MICHAEL T SWIFT

PROFESSIONAL DOCTORATE IN HEALTH PSYCHOLOGY

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Abstract

Michael Swift, Professional Doctorate in Health Psychology, 2024

This portfolio documents the work I have completed whilst completing the Professional Doctorate in Health Psychology at Staffordshire University from 2020 to 2024. Throughout this period, I my placement consisted of full-time employment in two professional settings. Initially, I was employed at a private psychiatric clinic in the West Midlands until June 2021. Afterward, I joined an occupational health organization, where I worked full-time until I completed my doctorate in June 2024. These roles gave me exposure to a variety of public and private organizations, offering opportunities to develop all the competencies required to meet the doctoral degree requirements.

The portfolio is structured into five chapters, each focusing on one of the core competencies of the Health Psychology programme:

1. **Professional Competence**
2. **Advanced Research Methods**
3. **Psychological Interventions**
4. **Teaching and Training in Health Psychology**
5. **Consultancy Skills**

Within each chapter, I include evidence of my professional development through research papers, case studies, and reflective commentaries. These documents highlight the projects I have undertaken and the expertise I have developed during my doctoral journey. More detailed descriptions of each chapter's contents are provided in the introduction.

Introduction

This portfolio documents my journey through the Professional Doctorate in Health Psychology at Staffordshire University, which I completed between 2020 and 2024. My training began six months into the first COVID-19 lockdown, and the pandemic significantly impacted my placements and the development of my competencies, particularly during the first 12 months. This period required an ongoing awareness of and adjustments throughout my training.

My initial placement was at a private psychiatric clinic in the West Midlands, where I remained until June 2021. Before starting the doctorate, I worked as a Cognitive Behavioral Therapist at the clinic and adapted my role to include health psychology training. My responsibilities included managing a caseload of individuals with anxiety disorders, long-term health conditions, and insomnia, as well as developing the clinic's health psychology service. I also worked on consultancy projects and teaching opportunities with external organizations, eventually taking on a more directorial role leading a team of therapists and assistant psychologists.

In June 2021, I transitioned to a full-time role with Working Minds UK, an occupational health organization where I continued to focus on psychological interventions related to health anxiety, long-term conditions, and behavioral management. I oversaw several consultancy projects, including psychological surveillance programs and employee satisfaction initiatives, and led the health psychology direction within the organization. In both placements, I was the sole professional with a health psychology background, which allowed me to integrate health psychology principles seamlessly into the services and multidisciplinary teams.

Chapter 1: Professional Competence in Health Psychology

This chapter consists of a reflexive report on my professional development as a Health Psychologist over the three years I completed the doctorate programme. The first section of the report focuses on the core competencies required to be a Health Psychologist. The second section highlights how I developed a range of key professional skills as outlined by the British Psychological Society (BPS) and the Health and Care Professional Council (HCPC). These skills include communication, development and maintenance of legal, ethical, and professional standards, understanding organizational and systematic issues, service user and carer involvement, teamwork, providing advice and guidance to others, and personal development and continuing professional development (CPD) as a health psychologist. The chapter was written with supplements from my weekly and monthly reflections, which formed the basis for my reflexive analysis.

Chapter 2: Advanced Research Methods

This chapter presents the three research projects I completed during the programme. It begins with my systematic review, which explored the effectiveness of third-wave psychotherapies for treating illness anxiety disorders and somatic symptom disorders using a narrative synthesis. It then details my quantitative project, which investigated perceptions and the perceived acceptability of various modalities of talking therapy (face-to-face, online video, text, telephone) before and after the COVID-19 pandemic, employing a retrospective survey that asked participants to share their likelihood of using these modes before and after the pandemic. Finally, the chapter includes my qualitative project, which utilized interpretative phenomenological analysis (IPA) to explore the experiences of psychological support among individuals with type 1 diabetes. Each research project is accompanied by a reflective commentary outlining the initial scoping and development of the project, the rationale behind my research decisions, and reflections on my experiences completing the projects.

Chapter 3: Psychological Interventions

This chapter presents two case studies that demonstrate the assessment, formulation, intervention design, delivery, and evaluation of psychological interventions I conducted during the programme. The first case study involves an individual face-to-face intervention where I worked with a client using Cognitive Behavioural Therapy (CBT) to address their symptoms of severe health anxiety. The second case study describes a group intervention aimed at improving the well-being and social functioning of individuals with ADHD, also utilizing CBT. Both interventions are supplemented by reflective commentaries that provide insight into the decision-making process and the development of my therapeutic skills throughout these interventions.

Chapter 4: Teaching and Training in Health Psychology

This chapter provides an overview of the teaching I engaged in during the programme, which included developing, planning, and delivering a series of five teaching sessions on the ‘Application of Therapeutic Techniques in Health Psychology’. These sessions, conducted between late 2020 and May 2021, catered to diverse groups such as trainee paramedics, assistant psychologists, barristers, and virtual reality therapy developers. The sessions incorporated various teaching methods, including face-to-face and online formats, and utilized a range of materials like PowerPoint presentations, handouts, case studies, and educational videos. The chapter further details the assessment and evaluation of learning outcomes through formative feedback, questionnaires, and qualitative feedback from organizers, emphasizing the importance of tailoring content to meet the specific learning needs and styles of different professional groups.

Chapter 5: Consultancy Skills

This chapter presents the consultancy project I completed with 'Psychonline,' an independent mental health startup, using Bellman's 'Ten Step Consulting Process'. The project began in December 2020 and involved developing a comprehensive self-help content area for their online platform. My role included creating a Cognitive Behavioural Therapy (CBT) workbook, psychoeducational materials, and evidence-based feedback on user experience. The consultancy process involved initial contact, contracting, development, action, feedback, and project measurement. Key stakeholders, including the CEO, CTO, and Director of Psychiatry, were engaged throughout the project. I conducted user interface meetings and developed content based on the COM-B model and health literacy principles. The project concluded successfully in April 2021, with positive feedback from Psychonline's executive team and users.

Chapter 1: Professional Competence in Health Psychology

1.1 Reflexive Report

Background

This reflexive report outlines my journey as a Trainee Health Psychologist, detailing the roles I have undertaken, the competencies I have completed, and the insights gained during my studies. My placement and work have spanned several settings and roles, each contributing significantly to my professional development.

The initial phase of my doctoral journey began with an 18-month role at a private psychiatry clinic in the Midlands, where I worked within a multidisciplinary team providing a range of psychological interventions, diagnostic assessments, pharmacological treatments, and neurostimulation treatments. As a registered Cognitive Behavioural Therapist (CBT), I provided individual and group therapy to clients with health anxiety, generalised anxiety disorders, long-term health conditions, and sleep difficulties. I also integrated health psychology services, including sleep, pain, fatigue and ADHD management interventions. In late 2021, I transitioned into a directorial role, overseeing the talking therapy service and consultancy projects. During the pandemic, I left the clinic and transitioned to an occupational health (OH) and psychological well-being organisation, focusing on mental health education, individual therapy, and consultancy services. My role emphasised leading the health psychology direction, advising on large-scale consultancy projects for employee wellness, and supporting individual clients with health anxiety, long-term health conditions, and sleep/behavioural challenges.

Throughout my roles and as a part of the professional Doctorate, I have maintained a weekly reflective diary that I have utilised as a tool for self-reflection, and professional self-development. I structured these weekly reflections by utilising Gibbs' reflective model (1988) as a framework for considering my experiences and thoughts (Fig. 1).

Figure 1. Gibbs Reflective Learning Cycle

The below information outlines my experiences and reflections on the professional skills I have developed and competencies I have completed throughout the Doctorate and is accompanied by excerpts from my reflective diary.

Professional skills:

Legal, ethical, and professional standards in health psychology and research.

I have navigated a variety of legal, ethical, and professional challenges that have shaped my development during training. These experiences have strongly reinforced the importance of adhering to the ethical guidelines and professional standards outlined by the British Psychological Society (BPS, 2009) and Health and Care Professions Council (HCPC, 2016).

In the first few months of my placement at the private clinic, I was assigned to a client who, outside the professional setting, was connected to a close friend. This scenario presented a potential for dual relationships, which could compromise the integrity of the psychological intervention and confidentiality. The HCPC highlights the importance of disclosing and promptly addressing possible dual relationships to protect the ethical and therapeutic integrity of psychological support. As this was my first experience of this scenario, I initially felt flustered and anxious, however I reviewed the internal policies, ethical guidelines and consulted with my clinical supervisory team to navigate this delicate situation (HCPC, 2016; BACP, 2018). Together, we devised a strategy that involved referring the client to another therapist within the clinic, ensuring their care remained uncompromised while upholding professional boundaries and confidentiality. This experience demonstrated the importance of being aware of and acting on the required codes of conduct, resulting in me feeling significantly more prepared handling these types of situations moving forward *(Excerpt 1).*

Whilst providing a group behavioural session for individuals with ADHD, I encountered complex confidentiality issues, particularly highlighted by a participant's concerns about privacy during the sessions. This situation made me feel nervous due to my limited knowledge of the ethical and legal aspects specific to group therapy. Prior to this experience I had not overtly considered the significant differences between group and individual therapy, which I felt exposed gaps in my understanding and training on this topic. To address these challenges, I sought guidance from a senior psychologist and developed a collaborative confidentiality agreement for the group, emphasising collective responsibility to maintain the privacy of shared information (Lasky & Riva, 2006). This agreement was crucial in fostering a safe therapeutic environment, alleviating the participants' concerns and ensuring adherence to ethical standards. This experience, whilst initially anxiety-inducing, significantly enhanced my competence in managing group dynamics and wider ethical challenges (Excerpt 2).

Finally, a novel experience surrounding the importance of ethical guidelines was in the context of my qualitative research. It was brought to my attention that I needed to complete a risk assessment for my ethics application due to the interviews with individuals living with Type 1 Diabetes. I had not particularly considered this prior to receiving this feedback and it highlighted potential gaps in my experience of applying these guidelines to research. This oversight initially concerned me as I felt I 'should have' been aware of this, however on reflection it also motivated me to enhance my understanding and implementation of these standards in my research.

It was a pivotal moment that reinforced my commitment to conducting research that prioritizes the safety and well-being of participants and was something I carried forward into my other research projects.

Advice & Guidance

There have been several instances of providing guidance and advice during my placements. Within talking therapy, ’advice’ is often dissuaded, however in a broader health psychology context can support in building rapport, developing understanding, and seeking solutions (Couture & Smoliak, 2006; Colladon et al., 2017; Sutherland et al., 2021). Therefore, developing my competence in this area was something I was particularly focused on.

In my role at the clinic, I supported a small group of assistant psychologists (APs) in their clinical and professional development. My AP colleagues often felt they were not meeting their professional milestones and often expressed dissatisfaction and anxiety about their experiences in the mental health service; a challenge well established in the clinical literature (Owen, Crouch-Read, Smith & Fisher, 2021). This evoked a deep sense of empathy in me, recalling my own early career struggles. To address their concerns, I provided structured supervision sessions with personalised advice and guidance. Through appropriate self-disclosure, I emphasised the importance of reflective practice and continuous professional development, highlighting how these practices had helped me overcome similar challenges. Recognising their struggles with work-life balance, I shared strategies rooted in psychological resilience and self-care principles, reflecting the BPS’s emphasis on psychologist welfare as fundamental to sustaining professional competence (BPS, 2018). Following up informally with the APs after our sessions, they shared that the advice helped them to navigate their immediate concerns and empowered them to pursue further education with greater confidence (Excerpt 3). I felt pleased that obtaining feedback confirmed my ability to provide guidance and generate a strong sense of fulfilment; recognising the positive impact of my guidance on the APs' professional growth which reinforced the importance of offering advice on issues related to health behaviour outcomes and care.

During my placements I have also been approached by colleagues seeking guidance on working with clients experiencing health anxiety, long-term health conditions, or sleep difficulties (Excerpt 4 & 5). This often left me feeling like an 'imposter,' a common phenomenon amongst psychologists (Robertson, 2018; Mullangi & Jagsi, 2019). These feelings of inadequacy pushed me to critically evaluate my knowledge and capabilities. To provide effective guidance, I requested the individual shared an email on what they would like to obtain guidance on for preparation, and subsequently combined behavioural, humanistic, and solution-focused supervision approaches (Pearson, 2006; Farber, 2010), which felt natural with my CBT background. This approach allowed me to develop relationships with my colleagues whilst enabling them to find their own solutions and specialist interventions when needed. Reflecting on this, I recognise the importance of integrating various theoretical approaches to offer comprehensive guidance (Excerpt 6). This method fostered a collaborative and empowering environment, aligning with the HCPC’s model of supervision (HCPC, 2021). These experiences have ultimately taught me to embrace my expertise, trust my training, and continue refining my skill of advice and guidance.

Communication Skills

Communication skills are paramount in health psychology, underpinning every aspect of practice from therapy sessions to interdisciplinary collaboration (Meyer et al., 2009; Solomon & Salfi, 2011). My doctoral journey has provided ample opportunities to refine these skills through clinical reports, collaborating with multi-disciplinary teams, and delivering presentations. Although my verbal communication was strong, I struggled with written communication during my undergraduate degree and there made a concerted effort to improve this during the Doctorate.

In my placements, clinical report writing for multidisciplinary teams was a significant area of focus. Initially, I felt overwhelmed by the need to convey complex information clearly and accurately. Attending a CPD event on effective clinical writing drastically improved my skills, teaching me to structure reports thoughtfully and ensure they were detailed and precise (Excerpt 7). These experiences underscored the importance of clear, accurate communication in fostering collaborative relationships and informed decision-making. My ability to communicate complex clinical issues to psychiatrists, GPs, universities, and employers regarding clients' well-being became a vital part of my role and one I want to ensure I continually develop.

On several occasions communication in challenging therapeutic contexts, particularly when clients became angry or upset, was also a key aspect of my role. Despite extensive training, these situations (often stemming from client's self-criticism around their therapeutic progress) made me feel anxious about maintaining a safe and constructive psychological environment. Employing active listening, maintaining a calm demeanour, and validating the client's emotions helped de-escalate tensions and foster open dialogue. This approach not only improved therapeutic relationships, but also enhanced my confidence in handling difficult emotions. I learnt to stay grounded and empathetic, which facilitated more effective therapeutic outcomes (Excerpt 8).

Additionally, the pandemic brought new communication challenges, particularly with the rise of video and telephone therapy sessions. Although I was initially comfortable with face-to-face sessions, the shift to remote communication was demanding. I often felt overwhelmed by the need to quickly adapt and ensure effective engagement with clients and colleagues. Reflecting on my tendency to 'over-speak' when feeling out of depth, I learnt to actively pull myself back and improve my verbal communication skills. Overcoming these challenges involved being more mindful of my language, seeking feedback, and continuously adapting my approach to ensure clarity and relevance (Excerpt 9). This journey emphasised the importance of adaptability and self-awareness in maintaining effective communication in evolving contexts.

Teamwork

Teamwork within healthcare settings is essential for clinical teams to work effectively (Rosen et al, 2018). In the private psychiatry clinic, my role necessitated seamless collaboration with psychiatrists, clinical psychologists, assistant psychologists, and therapists.

One of my key teamwork achievements was the development and implementation of integrated health psychology services, such as sleep management programmes and behavioural management for ADHD. These projects required several aspects of effective teamwork including ongoing communication, mutual respect, and shared goal setting. One difficulty highlighted by Freidl**,** Hoffman, and Albano (2018) that I found challenging was coordinating between different professional perspectives, particularly between health psychology, clinical psychology, and psychiatry; of which we often had varying approaches to service developments and treatments. This experience, although challenging, taught me the value of empathy, flexibility, and the importance of each team member's contribution to achieving the best outcomes for our clients. On reflection I feel that my approach has been shaped by these professionals, which would not have been possible without being open to the possibility of working collaboratively (Excerpt 10).

A further notable reflection on teamwork was when tasked with guiding the health psychology direction for our group of counsellors and psychotherapists. Initially, I felt frustrated when the team resisted the idea of integrating health psychology, often questioning its necessity given the presence of clinical psychologists. This resistance felt both challenging and familiar, as I had encountered similar attitudes in a previous placement. To address this, I emphasised the importance of multidisciplinary working, highlighting the unique benefits that health psychologists bring to the team. Despite my initial frustration, I channelled these feelings into fostering a collaborative environment. This approach helped me settle into the team and facilitated a broader understanding of the value of health psychology. Building on this, I organised a team workshop focused on promoting multi-disciplinary and shared learning. I feel that navigating differences in opinion within the team required strong negotiation skills and the ability to unify colleagues around common objectives; something that initially made me feel anxious but improved as we took steps forward. Reflecting on this experience, I felt a sense of accomplishment as we enhanced our service delivery and client outcomes, reinforcing the importance of teamwork and effective leadership in achieving our goals; and setting a precedence for me moving forward to trust in my ability to communicate with a range of professionals. (Excerpt 11).

Service User Involvement

The involvement of service users is a cornerstone of ethical and effective psychology practice (Thornicroft & Tansella, 2005). It ensures services are responsive, tailored, and continually improved based on direct feedback from those most involved within it (Wallcraft et al., 2011). Prior to starting the doctorate, I was mostly unaware of this process, as in my previous work it was something that felt largely unprioritised. My doctoral journey has deeply integrated the principle of user involvement across various settings, from creating feedback pathways in the OH company to involving service users in public service work and maintaining openness in therapeutic settings.

In my OH placement, I led the initiative to implement service user feedback pathways, introducing digital feedback forms post-consultation, regular therapist rating surveys, and open contact via email for service improvements. Initially, I felt a mix of excitement and apprehension, knowing the importance of this project and my responsibility to ensure its success (Excerpt 12). The data collected revealed significant barriers to user accessibility, such as clients being unable to access therapy support. Discussing these findings with my manager, I felt a sense of urgency and determination to make meaningful changes. We implemented simple automated scheduling software, allowing employees to book appointments more easily. This process of evaluation and change was incredibly rewarding. Seeing the positive impact of our efforts on service accessibility made me feel proud and accomplished, as it was my first directly managed project focusing on service user experience. This success reinforced my confidence in leading initiatives and underscored the importance of listening to and acting on service user feedback (Excerpt 13).

A further implementation of service user involvement and feedback has been demonstrated in my psychological interventions. Throughout the doctorate, I have focused on creating a sense of openness to feedback and client involvement in psychological sessions, motivated by the observation that feedback is often only shared at the end of therapy. Setting clear expectations and obtaining regular feedback during the process, as emphasised in research literature (Sundet, 2012), has become a crucial aspect of my approach. Initially, inviting feedback felt daunting, but it has significantly improved my intervention outcomes, client satisfaction and additionally enhanced my confidence in my interventions. This commitment aligns with HCPC and BPS standards advocating for service user involvement to enhance the quality and efficacy of psychological interventions and therapies (HCPC, 2015; BPS, 2018). Reflecting on this practice, I feel a deep sense of fulfilment and professional growth and moving forward I aim to develop a more structured system for incorporating feedback, potentially within a research study, to further refine my practice and contribute to the field of health psychology.

Organisational & Systemic Issues

I have been fortunate in my career to have several supervisors, mentors, and colleagues from a range of backgrounds. This has supported my education around the inherent organisational and systemic issues that can occur in healthcare settings. Being aware of these issues is essential to address health inequalities, service accessibility issues, and for promoting a culture of respect and integrity in organisations (Halford et al., 2018; Hui et al., 2020).

My first placement coincided with the onset of the COVID-19 pandemic, presenting organisational and systemic challenges in delivering health psychology services. The rapid transition to remote consultations and therapy sessions underscored the necessity of flexibility and innovation in maintaining service continuity. During this period, I felt a significant lack of service direction and often perceived our organisation's response as slow and unempathetic, particularly when discussions prioritised service continuation over employee well-being. This situation was frustrating and disheartening, as it seemed to conflict with my values and the fundamental principles of health psychology. Reflecting on this experience, I realised the importance of effective communication and organisational agility in responding to public health crises (Excerpt 14). It also reinforced my commitment to upholding my values, advocating for both client and employee well-being, and ensuring that empathy and support remain at the forefront of health services, even amidst systemic challenges.

A further experience of systemic issues came in the form of racism, which I found particularly challenging and disheartening. During a conversation, a colleague made comments that were deeply inappropriate. This situation left me feeling both angry and anxious about the potential repercussions of addressing it. After consulting with a non-work-related supervisor, I decided to bring the matter to the attention of the managing director. This decision was particularly anxiety-provoking, as I was unsure how it would be received and worried about potential backlash. Together, we developed a plan to address the issue, and despite my initial fears, the situation was resolved adequately (Excerpt 15). This process was emotionally taxing but ultimately reinforced the importance of standing up against discrimination and advocating for a culture of equality and respect. Navigating these situations highlighted the need for strong, principled action in the face of systemic issues, and reinforced my commitment to fostering an inclusive professional environment.

Continuing Professional Development (CPD)

CPD is crucial for maintaining clinical standards and enhancing knowledge among healthcare professionals (Wall & Halligan, 2006; Davis & McMahon, 2018). I have been fortunate that CPD has been mandated in my professional registrations and placements, making it a regular part of my schedule and subsequent something I greatly appreciate its value for in my professional growth.

My registrations with the BACP and BPS have been significant assets for my CPD, requiring me to maintain and submit a log of my CPD for 2023-2024. I feel that workshops, full-day training sessions, alongside reading their journals has kept me up to date with the latest psychological and therapeutic theories in an engaging and interesting way. This development has enhanced my clinical abilities in specific disorders (insomnia, health anxiety, and chronic pain) and therapies enabling me to better meet the complex needs of my clients. Engaging in various formats—visual, reading, and interactive workshops—has been particularly effective in keeping me engaged and motivated. Attending conferences such as the Staffordshire University Health Psychology and Birmingham OH and Workforce days has also been pivotal in my development. These events have expanded my perspective, connecting me with leading experts and novel research in health psychology; experiences I have found inspiring, thought provoking and highly rewarding.

Looking ahead, I am eager to continue my CPD, particularly in research methods and psychological intervention for cancer care; an interest that has become more personal following a family member's diagnosis in late 2022. I feel a profound motivation to contribute to this area of health psychology, driven by my personal experience and the desire to support others facing similar challenges.

Personal Development as a Health Psychologist

My journey as a health psychologist over the past four years has been a transformative experience, marked by significant personal and professional growth. Reflecting on this period, I can see how principles of professional autonomy and accountability have really shaped my practice and solidified my identity as a health psychologist. These principles have been my compass, guiding me through various challenges and underscoring the importance of self-reflection in my ongoing development.

The onset of the COVID-19 pandemic during my studies was a pivotal moment in my development. Faced with the sudden transition to remote therapy and teaching sessions, I felt a mix of anxiety and determination. Adapting to new technologies and methods of client engagement was daunting, but it also ignited a sense of responsibility and leadership within my placement role. Those initial days were filled with long hours, relentless problem-solving, and a profound fear of failing my clients. However, as I took charge of the therapy service and ensured a seamless transition, I experienced a significant boost in my confidence. This period underscored my ability to independently evaluate and respond to the service’s needs, reinforcing my professional autonomy and instilling a deep sense of pride and relief as we successfully navigated these unprecedented challenges.

Additionally, adherence to ethical standards were highlighted when I faced several ethical concerns at the private clinic. Leaving my job and a familiar environment was emotionally challenging and filled with uncertainty and a sense of loss. However, my conviction to uphold ethical standards was stronger, and this decision solidified my professional integrity. Furthermore, overcoming initial failures in research submissions through persistent effort and training transformed my skills, each success feeling like a hard-won battle that contributed to a deeper sense of competence and resilience (Excerpt 16). This process was crucial in my journey, as it not only enhanced my research capabilities but also built my confidence to tackle complex problems and persevere through setbacks. The experience underscored the importance of persistence and adaptability, key qualities that have strengthened my professional identity and prepared me for future challenges in the field.

Reflective practice and supervision have been crucial in offering valuable perspectives and fostering a deeper understanding of my professional identity. I vividly remember challenging cases discussed during supervision sessions and recall feeling overwhelmed and emotionally drained. Seeking my supervisor's feedback has continually provided me practical solutions and a different perspective on the emotional impact and challenges I’ve encountered. This combined with the reflective approach I have utilised, has now become a cornerstone of my practice. Learning from challenges, celebrating successes, and adjusting my path moving forward have become integral to my professional growth. Starting as a more inexperienced practitioner grappling with new concepts, theories, and competencies, I now feel I have grown into a significantly more confident and reflective psychologist. This four-year journey has laid a solid foundation for my future endeavours in health psychology, helping me build resilience, maintain my well-being, and enhance my professional capabilities.

Professional Competence

Following the HCPC ethical guidelines has been immensely useful in my journey to enhance my professional skills as a health psychologist. Throughout my doctoral journey, I have significantly improved these skills through reflective practice and supervision. Reflecting on my experiences has been essential, particularly during challenging times such as family bereavements, illnesses, and my own battles with pneumonia and COVID-19. These reflections have not only helped me in navigating these difficult periods but have also strengthened my awareness and patience. Supervision sessions have provided a safe space to discuss these challenges, allowing me to receive valuable feedback and support. For instance, during a particularly tough period when I was recovering from pneumonia, I felt eager to return to my work and studies, however my supervisor's guidance was crucial in helping me pace myself and manage my workload effectively. This experience underscored the importance of being kind to myself and reinforced the need for a balanced approach to work and personal life. Additionally, I have completed monthly, quarterly, and annual reports, which have further contributed to my personal growth and self-awareness. The practice of reflection, supervision, and regular reporting has set a solid foundation for my development as a health psychologist, helping me build resilience, maintain my well-being, and enhance my professional capabilities (Excerpt 17).

Becoming a member of the Midlands Health Psychology Network has also been instrumental in my professional growth and I now feel it is a necessary resource for my professional development. This network has provided me with opportunities to connect with experienced health psychologists, and access other free health psychology webinars. The network has also provided a platform for discussing future career progression, which has been invaluable in shaping my professional aspirations. Access to a variety of papers and resources through the network has further enriched my knowledge and kept me informed about emerging trends and innovations in the field.

Furthermore, working with a diverse range of practitioners and collaborating with mental health professionals, clinicians, teachers, and tech experts has significantly broadened my perspective and enriched my practice. These interactions have improved my ability to work in multidisciplinary teams and adapt to different professional environments. For example, working on a project with tech professionals to develop a virtual reality therapy tool was both challenging and rewarding. It required me to bridge the gap between clinical practice and technological innovation, enhancing my skills in both areas. Reflecting on these experiences, I have learnt the value of adaptability, continuous learning, and effective communication. These experiences have collectively contributed to my professional competence, equipping me with the skills and knowledge needed to thrive in my career as a health psychologist.

Advanced Research Methods

Research is an essential component of healthcare professionals' training and practice (Garzonis et al., 2015). A strong understanding and application of research support the development of evidence-based practices, treatment pathways, healthcare interventions, and policy (Elphinston & Pager, 2015; Melchert et al., 2019). My doctoral research explores the intersection of physical and psychological well-being with a focus on Type 1 Diabetes, Health Anxiety, and perceptions of therapy modalities in the context of the Covid-19 pandemic. It is important to mention that I failed the initial submission of both my qualitative and quantitative projects. Despite initial disappointment, I realised that rushing and poor time management (partly due to sickness absences) led to these mistakes. This became a profound moment of reflection, highlighting the necessity for organisation, thorough proofreading, and obtaining additional feedback on my work.

My qualitative research, "Exploring the experiences of psychological support for individuals living with Type 1 Diabetes (T1D)," extended my undergraduate and master's projects on the self-management of T1D. Though familiar with the qualitative paradigm, I felt overwhelmed by the workload of interviews, transcription, and analysis. To manage this, I set goals using a Gantt chart, which proved invaluable in keeping me on track. Another key component was my positioning as both a therapist and someone with lived experience of T1D. To mitigate bias, I maintained a reflective log and sought external perspectives from my supervisors. A key moment of reflection arose during the analysis phase, where I struggled to identify emergent patterns and themes. Sharing insights with my supervisors helped refine my themes, leading to a more nuanced interpretation of the data (Excerpt 18). This project was emotionally challenging but ultimately rewarding, enhancing my confidence in conducting qualitative research.

My quantitative research exploring the perceptions of multimodal therapy approaches in the context of the Covid-19 pandemic was the project I was most apprehensive about. Due to previous experiences and like many trainees, I found the prospect of quantitative analysis daunting. I have always struggled with utilising SPSS, so I conducted extensive reading on my research method (repeated measures ANOVA) and sought adequate supervision. One challenge from my initial submission was the potential methodological issues of seeking retrospective perceptions. Consultation with my supervisor allowed me to frame the research in a more helpful paradigm, setting the stage for future research. Despite my apprehensions, I was able to run the required analyses more easily than anticipated, leading to a renewed confidence in using SPSS. I feel I have gained confidence in using quantitative methods, and something ‘clicked’ after spending significant time with my data (Excerpt 19).

My final piece of research was a systematic review of third-wave therapies for illness anxiety. As I had not completed a systematic review before, I felt a mixture of apprehension and excitement. In hindsight, I think the apprehension led me to leave it until last, which was not the best idea given the time required to complete a review. The most crucial piece of information I learnt was the importance of being organised. Initially, my references felt messy, slowing down my process. I backtracked, organised my papers, and uploaded them to Rayyan (systematic review software). This organisation freed up mental space and sped up the screening process. The ability to maintain organisation ensured that the subsequent risk of bias assessment, inclusion of studies, and narrative synthesis went smoothly

(Excerpt 20). I feel proud of 'learning the skill' of completing a systematic review, and I am certain I will write more in the future. I found the collation of data enjoyable and the ability to condense large amounts of research into a comprehensive article insightful and fulfilling.

Consultancy

Consultancy plays a crucial role in health psychology by enabling practitioners to apply theoretical knowledge to practical challenges (Michie & Abraham, 2004; Ghag et al.,2019). Prior to my doctoral training, I had gained experience as a consultant in various health-related projects, albeit in a more junior role, which did not fully prepare me for the complexities of leading an entire consultancy project independently. As I navigated the contracting phase with 'Psychonline' (pseudonym), I quickly realised the delicate balance required between meeting client expectations, managing time effectively and maintaining professional boundaries. This phase was particularly challenging as the requested deliverables (I felt) were unattainable, which placed me in a situation requiring assertiveness and the ability to negotiate the expectations of the project (Excerpt 21). To gain some guidance, I spoke with my placement supervisor who had significant experience in consultancy, this mentorship and further reading around the consultancy process allowed me to return to the organisation and assert more realistic and attainable deliverables.

A particular challenge I identified within the consultancy project was when tasked with proposing and implementing a plan that balanced Psychonline's needs with evidence-based practices, which tested my adaptability, assertiveness, and advocacy skills. Presenting this plan to the executive team confirmed my initial hesitations that the prioritisation of releasing the resource quickly came before the requirement for a strong evidence-base. I found this somewhat disappointing as it highlighted how some organisations operate projects without the need for a well-defined scientific approach. To address this, I delved into literature on conflict resolution within consultancy settings, which I feel significantly improved my negotiation capabilities. These improvements in communication and decision-making were not just professional advancements but were also critical to my personal development, instilling a deeper confidence and a stronger commitment to ethical and informed practice (Excerpt 22).

Since completing my consultancy project, I have successfully applied the skills and processes learned to several projects, enriching my understanding of the diverse challenges and dynamics within various consultancy environments.

Psychological Interventions

Health psychologists often design and deliver psychological interventions at the juncture of physical and mental health paradigms (Thielke, Thompson & Stuart, 2011). Prior to commencing the doctorate, I had worked as a counsellor and CBT therapist for around 14 months. Due to this I felt most comfortable in my assessment, delivery and evaluation of psychological interventions which provided me a lot of confidence for this competence. As I was already working individually with clients, I was familiar with providing therapy for insomnia, health anxiety, long-term health conditions and mental health conditions. Although I had a strong foundation in psychological interventions, I felt that I could enhance these skills further during the doctorate; with particular emphasis on improving my behaviour change interventions, understanding of group therapy approaches and implementation of evaluation strategies in my interventions.

As part of my case studies, I completed both a 1-1 working with an individual with severe health anxiety (Molly) and group intervention for ADHD. Reflecting on the experience conducting a 1-1 intervention with Molly, I encountered both challenges and growth as a therapist. When developing the therapeutic relationship rooted in trust and collaboration, I faced the challenge of overcoming Molly's resistance to the homework aspect of CBT, which is pivotal in enhancing therapy outcomes (Excerpt 23) (Kazantzis et al., 2000). Due to my experience, I felt confident in my ability and decided to implement aspects of Socratic questioning and cognitive restructuring to balance validation of her concerns whilst guiding her towards the potential benefits of therapeutic homework (Beck, 2011). This process taught me the importance of patience, reflection and the critical nature of a strong therapeutic alliance, elements that empowered Molly whilst also enriching my professional capabilities. The ADHD group intervention provided a different set of dynamics and challenges. Notably, I found that creating a structured, yet flexible environment was essential to accommodate the characteristics of the group participants and foster positive group dynamics. This setting allowed for significant interaction among group members, who learnt from both the structured content and each other's experiences, highlighting the unique therapeutic benefits of group interventions (Excerpt 24) (Yalom & Leszcz, 2005).

Both experiences have profoundly influenced my professional and therapeutic approach. With Molly, I learnt the importance of adaptability and the non-linear nature of individual therapy (Norcross & Wampold, 2011). In the group setting, transitioning to online sessions during the pandemic tested our adaptability and reinforced the effectiveness of clear communication and technological integration. Moving forward, I will carry these insights into my practice, continually refining my approach to both individual and group therapy to better serve my clients and enhance therapeutic outcomes.

Teaching

An important tool for Health Psychologists is the ability to disseminate information through teaching (Wahass, 2005). During my placements, I conducted a series of five teaching sessions in a range of different settings. Prior to commencing my teaching, I was particularly nervous, as I had limited experience teaching, and often felt anxious at the prospect of 'presenting' to others. I therefore discussed my apprehensions with colleagues who put my nerves at ease by sharing their own experiences of starting teaching. Stilwell (2009) suggests that obtaining shared experiences from peers and colleagues about teaching can support in the development and delivery of sessions, and I certainly found this to be true for myself.

For my teaching I completed two online sessions ('CBT techniques to manage insomnia' and 'therapeutic understanding of Health Anxiety') and three face-to-face sessions ('the psychological impact of Diabetes management', CBT techniques for

Health Anxiety, and CBT for long-term conditions). Although I had some experience of teaching in person, facilitating the online sessions provided a steep learning curve. Initially, I found it challenging to manage a large group who I could not see (due to cameras being off), as I was unaware if the individuals were understanding the content and remaining engaged in the session. During the sessions, I quickly learnt to implement more group discussions to engage the group and was mindful for future sessions to implement more technological tools such as Mentimeter (a tool for learners to actively engage in educational games and surveys). This has been an invaluable resource that I will continue to use for my future teaching sessions (Excerpt 25).

The evolution of my role as a teacher has been marked by several challenges and reflections. Translating theoretical knowledge into practical skills for groups with varying backgrounds and psychological knowledge often felt daunting. To address this, I employed the learning partnership model of Baxter and King (2004), which allowed me to adapt my teaching sessions to be more appropriate for each group. A crucial component of developing my teaching style was the emphasis on setting expectations and formative feedback. Initially, I felt uncertain about whether my content in the sessions was always meeting learners' needs but using a feedback-focused model helped clarify their expectations and tailor the sessions accordingly. Often, what I thought learners required differed from what they felt was important, and this feedback approach was instrumental in aligning our goals (Excerpt 26). Reflecting on these experiences, I feel a deep sense of accomplishment and growth as the skills acquired through my teaching will ensure I maintain a learner-centred approach and continue to disseminate information relevant to health psychology.

Conclusion

In conclusion, my journey as a Trainee Health Psychologist has been marked by significant personal and professional growth, driven by a commitment to continuous learning, ethical practice, and reflective development. These four years have been inspiring, motivating, challenging, and incredibly rewarding. Moving forward, I am dedicated to applying these lessons to enhance my clinical practice, contribute to the field through research and teaching, and ultimately improve the well-being of those I serve.

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Chapter 2: Advanced Research Methods

2.1 Systematic Review Manuscript

Effectiveness of Third Wave Cognitive Behavioural Psychotherapies in the Management of Somatic Symptom and Illness Anxiety Disorders: A Systematic Review

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Abstract

Objectives

To systematically review the effectiveness of Acceptance and Commitment Therapy (ACT) and Mindfulness-Based Therapies, in treating Somatic Symptom Disorder (SSD) and Illness Anxiety Disorder (IAD) in adults. To compare these therapies' effectiveness against control groups in randomised controlled trials (RCTs).

Design

A systematic search of four databases (PsycINFO, PubMed, Scopus, and OpenGrey) was conducted to identify quantitative studies published between 2000 and 2024. Inclusion criteria focused on RCTs examining third-wave therapy approaches for SSD and IAD. Data extraction followed the Cochrane Collaboration's RCT data extraction form. Study quality was assessed using the Cochrane risk of bias tool (RoB 2.0).

Results

The review identified 447 references, with eight studies that included 764 participants, that met all inclusion criteria. Interventions were delivered face-to-face, online, or via telephone, with follow-up periods ranging from 3 to 15 months. Results showed significant reductions in health anxiety, somatic symptoms and improvements in quality of life for intervention compared to control participants.

Conclusions

ACT and Mindfulness-Based Therapies show promise in treating SSD and IAD, offering significant benefits in symptom reduction and quality of life improvement. These therapies provide flexible and adaptable treatment options that complement existing approaches. Despite promising results, heterogeneity in study designs suggest that further research is needed. Future studies should address methodological limitations, conduct comparative effectiveness research, and explore long-term outcomes to enhance the evidence-base and support the wider implementation of these therapies in clinical practice.

Keywords: Acceptance and Commitment Therapy, Mindfulness-Based Therapies, Somatic Symptom Disorder, Illness Anxiety Disorder, Systematic Review, Health Anxiety

Practitioner Points

- Third wave therapies, including ACT and Mindfulness-Based Therapies, show significant promise in reducing symptoms of SSD and IAD, offering flexible and adaptable treatment options.

- Further research is needed to address methodological challenges and compare the long-term effectiveness of third wave therapies with more established treatments.

Introduction

Somatic Symptom Disorder (SSD) is a mental health condition characterised by an intense focus on bodily sensations such as pain, weakness or shortness of breath accompanied by excessive thoughts, feelings, or behaviours related to these symptoms. This condition causes considerable distress and impairment in social, occupational, and general psychological functioning (American Psychiatric Association, 2013). Patients with SSD often experience ongoing anxiety about their health, despite minimal or no evidence of a serious medical condition, leading to frequent medical consultations and interventions (Scarella, Boland & Barsky, 2019).

Illness Anxiety Disorder (IAD), previously referred to as Hypochondriasis, is defined by persistent anxiety and worry about having or acquiring a serious illness. Individuals with IAD may not exhibit any physical symptoms, or if symptoms are present, the level of worry is clearly excessive or disproportionate (American Psychiatric Association, 2013). This level of disproportionate worry often leads to several behaviours including repeated bodily checking, seeking reassurance from healthcare professionals and avoidance of medical-related information (American Psychiatric Association, 2013). Despite some variation in the symptomatology of SSD and IAD, the diagnostic and statistical manual (DSM-5) recognises that both disorders involve hypervigilance of physical sensations, preoccupation with illness, and frequent healthcare engagement, leading to significant distress and impairment in daily functioning (American Psychiatric Association, 2013).

SSD and IAD not only impair quality of life but also place considerable demands on healthcare systems due to frequent medical consultations, investigations, and treatments seeking reassurance about health concerns (Dimsdale & Creed, 2019). It is difficult to estimate the prevalence of SSD and IAD due to their complex presentations and overlap with other psychiatric and medical conditions. However, studies suggest that SSD occurs in approximately 5% to 7% of the general population, with IAD prevalence rates ranging from 1.3% to 10% depending on the diagnostic criteria and assessment methods used (Kikas et al., 2024).

The treatments for SSD and IAD have traditionally combined pharmacological interventions and Cognitive-Behavioural Therapy (CBT). Pharmacological treatments often involve the use of antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs), given the comorbidity of SSD and IAD with depression and anxiety disorders (Tyrer & Tyrer, 2018). CBT has been the cornerstone of psychotherapeutic interventions for these disorders, focusing on identifying and challenging maladaptive thoughts related to health anxiety, improving symptom management, and reducing health-related behaviours, such as excessive checking or medical consultation (Caplan & Sockalingam, 2009). CBT has demonstrated efficacy in reducing symptoms of SSD and IAD; however, access to trained therapists can be limited, and not all patients benefit equally from this approach (Hedman et al., 2016).

The evolution of CBT has given rise to "third-wave" Cognitive-Behavioural psychotherapies. Unlike traditional CBT, which primarily focuses on the direct modification of maladaptive thoughts and behaviours, third-wave therapies emphasise awareness, non-judgmental acceptance of internal experiences, and the development of a more flexible and compassionate relationship with one's thoughts and feelings (Hayes & Hoffman, 2021; Hunot et al., 2013). Key third-wave approaches include Acceptance and Commitment Therapy (ACT), Compassion-Focused Therapy (CFT), Mindfulness-Based Stress Reduction (MBSR), Dialectical Behaviour Therapy (DBT), and Mindfulness-Based Cognitive Therapy (MBCT); approaches which integrate mindfulness and behavioural techniques to enhance emotional regulation, psychological resilience, and self-compassion across a spectrum of psychological disorders and long-term health conditions (Hayes & Hoffman, 2021).

The theoretical rationale for applying third-wave therapies to SSD and IAD lies in their emphasis on changing the relationship with one's thoughts and feelings rather than attempting to directly change the content of those thoughts or the frequency of those feelings. This approach can be particularly beneficial for individuals with SSD and IAD, who may experience intense fear or preoccupation with their physical symptoms or health status, despite medical reassurance (Hedman et al., 2016; Frostholm & Rask, 2019). By teaching patients to observe their thoughts and feelings with curiosity and openness rather than immediate judgment or action, third-wave therapies may help reduce the distress and functional impairment associated with these disorders. Furthermore, these approaches foster a greater sense of psychological flexibility, which can be critical in managing long-term conditions like SSD and IAD, where complete symptom elimination may not be possible (Vøllestad, Sivertsen & Nielsen, 2011).

Despite growing interest in third-wave Cognitive-Behavioural psychotherapies as promising approaches for treating SSD and IAD, the evidence-base remains fragmented and inconclusive (Balandeh, Omidi & Ghaderi, 2021; Schefft et al., 2023). The literature to date includes a variety of studies with varied methodologies, participant characteristics, and treatment modalities, making it difficult to draw firm conclusions about the overall effectiveness of these therapies for SSD and IAD. Moreover, existing reviews often lack a comprehensive synthesis of the latest research or fail to explore specific aspects of third wave therapies, such as the comparative effectiveness of different approaches or the impact of therapy length and modality on treatment outcomes (Frostholm & Rask, 2019). A recent systematic review exploring third-wave therapies was carried out to explore their impact on ‘Bodily distress’ and found that these approaches reduced symptoms of bodily distress, anxiety, and low mood (Maas Genannt Bermpoh, Hulsmann & Martin, 2023). Despite this, the study clustered a range of conditions including somatic symptom disorders, physical health conditions and medically unexplained symptoms, therefore as a result a clear focus on third-wave therapies for illness anxiety and somatic symptoms disorders were missing.

