior to TAU(p= 0.654),
Mourad et al; (2016) Sweden	15 (CBT = 7; C = 8)	CBT content was a guided internet-delivered intervention four sessions 30-60 per session /22minutes therapist time /internet programme	TAU	**Outcome measures** CAQ-Cardiac Anxiety Questionaries' BSQ – fear of bodily sensations Chest pain frequency Outcome measures decreased in both group	Baseline to 4 weeks No long-term follow-up	CBT showed more decrease in cardiac anxiety and depressive symptoms (NS Bicycle stress test led to conviction about heart tolerating physical activity which reduces avoidance

		Behavioural aspects which focussed on exposure to physical activities, e.g. bicycle stress Breathing based relaxation exercises Goal setting -Information on chest pain, its causes and how it is maintained or worsened		there were no significant differences between groups		
Van Beek et al; (2013) Netherlands	113 (CBT = 60; C = 53)	CBT content 4 group CBT and individual CBT content (45 minutes 6 sessions) Psychoeducation Cognitive restructuring Influencing Avoidance behaviour Adjusted Clark's model for panic disorder	TAU	CBT reduces anxiety and depressive symptoms **Primary outcomes – CGI- clinical global inventory indicating the** superiority of CBT in decreasing clinical severity **Secondary outcomes =HADS and STAI** measuring depression and anxiety	12 months	CBT reduces anxiety and depressive symptoms CBT (mean:2.3; SD:1.1)0.6(moderate) CGI(P<.001) HADS -depression (P=.01) STAI –anxiety (P=.11) FQ=(P=.13)

		The content of CBT is clearly explained including how it was adjusted and individualised, using Clark's model of panic making it more credible and delivered by trained staff		**Anxiety** CBT was not superior to TAU in anxiety and **Fear measures** -fear questionnaire(P=.13)		
Josbu et al; (2011) Norway	40 (CBT = 21; C = 19)	CBT content three sessions 60-90 minutes – CBT with physical activity exposure and working with misinterpretation of bodily symptoms	TAU	BDI- depression HRQOL- health-related quality of life CBT had significantly larger improvement fear of bodily sensations, Avoidance of physical activity post treatment 3-12 months and depression CBT and Control did not differ in pain frequency	Baseline, posttreatment, 3 months, 12 months	CBT had significantly larger improvement fear of bodily sensations, P=.008 P=.02 P=.007
Josbu et al; (2013) Norway	As above	CBT content as used above (Josbu et al. 2011) targeting illness perceptions in NCCP	TAU	BIPQ- Brief illness perception questionnaire to assess eight domains of illness perceptions	Baseline, posttreatment, 3 months, 12 months	CBT had significantly larger improvement fear of bodily sensations,

				Follow up at 3-12 months Illness perceptions mediate the effects of CBT There were significant differences between CBT and Control in the BIPQ items that measure personal control and illness perceptions which mediated for depression, Outcomes from baseline to 4 weeks no long-term follow up BSQ –Fear of bodily sensations		
Spinhoven et al; (2010) The Netherlands	69 (CBT = 23; Paroxetine = 23; Placebo = 23)	CBT content (16 weeks) CBT based on Clarks model and CBT for hypochondriac and PPS was the credibility of CBT, trained in CBT (importance of treatment that targets catastrophic misinterpretation)	Paroxetine Placebo	Chest pain frequency duration and intensity HADS – general anxiety CAQ – Heart focussed anxiety M.I.N.I plus – clinical diagnosis Both CBT and Paroxetine were superior to placebo		No significant differences in all three groups but CBT superior post treatment CBT (P=.04;d.66) (moderate at post treatment Paroxetine (P=.03; d.051)

				Both CBT and Paroxetine reduced heart-focused anxiety and cognitions CBT impacted on heart focussed anxiety, catastrophic cognitions and avoidance behaviours More acceptability for CBT than psychopharmacology in NCCP, Paroxetine was not more effective than placebo. No significant differences between Paroxetine and placebo No significant differences in all three groups but CBT superior post treatment		
Esler et al; (2003) USA	59 (CBT = 29; C = 30)	CBT content 60 minutes Based on panic Diaphragmatic breathing exercises	TAU	Chest pain interview- frequency of chest pain ASI-anxiety sensitivity index CAQ- Cardiac anxiety questionnaire	3 months	There was a decrease in the frequency of chest pain, anxiety sensitivity, and fear of cardiac symptoms in the CBT group

		Cognitive restructuring		MOS-SF –Medical Outcome study short form BSI – Brief symptom inventory Outcomes- there was a decrease in the frequency of chest pain, anxiety sensitivity, and fear of cardiac symptoms in the CBT group		
Van Peski-Osterbaan (1999) Netherlands	72 (CBT = 37; C = 35)	CBT content 4-12 sessions of 45-60minutes, cognitive restructuring, problem-solving, relation, breathing, Intervention was based on CBT for Panic, hypochondriasis, and MUS, targeting catastrophic misinterpretation of somatic symptoms, behavioural experiments CBTT - based on empirically validated models,	TAU	**Chest pain frequency** and intensity. **Anxiety** -There were significant differences between the two groups in 6 and 12 months in favour of CBT Respectively **Depression**-No values have been given **SF36** showed significant differences in physical limitation in	Baseline, 6 months and 12 months	Significant differences between CBT and Control groups at 6 and 12months Anxiety-P=0.01 and P= 0.02 respectively P=0.05 and P=0.02 No values P=0.05 and 0.03 P=0.04 and 0.33

				favour of CBT at 6 and 12 months **Emotional limitations** –significant differences were shown in favour of CBT at 6 and 12 months		48% of participants in the CBT group were pain-free compared to 13% in the Control group at 12 months
Potts et al. (1999) Scotland, UK	60 (CBT = 34; Control = 26)	**CBT Group intervention** - 6 2-hour sessions over eight weeks. Focus on interactions between physiology, affect, cognition and behaviour involved behaviour activities between session, thought diaries and challenging assumptions	26 waiting list	**Outcome measures** Chest pain frequency, intensity, GTN spray use, HADS – anxiety and depression Hyperventilation, the impact of illness and disability	Follow up post treatment and after six months	Group CBT improved psychological, physical and disability CBT improved in chest frequency and use of nitrate p=0.0001 Anxiety and depression as shown in HADS –p=0.05
Sanders et al. (1997) UK	57 (CBT = 26; C = 15)	CBT content – nurse-led 1-hour CBT following a negative result -information on the causes of symptoms and maintaining factors	Control 15)	**Outcome measures** BDI – depression STAI – anxiety Symptom checklist SF 36 9DEGREE OF LIMITATION	Three months by telephone	Control group improved on chest pain, mood, limitations but slightly, CBT group one person got worse, and the rest did not change, no statistical significance with control group doing better than CBT, Those who made progress found angiogram report reassuring No attempt made to use BHT

	-coping with symptoms Breathing and relaxation exercises Booklet to take home information -		Whitley index – health belief Both CBT and control improved on chest pain, mood, limitations CBT group found an explanation of noncardiac explanation reassuring and continued to use CBT techniques Control group upset at answering psychological questions		
	-	Care as usual	Chest pain interview- frequency of chest pain ASI-anxiety sensitivity index CAQ- Cardiac anxiety questionnaire MOS-SF –Medical Outcome study short form BSI – Brief symptom inventory **Outcome**s- there was a decrease in the	Three months	**Outcome**s- there was a decrease in the frequency of chest pain, anxiety sensitivity, and fear of cardiac symptoms in the CBT group

				frequency of chest pain, anxiety sensitivity, and fear of cardiac symptoms in the CBT group		
Mayou et al. (1997) UK	37 (CBT = 20; C = 17)	12 sessions CBT Individual therapy with research psychologist; cognitive restructuring, problem-solving, relaxation and breathing exercises, graded increases in activities and behavioural exercises	Care as usual AOC	Outcome measures Symptom severity Social activity measure, BSI – brief symptom inventory Whitley index measuring health beliefs	6months CBT superior to AOC at six months $P<0.05$.for both symptom severity and social activity	No significant differences in distress and pain-free days between two groups CBT was superior in improving activity levels in different domains The Control group showed very little changes in both symptoms and distress.

Appendix B

Search history

Date	Search terms	Database	Period included	Total Retrieved
07/07/2018 12/07/2018 11/07/-22/07/ 2018 14/08/-20/08 2018 21/08/2018 22/08/2018 28/08/-30/08/ 2018	“Cognitive Behavioural Therapy” OR “Behaviour Therapy” OR” Cognitive Therapy” OR “Behavior Therapy OR Psychological Therapy” AND “non-cardiac chest pain” or “chest pain” or “chest tightness” or “non-specific chest pain” AND “ emergency department” or” primary care” or “primary health care” or” primary healthcare” or “family practice” or “community care “or “general practice.” “Non-cardiac chest pain”, “Accident and emergency department” “Benign palpitations”	Scopus Cohrane review library OVID, Ovid full text PsyINFO Medline Embase Embase, Ovid PubMed, Medline Science direct Google scholar, Dare CINAHL, Campbell library	1997-2017	0 2 2550 2 210 22 5 0 4 0
Additional hand searches				11

			Total	2804

Professional Practice

Generic Professional Practice

Context of practice

Health psychologists work as specialists in different health settings with skills and knowledge for applying health psychology; accordingly, their roles and functions have expanded within these settings, including in the NHS. One of these contexts is IAPT, which has expanded its services to include psychological therapies for people with persistent physical symptoms (PPS), also known as medically unexplained symptoms (MUS) (DoH, 2014) and other long-term conditions (LTC). The role of an IAPT Champion for Long-term Conditions created opportunities for a health psychology trainee to work autonomously and ethically while showing commitment to professional codes and standards. The IAPT context provided opportunities for a health psychology trainee to develop, design and implement psychological interventions for people with LTC/PPS. The work involves designing both groups and individual behavioural interventions based on cognitive behaviour therapy (CBT) and other models used in IAPT for people with LTC. In this role the key responsibility for a health psychologist is to collaborate and expand the biopsychosocial approach towards health and illness, while also developing competencies for implementing psychological interventions for LTC/PPS. Such opportunities for developing clinical and interpersonal effectiveness have been described as lacking for health psychologists (Hilton and Johnston, 2017). These opportunities include having access to mandatory and continuing professional training that expands theoretical models and improves safe working with clients. See Appendix A for proof of placement.

Personal reflections

[redacted]

[redacted]

The role involved working within the multidisciplinary teams in GP surgeries. I was therefore involved in discussions about clients who were referred to IAPT who all suffered from LTC/PPS with comorbid anxiety and depression. There were opportunities to present case studies that integrated psychology and physical health problems. For instance, as part of my behavioural competency for this portfolio, I presented a client who suffered from both posttraumatic stress disorder and persistent pain, following having CBT sessions with the client in a GP surgery. I learned a lot from this work, and it highlighted the role of health psychologists in primary health. Most of the learning was gained from discussions and questions asked by other members of the team from different perspectives. This made my role and position as a health psychologist visible within the multidisciplinary team as it highlighted the important task health psychologists play in bringing the biopsychosocial approach needed for dealing with people with LTC/PPS. I learned to integrate my previously acquired skills and competencies as the role demanded CBT including the application of health psychology to be able to work with clients with LTC and anxiety and depression in IAPT. There were sometimes challenging presentations because of the complexity of the clients who presented with both physical and mental health difficulties. Some of the clients presented with interpersonal conflicts which needed discussion in supervision. This brought opportunities of being able to use a range of approaches, including role play, with my placement supervisor. These experiences also lead to valuing the importance of the therapeutic relationship with clients even in difficult times of disagreements and maintaining professional boundaries. It also led to the appreciation of power imbalances and how this is negotiated in therapeutic relationships while remaining assertive in communication. In these interactions I always acted in the interest of service users and practised according to required standards and ethics. I was also able to learn skills for collaborating and working with other agencies and professionals in multidisciplinary teams.

In this role I attended syndicate meetings with general practitioners (GP) and other community healthcare professionals. This included delivering presentations; for instance, one of these presentations I delivered was on ‘How psychological therapies can improve physical health conditions particularly long-term conditions. This was an opportunity to help General Practitioners appreciate the benefits of psychological therapies in improving mental well-being and therefore see the value of referring patients with LTC/PPS when a need is identified. (See Appendix for presentation example). This also included giving information on the available psychological therapies and group therapy for people with LTC in IAPT. The syndicate meeting also meant responding to questions from the doctors and managers. Sometimes this brought some challenges of not having all the answers. To learn to be comfortable with this ‘not knowing’ was helpful as it prompted me to seek information and do more research and reading about physical health conditions. Engagement with these responsibilities improved my clinical judgement and flexibility in making decisions about clients and pointing them to the right direction when I did not have the answers. There was an advantage to being a CBT therapist in this context as I had skills and knowledge which meant I was able to work collaboratively and therapeutically in a formulation-driven approach with clients. This therefore meant I was able to use my health psychology theories, including behaviour change taxonomies (BCTs) (Michie et al, 2013), to adapt and individualise for treatment of people with LTC/PPS (IAPT, 2018). Through supervision I advanced and gained confidence in developing psychological formulations, drawing from theories of health psychology and influenced by the biopsychosocial models including social cognitive theory and CBT.

Implementing and maintaining practice for legal and ethical professional standards

To develop as a reflective scientist-practitioner, I plotted my journey in line with the standards required by both the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC). As part of working in IAPT, I was also expected to practise as a competent CBT therapist and therefore had to observe the codes and scope of practice for the British Association for Behavioural & Cognitive Psychotherapies (BAPCP). To attain the generic professional competencies as well as maintain standards required by both the BPS and the HCPC, I attended a series of workshops which included consultancy in which I gained some knowledge and ability for skills transfer for the benchmarking project, a task I had to undertake as a consultancy project. These workshops included teaching and training, professional ethics, research competency, and other workshops for improving implementation of psychological interventions at City University. I was also attending regular relevant conferences and other workshops for continuing education at my workplace. The list is shown in the Appendix A.