To address these specific gaps and provide a more definitive assessment of the effectiveness of third-wave therapies for SSD and IAD, the current review focuses exclusively on randomised controlled trials RCT's. RCTs are considered the gold standard for evaluating the effectiveness of interventions because they minimise bias through randomisation and control groups, providing a higher level of evidence (Higgins et al., 2019). By exclusively including RCTs, this review aims to offer a more robust and reliable synthesis of the effectiveness of third-wave therapies for SSD and IAD, thus addressing the need for high-quality evidence in this field. Furthermore, focusing on RCTs allows for a clearer comparison of treatment outcomes across studies, enhancing the ability to draw firm conclusions about the effectiveness of these therapeutic approaches (Higgins et al., 2019).

Research Aim

The current review sought to investigate whether third-wave therapies are effective in the treatment of SSD and IAD in adults.

Methods

Protocol and Registration

This review was pre-registered with the International Prospective Register of Systematic Reviews (PROSPERO) database (registration number CRD42024531744).

Search Strategy

A systematic search was conducted for quantitative papers published between 2000–2024 using four electronic databases (PsycINFO, PubMed, Scopus and OpenGrey). This time point was chosen due to the rise in prominence of third wave therapies around this time (Hayes, 2004). In addition, the reference lists of included papers were manually searched for relevant articles. This review explored RCT's focused on third-wave therapy approaches for IAD's and SSD's based on the studies eligibility criteria. The search strategy contained keywords relating to evidence-based third-wave therapy modalities, and synonyms for IAD and SSD included health anxiety, somatisation, and hypochondriasis; a methodological decision to ensure a range of studies were obtained in the initial screening process. The study selection process adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (Moher et al., 2009), and the PICOS framework (Population, Intervention, Comparison, Outcome, Study design) was employed to define eligibility criteria (Liberati et al., 2009).

Study Selection

Articles from the database searches were uploaded to Rayyan systematic review software, where the first author screened all the articles and removed duplicate studies. Following this, the titles and abstracts were screened by the first author based on inclusion and exclusion criteria. The inclusion criteria were studies with adults over 18 years old with a diagnosis of IAD and/or SSD, including bodily distress syndrome or functional somatic syndromes with a primary diagnosis of IA or SSD. Additionally, to be included in the review, studies must have incorporated a third-wave therapy in at least one arm of the study and must have been a RCTs. The exclusion criteria included studies where participants experienced co-morbid conditions of substance abuse and psychosis. The last author (AD) screened 15% of the studies to ensure consistency and reliability. The first author then sourced and screened all the full-text articles and discussed them with the second reviewer to ensure agreement with the review criteria for inclusion in the review. Both first and last authors were in agreement for the full-text screening.

Eligible Studies

A total of 447 references were identified. After removing duplicate articles (n=99), 378 remained for title and abstract screening. From the title and abstract reviews, 42 articles were included in the full-text screening for eligibility and eight manuscripts met the inclusion criteria. Most studies were excluded due to the interventions, study design or outcomes not being relevant to the research question. Reference lists of the included studies were additionally screened for relevant literature. The reasons for study exclusion during the full-text assessment (n = 33) can be seen in Fig. 1.

[Insert Figure 1 Here]

Data Extraction

Data extraction was conducted by the first author utilising a summarised version of the Cochrane Collaboration's RCT data extraction form (Higgins & Green, 2011). The form was structured into a table including the following data: country, sample, study design, participants in intervention vs control, therapy approach, therapy duration and length, included IAD, SSD and secondary outcome measures, summary of findings and quality appraisal. The second author reviewed the table's structure and data to ensure agreement on the information being extracted from the studies.

Quality Assessment

To assess the methodological quality and risk of bias of the included studies, the Cochrane risk of bias tool for randomised trials (RoB 2.0) was employed (Sterne et al., 2019). This well-established risk of bias tool asks 'signalling questions' to assess five domains of bias including: D1- Bias arising from randomisation process, D2- Bias due to deviations from intended intervention, D3 - Bias due to missing outcome data, D4 - Bias in measurement of the outcome, D5 - Bias in selection of the reported result. Due to the inherent inability to blind participants in psychotherapy trials, the bias in the measurement of the outcome (D4) was removed from the scoring matrix. Boutron et al. (2015) suggest that blinding in non-pharmacological trials, such as psychotherapy, is often impractical and that bias assessment should be adapted to reflect the specific challenges of these studies. Similarly, Higgins et al. (2011) note that the absence of blinding does not automatically imply high risk of bias if other measures ensure objective outcome assessment which should also be reflected in the bias assessment. Subsequently, each study was appraised across the remaining domains and classified as having low risk, high risk, or some concerns. The first author independently appraised all the included studies prior to discussion with the last author.

Synthesis of Results

Due to the heterogeneity in the included studies regarding intervention content, length, delivery, and outcome measures, a meta-analysis was not feasible. As a result, a narrative synthesis was utilised to integrate and interpret findings from the included studies (Popay et al., 2006). The first author conducted the synthesis by conducting a preliminary synthesis that organised studies for structured comparison, followed by an exploration of the relationships within and between studies to identify patterns, inconsistencies, and potential factors moderating therapy outcomes. The synthesis was reviewed by the co-authors to ensure the data was compiled into a coherent narrative that addressed the research question.

Results

Study Characteristics

Table 1 summarises the studies included in the review. In total, four of the studies were conducted in Denmark, two in Iran, with one study in Holland and one in the United Kingdom. The average number of participants assigned to the intervention conditions was 55, while control conditions had an average of 48 participants. Participant numbers in the intervention arms ranged from 20 to 64, and control arms included between 20 and 63 participants. Sample populations varied across studies, featuring caregivers of patients with COVID-19, adults with severe health anxiety, and patients diagnosed with multi-organ functional somatic disorders, hypochondriasis, and somatisation disorder. All of the interventions were controlled with standard care, enhanced treatment as usual or waitlist.

[Insert Table 1 Here]

Participant Characteristics

All participants in the reviewed studies received diagnoses of SSD or IAD based on the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) criteria. The average age of participants across the eight studies was 40.7 years, with age ranges spanning from 19 to 67 years, reflecting a diverse adult population. Gender representation was mixed, with most studies having a higher proportion of female participants; on average, about 68% of the participants across all studies were female. Marital status was reported in six studies, indicating that most participants were married or living with a partner (Pedersen et al., 2019; Van Ravesteijn et al., 2013; McManus et al., 2012; Fjorback et al., 2013; Zargar et al., 2021; Shahidi et al., 2023). Educational attainment varied, with participants holding levels of education ranging from below diploma to higher education. All studies reported education levels, though the degree of detail varied. Notably, several participants in six of the studies were reported to be on sick leave or receiving a disability pension (Eilenberg et al., 2016; Pedersen et al., 2019; Hoffmann et al., 2021; Fjorback et al., 2013; Zargar et al., 2021; Shahidi et al., 2023).

Intervention Approaches

Four studies used Mindfulness-Based Therapies (McManus et al., 2012; Fjorback et al., 2013; Van Ravesteijn et al., 2013; Zargar et al., 2021), three studies used Acceptance and Commitment Therapy (Eilenberg et al., 2016; Pedersen et al., 2019; Hoffmann et al., 2021), and one study integrated Internet-Delivered Mindfulness Stress Reduction with Acceptance & Commitment Therapy (Shahidi et a., 2023). Therapy sessions were predominantly structured as weekly meetings, varying in duration from 2 to 3.5 hours over a period of 8 to 12 weeks. One study employed a brief intensive format with two full-day workshops (Pedersen et al., 2019), while another offered an extended program consisting of nine 3-hour sessions (Eilenberg et al., 2016). Of the eight studies, two were delivered online (Hoffmann et al., 2021; Shahidi et al., 2023), five were conducted face-to-face (McManus et al., 2012; Fjorback et al., 2013; Van Ravesteijn et al., 2013; Eilenberg et al., 2016; Pedersen et al., 2019), and one was conducted via telephone (WhatsApp) (Zargar et al., 2021). Follow-up periods for the studies varied. Shahidi et al. (2023) included follow-ups at 3, 6, and, 12 months post-treatment. Hoffmann et al. (2021) conducted follow-ups at 1, 2, 3, 4, and 10 months. Pedersen et al. (2019) had follow-ups at 4, 7, and 10 months. McManus et al. (2012) included follow-up assessments at 9-, and 15-months post-treatment. Fjorback et al. (2013) conducted follow-ups at 9 and 15 months. Van Ravesteijn et al. (2013) included follow-ups at 9 months. Eilenberg et al. (2016) had follow-ups at 14 and 15 months, and Zargar et al. (2021) conducted follow-ups at 6, 14, and 20 months.

Outcome Measures

A variety of outcome measures were used across studies to evaluate health-related anxiety and somatic symptoms. These included the Health Anxiety Inventory (HAI) (Salkovskis et al., 2002) and the Whiteley Index (WI) (Pilowsky, 1967) for assessing the severity of health anxiety and illness anxiety. Somatic symptoms were evaluated using the Somatic Symptom Scale-8 (SSS-8) (Gierk et al., 2014) and the Patient Health Questionnaire (PHQ-15) (Kroenke et al., 2002), which assesses somatic, anxiety, and depressive symptoms (Zargar et al., 2021; Van Ravesteijn et al., 2013; Pedersen et al., 2019). Quality of life was assessed using the Short Form Health Survey (SF-36 or SF-12), with its subscales measuring both physical and mental health aspects (Eilenberg et al., 2016; Hoffmann et al., 2021; McManus et al., 2012; Fjorback et al., 2013; Shahidi et al., 2023). Despite the use of validated instruments, some studies did not report effect sizes for their findings, specifically Zargar et al. (2021) and Shahidi et al. (2023), which limits the ability to compare results directly.

Quality Assessment

The risk of bias assessment across the eight included studies highlights a range of concerns primarily centred around deviations from intended interventions, missing outcome data, and selective reporting (Figure 2). All studies demonstrated a low risk of bias in the randomisation process (D1), indicating appropriate randomisation and allocation concealment. Deviations from intended interventions (D2) were minimal, reflecting adherence to the intervention protocols, although minor concerns were noted in Pedersen et al. (2019) and Van Ravesteijn et al. (2013) due to issues like session attendance and protocol fidelity. The domain of missing outcome data (D3) presented some concerns in most studies, with incomplete follow-up data; Hoffmann et al. (2021) and Eilenberg et al. (2016) had instances of missing data that were not adequately addressed, whereas Van Ravesteijn et al. (2013) managed missing data more effectively through strategies like intention-to-treat analysis and appropriate imputation methods. Selective reporting (D5) was another area of concern across all studies, with concerns that not all pre-specified outcomes were reported, potentially biasing the perceived effectiveness of the interventions, as seen in Zargar et al. (2021) and Fjorback et al. (2013). After excluding the D4 domain, which was inherently high risk due to the nature of psychotherapy trials, most studies were rated as having 'overall some concerns'. Pedersen et al. (2019) retained a high-risk status due to issues with missing data.

[Insert Figure 2 Here]

ACT Interventions

Three of the included studies utilised ACT-based therapy interventions. Control groups consisted of treatment as usual, waitlist, or standard care. Eilenberg et al. (2016) and Pedersen et al. (2019) employed a group intervention format, while Hoffmann et al. (2021) implemented an individual internet-delivered intervention. In Eilenberg et al. (2016), the group intervention consisted of nine weekly, two-hour sessions of ACT facilitated by two psychotherapists trained in ACT. Pedersen et al. (2019) featured an ACT intervention with nine three-hour group sessions over three months, delivered by a psychiatrist and a psychologist trained in ACT and the management of functional somatic syndromes. Hoffmann et al. (2021) utilised a self-guided ACT program over 12 weeks, facilitated by a clinician through weekly online sessions. All studies outlined evidence-based protocols and incorporated core ACT components such as acceptance, 'cognitive defusion', mindfulness, values clarification, and committed action.

All three studies used validated outcome measures, examining illness anxiety/health anxiety, global health improvement, quality of life, somatic symptom severity, and comorbid symptoms of anxiety and depression, with researchers extracting analogous measures from the heterogeneous outcomes to address the research question. All three studies used the validated Whiteley Index (WI-7) and a version of the Symptom Checklist (SCL-12; SCL-90) with Somatic Symptoms subscale to address variations in illness anxiety and somatic symptoms. Two studies evaluated both general and health-related quality of life using the SF-36 (Eilenberg et al., 2016; Hoffmann et al., 2021), while the third study explored quality of life in the context of 'disability assessment' (Pedersen et al., 2019). Each of the studies obtained outcome measures at baseline and at immediate post-intervention. Follow-up durations varied, with one study following up at 1, 2, 3, 4, and 10 months (Hoffmann et al., 2021), another at 4, 7, and 10 months (Eilenberg et al., 2016), and the final study at 6, 14, and 20 months (Pedersen et al., 2019).

Intervention Effects on Main Outcomes

All three interventions led to substantial reductions in health anxiety, addressing both cognitive and emotional components. Eilenberg et al. (2016) demonstrated a 38.8% reduction in health anxiety symptoms for the ACT group, with a large between-group effect size difference (Cohen's d = 0.89). Similarly, Hoffmann et al. (2021) reported dramatic decreases in health anxiety scores from 75.5 at baseline to 31.3 at the 6-month follow-up for participants undergoing internet-delivered ACT (iACT), with a large effect size (Cohen's d = 0.80). Pedersen et al. (2019) also observed statistically significant reductions in illness worry, with the extended ACT group showing a reduction in Whiteley-7 scores from 1.2 ± 0.8 to 0.9 ± 0.7, though specific effect sizes were not reported. These findings collectively suggest that ACT interventions, whether delivered face-to-face or online, consistently mitigated IAD symptoms.

The three studies also found that ACT interventions led to significant improvements in managing somatic symptoms. Pedersen et al. (2019) reported significant reductions in somatic symptom severity over 14 months compared to enhanced care. Hoffmann et al. (2021) observed significant reductions in somatic symptom scores among participants receiving internet-delivered ACT, with scores decreasing from 45.0 at baseline to 22.6 at the 6-month follow-up, demonstrating the therapy's impact on both health anxiety and somatic symptoms. Similarly, Eilenberg et al. (2016) observed a significant decrease in somatic symptom scores in the ACT-G group compared to the waitlist control group, with a mean decrease of 6.7 points in SCL-som scores, though specific effect sizes were not provided.

Interaction with Quality of Life

All three ACT interventions demonstrated improvements in quality-of-life measures. Pedersen et al. (2019) demonstrated significant enhancements in self-rated global health and quality-of-life, with notable improvements compared to control groups. These findings were also found by Eilenberg et al. (2016), who observed substantial increases in mental component summary (MCS) scores, indicating significant positive impacts on mental health quality of life (Cohen's d = 0.61). Hoffmann et al. (2021) also reported significant gains in HRQoL scores among participants in their study, with quality-of-life scores increasing from 31.8 at baseline to 55.6 at the 6-month follow-up, though specific effect sizes were not provided. Collectively, these studies highlight that ACT interventions significantly enhance quality-of-life for individuals with SSD and IAD.

Mindfulness Interventions

Four of the included studies evaluated mindfulness-based third-wave approaches. Two of the studies incorporated mindfulness-based stress reduction therapy (Fjorback et al., 2013; Zargar et al., 2021) and the further two, mindfulness-based cognitive therapy (McManus et al., 2012; Van Ravesteijn et al., 2013). All the studies were delivered in a face-to-face group setting. Group interventions were all carried out once weekly over an 8-week period. The interventions did however slightly vary in duration, with two studies providing 2-hour sessions (McManus et al., 2012; Zargar et al., 2021), and the remaining two studies 3.5 hours (Fjorback et al., 2013) and 2.5 hours (Van Ravesteijn et al., 2013) in length. The group interventions varied in the practitioner facilitating the sessions, with providers including trained psychologists (Fjorback et al., 2013), CBT therapists (McManus et al., 2012), experienced mindfulness practitioners (Van Ravesteijn et al., 2013) and one study not specifying who provided the intervention (Zargar et al., 2021).

A combination of self-reported measures were utilised in the studies to assess IAD, SSD, quality of life and comorbid anxiety/depression in the mindfulness-based interventions. Three of the studies explored IAD using the Whiteley Index, with one study opting to not obtain data for IAD (Zargar et al., 2021). Only one study directly explored SSD using the SCL-90 (Fjorback et al., 2013). Three of the four studies utilised the short form survey (SF-36), to assess health related quality-of-life, the remaining study did not assess physical outcomes but was the only study to incorporate a measure of mindfulness in daily living using the Five Facet Mindfulness Questionnaire (FFMQ) (McManus et al., 2012). All of the studies obtained outcome measures at baseline and at the end of the treatment intervention. Following this, all of the studies varied in their follow-up durations with one study having a one year follow up (McManus et al., 2012), one at 9 months (Van Ravesteijn et al., 2013) another at 3, 6 and 12 months (Fjorback et al., 2013), and the final only at post intervention (Zargar et al., 2021).

Intervention Effects on Main Outcomes

Mindfulness-based interventions significantly reduced health anxiety symptoms in individuals with IAD. Across studies, participants showed consistent reductions in health anxiety, with these effects sustained over time. Van Ravesteijn et al. (2013) found a decrease in WI scores from 23.1 at baseline to 20.6 post-treatment, maintaining this reduction at 20.6 at the 9-month follow-up. Similarly, McManus et al. (2012) reported WI score reductions with effect sizes of Cohen's d = 0.40 from pre- to post-intervention and d = 0.32 at the one-year follow-up. Fjorback et al. (2013) noted reductions in the mindfulness group with effect sizes of -0.62, -0.74, and -0.80 at 3, 9, and 15 months respectively, compared to the enhanced treatment group's reductions of -0.70, -0.79, and -0.66. Zargar et al. (2021) did not report effect sizes but found significant improvements in health anxiety scores. Despite minor variations in effect sizes and follow-up durations, the overall trend indicates that mindfulness interventions significantly reduce health anxiety symptoms, providing both immediate and long-term benefits.

Mindfulness-based interventions also show significant effectiveness in reducing somatic symptoms in individuals SSD. The reviewed studies consistently indicated that participants in mindfulness intervention groups experienced notable improvements in symptom management, as evidenced by significant reductions in scores on measures such as the PHQ-15. Zargar et al. (2021) reported that PHQ-15 scores in the intervention group decreased from 11.05 pre-intervention to 1.95 post-intervention ($p < 0.001$), with no significant change in the control group (10.94 to 10.27). Van Ravesteijn et al. (2013) similarly found PHQ-15 scores in the MBCT group decreased from 12.6 at baseline to 10.9 post-treatment, and 11.0 at the 9-month follow-up, while the control group showed no significant change. Fjorback et al. (2013) noted improvements in SSD, with effect sizes differences (d) for the mindfulness group at -0.27, -0.30, and -0.44 at 3, 9, and 15 months respectively, although these did not outperform the enhanced treatment group, which showed greater reductions of -0.41, -0.51, and -0.48. Synthesising these findings, mindfulness-based interventions are effective in managing somatic symptoms associated with SSD.

Interaction with Quality of Life

The impact of mindfulness-based interventions on QoL for individuals with SSD and IAD is well-supported by the reviewed studies. Participants generally experienced significant improvements in both physical and mental components of QoL following mindfulness interventions, with these benefits persisting over time. Zargar et al. (2021) found significant improvements in general health perceptions (SF-36 scores from 52.63 11 to 68.42) in the intervention group, while the control group showed no significant change (54.44 to 61.66). Van Ravesteijn et al. (2013) reported significant improvements in the MBCT group's SF-36 Mental Component Summary (MCS) scores, increasing from 44.3 at baseline to 47.4 post-treatment and 47.0 at the 9-month follow-up. The control group showed no significant changes. Fjorback et al. (2013) demonstrated greater improvements in the mindfulness group (effect sizes of 0.48, 0.50, 0.53 at 3, 9, and 15 months) compared to the enhanced treatment group (0.28, 0.43, 0.50). Although McManus et al. (2012) did not assess quality of life directly, they noted significant reductions in comorbid anxiety and depression, further supporting the beneficial effects of mindfulness interventions.

These findings collectively underscore that mindfulness-based interventions significantly enhance various dimensions of quality of life for individuals with SSD and IAD. The consistent improvements across different studies highlight the comprehensive benefits of these interventions, improving both psychological well-being and physical health.

Combined ACT & MBSR Intervention

Shahidi et al. (2023) utilised a unique combination of Acceptance and Commitment Therapy (ACT) and Mindfulness-Based Stress Reduction (MBSR) targeting caregivers of COVID-19 patients. Conducted over nine weeks via WhatsApp, the intervention included caregivers with Health Anxiety Inventory (HAI-18) scores above 27. The primary outcome measures were the HAI-18 for health anxiety and the Short Form-12 (SF-12) questionnaire for quality of life, assessing both the Physical Component Summary (PCS) and Mental Component Summary (MCS).

The intervention group showed significant improvements compared to the control group, which received only basic COVID-19 education and support via telephone. Health anxiety (IAD) scores in the intervention group decreased from 31.78 pre-intervention to 25.62 post-intervention. This reduction was seen across all HAI-18 subscales, including worry about health, awareness of bodily sensations, and worry about consequences. While SSD scores were not detailed, improvements in related symptoms were inferred from the reduction in HAI-18 subscale scores. Quality of life improvements were substantial, with PCS scores increasing from 14.72 to 16.06 and MCS scores from 13.65 to 16.78. The overall SF-12 score improved from 28.37 to 32.84. These results highlighted the effectiveness of the combined ACT and MBSR intervention in reducing health anxiety and enhancing quality of life.

Overall, the eight studies examining ACT and mindfulness-based interventions for IAD, SSD and quality of life outcomes reveals several consistent trends. Most studies demonstrated significant reductions in IAD and somatic symptoms, along with improvements in quality of life, indicating the effectiveness of ACT and mindfulness-based interventions. Collectively, these interventions demonstrated both immediate short term and sustained benefits. Mindfulness-based therapies showed significant reductions in health anxiety scores and enhancements in quality-of-life measures.

However, not all studies reported effect sizes, which complicates cross-study comparisons. While immediate post-intervention benefits are well-documented, long-term follow-up results were less consistent, with some studies showing sustained improvements and others indicating a need for ongoing intervention. Additionally, there is limited exploration of the mechanisms underlying these interventions' effectiveness. Overall, the synthesis underscores the potential of ACT and mindfulness-based interventions in effectively managing health anxiety and somatic symptoms and improving quality of life.

Discussion

Summary of Findings

The current systematic review of eight studies provides evidence that third-wave therapies, including ACT and Mindfulness-Based Therapies, are effective in alleviating symptoms of IAD and SSD. Collectively, the studies demonstrated that these therapies significantly reduce health anxiety and somatic symptoms, while also enhancing quality of life. ACT was consistently shown to mitigate health anxiety by promoting acceptance and reducing avoidance behaviours, which helped increase psychological flexibility. Participants in the reviewed studies consistently experienced reductions in health anxiety, highlighting ACT's effectiveness in addressing the cognitive and emotional components of the disorder (Eilenberg et al., 2016; Hoffmann et al., 2021; Pedersen et al., 2019). Similarly, Mindfulness-Based Therapies were effective in decreasing the intensity and distress of somatic symptoms by fostering a non-judgmental awareness of bodily sensations and cognitive restructuring (Fjorback et al., 2013; McManus et al., 2012; Van Ravesteijn et al., 2013). These findings underscore the robustness of third-wave therapies in providing substantial relief from anxiety and somatic symptoms.

The review also highlighted the benefits of Mindfulness-Based Therapies in managing SSD. Studies indicated that mindfulness-based interventions significantly reduced the severity of somatic symptoms and improved overall quality of life. Participants reported substantial improvements in their physical and mental health following mindfulness interventions, which were maintained over time. This was evident in studies that used various mindfulness approaches, such as Mindfulness-Based Cognitive Therapy and Mindfulness-Based Stress Reduction. The consistent positive outcomes suggest that mindfulness techniques, which encourage patients to engage differently with their symptoms, are effective in reducing the perception of pain and discomfort associated with SSD (Fjorback et al., 2013; Zargar et al., 2021; Van Ravesteijn et al., 2013). These interventions not only provide short-term symptom relief but also contribute to longer-term improvements in health-related quality of life.

Additionally, combined therapeutic approaches integrating ACT and mindfulness techniques demonstrated synergistic effects, offering enhanced benefits. The study integrating MBSR with ACT showed significant reductions in health anxiety and improvements in quality of life among caregivers of COVID-19 patients (Shahidi et al., 2023). These combined approaches amplified the benefits of each therapy, indicating a more robust treatment solution for individuals experiencing high levels of stress and anxiety.

Despite the overall positive findings, the review identified gaps such as inconsistent long-term follow-up results and limited exploration of the underlying mechanisms of these therapies' effectiveness. Future research should aim to standardise reporting practices, extend follow-up durations, and investigate these mechanisms to optimise third-wave therapeutic approaches for broader and sustained application.

Collectively, the reviewed studies affirm the substantial potential of third-wave therapies, such as ACT and Mindfulness-Based Therapies, in treating IAD and SSD. These therapies consistently demonstrate significant benefits in reducing anxiety, managing somatic symptoms, and enhancing overall quality of life. The studies varied in their designs and delivery methods, including face-to-face, online, and telephone-based interventions, highlighting the versatility and adaptability of these therapies across different settings and populations. While some studies exhibited limitations, such as issues related to missing outcome data and selective reporting, the overall risk of bias was low. For instance, the domain of missing outcome data presented some concerns, but strategies like intention-to-treat analysis and appropriate imputation methods, as seen in Van Ravesteijn et al. (2013), effectively mitigated these issues. Selective reporting was noted in some studies, but the robust methodologies employed by many studies helped ensure the reliability of the findings. By excluding the D4 domain (bias in measurement of the outcome), most studies were rated with an "Overall Some Concerns" status, indicating a generally sound methodological approach. Pedersen et al. (2019) retained a high-risk status due to significant unresolved issues with missing data, but this was an exception rather than the rule. These findings underscore the need for continued rigorous reporting and management of biases in future research to further solidify the evidence base for third-wave psychotherapies. Future research should also focus on exploring the long-term effects of treatments and expanding the demographic diversity of study samples to enhance the generalisability of findings.

Implications for Clinical Practice

For patients diagnosed with IAD and SSD, ACT and Mindfulness-Based Therapies provide substantial benefits that go beyond symptom management, significantly enhancing quality of life and empowering patients in the management of their health conditions (Veehof, Oskam, Schreurs, & Bohlmeijer, 2011). These therapies encourage patients to accept their symptoms and health-related anxieties without overly depending on medical interventions, potentially reducing frequent hospital visits and associated healthcare costs (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). For therapists, training in ACT and Mindfulness-Based Therapies equips them with a broader array of tools not only for managing symptoms but also for building resilience and improving overall well-being, essential for sustained recovery and health management (Hayes et al., 2006).

In clinical settings, implementing ACT and Mindfulness-Based Therapies may require substantial adjustments in treatment planning, patient engagement strategies, and ongoing professional development for healthcare providers. Clinics may need to develop new protocols to integrate these therapies effectively with existing treatments, continuously assess their effectiveness, and adjust therapeutic approaches based on patient feedback and clinical outcomes (Kahl, Winter, & Schweiger, 2012). Furthermore, healthcare providers could benefit from professional development opportunities that enhance their skills in these therapeutic techniques, ensuring they are well-prepared to deliver these treatments effectively and adapt them to meet the evolving needs of their patients.

Overall, the incorporation of ACT and Mindfulness-Based Therapies into clinical practice not only holds the promise of improved patient care and outcomes but also carries significant implications for healthcare delivery, professional training, and health policy. This supports a strong case for their broader adoption within mental health services, potentially transforming approaches to treatment and care in this field.

Limitations and Future Research

The review is subject to some limitations that primarily arise from the inherent constraints within the included studies. A concern highlighted within the quality appraisal is selective reporting and incomplete outcome data. This incomplete data limits the confidence in the findings and the capacity to draw broad, definitive conclusions. Additionally, the heterogeneity observed among the studies in terms of intervention methodologies, settings, and populations further limits the quantitative rigour of the results. These factors collectively underscore the need for future research to adopt more standardised intervention protocols, and to also ensure complete and transparent reporting of data to enhance the reliability and applicability of the evidence (American Psychological Association, 2020). By addressing these limitations, future studies can provide more robust and generalisable insights into the effectiveness of third-wave therapies for IAD and SSD

In conclusion, this systematic review highlights the potential effectiveness of ACT and Mindfulness-Based Therapies in managing SSD and IAD with promising implications for enhancing quality of life among affected individuals. These therapies demonstrate significant benefits across diverse settings and populations, offering flexible, adaptable treatment options that complement existing therapeutic approaches such as CBT. Future research should focus on addressing these methodological challenges, conducting comparative effectiveness research, and exploring long-term outcomes to solidify the role of ACT and Mindfulness-Based Therapies within clinical practice. Strengthening the evidence base will be crucial in ensuring that these therapeutic approaches can be confidently recommended and widely implemented to improve patient outcomes in clinical settings.

Figures

Figure 1 – PRISMA Flowchart

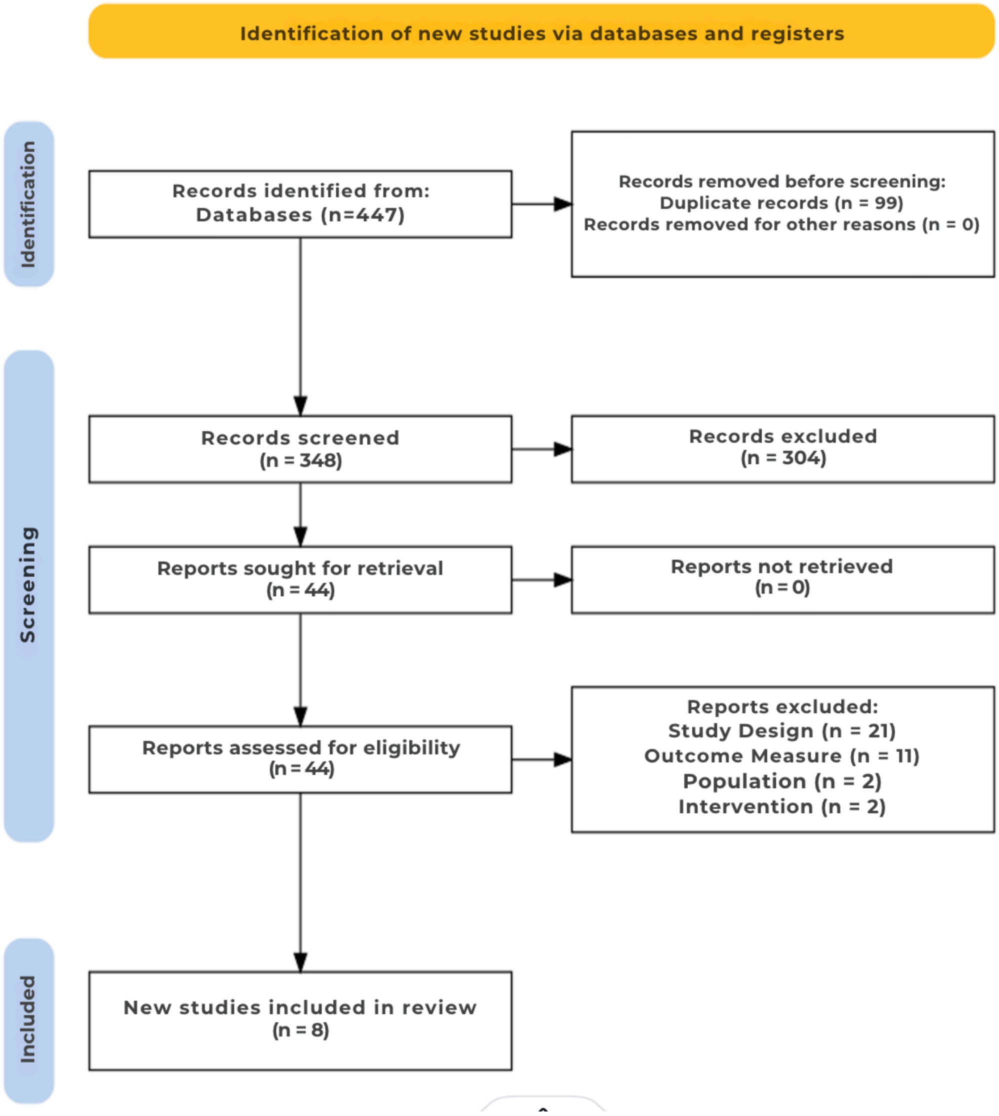
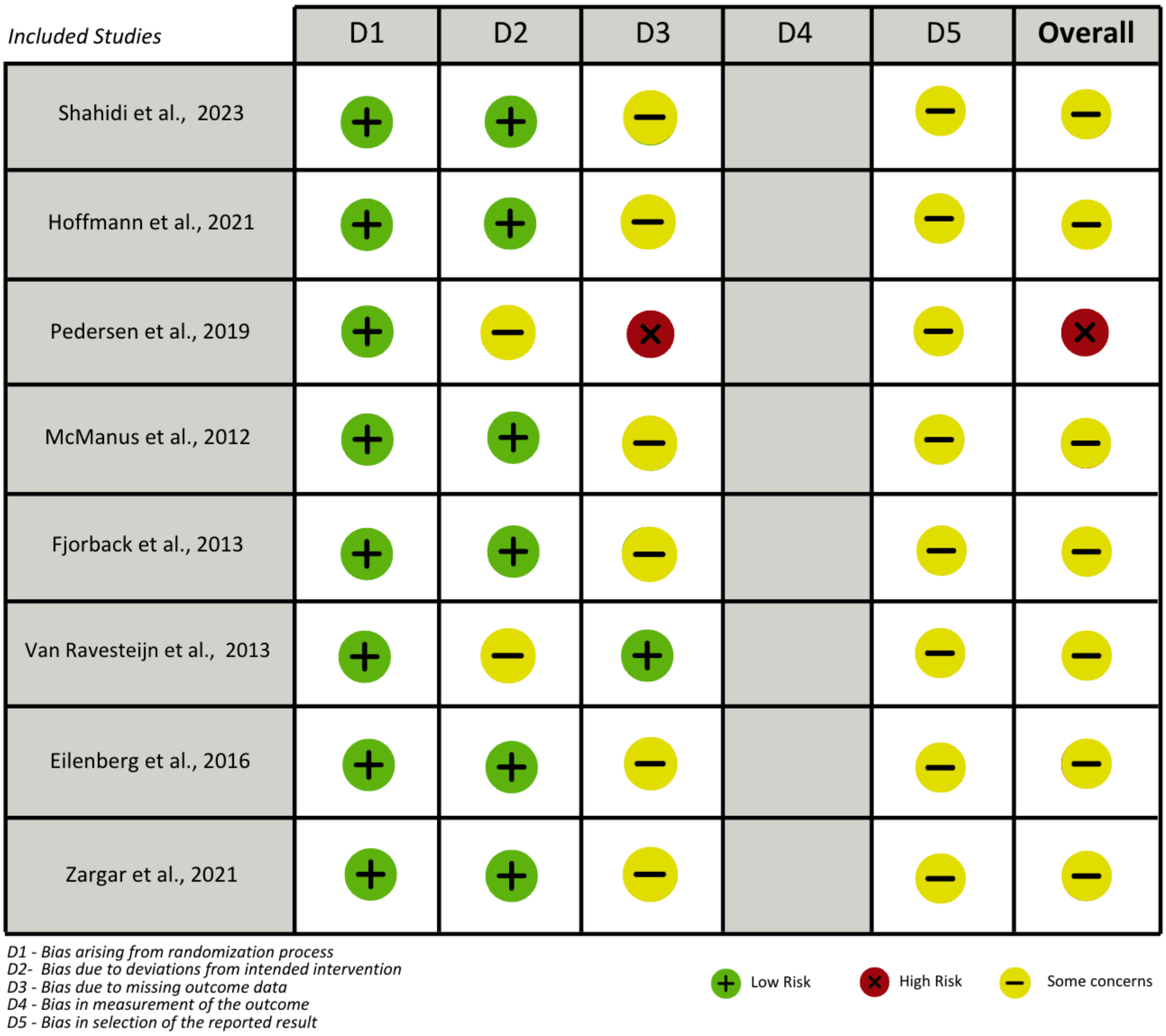


Figure 2 – Cochrane Risk of Bias Tool



Included Studies	D1	D2	D3	D4	D5	**Overall**
Shahidi et al., 2023	+	+	−		−	−
Hoffmann et al., 2021	+	+	−		−	−
Pedersen et al., 2019	+	−	×		−	×
McManus et al., 2012	+	+	−		−	−
Fjorback et al., 2013	+	+	−		−	−
Van Ravesteijn et al., 2013	+	−	+		−	−
Eilenberg et al., 2016	+	+	−		−	−
Zargar et al., 2021	+	+	−		−	−

D1 - Bias arising from randomization process
D2- Bias due to deviations from intended intervention
D3 - Bias due to missing outcome data
D4 - Bias in measurement of the outcome
D5 - Bias in selection of the reported result

+ Low Risk
× High Risk
− Some concerns

Tables

Table 1 – Study Overview Table

Authors (Year of Publication)	**Country**	**Sample**	**Study Design**	**Participants (Treatment & Control)**	**Therapy Approach**	**Therapy Duration**	**Outcome Measures**	**Summary of findings**	**Quality Appraisal**
Shahidi, S., Zargar, F., Khajelangi, H.A., Tarrahi, M.J. (2023)	Iran	Caregivers of patients with Covid-19 experiencing Health Anxiety	RCT	Intervention n=32 Control n=32	Internet Delivered Mindfulness Stress Reduction with Acceptance & Commitment Therapy	Once weekly for 9 Weeks	Whitely Index (WI) Quality of Life Questionnaire-12 (SF-12)	Significant improvements in health anxiety and quality of life in the intervention group compared to the control group. Health Anxiety Inventory WI scores decreased significantly in all subscales and the total scores post-intervention. There were also significant improvements in quality of life.	Some concerns
Hoffmann, D., Rask, C.U., Hedman-Lagerlöf, E., Jensen, J.S., Frostholm, L. (2021)	Denmark	Adults with severe Health Anxiety	RCT	Intervention n= 53 Control n=48	Internet Delivered Acceptance & Commitment Therapy	Once weekly for 12 Weeks	Health Anxiety Inventory Short From (SHAI) Whiteley Index (WI-7) Hopkins Symptom Checklist-92 (SCL-92)	The ACT Intervention significantly reduced health anxiety compared to the control group. Reduced HAI effects were further maintained at a 6-month follow-up	Some concerns

Pedersen, H.F., Agger, J.L., Frostholm, L., Jensen, J.S., Ornbol, E., Fink, P., Schröder, A. (2019)	Denmark	Patients with multi organ functional somatic disorders	RCT	Enhanced Care (Control) n= 59 Brief ACT n=61 Extended ACT = 60	Group Acceptance & Commitment Therapy	Brief - 2 Full day workshops Extended- 9 Weekly 3 hours sessions	Global health improvement scale (CGI) Short form 36 Health Survey (SF-36) Hopkins Symptom Checklist (SCL-92) Whiteley Index (WI-7)	Patients rated their overall health status as more improved after Extensive ACT than after EC; however, clinically relevant secondary outcome measures did not support this finding. No significant differences were found between Brief ACT and EC	High Risk
McManus, F., Surawy, C., Muse, K., Vazquez-Montes, M., Mark Williams, J.G. (2012)	United Kingdom	Patients with a diagnosis of Hypochondriasis	RCT	Unrestricted Services n= 38 MBCT n= 36	Group Mindfulness Based Cognitive Therapy	8 Weekly 2-hour sessions	Health Anxiety Inventory Short From (SHAI) Whiteley Index (WI-7) Beck Anxiety Inventory (BAI) Beck Depression Inventory (BDI)	Measures of health anxiety showed that the MBCT group's score was significantly lower than the US group's, both immediately following the intervention period and at the 1-year follow-up. No significant change was identified in reductions of depression or general anxiety.	Some concerns
Fjorback, L.O., Arendt, M., Ørnbøl, E., Walach, H., Rehfeld, E., Schröder, A., Fink, P. (2013)	Denmark	Patients with a diagnosis of Somatisation Disorder / Bodily Distress Syndrome	RCT	Enhanced treatment as usual = 60 MBSR = 60	Mindfulness Based Stress Reduction	8 Weekly 3.5 hours sessions	F-36 Physical Component Summary (PCS) Whitely-8-index CL-90-R Somatization Subscale	Mindfulness therapy was superior to enhanced treatment as usual at the end of treatment. However, at the 15-month follow-up, the enhanced treatment as usual group showed comparable gains. The trial demonstrated that mindfulness therapy is feasible and acceptable to patients with multi-organ BDS	Some concerns

Van Ravesteijn, H., Lucassen, P., Bor, H., Van Weel, C., Speckens, A. (2013)	Holland	Medically Unexplained Symptoms	RCT	MBCT = 64 Enhanced usual care n=61	Mindfulness-based cognitive therapy	8 Weekly 2.5 hour sessions	EuroQol 5D (EQ-5D) Medical Outcomes Study 36-Item Short Form (SF-36). Whitely Index (WI-14) Patient Health Questionnaire (PHQ-9)	Health status and physical functioning did not significantly differ between groups. However, participants in the MBCT group reported a significantly greater improvement in mental functioning at the end of treatment	Some concerns
Eilenberg T, Fink P, Jensen JS, Rief W, Frostholm L. (2016)	Denmark	Patients with a diagnosis of Health Anxiety	RCT	ACT-G n= 58 Waitlist n= 63	Acceptance and commitment group therapy	10 Weekly 3 hour sessions	Whitely Index (WI-7) 90-item Symptom Checklist 12-item somatization subscale, SCL-som Symptom Checklist scale (8-item, SCL-8)	Statistically significant improvements on the primary outcome of illness worry were seen in ACT-G compared to the waitlist. The therapeutic results were sustained at 10 months' follow-up with a large between-group effect size	Some concerns
Zargar F, Rahafrouz L, Tarrahi MJ. (2021)	Iran	Patients diagnosed with Somatic Symptom Disorder	RCT	MBSR+ Venlafaxine n=20 Only Venlafaxine n=20	Mindfulness Based Stress Reduction	8 Weekly 2 hours sessions	Depression Anxiety Stress Scale (DASS) 36-Item Short-Form Survey (SF-36) Patient Health Questionnaire Physical Symptom (PHQ-15)	MBSR along with venlafaxine can significantly reduce the levels of depression, anxiety, and stress in patients with SSD. MBSR significantly reduced the number and severity of physical symptoms of SSD based on PHQ-15 in the MBSR group, compared to the venlafaxine alone group.	Some concerns

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2.2 Systematic Review Reflective Commentary

Background

Within health psychology, the continual synthesis of research findings is crucial for evidence-based decision-making (Bridle, 2003). The impact of research reviews supports policymakers, healthcare providers, researchers, educators, and clinicians involved in the management of psychological and physical health disorders (Bridle, 2003). This commentary outlines the experiences and reflections developing and creating a systematic review exploring Third-Wave therapy approaches for Illness Anxiety Disorders (IAD) and Somatic Symptom Disorders (SSD).

Identifying the research area

My decision to embark on this systematic review was strongly motivated by my dual roles as a practitioner, teacher, and consultant. In my clinical practice, I extensively utilise third-wave therapies to treat individuals grappling with IAD, SSD, long-term conditions and insomnia. Additionally, in my academic role, I specifically teach on the management of long-term health conditions, employing a variety of third-wave therapeutic techniques. Although I had observed the benefits of these therapies anecdotally in practice and was aware of the benefits for long-term conditions, I felt that embarking on the review would bolster my confidence in their application for specifically IAD and SSD.

During the initial scoping phase of my research, I was struck by the overwhelming number of non-academic online articles discussing the benefits of third wave therapies. Despite the abundance of these claims, I felt a growing concern about the significant gap in the direct referencing of empirical research within these discussions. It was disheartening to see many sources discussing the intervention aspects of these therapies without robust scientific evidence to support their effectiveness. Additionally, I observed that existing studies often addressed IAD and SSD, but frequently intertwined this focus with conditions like irritable bowel syndrome (IBS), fibromyalgia, and chronic pain. This overlap blurred the lines between physical health and psychosomatic conditions. This gap in the literature suggested an oversight that fuelled my determination to pursue this systematic review.

The necessity for this review became even more apparent during conversations with my manager, whose scepticism about the effectiveness of third-wave therapies left me feeling a mix of concern and determination. His reservations mirrored a broader sentiment of cautious acceptance among healthcare colleagues, which underscored the urgency of investigating these therapies' effectiveness. These discussions not only emphasised the importance of surveying the available evidence but also highlighted the critical need to address gaps in the application of third-wave therapies for treating pure forms of illness anxiety disorders. This exploration felt essential to provide a clearer picture of the therapeutic landscape, ultimately enabling more informed decisions in both clinical practice and therapy education.

Designing the Systematic Review:

Writing the protocol

Drafting the protocol for my systematic review was an enlightening and formative experience. Initially, I intended to focus exclusively on health anxiety within the context of third-wave therapies. However, as I delved deeper into my research, I felt a growing awareness that IAD’s not only encompass health anxiety but are also closely related to SSD’s and Medically Unexplained Symptoms (MUS), a phenomenon well-documented in clinical literature (Sansone & Sansone, 2010). This realisation broadened the scope of my review, compelling me to address the nuances and overlaps between these conditions more comprehensively. The expanded focus aimed to provide a more holistic view of how third- wave therapies are applied across these related yet distinct conditions, enhancing the relevance and utility of the findings for practitioners and researchers alike. Drafting the review protocol for the first time felt like navigating unfamiliar territory, but it proved to be a crucial step in refining my objectives and streamlining the aims of the study.

Using PROSPERO for the first time when writing this protocol was an eye-opening experience that introduced me to a structured approach to planning systematic reviews. Initially, I was apprehensive about whether I could effectively manage the complexities of such a detailed review process. The detailed questions in the PROSPERO registration form prompted me to think critically about various aspects of my research, from methodological considerations to the implications of my findings. Completing this registration, followed by receiving ethical approval from Staffordshire University, not only formalised my review process but also significantly enhanced my understanding of the essential elements that underpin a rigorously designed systematic review. This process alleviated my earlier concerns, as it steered the direction of my research and provided a clear plan for managing each step of my review. This structured approach left me feeling more confident and prepared to undertake a thorough and systematic investigation.

Throughout the process of writing my protocol, the consultations with my academic supervisor and placement supervisor were invaluable. Initially, I was apprehensive about navigating the complexities of systematic review methodology. However, these discussions were instrumental in refining my research aims and further developing my protocol. Their insights helped me align my theoretical understanding with practical research applications, gradually alleviating my initial concerns. I feel that these interactions not only improved my protocol writing ability but also contributed significantly to my development as a trainee psychologist, enhancing my confidence and competence in conducting research of this nature. This experience has instilled in me a deeper appreciation for the meticulous planning that goes into a systematic review and has equipped me with the skills necessary to tackle future research projects with a structured and informed approach.

Defining the search terms and conducting the search

Defining the appropriate search terms for my systematic review presented a significant challenge, primarily due to the evolving and varied definitions of Third

Wave Cognitive Behavioural therapies. The complexity was further amplified by the continuous updates in clinical classifications, such as the transition from hypochondriasis in older diagnostic manuals to newer terms and criteria in the DSM (American Psychiatric Association, 2013). This ambiguity necessitated a thorough consultation with a placement colleague (who also works with IAD's), who provided invaluable guidance on navigating these classifications. Additionally, I engaged in a scoping review of existing literature within this domain to ensure my search terms were both current and relevant. This process was not only crucial for setting the boundaries of my review, but I felt also served as an important learning experience in understanding the dynamic nature of psychological classifications and their implications for research (Kellerman, 2019).

The initial attempt to conduct the search was overwhelming, yielding over 4000 papers. This vast output initially worried me, but clearly indicated a need to refine my strategy significantly. After discussing my approach with my academic supervisor, I received guidance on improving my advanced search techniques across databases such as PubMed and Scopus (Young, 2017). This advice was instrumental in not only reducing the number of irrelevant articles but also in enhancing my skills in database navigation; after refining this my results returned just over 500 papers in comparison. Once the search terms were correctly defined and the search strategy was refined, I found the process of conducting the search and managing the results relatively straightforward. I thoroughly enjoyed the process of downloading and organising the relevant articles into my reference management suite, which marked a satisfying progression in my research process. This phase of the systematic review not only improved my technical skills in executing complex searches but also boosted my confidence in managing large datasets, an essential skill for any researcher in the field of psychology (Booth, Sutton, & Papaioannou, 2016).

Conducting the Systematic Review:

Screening

Conducting the screening process for my systematic review was a crucial phase, significantly enhanced using Rayyan, a systematic review software. I feel very comfortable using technology due to experiences of using a range of suites for data collection and survey management. This meant that I found the software particularly user-friendly and efficient, streamlining the management and organisation of a large volume of literature. Rayyan was instrumental in enabling rapid elimination of duplicates and facilitating effective collaboration with my second reviewer. This collaboration proved essential during both the title and abstract screening phases and the full-text reviews, allowing my second reviewer and I to quickly resolve any discrepancies or queries that emerged. The digital tools not only made the process more enjoyable but also underscored the importance of leveraging advanced technology to enhance the accuracy and efficiency of systematic reviews (Ouzzani et al., 2016).

Despite the technological support, the screening process was not devoid of challenges. Most of the studies initially identified were excluded because they did not specifically address the domains of health anxiety, somatic symptom disorder, or third wave therapies, often focusing instead on standard CBT or pooling health anxiety with other physical health conditions. Of the initial pool, 33 studies warranted full-text reviews. I found this phase straightforward yet time-consuming and quite monotonous. This experience highlighted the critical value of having a second reviewer, demonstrating how collaborative efforts can mitigate the tedious nature of extensive screening tasks. In future projects, I plan to allocate more time for this process, appreciating the importance of thorough screening and the benefits of involving multiple perspectives in systematic reviews (Godin et al., 2015). This reflection has been crucial in my development as a trainee psychologist, enhancing my project management skills and deepening my appreciation for collaborative research dynamics.

Data extraction

For the data extraction phase of my systematic review, I adopted a summarised version of the Cochrane Collaboration's RCT data extraction form, which has been widely used in similar reviews focusing on therapy approaches (Higgins & Green, 2011). This form provided a structured and systematic framework for collecting necessary data, aligning with the guidelines I established in my initial protocol. I found the structured approach was immensely helpful in organising the data extraction process systematically and consistently, allowing me to maintain focus and efficiency despite the complex nature of the task. I feel that utilising a proven template not only facilitated a smoother extraction process but also ensured that all relevant data elements were comprehensively captured, enhancing the reliability of my review.

The data extraction process presented considerable challenges due to the heterogeneity of the studies included in my review. The diversity in therapies, outcome measures, and intervention lengths made it difficult to find consistency in the data extracted, and some studies lacked critical information on sampling methods and the qualifications of those making the diagnoses, as noted by Moher et al. (2009). This was frustrating and slowed my ability to extract and synthesize findings, requiring multiple readings to ensure accuracy. These inconsistencies forced me to adopt a more methodical approach to data extraction and interpretation, which ultimately proved beneficial by emphasizing the importance of attention to detail. Creating a detailed extraction table and having it reviewed by my module and academic supervisors was both a learning opportunity and a crucial quality control step, refining the data extraction process and ensuring accuracy. This experience, though initially daunting, enhanced my skills in managing and synthesizing heterogeneous research data. It instilled in me a deeper understanding of the intricacies of data extraction, boosted my confidence, and prepared me for future comprehensive research projects in my career as a health psychologist.

Quality assessment

The quality appraisal stage of my systematic review involved using the Cochrane risk of bias tool, as advised by my supervisor, tailored specifically for the appraisal of randomised controlled trials (RCTs). Initially, I faced significant challenges with this tool; its comprehensive guidance document was intricate, and I felt somewhat overwhelmed for someone who was not familiar with previously carrying out systematic review. This complexity meant a short delay in beginning the appraisal process as I dedicated time to thoroughly understand and correctly apply the criteria. Despite these initial hurdles, the process of familiarising myself with such a detailed and critical evaluation tool proved invaluable. It deepened my understanding of methodological nuances involved in assessing the quality of RCTs and reinforced the importance of a meticulous approach to systematic reviews (Higgins et al., 2011).

In my initial risk of bias assessment, I included all domains of the Cochrane risk of bias scale, including domain 4 which addresses blinding of participants and personnel. Since blinding is not feasible in psychotherapy trials, I removed the domain 4 section after consulting with my supervisor, which reduced most of the studies initial risk of bias from high to 'some concerns’. This proved a significant relief as I was initially apprehensive that my review would have a reduced validity as a result of the high risk across studies. I learned that some concerns related to risk of bias is a prevalent issue in psychotherapeutic RCTs and interventions. This understanding helped me develop a more critical and informed perspective as a trainee psychologist, recognising the limitations inherent in the field and learning to contextualise findings within the broader scope of evidence-based practice (Khan et al., 2016). This phase of the review not only enhanced my skills in critical appraisal but also prepared me for the complexities of conducting and evaluating research in real-world clinical contexts, contributing significantly to my development as a professional.

Writing up

Writing up my first systematic review was a multifaceted learning experience that was both challenging and rewarding. One of the primary hurdles of writing up was familiarising myself with narrative synthesis; a methodology I had not previously employed. This approach required integrating diverse quantitative data into a coherent narrative, a task that necessitated a thorough understanding of the research studies in my review (Popay et al., 2006). This steep learning curve was initially daunting; however, with guidance from my module leader and through extensive literature review, I feel that I was able to understand the required layout and requirements for the synthesis. I feel that this challenge not only enhanced my methodological skills but also taught me the critical importance of narrative in presenting research findings effectively. Simultaneously, managing the project under tight deadlines tested my organisational skills and personal resilience. Due to the deadline, I decided to work systematically each evening for at least two hours, which became a pivotal strategy in managing my time effectively, ensuring steady progress while maintaining a high standard of work (Boice, 2000).

Moreover, optimising my use of reference management tools like Rayyan and EndNote was crucial in keeping the vast amount of literature organised, which significantly streamlined the writing and editing process (Lipowski, 2008). Throughout this journey, the feedback from my academic supervisor and the insights from peer consultations were invaluable in writing my manuscript. I found that this consultation not only helped refine my analysis and enhance the narrative flow of the review but also instilled a confidence in my ability to write a coherent and competent review (Mullins & Kiley, 2002).

Dissemination

After conducting an extensive research process that involved reviewing previously published articles and identifying journals that align with the scope of my review, I chose to submit my findings to Psychology and Psychotherapy: Theory, Research and Practice. This decision was informed by several factors. First, the journal permits systematic reviews of up to 6000 words, offering sufficient space to present a comprehensive analysis of the data. This is particularly important given the depth and complexity of the review, which necessitates a detailed discussion of findings and their implications for clinical practice. Moreover, the journal has a strong track record of publishing systematic reviews and research on third wave therapies, including Acceptance and Commitment Therapy, Mindfulness Therapy, and other related approaches. I felt that the journal's commitment to advancing theory, research, and practice in psychology also aligned well with the objectives of my systematic review, which seeks to inform and refine therapeutic practices through rigorous analysis.

In addition to journal publication, I am acutely aware of disseminating my findings through my teaching and consultancy roles. Previously, although I was aware of the general research around third wave therapies for IAD’s and SSD’s, I now feel much more confident speaking on this area. I feel that I will be able to implement this into my teaching and use this research to inform trainee therapies, assistant psychologists, and other practitioners about the effectiveness of these therapies.

Lessons Learned

From the outset, the challenge of managing an extensive body of research was daunting. The importance of organisation in the systematic review process became quickly apparent, echoing the advice of seasoned researchers (Booth, Sutton, & Papaioannou, 2016). Initially, my approach to organising references and data was less structured, which led to inefficiencies that hindered my progress. The realisation of this oversight prompted a strategic shift; I restructured my workflow by categorising papers into designated folders and utilizing Rayyan, a tool designed for systematic review management. This not only streamlined the review process but also mitigated the overwhelming feeling of disorganisation, which I feel significantly accelerated my screening efficiency (O'Connor, 2019).

Reflecting on these challenges, the development of robust organisational skills was a crucial takeaway. The ability to pivot and adapt strategies in response to obstacles has enhanced my resilience and problem-solving capabilities, which are essential traits for a health psychologist. Furthermore, the detailed engagement with the literature deepened my understanding of third wave therapies, enriching my clinical and academic perspectives. This immersion into the subject matter significantly improved my expertise and confidence in discussing and teaching these concepts (Kahl, Winter, & Schweiger, 2012).

This systematic review not only reinforced my foundational research skills but also instilled a newfound appreciation for the synthesis of complex data into actionable insights. The process was immensely gratifying and has become a cornerstone of my academic and professional journey. It has sparked a keen interest in continuing to conduct systematic reviews, which I now view as integral to both evidence-based practice and teaching in health psychology.

Conclusion

In conclusion, the process of conducting this systematic review was a pivotal development in my progression as a trainee health psychologist. It challenged me to develop critical research skills, fostered a deep understanding of third wave therapies, and enhanced my ability to convey complex information effectively. The experience has profoundly shaped my professional approach and will undoubtedly influence my future work in clinical, educational, and research settings. As I continue my journey, the skills and insights gained from this systematic review will remain invaluable assets in my endeavour to contribute meaningfully to the health psychology field.

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2.3 Quantitative Research Manuscript

Exploring Perceptions of Therapy Modalities Before & After the COVID19 Pandemic.

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Abstract

Introduction: Amid the COVID-19 pandemic, mental health care rapidly transitioned to digital modalities. This study explores the change in individuals' reported acceptability such as perceived effectiveness and convenience, alongside perceived intent to use psychological therapy modalities before and after the pandemic.

Methods: The researchers conducted a retrospective cross-sectional survey with 188 participants, employing repeated measures ANOVA to compare preferences for face-to-face, online video, text, and telephone therapies at two different timepoints (before and after the Covid-19 pandemic).

Results: The study found a reported increase post-pandemic perceived intentions to engage in online video and text therapies. While the perceived intent for face-to-face and telephone therapies remained largely unchanged, the reported perceived acceptability decreased in contrast to the growing favourability of digital options. Demographic interaction effects were reported, indicating variances in therapy modality shifts across different populations**,** highlighting the influence of factors such as gender, location, and prior therapy experience.

Conclusions: Post-pandemic, participants reported a perceived increased acceptability toward digital therapy modalities. The study reported that face-to-face and telephone therapies maintained similar levels of acceptance and intention to use, both before and after the pandemic, underscoring the need for diverse therapeutic options in post-pandemic mental health care.

Keywords: Teletherapy, Covid-19, Online Therapy, Text Therapy, Digital Health, Therapy

Practitioner Points

- Practitioners should consider offering a variety of therapy modalities, including digital options, to meet diverse patient needs.
- Awareness of demographic influences can help tailor therapy modalities to specific patient groups.
- Training in digital therapy modalities may become increasingly important to accommodate the post-pandemic shift in patient preferences.

Introduction

The COVID-19 pandemic has precipitated an unprecedented mental health crisis, exacerbating pre-existing conditions and triggering new psychological challenges across the global population (Miyah et al., 2022). The pervasive impact of the pandemic, characterised by social isolation, economic uncertainty, and health-related anxieties, has led to a substantial increase in the prevalence of mental health issues, prompting more individuals to seek therapeutic support (Pandey et al., 2021). Studies have reported a significant rise in symptoms of anxiety, depression, and stress, reflecting the profound psychological toll of the pandemic (Pfefferbaum & North, 2020). Mental health services have seen a parallel rise in demand, as individuals have faced the multifaceted impacts of prolonged lockdowns, grief from the loss of loved ones, and a continuous state of heightened alert, prompted by the global health emergency (Cullen, Gulati, & Kelly, 2020).

The pandemic prompted a significant paradigm shift across various sectors, with mental health care experiencing significant transformations. This global crisis required a rapid and fundamental shift in how mental health services are delivered and highlighted the importance and reliance on digital health solutions. As face-to-face interactions became limited due to physical distancing measures, mental health practitioners and clients adjusted towards alternative modes of therapy delivery (Smith et al., 2020; Pandey et al., 2021). The pandemic not only accelerated the adoption of digital solutions but also highlighted their potential in enhancing the accessibility and effectiveness of mental health care and therapy (Phillippe et al., 2022).

Mental health care has recently been significantly influenced by technological advancements and societal shifts. Traditional therapy, predominantly conducted face-to-face, has long been the standard modality of talking therapy. This mode of therapy, emphasising direct personal interaction and presence, has long been argued to be foundational in establishing and maintaining therapeutic relationships (Wentzel, van der vaart, Bohlmeijer & Gemert-Pijnen, 2016). However, even prior to the COVID-19 pandemic, the field of mental health demonstrated a slow-growing emphasis on diversifying therapy modalities to enhance accessibility and convenience (Kopelovich et al., 2021).

One notable trend has been the rising popularity of online video therapy. Platforms such as Zoom, Skype, and Microsoft Teams have facilitated a near face-to-face experience with the added benefit of accessibility regardless of geographic location. A survey by the American Psychological Association (APA) found that before the pandemic, approximately 29% of psychologists were providing treatment via digital health solutions, including video conferencing. This number increased significantly during the pandemic, with more than 76% of psychologists reporting using digital health solutions to treat clients (APA, 2022).

In addition to online video therapy, text-based therapy, encompassing SMS and various messaging apps, represents another significant shift in therapeutic approaches. This modality offers flexibility, allowing for asynchronous communication and immediate support when needed. A study by Bucci et al. (2019) highlighted the growing acceptance of text therapy, especially among younger populations who are generally more comfortable with digital communication. The appeal of this modality is hypothesised to exist in its immediacy and the degree of anonymity it can provide, potentially reducing stigma and encouraging openness in therapeutic conversations (Dwyer et al., 2021). Telephone therapy, though a more established form of remote therapy prior to the pandemic, has also seen renewed interest. Its simplicity and accessibility, especially for those without reliable internet access or digital literacy, make it a vital option. According to Khademi et al. (2023), telephone therapy has remained a consistent and crucial element of services, offering an indispensable option for individuals facing barriers to in-person or online therapy.

The adoption of these various modalities, collectively known as teletherapy, digital health or e-therapy, has broadened the reach of mental health services. They address numerous barriers associated with traditional therapy, such as geographical constraints, physical disabilities, time limitations, and the social stigma of seeking mental health care (Turgoose, Ashwick & Murphy, 2017). For instance, in a survey conducted by Orsolini et al. (2021) it was found that among adolescents and young adults, there was a marked preference for digital communication methods in therapy, reflecting a generational shift in communication habits and comfort levels.

Despite these advancements, the adoption and effectiveness of different therapy modalities are influenced by a variety of factors, including the nature of mental health issues, client and therapist preferences, expertise in specific modalities, and the availability of technological infrastructure (Alang & McAlpine, 2020). Understanding these nuances and the changing preferences towards therapy modalities is critical, especially in the context of ongoing healthcare challenges and transformations like those induced by the COVID-19 pandemic. These shifts in therapy preferences were not only a reflection of the constraints imposed by the pandemic but also indicative of a broader acceptance and integration of technology in mental health services. The rapid adoption of teletherapy modalities has sparked discussions about the future of mental health care, highlighting questions about the long-term implications for therapist training, regulatory standards, and the overall structure of mental health services (Bekes et al., 2023).

Despite the wealth of studies focusing on the rapid transition to teletherapy during the COVID-19 pandemic, there remains a notable gap in the literature regarding the perceived acceptability and intention of clients towards varied therapy modalities before and after the pandemic. While there is acknowledgment of the increased use of teletherapy, research often does not distinguish between the unique shifts that occurred across different therapy modes such as face-to-face, online video, text, and telephone therapy. A further gap is the relative scarcity of research into the perspectives of those who may not have had prior experience with therapy before the pandemic. Understanding the perceptions and potential barriers for this group is essential for tailoring future mental health services to a potentially new demographic of therapy users.

Most existing research has concentrated on the effectiveness and client satisfaction of teletherapy modalities during the pandemic (Pierce et al., 2021), often with an emphasis on short-term adaptations rather than long-term changes in perceptions and preferences. Additionally, there is a scarcity of studies that consider the impact of these shifts across various demographics, including gender, and geographic location, which are crucial for understanding the broader implications of these changes (Borghouts et al., 2021).

This research aimed to provide a comparative analysis of therapy modality preferences before and after the onset of the COVID-19 pandemic. By establishing a retrospective baseline of perceived pre-pandemic preferences and comparing them with those following the pandemic, the study sought to offer insights into the potential impact of the pandemic on mental health care.

Research Question

The objectives of this study were to: 1) explore changes in individuals' perceived intent to use and acceptability of face-to-face, online video, text, and telephone therapy pre- and post-pandemic; and 2) examine the influence of additional variables such as gender, access to stable internet connection, experience of previous therapy and location on these perceptions.

Methods

Study Design

This research employed a retrospective cross-sectional study design, utilising a quantitative approach to explore perceptions of various therapy modalities before and after the COVID-19 pandemic. The study recruited participants between June and August 2023 and obtained their retrospective perceptions of intention and acceptability of four therapy modalities (online video, text, face-to-face, and phone) across two time points (their perception before and after the COVID-19 pandemic). The retrospective design utilised within this study was necessary due to the inability to obtain cross-sectional data for participants' intentions and acceptability prior to the pandemic; this study design was therefore suited to providing participants the ability to reflect on their beliefs prior to and following the pandemic.

Measures

The core measure for this study was a structured questionnaire informed by Sweeney et al.'s (2017) research and was adapted to explore perceptions of varying therapy modalities in the context of the COVID-19 pandemic. The measure used in the Sweeney study was developed based on previous online therapy research, in consultation with online therapy researchers and additionally demonstrated a high internal consistency within the prior study (Cronbach's α = 0.95). The adapted measure consisted of 8 initial Likert questions exploring likelihood to use four different modes of therapy (online video, telephone, text, face to face) prior to and following the Covid-19 pandemic (with higher scores demonstrating greater likelihood to engage with the therapy mode). A further 9 Likert questions were asked about perceived acceptability of the therapy modes (e.g. I feel I would be able to schedule this therapy easily around my routine, I feel I would be able to develop rapport with my clinician), with a maximum score of 36 and higher scores demonstrating increased perceived acceptability of the therapeutic mode.

Participants' demographic data were also collected including age, gender, location (rural, suburban, urban), access to stable internet connection and previous history of therapy. These variables are heavily referenced in the literature to interact with intentions to engage with different therapy services (Hull & Mahan, 2017). Exploring these factors therefore, allowed an additional layer of analysis to explore potential factors that influenced perceived intentions and acceptability of the therapy modes; a methodological recommendation for enhancing health research (Johnson, Collins & Onwuegbuzie's, 2011).

Participants

Sample Size and Justification

The study aimed to recruit a minimum of 160 participants based on power analysis principles for repeated measures ANOVA. According to Cohen (1992), a sample of this size is generally adequate to detect medium effect sizes ($\eta p2=0.06$) with a power of 0.80 at a significance level of 0.05. However, recognising the potential for non-response or incomplete data, which is a common issue in online surveys (Wright, 2017), the recruitment target was to oversample by around 15%; aligning with recommendations by VanVoorhis and Morgan (2007), who suggest over-sampling to compensate for anticipated data loss or attrition.

Participant Demographics

The current investigation surveyed 188 participants, with gender distribution being predominantly female, constituting 78.7% of participants (n = 148), with males representing 21.3% (n = 40). The sample was geographically diverse, with nearly half residing in suburban areas (n = 88, 46.8%), a similar proportion in urban settings (n = 82, 43.6%), and a smaller segment from rural environments (n = 18, 9.6%). The accessibility of stable internet was high among participants, with 91.5% (n = 172) affirming its availability. Prior engagement with therapy was less common, only reported by a third of the sample (n = 62, 33%), while the remaining two-thirds (n = 126, 67%) had no history of therapy engagement. The average age of participants was 34.41 years, with a standard deviation of 8.67 years, suggesting a predominantly middle-aged cohort.

[Insert Table 1 Here]

Recruitment Strategy

Recruitment was conducted through opportunity sampling on various social media platforms (Facebook, Instagram and LinkedIn), chosen for their extensive reach across diverse demographic groups. This method facilitated access to a broad audience, increasing the likelihood of recruiting a sample that is diverse in terms of age, gender, geographical location, and experiences with therapy (Elfil & Negida, 2017). The focus on recruiting a demographically diverse sample was essential to explore the potential variability in therapy modality preferences across different population segments. Diversity in the sample was key to examining how demographic factors such as gender, and geographical location might influence perceptions of and attitudes towards various therapy modalities.

Procedures

Following the procurement of ethical approval from Staffordshire University, an online recruitment strategy was implemented. Targeted social media postings on platforms such as Facebook, Twitter, and LinkedIn served as the primary recruitment channels, succinctly presenting the study's aims and inviting participation through an embedded link to the questionnaire.

As participants engaged with the study via the provided link, they encountered an informed consent form that confirmed the voluntary nature of participating, the confidentiality and anonymity of their responses, and the freedom to withdraw from the study without any consequence. Following consent being obtained, the participants proceeded to the online questionnaire, hosted on a secure web-based survey platform (SurveyMonkey Enterprise) to protect participant data.

The questionnaire was constructed to be both comprehensive and considerate of participant time, with an average completion duration of about 15 minutes. It methodically captured a wealth of data, starting with demographic details, then progressing to questions about technological access, prior experiences with therapy, and perceptions of various therapy modalities. On completion of the questionnaire, all participants were provided with an online debrief form containing further information on the study aims and signposting to free impartial support if necessary.

Following data collection, the responses were downloaded and anonymised, ensuring that personal identifiers were detached from the dataset.

Data Analysis

The analytical phase employed Repeated Measures ANOVA to explore any shifts in perceptions and attitudes towards different therapy modalities before and after the pandemic, thereby revealing possible changes in the participants reported perceptions for therapy preferences. Following the completion of data collection, the dataset underwent a thorough cleaning process. Participants with missing or incomplete data were removed from the research study (n=30). Due to this, the study analysed 158 participants and therefore did not meet the initially calculated minimum of 160 participants. Descriptive statistics such as means, standard deviations, and frequency distributions were then calculated for all demographic variables and key measures, providing an initial understanding of the sample characteristics and general patterns in the data.

Prior to hypothesis testing, data were examined to ensure the assumptions for conducting repeated measures ANOVA were met. The assumption of sphericity was tested and upheld via Mauchly's test, indicating homogeneity of variances across the repeated measures. Where the assumption of sphericity was upheld, a Greenhouse-Geisser correction was applied (Maxwell & Delaney, 2004). The data also met the assumption of normality, as assessed by Shapiro-Wilk's test, and there were no outliers, as determined by inspection of a boxplot. Significant findings from the ANOVAs were further explored through post hoc analyses, involving pairwise comparisons to delineate specific differences between therapy modalities and time periods.

Descriptive statistics were generated for demographic variables and key measures to provide a foundational understanding of the sample and to identify overarching data trends. The following analysis employed Repeated Measures ANOVAs; a statistical approach well-suited for data involving multiple measurements from the same subjects over time (Field, 2013). This analysis focused on examining within-subjects factors, namely the time period (pre- and during COVID-19), gender, location, previous experience of therapy, access to stable internet connection and the therapy modality (face-to-face, online video, text, telephone).

Results

In this study, repeated measures ANOVAs were employed to evaluate any changes in intentions and acceptability of therapy modalities reported post-pandemic.

Perceived Intention to Engage in Therapy Modalities

Results highlighted a reported change in the retrospectively reported intentions to utilise online video therapy with mean scores for intention increasing from 1.77 (SD=0.771) pre pandemic to 3.48 (SD=1.186) post pandemic F(1.000, 73.977) = 65.947, $p < .001$. This was a large effect size, partial $\eta^2 = .303$. Intentions to use text therapy also demonstrated a significant main effect of time, F(1.000, 196) = 6.001, $p = .015$, $\eta^2 = .034$, with the mean score rising from 2.46 (SD=1.111) pre-pandemic to 2.79 (SD=1.390) post-pandemic, indicating that participants reported being more likely to intent to use text therapy post pandemic. There were no significant changes over time for face to face or telephone modalities of therapy.

[Insert figure 1 here]

The repeated measures ANOVA also revealed a significant interaction between time, gender and previous therapy interaction for face-to-face therapy intent, F(1, 196) = 7.309, $p = .008$, $\eta^2 = .041$. This interaction suggests that the shift in therapy intent over the course of the pandemic was not uniform across all demographic groups. Specifically, males with a history of therapy engagement demonstrated a reported change in their intent to pursue face-to-face therapy post-COVID-19, with mean scores dropping from 4.71 (SD=0.756) to 1.86 (SD=0.690); these results however are predicated on a very small sample size (n=9). In contrast, females without previous therapy experience displayed no statistically significant difference. Males and females with no therapy history also demonstrated no statistically significant changes in intentions to use face-to-face therapy post-pandemic.

[Insert figure 2 here]

Time* Location* Internet Stability* Previous Therapy – Interaction for Online Video Therapy

Intent to use video therapy was influenced by an interaction of time, location, internet stability, and prior therapy, $F(1, 196) = 4.407$, $p = .037$, $\eta^2 = .025$. A reported change was observed among those in rural areas lacking stable internet who had not previously engaged in therapy, with mean scores increasing from 2.00 (SD=0.000) pre-pandemic to 4.50 (SD=0.707) post-pandemic, $F(1, 3.928) = 4.407$, $p = .037$, partial $\eta^2 = .025$.

[Insert figure 3 here]

Acceptability of Different Modalities of Therapy

The analysis found a statistically significant decrease in the retrospectively reported acceptability of face-to-face therapy over time with means declining from 28.03 (SD=4.655) to 24.24 (SD=4.750) $F(1.000, 4.783) = 107.688$, $p = .030$, with a small effect size, partial $\eta^2 = .027$. The acceptability of online video therapy reported a change from 23.52 (SD=5.033) to 28.8 (SD=4.374) $F(1.000, 33.756) = 791.643$, $p < .001$, with a large effect size, partial $\eta^2 = .166$. Text therapy also experienced change in perceived acceptability over time with scores increasing from 17.82 (SD=5.614) to 21.54 (SD=5.059), $F(1.000, 8.919) = 276.354$, $p = .003$, partial $\eta^2 = .050$. There were no statistically significant changes in telephone therapy.

[Insert figure 4 here]

Time*Location*Gender -Intention for F2F Therapy

Acceptability of face-to-face therapy was subject to significant time, location, and gender interaction effects, F(2, 194) = 4.070, p = .019, η^2 = .046. The data indicated a reported decline in acceptability among rural males from 28.50 (SD=2.121) pre-pandemic to 21.50 (SD=3.536) post-pandemic. Suburban females reported a reduction in acceptability, though to a lesser extent from 28.36 (SD=4.917) to 22.78 (SD=4.407). Post-hoc comparisons using the Bonferroni correction were conducted to examine differences in post-pandemic intent; with the results indicating no statistically significant differences.

[Insert figure 5 here]

Time*Internet Stability- Interaction for Online Video Therapy

Online video therapy's acceptability was contingent on a significant interaction between time and internet stability, F(1, 196) = 5.722, p = .018, η^2 = .033. Post-pandemic, individuals with stable internet connections reported a notable increase in acceptability from 24.15 (SD=5.447) pre-pandemic to 28.89 (SD=4.425) post-pandemic; similarly, those without access to stable internet also reported a greater increase in acceptability from 23.21 (SD=4.794) pre-pandemic to 28.75 (SD=4.367) post pandemic.

[Insert figure 6 here]

Discussion

This study explored the impacts of the COVID-19 pandemic on perceived intentions and acceptability of various therapy modalities. Post-pandemic, there was a reported increase in the intention to engage in online video therapy and a moderate rise for text therapy, while intentions for face-to-face and telephone therapies remained largely unchanged. Significant interaction effects were identified: males with previous therapy experience showed decreased intent for face-to-face therapy, whereas females without such history exhibited stable intentions. Rural residents without prior therapy engagement reported a notable increase in intent for online video therapy despite unstable internet connections. Perceived acceptability of face-to-face therapy was reported by participants to reduce, while online video and text therapies saw increased acceptability reported post-pandemic. No significant changes were reported for telephone therapy acceptability. Interaction effects revealed a decrease in face-to-face therapy acceptability among rural males, and a significant interaction between time and internet stability influenced the acceptability of online video therapy, highlighting the role of technological access in therapeutic preferences.

The study identified a retrospectively reported decrease in acceptability of face-to-face therapy. It is worth noting that the analysis interactions for location were split into small samples which does reduce the applicability of the findings. Nevertheless, the results could be indicative of sustained apprehensions regarding in-person interactions, a sentiment that might extend beyond the pandemic's lockdown restrictions. Such concerns may be amplified by the geographic and infrastructural constraints inherent to rural settings. In contrast, the lesser decrease in reported acceptability among suburban females may reflect a comparatively robust confidence in conventional therapy environments, potentially underpinned by improved healthcare systems and a diminished perceived contagion risk in these regions (Verhoeks et al., 2019).

In relation to online video therapy, retrospectively reported acceptability was noted to increase, particularly amongst individuals with access to stable internet services. Notably, acceptability was reported to increase by participants without access to stable internet. This finding is congruent with an overarching societal pivot toward telehealth and digital services, a trend that the pandemic has significantly accelerated. The convenience and perceived safety of online video therapy during the pandemic may have significantly contributed to its positive appraisal. With the growing entrenchment of technology in everyday life, the favourable perception of this modality is likely to persist and expand (World Health Organization, 2021).

The post-pandemic landscape has also seen a significant increase in the acceptability of text therapy, paralleling the cultural shift toward text communication as an integral facet of modern social interactions. This rise intimates that text therapy is transitioning from a supportive to a primary modality within the mental health services spectrum. Its informal nature, coupled with the potential for effective therapeutic engagement, positions text therapy as a less formal yet viable medium for mental health interventions (National Institutes of Health, 2020).

The reported shifts in therapeutic modality preferences, particularly in the wake of the COVID-19 pandemic, present insights into the evolving landscape of mental health care. A noteworthy finding emerged among males with prior therapy experience, who demonstrated a decrease in their intent to engage in face-to-face therapy post-pandemic. Although this conclusion was based on a small number of participants, the change may signify a broader, pandemic-led revaluation of therapeutic practices, potentially propelled by increased health-related anxieties and the newfound convenience of teletherapy alternatives (Simpson et al., 2021). Conversely, the slight increase in intent among females without prior therapy experience suggests a differing response to the pandemic's isolating effects, with face-to-face therapy potentially viewed as a novel and reassuring option.

In the domain of video therapy, the reported shifts in intent among individuals residing in rural locales, even those with unstable internet connections, may underscore the resilience of healthcare delivery adaptations, where traditional barriers such as technological limitations have not impeded the pursuit of online mental health services. The trend points to the indispensability of mental health support and the readiness of individuals to utilise whatever means available during times of crisis (Health Resources and Services Administration, 2021).

Additionally, the reported change in intent for text-based therapy reflects a concurrent global trend towards increased digital communication. This modality's growth may be ascribed to its inherent convenience, accessibility, and the anonymity it offers, aligning well with the public's preference for therapy options that offer flexibility and privacy, thus demystifying and destigmatising the process of seeking mental health support (Bucci et al., 2019).

Clinical Implications of the Study

The clinical implications of this study offer insights into the changing landscape of mental health care provision in the wake of the COVID-19 pandemic. The results highlight a potential change in individuals perceived preferences for therapy modalities, with an increased acceptance and intent to use video and text-based therapies.

Firstly, the perceived reduction in the reported intent to pursue face-to-face therapy among males with prior therapy experience may suggest that clinicians should be prepared to offer alternative modalities that meet clients' needs for safety and convenience (Simpson et al., 2021); it is however important to recognise that these results are predicated on a small sample size. Clinicians may need to consider proactive discussions about therapy modalities with their clients, ensuring that the clients are fully informed about the available options and are comfortable with the mode of delivery. The marked increase in the intent to use video therapy, especially among individuals in rural areas with unstable internet, indicates a pressing need to address technological disparities that could hinder the effective delivery of teletherapy (Health Resources and Services Administration, 2021). It underscores the necessity for clinicians to advocate for and possibly assist in improving the technological infrastructure that supports online therapy—a call to action that has been echoed by other researchers (Sagui-Henson et al., 2022)

Additionally, the overall rise reported in the intent and acceptability of text-based therapy suggests an opportunity for clinicians to integrate text messaging or chat-based platforms into their practice. Text-based interventions can offer a flexible, lower-threshold form of communication, which has been shown to be effective in engaging clients and providing support (Bucci et al., 2019). However, clinicians must also be mindful of maintaining confidentiality and establishing clear boundaries around the use of text-based communication.

The continuous intent and acceptability for telephone therapy across the study period also imply that this modality remains a vital component of teletherapy services. Despite the advent of more sophisticated technologies, telephone therapy continues to be a valuable tool, especially for clients who may have limitations in accessing video-based platforms or prefer the familiarity of voice-based communication and anonymity it provides (APA, 2022). The rapid evolution of digital health solutions, as noted by the World Health Organization (2021), is likely to influence teletherapy delivery and perceptions. Additionally, potential ambiguities in participants' interpretations of therapy modalities such as 'video', 'text', and 'telephone' therapy might have affected their responses.

In summary, this study suggests that the clinical practice of mental health care must evolve to remain responsive to the changing preferences and needs of the population. Clinicians are encouraged to embrace a multimodal approach to therapy, incorporating face-to-face, video, text, and telephone options to provide comprehensive care. Continued education on the efficacy and ethical considerations of each modality will be essential to ensure that clinicians are equipped to offer the highest standard of care in this new era of mental health services (NIH, 2021).

Study Limitations

The present study provides an informative exploration into the shifting preferences for therapy modalities during the COVID-19 pandemic; however, it is not without its limitations. Firstly, the study's retrospective cross-sectional design limits the ability to infer causality or the existence of observed changes over time. Longitudinal research is essential to establish the direction and permanence of the changes in therapy preferences. Additionally, the reliance on self-reported data introduces the possibility of response bias, where participants might offer responses perceived as socially acceptable or misremember past behaviours potentially compromising the findings' accuracy (Schwarz, 1999). Further limitations concern the sample composition, where there is a larger sample of female participants, which is a demographic consideration that may impede the generalisability of the findings to the broader population. This gender imbalance, as Cash et al., (2022) caution, can result in skewed interpretations that may not accurately convey a balanced perspective. Moreover, the participant demographic was predominantly from urban and suburban locales, potentially omitting the unique experiences and challenges faced by rural populations. These individuals often contend with different levels of access to technology and healthcare services (Leonardsen et al., 2020), and thus, the study's findings may not be wholly applicable to these communities.

Recommendations for Future Research

To further explore the trajectory of therapy modality preferences in the wake of the Covid-19 pandemic, future research should seek to include more longitudinal studies and to recruit more male participants. These would shed light on whether the attitudinal shifts noted are pervasive or reflect a short-term shift following the pandemic. Moreover, further investigations would benefit from adopting a more inclusive sampling strategy, aiming for more equal demographic inclusion, particularly in terms of gender, geographic distribution, and socioeconomic strata. This diversified approach, recommended by Roscoe (2021), would not only bolster the generalisability of findings but also ensure a comprehensive understanding of the varied needs and preferences reflective of a broader portion of the population.

There is also a pressing need for comparative effectiveness research that explores and evaluates outcomes and patient satisfaction across the spectrum of therapy modalities, including conventional face-to-face interactions and their telehealth counterparts. Such comparative analyses, as Chen & Bonanno (2020) advocate, are pivotal for equipping clinicians with empirical evidence to guide their modality choices in clinical settings.

In-depth qualitative insights are crucial for crafting more sophisticated, patient-centric clinical approaches, a stance reinforced by recent findings from the National Institutes of Health (2021). In light of these considerations, the study's outcomes should be viewed as preliminary, reflecting trends within a specific and turbulent period. They provide a basis for subsequent inquiries that could transcend these constraints, offering a more holistic grasp of how preferences for therapy modalities may continue to evolve in a post-pandemic world. The incorporation of qualitative methodologies into future research could significantly support the landscape, offering nuanced insights into the subjective experiences, perceptions, and rationales underpinning individual preferences for different therapy modalities. Qualitative data derived from interviews and focus groups can additionally support the complexities and contextual subtleties that quantitative approaches may overlook, as highlighted by the National Institutes of Health (2021).

Lastly, as digital platforms become increasingly embedded in the fabric of mental health care delivery, a concerted focus on the ethical and privacy aspects of teletherapy is imperative. Future research in this domain is crucial for the formulation of robust guidelines and best practices that ensure the preservation of client confidentiality and security in digital therapeutic environments (Benz et al., 2022).

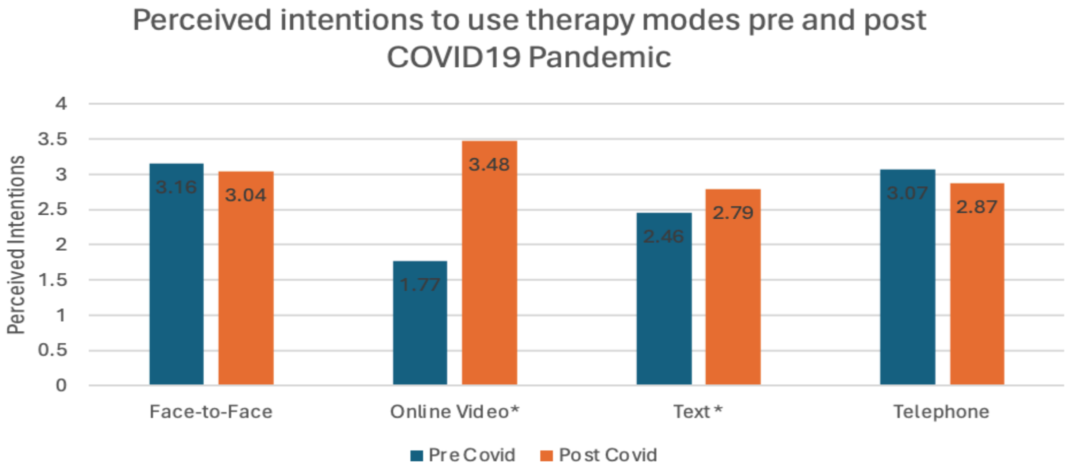
Conclusion

The findings of the study support our understanding of how the COVID-19 pandemic has reshaped public perceptions and preferences regarding various psychological therapy modalities. This research highlights a notable shift towards acceptability of digital therapy modalities, such as video and text-based therapy, while underscoring the persisting relevance of traditional face-to-face and telephone therapies. These shifts are reflective not only of the constraints imposed by the pandemic but also of a broader societal move towards embracing digital communication in all facets of life, including mental health care.

The research provides a snapshot of a critical juncture in mental health service delivery, reflecting a period of significant transition and adaptation. The COVID-19 pandemic has acted as a catalyst, accelerating the integration of digital technologies in therapy and potentially setting the course for future mental health care practices. As we navigate this new landscape, continuous research, adaptability, and a commitment to meeting the evolving needs of clients will be paramount in ensuring the effective delivery of mental health services.