In order to practice ethically and competently as part of my role I completed regular mandatory training (see Appendix A). The mandatory training included courses on equality and diversity, safeguarding adults, and children. The training helped me to develop skills and knowledge for working with a variety of client groups in IAPT and different contexts which work in collaboration with our service. Along this journey I recorded my professional and personal development by keeping practice logs while reflecting and documenting my growth and learning as well as dealing with challenges. This experience has made me mindful of practising consistently with the governing bodies of my profession within my context of practice in IAPT (BPS, BABCP, and HCPC) and helped my continuing development as a safe practitioner psychologist.

Providing psychological advice and guidance

In this role I was allocated a workload of clients and given responsibilities to work autonomously as a practitioner and health psychologist in training. However, as a health psychology trainee, the multiple roles and academic demands and responsibilities presented conflicts and challenges. There were times when I felt I was pulled in different directions and was unable to meet deadlines as a trainee due to overwhelming responsibilities and different expectations posed by the different roles. The roles of a Champion for IAPT and LTC/PPS demanded that I acted autonomously often thinking on my feet in advising others on health psychology issues and decision making about LTC/PPS. In this role it was helpful to have supervision from an academic supervisor who had experience of practice in pain management; she was always advising on how to correlate theory and practice. I also researched and read a lot to gain more information about the different long-term conditions. I was also able to invite speakers from physical health teams to come and speak to the team to clarify the pathophysiology of these conditions; this gave me more insight about their impact on the lives of the patients. Equally the placement supervisor had a lot of experience and had also worked in pain management and therefore was familiar with most of the challenges I was experiencing. During supervision I was able to engage in case discussions about assessments and share formulations. In order to reduce role ambiguity, it was agreed in supervision that my caseload would be mostly patients with comorbid mental health and LTC/PPS in order to develop and improve my competencies of working with this group of clients. This also included being placed in one of the doctor's surgeries to improve access to this group and work collaboratively with other members of the primary healthcare team. In this role improving time management was helpful in effectively meeting both practitioner and scientist roles and especially in adhering to targets for the doctorate in health psychology competencies. This advice from my supervisor contributed towards my development both as a person and practitioner needed for this role.

Interpersonal effectiveness

Working with clients with both LTC and psychological difficulties as well as collaborating with other professionals demands good interpersonal skills. My role provided opportunities to draw on my previous existing skills of unconditional acceptance, displaying warmth and empathy when communicating with clients. This work improved both verbal and non-verbal including understanding other people’s styles of communicating which encouraged me to read more books on this topic. Sometimes there were challenges when dealing with difficult and complex clients whom I was able to discuss and resolve in supervision. These opportunities provided further growth in interpersonal skills and ability to maintain the good professional and personal conduct required for a chartered psychologist.

Developing research competencies

In this role I contributed to the development, evaluation and monitoring of IAPT’s operational policies and services, through the use of health psychology skills using research methods in conducting service evaluation and auditing. As required in my role I was involved in projects that have implications for practice and quality improvements. These included service evaluation and research to improve behavioural interventions for people with comorbid long-term conditions (LTC) with depression and anxiety.

To improve the quality of our services and involve service users, I conducted a qualitative study using interpretative phenomenological analysis (IPA). The project involved conducting in-depth semi-structured interviews with a purposive sample of participants who attended both a CBT group for LTC and an eight-week mindfulness-based cognitive therapy (MBCT) course. The project aimed to explore their experience of these programmes. I was also hoping to gain some qualitative information from their experience to improve our programmes. MBCT was also used with these participants as relapse prevention following attendance at the CBT LTC/ pain management group therapy. To help me do a good job I attended a workshop on qualitative methods at City University which gave me insight into which questions are best suited to qualitative research. During the workshop, I gained more knowledge during the discussions with my peers and the academic presenter about how qualitative research could be used to complement quantitative research in mixed methods studies. I felt more confident in my choice of methodology for my service evaluation project. While conducting this project, I became more self-assured about using the different approaches of qualitative research methods and understood their strengths and limitations. Equally, this assisted me in advancing skills for writing research and service evaluation proposals. This prepared me to use research in improving the quality of care and service evaluation as a chartered health psychologist and I think I will continue to do so.

Teaching, training and supervising

As part of my role, I was supervising and mentoring other psychological therapists in working with people with LTC. To improve my abilities in this role, I attended a teaching and training workshop at City University and also completed a supervision course at UCL. In this role, I was also involved in conducting workshops and teaching different audiences which included students, healthcare professionals and service users. This teaching and training involved presenting topics related to health psychology as applied to psychological therapies for LTC for health professionals in IAPT and others dealing with LTC in the community. I also had opportunities to lecture at two universities on topics related to health psychology: these included CBT in anxiety disorders, HIV/AIDS and pain management. During one of these workshops, I was witnessed by my academic supervisor at City University. This was a good opportunity for constructive evaluation and feedback to improve my practice of teaching and training. During the two years of practice, I developed in my competency and I am becoming more proficient in planning and delivering training and teaching to different audiences.

This advanced my abilities to plan lectures and modules relevant to given learning objectives. It gave me a chance to research health psychology information for planning and delivering lectures for different audiences. There were also opportunities to expand my experience of working with diversity, for instance, I prepared and delivered training to the carers of black and minority ethnic groups (BME) in Greenwich. The presentation was about accessing primary mental health services available for people with long-term conditions and comorbid mental health. This training gave me a chance to plan and design training that takes into account the needs of different cultural understanding. It also created prospects for learning to adapt psychological practice and information for diverse audiences and cultures.

Gaining competencies in consultation

I was asked to conduct a benchmarking process of our IAPT service's existing protocols and procedures for improving psychological therapies for people with LTC. I accepted this challenge as my consultancy project which was outside my usual duties as LTC Champion with the hope of developing consultancy abilities as a health psychologist. I did not know anything about benchmarking when I agreed to carry out this project; however, I had already attended a workshop on consultancy at City University and therefore understood that I had to integrate the theory into my benchmarking project. The benchmarking needed an exploratory and authenticating process of the existing protocols and behavioural interventions used in our IAPT services in meeting the needs of people with comorbid mental health and long-term conditions against best practice standards as outlined in IAPT (2008, 2014).

This project was both challenging and interesting, requiring both academic and practitioner skills. During this process, I was able to appreciate both my strengths and limitations. My strengths included the competencies of a health psychologist which include research and theory for designing behavioural interventions, training and teaching, and my existing knowledge and skills of being a CBT therapist in IAPT. In consultation with both my supervisors, I identified workshops and other resources to help me bridge the gaps and gain skills and competencies for conducting my benchmarking consultancy project. Attendance at workshops and use of resources helped me to develop self confidence in delivering the benchmarking consultancy project.

During the delivery, I acquired insights on the processes of both benchmarking and consultancy. The experience taught me how standards are interpreted and put into practice by organisations. Engagement in this project has increased my awareness and knowledge of other organisations and useful forums and improved my skills of networking. I became more advanced in working with other disciplines and professions in matters that involve health psychology. This also provided opportunities for consultation and learning to communicate better with other health services working with physical health and mental health and wellbeing. I had a lot of encouragement and support from my supervisors.

Conclusion

During my journey, I benefited from receiving supervision from both my academic and workplace supervisor. I used this opportunity and supervision feedback to gain skills and knowledge as a scientist-practitioner and applied health psychologist needed for chartered status. The supervision gave me confidence in making autonomous decisions and risk taking when necessary. In supervision challenges related to both practice and academic issues were discussed. These were variable, for instance discussing which models or theories to be integrated into behaviour interventions or asking opinions about formulations and referrals to other professionals. This experience of having a work supervisor who is both a chartered psychologist and accredited CBT therapist and my academic supervisor who is both an experienced academic, author and chartered health psychologist in private practice with experience in pain management advanced my practice and confidence. I used my supervision to develop psychological formulations that draw on theories of health psychology and consider biopsychosocial influences and cognitive behaviour therapy. Supervision feedback often helped with new perspectives and understandings which have led to feeling more assertive and confident as a practitioner.

The prospect of working autonomously as a psychologist in IAPT advanced my confidence in assessments of clients and psychological formulations, including deciding on appropriate behavioural, psychological interventions for people with LTC. Through this work, I learned more about assessing risks and making appropriate referrals. This experience has prepared me to work independently as a practitioner health psychologist.

During this period of training, I also wrote abstracts and gained confidence in presenting at conferences. I have written three abstracts for two different professional journals and one for presenting a paper at a conference. All my abstracts were accepted and therefore I was also able to write articles and respond to peer-reviews. This experience together with the teaching at the university, the research and conducting the systematic review has developed my skills as an academic and a scientist-practitioner needed for chartered status. Apart from gaining the health psychology competencies and knowledge this experience demanded resourcefulness which includes management skills, collaborative working and good report writing as well as verbal communication, cooperation with others and leadership and commitment to the core values of the psychology profession.

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Appendices

Appendix A. Proof of placement

CITY UNIVERSITY
LONDON

Department of Psychology

City University

Northampton Square

London EC1V 0HB

Professional Doctorate in Health Psychology

Work Place Contract

Trainee's name:	**Lumka Tutani**
Chartered health psychologist supervisor:	**Dr Clare Eldred**
Work place contact:	[redacted] [redacted] [redacted] [redacted] [redacted]
Work place address:	[redacted] [redacted] [redacted]

	[redacted]
Work place email:	[redacted]
Work place telephone number:	[redacted]

Declaration

[redacted]

[redacted]	[redacted]	[redacted]	[redacted]

Appendix B. Training record 2015-17

Date	Topic	Venue	Facilitator
5/10/15	Meeting DPsych health Psychology competencies	City University	DPsych Team
8/10/15	Referral Pathways in psychological Therapies	Memorial Hospital	[redacted]
12/10/15	Professional skills and Ethic	City	[redacted]
18/11/15	Presenting at Quality Improvement Showcase – Poster on experience of CBT therapist Working with Interpreters in IAPT	Oxleas NHS	Presented at Conference Lumka Tutani
2/11/15	Consultancy	City	[redacted]
7/12/15	Researcher's workshop –Preparing abstracts,posters,and presentation for a conference	City	[redacted]
5/01/16	Working with Autistic Spectrum and ADHD screening for ASD	Oxleas	[redacted]
11/01/16	Problem identification and ICD10 Codes	Memorial Hospital	[redacted] Institute of Psychiatry
28/01/16	Initial Assessment, ICD10,Honos Treatment Planning and Clinical Record	Memorial Hospital	Consultant Psychologist and Clinical Lead [redacted]
1/02/16	Qualitative Research	City	[redacted]

2/02/16	Treating Post Traumatic Stress Disorder	Shrewsbury House	[redacted] Institute of Psychiatry
3/02/16	Understanding Role of Care Quality Commission (CQC)	GTTT-Eltham	[redacted]
7/03/16	Systemic Review	City	[redacted]
6/06/16	Teaching and Training	City	[redacted]
6/07/16	Annual Progress Review	City	Dpsych Team
01/02/17	Line management development workshop workforce to work with people with LTC	Oxleas NHS Foundation Trust	Oxleas CPD team
09/02/2017	Oxleas Integrated 9/02/17- Therapies conference to develop	Oxleas NHS	Conference
06/02/17	Quantitative research methods at	City University	[redacted]

Appendix C. Supervisor report

Department of Psychology

City University

Northampton Square

London EC1V 0HB

Professional Doctorate in Health Psychology

Supervisor's Report

Trainee Details:

Name: Lumka Tutani

Supervisors: Dr Clare Eldred

Competence: General Professional

Views on the Trainee's Competence

[redacted]

[redacted]

[redacted]

[redacted]

I verify that the above named trainee has undertaken the above mentioned competence. I am of the opinion it has been completed to a satisfactory professional standard.

Signature: **Date: 24/12/2018**

Appendix D Supervision Plan – Generic profession unit

Area of competence	Area of practice	Supporting evidence to complies	Changes
Generic Professional Skills Contribute to the continuing development of self as professional applied psychologist	**Setting** Long-term Conditions Champion/Lead IAPT services (Improving Access to Psychological Therapies)	Supporting evidence Case study report describing the process and personal reflections on professional practice A report on continuing assessment of training needs Case-study working with client with long term condition and mental health using evidence –based interventions and health psychology Case study – 3000 words Practice log	

Consultancy Competency

Supervision Plan

Trainee: Lumka Tutani

Supervisor: Dr Clare Eldred

Setting: Primary Health (IAPT) Improving Access to Psychological Therapies

Target Group: Adults with Long-term Conditions and Co-morbid Anxiety and Depression

Competency: Consultancy

Description of work: Benchmarking and improving access to psychological therapies for people with Long-term Conditions in IAPT (Improving access to psychological therapies) – 3000 words

Benchmarking and developing interventions and protocols for LTC/PPS in IAPT

Introduction

In this case study I reflect on how a consultancy project which involved a process of benchmarking to improve access to psychological therapies for people with long-term conditions (LTC) including those with persistent physical symptoms (PPS) in IAPT was carried out. The benchmarking consultancy required a process of examining and validating the existing protocols and interventions used in IAPT services in meeting the needs of people with co-morbid mental health and long-term conditions. The specific details of the process of consultancy are outlined as follows:

- Background and context in which consultancy was carried out
- Assessing the consultancy request
- The aims of consultancy
- The model of consultancy used

The process of consultancy which sets out the following:

- Budget costing, time and resources
- Developing and maintaining a working relationship with the client
- How this consultancy was planned
- How the consultancy, which was the benchmarking of LTC in an IAPT service was carried out. This includes outlining the benchmarking process and descriptions of projects and activities.

- Reflecting on the learning process, this includes discussing both challenges and benefits during this consultancy
- Presenting the outcomes of the consultancy including future directions for the organisation

- Conclusion and value of supervision support and guidance during this process

Background and Context

[redacted] is part of a national IAPT programme established in (2007) for ensuring equitable and accessible psychological services to all people. The IAPT has expanded its services to include psychological therapies for people with physical health conditions and comorbid anxiety and depression in particular LTC/PPS for residents of the [redacted] has been providing access to psychological therapies for people with mild to moderate depression and anxiety using Cognitive Behaviour Therapy (CBT) within a Stepped Care Model (Bower &Gilbody, 2005) since 2009.

The National Health Service (NHS) implementation five-year plan is focussed on being effected by 2020/2021.This plan recommends integration of physical health and mental health services, which will continue to increase access to psychological therapies. By this goal the document states:

"*There is already a well-developed data collection for Improving Access to Psychological Therapies (IAPT) services, and this will be expanded and improved to understand progress and allow services to benchmark themselves*" (Implementing the mental health forward view: NHS England, 2016, p. 19).

It was against this background that this consultancy was requested. Also as argued mental health services must evaluate their performance against national standards (Gilbert, 2005) therefore the client needed to see how they compared to other similar services and national IAPT standards for improving access to therapies to people with LTC/PPS.

Assessing the request for consultancy

During my first six months as a health psychologist trainee; in May 2015 the client who is the Lead Consultant Clinical Psychologist for IAPT services requested my health psychology expertise in improving access to psychological services for people with LTC's in IAPT services. In accepting this project, I was aware of my limitations and lack of experience in consultancy especially using healthy psychology competencies in a new area of expertise and context. Through a lot of research and encouragement from both supervisors I took the initiative.

Therefore, in tendering the proposal I outlined my health psychology competencies and prior knowledge and skills including evidence-based practice gained as High intensity and Specialist Psychological Therapist in IAPT. I took this as an opportunity to develop these competencies further in this process in my journey to becoming a competent autonomous health psychologist.

Meeting the aims consultancy

The thorough assessment of the request helped in developing an in-depth understanding of the consultancy. The aims of this consultancy involved evaluating current practices, procedures, interventions and performance standards for improving access to psychological therapies for people with LTC/PPS using benchmarking as a tool. However, physical health problems which include long-term conditions are a relatively new area of interest in most psychological programs including the training in CBT for High Intensity, Practitioner well-being practitioners (PWP), counsellors and psychologists, therefore, a gap in delivering access to psychological therapies for people with Long Term Conditions /Physical health conditions was identified by management. In the role as a consultant in this project the client expected that I would be able to use my health psychology theoretical knowledge in helping the organisation in improving the existing assessment pathways and protocols.

In a meeting with the client, we discussed the aims of this benchmarking consultancy. As the consultant, I prepared a proposal that demonstrated how I planned to carry out the benchmarking consultancy. The work plan demonstrated how I was going to conduct my consultancy. In a further meeting to discuss the proposal, the client and I were confident about my skills and competencies. I already had health psychology knowledge of theories and models of working including ability to draw on both Theoretical Domain Framework (TDF) and Behaviour Change Techniques (BCT's) to provide helpful guidance for carrying out this task (Michie et al; 2013). The consultancy created an opportunity to make this 'tacit psychology knowledge more explicit' in the implementation of this benchmarking project (Nolan & Moreland, 2014).

Contracting for Consultancy

To be able to carry out this consultancy I was given a leadership role of being the champion for long-term conditions in an IAPT service. Consultancy contracts include budget costing, time and resources, in this role the consultancy was going to be conducted free for the client as part of my new extended role. I was allowed 3.5 hours a week to focus on this consultancy role. This process would not have been different if I was an independent practitioner who was funded for the work. Regarding personnel, the organisation already had an existing working LTC project within the team. The LTC project consisted of practitioners who were interested in working and facilitating groups for people with LTC in IAPT. This was an opportunity for a leadership role in the IAPT for developing practitioner's competencies including reinforcing good practice for working with people with LTC/PPS, through drawing on prominent BCT's like education, training and enablement (Michie et al; 2011).

Developing and maintaining a working relationship with the client

As I had worked within the organisation both as High Intensity and Specialist Psychological therapist, I already had a good relationship with the team and my supervisor. However, the new role and responsibility required extending relationships to include the Clinical Governance, Lead Consultant for IAPT, the Head of Health Psychology for the trust and the LTC work project which was already established for helping to implement plans. We arranged regular meetings with all parties to monitor and discuss progress. The meetings also included proposals for implementations and feedback presentations which I prepared for the whole team at regular intervals during the stages of the consultancy to discuss the progress **(see Appendix C).**

The extension of relationships to the bigger IAPT team and management in addition to regular feedback presentations ensured that the consultancy was fully rooted within the GTTT–IAPT organisational procedures and protocols of performance to allow for the implementation of findings. This point is emphasised in studies (Earl & Bath, 2004). The core values of transparency and inclusiveness and open communication when delivering consultancy are further stressed by BPS (2012).

Consultancy models applied

This task required insights of both consultancy and benchmarking. The benchmarking process required that I draw on a variety of consultancy models that would be appropriate for this task. Accordingly, a combination of models was used as applicable and needed rather than being restricted by one model of consultancy. As described by Earl & Bath (2004) consultancy takes place within a relationship where one party needs the help of another within a professional role. In this consultancy health psychology skills and expertise were needed to benchmark protocols and interventions to improve access for psychological therapies for people with LTC/PPS in an IAPT service as requested by the client. Earl & Bath (2004) stress the 'helping 'and 'empowering 'nature of this relationship in consultancy. Therefore, in this consultancy I shifted between positions of being 'helper' using my existing skills and knowledge of the familiar organisation protocols and interventions and 'empowering' drawing from my health psychology expert knowledge. It was important for me to understand the clients request and to reflect on the knowledge I had for carrying out the consultancy. This included a model of consultancy that was best suited for this benchmarking project. As argued by Schein (1997) shifting applicably between models is an appropriate way of using expertise in consultancy. Shifting in this role was also deemed inevitable as this project was outside my duties as a CBT therapist in IAPT and therefore in a capacity as consultant to use my health psychology competencies. As a trainee this was an opportunity to gain competencies as a health psychologist, so I enthusiastically took up this challenge and discussed it with my supervisors at City University who agreed.

Planning Consultancy

To be able to carry out this consultancy an understanding of the concept of benchmarking, including the types and processes involved was an important step. Before the beginning of the consultancy, a literature review was carried out, including a search for any other IAPT services who have benchmarked their LTC/PPS working procedures. Extensive reading to understand the process of benchmarking from authors and professionals who have carried out and published on this process in mental health was performed.

Previous studies have described different types of benchmarking including internal and process benchmarking. Process benchmarking involved examining processes and protocols which are used by organisations (Bhutta and Huq, 1999). Through the literature search my understanding was that benchmarking is a concept that has been contested and debated across contexts and timelines. This understanding includes its origins from industry to encourage competition and being adopted by health care to improve best practice. As contended; at the heart of benchmarking in healthcare is delivering best practice to achieve best outcomes and good experience for patients in line with their valued goals and needs for seeking care (Hibbert et al; 2019).

Recently during the Covid 19 pandemic health practitioners have learned more about the importance of benchmarking and sharing good practice especially making this information transparent for use by others. During the pandemic it was key for health practitioners internationally to benchmark and share good practice to help in curbing the spread of the disease (Timmis, Brüssow, 2020). Therefore, context and purpose determine how benchmarking is understood and applied.

For the current consultancy project, this included how the organisation's interventions for improving access for people with LTCPPS were meeting IAPT best practice standards. A method of benchmarking seen as suitable for use in healthcare services is internal benchmarking as it identifies both strengths and weaknesses, as used for instance by Etu et al; (2020) this method seemed to also be inclusive of examining processes used in organisations. The authors also used a structured step by step process commencing with(1) planning, a process of gathering information needed for the activities of benchmarking (2) doing, involves analysing the information and identifying processes of benchmarking (3) checking process of identifying strengths and gaps (4) acting refers to implementing what is needed following the process (Bhutta & Huq, 1999; Etu et al; 2020). The process of benchmarking can be used creatively to implement ideas for improving best practice., equally it can be used to improve standards for comparing and achieving best outcomes (Northcott & LLeywellin,2005).

In this consultancy both research and literature review skills and knowlegde were very empowering and enabling. This process required thorough review and understanding of the organisational standards, including supporting and encouraging outstanding good practices within the organisation as noted from studies (e.g. Barkham & Mellor-Clark, 2003; Barkham, Hardy, & Mellor-Clark, 2010; Delgadillo et al; 2014; Mellor-Clark et al ; et al; 2006; Kyrö, 2003). Equally the review increased both theoretical and pragmatic understanding of consultancy from similar authors and publications (e.g. BPS, 2012; Earl & Bath, 2004; Patel, 2014).

After a thorough process of reading and reviewing the IAPT good practice standards from the documents, these were understood and interpreted in the context of the organisation. For this consultancy, an eclectic benchmarking was adopted as both internal and process benchmarking approaches seemed appropriate (Etu et al, 2019; Bhutta & Huq, 1999). An internal benchmarking approach was adopted to allow the service to have a baseline of how they were performing in improving access to people with physical health conditions /LTC/PPS with Comorbid Depression and Anxiety. Process benchmarking process involved looking and analysing the procedures and protocols which included pathways and assessment to examine how easily usable these were in improving access to psychological therapies for people with LTC/PPS.

Both consultancy and the benchmarking processes draw heavily on the knowledge and competencies of those implementing the protocols and procedures and this had implications for me as consultant and trainee health psychologists. In this consultancy project the process relied heavily on understanding evidence-based interventions used in IAPT and being able to implement them in a contextually sensitive manner that required resourcefulness and scientist practitioner skills (Barkham et al., 2010). The aims of the consultancy were broad and multifaceted involving a range of health psychology competencies. In this consultancy the action phase of implementing the plans required skills of quality improvement, research, teaching and training including knowledge of behaviour interventions. Consequently, my task was the practical application of these insights to improve IAPT/LTCPPS current standards of working, comparing, evaluating, and improving them.

Mapping and identifying benchmarks

The overall aim of benchmarking is to identify best practice and make improvements or adaptations to achieve those standards (Bhutta &Huq,1999). Best practice and standards against which to benchmark were identified. At the time of this project there was no information available for benchmarked IAPT services to compare with; together with the client we agreed the benchmarking was against IAPT Practice guidelines as outlined (2008/2014) and IAPT LTC /MUS Pathfinder (2012). The overall aim of the IAPT LTC/MUS Pathfinder Project (2012) is to improve access to psychological therapies for people with long-term conditions (LTC) and medically unexplained symptoms (MUS) also referred to as persistent physical symptoms (PPS) Chalder & Willis (2017). Assessment and referral carepathways were prioritised and identified as important benchmarks. We collaboratively agreed key performance indicators (KPI, s) which included (1) improved access rate for LTC/PPS (2) Improved recovery rates for LTC/PPS and (3) Improved access and retention to the LTC/PPS group; would be used to evaluate the consultancy after a year of benchmarking and implementing. Consistent with the collaborative consultancy the benchmarking questions were drawn and discussed with the client as follows:

- How well is the organisation performing against National IAPT standards in working with LTC's?
- Do we know how other IAPT perform if not how do we gain access to this information to benchmark?
- What are the best practices for improving access to psychological therapies for people with LTC?
- How far is the organisation meeting these standards of performance?
- What improvements are needed to improve performance standards for working with people with LTC's
- What are the existing strengths and are there any obvious weaknesses in working with LTC/PPS?
- What would be the specific plan for [redacted] to be able to implement needed improvements?

The benchmarking processes

Process benchmarking

This process involved looking and analysing the procedures and protocols which included pathways and assessment to examine how easily usable these were in improving access to psychological therapies for people with LTC/PPS. During this process available information that measures key performance indicators (KPI's), specifically for LTC/PPS were analysed and compared to other mental health conditions within the IAPT. These comparisons included the number of people accessing psychological services with LTC/PPS, including the recovery rates for these conditions. This information was collected and analysed to identify gaps for improvements. Both strengths and areas of improvements for the organisation were identified. Projects for adaptation and improvement were identified, these were: improving assessment and referral care pathways including and adapting existing LTC/PPS group interventions to improve quality.

Improving assessment care pathways.

This involved analysing the assessment protocols and care pathways that were available and used for people with LTC's and comorbid anxiety and depression to access IAPT service.

Strength - The organisation already had an existing initial assessment proforma for clients to be assessed for IAPT mild to moderate anxiety and depression.

Gaps: During the benchmarking process I identified that asssessment profoma did not include and assessing questions for checking if people being assessed had any long term conditions and whether the anxiety and depression they were presenting with was related to these long term conditions. One of the strategies of validating and improving the assessments was ensuring that people were asked about their physical health history and labelled appropriately during referrals and assessments. It was also important to ask questions that were relevant and able to identify LTC/PPS with co-occurring anxiety and depression. To improve the assessment of co-morbid LTC/PPS; I devised and added good practice prompting questions in the assessment proforma **(see Appendix D**) used in the organisation. The effectiveness and usefulness of these prompting questions were audited using Monkey Survey. The survey results revealed that these questions were helpful in encouraging practitioners for assessing LTC and co-occurring anxiety and depression. Achieving this was a good outcome for my consultancy and I reported this to both the team and management and a new assessment profoma was used for the team.

Improving referral care pathways

Strength - The organisation already had an existing pathway for clients to be referred for mild to moderate anxiety and depression

Gap - The goal was to ensure that General Practitioner's (GP's) and other health professionals have easy access to IAPT referral systems and information for people with LTC with comorbid anxiety and depression. Therefore, ensuring that working processes and procedures for LTC/PPS e.g. referrals and care-pathways, with community health nurses including Diabetic team, Cardiac rehab team and other physical health services was important as they provide services for these clients. To further advance these protocols an additional referral form which clearly outlines the criteria and information on psychological services in IAPT was drawn out and made accessible on the intranet website.

There were several reasons for choosing the care pathways as benchmarks during this consultancy project. IAPT guidelines (2008,2014) has identified these as important indicators for improving barriers to access, consistently in this project benchmarking has been used as creatively both a research and developmental tool for quality improvement. During this consultancy helping the organisation to improve their assessment pathways and referral care pathways including LTC interventions was in line with the IAPT Guidelines for removing barriers to access to psychological therapies for people with LTC/PPS). Equally it was important to ensure that GP's and other health professionals have easy access to IAPT referral care pathways and information for people with Co-morbid LTC/PPS(IAPT,2014). Other important benchmarks would be to improve recovery rates and improved access rates but these KPI's could only improve if barriers to access and interventions were improved.