Figures

Figure 1 - Figure 1: Repeated measure ANOVA for Intentions to use different modes of therapy pre and post pandemic.



* = Comparison where p < .05

Figure 2 - *Figure 2: Repeated measures ANOVA for Intentions to use face-to-face therapy modes of therapy pre and post pandemic.*

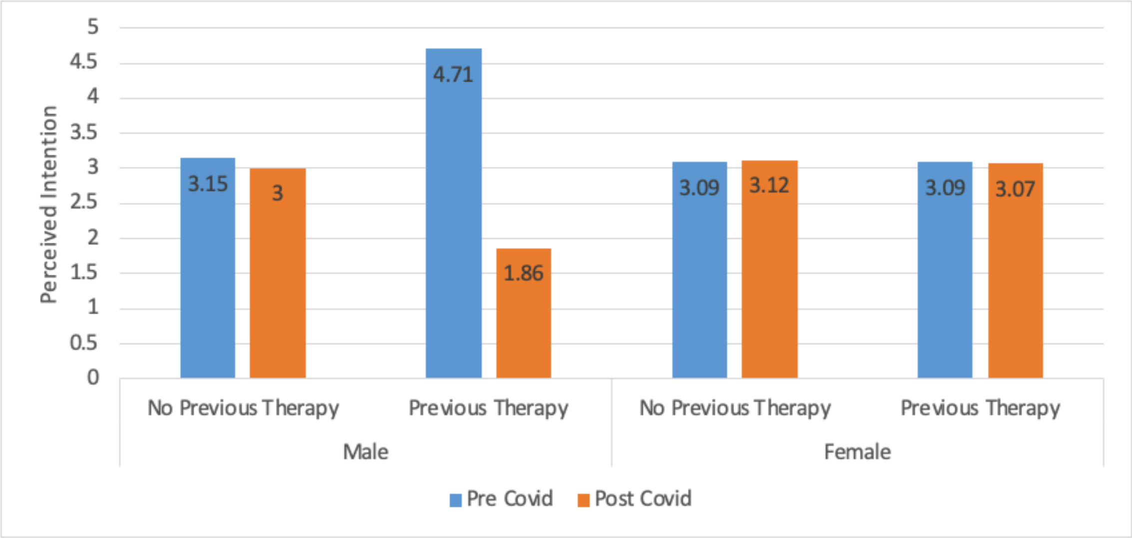
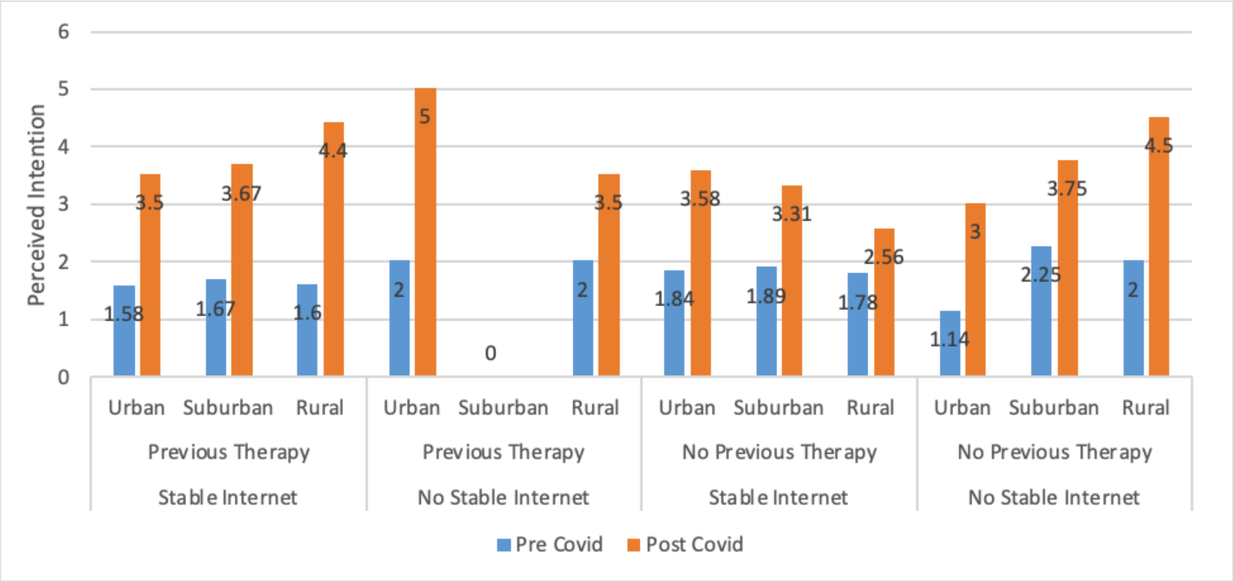
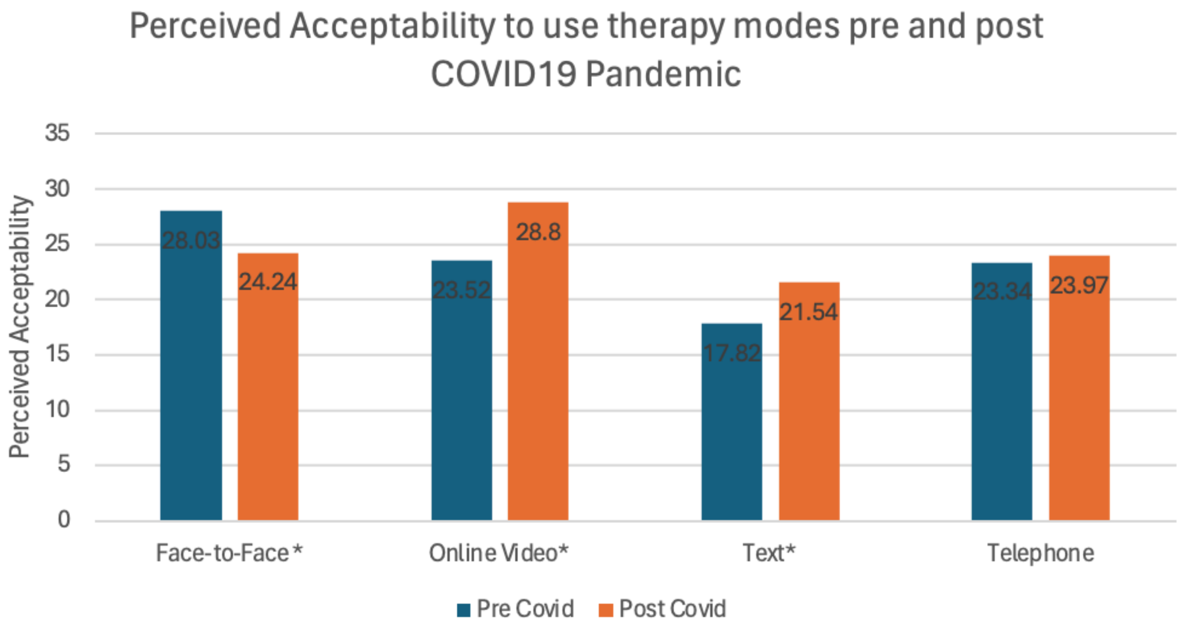


Figure 3 - *Figure 3: Repeated measures ANOVA for Intentions to use video therapy pre and post pandemic.*



*0 Represents no participants meeting suburban x previous therapy x no stable internet

Figure 4 - *Figure 4: Repeated measures ANOVA for Acceptability of different modes of therapy pre and post pandemic*



* = Comparison where $p < .05$

Figure 5 - *Figure 5: Repeated measures ANOVA for acceptability of use face-to-face therapy pre and post pandemic.*

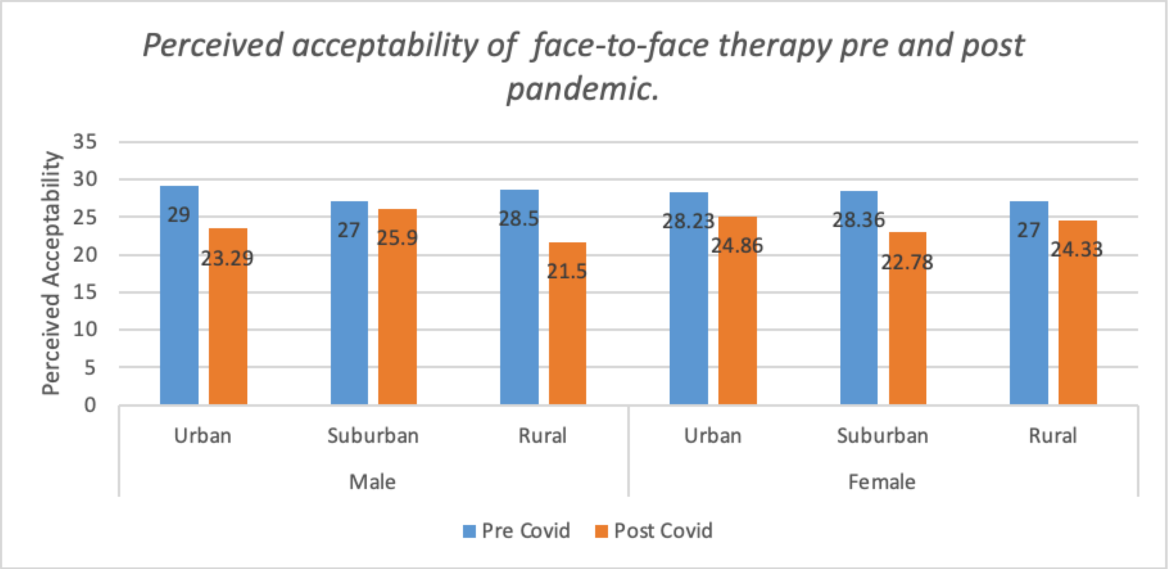
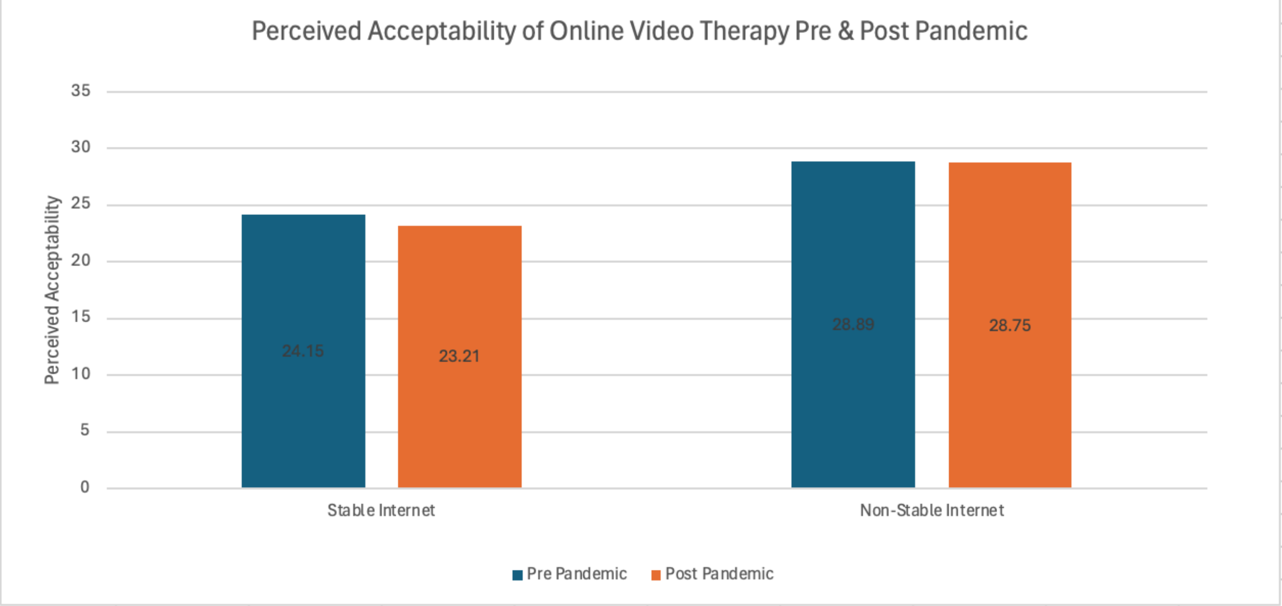


Figure 6

Figure 6: Repeated measures ANOVA for acceptability to use online video therapy pre and post pandemic.



Tables

Table 1 – Participant Demographics

	n	%
Gender		
Female	148	78.7
Male	40	21.3
Location		
Suburban	88	46.8
Urban	82	43.6
Rural	18	9.6
Stable Internet		
No	16	8.5
Yes	172	91.5
Prior Engagement in Therapy		
No	126	67
Yes	62	33

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2.4 Quantitative Research Reflective Commentary

Introduction

This reflective commentary outlines the development and completion of my quantitative research study 'Exploring perceptions of therapy modalities before and after the Covid-19 pandemic'. This study commenced at a pivotal moment in my professional career, where throughout the course of the COVID-19 pandemic the logistics of healthcare and shift to alternative modes of talking therapy were commonplace. I felt that the sudden shift towards online therapy was so swift that it necessitated an evaluation of therapy delivery methods and their perceived acceptability by the public. The core of this research was to explore potential shifts in public preference towards various therapeutic modalities, with a particular focus on the adoption and perception of teletherapy in the wake of societal changes.

Identifying the research area

The creation of this quantitative study was deeply rooted in my clinical observations as a Cognitive Behavioural Therapy (CBT) practitioner. The advent of the COVID-19 pandemic and subsequent restrictions marked a significant shift in my practice from conventional face-to-face therapy to online video therapy sessions, initially causing me a lot of uncertainty and apprehension. Transitioning to these new modalities presented challenges, such as adapting to technology, ensuring confidentiality, and maintaining the therapeutic alliance. Despite moments of frustration and missing the nuances of in-person interactions, discussions with colleagues highlighted varying client responses to these changes. As pandemic restrictions lifted and digital health continued to rise, I felt a growing need to understand public and client perceptions of these approaches. This study represents my effort to substantiate anecdotal observations with systematic data, exploring whether preferences had shifted significantly and what that might mean for the future of therapeutic practices.

The research literature also provided a precedence for the exploration of this phenomenon, indicating a trend towards digital solutions in mental health, well before the pandemic (Hilty et al., 2017). However, the urgency to understand this shift in a post-pandemic context was magnified, as researchers highlighted that telehealth services experienced unprecedented growth (Whaibeh et al., 2020). As a practitioner, I observed that while the transition to online modalities maintained continuity of care, it also opened a discourse on the therapeutic efficacy as perceived by clients; with many expecting reduced efficacy, concerns around confidentiality and generally poorer therapy outcomes. For me it felt essential to identify if these modalities were merely a short-term 'stopgap' solution, or if they represented a new era in therapeutic delivery. Consequently, this research area became a combination of professional practice, developmental interest, and societal evolution, each aspect offering a unique exploration to therapeutic modality preferences. The aim was to contribute a body of knowledge that could serve as a cornerstone for future mental health service provision and innovation.

Methodology

Ethics

Given the nature of exploring people's perceptions of talking therapy, I was aware of the importance of ensuring that the research was ethically sound and appropriate considerations were made. I applied for ethical approval in October 2022 and felt anxious about this process as I felt most apprehensive about my quantitative project. This process included the development of participant-facing materials including the questionnaire, the research invitation (for social media advertisement), consent form and debrief information. These materials were developed using the revised templates from Staffordshire University and were reviewed by my placement supervisor to ensure I had addressed all the areas of my ethics application.

The ethics form was initially rejected due to some required amendments to my application. After the initial feelings of disappointment, I could understand that there was a requirement for more explicit clarification on the analytic procedures to be employed in the study. Given my apprehension at the time, I feel like I avoided in-depth information at this point as I felt unsure of my analysis. In retrospect however this provided a positive opportunity for me to delve deeper into my analytic steps. Following my ethics amendments, I felt a greater sense of certainty in the process of obtaining informed consent. This confidence stemmed from my recent qualitative research, where I had become adept at articulating the study's objectives clearly to ensure participants' understanding. This fostered an environment conducive to informed and voluntary participation. However, addressing the confidentiality and security of data, especially in an online research context, introduced an additional layer of complexity. Revising my initial ethics application to address these issues was invaluable, as it allowed me to deeply understand the importance and necessary steps for obtaining and securely storing participant data. This process not only enhanced my ethical rigor, but also boosted my confidence in conducting ethically sound research.

My ethics was unfortunately delayed due to a short leave of sickness absence, followed by some administrative issues outside of my control and was formally approved in May 2023 which allowed me to shortly commence my study after this point.

Study Design

Reflecting on the study's design, one of the main features that I recognise was potential limitations of the cross-sectional approach I employed. As research suggests, this method can be effective in capturing public preferences particularly within health settings and was subsequently selected for its ability to provide a snapshot of attitudes in the broad demographic I was exploring (Smith et al., 2019). However, in hindsight, I now have a greater appreciation that cross-sectional studies, whilst powerful in descriptive analysis, have constraints in establishing cause-and-effect relationships (Jones & Lee, 2020). This understanding emphasised the need for cautious interpretation of results, ensuring they were contextualised appropriately and not overstated; feedback of which I received on my initial submission.

Overall, I feel that the methodological choice aligned well with my study objectives and provided a valuable insight to the public's shifting therapy preferences during a significant period (Wang & Cheng, 2020).

Selection of Methodology

The selection of a quantitative methodology for this research was an effective choice as several studies had already employed this form of inquiry to examine attitude changes during and after the Covid-19 pandemic. Developing the questionnaire, which included a range of demographic and experiential questions, was both a challenging and enjoyable process. At my placement, I had previously had the opportunity to develop questionnaires for health surveillance purposes, and I feel that this provided some applicability to my research. Due to this experience, I felt confident in my ability to adapt a validated measure to my study and sought advice from my placement and university supervisors to support in this process.

Nevertheless, embarking on this methodological route involved an exploration into questionnaire design, which I found was best informed when I utilised best practices as suggested by Yaddanapudi and Yaddanapudi (2019). Using my training in Socratic questioning and scale design, I developed a set of questions that were clear, unbiased, and relevant to the study's objectives. To try and reduce my potential bias within the research, I also approached a quantitative tutor and psychologist in my service who has developed scales in occupational health domains.

Implementing this methodology, particularly in an online environment, was somewhat challenging. Although most people are more familiar with completing online questionnaires, the fact that the measure took around 10-15 minutes to complete meant that I encountered challenges in ensuring participant engagement and had around 30 participants drop out from the study during completion (Singh & Sagar, 2021). In hindsight I am pleased that my timeline allowed enough time to receive the necessary number of responses. I will keep this in mind for future research as my initial timeline of 4-6 weeks was too short; with the final data collection process taking around 8-9 weeks in total.

Sampling Procedure

The methodology of the study hinged on an opportunity sampling strategy, a choice informed by the practical constraints and objectives of the research. Contrary to a stratified approach which I had utilised before, I felt that an opportunity sampling allowed for the collection of data from a conveniently accessible subset of the population, which I chose as I felt it would be quicker to conduct, whilst being mindful it did not necessarily guarantee full demographic representation (Bryman,2016). I found this approach to sampling was informed by my recognition of both the benefits and limitations inherent in non-probability sampling techniques. It allowed me to obtain participants who were readily available, offering insights into their experiences and perceptions related to therapy modalities during the pandemic. However, it also underscored the challenges associated with achieving a balanced demographic cross-section, a common issue in quantitative research that prioritises accessibility over representativeness (Smith & Hasan, 2019). A concern that I recognised from this approach was significant skews towards female participants, which made me feel concerned about the possible applications of the research. Nevertheless, I felt that this approach allowed me to address my research question and enabled a relatively simple and smooth acquisition of participants; a process that significantly supported my ability to transition to data analysis swiftly.

Data Analysis

The data analysis phase was the most apprehensive part of my study, prompting me to seek extensive support from academic literature and my mentors at Staffordshire University. The objective was to examine changes in the intentions and perceived acceptability of various therapy modalities before and after the pandemic, using repeated measures ANOVA. I was particularly nervous about meeting the statistical assumptions of sphericity, normality, and homogeneity of variances, stemming from my previous struggles with ANOVA at the undergraduate level. Overcoming this challenge involved substantial guidance from my supervisors, which boosted my confidence and understanding of the process. This experience highlighted the importance of thorough data screening and the need to strengthen my statistical skills. Moving forward, I plan to deepen my knowledge of statistical analysis and approach such tasks with greater planning, seeking support early and engaging with CPD in the future to improve my confidence with statistical methods.

Overall, the prospect of employing quantitative methods and using SPSS was something I found fearful, particularly given my background primarily in qualitative research. During my career I have often ‘avoided’ quantitative methods due to an overarching fear that I would not understand or be able to complete the work. Although anecdotal evidence and even literature suggests that this anxiety is not uncommon among researchers transitioning to quantitative methods, at times I felt a sense of hopelessness as I was unsure as to whether I had the capability to complete the project, however seeking support and supervision from my peers, colleagues and supervisors helped me to normalise this feeling (Creswell & Creswell, 2017). However, as I dived deeper into the methodology, particularly discussion with RC and EB, (alongside watching some of the recommended videos on my analysis) I noticed that a significant transformation occurred. The more I engaged with SPSS, the more intuitive I found it. This experience echoed the findings of Field (2018), who noted that practical engagement with statistical software often demystifies its complexity, leading to increased confidence. By the project's end, what had started as a source of apprehension had turned into a skill, I felt significantly more confident in using.

Writing up and Dissemination

The journey of writing up this study was likely the most difficult I have encountered during the doctorate so far. Initially, I had decided on submitting my manuscript to the Journal of Health Psychology, drawn by its relevance to my course. However, the realisation that they do not accept cross-sectional studies presented a challenge. This required a strategic redirection towards Psychology and Psychotherapy: Theory, Research and Practice, a decision that I discussed with my supervisor. On reflection, I feel that this was a more sensible decision as my research (irrespective of the cross-sectional nature) has implications for psychological and psychotherapy domains. In addition the journal has published similar studies relating to therapists experiences of multimodal approaches prior to and following the pandemic. I therefore spent a significant amount of time reviewing the author guidelines and developing my research to adhere to the required procedures.

The process of writing up the manuscript was a challenging endeavour, however one I felt prepared for as I had recently completed my qualitative paper, which meant I was already in a process of regularly writing. I commenced this process with a structured outline of the project write up, I aimed to ensure a coherent flow of writing with a particular focus on the data analysis, results and discussion; areas I felt that needed the most attention to detail in order for the quantitative inquiry to be disseminated. I found that the necessity to effectively link the findings back to the broader context of existing literature was a demanding task, however this was made easier by the fact that my findings were largely supported in the wider research.

One particular challenge was ensuring I could maintain the momentum of writing-up; keeping a strict timeline of writing at least 100-200 words every couple of days. As I was already in the routine of doing this for my qualitative project, I felt confident in my ability to generate the manuscript and in total this took me around 7 weeks to write. Seeking and incorporating feedback from peers and my supervisory team, while invaluable, also meant revisiting and revising sections. For future projects I would incorporate this additional time required to ensure that I could take a short break before diving into the process of writing up.

In retrospect, I feel that the challenges I faced in writing and disseminating the study were crucial to my growth as a researcher. They pushed me to develop not just as an academic but also as a researcher, deepening my understanding of the intricacies involved in turning a research project into a published manuscript. This journey, whilst with many obstacles, felt like a pivotal part of my professional development, equipping me with skills and insights that I will carry into future research endeavours.

Manuscript Resubmission

Unfortunately, my first submission for this assessment failed. Reflecting on this, I experienced a mix of disappointment, frustration, and significant self-doubt. This failure stemmed from rushing my work and neglecting to thoroughly proofread due to my attempt to balance too many projects simultaneously. I felt disheartened and questioned my abilities as a trainee health psychologist and worked through this by speaking with my supervisor, doctorate 'buddy' and peers. Now with hindsight, I feel this experience was crucial for my professional growth. It underscored the importance of meticulousness, time management, and the necessity of balancing quality with quantity in my work. Through this process, I learned the value of taking a step back and thoroughly reviewing my work before submission. It highlighted the significance of not only managing my time effectively but also ensuring that I allocate enough time for each task, particularly those as critical as a research manuscript. The emotions I felt, though challenging, pushed me to reflect deeply on my work habits and strategies. In the future, I will prioritise gaining more feedback from my supervisor and peers, organise my time more effectively, and utilise the resources available to me. Seeking feedback provided diverse perspectives and helped me identify areas for improvement that I may have overlooked. Additionally, effective time management allowed me to allocate sufficient time for thorough proofreading and revision, ultimately enhancing the quality of my work. This experience, while initially disheartening, has been invaluable in shaping my approach to research and professional responsibilities. It has equipped me with essential lessons and a renewed determination to improve, ensuring that I become a more diligent and successful in my ongoing research.

Lessons Learned

The completion of this quantitative project was a daunting yet profound experience. The below headings outline some of the key lessons from my experiences completing this research project and is leads on from the reflections within my reflective diary.

The importance of taking breaks

I feel that taking a brief break (around 2 weeks) from data analysis proved to be a pivotal decision and one I will certainly use in the future. After spending a lot of time with my data, I felt that I was getting ‘bogged down’ within it and unable to focus my energy as effectively. This break allowed me to return to the data with a fresh perspective, a strategy supported by research on cognitive processing (Ginns, Muscat & Naylor, 2022). Upon my return, patterns and trends in the repeated measure ANOVA, previously what felt unanswerable, became apparent, facilitating a more effective and efficient analysis. This aligns with the findings of Albulescu et al. (2022), who highlighted the benefits of intermittent breaks in enhancing cognitive clarity and problem-solving abilities in research settings. For future projects I will certainly allow myself some breaks from this type of work to support me in generating motivation and subsequent progress with the project.

Research Insights for Professional Application

The insights I found from this research have had profound implications for my own practice as a practitioner and trainee health psychologist. The study's findings on therapy modality preferences are particularly relevant to adapting my practice to meet clients' evolving needs and to inform policies within my respective organisations. For future projects this process has significantly reinforced not only my confidence, but my desire to explore more phenomena in a quantitative paradigm to empirically support my work. This experience also closely aligns with the work of Kristense, Nymann and Konradsen (2019), who emphasized the importance of research in informing and enhancing clinical practice in therapeutic settings. The hands-on experience with cross-sectional studies and data analysis has been invaluable, highlighting to me the importance of experiential learning in research methodologies. I now feel more confident in integrating these methods into my therapy practice, informed by a solid foundation in quantitative research principles.

Conclusion

In conclusion, this research journey, from conceptualisation to data analysis, has been immensely enlightening and an achievement I feel proud of. I feel it has not only contributed valuable insights into the evolving preferences for therapy modalities but has also significantly enhanced my skills and confidence in quantitative research methods. The experience of navigating through various challenges and learning from them I feel has significantly prepared me for future research endeavours.

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2.5 Qualitative Research Manuscript

Exploring the Experiences of Psychological Support for Individuals Living with Type 1 Diabetes: A Qualitative Study

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Submitting to: British Journal of Health Psychology.

Abstract

Objectives: This qualitative study explores the lived experiences of individuals with Type 1 Diabetes (T1D) who have received evidence-based psychological support.

Design: An inductive approach was applied to capture the subjective lived experiences of individuals living with T1D, adopting Interpretative Phenomenological Analysis (IPA) to explore their experiences of psychological support.

Methods: Six online semi-structured interviews were conducted with UK-based individuals with T1D who had previously received psychological support. IPA was used to explore patterns in the participants data.

Results: The interviews highlighted three Group Experiential Themes including barriers to accessibility of psychological support, the importance of the therapeutic relationship and the impact of psychological support on daily T1D management.

Conclusions: Psychological support was found to improve diabetes management through positive reframing and empowered communication. The study highlights the need for integrated diabetes care that includes psychological support, advocating for increased awareness and specialised training for healthcare professionals to meet the specific needs of T1D patients.

Keywords: Type 1 Diabetes Mellitus, Psychological Support, Interpretative Phenomenological Analysis, Therapeutic Relationship, Diabetes Management, Accessibility

Statement of Contribution

What is already known on this subject?

- Type 1 Diabetes Mellitus (T1DM) management requires diligent, continuous attention to both physical and psychological aspects to prevent acute and chronic complications.

- Psychological distress, including higher incidences of depression and anxiety, is prevalent in individuals with T1DM, affecting their disease management and quality of life.

What does this study add?

- It highlights the barriers to accessing psychological support, such as stigma and healthcare professional gatekeeping, which are important for improving accessibility to support and developing targeted interventions.
- The research highlights the benefits of specific psychological support for individuals living with T1D, illustrating the importance of support to develop alternative perspectives, fostering acceptance and enhancing communication with healthcare professionals.

Introduction

Type 1 diabetes (T1D) is a long-term health condition typically caused by an autoimmune response within the body (DiMeglio, Evans-Molina & Oram, 2018). This response leads to the body's inability to create the hormone insulin, which is essential for the processing of glucose in the body (Atkinson, Eisenbarth, & Michels, 2014). The onset of T1D is typically during childhood or adolescence, and therefore requires individuals to quickly adapt to lifestyle changes (Dabelea et al., 2014). T1D management necessitates the continuous monitoring of blood glucose levels and exogenous insulin administration, leading to a considerable emotional, physical, and psychological impact on individuals (Hagger & Orbell, 2003).

Alongside blood glucose monitoring and external insulin injections, individuals living with T1D often require lifestyle changes including meticulous dietary tracking and modifications alongside increasing physical activity to manage the condition (Holt et al., 2021). Each component plays an essential role in ensuring that blood glucose levels remain within a targeted therapeutic range, therefore preventing a spectrum of acute and chronic complications (American Diabetes Association, 2020; Chiang et al., 2014). The evidence suggests that individuals living with T1D can most effectively reduce the likelihood of complications by ensuring that blood glucose levels are stable; therefore, preventing episodes of hypoglycaemia (a significantly low blood glucose level) or hyperglycaemia (a significantly high blood glucose level) (Holt et al., 2021).

Inadequate, or inconsistent management of T1D can lead to a wide range of complications. Acute complications, such as hypoglycaemia and diabetic ketoacidosis, require immediate medical attention as they can lead to unconsciousness and hospitalisation (Kahanovitz, Sluss & Russell, 2017; Akil et al., 2021). In contrast, chronic complications, including diabetic retinopathy, neuropathy, and cardiovascular diseases, develop over extended periods of ineffective T1D management and have been found to lead to reduced quality of life, and increased mortality (Cho & Kim, 2021; Bronner et al., 2020).

The demands of T1D management alongside perceived consequences of ineffective management, can often lead to increased psychological distress (van Duinkerken, Snoek, & de Wit, 2020). Several researchers have highlighted comorbidities including double the incidence of Depression, Anxiety, and burnout (Kang, 2022; Young-Hyman et al., 2016). The reciprocal relationship between mental well-being and diabetes management is additionally well-documented, with studies recognising that psychological distress can impede diabetes management strategies and, conversely, challenges with diabetes management further exacerbating psychological distress (Schmidt et al., 2018). Given the complex interplay between the physical and psychological elements of managing T1D, it is essential that individuals living with the condition have access to medications, understand the risks involved with poor diabetes management and are provided sufficient emotional and psychological support.

Due to the psychological challenges that individuals living with T1D experience, there's been an emphasis on exploring psychological support for this population. Recent studies suggest that a considerable number of T1D patients in the UK access psychological support in various forms, this mostly includes individual 1-1 Cognitive

Behavioural Therapy (CBT) in the NHS, group CBT therapy and to online support communities (Małachowska et al., 2023). These interventions have shown positive outcomes, with patients reporting better blood sugar control, improved adherence to treatments, and an overall better quality of life. However, despite the evident benefits, less than 15% of individuals living with T1D receive psychological support (Diabetes Research Foundation, 2019). Research has suggested that there exist several barriers to seeking support such as stigma, lack of awareness, and limited specialised services; all of which can reduce the likelihood of individuals seeking support and subsequently leading to reduced T1D management (Małachowska et al., 2023).

Despite a growing body of research exploring the psychological challenges that individuals with T1D experience, a significant gap still exists in understanding the experiences and specific needs concerning psychological support (Petrak et al., 2015; Green et al., 2019; Strandberg et al., 2014). Several studies have identified the tangible benefits of psychological interventions including individual, and group therapy in improving glycaemic control, adherence to medication routines and improvements in overall quality of life (Hilliard et al., 2016; Anderson et al., 2017). However, comprehensive insights into the lived experiences of T1D individuals concerning psychological support, its accessibility, its perceived efficacy, and its impact on overall diabetes management remain sparce.

The necessity for qualitative research into the psychological support of individuals with T1D is strongly supported by recent studies highlighting significant emotional and psychological challenges, such as distress, self-consciousness, and stigma (Mc Sharry, Moss-Morris, & Kendrick, 2011). Additionally, a meta-synthesis on insulin restriction behaviours stresses the urgent need for empathetic healthcare and specialised support pathways (Goddard & Oxlad, 2022). These insights reveal the substantial impact of T1D on psychological well-being, indicating that current protocols do not fully address these psychosocial factors. Therefore, qualitative research is essential for an in-depth understanding of T1D patients' lived experiences, crucial for developing effective psychological support strategies

(Malterud, 2001). Interpretative Phenomenological Analysis (IPA) is particularly suited for this research, as it delves deeply into how individuals make sense of their psychological and emotional challenges (Smith, Flowers & Larkin, 2021), making it a highly effective approach for understanding individuals with T1D experiences.

Given the combined nature of psychological and physical well-being in T1D management, a comprehensive understanding of patients' experiences, perceptions, and needs concerning psychological support is essential (Lawrence et al., 2018; Rubin & Peyrot, 2019). These insights can provide a clearer picture of the potential barriers, facilitators, and gaps in accessing psychological support, allowing the development of specific and tailored interventions that are useful to the unique needs of individuals with T1D. The exploration of this phenomena can serve to inform effective clinical and therapeutic interventions, shape policy decisions, and guide future research directions to enhance the holistic management of T1D (Cartagena, Tort-Nassare, Labayen & Vidal, 2022).

Study Aims

The research seeks to answer the following research questions: (1) What are the experiences of individuals living with T1D regarding their experiences of evidence-based psychological support ?(2) What has been the perceived impact of psychological support for individuals with T1D?

Methods

Study Design

This study employed an inductive qualitative approach, using online semi-structured interviews to explore T1D individuals’ experiences of psychological support. The research approach was grounded in a phenomenological epistemological perspective, employing an Interpretative Phenomenological Analysis (IPA) methodology as outlined by Smith, Flowers & Larkin (2021). The IPA methodology permits the capture of in-depth and nuanced experiences of participants' personal experiences, providing rich insights into how individuals make sense of specific life events or circumstances (Smith, Flowers & Larkin, 2021). IPA is particularly suited for the current research aims due to its emphasis on understanding individuals' lived experiences, offering insights into how healthcare participants perceive and navigate health-related phenomena (Smith, Flowers & Larkin, 2021). The choice of semi-structured interviews was based on its compatibility with IPA as a method, its precedence in prior research for data collection and its ability to address the research objectives (Gauci, 2019; Kvale, 2009). Prior to commencing research, ethical approval was obtained from Staffordshire University Ethics Committee.

Setting and recruitment

The participants were recruited via an opportunity sampling approach by seeking volunteers through an online social media group created for and by individuals with T1D. The group is a UK based group supporting individuals living with T1D. Following permission from the group administrator, a notice of invitation to the study was posted in the group. Participants were asked to express their interest in the study by contacting the researcher using an organisational email address. This ensured that the participants could retain confidentiality in expressing their intention to take part in the study outside of social media. To take part participants needed to (1) have a diagnosis of T1D, (2) have received a form of individual, or group psychological support within the UK in the past two years.

Following the study invitation, nine participants expressed an interest in participating. Of the nine participants, six met the eligibility criteria for the study. Three participants were excluded from the study due to not previously receiving psychological support from a healthcare provider. This criterion ensured that the research was tailored to understanding the lived experiences of T1D individuals who had received evidence-based psychological support.

Data Collection

All interviews were conducted via online video calls due to potential geographical constraints. Prior to the interviews, participants were provided with a participant information sheet and gave written consent to participate in the study. Participants were reminded of their right to take breaks or withdraw from the study if they felt uncomfortable during the interview.

The interviews followed a semi-structured format based on guidance by Smith, Flowers, and Larkin (2021). This approach allowed a focus on the research aims while providing flexibility to explore participants' lived experiences (Smith & Osborn, 2007). The interview schedule was reviewed by the second and third author alongside a university ethics panel to ensure the questions appropriately captured the data required to address the research aims.

Participants were asked open-ended questions about their experiences of accessing psychological support, as well as their perceived benefits and barriers of this support for their T1D management and overall well-being. Examples of questions included, "Could you tell me about your experience of psychological support for managing your T1D?" and "What aspects of psychological support have you found useful?". The interviews lasted between 30-60 minutes, and participants were given an opportunity to share any final thoughts before concluding.

Upon completion of the interviews, participants were provided with debrief forms, including contact details for free and impartial support organisations if additional support was required. Participants were informed they had 14 days to contact the researcher to remove their data following data collection.

The interview audio data was collected using MS Teams, downloaded to the researcher's securely password-protected laptop, and transcribed verbatim. The data was analysed using an IPA approach as outlined by Smith, Flowers, and Larkin (2021). This approach was deemed appropriate due to its explorative nature and its use in previous research exploring health-related phenomena and experiences of individuals living with T1D.

Analytical Strategy

IPA emphasises idiographic approach and phenomenology to ensure a nuanced exploration of the individual lived experiences (Smith, Flowers & Larkin, 2021). The idiographic approach focuses on detailed examination of each case, emphasising the uniqueness of individual experiences, while phenomenology, a central aspect of IPA, involves exploring how individuals perceive and make sense of their experiences, aiming to capture the essence of these experiences by focusing on participants' subjective perspectives (Smith, Flowers & Larkin, 2021). Prior to analysis, the participants were provided with a pseudonymised name to protect their identity. The analytic process commenced with thorough engagement through reading and re-reading transcripts for deep immersion, followed by initial note-taking that led to the development of experiential statements. Each transcript was coded individually with the analysis of the experiential claims, concerns and understanding of each participant into Personal Experiential Themes. Following this, themes were organised in a table and themes across the sample were reviewed to generate Group Experiential Themes *(Smith, Flowers & Larkin, 2021).* This approach not only adhered to the phenomenological commitment to capturing the essence of lived experiences but also allowed for an in-depth analysis of the data.

Quality Checks

Reflexivity was paramount throughout this research process, particularly given the positioning of the first author as both a trainee health psychologist and a qualified therapist, as well as a person with Type 1 Diabetes (T1D). This unique perspective provided valuable insights but also necessitated a critical evaluation of potential biases. Awareness of the 'double hermeneutic' (Smith et al., 2009) within IPA was instrumental in assessing how the researcher's professional and personal background influenced the interpretive process. The hermeneutic cycle, a process of understanding involving interpreting parts of the text in relation to the whole and vice versa, was essential in ensuring the analysis remained deeply rooted in the participants' perspectives (Gyollai, 2020).

The lead researcher maintained a reflexive log during the process of data collection and analysis. This reflexivity permitted an examination of potential biases, preconceptions, and influences the researcher might have had during the study (Finlay, 2008). Additionally, to further ensure the study's management of potential bias, Groupe Experiential Themes were presented to and reviewed by two independent researchers familiar with IPA. This "auditing" process ensured that themes accurately reflected participants' experiences, not solely the researcher’s interpretations (Rodham, Fox, & Doran, 2015). In conclusion, these approaches to improving the quality control of the research enhanced the validity of grounding the analysis in participants' lived experiences

Results

The experiences of individuals living with T1D as they navigate the complexities of psychological support were multifaceted. A summary of the participant information is provided in Table 1. Participants ranged in age from 20-36 years of age, with an average time since diagnosis of 15.5 years (ranging from 9-22 years), there was an equal sample of three males and three females. The number of participants aligned with best practice for IPA studies; specifically for obtaining rich, in-depth narratives in the data (Smith, Flowers & Larkin, 2021). Four of the participants received psychological support via the NHS (two received CBT and two receiving person-centred therapy) and two participants received private therapy outside of the NHS.

[Insert Table 1 Here]

The analysis identified three Group Experiential Themes with their respective subthemes, a summary of themes is available in Table 2. The first GET, 'Barriers to Accessibility of Psychological Support,' included recognising the need for support, overcoming stigma, and the role of healthcare providers in facilitating access. The second, 'Importance of the Therapeutic Relationship,' included building trust with the therapist, the importance of empathy and understanding, and clinicians’ lack of diabetes-specific knowledge, the third, 'Impact of Psychological Support on Daily Diabetes Management,' explores positive reframing and fostering acceptance, as well as impact on adherence to medical routines and empowered communication. Each of the themes is broken down into further detail below.

[Insert Table 2 Here]

Barriers to Effective Psychological Support

The theme ‘Barriers to accessibility of psychological support’ encompassed the participants emotional and practical challenges to seeking support. These challenges were rooted within the participants societal perceptions, personal beliefs, and perceived systemic issues. Participants highlighted three main areas that served as barriers to them seeking or accessing support including i) Recognising the need for support ii) Overcoming Stigma iii) The Role of Healthcare Professionals in Facilitating Access to Support; each of these is explained further below.

Recognising the Need for Support:

For many of the participants, the realisation that they would benefit from psychological support came after a prolonged period of challenge in managing the practical components of the condition. The participants described a transition where they had to acknowledge the emotional and psychological challenges, they faced due to their condition before seeking help. For many of the participants, the barrier to seeking support was their perceived inability to recognise that they needed it coupled with the realisation of potential T1D complications from poor self-management.

Jen shared her experience of realising the important relationship between her emotional well-being and diabetes management. In particular she references a revelation or ‘light bulb moment’, in which after some time Jen has a ‘realisation’ of the important connection between the aspects of her physical and psychological well-being. Notably, this demonstrates that Jen had for some time not considered that her psychological well-being was an important factor in managing her condition:

"It was like a light bulb moment for me when I realised that taking care of my emotional health is just as important as managing my blood sugar levels."[Jen]

This process of realising the need for support was also recognised by Alex and Vanessa. Alex shared a similar semantic in his experience of coming to the realisation that he had been managing several aspects of his T1D without support. For Alex, recognising that he needed support was a function of ensuring his T1D management did not become ineffective and lead to subsequent complications of his illness. Alex shared the significant realisation of 'being hit' by the fact that he was managing several elements of his T1D without support. Notably, Alex uses the word 'juggling' and 'uphill battle' sharing the experience of having to control multiple parts of his T1D and well-being that were perceived as challenging:

"I was sat on my sofa just mulling things over, you know? And it hit me like a ton of bricks. I've been juggling so much on my own. And when you start falling behind on managing your diabetes, it's a bit of an uphill battle. So, I just thought, let's not wait till things get worse." [Alex]

Vanessa mirrored Alex's experiences of realising the need of support by proxy of the potential consequences of poor T1D management. For Vanessa, an important factor was the recognition of T1D complications including diabetic retinopathy, potential amputation, and the well-established symptoms that healthcare providers would remind her of. Vanessa, mentions a 'turning point' signifying a distinct change in her perspective and subsequent recognition of the need for support:

"Realising that I couldn't do this alone was a turning point for me. It was an 'oh s%t' moment. Especially when you're constantly reminded of losing your legs, eyesight and all the other lovelies that come with diabetes." [Vanessa]*

For many of the participants, their perceived inability to recognise the impact of their T1D and the bi-directional nature it played with their emotional health, served as a significant barrier to seeking support sooner.

Overcoming Stigma:

Stigma was discussed by the participants as both internalised and societal and was a significant barrier for individuals living with T1D accessing psychological support. Firstly, all the participants shared feeling "judged" and "misunderstood" when discussing their psychological needs related to their T1D management. This aspect of stigma stemmed from the individuals' internalised beliefs that seeking support reflected a negative quality about them.

Jen and Vanessa share strong negative emotions related to stigma. Jen highlighted that she felt seeking support for her mental health was a personal weakness and felt it took her some time to recognise the potential benefits of receiving support (*"I had to get over the idea that seeking help for my emotions was weak or shameful. It took me a while to realise it's alright to ask for support." [Jen].* Vanessa also shared negative emotions of feeling 'embarrassed' and of being a burden to others (*"I used to feel embarrassed about my diabetes, like I was burdening others with my needs. I didn't get help for a while because of it." [Vanessa].)* Both individuals shared that these stigmatised feelings led to delays in them seeking or accessing support.

In addition to internalised beliefs, the participants also highlighted the role of societal perceptions of mental health support. This was expressed by the participants as the negative judgement from others relating to seeking emotional support. Alan shared an experience of telling friends about seeking psychological support in a social setting where he perceived the people around him made judgements. Alan refers to seeking support as needing 'mind-tinkering' and refers to the 'funny looks' he perceived, demonstrating his perception of what emotional support entailed and the perception of stigma associated with it: *("Admitting you need a bit of mind-tinkering gets you some funny looks at the pub, but I reckon it's more about courage than anything else." [Alan]).*

Charlie mirrors Alan's experiences, with a particular emphasis on the judgement from others towards males. Charlie explores the potential stereotype that men 'don't need help' and shared his internal process of transitioning through social perceptions of weakness to viewing support as a strategy to enhance his well-being and T1D management. Charlie refers to 'being a bloke' and 'daft stereotypes' alluding to the internal challenge he faced between recognising the inaccuracy of the stigma surrounding support, and ability to seek it himself:

"You know, people think that because you're a bloke with a fire in your belly, you don't need help. That's the first fight, against those daft stereotypes. I had to remind myself, seeking support ain't weakness; it's strategy." [Charlie]

These shared experiences of the participants underscore the pervasive nature of stigma and its role in delaying or deterring individuals from seeking the psychological support that they needed to support their T1D management and general well-being.

The Role of Healthcare Providers in Facilitating Access:

All the participants recognised the role healthcare providers and systems played in gatekeeping psychological support. Most of the participants referenced providers including their GP, specialist Diabetes Consultant or Diabetic Nurses.

Although June shared a positive experience with her consultant in accessing support (*"My consultant, bless him, saw it before I did. He gently suggested I see someone to talk through things. I'm forever grateful for that"* June), most of the participants found that their healthcare providers or systems acted as a barrier to seeking psychological support.

Charlie describes a situation in which he felt that his healthcare team, and in particular his consultant endocrinologist was 'working against him' when it came to seeking support. Charlie felt that there were several steps to access the support he felt he needed at the time and compares it to 'walking through a maze'. Charlie shared that a quicker referral process would have allowed him to seek support quicker and reduced the frustration he had in accessing therapy:

"To me it literally felt like the Doctors were against me. Like how many steps do you need to take just to make a referral right?... On one hand, the system's there, but navigating it felt like trekking through a maze blindfolded. Streamlining the process literally would have made my life so much easier. Why's it got to be such a pain to get it sorted." [Charlie]

This view was also supported by Alan who felt that the mental health services within his T1D care were 'gatekept'. For Alan this acted as a both a logistic and emotional delay, meaning that when he felt he had overcome the stigma of seeking support, the referral through to mental health services was delayed, leading to a sense of frustration:

"My mental health and diabetes has always been gatekept by my GP and consultant. They know I need support, they just weren't willing to refer me quickly enough for it when I needed it" [Alan]

Both Alan and Charlie highlight share the feature of communication during the referral process. All the participants felt that proactive communication and the need for providers to recognise and address the psychological aspects of living with T1D (particularly within NHS referral pathways) was lacking. Notably, the perceived barrier of healthcare professionals facilitating access meant that some participants were hesitant to seek support. Alex shared her experience of apprehension regarding accessing support due to her healthcare team not bringing this provision to her attention:

"I did have mixed feelings about it [accessing support], because I'd been under the consultant at the hospital for literally 4 years, and none of them mentioned it." [Alex]

The narratives shared by these participants underscored their need for healthcare providers to be more proactive and transparent in facilitating access to psychological support and to limit the barriers to accessing specialist psychological support to manage T1D.

Importance of the Therapeutic Relationship

The therapeutic relationship, as described by the participants, emerged as a pivotal aspect of effective psychological support. The depth and quality of the relationship that the participants established with their therapeutic provider significantly impacted the perceived benefits of the psychological support.

The participants referenced the therapeutic relationship within two paradigms; one where building trust with a therapist and generating a sense of understanding significantly improved their psychological well-being. Conversely, one in which oversimplification of their challenges and the clinicians lack of specific knowledge of their condition hindered the relationship, leading to a perceived reduction in the benefit and utility of the psychological support. The subthemes are categorised into three aspects; firstly, those that were conducive towards effective therapeutic relationships, and the latter two which were detrimental to the relationship and efficacy of the support.

Building Trust with the Therapist:

All the participants highlighted the importance of building trust with their practitioner to generate a conducive approach to psychological support. Trust was defined by the participants as feeling comfortable to share the intricate parts of the T1D management alongside the emotional impact that this had upon their daily life. June shared the importance of trust in her relationship with a mental health practitioner; particularly focusing on the gradual process of building trust that is needed to develop a strong therapeutic relationship. Notably, June refers to placing another 'brick into the foundation', suggesting that each session permitted a gradual and increased level of trust:

"Establishing trust, it's really important, I think. In every relationship but especially when you've gotta tell someone about every single bit of your life [laughs]. Every session, every moment of understanding, it's another brick in that foundation." [June]

This sentiment was also shared by Vanessa, who highlighted the importance of building trust to create a more positive therapeutic relationship by nature of facilitating discussions around her experiences. Vanessa recognised how developing trust allowed her to be more open in sharing her experiences and to move from the medical management of her T1D to the emotional impact it was having on her. Vanessa refers to the transition from 'surface level' to 'getting beneath the surface' suggesting that trust permitted her to be more open and vulnerable in her therapy:

"I think that when I started to realise that [therapists name] probably had my best interests at heart, our conversations got more deep, more kind of in depth about my experiences. Trust was the bridge that took us from surface-level chats to digging a bit more beneath the surface of just injections and BM's [blood monitoring]." [Vanessa]

All of the participants indicated that a deep, quality relationship with their therapist significantly enhanced the perceived benefits of psychological support, highlighting the importance of trust in the psychological support process.

The Importance of Empathy and Understanding:

Empathy and understanding were discussed as essential components of the therapeutic relationship and subsequent the ability to create positive outcomes with a therapist or mental health provider. The participants described the importance of these constructs as having an impartial person who did not provide a judgement on their experiences relating to their emotions or T1D management.

All the participants noted that in order to develop a positive experience, it was essential to feel ‘heard’. June shared that one of the most important features of the discussions with her therapist related to ‘just being listened to’:

"When my therapist would just... listen, not judge, just truly listen, they meant everything." [June]

A notable effect of empathy and understanding in the relationship shared by Alex, was the sense of ‘not feeling alone’. In the context of the therapeutic relationship, this is where practitioners displayed and nurtured empathy with the individual with T1D to reduce their feelings of isolation with their T1D related challenges. All the participants recognised alleviation in ‘diabetic loneliness’ from being understood, and Alex highlights this within a specific situation in which their therapist demonstrated empathy which had a profound impact on their feelings of isolation:

“I’ll never forget one of our later sessions. She knew me pretty well at this point. I have this tendency just to shut everything down you know and she looked at me and said, 'Alex, I can't fully understand the weight of living with diabetes, but I'm here with you in this.' That was life changing. I just thought or felt that for an hour or so I wasn’t alone you know.” [Alex]

In conclusion, the role of empathy and understanding served as a highly beneficial process to enhance the therapeutic relationship when used effectively. The participants highlight not only the emotional impact of receiving empathy, but also the impact this had on feelings of isolation and T1D management.

Simplification of diabetes management from healthcare professionals

A barrier to the therapeutic relationship was the participants’ perceptions of simplification and general lack of clinical T1D specific knowledge. For many of the participants, they felt that there was a significant gap in their practitioners’ knowledge which often led to negative perceptions of the therapeutic relationship, and subsequent progress through psychological support.

Several of the participants felt that their practitioners provided generic therapeutic advice that lacked a specific understanding of T1D. Alex, Alan, and Vanessa recall frustrating experiences where they felt that their therapist made ill-informed comparisons or was unaware of the nuances of T1D management. This perceived lack of understanding in their relationship diverted from the required empathy, understanding, and trust.

Alex expressed his frustration with his therapist's lack of understanding by sharing an experience where his therapist compared blood sugar fluctuations to mood swings. This comparison oversimplified the complex nature of managing T1D, leading Alex to feel misunderstood. His desire for a deeper understanding from his therapist highlights how his perception of a superficial analogy failed to capture his daily realities of living with T1D.

"I remember telling my therapist about the ups and downs of blood sugar levels. She nods and says, 'It's just like mood swings, yeah?' I couldn't help but think, 'It's a bit more complicated than that.' I wish more people would get the nuances of living with Type 1." [Alex]

Similarly, Alan found his therapist's questions about his dietary habits to be indicative of a lack of knowledge about T1D:

"The therapist genuinely asked if I eat a lot of sweets every time I'm low. I had a chuckle. I knew it was bad if that's all they knew about diabetes." [Alan]

Alan's reaction of amusement masks an underlying disappointment that his therapist didn't understand the physiological aspects of T1D. This gap in knowledge created a barrier to effective therapy, as Alan felt his therapist's advice was not grounded in a realistic understanding of his condition.

Similarly, Vanessa also encountered a lack of specific knowledge from her therapist, particularly regarding dietary advice. Vanessa shares an experience where she felt her therapist didn't take into account the complex interplay between diet and blood sugar management in her T1D. Vanessa highlights that although her therapist was well-meaning, she found their suggestion highlighted a disconnect that made Vanessa feel that her unique needs were not fully understood.

"During our earlier sessions, it became clear that my therapist, while well-meaning, wasn't fully clued in on the daily nuances of managing diabetes. Like that one time they suggested a specific diet without realising how it could impact my glucose levels." [Vanessa]

Similarly to Alex, Alan and Vanessas experiences, when the other participants felt that generic advice was provided, they felt a significant barrier was created between them and the practitioner. This barrier generated a feeling within several of the participants that they were not being fully understood, or that the practitioner could not relate to their difficulties. As a result, they felt that the improvements or benefits they could create throughout the course of the psychological support were limited.

Charlie demonstrates how a lack of knowledge led to him 'closing down' in his discussion with his therapist. Charlie shared that although the therapist was a 'nice person' he felt that by using a general approach to the therapy and not understanding the nuance of T1D he was at times unable to engage in a useful discussion:

"In all honesty, I feel that [therapists name] was a nice person. But she was clueless, treating it like any other condition. It's the difference between a productive conversation and a dead-end one. If you get the context, you get the emotion." [Charlie]

Alan also mirrors this experience by using the same language- notably feeling that the therapist 'didn't have a clue'. For Alan, the clinicians lack of specific knowledge led to him feeling that the practitioner would more generally be unable to support him with his well-being:

"I realised quickly that he just didn't have a clue and it made me think 'what on earth could you possibly do to help me if you don't even know the basics eh mate'". [Alan]

In summary, the participants felt significant barriers in the therapeutic relationship due to their clinicians perceived lack of knowledge surrounding T1D management. The participants highlight frustration, disappointment and therapeutic fractures as a result of a lack of clinician knowledge; demonstrating the sensitive dynamic that exists when the participants felt 'unheard' or 'misunderstood'.

Impact of Psychological Support on daily Diabetes Management

The significant impact of psychological support on daily T1D management was evident within all the participants narratives. The participants reported a range of positive outcomes that extended beyond their emotional well-being, but also in influencing their daily T1D management routines and interactions. This Group Experiential Theme encapsulated the tangible changes that participants recognised from receiving support and was demonstrated by a sense of reframing their struggles, being able to improve and overcome the practical challenges of T1D management, alongside enhancing and empowering their communication with others. These sub-themes are further explored below.

Positive Reframing & Fostering Acceptance:

Positive reframing and fostering acceptance were shared as a psychological change for all the participants as something that resulted from their psychological support. The participants recognised that these two processes were due to the therapeutic skills aspect of the psychological support: often referencing Cognitive Behavioural Therapy (CBT) techniques as the foundation for reframing their challenges and enhancing a sense of acceptance regarding their T1D.

A key feature of reframing thoughts was the participants ability to change how they viewed difficulties related to their T1D. For example, Vanessa highlights the perceived utility of practicing a CBT technique from her therapy sessions. Vanessa found the skill to open up her perspective around viewing her T1D negatively and developed more balanced perspectives on the long-term effects of her condition. Vanessa praised the therapy skills in helping her to reframe her difficulties and shared:

"Therapy taught me to reframe my challenges as opportunities. I really liked theory a theory b technique. Ways of I found to look at challenges differently. I remember an example of me thinking that I'd never control my diabetes and would die before my time. My more balanced theory is, I have control over my health and if I exert it I'll be okay!" [Vanessa].

This ability to restructure negative thought processes about T1D is also highlighted by Alex who similarly received CBT. Similarly to Vanessa, Alex found that the psychological support permitted an adjustment in his thought patterns, creating a positive shift from 'why me' to 'how can I view this as a learning opportunity'. This reframe allowed Alex to view his condition through a different lens, and notably supported him in no longer viewing the condition as a 'curse':

"In those early sessions, I'd often rant about why I had to have diabetes. But my therapist, she helped me shift that 'Why me?' to 'What can I learn from this?' Suddenly, diabetes wasn't just a curse; it was a bit of a teacher as well you know." [Alex]

In addition to reframing thoughts and beliefs, Alan, Alex, June, and Jen also referenced the impact of psychological support on acceptance; particularly surrounding the transition from frustration, denial, and avoidance to understanding and perceived control. Alan directly references his experience of acceptance and shared that the therapy process allowed him not necessarily to 'be happy' with his T1D, but to focus on the positives in his life despite his diagnosis:

"I've come to see that accepting my illness isn't necessarily about embracing diabetes, like 'woo this is a great thing for me', but more about not letting it cast a shadow on the better bits of life you know." [Alan]

"Acceptance isn't about giving in; it's about understanding and making peace. And therapy played a huge part in that for me." [June]

The participants highlighted the positive impact that psychological support had upon their T1D management and more broadly their quality of life. Both positive reframing and fostering acceptance were conducive to positive outcomes for the participants and permitted overwhelmingly positive shifts in the perspective of their condition.

Impact on Adherence to Medical Routines:

Impact on adherence to medical routines encapsulates the participants experiences of support on the day-to-day management of their T1D. This theme particularly referenced the participants perceptions of support on keeping to a routine of external insulin injections, blood glucose monitoring and general discipline towards their personal healthcare.

All the participants highlighted the relationship they felt between having a sense of psychological support and tangible management of their T1D. The participants recognised the practical utility of the support which not only improved the adherence to their medical routine, but also adjusted the perception of daily management. Alex encompasses this experience, by sharing how psychological support changed his perception of T1D management from a 'burden' to a choice. Alex recognised the impact of therapeutic support in improving discipline for their medication 'regimen':

"It [therapy] didn't just help me mentally; it made me more disciplined. Understanding the emotions behind my actions meant I could address the root issues. Suddenly, my regimen wasn't a chore; it was a bit more of a choice you know." [Alex]

Alan also highlights the impact of support on daily management in reference to the necessity to be consistent in managing their T1D. Alan builds on Alex's exploration of being more disciplined and shared that it also supported him in the day-to-day management of his T1D:

"I think [therapists name] did help me a bit in just understanding what I needed to do on a day-to-day basis to stay on top of the practicalities of being a diabetic, or person with diabetes." [Alan]

In conclusion, this Group Experiential Theme highlighted that psychological support positively impacted participants' adherence to medical routines for managing their T1D by concurrently improving their perceived discipline and shifting their perception of daily management from a 'burden' to a more manageable choice.

Empowered Communication:

A further positive aspect of psychological support was the process of empowered communication. The participants shared that receiving psychological support, equipped them with the ability to communicate more effectively about their T1D management needs and challenges. This was demonstrated by Alex who shared the impact of psychological support when speaking with his social network. Alex described an experience of transition from struggling to share information with his friends and colleagues, (which he links back to the stigmatisation of seeking support) to being able to share frustrations with their condition more easily:

"I used to struggle, explaining to mates or colleagues about me condition. But I definitely, I found the words, the confidence to speak up, to make them get it. Now, it's easier to let them know what's pissing me off, what I'm struggling with you know, just to make folks understand what living with Type 1 is like." [Alex]

The participants shared a mixture of benefits of empowered communication in terms of the skills they developed to communicate more effectively with others about their needs. June similarly to Alex shared that her experience of developing effective communication skills in the therapy room, allowed her to communicate her needs with her doctor and family; allowing her to have 'difficult conversations' that she would have previously avoided:

"Therapy gave me the tools to communicate better with my doctor, my family as well you know. You just feel like you can't always have those conversations, they're difficult ones to have- at least they were for me." [June].

In summary, participants identified that psychological support significantly enhanced their ability to communicate effectively about their T1D management needs and challenges. This empowered communication allowed them to articulate their experiences and frustrations more confidently to their social networks, doctors, and family, thereby fostering better understanding and support.

Discussion

The experiences of psychological support for individuals with T1D is a multi-faceted phenomenon that is comprised of features related to accessibility, therapeutic relationship, difficulties within communication and applicability to T1D management. This study offers a comprehensive understanding of the complexities associated with seeking and receiving psychological support. The research highlights three areas surrounding psychological support including i) Barriers to Psychological Support ii) The Importance of Therapeutic Relationship iii) Impact of Support on Daily T1D Management. The findings of this study are consistent with prior research suggesting the importance of a holistic approach to managing T1D, which includes the importance of psychological aspects in addition to the physical component (Smith & Harris, 2018). The interpretation of the key themes highlighted by the participants is further discussed below.

Barriers to Accessing Psychological Support

The barriers to accessing psychological support, particularly stigma and the role of healthcare providers in facilitating access, are very consistent with existing literature on psychological support for T1D and the management of long-term health conditions more generally (Dewit, Trief, Huber & Willaing, 2020). The pervasive nature of stigma, both internalised and external, acts as a significant deterrent for many individuals in seeking support. The findings of this study mirror research from other studies that have explored the role of stigma in not only hindering access to mental health services, but in significantly delaying or reducing the likelihood of individuals to seek such support (Inagaki et al., 2022).

Moreover, the wide-spread societal perceptions of mental health from individuals social, familial, and healthcare professional groups act as significant barriers to seeking support. Studies have highlighted the role of societal stigma in the context of long-term health conditions which is also highlighted within this study; particularly relating to the deeply rooted misunderstanding, shame and embarrassment that exist within the cultural norms of people around those with long-term health condition (Earnshaw, Quinn & Park, 2011). Overcoming these barriers requires not only individual resilience but also making HCPs aware of the importance of the impact that they have on the overall physical and psychological well-being of individually living with T1D.

Importance of Therapeutic Relationship:

The participants within the study all placed a significant emphasis on the therapeutic relationship, particularly surrounding trust, and empathy. This is a feature that resonates with the broader literature on therapeutic outcomes in a counselling and psychotherapy setting (Norcross & Wampold, 2019). Trust, as a foundational element of psychological support, was deemed crucial for effective therapeutic engagement and subsequent perceived outcomes of the support. Although the need for empathy and understanding is well-documented in psychotherapy literature, the impact of therapeutic relationship specifically for the nuanced management of T1D and long-term health conditions is largely unreported (Gelso & Carter, 1994).

The concerns regarding the oversimplification and lack of diabetes-specific knowledge among therapists are highly significant in the scope of ineffective psychological support from healthcare providers. These findings for several participants created an immovable layer of distrust with their healthcare provider that in some instances irreparably damaged their perception of support. This suggests a significant gap in training which could be made more widely available to HCP's and further emphasises the need for specialised therapeutic approaches for individuals with T1D, a notion that is highlighted in previous studies (Harris et al., 2019). Fundamentally, the perceived depth and quality of the therapeutic relationship with the individuals' practitioners significantly influenced the overall experience and perceived outcomes of the support, with trust and empathy being paramount to more positive outcomes.

Impact on Daily Management:

The practical impact of psychological support on daily diabetes management highlights the important connection between emotional well-being and effective diabetes management, particularly in reference to blood glucose monitoring and adherence to medication routines. Due to the high comorbidity with negative health outcomes of poor T1D management, this link has impacts on not only short-term but also long-term consequences for individuals receiving support. The impact of psychological support on practical condition management aligns highly with previous research that has demonstrated that psychological well-being can significantly affect blood glucose outcomes, long-term complications, and overall quality of life in T1D individuals (DiMatteo, Lepper & Croghan, 2000). Therefore, a greater focus should be placed on how to best support individuals with T1D using an integrated approach that highlights both physical and psychological barriers to self-management of the condition.

Clinical Implications

This study highlights several potential clinical applications in T1D care. Firstly, it highlights the necessity for healthcare providers within Diabetes psychological and physical health services to be aware of the psychological and practical challenges faced by individuals living with T1D and be more proactive and responsive in facilitating access to psychological support. The study highlights several areas where individuals with T1D felt that psychological support in the clinical setting was ineffective: particularly pertaining to clinicians' knowledge and underestimation of T1D management demands. This is in line with the recent recommendations from the American Diabetes Association (2020), who call for integrated care that includes specific and tailored psychological support for individuals with T1D.

In addition to clinician implications, the study findings also recognise the need for public health campaigns to address features related to stigma associated with seeking psychological support at an individual and societal level (Malachowska et al., 2023). Researchers have previously recognised the necessity of campaigns to encourage intentions for individuals living with long-term conditions to access psychological support, however few campaigns have been specifically targeted at T1D groups (Malachowska et al., 2023). Finally, this research demonstrates and underscores the importance of patient education surrounding the empowerment of individuals to advocate for their psychological needs and seek out appropriate support to manage the specific demands of T1D.

Implications for Future Research

The findings from this study provide a detailed exploration of participants experiences of receiving psychological support for T1D. Further research in a quantitative paradigm is recommended to explore whether these individual differences are experienced on a wider scale in the population; allowing for further support of the clinical recommendation found within the study (Johnson & Onwuegbuzie, 2004). This study also highlights the clear necessity for training programs for therapists focusing on the specific challenges associated with T1D management. Subsequently, further work needs to be conducted to increase practitioners' awareness of the impact that a lack of knowledge can have on the therapeutic relationship. Leading on from this, research should aim to explore the effectiveness of such specialised training programs and recognise potential gaps within clinicians' knowledge base to improve therapeutic outcomes (Harris et al., 2019).

Conclusion

In conclusion, this study explored the intricate connection between the perceptions and experiences that individuals with T1D encounter as they navigate the process of psychological support. Addressing the challenges that individuals encounter and reinforcing the benefits of efficacious psychological support is imperative to ensure positive long-term health outcomes at both and individual and national level. Psychological support for individuals with T1D should integrate psychological care into routine diabetes management, ensure that therapists are trained to a suitable level to understand the specific challenges associated with diabetes, and addressing of societal barriers including stigma. These findings contribute to a continuously growing body of literature that calls for a more tailored, integrated and encompassing approach to managing chronic illnesses.

Tables

Table 1 – Participant Demographic Summary

Participants*	Age	Length of Diagnosis	Type of Support Received
Jen	23	9 Years	CBT (NHS)
Alex	20	10 Years	CBT (Private)
an	36	20 Years	CBT (Private)
Alan	27	14 Years	Counselling (NHS)
Charlie	26	18 Years	Counselling (NHS)
Vanessa	30	22 Years	CBT (NHS)

* Participant names have been replaced by pseudonyms to ensure anonymity.

Table 2 – Overview of Themes

Group Experiential Themes	**Subthemes**
Barriers To Accessibility of Psychological Support	• Recognising The Need for Support • Overcoming Stigma • The Role of Healthcare Providers in Facilitating Access
Importance of the Therapeutic Relationship	• Building Trust with The Therapist • The Importance of Empathy and Understanding • Simplification Of Diabetes Management from Healthcare Professionals
Impact Of Psychological Support on Daily Diabetes Management	• Positive Reframing & Fostering Acceptance • Impact On Adherence to Medical Routines • Empowered Communication

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2.6 Qualitative Research Reflective Commentary

Introduction

The following reflective commentary describes the process of developing and completing my qualitative research project. Within this reflection I explore and describe the process of identifying the research area, developing a methodology, conducting data collection alongside IPA analysis, and discuss the process of writing up my project.

Identifying the research area

My doctorate placements over the past two years have heavily focused on providing individual psychological intervention with people living with long-term health conditions; particularly focusing on Type 1 Diabetes (T1D). Working closely with individuals living with T1D, I was frequently met with experiences of what my clients with T1D felt was insufficient or non-tailored psychological support. They also shared challenges in finding and accessing support. Additionally, after having the opportunity to provide some teaching sessions to qualified CBT therapists taking part in Diabetes specific CBT training, I further recognised that there was a significant misunderstanding and uncertainty of how to support individuals living with T1D; particularly closing the gap between managing the individuals physical and emotional well-being. This highlighted the potential benefit of understanding the experiences of individuals living with T1D to inform practices not only within my own clinical work, but also in my provision of training and consultancy to organisations working with long-term health conditions andT1D.

My first step was to review previous research in the area which highlighted those individuals with T1D had mixed feelings around psychological support and working with healthcare professionals, which further confirmed that this may be a notable area of research. Following this I decided to conduct a more thorough scoping of the research area in conjunction with my placement supervisor. My review highlighted an ongoing recommendation to better understand the intricate psychological challenges that accompany the management of chronic conditions and in particular T1D. Over the years, a vast array of literature, notably high impact studies from Anderson et al. (2001) and Delamater (2006), has underscored the pivotal correlation between T1D, psychological health and quality of life. In addition, several studies recognised how individuals who felt unable to manage the cognitive and psychological aspects of their T1D were more likely to experience health related complications including higher prevalence of Diabetic retinopathy, kidney disease, deterioration of vision and ulcerations (Van Duinkerken, Snoek & de Wit, 2020). However, despite recognising this correlation limited studies have explored the accessibility, experiences and impact of psychological interventions that would make improvements in cognitive and psychological well-being possible. Furthermore, of the few studies that were identified to explore experiences of psychological support, these were conducted in populations children and/or teenagers, which are groups that are not typically individually managing their condition (Guthrie et al., 2003).

Predominantly, the research landscape in this area has been saturated with quantitative studies (Ng et al., 2022; Whittemore et al., 2012). These studies, although invaluable, often tend to generalise the experiences of individuals, potentially overlooking the subjective intricacies that individuals with T1D experience (Snoek & Skinner, 2002). Given this backdrop, the primary research objective was committed to exploring personal narratives, extracting, and understanding individual's perceptions, concerns, benefits, and challenges in relation to psychological support. It was recognised that this would not only shed light on the lived experiences of those with T1D but also position this research to fill an existing gap, offering a nuanced perspective to the academic discourse.

Methodology

Study Design

To address the research question of exploring participants lived experiences of psychological support, it was decided that an inductive qualitative study design would be best suited (Creswell & Poth, 2018). I had significant prior experience of using qualitative methods, particularly thematic analysis and Interpretative Phenomenological Analysis (IPA) for health-related research; subsequently although I had not conducted qualitative research in 2-3 years, I felt relatively confident in the steps I needed to take with the research design.

Selection of Methodology

My prior experience in selecting IPA as a methodology demonstrated it was a cornerstone of qualitative research. Therefore, this methodology was selected on its strength of exploring individual lived experiences within health contexts (Smith, Flowers & Larkin, 2021). IPA's specific nuanced exploration of participants emotions, experiences and cognitive processes were central to the research question and so I felt confident in the selection of this approach.

Ethics

Given the sensitive nature of exploring the lived experiences of individuals with T1D, I was mindful that ascertaining ethical approval may take some time to ensure that all the appropriate considerations had been made. To begin this process, ethical approval was sought from Staffordshire University. This process included the development of participant-facing materials including the participant information sheet, the research invitation (for social media advertisement), consent form, debrief information and semi-structured interview schedule. These materials were developed utilising the recommended best practice templated from Staffordshire University and were individually reviewed by my placement supervisor and academic supervisor to ensure I had addressed all the relevant areas of my ethics application.

There were a few considerations highlighted throughout the development of my ethics application including adjustments to my participant recruitment invitation; this included clarifying exactly what the study would entail and ensuring that I received suitable consent to post the research invitation within the online group. I wanted to ensure that the research did not in any way exploit the community or infringe upon the privacy and rights of its members, and I am pleased that I had the opportunity to clarify this in my ethics application.

After submitting my ethics application, I was advised by the board that I would need to revise and resubmit; mostly due to further information surrounding data collection and handling. I made amendments to my application and provided a cover letter to confirm the updates I had made. One of the amendments which required some further thought was the consideration of emotional distress. Given the nature of the topic, it was suggested that a risk assessment should be conducted, and the risk be recognised as moderate rather than low. To mitigate this, a thorough risk assessment was conducted, and I included further resources and contacts for free impartial psychological support, should the participants require this post-interview.

A further aspect highlighted in the amendments were data handling and storage. This was my first experience of using digital transcription through Microsoft Teams and so I had to refamiliarize with how the data and transcripts could be stored securely with restricted access. The reviewing of this process I found incredibly helpful, and I feel provided me confidence that I can effectively handle and store data for any future research projects.

Due to delays in receiving feedback on my ethics application, I was unexpectedly delayed in commencing my project. After some follow up with my academic supervisor and the ethics team, I was formally approved to start my qualitative project in May 2023.

Interview Strategy

The study consisted of a semi-structured interview format for data collection. This approach, as highlighted by research including Brinkmann and Kvale (2015) provides an equal approach towards structured guidance of the discussion and participant-led dialogue. In my previous experience, I found semi-structured interviews to be highly beneficial in not making participants feel that they were 'on trial' or answering a large series of questions, whilst also ensuring that I had the ability to steer the participant if needed to address the research question. This approach felt fairly comfortable for me as it closely mirrors a style of Socratic questioning (a key therapeutic skill I have had extensive training in)- an approach that provides direction without completely taking control of the conversation (Braun & Clarke, 2013).

A further consideration I did make within my interview strategy was to be 'a researcher and not a therapist'. My qualitative supervisor shared that sometimes there is an inclination to be therapeutic within an interview setting. I was therefore reflexive of my role as the researcher when developing the interview questions and sought feedback from my qualitative supervisor, placement manager and academic supervisor to ensure the questions effectively answered my research question. There were comments from my supervisors to ask more open questions; and this led to further revisions before completion of my interview schedule. A further consideration was my lived experience of T1D which additionally led to me being mindful of not allowing this to influence the research questions, interpretation or results.

Sampling Procedure

Following the recommended IPA approach as outlined by Smith, Flowers and Larkin (2021) a purposive sampling technique was employed to recruit participants. Given the relative distribution of individuals with T1D in the population, this sampling approach allowed me to target the demographic that would support in answering my research question. I had previously conducted research surrounding T1D and therefore had the consent and access to social media groups for these individuals. Subsequently, participants were strategically targeted from this social media group, ensuring relevance to the research topic; a feature that has been recommended by Lupton (2014) as an effective means of acquiring participants through digital health communities.

Although I had little difficulty during my sampling procedure, one aspect that previous research has highlighted is the potential bias of data that comes from an online group (Hewson, 2014). Given that participants within the group are an active part of the online T1D community, this could infer that they are more active in their T1D management; and would be somewhat limited in its applicability. However as this was a qualitative exploration, this was not deemed as being too concerning for the research study.

In conclusion, the study's design was carefully developed to explore the depth and richness of the lived experiences of those with T1D. This research methodology supported in conducting a comprehensive, multi-dimensional perspective to the discourse on psychological support mechanisms for individuals living with T1D.

Data Analysis

My prior experience of qualitative analysis was that I should expect it to take longer than anticipated. Previously I have significantly underestimated the time required to work through the process of transcription, initial coding, and the development of themes; subsequently I entered this process being mindful of sticking to my timelines and maintaining momentum throughout the analytic process.

As recommended by Smith, Flowers and Larkin (2021), the first step of my analytic process was transcribing my audio recordings. Despite the availability of some technologies to speed up this process, my familiarity with transcribing interviews into Microsoft word took me just over two weeks to complete. Through my placement I was able to acquire a transcription pedal (which I had previously used at my MSc level), this significantly supported and sped up the process of transcription.

Following transcription, I worked through the 'seven steps of IPA data analyses as suggested by Charlick, McKellar, Fielder, & Pincombe, (2015) as adapted from Smith, Flowers and Larkin (2021). I personally find working through a visual process supports me in clarifying the goals of each stage of my analysis. Following these seven steps kept me accountable to a more rigorous analytic process and is outlined in further detail below:

Reading and Re-reading: Immersing myself in the data to understand participants' experiences was essential. Although I enjoyed exploring the participants' stories, this process took longer than expected, adding pressure to my timeline.

Initial Noting: This was my favourite part of the analysis. Making descriptive, linguistic, and conceptual comments allowed me to delve into participants' experiences deeply. I felt a profound sense of satisfaction in developing a system that streamlined my noting process.

Developing Experiential Statements: Identifying potential emergent themes from initial notes provided a sense of accomplishment, but was challenging . Grouping segments of the transcript into conceptual sentiments helped me build a more complex understanding of participants' experiences.

Searching for Connections: This step involved grouping potential themes based on similarities, contrasts, and narrative sequences. It was challenging yet rewarding to build connections within the data, enhancing my understanding of participants' journeys.

Moving to the Next Case: Analysing each transcript with a fresh perspective was crucial. Keeping a reflexive diary helped me manage any preconceptions, drawing from my experience in psychotherapy and qualitative research. This step was both challenging and enlightening.

Looking for Patterns Across Cases: Highlighting patterns across individuals provided a comprehensive view of the data. Compiling themes into research tables was enjoyable and rewarding, as it answered my research question and validated my efforts as one of the final aspects of my analysis.

Overall, the analysis process was rigorous and demanding but also deeply fulfilling. It taught me the importance of time management, meticulous attention to detail, and the value of a structured approach in qualitative research. This experience has significantly enhanced my skills and confidence as a researcher.

Writing up and Dissemination

For this research, I opted to submit to the Journal of Health Psychology. This decision was based on recommendation from my academic tutor and individual research. Given my lack of experience with publishing academic research, I had to thoroughly consult its author guidelines and actively seek guidance from academic mentors and supervisors to ensure my work aligned with their standards. This entire process felt quite daunting as it marked my first attempt to navigate such a process. One challenging aspect of choosing a journal to submit to be my own feelings surrounding the quality of my work; particularly an overarching sense of being an 'imposter' when it came to the prospect of publishing. I had to be mindful of my lack of experience in this form of dissemination and ensured that I sought feedback at all points of this process to allay my concerns. In addition to the journal, I was mindful of how I would adjust the findings of my research for potential T1D conferences and future teaching opportunities.

My clinical placement often meant that my day was split between research and providing individual psychological intervention. Therefore, to maintain consistency and discipline in my writing, I set a personal goal to write one to two paragraphs daily, aiming for a submission of my qualitative work in January 2024. This structure I feel strengthened my academic writing, as I found myself increasingly focused to my qualitative work during this time. As I was additionally writing my quantitative manuscript in parallel with my qualitative work, I found this approach allowed me clarity and often a welcome change of attention between my other manuscript. Structuring my week, I allocated specific slots Monday through to Friday for dedicated manuscript writing. A provisional deadline was set for the initial draft, with consideration for time needed for feedback from my supervisor and subsequent revisions.

The most challenging part of writing my manuscript was making decisions on which parts of my qualitative interview excerpts to include, especially with a strict word count in play that I needed to adhere to. To address this, I frequently reflected on my research question and the essence of the study, focused on the psychological challenges faced by individuals with T1D. My supervisor's insights were instrumental, particularly in highlighting the need to enhance the introduction section to adequately highlight the challenges individuals living with T1D experience.

Manuscript Resubmission

Unfortunately, my initial submission for my qualitative paper failed. Reflecting on this, I initially felt a deep sense of disappointment and frustration. The rush to meet deadlines amidst a heavy workload led to crucial oversights in formatting, analytic processes, and the depth of methodology. Initially, this failure left me feeling overwhelmed and questioning my capabilities as a researcher. However, as I processed the feedback, I began to understand the specific areas that needed improvement, which sparked a renewed determination to address them. This experience taught me the critical lessons of time management and meticulous attention to detail. The realisation brought a mix of relief and confidence as I saw the potential for growth. The process of revising the manuscript required a deeper engagement with the material and a more thoughtful consideration of methodological frameworks, which enhanced my understanding and skills as a researcher Moreover, this experience highlighted the importance of resilience and adaptability in academic work. It was not just about correcting mistakes but about transforming my approach to research. I learned to prioritise tasks effectively, ensuring that future work meets the standards I need to obtain. This reflective process has significantly contributed to my growth as a researcher, instilling a commitment to rigor, clarity, and relevance in my future academic work. While the initial failure was disheartening, it ultimately became a catalyst for personal and professional development, reinforcing the value of perseverance and continuous improvement.

Lessons Learned

As I shared with my qualitative and academic supervisors, I felt excited, honoured, and ambitious about conducting this piece of research. Personally, I feel that in some ways qualitative research methodologies closely mirror the reflexive, and exploratory nature of psychological therapy. One aspect that has been invaluable about this process has been my ability to develop a deeper understanding of the research and methodologies associated with IPA. I feel grateful that I was provided the opportunity to explore the thoughts of individuals who have experienced at times significant challenges, doubts, and apprehensions; but have also demonstrated courage, resilience, and optimism in the face of these challenges.

I feel proud of the work I have been able to produce and difficulties I have overcome with this project. This process has highlighted my necessity to be more attentive to preparing for my research- particularly surrounding considerations for potential distress, relevant signposting, and data handling. I also feel that I will need to be more reflective of my potential interview schedules in the future to ensure that the semi-structured nature allows participants to authentically share their thoughts, perceptions, and experiences.

I have no doubt that moving forward I will certainly continue to use and implement qualitative research to understand specific health-related contexts throughout my career. I feel that the detailed completion of my manuscript and this reflective commentary will give me the confidence to conduct interviews, handle sensitive data in secure ways and interpret complex and nuanced participant experiences.

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Chapter 3: Psychological Interventions

3.1 Individual Intervention Case Study

Background & Introduction

This case study describes a one-to-one psychological intervention conducted in my private psychotherapy work at The private Midlands clinic. The client I was working with, who will be identified as 'Molly', was referred by her general practitioner for psychological support following increased and persistent concerns around her physical health.

Molly is 26 years old and had a longstanding history of anxiety since her grandmother passed away in 2010. In 2019, Molly attended a routine smear check at her local hospital, the results of which showed positive for pre-cancerous cells. Following this consultation, the cells were successfully removed, however, Molly began to experience excessive worry and checking behaviours related to any bodily changes. Over the following months, Molly visited her GP over 20 times and was told there were no signs of an organic illness. Due to this, the GP suggested that she may be experiencing illness anxiety and made a recommendation for Cognitive Behavioural Therapy (CBT).

A CBT-oriented treatment was chosen as it is both evidence-based and recommended within the National Institute for Clinical Excellence guidelines (NICE) for the treatment of anxiety and comorbid somatic disorders (NICE, 2014). There is a substantial body of evidence that highlights the efficacy of CBT for health anxiety, particularly when used to identify dysfunctional thought patterns and reassurance seeking behaviours (Axelsson & Hedman-Lagerlof, 2019). Within the directed and collaborative approach of CBT, it is possible to achieve manageable goals by developing more rational thinking, supporting tolerance of distress and prompting effective coping strategies over the course of 6-20 sessions (De Geest & Meganck, 2019; Hofmann, Asnaani, Vonk, Sawyer & Fang, 2012).

The following case study explores the stages of the psychological intervention I followed whilst working with Molly and is accompanied by a reflective report and supervisor report following observation of a client session.

Assessment

My assessment with Molly was conducted in the first session of our intervention. The desired outcomes of this assessment were to initiate building a therapeutic relationship, identify Molly's presenting concerns and develop both longitudinal and maintenance formulations. At this point, it is most important to develop a sense of therapeutic relationship which is often a significant predictor of the therapy progress. In order to initiate the therapeutic relationship, I utilised an ice-breaker technique in which I asked Molly to share three things that she enjoys and three expectations that she had of the therapy process. After taking a few moments to continue to build from this informal conversation, I discussed with Molly that we would develop a treatment plan together that addressed the four areas of the CBT approach including thoughts, (safety) behaviours, physiological sensations and emotional aspects of the presenting concern. Molly was relieved and also surprised to see how this varied from her expectations of the process.

During the assessment stage, I used a range of assessment methods (psychometric tools, clinical interview, goal setting and self-monitoring measures) to provide a more detailed representation of Molly's difficulties, and to mitigate the possible biases that exist within singularly self-reported measures or clinical assessment (Rosenman, Tennekoon & Hill, 2011).

Psychometric Tools

Prior to the initial assessment, Molly was asked to complete three self-reported psychometric tools including the Health Anxiety Inventory (HAI), Clinical Outcomes in Routine Evaluation (CORE-OM) and the Hospital Anxiety and Depression Scale (HADS). These tools are all validated measures commonly used when working with health anxiety and permit a quick method for assessment and ongoing evaluation of symptoms. (*The rationale and outcome for these measures are outlined in Table 1*).

Table 1: Psychometric measures used for assessment and ongoing evaluation

Psychometric	Rationale	Score	Interpretation
Health Anxiety Inventory (HAI)	The HAI is a popular and validated tool prominent in the screening and evaluation of somatic disorders. A reduction in health-related symptomatology was the primary goal of the intervention.	37.0	This score would suggest severe health anxiety and in line with Salkovskis, Rimes, Warwick & Clark (2002) determination of the scoring as 'Hypochondriac patients'.
Clinical Outcomes in Routine Evaluation-Outcome Measures (CORE-OM)	The CORE-OM is a validated tool that is mandatory at the clinic for establishing outcomes within my private practice. The CORE-OM is also an effective tool in establishing psychological functioning, general wellbeing and potential risk.	69.0	A score of 69 would suggest that Molly is experiencing moderate to severe psychological distress requiring high-intensity support. Molly scored particularly high on well-being and function; suggesting specific deficits within these sub-domains.
Hospital Anxiety and Depression Scale (HADS)	The HAI is one of the most widely used tools for	14.0	A score of 14 on the HADS suggests an 'abnormal' or elevated score. Molly scored

	screening anxiety and depression. This allows early identification and monitoring of comorbid low mood with anxiety.		significantly higher on anxiety than depression, which was expected given Molly's expression of specific anxiety symptomatology

Clinical Interview

Within my initial assessment with Molly, I utilised the 5 P's framework and 'FIDO' (Macneil, Hasty, Conus & Berk, 2012). The 5 P's is an approach for best practice with CBT interventions and seeks to elicit information regarding: the presenting problem, predisposing, precipitating, perpetuating and protective factors. The 5P's seeks to elicit qualitative information through a narrative that serves to contextualise the client's concerns within a manageable and understandable manner (Macneil et al.). Throughout the process of using the 5P's, I was also mindful of the FIDO framework (Frequency, Intensity, Duration, Onset) as this provides a concise representation of the clients presenting concern. Cumulatively both of these models permit the acquisition of both the longitudinal components of the issue and the comprehension of factors that may be maintaining the problem.