Internal benchmarking

The performance (i.e., recovery rates, retention, and dropout rates) of the LTC group was also compared to others Group therapies within the service e.g. CBT for Self-esteem, CBT for Social Anxiety CBT for Depression and outcomes for individual therapies within in the service. This plan ensured that LTC project was working and contributing towards the overall goal of IAPT of improving access to psychological therapies. The benchmarking process provided opportunities for the organisation to make explicit gaps and strengths in their processes for working with people with LTC/PPS.

Evaluating existing LTC/PPS interventions

Strength: The organisation already provided psychological services which included group therapy for people with LTC/PPS which was a ten-session CBT group for people with various LTC/PPS with pain and fatigue. The provision of LTC group sessions was identified as a great strength for the organisation. The LTC CBT group was an important source of psychological therapy at the time as it provided for most of the LTC/PPS clients accessing the service.

Implementation: quality improvement of LTC/PPS Interventions

In this benchmarking process, quality improvement project involved exploring the experience of clients using the CBT group intervention for people with LTC/PPS. The plan was to use both quantitative and qualitative information from clients attending the groups in order to carry out the service evaluation. A questionnaire was designed and given to group participants at the end of their group sessions to determine which parts of the CBT interventions they were finding as helpful or unhelpful including their comments on group processes. This qualitative information was used to develop a CBT programme which was later adapted as reported in the research component of this portfolio (Chapter 2). The goal of this project was to gain feedback that would be used as benchmarks to improve the experience of recovery for the participants of the group. It was hoped that this qualitative feedback would help improve the processes of facilitating this LTC group. These would be gauged in the outcomes through quantitative research methods, these would be indicated by the following key performance indicators.

- improved recovery rates,
- improved attendance and retention to the LTC/PPS group
- Reduced attrition and dropout rate to less than 50%.

A full report of the service development and quality improvement of this benchmarking project including the results is discussed under the research component of this portfolio. This consultancy was fully rooted within IAPT's organisational procedures and processes to allow myself and the client to collaboratively implement identified changes without difficulty (Earl & Bath, 2004).

Evaluations

The success of the consultancy depended on the ability of the benchmarking process to identify performance standards, evaluate them and devise solutions to improve access for people with LTC/PPS. The process of benchmarking identified both strengths and areas of improvements. Due to time limitations and the enormity of the scale of the benchmarking process it was difficult to achieve all the objectives, however good outcomes were achieved, and the client was satisfied with the consultancy as shown in Appendix E. The interim results are shown in Appendix A.

Challenges and limitation

One of the limitations of this consultancy was limited time frames and weekly time given for the consultancy considering the amount of work expected by the client. The time allocated for consultancy was only 3.5 hours. The first challenge identified was that due to the scale and the scope of work involved the six-month deadline time scale seemed impossible from the start. Although there was a lot of learning and a scope and role developed for a health psychologist through this consultancy project, it proved to be very ambitious in terms of time frames and the scale of work. The benchmarking included measuring internal processes, subsequently it was hoped that measuring these processes would help to benchmark while also highlighting plans for improving processes and procedures. The other challenge was that I tried to do everything. The consultancy used both quantitative and qualitative methods but due to the enormity and scale of the work done it was not possible to report on all this information because of both time and resources. I was unable to complete all the projects I wanted to complete, but I learned that during the process of consultancy 'you could identify and suggest what is needed to be done to the client rather than try to do it all by yourself'. I learned a lot from Shein's (1999) principles of the process of consultation, I became aware of how much I overidentified with the organisation and I owned their problems. This was the difficulty of taking up an extra role of consultancy in the same workplace. In this project I acted as a 'benchmarker 'and similar to Kyro's (2003) definition I saw myself as part of an organisation that was seeking to improve its processes of working to improve access to people with LTC/PPS. It is possible that being in this position prevented me from taking a more objective role as a consultant. Located as a benchmarker in an organisation I was part of, added more pressure and sense of accountability including responsibility for its success rather than handing this over to organisation. This position had both strengths and challenges. The strengths were that it was easy for me as a consultant to understand the organisation's difficulties and identified needs in the process of benchmarking and this understanding improved the consultant client relationship. In this position, benchmarking was used as a research tool for improving the services rather than comparing the organisation to other services. This provided a lot of learning opportunities and developing competencies of health psychology.

The challenges of working within boundaries and time limits were some of the lessons learned. The process of benchmarking required that I identified both strengths and weaknesses and help by offering health psychology input where necessary, but I think I tried too hard to do too much within a short space of time.

The other challenge was that I was too eager to show outcomes of the consultancy benchmarking process. This would be shown by increasing the number of people with LTC/PPS who accessed the service. This would also be more obvious through the auditing and service evaluation projects. The goal was to use the information as benchmarks and plan to improve standards of practice as identified. For the client an important indicator would be to improve both access numbers and recovery rates for LTC/PPS.

Reflections and learning from the process

There have been many facets and learning points for me, first as part of gaining competencies for my DPsych it was carried out as a consultancy project and therefore had to meet the criteria as such. Although challenging, the benchmarking process fitted very well as a consultancy project. I learned a lot about how I was able to deal with my own emotions and those of my client as a consultant. In this project I struggled a lot time and therefore meeting deadlines was difficult due to the complexity and scale of the project I undertook, in a role as trainee, and I learned about my tendencies to want things to be perfect which affected me emotionally and physically. This also included understanding professional scope and role, this meant I had ongoing support and supervision from both my workplace and academic supervisor. My academic supervisor helped me to focus and identified opportunities for good correlation of practice and theory as well as improving other competencies alongside consultancy. During supervision we identified conferences where the work could be presented. This gave me an opportunity to practise writing abstracts and preparing presentations. As contended, this has been a good way of making sense of research to improve quality and practice for the organisation (Mellor-Clark, et al, 2006). The consultancy required both quantitative and qualitative research skills which included collating feedback from clients and the ability to interpret this information. The benchmarking process also involved knowledge of auditing and service evaluation, which gave me an opportunity to improve these competencies. I have learned that the benchmarking process is an important research activity that taps into both your competencies as a scientist and practitioner. As a trainee health psychologist, this was the most interesting part of this portfolio.

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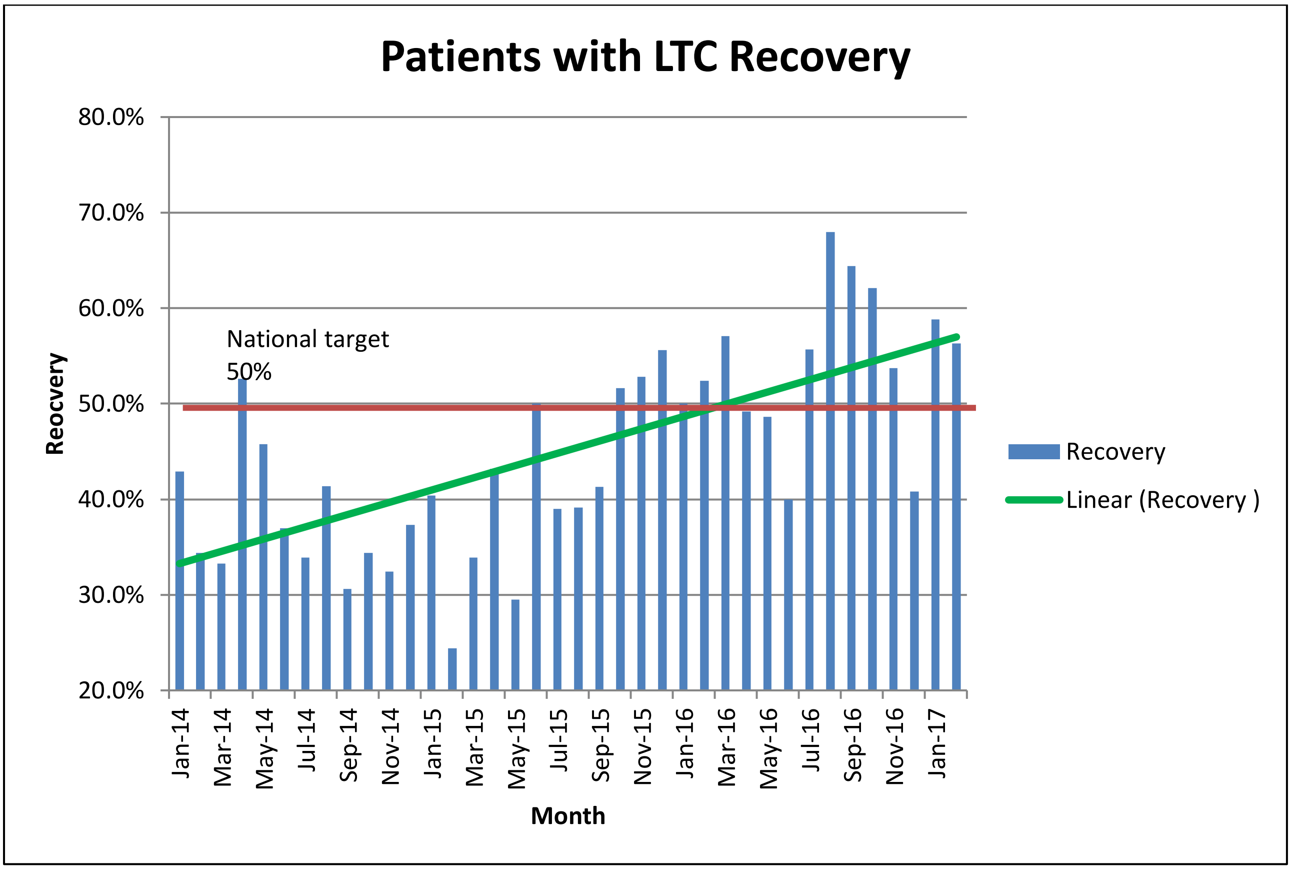
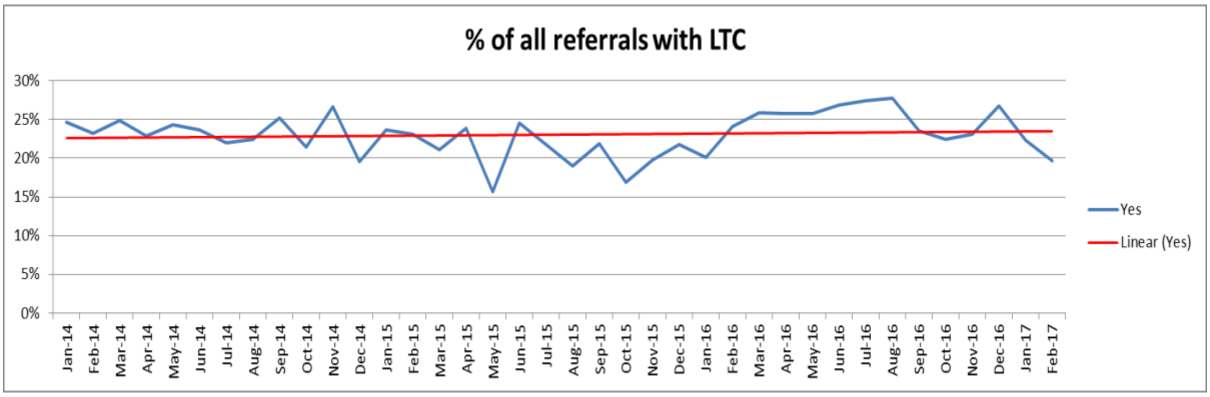
Appendix A. **Interim results and disseminating information**

The impact of the consultancy to the organisation has been good as shown by the interim results. These results show improved linear recovery rates for people with LTC's accessing services. The results also show a steady linear uptake of LTC by IAPT during the consultancy. The findings from both service evaluation and quality improvement projects will be reported later as part of the research competency.





Improved access of LTC/PPS [redacted]

APPENDIX B.

Contract for consultancy project

Client Name: [redacted]

Job Position: [redacted]

Organisation: [redacted]

Consultant: Lumka Tutani (Health Psychologist Trainee)

Contract Time: 9 months

3.5 hours a week

Cost - £0

Dates of Benchmarking: 30/05/2015 – 30/03/2016

Aim of Consultancy

The objective of this consultancy was to benchmark how the processes and interventions used within the organisation were meeting the needs of people with LTC/PPS against IAPT best practice standards**.**

> How well is the organisation performing against National IAPT standards in working with LTC's?
>
> Do we know how other IAPT perform if not how do we gain access to this information to benchmark?
>
> What are the best practices for improving access to psychological therapies for people with LTC?

How far is the organisation meeting these standards of performance?

What improvements are needed to improve performance standards for working with people with LTC/PPS?

What are the existing strengths and are there any obvious weaknesses?

What would be the specific plan for [redacted] to able to implement needed improvements?