When using both the 5P's approach and FIDO to understand the context of Molly's concerns, I was very mindful of Rogerian psychotherapeutic principles of empathy and unconditional positive regard (Rogers, 2011). Throughout the assessment, I ensured that I was listening attentively and communicating effectively with Molly. This was based on my non-verbal cues such as nodding where appropriate and also verbal cues such as "it sounds like this is something that has caused you concern for quite a while" or "I can see that you've worked really hard in the past to try and manage this". (*Examples of questions asked to acquire each component of the 5P's and FIDO are shown in Table 2*).

Table 2: Examples of Assessment Questions

Assessment component	Example of question
Presenting	Could you tell me what brought you here today? How intense would you say your anxiety is currently? How often do you experience this anxiety?
Predisposing	Is there anyone in your family with a history of mental health concerns? Have you experienced anxiety in the past?
Precipitating	When would you say this problem started? Was anything notable happening around this time?
Perpetuating	What do you do when you start to feel this anxiety? If I was a fly on the wall what would I see you doing when you're anxious?
Protective	What helps reduce your level of anxiety? Is there anyone you can talk to about the things that you're experiencing?

Goal Setting

A significant component of the CBT approach is that it is goal-oriented and collaborative (Gaudiano, 2008). Goal setting is recommended within the assessment phase as it emphasizes the importance of the client as an active participant throughout the therapeutic process (Gaudiano). Towards the end of the initial assessment with Molly, I asked her if we could consider some short and long-term goals. When creating these goals, we introduced the SMART goals framework and used this to ensure Molly's goals were: Specific, Measurable, Achievable, Relative and Time-Oriented (Ogbeiwi, 2017). Utilizing smart goals ensures that the client and therapist collaboratively set achievable goals that increase the likelihood of positive outcomes throughout the process (Ogbeiwi).

Molly stated that she would like to achieve 3 short-term goals and 1 long-term goal including: -

1. *To reduce her level of anxiety related to her health by 50% at the end of 8 weeks*
2. *To "stop asking people for reassurance about health-related issues"*
3. *To minimize Molly's use of Google to 'look up' physical symptoms*
4. *To increase the number of "fun stuff" Molly and her boyfriend participated in*

Within the therapeutic process, it is common for clients to have unrealistic expectations of their outcomes and often these can be 'all-encompassing' lifetime goals, rather than specific achievable goals throughout the therapy. At this point, both Molly and I discussed her expectations of the process and we decided that goals 1-3 would be our priority; with the anticipation that as her anxiety lifted, she would be more confident in taking part in activities with her partner.

Self-Monitoring

The final component of the assessment was the utilisation of self-monitoring tools or thought monitoring records. Identifying and reflecting on thoughts outside of the therapy room is a central feature of the CBT approach (Tang & Kreindler, 2017). Following the initial assessment, I asked Molly to take away and complete a thought record; noting down thoughts, emotions and behaviours that may have related to certain scenarios she encountered. Within the therapy room, it can often be challenging to identify thoughts in retrospect, so recording thoughts as she experienced them would provide both Molly and myself with insight into some of the negative thoughts and habitual actions that Molly experienced. Bennett-Levy, Thwaites, Chaddock and Davis (2009) suggests that reflecting upon previous negative thoughts is a positive and motivational action for maintaining progress. Therefore, we ensured that this thought log completed in the first two sessions was used to reflect on the progress made later on in the therapeutic process.

Formulation

Developing the Formulation

Within the second session, Molly and I utilized the information from the initial assessment to collaboratively construct a longitudinal formulation and series of maintenance formulations that were perpetuating Molly's presenting concerns. Eells (2009) research suggests that although formulation structures are somewhat standardized in delivery, they allow for exploration of the clients' issues in a collaborative and non-diagnostic paradigm. It is argued that the maintenance formulation is integral to the CBT process to both identify concerns and highlight possible treatment mechanisms (Fenn & Byrne, 2013). Currently, the most popular maintenance formulation is the five areas model which is a current conceptualization of the client's concerns and relates to how thoughts, emotions, physical sensations and behaviours are generating patterns or vicious cycles for clients (Fenn & Byrne). Within Molly's sessions, this was incorporated with a longitudinal formulation as this permits an exploration of the factors which have led to the onset of the presenting difficulties; an approach that was necessary to support Molly in comprehending the progression of her symptoms.

Communicating the formulation

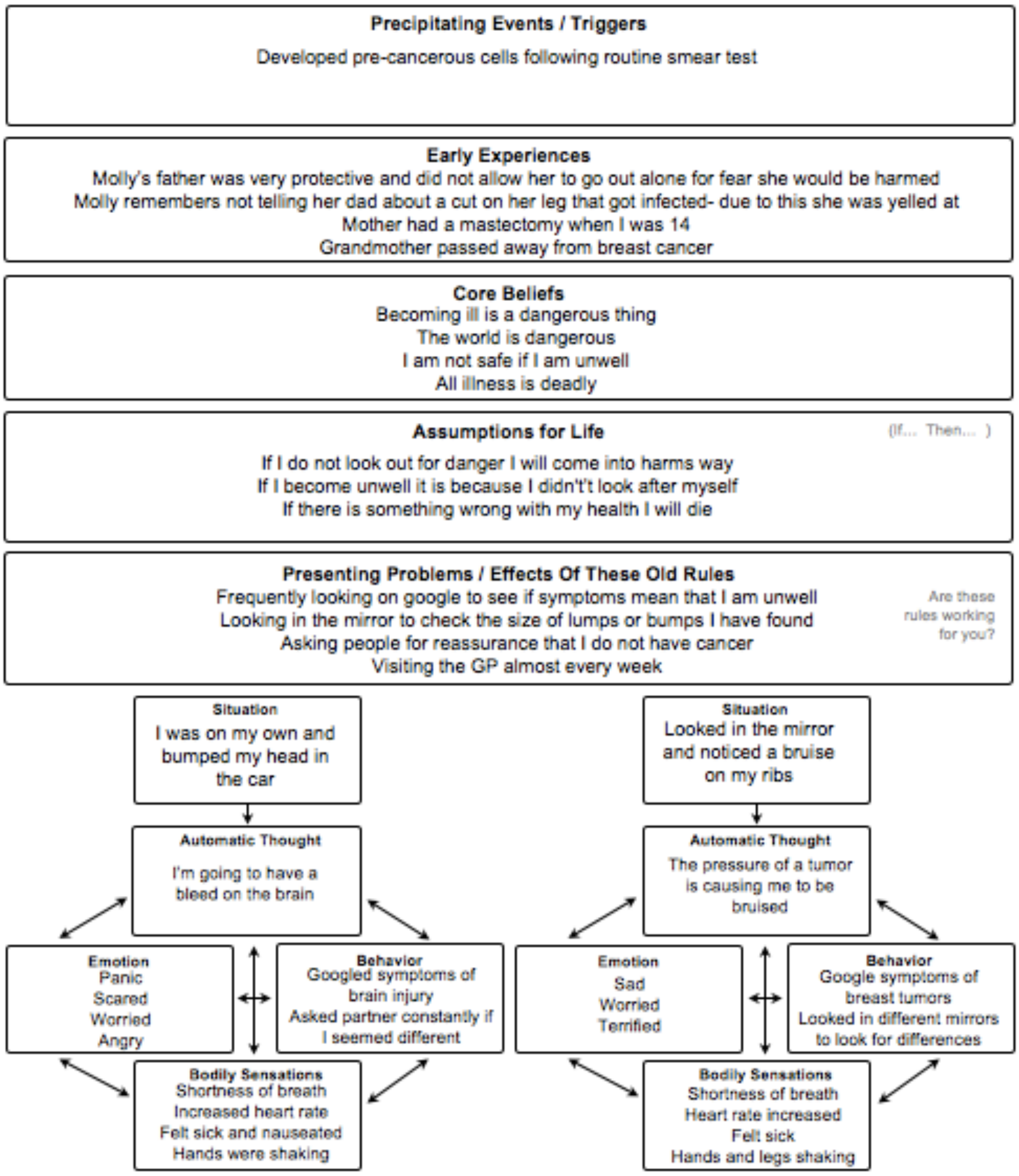
The collaborative nature of CBT suggests that the therapist is viewed as a facilitator to change rather than the position of an 'expert' and it is, therefore, important to remember this when discussing the formulation (Proctor, 2008). A unique component of the CBT approach is the ability to change and update the working formulation as new information is identified and therefore, I was mindful of informing Molly of this within our second session.

The approach to communicating the formulation was influenced by the BACP ethical guidelines of honesty and transparency alongside the guidelines for CBT best practice (BACP, 2014). During the second session, Molly and I spent a significant portion of time discussing both the longitudinal and maintenance formulations (See figure 1). Fenn and Byrne (2013) suggest that both the client and therapist should work collaboratively to develop the formulation, therefore after providing Molly with the formulation layout she built the conceptualisation of longitudinal and maintenance with my support. Following this, I asked Molly if there was anything that did not make sense or she would like me to clarify and provided the formulations as a framework for how we would develop the treatment plan, in order to enhance coping and break down the 'vicious cycles'.

Formulation Overview

My clinical impression of Molly’s concerns was that of health anxiety with persistent intrusive thoughts exacerbated by behaviours of frequent body and symptom checking. Molly’s earlier experience of developing pre-cancerous cells activated her core beliefs of needing to stop something bad from happening to her, resulting in the catastrophic misinterpretation of her physiological sensations. (*The conceptualization of Molly’s concerns can be seen in Figure 1 below*).

Figure 1: Longitudinal and maintenance Cognitive Behavioural formulation



Precipitating Events / Triggers
Developed pre-cancerous cells following routine smear test

Early Experiences
Molly's father was very protective and did not allow her to go out alone for fear she would be harmed
Molly remembers not telling her dad about a cut on her leg that got infected- due to this she was yelled at
Mother had a mastectomy when I was 14
Grandmother passed away from breast cancer

Core Beliefs
Becoming ill is a dangerous thing
The world is dangerous
I am not safe if I am unwell
All illness is deadly

Assumptions for Life (If… Then…)
If I do not look out for danger I will come into harms way
If I become unwell it is because I didn't't look after myself
If there is something wrong with my health I will die

Presenting Problems / Effects Of These Old Rules
Frequently looking on google to see if symptoms mean that I am unwell
Looking in the mirror to check the size of lumps or bumps I have found
Asking people for reassurance that I do not have cancer
Visiting the GP almost every week
Are these rules working for you?

Situation
I was on my own and bumped my head in the car

Automatic Thought
I'm going to have a bleed on the brain

Emotion
Panic
Scared
Worried
Angry

Behavior
Googled symptoms of brain injury
Asked partner constantly if I seemed different

Bodily Sensations
Shortness of breath
Increased heart rate
Felt sick and nauseated
Hands were shaking

Situation
Looked in the mirror and noticed a bruise on my ribs

Automatic Thought
The pressure of a tumor is causing me to be bruised

Emotion
Sad
Worried
Terrified

Behavior
Google symptoms of breast tumors
Looked in different mirrors to look for differences

Bodily Sensations
Shortness of breath
Heart rate increased
Felt sick
Hands and legs shaking

Psychological Intervention

Based on the above formulation, it was clear that there was a combination of cognitive and behavioural components that were contributing to Molly's experience of health anxiety. Subsequently, I aimed to conduct roughly between 6-8 sessions of psychological intervention to support Molly to build her coping skills, modify appraisals of threat and work to reduce her reassurance-seeking behaviours.

Throughout the therapeutic intervention stage, I planned to use a combination of tools that combined aspects of a CBT approach, behavioural change techniques and interventions tailored towards supporting Molly overcome difficulties in her life. Outlined below are some of the key components and rationales for my treatment intervention phases and processes that were used to work with Molly.

Socratic Questioning

A fundamental component of the CBT approach is Socratic questioning. Socratic questioning refers to the processing, challenging and modification of irrational thoughts (Braun, Strunk, Sasso & Cooper, 2015). Using this technique with Molly would enable her to be supported in consciously questioning her own negative automatic thoughts (Carona, Handford & Fonesca, 2020).

Homework

Homework is a further fundamental important component of CBT in which the client is asked to complete work to develop from the individual therapeutic sessions (Mausbach, Moore, Roesch, Cardenas & Patterson, 2010). When working with health anxiety, there are often several beliefs and behaviours which cannot be directly addressed within the therapy room and homework activities were planned for Molly's sessions to support the progress made in the face-to-face appointments.

Psychoeducation

Psychoeducation, or providing information that helps clients to better understand their presenting problem is particularly important when working with health anxiety as individuals often experience a ‘catastrophic misinterpretation of physiological sensations’ (Kaczkurkin, 2015). When working with Molly I was also mindful that psychoeducation could support her to explore how excessive health anxiety-related behaviours, such as physical checking and monitoring, can lead to an increased focus on the body’s normal changes and reactions.

Relaxation Training

A further treatment component that I planned on incorporating was relaxation training. The current evidence suggests that teaching relaxation techniques can be effective in mitigating the symptoms of anxiety disorders; primarily those related to anxiety, fear, and acute stress (Kaczkurkin, 2015). Within Molly's treatment I considered introducing her to 4-7-8 breathing and progressive muscle relaxation. These techniques could be easily modelled by myself as based in the behavioural change techniques taxonomy and practiced by Molly in between sessions to support her alleviation of cognitive and physical stress.

Cognitive Restructuring

Salkovskis & Warwick (2001) highlight that individuals with health anxiety typically experience catastrophic thoughts about their physical symptoms. A well-documented technique to manage these thoughts is cognitive restructuring; in which the clinician identifies and deconstructs unhelpful thoughts and moderates them in a more balanced way (Salkovskis & Warwick, 2001). Helping Molly identify and restructure her negative thinking patterns and subsequent behaviours would be a key part of the intervention.

Behavioural Change & Substitution

The final component of Molly’s proposed treatment plan was behavioural change techniques. Within CBT, practitioners often use specific interventions that are unknowingly drawn from behavioural change taxonomies. Within my approach to working with Molly and utilising the COM-B model; I conceptualised that Molly was having difficulty with her capability to manage her behaviours due to an inability to utilise skills that would reduce her anxiety. Subsequently, both at the beginning and throughout our sessions I was mindful to refer back to the behavioural change techniques as suggested by Carey et al. (2019) to ensure that the behavioural modification was both evidence-based and tailored to Molly's concerns.

Proposed Intervention Delivery

Following the initial assessment with Molly, I wanted to ensure that I had a sufficient treatment plan that was supported by empirical research, alongside behavioural change techniques that would be facilitative of reducing Molly's anxiety. This process was conducted by generating a treatment plan as outlined below in Table 3.

Table 3: Proposed treatment plan

Treatment Session	Treatment Plan	Treatment Rationale & Behavioural Change Techniques	Proposed Behavioural Change Techniques
1	Assessment of existing concerns including development 5p's formulation and comprehension of maintaining factors. Orient Molly towards the cognitive model and set short and long term goals. Monitor health anxiety symptomatology with HAI, CORE-OM and HADS. Provide Molly with a thought log to note events during the week.	Using sufficient formulation in practice- Macneil, Hasty, Conus & Berk, (2012). Importance of orientation to the CBT approach- Fenn & Byrne, (2013) Necessity for standard outcome measures in clinical work- Paz, Mascialino & Evans, (2020)	-Feedback on behaviour -Goal setting -Problem solving -Feedback on outcomes of behaviour -Social support

2	Review thought log from first session and discuss a recent 'hot event'. Continue to work through a series of maintenance formulations and provide psycho-education on health anxiety symptomatology and the fight or flight/anxiety response. Orient Molly to her current physiological sensations (as shown in physiological sensations'. Introduce relaxation techniques such as 4-7-8 breathing and provide a practice log for relaxation.	Clinical effectiveness of psychoeducation in CBT approaches- Schaub, Hippius, Moller & Falkai, (2016) Benefits of diaphragmatic breathing for anxiety- Ma et al., (2017) Effectiveness of homework compliance and outcomes in CBT- Mausbach, Moore, Roesch, Cardenas & Patterson, (2010)	-Information about health consequences -Framing/Reframing -Incompatible beliefs -Salience of consequences -Self-monitoring of behaviour -Pros and cons -Discrepancy between current behaviours and goal
3	Review relaxation and effects of breathing intervention on anxiety. Introduce progressive muscle relaxation if needed. Begin to utilise Socratic questioning to explore Molly's negative	Progressive muscle relaxation for improvement in mood and anxiety reduction- Hashim & Yusof, (2011)	-Framing/Reframing -Incompatible beliefs -Salience of consequences

	automatic thoughts and commence cognitive restructuring to explore other reasons for physiological sensations. Provide as a homework task over the following week.	Treatment of health anxiety with CBT cognitive restructuring and Socratic questioning- Salkovskis & Warwick, (2001)	-Self-monitoring of behaviour
4	Review thoughts on trial from previous session and use again in session to consolidate. Discuss frequency of reassurance seeking and/or checking/ avoidant behaviours. Recommend a behavioural experiment or exposure therapy regarding catastrophizing of physiological sensations and beliefs.	Necessity to reduce avoidant behaviours in the CBT approach to mitigate impact of physiological sensations Salkovskis & Warwick, (2001) Using behavioural change techniques including exposure or behavioural experiments to reduce emotional response or avoidance -Hoffman & Hay (2018)	-Self-monitoring of outcomes of behaviour -Graded tasks -Focus on past success -Behavioural practice -Reduce Negative Emotions -Framing/Reframing -Incompatible beliefs

			-Salience of consequences
5	Review behavioural experiment and discuss findings. Use Socratic questioning and reframing to explore negative automatic thoughts related to health behaviours. Refer back to cognitive restructuring techniques to consolidate thoughts. If needed incorporate components of Acceptance work from third-wave CBT approaches or establish core beliefs using a continuum task. If a core belief is uncovered use an additional session to explore and reframe this.	The benefit of Acceptance & Commitment therapy techniques working with Health Anxiety- Hoffman, Rask & Frostholm, (2019) Identifying the importance of cognitive restructuring to consolidate negative patterns of thinking- Salkovskis & Warwick, (2001)	-Self-monitoring of behaviour -Self-monitoring of outcomes of behaviour -Graded tasks -Focus on past success -Behavioural practice -Reduce Negative Emotions -Framing/Reframing -Incompatible beliefs -Salience of consequences
6	Review continuum homework and identify		-Anticipated regret

	any further concerns brought to therapy by Molly. Discuss how to maintain progress and plan for relapses in future events. Provide relapse prevention as homework.	Importance of relapse prevention planning to reduce future difficulties and set-backs Melemis, (2015)	-Review outcome goals -Self-monitoring of behaviour -Focus on past success
7	Review relapse prevention plan and maintaining progress. Orient towards the end of therapy and provide feedback on the process whilst reinforcing the interventions learnt. Review learning and address future goals.	Importance of relapse prevention planning to reduce future difficulties and set-backs Melemis, (2015) Importance of concluding the therapy safely and effectively that is facilitative of the client- (Moola, 2016)	-Anticipated regret -Review outcome goals -Identity associated with changed behaviour -Feedback on outcomes of behaviour

Actual Intervention Delivery

Following the development of the treatment plan, I arranged the following appointment with Molly. I was particularly mindful that although a treatment plan provides a conceptualisation for how treatment can proceed; it often does not dictate how the treatment is actually provided (Tsai et al., 2019). Below in *Table 4*, the session content and observations throughout the course of the treatment can be seen.

Table 4: Session content and observations from 1-1 intervention

Treatment Session	**Session Content**	**Session Observations** ***Excerpts from reflective diary***
Session 1	Within the initial assessment, Molly and I began to develop a therapeutic relationship based on similar music tastes which she shared with me and further exploration of her perceptions of what we would be doing in the therapy. I completed a 5p's formulation alongside FIDO before providing Molly with a thought log to complete ahead of our next session.	Molly and I were quickly able to develop a rapport through a mutual use of humour. A poignant moment was asking Molly for her expectation of the therapeutic process… 'that I would be an old man sitting back in his chair'. This experience allowed me to display ethical considerations of transparency whilst also using humour as a communicative tool to build rapport. Molly appeared slightly hesitant towards completing the thought log as 'homework'. However, after some discussion as to how to view this more so as 'development', Molly shared that she was 'very motivated to turn her life around'.
Session 2	Molly and I reviewed her thought log which identified a combination of negative automatic thoughts and	Molly had completed the thought log very comprehensively. It appeared that Molly found the 4-7-8

	behaviours likely to perpetuate health anxiety symptoms. In the session, we used Molly's thought log to develop both a series of maintenance formulations and a longitudinal formulation. Molly noted physical sensations including an increased heart rate and palpitations. I introduced Molly to 4-7-8 breathing as a way to manage the physical symptoms of her anxiety and provided a log for her to track this over the following week.	particularly useful- even noting feeling a bit 'sleepy' after using the technique. This supported Molly's trust in using breathing techniques and subsequently shared excitement for using this over the coming week. Molly also shared open transparency for feeling doubtful as to the benefit of relaxation techniques and this appeared to alleviate as a consequence.
Session 3	Molly found the 4-7-8 breathing technique to be very effective in managing her cognitive and physical symptoms of anxiety. In this session, we focused on cognitive restructuring utilising a tool called 'thoughts on trial' to weigh up the evidence both for and against Molly's negative automatic thoughts. Utilising Socratic questioning we moderated "I'm going to develop cancer and die" to "I may get ill at some point but it's not very likely". I provided this task to Molly as homework over the next week and also asked her to keep a log of how many times she was	Molly initially found the concept of cognitive restructuring difficult 'how do I just change my thoughts'. I worked through a series of metaphors related to Molly including the gym- 'How do we build up our muscles' – 'through practice and using our muscles in a different way'. This clearly made more sense to Molly and we managed to make some significant 'eureka' moments when focusing on the element of Socratic questioning. We were effectively able to transition Molly's negative automatic thoughts from- 'If there is something different in

	seeking reassurance from friends/family about her physical health.	my body it is a serious problem that will cause my death’ to – ‘I have noticed loads of changes in the past and nothing serious has ever happened so it’s not likely this time will be different’. This was a strong finish to the session which led on nicely to the development task over the following week.
Session 4	Molly successfully moderated 12/14 thoughts over the week and noted not seeking reassurance from any family members. We consolidated using the cognitive restructuring skills in the session and explored why she did not feel the need to ask for reassurance. Utilising an Acceptance & commitment therapy technique of ‘the bus driver’ I asked Molly to notice her thoughts over the next week but not to engage with them and provided this as homework.	I felt that Molly had worked really hard over the previous week as was shown by her comprehensive thought log. I shared with Molly how well she had done and this appeared to prompt her to state that she felt she was making steady steps towards her well-being…. One component I did note was that Molly found it difficult to comprehend the acceptance components of the treatment. Despite some hesitance, I recommended gaining some practice and communicated that this is a process for us to learn together what will and may not work for her. This appeared to resolve some of the ambivalence that Molly was experiencing.

Session 5	At the commencement of this session Molly appeared upset. On further questioning, Molly stated that she had still been occasionally googling. We used this session to explore why and developed a behavioural experiment that would have Molly 'over check' google on 3 days (up to 20 times) and only once on the other 4 days; monitoring her anxiety accordingly. We also completed a visualisation intervention to explore where Molly would be if she continued her behaviours over the next 6 months, 1 year and 5 years. I provided Molly with a behavioural experiment log to complete over the next week and asked her to reflect daily on her visualisation technique.	When Molly entered the room, I instantly noticed that something was 'off'. I reassured Molly that this was a safe place where it was fine to both feel and explore these emotions. At this point, Molly became visibly upset and shared that she had been continuing to google her symptoms. Despite myself feeling disheartened, I shared a metaphor with Molly that the therapy process "is a walk through all of the seasons rather than a sunbathe". Molly found this quite humorous and then began to share why she had found it difficult to inform me of this. We were effectively able to resolve this and put in place measures to ensure that she could share this information with me again if needed.
Session 6	In this session, Molly noted that she felt more anxious on the days she checked google 20 times. Using Socratic questioning Molly identified that this behaviour was increasing her anxiety in a counterproductive way. She also found the visualisation technique upsetting	This appeared to be the most beneficial session for Molly so far. Molly displayed a strong sense of 'taking on the role of her own therapist' which was apparent in the way she had begun to restructure her own thoughts. Reflection on the visualisation technique elicited a

	'in a productive way' as she felt this was not the way she wanted her life to go. 3 days into the experiment Molly had completely stopped checking google and was feeling that her anxiety had significantly alleviated. I asked Molly to write down how she was feeling, to read this back every morning and complete a behavioural log for reassurance-seeking, body checking and googling.	strong emotional reaction for Molly which I interpreted as frustration as to the possibility of how her life would continue with said anxiety features. We were able to successfully switch this from a negative to a positive
Session 7	From the previous session, Molly appeared very elated and was pleased to inform me she had not checked any symptoms on her body, google or asked for reassurance. We consolidated these findings and explored why this may have been. Molly was very pleased with herself and we used the remainder of the session incorporating SMART goals to explore how she could use this momentum to do more 'fun things' with her partner. I supported Molly to create a behavioural activation log to complete these tasks over the following week.	Molly almost came 'running' into the session to tell me that she had not engaged in any symptom or behavioural checking behaviours. I asked Molly why she believed she was able to make this change and took significant time to consolidate these findings. At one point, I did feel that Molly was potentially 'getting ahead of herself'- and at this point I subtly suggested the importance of maintaining this progress. I, therefore, recommended keeping in mind how she was able to do this whilst also focusing on the behavioural log

Session 8	In this session, Molly informed me that she had completed some activities with her partner and continued to 'not even think about my body'. I introduced Molly to relapse prevention planning and how we could look at maintaining progress at the termination of therapy. Collaboratively we worked through this process together before I provided Molly a written plan to take away and add to ahead of our final session.	Molly was significantly more 'euthymic' in mood throughout this session. I reflected to Molly how I had noticed this change to which she summarised "I can just feel it working…I'm proud that I've been able to do it". Molly was very engaged in creating the relapse prevention plan and even took a leading role in sharing her thoughts for making this intervention more 'suited to her'. Molly stated that she felt confident in using this tool and was abundantly capable in reiterating the primary interventions used throughout the treatment.
Session 9	Molly and I reviewed her relapse prevention plan and ascertained how she would manage if a future setback was to arise. Molly provided a comprehensive account of the steps she would take and reiterated the interventions she has found most useful throughout the session. I asked Molly for feedback on the sessions and discussed the pathways to seek support in the future if needed. I also allowed	Molly had created a very comprehensive relapse prevention plan with a combination of cognitive, behavioural and distress tolerance skills. Molly was very grateful for the process and stated that she was "not upset but a bit disheartened" that the process had come to an end. I took this opportunity to share that I had also enjoyed working with Molly and that the end of the therapeutic process can

	time for Molly to share how she had found the CBT process.	often leave mixed emotions. Molly did however feel confident that she was now significantly more equipped to manage her anxieties and worries in the future.

Treatment Evaluation

Within the context of therapy, evaluation is the fundamental process of obtaining data to determine the context of change (Gondek, Edbrooke-Childs, Fink, Deighton & Wolpert, 2016). The process of evaluation whilst working with Molly was generated through a series of subjective mental status evaluations, reflection on initial goals and changes in psychometric scores.

Subjective Mental Status

A key component of the treatment evaluation particularly in private practice is to establish whether the client displays a subjective change in attitudes and behaviours. To do this, I utilised aspects of the Mental Status Examination tool and Socratic questioning to establish the impact of the treatment on Molly’s well-being (Martin, 1990). From a discussion towards the end of the treatment, it was apparent that Molly was visually more relaxed and able to convey her thoughts much more clearly. In addition, Molly appeared less startled than in our initial sessions and could maintain good eye contact throughout. From Molly’s expression of her thoughts, emotions and feelings, it was apparent that she had received significant benefit from the treatment and stated that “thinking about me a few months ago is like a different person… there are so many things I can do because I’m not constantly thinking all of the time about what’s going on with me”. This was also supported by the qualitative feedback that Molly provided.

Reviewed Goals

Within the initial assessment, Molly stated that she wanted to obtain four goals. Following both objective and subjective feedback, Molly's obtainment of these goals is outlined below:

1. *To reduce her level of anxiety related to her health by 50% at the end of 8 weeks*

At the termination of treatment, Molly informed me that she had noticed a dramatic reduction in the level of health anxiety symptoms. Molly now felt that she only had 'fleeting thoughts' about her health which lasted for seconds at a time. Molly further stated that she felt she had made a 'full recovery' from how she presented at our initial assessment. On objective examination, Molly also displayed an approximate 70% reduction in her health anxiety symptomatology as assessed by the HAI.

2. *To "stop asking people for reassurance about health-related issues"*

A fundamental component of our treatment was to reduce the typical symptom of reassurance seeking concerning health-illness behaviours. From the 4th-5th session with Molly, she had self-reported to have alleviated asking family members and friends for reassurance. This was particularly poignant with an example of noticing a bruise on her leg which 'would have instantly made me ask someone before'.

3. To minimize Molly's use of google to 'look up' physical symptoms

Despite Molly finding this one of the most challenging components of the treatment, she had successfully abstained from using google for 30 days and informed me that she had no further intention of doing so as 'I know the harm that it has caused me all those years and I'm glad I felt comfortable enough to tell you when I was still doing it'.

4. To increase the number of "fun stuff" her and her boyfriend participated in

At the termination of treatment, Molly shared that she and her boyfriend had begun doing ‘more things together’ including watching movies, having ‘date nights’ and listening to music. Although this was a secondary goal of the treatment, it appears that Molly has started to take more steps towards making this a reality.

Psychometrics

At the commencement and termination of therapy, Molly was asked to completed three psychometric tools including the HADS, CORE-OM and HAI. At these two points, there were significant decreases within the linear scales, suggestive of a reduction of anxiety symptoms and improvement in psychological well-being. The treatment scores and interpretation can be viewed in full in Table 5 below.

Table 5: Evaluation of psychometric scores across treatment.

Psychometric Scale	Pre-Intervention Score	Post-Intervention Score	Interpretation
Hospital Anxiety and Depression Scale (HADS)	14.0	6.0	The HADS score showed a reduction by over 50% and now means Molly is within a ‘Normal’ category as defined by the measure. Most notably, Molly saw dramatic reductions in her levels of anxiety which was expected throughout the process. There were also marginal decreases in the depression subscale which

			is further expected after receiving a CBT treatment.
Clinical Outcomes in Routine Evaluation-Outcome Measures (CORE-OM)	69.0	21.0	Molly’s CORE-OM score now suggests that she would be determined at the lower level of ‘Low risk’. This has shown a dramatic change in well-being and functioning and a further 1-point decrease would place Molly in the ‘healthy’ categorisation.
Health Anxiety Inventory (HAI	37.0	12.0	This appears the most significant finding and displays that Molly’s health anxiety symptoms have dramatically alleviated over the course of the treatment. A score of 12.0 places Molly slightly above the threshold of 11.0 which is deemed as the control for health anxiety. We have discussed moving forward how Molly can continue to mitigate the impact of her anxieties returning alongside how to maintain progress.

Conclusion

Working with Molly was a rewarding process that was only reinforced through seeing her progress throughout the sessions. It was particularly useful to have a strong therapeutic relationship alongside a parsimonious formulation both at the beginning and throughout the treatment. I believe that Molly found the CBT treatment to be very effective in managing her anxiety that was not only reflected in her psychometric scores but also alongside subjective evaluation of her current well-being.

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3.2 Individual Intervention Reflective Commentary

Therapeutic Competence

Prior to commencing work with Molly, I have been a practising integrative psychotherapist for several years. Throughout my practice, I have utilised a combination of Person-Centred, Cognitive Behavioural and third wave psychological therapies mostly working with individuals experiencing severe anxiety disorders. Generally, I feel very confident in providing psychological interventions after completing over roughly 1500 hours of 1-1 and group sessions, however, this competence provided me with an opportunity to inspect my own approaches, assumptions, ethical considerations and evaluation of treatment.

Therapeutic Relationship & Communication

Developing a therapeutic relationship with my client is the reason why I chose and continue to work in psychotherapy. As someone interested in peoples lived experiences, I am always privileged to share my knowledge and communicate with others in a way that allows them to feel supported, safe and 'listened to'.

A component of Molly's treatment that has historically been quite challenging was the question of 'will CBT definitely work for me?'. As Ardito and Rabellino (2011) suggest, one of the key indicators for the outcomes of CBT is the therapeutic relationship and I always approach this topic with openness and transparency. To paraphrase I informed Molly "it's a difficult question and there's no simple answer. Certainly, many people benefit from CBT and it is well documented in the research, however, many components determine how beneficial the treatment can be". I think it is increasingly important that as practitioners we don't just say 'yes' because it's what our clients want to hear. I think that ultimately our clients would prefer an answer that was genuine and honest- and often I think our clients can tell when we are embellishing the truth with overly technical language. From the outset, Molly told me that she appreciated the honesty and how it did not mirror the experience she had received in a previous IAPT service. As this was one of our first interactions, the proceeding process felt to flow very easily as it appeared Molly felt confident that I would be transparent with her throughout the therapy sessions.

Assessment & Formulation

Assessment and formulation of client difficulties is something that has been ingrained through both my formal training and ongoing training in CBT. I think that formulation is a very misunderstood component of the treatment and this is why I ensure that a full session is spent comprehending this at the outset. I find that models such as maintenance formulations and even the COM-B are very easy to use with clients as they are readily comprehensible. There is a significant amount of evidence suggesting that Acceptance and Commitment Therapy is a strong treatment for Health Anxiety, and although I enjoy employing these techniques I feel that the formulation is rather complex. Due to this, I felt confident that the chosen formulation was both suitable and understandable for Molly's presenting difficulties.

Ethical Considerations

Under my accrediting body the British Association of Counsellors and Psychotherapists I regularly have to partake in ethical awareness courses and ongoing mandatory training. During my first appointment with Molly, I ensured that I made her aware of my ethical and legal requirements including the right to confidentiality and the circumstances in which I am obliged to breach them (BACP, 2018). As Sookman (2015) suggests, ethical considerations are often not as clear as they are within guidelines and it is very common that I am faced with scenarios in which I have to make decisions to protect both my client’s well-being and my own representation.

Whilst working with Molly, there was a key moment in which these ethical considerations became apparent. During our second session, the administrative team received a call and subsequent request for information regarding Molly’s treatment. On this call being transferred to me, I had to kindly yet assertively state to the individual that “I would be unable to confirm if this individual was receiving treatment and would not be at liability to disclose anything about my client respectively". In turn, I received a 'non-amicable response' that was unpleasant in tone. On terminating this call I had to speak with the administrative team to convey that this call should have been terminated at the outset based on the GDPR guidelines to non-disclosure of sensitive information (ICO, 2018). Although this was not an enjoyable conversation, on reflection it has displayed the confidence and understanding of ethical principles that are so central to my role as a psychotherapist. This has also prompted ongoing development within the wider clinic team to address how to manage these calls in the future.

Evaluation

Within my practice, I often utilise psychometrics (very cautiously). From prior experiences, psychometric scores can often mask how a client is feeling, particularly if this is the only insight used to evaluate the clients progress. In my role as the director of therapy services at the private clinic, it was my recommendation to implement a combination of psychometrics in order to trace well-being, disorder-specific quantitative data and potential comorbidities. I have found that this approach more sufficiently allows me to view the whole person's well-being rather than just focusing on what would have been the Health Anxiety Inventory. As Rosenman and Tenekoon (2011) suggests, as psychologists we have to be aware of the limitations of self-reported questionnaires and this is why I felt that following qualitative discussions with Molly- she was indeed ready for discharge from the clinic.

Therapeutic 'Set Back'

Within the 5th session, Molly stated that she had not been able to abstain from googling her symptoms as well as she had expressed. As a therapist, I always want my clients to be able to tell me if they are struggling with anything, and despite an initial feeling of slight disappointment with myself- I reflected that this was a positive experience. Not only did this provide an opportunity for Molly and myself to correct our approach to challenging the behaviours, but it also reinforced that despite feeling quite embarrassed, Molly was able to communicate her 'secret' to me. I think that this was one of the main turning points in the therapy as it allowed Molly to see that I was not disappointed in her but rather only wanted the best for her progress. Following this, Molly was increasingly honest with me towards the end of the therapy in which she continued to reach the goals set in the initial assessment.

Role of Clinical Supervision

A fundamental component of my practice is that of receiving clinical supervision. Although this is a requirement of my accrediting body (BACP, 2018) I find clinical supervision useful in exploring my own thoughts, feelings and emotions throughout the therapeutic process. Within the sessions with Molly, she mentioned her beliefs around relationships that I felt was very polarised to my own beliefs. I am fully aware that in line with the Rogerian principles of my practice I have a duty to remain non-judgemental, however, I noticed that this elicited a certain reaction that I was unfamiliar with (Rogers, 2011). After taking this to my clinical supervisor, I was able to explore how I viewed my client's action as 'unethical', however, I was praised for my continued use of empathy and understanding with Molly. This was good to hear as working with individual clients often exposes me to a range of traumatic, moral and ethical 'grey areas'. Often, I place myself in a position where I should be impartial by nature, however, this experience highlighted that I am permitted to have reactions- particularly when they are arguably subconscious. More importantly, however, I think that taking this to supervision allowed me not only to build a stronger relationship with Molly but also develops a great understanding of myself. Self-awareness is a fundamental component of the BACP ethical guidelines and so I felt that this displayed growth not only as a person but additionally as a competent therapist (BACP, 2018).

Conclusion

Overall, it was an exceptionally enjoyable and knowledgeable experience working with Molly. I was and still continue to be very pleased with the progress that Molly made, and she will certainly be a client whom I will remember going forward. This competence has highlighted the intricacies of the psychological interventions that I provide, and I hope will continue to inform my practice as I commence training as a clinical supervisor myself. I am tremendously grateful for the experience of scrutinising the way in which I practice in psychology- which has only served to make me want to continually improve on the approach, tools and techniques that I am incorporating.

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3.3 Group Intervention Case Study

Introduction & Background

At the private clinic, I have been providing psychological group sessions for individuals experiencing social anxiety, obsessive-compulsive disorder and bereavement support. In late 2020, a consultant psychiatrist pointed out the necessity for individuals with Attention Deficit Hyperactivity Disorder (ADHD) to receive supportive behavioural interventions to enhance their well-being. Given the prevalence of difficulties including poor dietary management, sleep difficulties, frequent inactivity and social challenges within the ADHD community, I decided to develop a programme implementing psychoeducation, practical interventions and shared experience of people living with ADHD (Pelsser, Frankena, Toorman & Rodrigues Pereira, 2017; Mehren et al., 2020; Wilens & Spencer, 2010). Due to my psychological experience, I felt that this was well within my competence as I had prior experience of working 1-1 with individuals with a primary diagnosis of ADHD; which would lend itself well to the group sessions.

The following case study and the reflective report, documents the stages of the (ADHD Wellbeing & Social Development Group) intervention including recruitment, assessment, formulation, implementation and evaluation; over a six-session group conducted from January through to February 2021. The primary aim of the group was to enhance wellbeing by raising awareness of, and implementing interventions tailored to the groups perceived challenges related to their ADHD diagnoses.

Recruitment & Assessment

Recruitment to the ADHD group was a relatively simple process as the consultant psychiatrist, with whom I work closely with at the clinic, had discussed the process of developing a group to help individuals newly diagnosed with ADHD to become develop awareness and better manage their well-being. Due to this, the psychiatrist had been making referrals to the group waiting list from late 2020. This meant that I was provided with a waiting list of roughly 18 individuals who were both motivated and very keen to commence group sessions.

Thimm and Antonsen (2014) suggest that attention should be paid to the idiosyncrasies of the individuals who will be receiving therapeutic support within the group. Biggs et al. (2020) further suggest that the members of the group should display characteristics of being motivated, comfortable in disclosing their experiences and unlikely to be particularly disruptive to the group dynamic. Given the characteristics of some individuals with ADHD to be more 'fidgety', impulsive and experience challenges with concentration; I felt it was necessary to go through their electronic patient records to determine a group of individuals who would most likely be suited together. This process was also supported by the consultant psychiatrist who had strong relationships with all of the individuals at this time.

Biggs et al. (2020) recommend that group interventions should contain between 6-10 individuals to obtain maximum efficacy of the therapeutic support. Due to this and the current Covid-19 guidelines, I decided to limit the group to 6, as this permitted a safe environment in which we could all maintain a minimum of a 3-metre distance between each other. Prior to identifying the suitability of this group size given the current government guidelines, I requested a risk assessment governance meeting to ensure safe practices were upheld; to which the group was approved alongside the mandatory wearing of face coverings, suitable ventilation of the space and temperature checks on entry to the building.

Initial Contact

I conducted one-to-one online Zoom meetings with the individuals I felt would be most suitable for the group. There were three primary objectives of this online meeting: to develop a working therapeutic relationship early on into the process, to orient the clients to the structure of the possible group interventions and finally to assess the specific objectives of the group. From the discussions, it was clear that all of the members felt that they needed support in: understanding the role of sleep and how to improve sleep hygiene, learn 'tips and tricks' to increase knowledge of diet and physical activity, reduce procrastination and moderate negative thinking patterns associated with ADHD. As this intervention was a global well-being support group, I stated that we would incorporate key components of these objectives into the group.

Prior to the first session I sent each participant three psychometric tools to complete (the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM), World Health Organisation Quality of life scale Brief Measure (WHOQOL-BREF) and the Adult ADHD Self Report Scale (ASRS)). The rationale for selecting these validated measures are outlined below in Table 1 and pre-intervention scores in Table 2. Although I could have utilised specific scales for behaviours such as sleep and physical activity, the primary focus of the group was to orient the newly diagnosed individuals to global challenges and ultimately to support in improving overall quality of life; allowing for further 1-1 support after the group if required to focus on more specific behaviours.

Table 1: Rationale for selected Psychometrics

Psychometric	Rationale
CORE-OM (Evans et al., 2000) ***Max Score: 136*** ***Higher Score=Negative Outcomes***	The CORE-OM is a validated tool that is mandatory at the clinic for establishing outcomes within my private practice. The CORE-OM is also an effective tool in establishing psychological functioning, general wellbeing and potential risk.
WHOQOL-BREF (World Health Organisation, 1996) ***Max Score:100***	The WHOQOL-BREF is a validated tool to assesses quality of life. It also accounts for an individual's value system, personal goals, standards for life and potential concerns.

Higher Score= ***Positive Outcome***	
ASRS (Kessler et al., 2005) ***Max Score:72*** ***Higher Score= Greater prevalence of symptoms***	The ASRS is the current best practice measure utilised in the private clinic for the screening and assessment of inattentiveness and hyperactivity; components of which the majority of individuals living with ADHD experience.

Table 2: Pre-Intervention Group Psychometric Scores

Psychometric	P1	P2	P3	P4	P5	P6
CORE-OM	32	18	22	25	39	24
WHOQOL-BREF	62	59	82	64	55	78
ASRS	34	51	62	62	65	49

The pre-intervention scales above identified that the participants had an overall lower quality of life than the standard population. Based on the CORE-OM, participants identified greater difficulty with functioning, this was also reflected in higher ASRS scores. The WHOQOL-BREF quality of life scale identified that four of the individuals (with scores lower than 65) perceived their quality of life to be moderate/poor; information of which was corroborated within the telephone calls. Most notably, these scales confirmed that the group members found difficulty in managing negative thoughts, removing distractions, obtaining enough sleep, ensuring a healthy diet and including physical activity.