Signature Date

APPENDIX C. Benchmarking plan

IAPT GUIDELINE	**KEY OUTCOMES**	**ACTIONS**	**TARGET DATES**
Removing barriers to access	Improving assessment and accessible referral pathways for people with different Comorbid LTC and FS to IAPT during initial assessment	Compiling a Criteria for assessing Co-morbid LTC and FS Compile prompting questions for assessing LTC/FS co-morbidity and Criteria for LTC /Group during initial assessments	30/10/2015 30/10/2015
Engagement	Ensuring that GP's and other health professionals have easy access to IAPT referral care pathways and information for people with Co-morbid LTC/FS Audit usefulness of prompt questions Give a presentation to [redacted] staff with regard assessing and making decisions about people with LTC/FS Search from [redacted] files and Liaise with [redacted] for	Audit usefulness of prompt questions Give a presentation to [redacted] staff with regard assessing and making decisions about people with LTC/FS Search from [redacted] information on Care pathways for LTC/FS and make it accessible in G-Drive and up to date for IAPT STAFF to use Discuss accessible versions of a G-drive at next meeting with [redacted] Compiling a Criteria for assessing Co-	

	information on Care pathways for LTC/FS and make it accessible in G-Drive and up to date for IAPT STAFF to use Discuss accessible versions of a G-drive at next meeting with [redacted] Engaging with GP's through improved communication Working in GP surgeries with people with Co-morbid LTC/MH Monitoring uptake of IAPT by People with LTC Effective engagement and assessment of people experiencing Co-morbid LTC by IAPT staff Engaging and working collaboratively with LTC Teams	morbid LTC and FS Compile prompting questions for assessing LTC/FS co-morbidity and Criteria for LTC /Group during initial assessments Audit usefulness of prompt questions Give a presentation to [redacted] staff with regard assessing and making decisions about people with LTC/FS Search from [redacted] files and Liaise with [redacted] information on Care pathways for LTC/FS and make it accessible in G-Drive and up to date for IAPT STAFF to use Discuss accessible versions of a G-drive at next meeting with [redacted] Deliver leaflets and information about LTC groups and other LTC /FS /CBT interventions to GP surgeries and other LTC Teams	

	Involving service-users with LTC in IAPT	Deliver Public Workshop at WMHD Attending GP meetings to provide psychological input and recognition of LTC Co-morbidity (Lumka) Arrange meeting with GPs with [redacted] (practice manager Organize key message for GP meeting including material to take Organize material to take e.g. A3 Poster, and leaflets Conducting LTC/Pain Management/Step2 Groups at GP's and other Health centres e.g. [redacted] [redacted] Involve PWP In setting up Step 2 LTC interventions To review the Diabetic Training and its relevance to	

		Psychological Therapists put it on training for [redacted] again	
Evaluate effectiveness by Benchmarking using IAPT LTC Good Practice	Improve performance standards in line with IAPT LTC good Practice Identify strengths and weaknesses in our protocols and practice	Organize available LTC information on G-drive Outline plan for organising G-drive Finish Self-help Book with LTC work stream	30/11/15
Auditing and Evaluation guidelines	Identify strengths and weaknesses in our protocols and practice To improve percentage of clients with Comorbid LTC recovering and showing reliable change scores at discharge from individual or Group therapy	E- mail referral care pathways and criteria for Co-morbid LTC to GP surgeries and other LTC Teams Compile a robust process to follow once referral has been received Attend CCG meeting with [redacted] and [redacted] Ensuring that people are asked about their Physical health history and labelled appropriately during referrals and assessments IAPT staff engaging difficult to engage clients within GP surgeries alongside other professionals	15/09/2015 On-going To organise and discuss on-going 30/11/15

		including GP'S and Practice nurses	
		To organize a meeting with Practice nurses at GP surgeries	On-going
		To meet with Link practitioner and organise meeting	30/10/2015
		Monitoring and evaluating patient experience at the end of Individual and Group Therapy	30/12/15
		Inviting service users with LTC to share their stories and experience with others	30/11/15
		Review IAPT LTC good practice and LTC pathfinder	On-going
		Perform a Service Evaluation of current LTC group	
		Write up a QIP evaluation and send to [redacted]	

Appendix D - Example of Prompt questions included in assessment profoma

PROMPT QUESTIONS FOR SELF REFFERALS:
Establish if their condition is acute or chronic ask the following questions:
• Do you have a LTC diagnosed by your doctor?
• Has your doctor recommended CBT for LTC?
• How long have you had these difficulties related to your LTC?
• Have you had other treatments and investigations done by your GP?
• Would you ask your GP to refer you for CBT?

Appendix E. Evaluation of consultancy project

Client Name: [redacted]

Job Position: [redacted]

Organisation: [redacted]

Consultant: Lumka Tutani (Health Psychologist Trainee)

Contract Time: 9 months

Dates of Benchmarking: 30/05/2015 – 06/06/2017

Aim of Consultancy

The objective of this consultancy was to benchmark how the processes and interventions used within the organisation were meeting the needs of people with LTC/PPS against IAPT best practice standards**.**

> How well is the organisation performing against National IAPT standards in working with LTC's?
>
> Do we know how other IAPT perform if not how do we gain access to this information to benchmark?
>
> What are the best practices for improving access to psychological therapies for people with LTC?
>
> How far is the organisation meeting these standards of performance?
>
> What improvements are needed to improve performance standards for working with people with LTC/PPS?

What are the existing strengths and are there any obvious weaknesses?

What would be the specific plan for [redacted] to able to implement needed improvements?

How well were your needs as a client met?

Lumka provided me with information and framework to understand our provision for people with long term needs. Lumka then helped the service develop appropriate and effective interventions.

Please comment on the consultant's professionalism, enthusiasm for project and meeting deadlines etc.

Lumka has always been very professional and a very good and enthusiastic advocate for the project. Lumka has reflected on her timekeeping and the role of perfectionism in her work.

Signature Date

Survey Results

Piloting prompting questions for identifying Comorbid LTC/Mental Health during Initial Assessment

Analysing the survey results

Question 1

How helpful was using Prompt LTC questions and information on Ref page during initial assessment.

75% of respondents rated the questions as moderately helpful

25% rated the prompt questions as very helpful

Question 2

How helpful was using the prompt questions during the initial assessment

100% rated the use of questions as moderately helpful

Question 3

Did it help you in making decision about the client

75% rated prompt question as moderately helpful in making decicions

25% rated it as very helpful

Question 4

Has it increased your awareness of the implications of Comorbid/LTC client and treatment options available?

50% rated the use of LTC prompt questions Ref page as moderately helpful

50% rated this as very helpful

Question 5

Is there anything would change about the questions to make this process more helpful

100% answered no -All respondents said they would not change anything about the questions

Question 6

How helpful were the questions in helping to make the decision about the client

80% moderately helpful

20% very helpful

Question 7

How helpful was using prompt questions and information on ref page in increasing your awareness of the implications of comorbid LTC clients and treatment options

Question 8

Teaching and Training Competency

Case Study 1: MSc Health Psychology students

Introduction

For the completion of the teaching competency I reflect on my experience with a workshop with MSc students at City University. I was given an opportunity to deliver some workshops to health psychology MSc students on the behavioural medicine and long-term conditions modules. As part of my role as the Champion for long-term conditions in an IAPT service, I have worked with people with long-term conditions and have been involved in compiling pain management programmes as well as facilitating group therapy both in IAPT and secondary outpatient services where there is an emphasis on the use of the multidisciplinary team. I have been involved in training, mentoring and supervising others in this area. In my capacity as a trainee health psychologist, this was an opportunity to share skills from my direct clinical experience and correlate this with up-to-date theoretical knowledge in a teaching role.

Plan and design

The planning and designing the teaching programme was consistent with the aims of the course objectives of behavioural medicine and long-term conditions. In planning, I considered the topics already taught in the module which indicated the pre-requisite information including a course I had already delivered as a workshop to this group of students. In line with the objectives of this course, I planned content and learning objectives so that the students could gain skills and knowledge for working with people with persistent (chronic pain) and be able to critically evaluate research.

It was also important to familiarise them with evidence-based practise related to this area of working with long-term conditions. Teaching in health professions involve being familiar with the subject as well as evidence-based practice e.g. NICE guidelines and best practice in the area. The plan and content was sent to the course director and was approved. The programme was planned and designed to ensure that the learners would be able to appreciate how psychological knowledge and theory are applied in a different context for pain management programmes. It was also an opportunity for the students to appreciate how health psychologists in practice correlate theory and practice in pain management. In this planning, I drew on a range of health psychology theories and NICE guidance so as to give student relevant and current knowledge in the field. The dominant theory and model used was the cognitive behaviour model.

The learning objectives

The aim of the course was for student to have a general understanding of long-term conditions and its management (course code HYM006). The following were learning objectives of the session:

- To have a critical understanding of historical trends that informs our understanding of pain
- To evaluate current research and evidence on pain management
- To critically evaluate trends and psychological approaches to pain
- To contemplate about the role of health psychology in pain management
- To develop an awareness of current pain management interventions
- To develop an awareness of assessment tools in pain management
- To critically analyse the issue of measurement in pain management

- Understanding pain mechanisms
- To differentiate between acute and chronic pain
- Awareness of different approaches to pain management

Delivery and approach to teaching

As a reflective practitioner, it was important to utilise feedback from these previous experiences in my planning to improve future performances during the teaching-learning process. Therefore, I was able to approach this workshop with confidence and awareness of my strengths and weaknesses. In preparing for this workshop, I was drawing on feedback given previously by the same group of MSc students. This presented an opportunity to reinforce good abilities and reflect while improving on areas of weakness using suggestions from previous feedback. One of the important feedbacks from my last lecture on HIV/AIDS, students commented positively about my teaching abilities, but they also asked me to add more information on the views of service users in the NHS. I had therefore researched and included stories and experiences of recovery and planned to inform students about useful websites for pain management. The plan for teaching, therefore, involved a variety of methods and approaches to familiarise the students with a range of knowledge and skills in the field of pain management. There was a mixture of lecture presentations with slides and planned group activities.

As pointed out by Moore, (2010) competency in teaching requires knowledge of the subject matter, as well as a thorough understanding of the learning and teaching processes. These tasks and processes include a good alliance with the learners. To promote this good alliance, I became aware of the strengths cited by students in their feedback of being ‘objective and non-biased’. This awareness gave me the confidence to go round the lecture room when they were busy with their group work to talk to each group and some individuals. Race (2014) contends that it is important to create a friendly accepting environment when teaching. As this was a small group, I was also able to respond to their personal questions individually during the rounds.

During the workshop, I also reflected both on my style of teaching and learning and took into consideration the different styles of learning for students as described by Kolb (1984). To put this in context, I adjusted my teaching by giving practical examples of how the theories of pain management were understood and implemented in real life situations using case studies in hand-outs. I showed live videos with personal stories of how people had experienced attendance at the pain management programme. I also showed them an example of reflections from patients from one of my group. Equally various philosophical approaches to teaching and learning were applied during the workshop. These approaches included the use of activities in social interactions so that less knowledgeable students could learn from others. In order to do this I asked the students which of them had experience of working in pain management, however there were very few wit this experience so collaboratively we decided they would each join the two groups with the less experienced students. These also encompassed Kolb's (1984) experiential learning theory and learning styles.

Consequently these approaches demanded a skilful engagement that allows students to be interactive; therefore, my style was both collaborative and facilitative. Correspondingly I adopted an inclusive approach during the teaching, which involved asking students to draw on their experiences. Through this sharing of practical ideas, the teaching accommodated the 'pragmatists' those who learn best by trial and error or by doing. Alike I made sure that 'reflectors' were contained within this teaching and learning process by having scenarios and videos for students to watch and reflect. The workshop included presenting theoretical explanation and drawing on historical trends of pain management to allow the teaching to be inclusive of those described as ‘theorists’ I sensed that this use of groups and pairing, as well as lecturing, could have benefitted all learners as I believe that learners do not categorically use one style of learning.

Moreover drawing on Vygotsky’s theory of social development these approaches were used to allow an opportunity for the learners to construct their knowledge from different perspectives. This theory is located in social constructionism and contends that students are not passive in the learning process. It, therefore, stresses the importance of facilitating the learning process so that students can construct their knowledge. With these notions in mind, I allowed an interactive approach which also acknowledged their existing skills and knowledge. Consequently, this firmly positioned me as the facilitator of the learning process which helped devolve both power and responsibility for knowledge construction. I felt comfortable during this workshop as these skills come naturally for me.

It has been suggested that strategies which actively encourage engagement during the teaching process are better at developing critical thinking than the traditional lecture method (Bonwell & Eison, 1991). All students were able to share their reflections after watching a video which created interesting debates and different perspectives. As it was a small group, I asked them to discuss their views on pain management in pairs, and then shared and debated their views the bigger group. One of the challenges during the delivery of this workshop was the lack of clinical exposure of the students to this area of health psychology practice. The lack of exposure was apparent in the content of group work and debates. This made it harder for them to have an appreciation of the roles and functions of a health psychologist in this area. This awareness was helpful as I was able to be more flexible and moderate my pace of delivery to accommodate the students. I presented some of the information using the lecture method and gave students references for continuing learning. My goal was to increase their motivation and interest in this area of health psychology. A summary of teaching approaches and materials used is presented in Table 1, and a sample of lecture slides are attached in Appendix A.

Table 1.

Summary of teaching methods/approaches and materials used

Methods and approaches	Teaching materials
Videos with examples and experiences of service users and their opinions	Powerpoint slides used to give the presentation using lecture method and references for continuing development
How pain is viewed in different contexts and cultures so that they can be familiar with working with service users across cultures and nationalities	Flip chart paper used during the group activity
Different experiences of service user view in the NHS on what is available	Photocopies of case studies
Group work and exercises	Projector with internet to show YouTube videos

Evaluation

For this teaching, a cyclic approach of needs assessment, delivery including the teaching learning process and evaluation was adopted. The learning needs and objectives were consistent with what was specified and required for the course (HYM006-2016-17) at City University. The content and its relevance to the health psychology students, including appropriate approaches for delivering the workshop were discussed with the course co-ordinator during the planning. A cyclical approach to evaluation was adopted, using an adapted model of this approach is presented and explained below as Adapted from Cox & Harper's (2000) (see Figure 1).

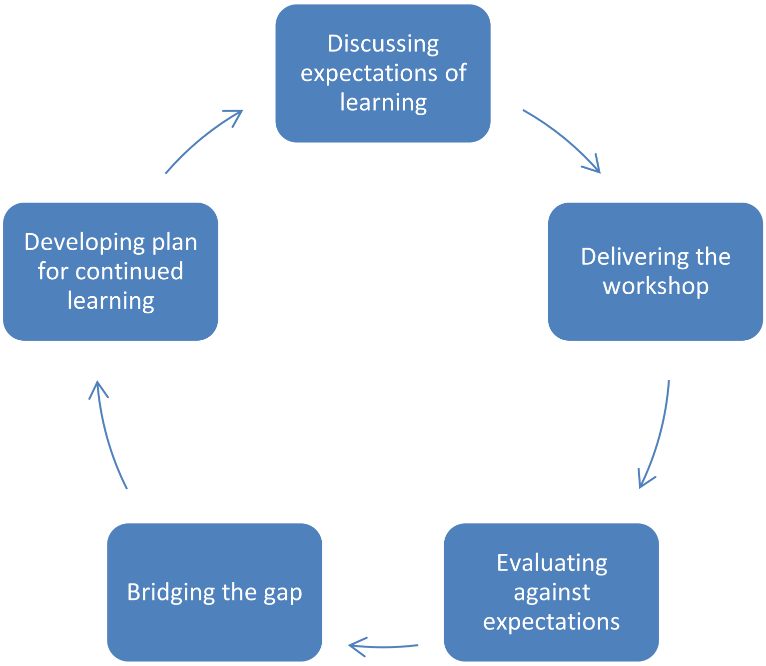


Figure 1. *Adapted cyclic approach for evaluation (adapted from Cox & Harper, 2000)*

In designing and delivering this workshop, I had already learned about my strengths and weaknesses from my previous workshop with the same group of students. This previous experience prompted me to keep the evaluation and expectations of the learners throughout the process. Still an informal assessment of student's expectations was carried out at the start of the lecture so that students were also included in this process. Unfortunately, it was a very small group of students who did not have much expectation; the only expectation was for them to find more about chronic pain. This involved an interactive approach of grouping students into pairs to discuss what they expected from the lecture on chronic pain. This information was then shared with the whole group and collated on a flip chart to be reviewed at the end of the lecture.

The previously discussed expectations were discussed and evaluated creating useful debates and bridging gaps where applicable. Towards the end of the workshop one of the students asked about pain related to Medically Unexplained Symptoms (MUS) also known as persistent physical symptoms (PPS) and approaches related to these. I realised that I was not adequately prepared for this question and, in hindsight I should have done more research on this pertinent area and included this content in my workshop. I learned from this omission of an important aspect of teaching about pain to psychology students. Since that challenging question I have researched and learned more about persistent pain related to these conditions and my teaching in the future will be more informative. However the aim of this approach to evaluation was to demonstrate that learning and teaching is not a static linear process and that this particular workshop would not give students all the answers but rather a continuous process of learning and adapting knowledge (Cox & Harper, 2000). Consequently, we discussed future opportunities for continuing development in this field including some useful references and credible websites in pain management which were shared with students during the workshop.

Reflections

The workshop created an opportunity for me to reflect on the use of teaching and learning styles as well as previous feedback from the same group of students. My overall opinion was that the delivery of the workshop went well; I was able to give them more live case studies as they pointed out in their last feedback. I felt that this use of case studies on paper and videos made sense as most of the students did not have any practical experience in this field. I found using examples from my direct clinical experience with clients with chronic pain helpful and equally meaningful for learning.

One of the challenges for me was having a much smaller group, than previously. I often find smaller groups too intense and more intimidating than bigger groups. In my experience and role, I feel more inspired when I speak to bigger groups. I often experience bigger groups more at a distance and therefore less anxiety provoking. However, this did not affect my confidence, and the feedback from the group was positive as indicated in the evaluation form. The new learning for the future is to acquire skills for both small and big groups during training and teaching. I also had an opportunity to get feedback from my supervisor who was observing during this workshop. My supervisor was happy with how I managed and handled the question (See feedback on Appendix B).

Case study 2:

Training and Teaching Healthcare Professionals

Introduction

As Champion for the long-term conditions (LTC) in IAPT which in this context, forms part of the roles and responsibilities of Health psychologists; part of this role is to improve competencies for the IAPT team to be able to work with people with anxiety and depression who also have co-occurring physical health long-term conditions including functional syndromes/ medically unexplained symptoms (MUS) that comes along with persistent physical symptoms. Long-term conditions (LTC) also commonly spoken of as chronic illnesses, refers to those medical conditions that cannot be completely cured but can be managed to improve people's health and quality of life (IAPT, 2014). The most common long-term conditions seen in IAPT include cardiovascular diseases, diabetes mellitus, chronic obstructive pulmonary disease (COPD). These persistent physical symptoms (PPS) include fatigue and chronic pain. In this case study these are referred to as LTC/PPS. I was responsible for designing and delivering training for practitioners to build their knowledge and skills in working with people with long-term conditions. In my capacity as Health Psychology doctorate trainee, I already possessed the expertise including psychological theories needed in this teaching role. Alongside psychological theories knowledge: health psychologists are trained in behaviour change techniques including skilful use of feedback and goal setting to support clients make helpful behaviour changes to improve their health. Therefore, as an accredited CBT therapist, the role of supporting and training other psychological therapists was seen as suitable. With health psychology theories and knowledge of LTC/PP's I was able to add value to their already existing skills, to support people with physical health problems and LTC/PPS are appropriate.

Plan and Design

This planning recognised that therapists working with people with physical health conditions require a different set of skills and competencies as identified by experts in this field of health psychology (Rimes et al; 2014). In preparing for this workshop I read the IAPT guidelines thoroughly in order to understand its implementation and also researched to understand the commonly found LTC/PPS accessing IAPT. Part of this objective is to improve assessment and accessible referral pathways for people LTC/PPS to IAPT during initial assessment (IAPT, 2014). To achieve this goal psychological therapy practitioners conducting the assessment need to understand the criteria for working with LTC/PPS in psychological therapy. These include having some knowledge into the different LTC/PPS as defined above. In this case study I reflect on one of the workshops I conducted during my health psychology training.

Assessing learning needs

There was no formal learning needs assessment carried out before this workshop; in my role I identified that the assessment proforma did not have any questions for assessing psychological needs for people with LTC/PPS accessing the service. However, a brief assessment of learning needs to identify the knowledge and skills needed by the psychological practitioners assessing and working with people with LTC /physical health was carried out at the start of the workshop. The participants in the workshop were divided into small groups and given flip charts and pens to summarise their needs. Their learning needs were summarised as below:

- To understand what these long-term conditions are
- How to identify if people have LTC during assessments
- Understanding the mechanism of pain
- Understanding COPD

- Understanding Cardiac conditions
- Understanding Diabetes Mellitus

The current workshop met the first two objectives in terms of the content, and plans were later made to meet the other needs as part of continuing professional development for the psychological therapists. The workshop aimed to improve assessment and care pathways in the IAPT service. The content of the workshop was consistent with goals and objective set up in the IAPT (2008) long-term conditions positive guide. The IAPT guide highlights the advantages of psychological services for people with LTC with co-morbid anxiety and depression. Equally the guide recommends practice standards for improving access to these services in primary care (IAPT, 2014). As part of this undertaking, the workshop aimed to improve the IAPT psychological therapist's competencies in identifying and carrying out initial assessments for clients who present with comorbid long-term physical/ health conditions (LTC) and mental health/depression and anxiety. The intention was to help practitioners make informed decisions about allocating patients who present with comorbid LTC/depression/anxiety and allocate to appropriate care pathways and available options for LTC.

Delivering the training

The workshop was delivered to a group of forty-three (43) psychological practitioners who included psychologists, assistant psychologists, PWP's, counsellors and High intensity trained CBT therapists working in IAPT. The presentation was planned for one and a half hour (90minutes) in the afternoon. The planning of time was done in advance for all the workshops as it was important for them to set time aside for continuing development. The role of teaching and training of health care professionals in this context requires a comprehension of competency-based education (CBE). Regarding this workshop, this meant identifying prior knowledge as well as skills and attitudes needed by the psychological therapies in engaging clients with LTC during the assessment (Frank et al., 2010). The health care practitioners in IAPT are trained in Cognitive Behaviour Therapy (CBT) for anxiety and depression (NICE, 2009) and in the treatment of MUS (Rimes et al, 2014) As this was a big group and lots of information to be presented, most of the information was presented using slides and lecture method (a sample of slides are presented in Appendix C). There were benefits to using the traditional lecture method as it helped to cover more information in the groups. I was also confident with the use of slides and technology which included using the projector and power point. My slides were well written, as I chose a font and size that was easy to read. Despite criticisms of the traditional lecturer methods, it can still benefit large groups where common updates and sharing of new ideas is necessary (Race, 2014).

However as this was a big group I felt the need to break from the traditional lecture approach, I divided the group into four small-groups and gave them a task to identify what knowledge and skills they already possessed for assessing clients in IAPT. The second question was to identify what extra skills and knowledge they needed. The use of the groups was an attempt to involve the therapists in the learning-teaching process and to recognise their needs and motivation as health care professionals in this aspect. In recognition of Knowles's assumptions about adult learners, this approach acknowledged their experience and existing skills and competencies. According to these assumptions adult learners are self-directed and often motivated when learning is relevant to their needs, this could either at work or in life in general. It was helpful to keep in mind during the training that as psychological therapists were used to working as autonomous, independent practitioners in health care. In the workshop I did not need anybody for help in facilitating the group work. The activity boosted their motivation and seemed to have directed the learning to what they were already doing in their practice in IAPT and what they wanted to know to improve their practice (Knowles, 1984). This was obvious in their needs assessment as they highlighted what they were doing well in assessing clients. Equally the activity was consistent with approaches in competency-based education as it was meant to emphasise the abilities they already had for doing the assessments and also highlights gaps (Frank et al., 2010). The discussion was about what would be the relevant questions and information to gather the in order to allocate patients presenting with both LTC/PPS including anxiety and depression.

Evaluation

Following the workshop good practice LTC Prompting question were added on the current initial assessment document under the heading *Identification of problem as 2.4 of the assessment* (See Appendix D). After two weeks following the workshop which started 24th November to the 8th of December 2015 the psychological practitioners were asked to use this new version of the initial assessment to test out if it would improve assessment and decisions about Comorbid LTC and Mental Health in IAPT/[redacted].

At the end of two weeks feedback was collated through Survey Monkey. All respondents said they would not change anything about the questions. The limitation of this evaluation was a low participation rate in the survey, which could have affected the power of the survey responses. However, this was the first time that LTC prompt questions were included in the initial assessment protocol at this IAPT, and therefore there was no comparative data or benchmarking for this survey. During the evaluation, the psychological practitioners identified further learning needs to prepare them to work with LTC/PPS in IAPT.

Reflections

As this was one of the first workshops in my role, it made my role as health psychology more visible in IAPT. Psychological practitioners consulted me more for expert advice on working with people with LTC and referred more clients to our existing LTC groups and face to face individual CBT therapies more complex presentation who could not take part in our groups. I felt more confident in my role and my abilities for carrying out health psychology consultations within the team and outside with other physical health teams including GPs. However, as a reflective practitioner, I was able to identify my limitations in my professional knowledge and scope of practice. Following the workshop, I discussed the feedback in supervision identifying both strengths and weaknesses. In collaboration with my manager, we implemented strategies for closing these gaps in knowledge and expertise by inviting experts in the field to collaboratively deliver other courses with me. We also identified opportunities for continuing development in the role. In hindsight I think I would have been more informed in my planning and preparation of the content if I had prepared a questionnaire and assessed their needs before the workshop. I also felt that the time scale to test the usefulness of the questions was to short and could have added a longer follow up after the initial two weeks follow up of at least three months. The supervisor’s report for this competency is attached in Appendix E.

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Appendix A: Teaching Slides

Appendix B: Student feedback summary

On a scale of 1 (would not recommend at all) to 10 (would definitely recommend), how would you rate the:	
Content of the lecture	8 out of 10 rated content as good
Presentation skills of the lecturer	8 out of 10 rated the presentation as good
Slides of the lecture	7 out of 10 rated the slides as helpful
Quality of reading materials recommended	7 out of 10 rated the reading as complementary to the lecture
Relevance of the lecture to the module	The content of the lecture was relevant, but would appreciate NHS cases to contextualise pain management rather than those outside the UK
Please use this space for any other comments: Lecturer was unbiased and had a good knowledge of pain management especially internationally with good cultural examples but more local knowledge e.g Fibromylgia A recommendation of other approaches either than CBT would be appreciated We would like more comfort breaks	

Appendix C: Training Slide

Appendix D - Evaluation of training: Results of Survey Monkey

Survey Results

Piloting prompting questions for identifying Comorbid LTC/Mental Health during Initial Assessment

Analysing the survey results

Question 1

How helpful was using Prompt LTC questions and information on Ref page during initial assessment.

75% of respondents rated the questions as moderately helpful

25% rated the prompt questions as very helpful

Question 2

How helpful was using the prompt questions during the initial assessment

100% rated the use of questions as moderately helpful

Question 3

Did it help you in making decision about the client?

75% rated prompt question as moderately helpful in making decisions

25% rated it as very helpful

Question 4

Has it increased your awareness of the implications of Comorbid/LTC client and treatment options available?

50% rated the use of LTC prompt questions Ref page as moderately helpful

50% rated this as very helpful

<u>Question 5</u>

Is there anything would change about the questions to make this process more helpful

100% answered no -All respondents said they would not change anything about the questions

<u>Question 6</u>

How helpful were the questions in helping to make the decision about the client?

80% moderately helpful

20% very helpful

<u>Question 7</u>

How helpful was using prompt questions and information on ref page in increasing your awareness of the implications of comorbid LTC clients and treatment options

<u>Question 8</u>

100% - NO

All responded said they would not change anything about the questions

Limitation

There was a low participation rate, and this could affect the power of the survey responses

This is the first time that LTC prompt questions have been added to the initial assessment protocol at GTT T and therefore there was no comparative data or benchmarking for this survey.

However, since the information and LTC prompt question were presented there has been a slight improvement in how clients are allocated to the LTC groups.