Formulation

Within the group setting, I utilised both a Cognitive Behavioural Therapy (CBT) approach and formulation. I decided on a CBT approach as it firstly allows a simple and clear approach to understanding the impact of thoughts and behaviours; alongside having significant empirical research to support the adaptation of CBT to groups experiencing depression, anxiety, physical health conditions and ADHD (Thimm & Antonsen, 2014). Thimm and Antonsen also suggest that the structured approach of CBT, alongside the reviewing of homework, facilitates a group dynamic and ensures that the session content is continuously built upon. As Macneil, Hasty, Conus and Berk (2012) suggests, the process of formulation should provide adequate possibilities for an update, feedback and collaboration; aspects of which I could not feasibly incorporate within the ADHD group sessions.

Before the development of the group sessions outline, I ensured that the first 90-minute session provided an introduction and sufficient time for icebreakers, but also encapsulated the development of the CBT formulation's essence. To accomplish this, I asked one of the individuals in the group to volunteer to work through a maintenance formulation that was also raised by the other group members. I utilised a maintenance formulation as it draws directly from CBT theory and provides a simple process to identify components of thoughts, emotions, behaviours and physical sensations. After working through the formulation, I requested feedback from the group members as to whether they noticed any particular links or connections between the components. Due to the variation in symptoms experienced by those with ADHD, I then asked each member to provide an example which was then completed by the group as a whole. In turn, this permitted not only the conceptualisation of formulations for the individual group members but further allowed discussion from the entire group when feeding back. We completed a series of maintenance formulations for each of the main group objectives, allowing us to effectively identify the challenges and to support the group members in understanding how we would work to moderate these difficulties.

The primary benefit of taking this approach to formulation is that it is in keeping with the CBT approach that was utilised throughout the group sessions and provided a foundation for updating formulations throughout the session more specifically focused on sleep, inattentiveness, diet and exercise. A notable finding as each member was commenting on the formulation was that many of the individuals within the group had almost identical personal experiences in terms of their challenges; not only did this improve the therapeutic relationship between the group but also prompted the sharing of 'tips' which is well established as a fundamental component of therapeutic group processes learning (Biggs et al., 2020).

Intervention Implementation

Aims & Objectives

Based on both the assessment of the group's needs and series of maintenance formulations to identify the specific mutual concerns of the group, I structured intervention with the following aims and objectives:

1. *Improve knowledge of sleep and techniques to improve sleep quality and duration*

2. *Increase knowledge of the benefits of physical activity and diet with accompanying plans for implementing changes*

3. *Reduce procrastination and support engagement in college, university or work activities*

4. *Moderate negative thoughts associated with direct ADHD symptoms or outcome of behaviours due to ADHD*

I decided to break these components down into a formal treatment plan which would span the six, 90-minute sessions. As suggested by Wolgensinger (2015), my treatment plan was built upon a foundation of empirical research, behavioural change techniques and established CBT techniques that have shown support with individuals living with ADHD (Huang, Qian & Wang, 2015). The specific treatment plan can be seen below in Table 3.

Table 3: Group intervention treatment plan, rationale and behavioural change techniques

Session Number	Session Plan	Behavioural Change Techniques *Carey et al. (2019)*	Intervention Rationale
1	**Assessment & Formulation** Introduce rationale for the group and prompt an icebreaker to familiarise members of the group. Acquire shared experiences of ADHD symptoms and expectations of the group. Introduce clients to CBT maintenance formulation and share feedback.	-Feedback on behaviour -Goal setting -Problem solving -Feedback on outcomes of behaviour -Social support -Self-monitoring of outcomes of behaviour	Using sufficient formulation in practice- Macneil, Hasty, Conus & Berk, (2012). Importance of orientation to the CBT approach- Fenn & Byrne, (2013) Importance of groups sharing shared experiences in therapy- (Biggs et al., 2020). Effectiveness of homework compliance and outcomes in CBT- Mausbach, Moore, Roesch, Cardenas & Patterson, (2010)

			Using sufficient formulation in practice- Macneil, Hasty, Conus & Berk, (2012).
2	**Behaviour Change Psychoeducation** Provide psychoeducation on sleep, diet and exercise. Particularly orient to maintenance formulations and behaviours that may inhibit engagement in these activities. Using the COM-B model identify where difficulties may be experienced and share techniques such as SMART goals that can support progress.	-Information about health consequences -Framing/Reframing -Incompatible beliefs -Salience of consequences -Self-monitoring of behaviour -Pros and cons -Discrepancy between current behaviours and goal	Importance of orientation to the CBT approach- Fenn & Byrne, (2013) Clinical effectiveness of psychoeducation in CBT approaches- Schaub, Hippius, Moller & Falkai, (2016)

		-Feedback on outcomes of behaviour -Social support -Self-monitoring of outcomes of behaviour	
3	**Goal Setting** Review SMART goal progress and outcomes. Titrate and share skills learnt regarding sleep, activity and dietary monitoring. Introduce practical behavioural tips for reducing procrastination such as 'eat the toad' and generating schedules to accomplish work.	-Feedback on outcomes of behaviour -Social support -Behavioural practice -Review outcome goals -Graded tasks -Self-monitoring of outcomes of behaviour	Efficacy of SMART goals when utilised in the therapeutic process- (Aghera et al., 2018) Benefits of behaviour skills in the management of ADHD- (Lopez et al., 2018) The utilisation of organisation and planning in the management of ADHD- (Kreider, Medina & Slamka, 2019)
4	**Mindfulness** Review effects of planning to accomplish goals and share	-Feedback on outcomes of behaviour	Benefits of diaphragmatic breathing for anxiety- Ma et al., (2017)

	feedback within the group. Ask for tips that others have developed in order to consolidate this work. Introduce mindfulness as a way of reducing distress and focusing on the task. Utilise a guided mindfulness walkthrough combined with diaphragmatic breathing and support individuals on how to implement these tasks over the coming week.	-Social support -Behavioural practice -Review outcome goals -Self-monitoring of outcomes of behaviour	Benefits of mindfulness for individuals experiencing ADHD- (Zylowska et al., 2007)
5	**Coping with ADHD** Review the effects of mindfulness practice over the previous week and discuss as a group the perceived benefits or challenges to implementing this tool. Move focus to cognitive appraisals of ADHD and difficulties.	-Framing/Reframing -Incompatible beliefs -Salience of consequences -Self-monitoring of behaviour	The benefit of Acceptance & Commitment therapy techniques working with Health Anxiety- Hoffman, Rask & Frostholm, (2019) Identifying the importance of cognitive restructuring to consolidate negative

	Utilise a series of maintenance formulations to identify negative automatic thoughts and utilise a combination of cognitive restructuring and acceptance-based tasks.	-Feedback on outcomes of behaviour -Social support -Self-monitoring of outcomes of behaviour	patterns of thinking- Fenn & Byrne, (2013) Using sufficient formulation in practice- Macneil, Hasty, Conus & Berk, (2012).
6	**Relapse prevention** Develop relapse prevention plans that can be utilised to support ongoing progress. Ascertain group feedback and distinguish the most useful features of the group that the members can take forward at the termination of the group	-Anticipated regret -Review outcome goals -Self-monitoring of behaviour -Focus on past success -Feedback on outcomes of behaviour -Social support -Self-monitoring of outcomes of behaviour	Importance of relapse prevention planning to reduce future difficulties and set-backs- Melemis, (2015) Guidelines for bringing the therapeutic relationship of the group to an end in a supportive and facilitative manner- Moola, (2016)

Intervention Techniques

The intervention techniques utilised throughout the group were primarily taken from CBT-based approaches. CBT is a goal-oriented and often short term treatment that supports the obtainment of progress utilising cognitive and behavioural modification (Fenn & Byrne, 2013). Due to the formulation and assessment stages highlight the necessity for cognitive and behavioural change, this appeared to be the most suitable approach to incorporate interventions and develop the treatment plan from. When providing the intervention, I was mindful that the most supportive element is often the ability for the individuals to collaborate on their shared experience through the mechanism of the group process (Biggs et al., 2020). In table 4 below I describe the brief outline of each session and the observations recorded in my reflective diary.

Table 4: Group intervention session content and observations

Session Number	Scheduled Vs Actual Session Content	Session Observations
1	Session Delivered as planned with all members present in the group.	The group appeared to immediately 'click. All of the individuals were very friendly towards each other and shared a mutual sense of humour about their ADHD which was only further supported by the icebreaker activity. On sharing their experiences all of the individuals took turns and were mindful of leaving enough time for each person to speak. There was a

		sense of support within the group which was very positive to see. The maintenance formulation "made a lot of sense" to all of the individuals and they reflected the idea of "why did I not think of this before".
2	This session was delivered as planned with all members present in the group.	This session went very well. There was a lot of surprise as to the science behind some of the behaviours they engaged in such as energy drinks and "not feeling like doing exercise". All of the members were quickly able to identify the challenges with these behaviours and how they were impacting their current lifestyles. One individual [P] did struggle in understanding what the COM-B model was for, however, I asked the other members to explain to consolidate their learning. After further discussion, this individual felt they comprehended the model further. The list of interventions to change these behaviours was very useful as it provided a basis of techniques that I was going to suggest

		anyway- which allowed the session to flow more naturally and supported the individual's autonomy in making these decisions.
3	Session Delivered as planned with all members present in the group.	The beginning of this session was slightly challenging as everybody had set themselves different goals and so we spent a bit more time than planned on consolidating these findings. Although I was pleased to see that many of the group had noticed improvements particularly concerning their sleep and diet. Swallow the toad was something the group found amusing which I think is supportive as it will 'stick in their heads'. All of the individuals took turns in explaining how they were going to complete this over the coming week. The group did start having discussions amongst themselves at some inappropriate times, however, I used a humorous tone to bring everyone back into the room. We agreed that the group would be happy for me to say the code word 'productive

		procrastinators' if I felt we needed to get back on the topic which was supportive for the remainder of the session.
4	Session Delivered went very well with all members present in the group. At the commencement of this session we took an additional 10 minutes to speak to the member who was visibly upset. We took a few moments as a group to comfort this individual- and it was very inspiring to see the other group members comforting the individual and sharing stories of their own pets before the group was brought back delicately to the session content.	I was pleased that all individuals had clearly worked on and been able to complete the "swallow the toad" task. One of the individuals was quite upset in this session due to the unfortunate passing of her cat- however, I was again happy to see that all of the group were supportive and offered empathy towards her. We took a few moments to discuss this and it appeared that the individual felt much more relaxed. There was significant hesitation to utilising the mindfulness tools and so I shared that I do not particularly enjoy 'new wave' mindfulness due to its confusion in the current climate. When I provided the simple mindfulness task it was clear that the group would find this more useful and were excited to use this over the coming week.

5	Session Delivered online as planned. Unfortunately, due the moving online for sessions, two of the individuals were late for the group. This was identified as occurring due to individuals having technical issues with using the Zoom platform. We amended the session to provide an additional 5 minutes at the end of the session to discuss how the members could alleviate the technical issues within the next sessions.	It was slightly nerve-racking to take the sessions online but a decision that I believed would keep everyone the safest. The flow of the session actually felt slightly better as I was able to focus on one person at a time more effectively. However, I did notice that the collaborative nature of having everyone in the room was slightly reduced. The incorporation of thoughts and trial and the bus driver was very effective. Many of the members of the group were sufficiently able to moderate some of the negative thoughts that they experienced and showed "shock" in the way that they currently processed events.
6	Session Delivered as planned with all members present in the group. On this occasion we did not have any technical issues. Within this session, we slightly changed how we developed the relapse prevention plans. It was planned to utilise the whiteboard to mutually discuss how the	I noticed that in the commencement of this session there was an air of 'flatness'. After asking the group why this may be, they stated that they have enjoyed the sessions and would be sad that they would be concluding. I addressed the groups feelings and was informed that they had

	members could continue to make progress. Instead we brought up a 'virtual whiteboard' and went around the group members to identify what they had learnt and how they could all continue to maintain the progress that they had made. As a final component, I asked the group members to share their favourite aspect of the group and fellow members. This provided a very considerate and positively emotional ending to the group.	already planned to meet regularly after the group finished. The group was very supportive of each other when working through the relapse prevention plans and clearly showed an understanding of the techniques we had built on throughout the course of the group. The end of the session was quite emotional and it was great to see the connection that all of the individuals had made with one another. There was a bittersweet ending with each member sharing a positive thing they had noticed about their fellow members. Overall this has been a great experience and the feedback I have received has been exceptional.

Evaluation

One of the fundamental components of any intervention is to evaluate the outcomes (Gondek, Edbrooke-Childs, Fink, Deighton & Wolpert, 2016) and in so doing to understand the impact of the intervention (Gondek et al). In Table 5 below I have compiled both the pre-and post-intervention scores for the three measures utilized throughout the intervention: the CORE-OM, WHOQOL-BREF and ASRS.

Table 5: Pre-and post-intervention scores

Psychometric	P1	P2	P3	P4	P5	P6
CORE-OM: Pre-Intervention	32	18	22	25	39	24
CORE-OM: Post-Intervention	21	16	20	25	23	23
WHOQOL-BREF: Pre-Intervention	62	59	82	64	55	78
WHOQOL-BREF: Post-Intervention	79	65	85	71	60	78
ASRS: Pre-Intervention	34	51	62	62	65	49
ASRS: Post-Intervention	31	42	60	61	61	47

The most notable finding was that there was an aggregated 10% improvement in quality of life scores, the findings of which are concordant with the improvement in functioning as documented by the CORE-OM outcomes. The lowest reduction comes from the ASRS scores which is not entirely surprising given that it is not attainable to reduce the symptoms of a neurodevelopmental condition that these individuals will experience for life. As the goal of the intervention was to improve overall psychological and physical functioning and well-being this appears well supported by the findings.

Quantitative Feedback

The quantitative component of feedback provides an objective perception of the group's experience of the therapeutic sessions (see Table 6). Each group member was invited to complete an overall session rating scale at the end of the treatment. This short questionnaire adapted from the Therapeutic Session Rating Scale (SRS) as conceptualised by Duncan et al. (2003). The highest score of 10 represents total agreement and a score of 0 represents total disagreement.

Table 6: Quantitative feedback from session rating scales

SRS Question	P1	P2	P3	P4	P5	P6
I felt heard, understood and respected throughout the sessions?	10	9	9	10	10	10
The group worked on things that I wanted to work on throughout?	9	9	9	10	10	9
The therapists approach was suited well to me?	8	9	9	8	10	10
The therapist managed the group well?	10	10	9	9	10	8
Overall the group helped me with what I needed?	8	8	9	9	10	9
Average Score	9	9	9	9.2	10	9.2

The results indicate that the intervention was taken very well by all members of the group. Although it is important to be mindful of the possibility of self-reported bias, the combination of this with the qualitative feedback below suggests that my approach was appreciated by the group and met the group's perceived expectations.

Qualitative Feedback

The final component of feedback was received via written responses. As (Biggs et al., 2020) suggests, the process of receiving in-depth feedback serves not only to support future interventions but provides the facilitator with the possibility of reflecting on their approach. All members of the group provided qualitative feedback on their experience. Each individual was asked to reflect on their progress throughout the group, the facilitator's ability to support the group and any further comments for upcoming groups. The results of the qualitative feedback can be viewed in Table 7.

Table 7: Qualitative feedback on group intervention

Participant	1	2	3	4	5	6
Progress throughout the group	After Dr (M) recommended this group I was really excited to get started. I was a bit apprehensive about being in a group but it was actually really helpful! The things that I have learnt will help me in my studies and at work. And finally I'm able to get more than 2 hours sleep. Who would	My biggest difficulty was seeing how these things were affecting me like. I loved the boxes that showed me what was going on because it made it dead simple to work out where I was buggering up. I recon that in a few more	Really great progress. Have been able to do things I haven't since before I knew I even had ADHD. Had fun with the online stuff and although a bit sad didn't get to see everyone at the end face to face will look forward to meeting up on	The whole group was really supportive of each other which I think I found the most useful thing. I didn't really know that other people had problems like me so it was nice to meet like minded people. I found the transition to	I made a lot of progress with my sleep, diet, exercise, how to manage work, how to stick to deadlines, how to organise my team better, how to set goals that I can do	I was waiting for the group to start from my assessment and was so excited to get started. I think I have progressed very well through the group. My main issue was getting to sleep and being able to actually get my day to day things done. Parts of the acceptance work of

	have thought that not sleeping or eating well was having such an effect on my normal day to day stuff.	months ill be able to see where I’m going wrong and just stop it because now I know	our own at some point. All around feel this was really great value for money and much better than any of the support I’ve had form the NHS historically. No surprise there really	online work difficult but actually when we got started it didn’t feel much different and actually made it a bit easier because I didn’t have to travel from very far		noticing when I’m feeling not capable of doing something and remembering this is okay was really useful. I also think that structuring things into smaller chunks will make things like worry and work much easier I think
Facilitators ability to support the group	Mike was really great. He made us all feel so comfortable. Even when we had to unfortunately go to online sessions I	10/10	Perfect. Knew what he was talking about throughout.	Supported the group brilliantly. Never a moment where he didn’t seem in control or surprised by	Very friendly and supportive. Really liked he listened to me like a person and not a	I loved working with everyone in the group I think it was really useful but it wouldn’t have been possible without Mike. I

	still felt like he was right in the room with me. I'm so used to people telling me to stop talking or speaking over me but because Mike told us from the beginning he may interrupt to help other people it felt much easier and made it fairer for everyone			anything. I'd do it all again with Mike and the pieces of work he got us to do in the middle of the sessions was really useful as well	patient. Found he was dead friendly and did not patronise any of us especially as he is neuro-typical	loved the games we played in the online sessions of finding all the things in our houses. I would love to even work individually with Mike in the future he is just so laid back and genuine
Further comments	It was so much fun! A massive thanks to Mike and the admin team for keeping me reminded of the	Very much enjoyed the process and meeting	All around good experience. Thank you!	N/A	Informative Good fun Enjoyable Would do again in future	I can't believe I actually did mindfulness haha! Sorry about being a bit unsure about

	appointments when we started! I hope that in the future I've learnt so many skills that will be so helpful for a long time and quite possible for ever! Cheers Mike	everyone involved.				it Mike, but it was great fun and I'll definitely remember to use it next time I can't slow those thoughts down!

I was very pleased to see the feedback above and was reassured to see that all of the members would recommend the group to someone that they knew. It was also positive that all of the group members felt that they were given a suitable amount of time to speak and listen. Often within group settings, a challenging process can be 'holding' the group whilst allowing an equal sharing of concepts and ideas (Biggs et al., 2020).

Conclusion

The amalgamation of the positive feedback received from all of the participants, alongside my own reflections and observations of the sessions, would suggest the group intervention was very successful. All of the individuals identified a significant improvement in their overall well-being, with several now feeling more confident to ‘go into the world’ as a person with ADHD. Moving forward this has only supported my desire to conduct group sessions with others and I will take these reflections forward with me into the near future.

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3.4 Group Intervention Reflective Commentary

Within my private practice at the clinic, I am very familiar with the role of psychological intervention. Throughout my training and professional work, I have facilitated several psychological intervention groups. This experience however, provided an opportunity for me to step back and actively reflect on the specific steps of group interventions; components of which I feel have become subconscious. Although I have experience with groups, this intervention provided a new challenge as I had not provided group support for individuals with ADHD. This was therefore one of my first opportunities to combine both cognitive and health behavioural change within one intervention.

Therapeutic Competence

This was an overall enjoyable and effective group to facilitate. Prior to the commencement of the group I was ambivalently confident. I have prior experience of running groups for social anxiety and obsessive-compulsive disorder, more so than ADHD; however, I have been involved in the care of many of these individuals. Due to this, I felt confident I would be able to provide a mixture of a strong therapeutic relationship with the group and additionally provide several evidence-based techniques to support them in achieving their desired goals. I felt that I was effectively able to complete the online assessments and filter the correct individuals to the intervention. Due to my prior experience of developing cognitive behavioural formulations, I also believe that this was an effective experience. Given that all of the clients found the maintenance formulation to be a key foundation in assessing their difficulties, I would certainly use this tool again in the future. A further adaptation if clients found difficulty in understanding formulation in the future, would be to utilise a functional analysis (A) Activating Event (B) Belief/Behaviour (C) Consequences. This would further provide a simple and effective way of conceptualising the impact of cognitive and physical difficulties.

Managing the Group Dynamic

Individuals with ADHD often experience symptoms of impulsivity and fidgeting (Wilens & Spencer, 2010). Due to this, and prior to the commencement of the group, I was mindful that I would most likely need to manage the group dynamic to keep it both facilitative and progressing. As Biggs, et al. (2020) suggests, facilitating a therapeutic group means that the practitioner needs to adapt to the requirements of the individuals, and so I entered this process prepared with techniques I could use to manage if the group was to become disruptive. One significant example of this was the group's permission to use a phrase ("Bingo") to bring their attention back to the room. From the initial session, it was clear that some of the individual's attention was beginning to wander, often looking at phones or having inter-group discussions. Borek and Abraham (2018) suggest that it is important to set the ground rules for the group early on, and so the incorporation of this at the commencement of the sessions was an effective way to facilitate an effective experience.

Intervention Implementation

Although I believe the interventions were very supportive of the group's development throughout the session, the most beneficial aspect appeared to be the connection that the members made with one another. As suggested by Biggs et al. (2020) the group context provides opportunities for the individuals to support one another and supports the exchange of not only information but emotional support. This dynamic was very clear to see from all of the sessions as the members were frequently bouncing ideas off one another and raising questions that urged one another to reflect on their experiences.

Furthermore, I believe the incorporation of the CBT maintenance formulation was very supportive of the group's facilitation. Completing this task early on made it very easy for the individuals to identify the difficulties and potential reasons why this may have been perpetuating (Kahlon, Neal & Patterson, 2014). The ability to consistently refer back to the formulation provided a basis for all of the work that we completed and when combined with the COM-B model, gave a clear basis on why some individuals were struggling to make changes within their daily lives. If I were to commence this group again, one change that I would include is to spend more time working through the formulations. Although we spent roughly 45-60 minutes on this task, it may have been more useful to spend a full session discussing these. I feel that this may have allowed for more introspection of the clients and subsequently raised questions regarding their thoughts and behaviours that may have been more explicit over the following week.

Evaluation

The incorporation of psychometrics for evaluation appeared to be very effective with this group. Although Rosenman and Tenekoon (2011) suggest that we are required to be mindful when assessing psychometric outcomes, I believe that the significant improvements across the WHO quality of life questionnaire and CORE-OM show the consistency of the intervention delivery. In hindsight, I would have preferred to use the ADHD quality of life scale as an outcome measure, however, given the commercial license required I was not permitted access due to funding concerns by the clinic. This tool would however have been more useful than the ASRS, as this measure alone explores the symptoms of specific ADHD traits which are unlikely to be modified by a cognitive behavioural intervention.

I believe both the qualitative and quantitative feedback that I received also identifies the success of the intervention; with high scores proposed for the intervention delivery and progress throughout. It was supportive to see that many of the individuals felt the transition to online sessions was a smooth process as I was partly concerned about the effect that this may have had on the client’s outcomes.

Transition to Online Practice

The transition to online sessions was very daunting. The current research is somewhat unclear as to the efficacy of online therapeutic work, however, some studies suggest it is as facilitative of face-to-face sessions (Stubbings, Rees, Roberts & Kane, 2013; Marcelle, Nolting, Hinshaw & Aguilera, 2019; Markowitz et al., 2020). The decision to move to online sessions was due to the increasingly concerning situation with Covid-19. As a practitioner, the safety of both the clients and myself must be upheld and with news of a new increasingly transmissible variant, I felt it was appropriate to do so. Although I have significant experience of 1-1 online sessions, I have only occasionally been involved in larger groups within a teaching setting. To ensure that the session flowed as smoothly as possible, I reviewed some best practices for online sessions and ensured that the approach would remain engaging through the incorporation of videos, screen sharing and activities that were suited to online work (Thompson 2016; Situmorang, 2020). For future online groups, I think it may have been useful to provide the individuals with a 'how to'- as two of the members were unsure on how to use Zoom (a component which I had not considered until that moment). For the second session, I took a short phone call with the relevant individuals to talk them through this process, to be able to smoothly enter the group in the final session.

Conclusion

In conclusion, the excitement and depth of inspiring shared experience made this group particularly memorable. There were several challenges which I felt I was professionally and autonomously able to overcome, however, it has certainly left me with much to reflect on for my future groups. The most noticeable and inspiring component of the group for me was the impact of shared experience. Going into the group, I believed that the clients would find the most significant benefit from interventions; on the contrary, the group built strong inter-personal relationships which enhanced not only the flow, but consolidation of the skills learnt. For future sessions, I will be aware of how effective this shared experience can be and provide additional time for clients to ‘bounce ideas’ and concepts off one another.

I was very pleased to see the extent of the improvements all group members had made and I have already been in discussions as to the commencement of the next group cohort. I have further considered how my future sessions could be enhanced by bringing in a client from this group who can share their experiences and their perceived benefits of the sessions. After working as primarily a 1-1 therapist for several years, we often ascertain the role of speaking, then listening, then speaking.

This group provided me with a different dynamic of allowing my clients to take part of the lead; with me as a facilitator. Certainly, this group has provided a beneficial template of the challenges, barriers and successes that group psychological intervention entails and I will look forward to the future opportunities that may arise from it.

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Chapter 4: Teaching & Training in Health Psychology

4.1 Teaching & Training Case Study

Introduction

This case study outlines the conceptualisation, planning and delivery of a series of five individual teaching sessions exploring the 'Application of Therapeutic Techniques in Health Psychology'. The teaching sessions were delivered to groups ranging from 6 to 65 participants and included trainee paramedics, assistant psychologists, barristers, and developers of virtual reality therapy. The sessions were conducted between late 2020 up to May 2021 and incorporated a variety of different settings and target learners which has been further outlined later in this case study.

To develop the teaching sessions, I incorporated the approach taken by Biggs and Tang (2011), in which there are five processes involved in both surface and deep learning. Biggs and Tang identify surface learning as increasing knowledge, memorising, and acquiring procedures; with deep learning defined as abstracting meaning and understanding reality. Howie and Bagnall (2012) have argued that the concept of deep and surface learning lacks specific definition, however this model was incorporated as researchers also argue that both methods are needed to not only understand, but to apply therapeutic techniques; an integral process in the outlined teaching sessions (Bruijniks, DeRubeis, Hollon & Huibers, 2019).

The process of adopting deep and surface learning was implemented in the current sessions through Race and Brown's (2007) 'Ripple in a pond' model which has distinct overlaps with the conceptual techniques Biggs and Tang (2011) suggest enhancing effective learning. This model indicates that there are five components to effective learning (wanting, needing, doing, feedback and making sense) which operate non-linearly; suggesting that several components overlap at any given time. Based on this assumption, I developed and presented my sessions according to the content and requirement of the learners; such that surface learning for example was suitable for a barrister's knowledge of the autonomic nervous system, rather than requiring the deep learning application of how to make sense of this mechanism in relation to sleep. Based on these two approaches to learning, a series of teaching sessions were developed and are briefly outlined in table 1 below:

Table 1: Outline of a series of 5 teaching sessions.

Session Name	Duration	Session Context
1 - Understanding the Psychological Impact of Diabetes Management	2 Hours	This session was delivered at Birmingham City college to 15 trainee paramedics as part of their module to understand therapeutic principles in the management of chronic illnesses
2 - Cognitive Behavioural Therapy Techniques for Managing Insomnia	1 Hour	The session was delivered to 65 barristers through an online platform (Zoom) as part of the Midlands Barristers psychological well-being day
3 - Therapeutic Understanding of Health Anxiety	1 Hour	A session to support 5 Virtual Reality Therapy developers to enhance their understanding of Cognitive Behavioral Therapy (CBT) and its application to somatoform disorders
4 - Introduction to Cognitive Behavioral Therapy Techniques in Health Psychology Settings	4 Hours	A workshop delivered to a group of 6 assistant psychologists and one CBT therapist to enhance their knowledge of Cognitive Behavioral Therapy in Health Psychology Settings
5 - Cognitive Behavioral Therapy Techniques for Chronic Illness Management	4 Hours	Session five was a follow-up training session from session four and took place at the clinic. The assistant psychologists had requested a further workshop to apply techniques learnt in session four.

The range of teaching sessions provided opportunity to work with individuals from varying professional backgrounds and due to this, I aimed to implement Baxter and King's (2004) 'learning partnership model' to engage the learners in the process; providing them ample opportunity to develop their knowledge through shared experience, discussion, and active participation in workshop activities. The theme throughout the sessions also emphasized the role of therapeutic alliance as I was sharing my knowledge and application of implementing therapeutic skills. As a result of this I noted two distinctions, firstly the need to model the therapeutic process for healthcare professionals whilst also enhancing collaboration and empowerment for learners in non-healthcare professionals.

Teaching Opportunities & Assessment of Needs

Although the groups I worked with shared commonalities across the need to develop knowledge and apply this knowledge to a specific behavior, each group demonstrated specific learning needs and learning styles. To provide a tailored approach to the varied learners I ensured that adequate time was provided to identify the learning needs of each session. Le, Janssen and Wubbels (2017) suggests that assessing the needs of learners should be a collaborative process. Due to this, prior to each session I had a meeting with the primary contact who had invited me in order to establish the goals and needs of the learners. A summary of the request for me to teach alongside the processes of assessing the learners' needs are outlined more in depth below.

As my placements with the private clinic and Working Minds involve frequent interactions with a range of mental health professionals, I have been able develop a strong occupational network of colleagues who are aware of my subject expertise in Cognitive Behavioural Therapy. Due to this my entry into sessions 1, 2 and 3 was the result of existing contacts with prior experience of my clinical or academic work. For session 1, a lecturer I had an existing rapport with approached me as he was aware of my expertise in Diabetes management. This rapport was beneficial as it allowed an in-depth discussion of the students' needs and preferred learning styles. This was also mirrored in session 2 and 3 where I was contacted directly by the organisers for my subject knowledge of Cognitive Behavioural Therapy and well-being alongside virtual reality therapy.

The assessment of needs within these groups was easier to identify and probe as I felt comfortable in querying the organisers intentions and requirements. Using this existing rapport, I was able to establish that as part of the learner's future examination in session 1, they were required to complete a role play with a service user. Therefore, the ability to practically utilise the skills from this session was a central part of establishing needs and planning the content delivery of this session. This requirement for not only knowledge, but application, was mirrored within session 3 in which the organiser shared the learners need to understand health anxiety to generate treatment protocols within virtual reality environments. Subsequently, in sessions 1, 2 and 3, I was guided by the organisers needs, however used my subject knowledge expertise to develop the overall content.

This was slightly varied in session 2 as after a short meeting with the organiser and upon receiving a list of well-being topics from the head of occupational health, I took the opportunity to ascertain which topic was most requested by the employees; with an internal email poll suggesting that most barristers were experiencing sleep difficulties. I was informed that due to Covid-19 restrictions this session would be conducted on Zoom which led to further logistical discussions about requirements such as login details, number of attendees and time limits. Fundamentally, the assessment of needs for this session slightly varied as this contained learners with varied knowledgebases regarding sleep. Due to this, after discussion with the organiser they suggested a session to enhance knowledge with more specific application to a handful of sleep-management techniques; an approach I thought felt appropriate and most effective for the session.

Session 5 led on from session 4 in which a group of assistant psychologists at the private clinic requesting training on utilising CBT techniques with a range of clients with whom they were conducting low-intensity counselling. As the lead CBT therapist at the practice, this prompted an opportunity for me to share my knowledge of the therapeutic approach whilst also permitting a wider initiative to improve the clinics therapy provision. Within my role as the director of therapeutic services, I developed strong relationships with the assistant psychologists which allowed us to have a short meeting to ascertain the specific concepts they would like to learn.

Following the introduction to CBT session (session 4), several assistant psychologists requested further training in utilising the skills. After a further session being approved by the management team, I was approved to run a three-hour CBT skills workshop. A significant benefit of this session in comparison to session 4, was the ability to receive qualitative feedback I could restructure into the next session. To ascertain the learners needs I requested each assistant psychologist to write three techniques that they would like to develop; permitting a selection of objectives that I could implement into the workshop. The primary difference I noticed within these sessions when compared to sessions 1-3 was the freedom to create content I could curate. This in turn allowed me to more easily ascertain the learners needs and be more flexible in the structure and content of the session.

Teaching Structure & Content

According to Race (2007), the effective development and implementation of learning outcomes serves to ensure taught content is at a suitable level, depth, and context. The process of developing learning outcomes not only allows learners to mutually understand the rationale for the session, but also determines the information which should be conveyed by the teacher (Erikson & Erikson, 2018).

In order to develop the learning outcomes for my sessions I had arranged discussions with the organiser to ascertain their expectations and requirements for the session. Where possible, I further requested insights into the expectations of the learners, which is demonstrated in the employee poll in session two, and the scoping meetings for sessions three and four. Linder and Schwab (2020) suggests that learners often experience varying needs of learning to their respective teachers or organisations; developing the learning outcomes I therefore aimed to amalgamate the organisers requirements alongside the student's expectations. I placed particular emphasis on the wording of learning outcomes within the sessions, utilising phrases such as 'to develop further understanding of…' rather than 'will be able to'. This was important as I wanted to emphasise the learners existing knowledge and treat the session as an opportunity for ongoing development.

Following the above process of developing learning outcomes, I then conceptualised the delivery of the sessions. To accomplish this, I integrated processes of surface and deep learning with Bligh and Brice's (2010) RIFLE model outlined below in Table 2.

Table 2: Definition of RIFLE principles

Rifle Principle	**Definition**
Realistic	Providing information in a way that allows real world application of the taught principles.
Integrated	Ensuring that the information provided to the learners can be incorporated to their existing knowledge and experiences.
Feedback	Receiving ongoing feedback throughout the session to ensure that learners comprehend are engaged with the content.
Learning	Ensuring that the learners are actively engaged in the process of learning through participation in the session.
Evaluation	Receiving learner feedback in order to improve the teacher's future session delivery.

For the specific session content, I utilised RIFLE principles as outlined above with Bligh and Brice's (2010) recommendations to enhance deep learning through providing succinct information stemming from evidence based research alongside practical application of the taught principles to the real world. Utilising this model, I developed content for my sessions by drawing from empirical research within the topic field, group discussion, case studies and anecdotal ‘stories’ from my experience as a psychotherapist. This worked particularly well throughout my teaching sessions as there were often moments to acquire knowledge of the subject and subsequently apply the concept to a given case study; a process that was modelled throughout the session.

To support the learning groups to feel relaxed and engaged throughout the sessions I attempted to adopt a relaxed yet enthusiastic approach to the groups. Throughout the sessions, I adopted aspects of person centred and CBT inter-personal skills; ensuring that I was displaying empathy, congruence, and a non-judgemental attitude to the learners (Gibson, 2005). An outline of the session content is further outlined below.

Within session 1 I was aware that the trainee paramedics had a fundamental comprehension of health-related concepts. Due to this, I emphasised how CBT could be incorporated within diabetes management; placing particular emphasis on how this could benefit individuals they would meet within their work environment. Within the session, I acquired videos of CBT techniques for the learners to critique and following this allowed the group to join a group discussion for how the knowledge could be applied within their future encounters.

This approach varied to both sessions 2 and 3 as the learners were from a non-healthcare background. As both groups were non-healthcare professionals, I incorporated information that could be easily understood by the learners; a key component in enhancing knowledge acquisition in this population (Beber et al., 2015). This was accomplished through keeping my content clear by minimising complex information into short bullet points and incorporating metaphors or personal experiences to provide context to the information. Continuing to use empirical research, I adapted my approach, using ‘legal’ concepts in session 2, such as ‘putting thoughts on trial’; a common CBT technique to modify thoughts around sleep and utilising a range of videos and images in session 3 to keep the learners engaged with the content. This allowed the learners to apply the knowledge I was sharing with them in a practical setting of which they were already familiar.

Within session 4 and 5 I utilised a more in-depth and comprehensive outline of how psychological principles can be used to work with chronic illnesses and psychopathology; a variation from sessions 1-3 in which learners were less likely to have qualifications within mental health settings. Developed as a more interactive session, in sessions 4 and 5 I drew on the assistant psychologists existing knowledge of person-centred counselling and CBT, allowing the learners to share experiences of their current practice. To keep the learners engaged I utilised anonymised examples of my previous cases to support the progress of deep learning (Sølvik & Glenna, 2021). The main variation in session 5 was that it was developed as a practical workshop to practice CBT techniques. Therefore, although I still incorporated a PowerPoint presentation to convey key principles, I integrated videos to provide examples of 'effective and ineffective' application of the tools. Most of this session was composed of breaking into small groups to conduct role plays or case study vignettes based on applying cognitive restructuring, allowing more active participation than sessions 1-4.

Training Materials & Activities

The training materials and activities required for each session were largely dictated by the mode of delivery. Roddy et al. (2017), suggests that the delivery of teaching in person compared to online requires adaptation in order to keep the learners engaged. Due to this, I curated an assortment of materials for each group dependent on not only the learning outcomes, but the way in which I could interact with the individuals.

Face-to-Face Session

For each of the three face-to-face sessions I was aware of the room layout which allowed me to ascertain how I would deliver the session whilst reducing the likelihood of typical challenges I have encountered in the past, such as working projectors or setting up presentations. Within the sessions, I utilized a range of materials including a PowerPoint presentation, handouts, case studies and educational videos**.** Jones (2003) suggests that teaching materials should ultimately support the delivery of the session without distracting from the content. Due to this, I carefully selected the resources to help in conveying the information from the presentation, rather than handing these out without a specific purpose.

Jones (2003) suggests that when using a presentation to aid the teaching process, the teacher should be mindful to engage the individuals rather than the PowerPoint. Due to this, I kept the information on the slides as succinct as possible and created a clear contrast by using headings, a clear font and suitable text size. Throughout the presentation, I was mindful to not just read off the slides and utilized elements of Biggs and Tang's (2011**)** deep learning processes by linking the presentation to stories, embedded videos and group tasks which the learners can use to build abstract meaning, alongside comprehension of the reality of the topic.

Online Sessions

A significant challenge in the delivery of online teaching sessions is to keep the learners engaged in the process. Reflecting on Gedye's (2015) review, I was aware that ascertaining formative feedback would be of great importance; therefore, I was mindful to frequently take moments to establish if there were any questions or difficulties in comprehension prior to transitioning into the next slide or activity.

A further consideration for implementing materials into the online sessions was the ability to share concepts and ideas amongst the learners. Unlike the face-to-face sessions, I was unable to share thoughts on a whiteboard and subsequently I utilized 'Mentimeter'; an interactive tool to obtain real time responses and share feedback from the learners. This tool worked well in the session particularly when used in conjunction with the sharing of videos and significantly contributed to the shared experiences and thoughts of the group.

Jones (2007) highlights the benefit of utilizing smaller groups to increase the generation and sharing of ideas. Within the online sessions, I was able to split the larger group into several 'breakout rooms'; a technique I found particularly effective when generating ideas around sleep hygiene or working through a CBT case study.

Assessment & Evaluation of Learning Outcomes

Erikson and Erikson (2018) suggest that the process of assessment learning outcomes provides tangible benefits for both teachers and students alike. My assessment of the teaching sessions was comprised of formative feedback, teaching evaluation questionnaires and qualitative feedback from session organizers.

As the sessions I provided were varied in group size and professional background, I utilized a mixture of feedback to tailor and assess the progress of the learners. The primary component of assessment was through formative feedback to assess the learners progress as they developed knowledge and skills of the topic. This was strongly demonstrated in session four and five, where individuals were encouraged to lead discussions around a case study and generate ways in which to demonstrate the incorporation of therapeutic interventions in a role-play. This further served to promote deeper learning processes through both making sense of the taught techniques in 'real world' application alongside feedback from other learners (Biggs & Tang, 2011).

In addition to formative feedback, at the end of each session I provided the learners with a questionnaire to elicit a more objective view of the learners' experiences. Sumaryanta et al. (2018) suggests that the adoption of quantitative feedback in teaching serves as a crucial component to identify the learners progress and also improve the teachers' future competence. Based on Sahlqvist et al. (2011) recommendations I provided a 10-item questionnaire; five of the questions explored the learners perceived progress alongside the learning outcomes and the remaining five assessed their perceptions of the teaching experience.

Anderson (2010) suggests that receiving qualitative feedback allows a more reflective account of the learner’s experiences. Due to this I emailed the teaching event organizers following the sessions in order to evaluate their view of how the learners perceived the session to be. This provided an invaluable opportunity to develop a rapport with the organization whilst simultaneously increasing the likelihood of honest feedback to enhance future sessions.

Conclusion

Overall, the process of planning, designing and conducting these teaching sessions has highlighted my enjoyment and passion for teaching. Although I have provided teaching sessions in the past, this has often been an autonomous process and has not permitted the delicate introspection needed in order to provide by definition an ‘encompassing learning experience’. I was very pleased by the positive feedback I received from both the event organizers and learners (further outlined in the accompanying reflection) and hope that I will have the opportunity to provide more teaching sessions in the future. I am aware that I have several areas of development including building my own confidence to contend with in future sessions, however I look forward to this challenge and see opportunities to continually improve my teaching skills.

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4.2 Teaching & Training Reflective Commentary

Introduction

The following case study provides a reflection of the 'Therapeutic applications to Health Psychology Settings' teaching series. Race and Brown (2007) suggest that the ability to evaluate and critique our own teaching styles provides opportunities to enhance not only our own approach to teaching, but the transition of knowledge to learners. I reflected on my teaching sessions through a combination of learner feedback, organiser feedback and my own personal reflections of the sessions. This multi-faceted approach allowed me to examine not only my experiential assumptions of the sessions, but a more objective view of the individuals who were able to acquire knowledge (Bashir, 2016).

I feel that overall, I was able to provide an effective and collaborative teaching experience for the learners within the sessions. The feedback I received was overwhelmingly positive, however there were certainly areas within my teaching which I felt could use improvements. Butcher, Davies and Highton (2006) suggests that the ability to consider feedback as part of the teaching enhancement process is not only essential but continual and thus my approach to the sessions was to recurrently enhance my approach from session-to-session.

Session Resources

Lari (2014) suggests that the selection of teaching resources is crucial from both knowledge acquisition and learner engagement. Prior to developing the presentations, I had researched the best practices for collating PowerPoint slides. Based upon the literature and recommendations from experts within the public speaking field, I gained significant input on how to keep my presentations clear, effective and engaging (Lari, 2014; Jones, 2003**)**. A key principle when presenting which I placed great emphasis on was the ability to keep information on the slides to a minimum. This approach allowed me to build upon information in an enthusiastic manner and was noted by the learners who highlighted their enjoyment of the 'stories' tied into the teaching sessions.

I attempted to use a mixture of 'active participation activities' in order to break up the sessions and allow the learners to migrate from 'knowledge acquisition' to 'reality-based learning' (Biggs & Tang, 2011). Although these activities were an effective way of engaging the learners, for future sessions I would provide a greater selection of case studies, vignettes and discussion topics. Particularly within sessions one, four and five there were moments in which I feel the learners quickly adapted to the activities leading to a sense of over simplicity. Within future sessions I would likely utilise a hierarchy of case studies which would allow the learners to work through the fundamental concepts of the topic before applying their knowledge to more challenging scenarios.

An effective resource following the session was the learner feedback form. In order to obtain a combination of quantitative and qualitative information I developed a 10-item questionnaire; five questions related to learning outcomes and progress, with five questions to assess the learners experience of the teaching session. I also provided an open-ended question at the end to ascertain any further comments that the learners would like to make about the session. As Jones, Baxter and Khanduja (2013) suggests, questionnaires provide a strong method to obtain data in a simple and convenient way. Although this was certainly the case, I believe that the open-ended questions provided some of the most useful feedback as they highlighted elements (both specific to taught content and learning environment) that may be missed in a more qualitative approach.