Staff has been coming forward for expert LTC help and referring clients for LTC 1-2-1 CBT

Appendix E

Supervision Plan – Teaching and training

Area of competence	Area of practice	Supporting evidence to complies	Changes
Teaching and training **Teaching** **Case Study 1** Title of workshop: Pain management Plan and Design Training Programmes That Enable Students to Learn About Psychological Knowledge, Skills and Practices Assess training needs Evaluate teaching and training	Target Group: University Students MSc Health Psychology Description of work: Delivering lectures on Long-term conditions To deliver lectures in the Behavioral Medicine Course (PSM407) on topics which include Pain and other Long-term Conditions e.g. HIV/AIDS at City University to MSc Health Psychology Students.	Supporting evidence Case study reports describing the process and personal reflections teaching and training Case-study – 2000 words	
Casestudy 2 **Setting IAPT** Training of health professionals to improve competencies for working with people with LTC/PPS	Target group Cognitive Behaviour Therapist (CBT), Psychological Wellbeing Practitioners (PWP's), Counsellors, Clinical/Counselling Psychologists working in IAPT	Case study – 1000 words Practice log	

Appendix F: Supervisor's report

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Professional Doctorate in Health Psychology

Supervisor's Report

Trainee Details:

Name: Lumka Tutani

Supervisors: Dr Clare Eldred

Competence: Teaching and training

Views on the Trainee's Competence

[redacted]

[redacted]

Declaration

I verify that the above named trainee has undertaken the above mentioned competence. I am of the opinion it has been completed to a satisfactory professional standard.

Signature:

Date: 24/12/2018

Unit 3: Behaviour Change Intervention

Introduction

In the field of health psychology, behaviour change interventions are designed to work with individuals, families, and populations, for encouraging healthy behaviour patterns to improve quality of life in different contexts and situations (Michie, et al ,2013). In this portfolio a report on how an assessment and treatment were carried out using evidence-based Cognitive Behaviour Therapy (CBT) interventions alongside health psychology models and behaviour change interventions during face-to-face sessions for a client who suffered from both mental and physical health problems.

Contribution of health psychology to behaviour change interventions

The development of behaviour change science has broadened in applying various approaches which include health psychology theories and their constructs to contribute to current behaviour change interventions. Of relevance to these developments was the implementation of the behaviour change wheel (BCW) and theoretical domain framework (TDF) (Michie, et al; 2011). Located at the centre of the BCW is the COM-model, and more importantly the outer wheel consists of behaviour change techniques.

At the heart of these developments is to help practitioners in various contexts choose appropriate theory and evidence-based interventions to use in behaviour change interventions. The importance of the "content and context" of behaviour change interventions including the competencies of those who deliver them has been emphasized (Michie, et al; 2013). These notions have relevance for the choice of health psychology model for use in implementing behaviour change, as these has been recommended for maximising effectiveness in interventions (Davis, et al; 2015). Health psychologists work in different contexts which include public health, scholars, and NHS. In the last 10 years these has increased to include IAPT.

The COM-B model is a relatively new model for understanding behaviour change developed by experts in behavioural scientists. According to this model there are three conditions that are needed for behaviour to take place, these are, Capability, Opportunities, and Motivation. In this model, firstly capability requires the practitioner to assess whether the individual has both physical and psychological ability for performing actions for engaging in behaviour change as needed, secondly, the model considers the availability and accessibility of opportunities for the change to take place and the third aspect is assessing whether there is enough motivation and drive to engage in behaviour change intervention for the client (Michie et al; 2011). The COM-B model has been used in practice at individual level for instance Asmakopoulou & Newton (2015) demonstrated how it can be applied successfully in dental hygiene, likewise Barker et al; (2016) applied the model to improve collaborative interventions between audiologists and their clients in the use of hearing aids. This model has been criticised for lacking an important construct of ‘want’ which acts as a strong motivator for the behaviour to take place and thus closing the gap between intention and behaviour (Marks,2020). Recently the model has been improved and its principles applied for behaviour change interventions for preventing the spread of Covid-19 to improve behaviours for personal protection (West et al; 2021).

In IAPT there are numerous opportunities for health psychologists to use their skills and knowledge including working with patients face to face, groups, and improving skills and knowledge for other psychological therapists in behaviour change interventions specifically with people with long term conditions and persistent physical symptoms (LTC/PPS). The BCW provides a helpful guide from which health psychologist can choose when working with patients and other professionals in training and teaching to improve skills for working with long term conditions and persistent physical symptoms with comorbid anxiety and depression (LTC/PPS).This include on the most prominent BCT's like training, education and enablement used with contextual sensitivity (Michie et al,2011).

In this section I will describe a few of the social cognitive models that could have been considered in developing this behaviour change intervention. The Transtheoretical model (TTM) also known as the stage model has been postulated to offer flexibility in encouraging individuals to change behaviours, TTM helps in assessing readiness for change through its stages of precontemplation, contemplation, preparation ,action ,maintenance including relapse which is used to support therapeutic gains and prevent re-occurrence (Prochaska & DiClemente 1983). The stage theory has led to the development of the popular use of the Motivational Interviewing (MI) style of counselling (Rollnick & Miller,1995; Rollnick et al 2008) applying the stages of readiness and has been successful with smoke cessation (Lai, et al; 2010) and in reducing alcohol addiction (Rollnick et al ; 2008). According to this theory self-efficacy is viewed as relatively low during the initial stages of change and increases in later stages. Through the theory practitioners uses the strategies to activate processes of change for the client which are both experiential, and behavioural. Alongside other social cognitive models (SCM) which have been criticised for their focus on psychological processes, a reductionism that can lead to other important mechanisms of action that are outside of the theoretical framework being left out, for instance behavioural processes which include avoidance of physical activity as was the case with my client (Luszczzynska &Schwarzer, 2020). The TTM However, is therefore criticised for not being effective in enhancing interventions (Moore and Evans ,2017) and therefore, was not chosen for this intervention. The Implementation Intention Theory (IIT) was equally relevant and compatible with this BCI in its the application of goal planning. As a theory of motivation, IIT focuses on ensuring goal achievement through ensuring that people can successfully utilise opportunities available to them, using intentional self-regulatory actions (Gollwitzer & Sheeran, 2006).

In this intervention, there was a need for a theory with constructs that have been used effectively within in the field of pain management alongside CBT. The Social Cognitive Theory (SCT) was seen more applicable together with its constructs of self-efficacy and outcome expectancies (which have been described in Chapter 2 / research section of this portfolio). The strength of integrating SCT was that it has been used successfully with most applicable BCT's, for instance prompting barrier identification, information giving, goal planning in the development of self-efficacy and use of graded tasks for pacing activities (Luszczynska & Shwarzer, 2020). Other relevant BCT's during this behaviour change intervention was prompting intentions and setting small achievable goals and encouragement (Michie et al ,2013) given the client's low confidence as reflected in her self-efficacy scores as shown below.

As part of this complex intervention, it was important to choose behaviour change techniques that would support interventions for both physical and psychological difficulties while improving both engagement and adherence to treatment. Michie et al (2013) stresses the importance of making explicit the behaviour change techniques used especially when conducting complex intervention so that they can be easily replicated. The client presented with a complex presentation of co-occurring physical and psychological difficulties incorporating behaviour change techniques was needed to improve the effectiveness of the interventions.

Assessment and formulation

Presenting problem: (RD) who was thirty-nine years old (not her real details) was referred by her General Practitioner (GP) to our local (IAPT) services for an assessment for suitability for CBT. RD had been attending GP surgery for persistent pain and other physical symptoms. The GP had noticed low mood and anxiety alongside these physical symptoms. The guidelines for National Institute for Excellence (NICE) recommends CBT for anxiety and depression (Clark, 2011) and, there is growing evidence for the effectiveness of CBT in managing other physical health conditions including pain (Morley et al.,2013). This referral was therefore appropriate for the IAPT service. RD spoke extraordinarily little English, and therefore an interpreter was arranged for the assessment and subsequent therapy sessions.

Predisposing factors: Following a thorough interview with the help of an interpreter; RD reported a history of harassment and coercion, financial and emotional abuse which happened during an intimate relationship. In addition to this trauma, related violence she had incurred losses linked to her immigration status and was unable to work and not qualifying for any financial benefits.

Outcome measures used to gain baseline information

In the IAPT, routine outcome measures are used during assessment and throughout therapy to monitor progress as previously discussed in this portfolio. These outcome measures have been proved to have reliability and validity across a wide range of anxiety disorders and for depression (Clark et al; 2009). The questionnaires chosen for this behavioural intervention are well-validated self- reports measures used to gain a thorough comprehension of the co-occurring mental health disorders and chronic pain. The following questionnaires were used:

Patient Health Questionnaire (PHQ9) used to assess depression on a scale of 0 -27 in which a score of 10/27 indicates caseness for depression (Kroenke et al; 2001).

Generalised anxiety scale (GAD7) was used to measure the severity of anxiety. The GAD7 also uses a scale of 0-21 and has a cut point of 10 representing caseness (Spitzer et al; 2006).

To assess for PTSD the **Impact of Event Scale-Revised (IES –R**) (Weiss, 2007) was used. This scale measures symptoms of Post Traumatic Disorder which include re-experiencing, hyperarousal and avoidance of situations following a traumatic experience (Weiss,2007).

Work and **Social Adjustment Scale (WASAS) (Mundt et al; 2002).** As a self-report, the WASAS measures changes in adjustment socially to home and work-related activities (Birchwood et al; 1990).

The **Posttraumatic Diagnostic scale PDS (Foa et al; 1997),** this scale measures symptoms of PTSD, which are synonymous with those listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR).

Brief Pain Inventory scale (BPI) (Bann et al; 2004), this validated self–rating scale allowed RD to rate her pain experience including how much it interfered with her mood and activity levels.

Pain Self-efficacy Questionnaire (PSEQ) (Nicholas,1989) This is a 10-item scale is used to assess confidence and self-efficacy for people with ongoing pain on a range of functional and social activities

Table 1.

Summary of baseline assessment

Psychometric test	Assessment outcome	Severity
PHQ9	26/27	Severe
GAD7	21/21	Severe
WASAS	36/40	Severe
IES	58/88	Severe
PTSD (PDS)	42/51	Severe
BPI	8/10	Reporting severe pain/impact
PSEQ	18/60	Low (Score)

Formulation: RD had been attending her GP surgery constantly with a variety of persistent physical symptoms, which included pain and other physical symptoms around her face, jaw, and lower abdomen. Alongside these persistent physical symptoms RD also presented with low mood and anxiety. RD has had several medical and dental investigations which included blood tests, X-rays, and MRI scans.

During this formulation it was important to help RD make sense of the co-occurring persistent pain and her difficulties related to trauma. It was therefore important to make explicit both **perpetuating** factors that were maintaining the low mood and pain. Pain is one of the most common persistent physical symptoms in patients with PTSD. The physical symptoms of re-experiencing are related to increased pain (Otis et al, 2004). In turn this combination of pain and PTSD was leading to distress which included low mood as shown in both severe (PHQ9 and GAD7) including avoidance of situations and reduced activity, which increased the severity of pain. There is compelling evidence that PTSD and Chronic pain co-occur. A likeness in symptoms has been detected in both chronic pain and PTSD. Equally both chronic pain and PTSD have been associated with poor stress response and dysregulation of pain modulation. The co-occurrence of both conditions is associated with shared vulnerability and mutual maintenance of symptoms in which anxiety is a core symptom in PTSD (Asmundon, 2002).

Implementing Behaviour Change interventions to improve physical activities

Assessing needs using the COMB-model

Capability: In terms of capability for engaging in psychological interventions RD had physical and psychological ability despite the severe levels of anxiety and low mood including co-occurring physical problems and physical inactivity.

Motivation: RD showed both motivation and willingness to engage in CBT interventions. She had agreed to be referred by her GP and agreed to work and expressed her goals. These were motivated by her need and wants for instance in her goals she stated:

- I want to be able to feel good about myself
- I want my life back again
- I want to be able to go back to the gym and be physically active again

It was also important to understand that physical inactivity was a consequence of other contributing factors and had an impact in maintaining other safety behaviours which prevented RD from learning about her perceived fears. In summary the goals to target in the behaviour change interventions included, managing PTSD using a CBT model, improving physical activity, managing pain and adherence to medication.

Opportunities: RD had both constraints and contextual factors which included space and time for instance RD, lived in a communal house with others, sharing amenities with them because of her immigration status. Due to her psychological and language difficulties, she was also not confident to speak to others to negotiate use of space and tended to withdraw to her room when others were around which limited activity. In summary both capability and motivation served as **protective factors** and strengths during the intervention. Furthermore, there were opportunities to improve both motivation and capability through using behaviour change techniques for example through information giving and providing encouragement including helping RD engage in interventions. This comprised helping her to identify barriers that were stopping her and supporting her to be more realistic about the perceived dangers.

Implementing CBT interventions

Despite CBT having the best evidence for both PTSD (Ehlers & Clark) and PPS (Chalder & Willis, 2017), RD presented with some unique challenges which made behaviour change interventions more complex. During supervision, it was agreed that RD would be unable to benefit from attending the group pain management programme due to the complex and co-occurrence of PTSD and chronic pain including her need for an interpreter. This decision from supervision was also backed by findings that some patients with comorbid PTSD do not usually benefit from attending Group Pain Management Programmes (Asmundson et al; 2002). While most patients who present with a single disorder of either PTSD, depression or chronic pain usually benefit from a minimum of 6 – 12 of 1-hour weekly sessions during assessment and supervision we agreed that RD, needed longer sessions of 90 minutes and a minimum of 12-20 sessions due to complexity which included physical inactivity and language needs. It was decided during supervision that the priority in the first 12 sessions would be to work with PTSD using an evidence-based model by Ehlers & Clark, (2000).

There were limitations on how the CBT model for PTSD with RD could be used without modification as a behavioral change intervention due to these contextual issues which included previous experience of intimate partner violence and language barriers. RD's poor management of persistent pain which included poor physical activity was a significant maintenance factor which needed, integration of behavior changes techniques to be targeted effectively. Psychoeducation about the disorders and behaviors' which needed to be changed including normalisation of symptoms and feelings was especially useful. Other interventions and strategies of reliving, which included revisiting the scene, were not appropriate due to the nature of her trauma.

It was immensely helpful to discuss my experience and challenges of working with comorbidity during behavior change interventions in supervision. This was an important learning of working across cultures, language and ethnicity including individualising therapy and behavioral interventions for clients. I was able to seek advice and guidance during supervision on what to prioritize including which appropriate behavior interventions techniques to apply especially of overusing tablets and inactivity. I learned how to adapt usual practice to meet RD's idiosyncratic needs, psychoeducation and information giving were challenging. There were language and cultural understandings which made some of the health-related cognitions and behavioral responses more complex to work with. These challenges could have affected the quality and content both assessment and therapy outcomes. However, my experience of conducting this behavior change intervention has been rewarding despite the challenges. The experience taught me that the skills and knowledge of health psychology is invaluable and can be used flexible in different contexts.

Improving knowledge of co-occurring conditions

The first three sessions of the behaviour interventions included socialising RD to the CBT model and developing an idiosyncratic formulation. This included providing information on her difficulties with PTSD, depression, and chronic pain. Psychoeducation as a behavioural change intervention helped RD to normalise symptoms and her experience and modified some of her misperceptions and beliefs which were perpetuating her fears and anxiety (Elhers & Clark; 2000; Grey, 2007). Behaviour change techiques which included feedback and selfmotinoring behaviours were utilised to increase effectiveness of interventions. This was done through use of diaries to log her responses and to identify triggers, these fitted well with behaviour techniques of self-monitoring behaviours (Michie et al, 2013). This information was useful in helping RD to recognise the consequences of unhelpful responses and therefore appreciate the justification for the implemented behavioural interventions.

She also took a copy of the individual formulation interpreted in bold letters in her language by the interpreter to help her understand the processes that were maintaining her difficulties. Despite some of RD’s health beliefs which acted as barriers at times that needed more understanding and support her goals of gaining confidence and returning to be herself proved to be facilitators towards engagement. Working together on these goals was a major facilitator of the therapeutic relationship that developed. On reflection this success was motivated by the skilful use of integrating heath psychology theories and techniques to adapt and individualise interventions for behaviour change.

Working with safety behaviours

In line with Elhers & Clark's (2000) model of working with PTSD, the main goal of sessions four to six was to challenge avoidance behaviours which had an enormous impact on her mood and activity levels.

To reduce the re-experiencing

These sessions focused on reducing re-experiencing and safety behaviours of hyper-vigilance and selective attention identified during assessment. for RD to understand what was maintaining her arousal and reactivity could be achieved through the elaboration of the trauma memory (Elhers &Clark ,2000). The last four sessions focussed on working with negative appraisals using cognitive restructuring**.** The thought diaries were interpreted and explained during sessions allowing RD to use her language when completing them. To challenge unhelpful beliefs, caused by PTSD, socratic questioning was used during sessions to help RD discover alternative views for the beliefs (Padesky, 1993).

Goal planning to improve physical inactivity

During a collaborative attempt to clarify goals we identified that RD had health beliefs and cultural views about pain which were barriers to behaviour change and health outcomes. These were strong beliefs about taking tablets and resting when she had pain which were perpetuating her excess use of tablets and physical inactivity. To RD limited activity was part of self-protection from pain and further harm to her body. The physical inactivity was worsened by RD's fears of going out as she worried, she might meet the previous abuser. Her predictions and beliefs were discussed with her in sessions and challenged as appropriate. For RD, the difficulties related to physical inactivity seemed to have the greatest impact on her sense of self because of her previous valued activity like going to the gym. She valued physical fitness and experienced it as a loss. Behavioural experiments are a powerful and effective way of targeting beliefs and creating behaviour change during CBT interventions (Bennett-Levy et al; 2011). For RD improving physical activity became easy to measure and implement by setting small achievable goals which made her experience pleasure and a gradual improvement in her confidence. Through using behavioural experiment and goal setting there were numerous goals to achieve while also targeting some of her beliefs.

Equally, within in the SCT, self-efficacy is a key construct that correspond well with goal setting. As shown on the outcome measures, RD scored low on self-efficacy (PSEQ=18/60) and therefore to improve physical activity (despite pain), goal setting was a useful behaviour change techniques that encouraged her to walk using pacing, small achievable goals of up to twenty minutes a day both as an experiment to target her fears of going outside her house, while increasing physical activity which would also reduce her pain and improve confidence. This was agreed collaboratively, and she was able to walk to her local gym. She was incredibly happy with this achievement. As identified behaviour change techniques that specify goals makes intentions and commitment for change more explicit for the client (Michie et al; 2013).

Behavioural experiments

Behavioural experiments alongside pacing activities were also introduced as discussed. For instance, prompting intention formation through small tasks helping RD to appraise consequences for instance being realistic about the impact of inactivity, e.g. staying in bed all day which lead to pain and stiffness. She was encouraged to take short walks alone as part of introducing activities and challenging her beliefs about what might happen.

Relapse prevention

The last few sessions were focused on facilitating relapse prevention using CBT interventions including psycho-education, RD was helped to understand and identify changes in her behaviours, thoughts and mood which would indicate a relapse to a state of being unwell (Paykel, 2007; Segal et al; 2012). These sessions included reviewing goals for both cognitive and behavioural changes achieved, including identification of barriers that might hinder her progress and devising a plan for coping. RD was able to articulate how she would maintain physical activity through regular walk and had gained better understanding about the consequences of not taking medication and inactivity.

Evaluation

Progress and behaviour changes were monitored at every session both quantitatively using reliable and validated questionnaires as described above. The objective data was plotted as scores on a graph during one to one meeting in line with IAPT protocols. Qualitative data for measuring progress was also collected from subjective verbal reports, diaries and records of thoughts and behaviours from RD. It took longer to socialise RD to the CBT models, and explanations for interventions were harder to explain and simplify both due to language and complexity of presenting problems. The reports below show a summary of changes from assessment before the implementations of interventions to the last session. She verbally reported substantial progress in her mood and activity levels. The table shows pre-and post-treatment scores from the questionnaires used during the behaviour intervention. All the outcome measures show marked reduction consistent with her subjective report. There was still room for improvement in self-efficacy, but it is possible that this low score was related to other maintenance factors which included social and economic circumstances that did not change.

Table 2.

Summary of outcome measures pre- and post-treatment.

Outcome measure	Pre-Treatment scores	Post –Treatment Scores
PHQ9	26/27– Severe for Depression	6/27 – Below caseness for Depression
GAD7	21/21 – Severe for Anxiety	8/21 Mild – Below caseness for Anxiety disorder
WASAS	32/40 – Indicating severe impairment in functioning	10/40 – Good level of work and social adjustment
IES	58/88 – Severe PTSD	22/88 – Mild PTSD
PTSD	42/58 – Severe PTSD	18/58 – Mild PTSD
BPI – Pain inventory	8/10 – reporting severe pain and impact on functioning	2/10 – Reporting mild pain with an improved level of functioning in all areas
PSEQ - Pain self-efficacy questionnaire	18/60 reporting low confidence in dealing with pain	32/60- reported improved confidence in dealing with pain

Critical review and Reflections

In this section, I reflect on the interpersonal aspect during the behavioural intervention as well as learning and use of supervision from assessment to therapy endings. The assessment was at times perplexing as RD would get animated while reporting experiencing pain around the jaw and abdomen consistent with her description of persistent pain. This highlighted the difficulties of working with people experiencing both physical and mental health difficulties who are often referred to Health Psychologists. As a Health Psychologist in training I felt challenged and overwhelmed by the responsibility, but the use of supervision and referring to evidence and research as well as my previous role as a CBT therapist was helpful in giving me the confidence to work with RD. At times during sessions, RD cried as she completed the questionnaire as some of the questions seemed to match elements triggering some physical and emotional reactions. While talking about the traumatic experience, she would move from verbal to non-verbal communication using gestures and becoming very animated.

She had difficulty remembering the chronology of events, but there were certain events which she remembered clearly, and which triggered difficult emotional and physical reactions. I was sometimes finding it exceedingly difficult to listen to the extent of abuse RD had experienced in her relationship. I struggled with my own emotions of anger towards the perpetrator and sympathy for RD which at times interfered with objectivity and professional judgement, for instance, it could have been immensely helpful to debrief the interpreter as she could have been affected by the exposure to the sessions as well. Fortunately, I was able to discuss these feelings in supervision and had time to reflect on them. I was also able to carry out my professional and ethical responsibilities as required. In supervision, I was helped to identify my assumptions and strong beliefs which helped to reflect on practice.

During the sessions, I felt that the lack of direct communication due to the use of an interpreter affected the quality of engagement from the assessment and throughout the therapy sessions. On reflection, these interpersonal aspects could have affected the degree of rapport and engagement. After discussions and feedback from supervision, I allowed RD to speak directly to me to observe her affect and make my judgement to improve the rapport and engagement. We agreed that she could speak directly to me in her limited English and even to try and write her home tasks in English as she was trying to learn English at college. Making this small modification helped to improve the behavioural intervention. However, there were limitations to how this goal could be achieved as RD felt discouraged from writing and making mistakes affected her confidence. Working collaboratively with the interpreter we allowed her to use her language and had the diary interpreted. She often felt discouraged and expressed a sense of feeling disempowered by her inability to speak or write English. RD often felt that this inability was used by others and her partner to belittle her.

To conclude as a health psychologist draws on a large repertoire of theories, skills and models which help them contribute meaningfully within the multidisciplinary team in primary health care. Interventions for helping clients modify unhelpful behaviours is a sophisticated process that requires both the application of psychological models as well as understanding the active components that facilitate this change. In my role, I felt confident in my application of health psychology theories. Using behaviour changing techniques which included, goal planning for instance to achieve walking through pacing, self-monitoring, and challenging beliefs and assumptions fitted seamlessly with CBT interventions. These also worked well when holding in mind health psychology theories and their constructs during formulation.

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APPENDICES

Appendix A: Supervision plan

Setting:

Long-term Conditions Champion/Lead IAPT (Improving Access to Psychological Therapies) services NHS.

Target Group:

IAPT psychological clients with a Comorbid Long-term Condition and Mental health diagnosis

Description of work:

Working with an individual with chronic pain and Comorbid PTSD and Depression related to intimate partner violence.

Key tasks and responsibilities for meeting this competency

To meet this Behavioral Change Competency, I intend to:

Design and deliver an intervention for an individual client suffering from LTC and Comorbid Depression and Anxiety employing health psychology methods based upon evidence of efficacy, for instance adapting CBT using health psychology theories and behavior change techniques.

Supporting evidence

- 3000-word Case Study detailing the process of conducting a health psychology intervention.
- Evidence for directing implementation of intervention (Consent attached)
- Needs assessment report explaining why this particular intervention was necessary (see Appendix)
- Plan of supervision (this document)

Reflective analysis of problems that could be encountered in implementing

Appendix B: Needs Assessment Report

Context and appropriateness for health psychology

Following a referral from a General Practitioner (GP) to IAPT Long Term Conditions Health Psychology work stream, a comprehensive literature review was carried out to investigate research and evidence for the most appropriate behavior change interventions for working with a client who presented with Post Traumatic Stress Disorder (PTSD) with Co-morbid Depression and Persistent Pain related to Intimate Partner violence (IPV). The literature review included a search for theoretical explanations and needs of people who have experienced Intimate Partner Violence presenting for help in Primary Health. A referral to primary health via a GP or a Primary health care nurse is usually the first point of contact for victims of Intimate Partner Violence (IPV). IPV is more prevalent in women than in men. As described by World Health Organization (WHO), IPV is characterized by intimidating and controlling behaviors comprising of emotional, physical and sexual abuse by an intimate partner in a relationship (Van Wijk, Duma, and Mayers, 2014).

IPV is a public health problem with consequences for both emotional and physical health placing an enormous economic encumbrance on national health resources. IPV stems from patriarchal ideologies which sanction the use of power and control by men to women who are often less privileged than them economically and physically (Van Wijk et al; 2014). The most common mental health disorders associated with IPV include depression and PTSD (Iverson, Gradus, Resick, Suvak, Smith, and Monson, 2011; Stover, Meadows, and Kaufman, 2009). Emotional numbing often experienced by victims of IPV who suffer from PTSD alongside Depression and Anxiety are all associated with future victimization for survivors of IPV (Iverson et al, 2011).

Theoretical understanding of the co-occurrence of PTSD and Chronic Pain

Pain is one of the most common persistent physical symptoms in patients with PTSD. The physical symptoms of re-experiencing are related to increased pain (Otis et al, 2004). In turn this combination of pain and PTSD leads to distress which includes low mood, avoidance of situations and reduced activity, which increase the severity of pain.

There is strong evidence that PTSD and Chronic pain co-occur. A likeness in symptoms has been detected in both chronic pain and PTSD. Equally both chronic pain and PTSD have been associated with poor stress response and dysregulation of pain modulation. The co-occurrence of both conditions is associated with shared vulnerability and mutual maintenance of symptoms in which anxiety is a core symptom in PTSD (Asmundon, 2002).

As Health Psychologist in training, this will include the use of specialist psychological assessments based on knowledge and frameworks of health psychology including knowledge of LTC based upon the appropriate use, interpretation and integration of complex data from a variety of sources including psychological tests, self-report measures, rating scales, direct and indirect structured observations and semi-structured interviews with clients, family members and others involved in the client’s care if necessary used in IAPT.

The Behavioral Change intervention included adjusting and refining psychological formulations to include knowledge and skills of Health Psychologists for individuals with LTC, drawing upon evidenced based explanatory models. In accepting to work with RD I had already noted during the assessment that there were other health behaviors and health beliefs for instance her inactivity was motivated by these beliefs.

Appendix C – Consent – Removed

CITY UNIVERSITY
LONDON

Department of Psychology

City University
Northampton Square
London EC1V 0HB

Professional Doctorate in Health Psychology

Supervisor's Report

Trainee Details:

Name: Lumka Tutani
Supervisors: Dr Clare Eldred

Competence: General Professional

Views on the Trainee's Competence

[redacted]

[redacted]

Declaration
I verify that the above-named trainee has undertaken the above-mentioned competence. I am of the opinion it has been completed to a satisfactory professional standard.

Signature: **Date: 24/12/2018**