Session Content

I believe a crucial component of my teaching sessions running smoothly was the ability to use my existing knowledge base of therapeutic principles. When building the session content I was able to adaptively implement information from the empirical research alongside the knowledge I have gained from years of training within Psychotherapy. This was a prominent revelation for me as this reinforced the Health Care Professions Council and British Psychological Societies ethical guidelines for 'working within your competence' (HCPC, 2016; BPS, 2014). The ability to work within my competence subsequently allowed me to curate content that was not only essential to the learners desired outcomes but also in-line with current evidence-based recommendations.

A further poignant reflection was the efficacy of incorporating a range of content modalities. As an individual who has received ongoing lectures and training sessions I appreciated- however did not consider the importance of including case studies, vignettes and videos. Throughout my feedback, several of the learners suggested that these deviations from 'purely lecturing' kept them engaged within the sessions. These findings are reinforced by Tuma (2021) who identified that lectures are most efficacious when combined with interaction activities; findings that are mirrored within the model of deep learning processes (Biggs & Tang, 2011).

Effective Demonstration of Teaching

The feedback that I received from the teaching series was overwhelmingly positive. Overall, the learners felt that the content and delivery of the sessions were well thought out and engaging; suggesting that the sharing of stories and personal experience was an effective tool in the application of the taught information "*It all really came together and made sense when Mike shared his experience of working with people with Diabetes… this made it clear in my head of how I could work with someone with this condition in the future*".

I was particularly pleased in session 2 in which I was provided the opportunity for substantial feedback due to the large number of individuals taking part in the session. A consideration I took into this session which was not required in my other sessions was my ability to keep the learners engaged despite the session being conducted online whilst also facilitating many individuals. Throughout all my teaching sessions I incorporated a series of short videos which I interweaved with the topics I was discussing. The short videos I utilized were 'non-clinical' in sessions 2 and 3 which made the information more accessible whilst keeping the individuals in the session engaged with the content. The benefits of implementing videos were identified by one learner as following: "*I was initially reluctant for this session to be* *online, however Mike did a great job. The range of videos and ability to ask questions along the way made everyone feel welcomed to the session*."

A further piece of positive feedback received throughout session 2 was the learner's appreciation of the 'Mentimeter' survey tool. One of the members of the group stated, "I really enjoyed the poll because it helped me to understand what you were presenting and also didn't make me feel stupid in front of others because it was anonymous". This feedback presented an interesting reflection for me; that some individuals may not feel comfortable in sharing their thoughts within the teaching session. Due to this, for my future teaching sessions I placed emphasis on taking time with the individuals in the group, rather than just the entire group dynamic. I believe that this process of providing and receiving feedback will support me in developing a more engaging and supportive teaching environment in the future.

There was significantly positive feedback from the progression of session 4 to 5 in which the assistant psychologists identifying they felt more confident in identifying when to utilize CBT techniques. As session 4 encompassed an introduction to CBT, there was a greater emphasis on the efficacy of the therapeutic approach within health psychology settings. This prompted several discussions about health psychology with the learners stating "*I didn't know about all of the possible implications of CBT in health psychology. I would definitely think about a career in health psychology in the future!".*

The feedback that I had received from my initial 4 sessions all came together within session 5; an element I feel was reflected in the assistant psychologists' views of the teaching session. I was pleased to see that the feedback for session five was overwhelmingly positive. This reinforced that not only had I implemented the recommendations from the session four feedback, but also supported the assistant psychologists in developing their application of CBT techniques. Following the session four feedback I modified this session to incorporate a series of case study vignettes which the learners stated, "*really helped me to understand exactly how to use them… the case study reminds me of someone I'm working with so will help me* *plan for her future sessions*". I would certainly be mindful to use a more varied style of vignettes for future sessions as although these were useful in sessions 1, 4 and 5, it did become apparent that the use of only 1 or 2 vignettes led learners to share the same answers, rather than thinking about how to apply their knowledge to a range of scenarios.

One of the most poignant reflections on the teaching series was the learners' comments on session delivery. Most learners throughout sessions 1-5 felt that the flow of the sessions promoted engagement; intertwined with the story elements and personal experiences students felt much more able to apply this knowledge to a given situation. The learners particularly in sessions 1, 3, 4 and 5 suggested that they felt comfortable to ask questions and as outlined by one student "I *felt like I was allowed to make mistakes in the role play*". Carrasco and Torres (2018) suggest that learners should acquire knowledge in an environment that not only supports their development but allows for open inquisition; subsequently this feedback reinforced that my approach was relaxed and supportive throughout the series of sessions.

Areas for Improvement

In terms of improvement, there were several areas which the learners provided feedback. A key component that I identified within my own approach is the need to reflect on 'just because I understand this doesn't mean other people do'. This was highlighted to me on review of the session 1 content with the module leader who reminded me to 'remember that for many, words like thought moderation will not mean much'. This resonated as I had previously received this feedback within a teaching session and believe that my knowledge of CBT can sometimes lead me to 'brush over' concepts that others may find challenging. This prompted me to acquire greater formative feedback throughout my sessions; often asking if any of the learners had queries on the content or did not understand terminology. As I transition into session 2 and 3, I was increasingly mindful to incorporate this reflection which led me to amend my presentations to be more readily understandable to non-healthcare professionals.

A further key component that I have identified within sessions 1 and 4 was the necessity to encourage shared discussion amongst the learners. In session 1, a member of the group suggested that it would have been useful to have been provided with a more comprehensive outline to "*the link between specific diabetes symptoms and mental health*". Although there was a case study identifying how hypoglycaemia can lead to anxiety symptoms, for future sessions I think it would be beneficial to elicit further discussion which would in turn reinforce the learner's knowledge and identify any learners who may not grasp the applicability of this knowledge to practice. I feel this in turn would allow the learners as Roshni and Rahim (2020) suggests building a competent knowledge base in which they could later apply to further examples.

One area in which I am fully aware I need to improve my competence is when managing disruptive or non-engaged learners. During session 1 there was an individual who was not particularly engaged in the session. This individual felt that they "*already had a good knowledge of diabetes*" which was mirrored in the session alongside their feedback. As Hornstra et al. (2015) suggests, the teacher should be adaptable within their approach to non-engaged learners, and within future sessions I would place greater emphasis on trying to engage this individual by possibly asking them to share their experiences of knowledge with the group. I feel this would place the learner as a part-facilitator to the group whom I could draw on to support others with challenging concepts or to lead discussions. Despite this, I was mindful not to let this individual to become 'resistant' to the session and although I did ask them questions, I would be mindful to not let this interrupt the dynamic of the group in future sessions.

Online Teaching

A consideration which I had not previously considered was the need to tailor my approach to online teaching sessions. Within session 2 I was required to conduct an online session with many individuals (the majority of which I could not see). To keep the learners engaged in the session I provided several opportunities to query as to if there were any questions from the members of the session. Leaning on the principles identified by Gedye (2010), this process of ascertaining formative feedback allowed me to establish the general 'feel' within the session and identify learners who may experience difficulties. I feel that an effective technique that was implemented in this session was asking the individuals to split into break out groups to discuss how they could implement sleep hygiene in their daily routines. This process of leading from knowledge acquisition to reality-based learning provided opportunity for the barristers to apply the information they had learnt in a supportive and facilitative environment; that of which is typically more challenging in online settings. The subsequent sharing of the learners' key findings in the breakout groups back to the whole group further enhanced the shared experiential learning of the teaching group and more closely resembled a group, rather than 65 individuals.

Technology Applications

The series of teaching sessions has highlighted the possible future application of more technology elements including polls, videos, and presentation integrations (such as hyperlinks). A resource that I utilized within sessions 2 and 3 was 'Mentimeter'; a survey tool which can be used to obtain learners thoughts seamlessly whilst conducting an online or face-to-face session. This was a particularly beneficial tool as it allowed the individuals to anonymously share their level of knowledge whilst simultaneously allowing me to assess the learners understanding. Within session 3, I did encounter a small technical issue in loading the survey tool and although this was resolved relatively quickly, for future sessions I would ensure that I had trialled the activities with the computer software or platform that I was using.

A further tool that supported the delivery of my teaching in session 2 was the ability to split individuals into smaller break out groups. This was used to support the learners in applying their knowledge to ascertain how they could implement sleep hygiene in their daily routines. This process of leading from knowledge acquisition to reality-based learning provided opportunity for the barristers to apply the information they had learnt in a supportive and facilitative environment. The subsequent sharing of the learners' key findings in the breakout groups back to the whole group further enhanced the shared experiential learning of the teaching group. Although I am mindful that this break-out group function would not provide added benefit in a face-to-face setting, I would certainly use this feature again as the learners stated, "it felt like this broke up the very typical sit down- listen approach that most professionals who speak to us tend to do".

A minor limitation of incorporating technology that the learners did identify in sessions 1 and 4 was the quality of the 'Diabetes Processes' and CBT video role plays. Unfortunately, due to the availability of these niche videos I was quite restricted in finding a high-quality video and subsequently for future sessions I will be mindful to consider how this may affect learning whilst also searching more comprehensively for high quality media; opening the possibility to develop my own illustrations or videos when necessary.

Despite the incorporation of technology including break out groups, poll surveys and videos supported the delivery of my teaching, they did also prompt some challenges. One of the most encompassing pieces of feedback was provided by the event organizer in session 2; who shared that for future sessions they would prefer to conduct teaching on MS Teams rather than zoom. Although this wasn't possible on the information I was provided by the organizer, this highlighted the necessity for me to understand the logistical challenges that may arise when using technology in the future. This feedback is further reinforced by Hattie and Timperley (2007) who suggest that organizers or 'gate-keepers' are particularly useful contacts in the delivery of teaching sessions as they can summarize the learner's view of the content and overall learning experience.

Concluding Thoughts

The process of conceptualising, developing, delivering, and evaluating my teaching session has been an eye-opening experience. Although I have experience of teaching within several environments, I have often not had the ability to appraise my own processes or assumptions. From this experience, I have gained a comprehensive understanding of the intricacies of utilising session resources to not only engage, but improve the outcomes of the learners.

A notable finding of this process was that I ultimately felt much more comfortable when presenting on the topics in a relaxed manner, which has prompted me to reflect on my intrinsic ability to share concepts and ideas with others. Overall, I believe that these experiences have increased my confidence to design and facilitate an effective teaching session and I look forward to the possibility of becoming more involved in teaching as I progress throughout my career.

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Chapter 5: Consultancy Skills

5.1 Consultancy Skills Case Study

Introduction

In this case study, I will discuss the completion of my consultancy project with an independent mental health provider I will refer to as the pseudonymised 'Psychonline'. Psychonline is a start-up company in the early stages of providing a range of psychiatric and psychological services to clients via an online platform. The Psychonline platform allows clients across the UK to connect with experienced clinicians through integrated video consultations. The Psychonline group have been in development since February 2019 and were seeking to launch their platform at the end of April 2021. A significant component of their launch was the development of an expansive self-help content area. Due to the increasing demand and evidence for the efficacy of psychoeducational materials, Psychonline proposed a section of their platform that included information about mental health conditions, low-level interventions to reduce psychological concerns and guided self-help treatment workbooks (Coull & Morris, 2011). In December 2020, I was approached by the Chief Technological Officer (CTO) of Psychonline and invited to support the development of their self-help approach and content.

Having reviewed a range of consultancy models to guide my approach, I decided on Bellman's model over specific health consultancy models such as Earl and Bath (2004) and Michie and Abrahams (2009), as Bellman's model provides a more explicit structure appropriate for the type of corporate consultancy I would be completing. Bellman's consultancy philosophy is client-centred, but also emphasises the need to bring the consultant's personality and skills to the process. The following report describes the consultancy process with Psychonline drawing from Bellman's (2012) 'Ten Step Consulting Process'; transitioning through Entry, Contracting, Inquiry, Interpretation, Feedback, Alternatives, Decision, Action, Measurement and Ending.

Entry

Bellman (2012) describes entry as the initial contact between the client and consultant. Entry to this project commenced in late December 2020 when the CTO approached me directly to support their organisation. As their approach evolved, the CTO desired to understand more about the nature of psychological interventions and based on a psychiatric colleague's recommendation, contacted me to discuss the development of Cognitive Behavioural Therapy and self-help resources. Towards the end of December 2020, the CTO and I shared brief emails and a 30-minute phone call as an introduction to the team, intended goals, timelines and expectations. Following these discussions, we agreed to schedule a discovery meeting on the 4th January 2021 with the wider Psychonline team.

Contracting

On January 4th 2021, I participated in a 2-hour online meeting with Psychonline's Chief Executive Officer, Director of Psychiatry, Director of Finance and CTO. The purpose of this meeting was to initiate the discovery process, allowing me to understand the specific nature of what Psychonline's ambitions were and how I might support the obtainment of their desired goals. As suggested by Jacobson, Butterill and Goering (2005**)**, I began by sharing information about my expertise and allowed the members to ask me any questions as a way to develop an initial rapport with the clients. This provided an opportunity for both the clients and me to establish a relationship that would be facilitative of the project.

The initial meeting also provided opportunity to explore the dynamics of the executive directors and identify whom my primary contact would be. My main point of reference for identifying the relevant stakeholders was Scheinn's (1997) conceptualization of clients falling into 6 client types: (a) contact clients, (b) intermediate clients, (c) primary clients, (d) unwitting clients, (e) ultimate clients, and (f) involved "non-clients". The applicability of this model to my project can be seen below in [*Table 1*]:

Table 1: Identification of relevant stakeholders according to Scheinn 1997.

Scheinn's Client Definition	**Application to Psychonline**	**Rationale**
Contact Client	Chief Technological Officer	The CTO was the individual who initially reached out to me for support with the project.
Intermediate Clients	Director of Psychiatry, Director of Finance	Throughout the meetings, these directors provided input to the project as it evolved.
Primary Clients	Chief Executive Officer	The CEO was ultimately the individual who would be releasing the workbooks and was also responsible for funding the CTO to allow the progression of the project.
Indirect Clients	User Design Team	The design team members were aware that I would be providing input on making the portal evidence-based but were unknown to me.
Ultimate Clients	Psychonline Service Users	The clients of Psychonline would be the main individuals affected by the

		project and also whose welfare was considered throughout the consultancy period.
Unwitting Clients	Not Applicable	To my knowledge, there were no members of the Psychonline team who would be impacted by the consultancy project without their prior knowledge.

During the discussion, identification of need was clear as Psychonline was requesting the development of a CBT workbook, psychoeducational materials, incentivisation methods, audible mindfulness resources and evidence-based feedback on their portals user experience. The CTO informed me that the portal would be launching at the beginning of May 2021, meaning I would have three months to complete the allotted requests. I was very aware that this was a significant amount of work and informed the team I would review the information alongside the proposed budget to ascertain the viability of the project. This provided me opportunity to negotiate the terms that would allow both Psychonline and myself to mutually benefit from.

Leblanc and Nosik (2019) stress the importance of follow up meetings to allow the advancement of progress for the project. Subsequently, I concluded this session by informing the executives I would create a contract outlining the discussed deliverables alongside my proposed plan of action, and recommended meeting again within 2-3 weeks to provide my feedback. Over the following week, I generated the contract and relevant actions, however, I stated that with the existing time limitations, it would not be possible to complete all of the deliverables. I, therefore, suggested that ascertaining how to fully incentivize the platform and production of mindfulness resources could not be feasibly completed before April; making a recommendation to outsource this to a tertiary provider with the existing tools and infrastructure to complete this work.

The process of generating the contract was something that felt both exciting and familiar. In previous roles, I have taken responsibility for significant portions of contracting and clinical governance; allowing me to have a strong idea of the general template and required clauses for such work. This meant that I was familiar with the creation and review of contracts, service level agreements and statements of work. Nevertheless, I am constantly mindful of the importance of contracts and ensured that my previous experience did not pose a relaxed approach which could make me liable to the inclusion of clauses that would protect both the client and myself.

On Monday 11th January 2021, I met once again with the CEO and CTO who informed me they were happy to proceed with the suggested actions and understood the rationale to alleviate the mindfulness and incentivisation components of the project. This was an important moment, as it is often necessary to negotiate the scope of the consultancy project to enhance the client's ultimate outcomes (Jacobson, Butterill & Goering, 2005).

Inquiry

The next component identified by Bellman (2012) is inquiry. This refers to using 'positive curiosity' to gather information about the organisation and methods required to complete the task effectively. I utilized a three-pronged approach to obtain information at the inquiry stage: *Stake Holders, Existing Tools and Evidence-Base.*

Stake Holders

In order to accomplish this, I asked the CEO, CTO and director of psychiatry to send me a brief quarter-page summary of what their company's values are and how they want to be perceived by their clients**.** The primary benefit of this activity was that it not only permitted me a deeper understanding of the project but also ensured that I could involve the team to confirm the prospective deliverables were aligned to their requirements.

Existing Tools

To understand the overall market of self-help and guided psychological resources, I also completed my research into the top 5 providers of these services. Kipping and Clark (2012), states that understanding the overall market before developing new resources permits the comprehension of existing tools, whilst allowing identification of factors missing within the current provision of services. Therefore, I used this information to develop a further overview of the nature of these services and later compiled this with the director's visions of the consultancy project (*Key findings from existing tools can be seen in Table 2*). This ultimately permitted a clear vision of the existing literature and resources available; allowing a directive yet novel approach to Psychonline's content.

Evidence Base

The final inquiry was a thorough comprehension of the evidence-based literature regarding the self-help paradigm. Rather than conducting a literature review into individual studies, I chose to summarize findings from two recent systematic reviews; an approach praised for filtering data to produce relevant information (Ganeshkumar & Gopalakrishnan, 2013). The findings of these reviews provided a defined template for both the specific interventions and methods that would support Psychonline's goals [*Synthesis of reviews can be seen in Table 2*].

Interpretation

Following the acquisition of information from the shareholders, existing tools and evidence base, I sought to synthesize this data into a plan that I could feedback to the directorial team before creating the CBT resources. Bellman (2021) states that interpretation should seek to answer the questions: what does this information say and what does this information mean. I, therefore, created a framework for each of these components as seen in [*Table 2*] before feeding this information back to the directors. I found this exercise useful in enhancing my understanding of the project, in addition to providing an overview of how I should develop and communicate the information I planned on curating.

Table 2: Synthesis of Inquiry Data

Data Sources	**What does the information say?**	**What does this information mean?**
Shareholders	"Communicate a level of trust and transparency" "Clear rationale for self-help interventions utilizing a CBT model" "Should enhance the brand image of Psychonline- such that the workbooks are synonymous with a high quality of psychological support" "Should establish the workbook as guided self-help, but not an alternative to high-intensity psychological intervention"	• The booklet should include an outline as to why a CBT model is being utilized • Full transparency in the decision to use and implement a self-help intervention • Signpost to healthcare professionals if the level of risk is significant
	Too much information with strong medicalized language	• Use of 'clinical' information only

Existing Tools	Good quantity of descriptive information No clear definition of a model being used to support the clients Use of interventions that can be practiced within the client's own time Poor use of colours (mostly white pages) No use of images Where models are shown, the pathways are not clearly defined (i.e. how do I use stages of change model)	where needed to discuss aspects of psychopathology • Provide a clear definition of CBT prior to interventions • Include interventions that can be used completed at the client's own pace • Incorporate images and interactive materials (diagrams, charts etc). • Use Psychonline colours to highlight their brand image
Evidence Base (Bennett et al., 2019)	Needs to instill confidence in the client Should be easy to read and accompanied by models Non-patronizing or judgmental	• Use the COM-B model to highlight the client's ability by enhancing motivation,

(Coull & Morris, 2011)	Needs to incorporate an evidence-based model of treatment Should not include high-intensity interventions i.e. trauma rescripting/reliving Incorporate relapse prevention for improved longitudinal outcomes	capability and opportunity throughout. Possibility of implementing SMART goals • Use easily comprehended language • Include evidence-based interventions i.e. behavioural activation etc. • Do not include interventions for severe trauma

Feedback

Bellman (2012) and other experts in consultancy have recommended providing the client opportunities to provide verbal feedback prior to 'actioning' tasks (Hardavella et al., 2017). After the interpretation of the relevant information and development of proposed actions, I requested a 1-hour online meeting with the CEO, CTO and director of psychiatry services. I viewed this as an opportunity to propose my refined plan; referencing the decisions for my choice and comparison to existing tools.

I presented the information as a PowerPoint slide to provide an engaging and effective overview of the data I had obtained**.** I found this particularly challenging as I was not overtly familiar with providing presentations online, which meant I had to consistently ask the team if they were able to comprehend the information I was conveying**.** Following the presentation, I asked for feedback regarding the approach and provided time to adequately respond to any questions. During this meeting, there was a particularly challenging conversation with one of the psychological members of the team who suggested introducing interventions from non-evidence-based theories. Although this interaction was 'uncomfortable', I was able to effectively convey that I believed we should focus on treatments that have been well established within the literature; referencing the NICE guidelines for the treatment of anxiety and depression as well as COM-B for behavioural change.

Alternatives

During the previous section related to receiving feedback from the relevant stakeholders, I enquired about possible alternatives; described by Bellman (2012) as taking a step back from judgement and ensuring a balanced view of the project is being taken. The team were however unanimous in the decision that they were happy with the current direction and subsequently did not require any further alternatives to the workbooks.

Decision

Throughout the pre-action phases, I was highly aware that there was a multidisciplinary team with slightly mixed views on the direction of the psychological content. It was therefore pertinent for me to review the information at the inquiry stage to provide a comprehensive account of the approach to developing resources. Bellman (2012) suggests that decisions should be determined by the client based on: people with related and useful expertise, people with the necessary authority and those required to support the decision. With this in mind, I proposed a final meeting to determine the process moving forward. This meeting consisted of the relevant stakeholders in Psychonline, based on my interpretation of the needs and discussions related to alternative approaches.

Within this meeting, I suggested that the outline of the workbook would include: Psychoeducation about common mental and physical health concerns (i.e. anxiety, low mood, stress, insomnia, sedentary behaviours), behavioural activation, cognitive restructuring, facing fears, problem solving, and maintaining progress. I discussed the necessity to make the workbook engaging and suggested that we would include images and interactive tasks for Psychonline’s clients to utilize. Ultimately the team and head of the project (CTO) were happy to proceed based on my plan which led us to the action phase.

Action

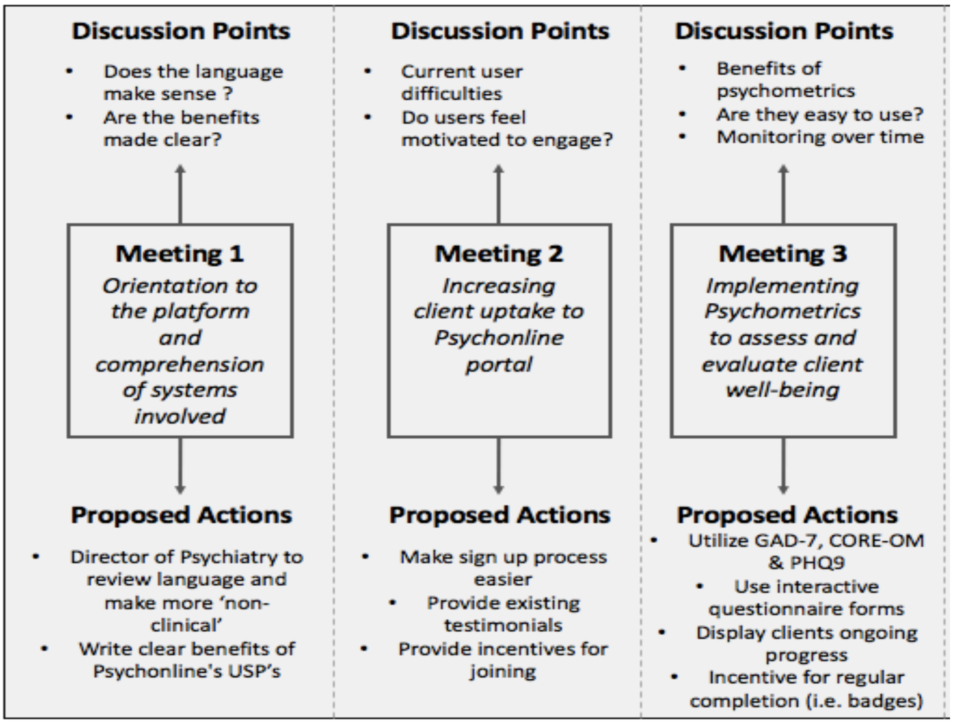
The action phase is the consultant’s opportunity to ‘show their talents’ and ultimately solve the clients ‘problem’ (Bellman, 2012); within this instance filling Psychonline’s vacancy for psychological content. The first step to completing this work was developing a Gantt chart to ensure I was able to obtain Psychonline's desired time frame. Based on this chart, I set deadlines as shown in and liaised with the CTO so that both parties understood the expectations of the deliverables. The two main components of the consultancy were broken down into user interface meetings and content development to ensure that time was managed effectively between both aspects.

Due to my previous experience in completing consultancy projects I already had an existing model for planning, documenting and monitoring the work. This was mostly generated through frequent updates to my previously generated Gantt chart as well as keeping weekly updates where I could review my progress throughout the project. To ensure I was meeting deadlines, I ensured that I had regular phone calls with the CTO which permitted me to both keep accountability and autonomy throughout the project. To make the project more manageable, I broke down the consultancy into two main components: the user interfaces meetings and content development- as outlined below.

User Interface Meetings

Within the user interface meetings, my role was to provide an 'expert' opinion; what Schein (1997) refers to as a Doctor-Patient consultation. As previously agreed, these meetings consisted of discussions around how to enhance user uptake, implementation of psychometrics to assess user's well-being and enhance user engagement over time. The primary discussion points and feedback I used to consolidate my findings with Psychonline are outlined below in [*Figure 1*].

Figure 1: Summary of User Interface Meetings with Psychonline



Martinez, Ferreira and Can (2016) suggests that sharing expertise in a consultancy context should balance both innovation and empirical research. Due to this, I structured the majority of the meetings and modifications of the portal around the COM-B model (Mitchie, van Stralen & West, 2011). Given the flexibility of the COM-B and behavioural change wheel, I structured my feedback according to the client's capability, opportunity and motivation to engage with the portal. Bellman (2012) suggests that communicating concepts to key stakeholders in a consultancy project should clarify the ‘problem’ in a parsimonious nature; this was very achievable given the simplicity and general readability of the COM-B model.

Content Development

After reviewing the information from the inquiry, interpretation and feedback stages, I began to curate content for the CBT workbook. I have previously completed short written interventions to be used with psychological well-being practitioners, and so this, combined with my CBT knowledge, allowed me to develop content in a structured manner. The first step in the content development phase was to develop headings based on my existing literature searches, contracted deliverables and knowledge of CBT interventions as follows:

i. Enhancing sleep behaviours

ii. Improving dietary activity

iii. Maintaining exercise routines

b. Psychological content regarding:

i. Managing thoughts

ii. Behavioural activation

iii. Overcoming fears

iv. Problem-solving techniques

v. Maintaining progress

To develop the content, I referred back to my resources developed in the inquiry stage and generated a combination of psychoeducation materials and interventions based on existing literature and NICE guidelines which I ensured was wrapped within Cognitive theories and the COM-B model (Falbe-Hansen, 2009; Mitchie, van

Stralen & West., 2011; NICE, 2019). When structuring the interventions, I felt confident that I could convey the information necessary to support the client's well-being but incorporated Nutbeam's (2000) classification of health literacy as a template to develop the resources as outlined below in [*Table 3*].

Table 3: Outline of Nutbeam's Health literacy principles for incorporation to CBT workbook

Nutbeam's Health Literacy Indicators	**Description**	**Incorporation to Workbook**
Functional	*"Basic/functional literacy*—sufficient basic skills in reading and writing to be able to function effectively in everyday situations, broadly compatible with the narrow definition of 'health literacy' referred to above."	Converting evidence-based research into comprehensible information Incorporation of easily readable graphs and charts Maintaining an easily readable font and size Abstaining from academic language Utilization of related images to accompany textual information

Interactive	*"Communicative/interactive literacy—* more advanced cognitive and literacy skills which, together with social skills, can be used to actively participate in everyday activities, extract information and derive meaning from different forms of communication, and to apply new information to changing circumstances."	Produce activities for clients to complete i.e. creating an exposure ladder Prompt clients to involve their immediate support network Utilizing second person language to allow personification
Critical	*"Critical literacy—*more advanced cognitive skills which, together with social skills, can be applied to critically analyze information, and to use this information to exert greater control over life events and situations."	Incorporation of 'quiz-like activities to allow clients to track their progress. Inclusion of motivational interviewing tasks and reflections Focus on stages of change model and COM-B to identify factors needed to generate change

Throughout the process, I consistently met with the directorial team and ensured that the progress was meeting the deliverable requirements as outlined in the contract and through synthesis at the inquiry stage.

Measurement

In order to continue my progress as a consultant, I believe it is crucial to seek feedback about my work and therefore in line with Bellman's recommendations sought feedback from clients, my immediate supervisor and the larger team.

To assess the client outcomes, I asked Psychonline to provide me feedback after launching their self-help materials to their users. Unfortunately, there was no metric in place to provide detailed client feedback, nevertheless, after the initial launch Psychonline provided a poll that suggested 58 out of 62 users (93%) would recommend the self-help content. This provided some tangible feedback which served to confirm the resources I had developed were effective in ultimately supporting the client’s well-being. For future projects, where appropriate, I would seek to ascertain client feedback as part of the consultancy contract; allowing a more comprehensive understanding of how effective the content was for the target demographic.

In order to assess the team’s satisfaction with my outcomes, I provided a short questionnaire to the CEO, CTO and Director of Psychiatry services. This questionnaire was based on their perception of my performance throughout the project, which indicated they were very satisfied with the service I had provided. Finally, I kindly requested a short statement of feedback from the CTO*.* The information provided identified that he was particularly pleased with the outputs of the consultancy and felt that the project ran smoothly throughout.

Ending

From my previous experience in consultancy, I have found that ending the project is a crucial moment for maintaining positive relationships. When the project was concluded on the 8th of April 2021 the executive team scheduled a final online meeting. During this meeting, I naturally encompassed Bellman’s (2012) principles of sharing the difficulties and successes of the project, discussing the value that I gained from the process and enjoying the celebration of meeting the client's goals.

Concluding Thoughts

The most significant challenge within this project was to be assertive within the directorial team to ensure that we were proceeding with a product that not only met the needs of the client, but the needs of the patients who would be using the resource. An experience that particularly stands out to me was the challenges with one of the directorial team on whether to use a 'non-evidence based' form of therapy to inform the self-help booklet. I feel proud that I was able to calmly and professionally manage this individual's expectations; referring back to my ethical duty to provide information that is not only up-to-date but supported within academic literature. On reflection, I am proud of the deliverables produced for Psychonline as I have confidence that they have been generated via well-established empirical research and theories. The feedback and evaluation clearly displayed that the client found the consultancy beneficial and highlights my ability to act autonomously as a consultant.

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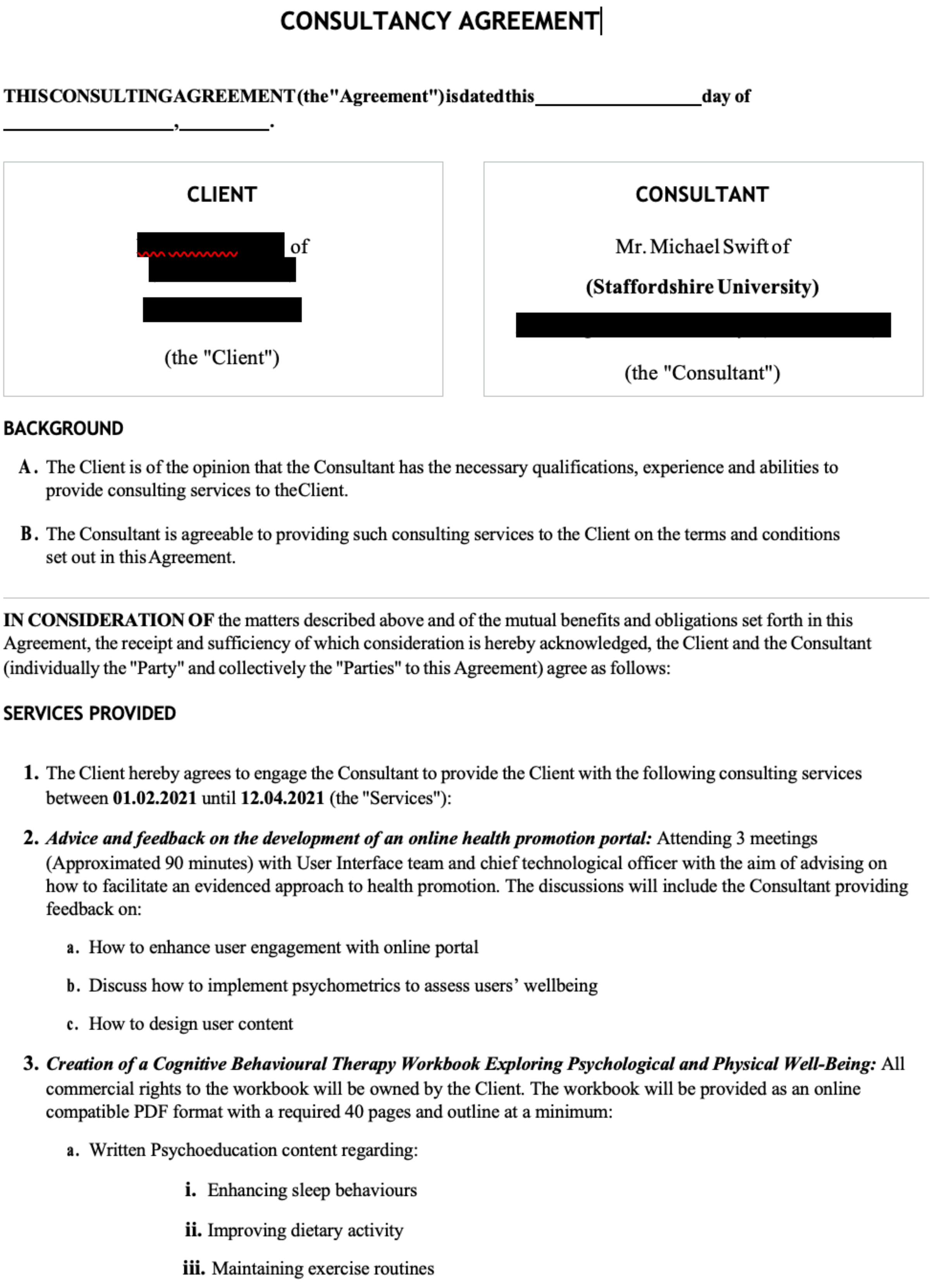
5.2 Consultancy Contract & Working Agreement



CONSULTANCY AGREEMENT

THIS CONSULTING AGREEMENT (the "Agreement") is dated this ________________ day of ________________, _________.

CLIENT

[redacted] of
[redacted]
[redacted]

(the "Client")

CONSULTANT

Mr. Michael Swift of
(Staffordshire University)
[redacted]

(the "Consultant")

BACKGROUND

A. The Client is of the opinion that the Consultant has the necessary qualifications, experience and abilities to provide consulting services to the Client.

B. The Consultant is agreeable to providing such consulting services to the Client on the terms and conditions set out in this Agreement.

IN CONSIDERATION OF the matters described above and of the mutual benefits and obligations set forth in this Agreement, the receipt and sufficiency of which consideration is hereby acknowledged, the Client and the Consultant (individually the "Party" and collectively the "Parties" to this Agreement) agree as follows:

SERVICES PROVIDED

1. The Client hereby agrees to engage the Consultant to provide the Client with the following consulting services between **01.02.2021** until **12.04.2021** (the "Services"):
2. ***Advice and feedback on the development of an online health promotion portal:*** Attending 3 meetings (Approximated 90 minutes) with User Interface team and chief technological officer with the aim of advising on how to facilitate an evidenced approach to health promotion. The discussions will include the Consultant providing feedback on:
    a. How to enhance user engagement with online portal
    b. Discuss how to implement psychometrics to assess users' wellbeing
    c. How to design user content
3. ***Creation of a Cognitive Behavioural Therapy Workbook Exploring Psychological and Physical Well-Being:*** All commercial rights to the workbook will be owned by the Client. The workbook will be provided as an online compatible PDF format with a required 40 pages and outline at a minimum:
    a. Written Psychoeducation content regarding:
        i. Enhancing sleep behaviours
        ii. Improving dietary activity
        iii. Maintaining exercise routines

b. Psychological content regarding:
    i. Managing thoughts
    ii. Behavioural activation
    iii. Overcoming fears
    iv. Problem solving techniques
    v. Maintaining progress

4. The Consultant will liaise with the chief technology officer once every 2 weeks extending the 12 weeks outlined in this contract. This will entail providing feedback via an online 30-minute meeting to discuss progression of the written content for the CBT workbook and any proposed recommendations to the user interface team.

TERM OF AGREEMENT

5. The term of this Agreement (the "Term") will begin on the date of this Agreement and will remain in full force and effect until the completion of the Services, subject to earlier termination as provided in this Agreement. The Term may be extended with the written consent of the Parties.

6. In the event that either Party wishes to terminate this Agreement prior to the completion of the Services, that Party will be required to provide 10 days' written notice to the other Party. Upon written notice, the Client will return works completed up until the date of receiving or providing the early termination of the agreement.

PERFORMANCE

7. The Parties agree to do everything necessary to ensure that the terms of this Agreement take effect.

CURRENCY

8. Except as otherwise provided in this Agreement, all monetary amounts referred to in this Agreement are in GBP.

PAYMENT

9. The Consultant will charge the Client a flat fee of [redacted] for the Services (the "Payment").

10. The Client will be invoiced at key milestones throughout the project and are outlined as follows:

    a. [redacted] ue on completion of three user interface meetings

    b. [redacted] due on completion of content including: Enhancing Sleep Behaviours, Improving Dietary Activity and Maintaining exercise routines

    c. [redacted] due on full completion of the cognitive behavioural therapy workbook as defined as providing content outlined in 10.a. in addition to: Managing thoughts, Behavioural Activation, Overcoming Fears, Problem Solving Technique and Maintaining Progress

11. Invoices submitted by the Consultant to the Client are due upon receipt.

12. In the event that this Agreement is terminated by the Client prior to completion of the Services but where the Services have been partially performed, the Consultant will be entitled to pro rata payment of the Payment to the date of termination provided that there has been no breach of contract on the part of the Consultant.

13. The Consultant will be responsible for all income tax liabilities and National Insurance or similar contributions relating to the Payment and the Consultant will indemnify the Client in respect of any such payments required to be made by the Client.

REIMBURSEMENT OF EXPENSES

14. The Consultant will be reimbursed from time to time for reasonable and necessary expenses incurred by the Consultant in connection with providing the Services.

15. Pre-approval is not required for expenses.

CONFIDENTIALITY

16. Confidential information (the "Confidential Information") refers to any data or information relating to the Client, whether business or personal, which would reasonably be considered to be private or proprietary to the Client and that is not generally known and where the release of that Confidential Information could reasonably be expected to cause harm to the Client. The Consultant agrees to maintain where appropriate GDPR compliance throughout the continuity of this project.

17. The Consultant agrees that they will not disclose, divulge, reveal, report or use, for any purpose, any Confidential Information which the Consultant has obtained, except as authorized by the Client or as required by law. The obligations of confidentiality will apply during the Term and will end on the termination of this Agreement except in the case of any Confidential Information which is a trade secret in which case those obligations will last indefinitely.

18. All written and oral information and material disclosed or provided by the Client to the Consultant under this Agreement is Confidential Information regardless of whether it was provided before or after the date of this Agreement or how it was provided to the Consultant.

OWNERSHIP OF INTELLECTUAL PROPERTY

19. All intellectual property and related material, including any trade secrets, moral rights, goodwill, relevant registrations or applications for registration, and rights in any patent, copyright, trade mark, trade dress, industrial design and trade name (the "Intellectual Property") that is developed or produced under this Agreement, will be the sole property of the Client. The use of the Intellectual Property by the Client will not be restricted in any manner.

20. The Consultant may not use the Intellectual Property for any purpose other than that contracted for in this Agreement except with the written consent of the Client. The Consultant will be responsible for any and all damages resulting from the unauthorized use of the Intellectual Property.

RETURN OF PROPERTY

21. Upon the expiry or termination of this Agreement, the Consultant will return to the Client any property, documentation, records, or Confidential Information which is the property of the Client.

CAPACITY/INDEPENDENT CONTRACTOR

22. In providing the Services under this Agreement it is expressly agreed that the Consultant is acting as an independent contractor and not as an employee. The Consultant and the Client acknowledge that this Agreement does not create a partnership or joint venture between them, and is exclusively a contract for service.

RIGHT OF SUBSTITUTION

23. Except as otherwise provided in this Agreement, the Consultant may, at the Consultant's absolute discretion, engage a third party sub-contractor to perform some or all of the obligations of the Consultant under this Agreement and the Client will not hire or engage any third parties to assist with the provision of the Services.

24. In the event that the Consultant hires a sub-contractor:

- the Consultant will pay the sub-contractor for its services and the Compensation will remain payable by the Client to the Consultant.
- for the purposes of the indemnification clause of this Agreement, the sub-contractor is an agent of the

Consultant.

AUTONOMY

25. Except as otherwise provided in this Agreement, the Consultant will have full control over working time, methods, and decision making in relation to provision of the Services in accordance with the Agreement. The Consultant will work autonomously and not at the direction of the Client. However, the Consultant will be responsive to the reasonable needs and concerns of the Client.

EQUIPMENT

26. Except as otherwise provided in this Agreement, the Consultant will provide at the Consultant's own expense, any and all equipment, software, materials and any other supplies necessary to deliver the Services in accordance with the Agreement.

NO EXCLUSIVITY

27. The Parties acknowledge that this Agreement is non-exclusive and that either Party will be free, during and after the Term, to engage or contract with third parties for the provision of services similar to the Services.

NOTICE

28. All notices, requests, demands or other communications required or permitted by the terms of this Agreement will be given in writing and delivered to the Parties at the following addresses:

[redacted]

b. Mr. Michael Swift of (Staffordshire University) 32
[redacted]

or to such other address as either Party may from time to time notify the other.

MODIFICATION OF AGREEMENT

29. Any amendment or modification of this Agreement or additional obligation assumed by either Party in connection with this Agreement will only be binding if evidenced in writing signed by each Party or an authorized representative of each Party.

TIME OF THE ESSENCE

30. Time is of the essence in this Agreement. No extension or variation of this Agreement will operate as a waiver of this provision.

ASSIGNMENT

31. The Consultant will not voluntarily, or by operation of law, assign or otherwise transfer its obligations

under this Agreement without the prior written consent of the Client.

ENTIRE AGREEMENT

32. It is agreed that there is no representation, warranty, collateral agreement or condition affecting this Agreement except as expressly provided in this Agreement.

TITLES/HEADINGS

33. Headings are inserted for the convenience of the Parties only and are not to be considered when interpreting this Agreement.

GENDER

34. Words in the singular mean and include the plural and vice versa. Words in the masculine mean and include the feminine and vice versa.

GOVERNING LAW

35. This Agreement will be governed by and construed in accordance with the laws of England. The consultant will comply with the British Psychological Society 'Code of Ethics and Conduct' (2009) and the Health & Care Professions Council Standards of Conduct Performance and Ethics (2012).

SEVERABILITY

36. In the event that any of the provisions of this Agreement are held to be invalid or unenforceable in whole or in part, all other provisions will nevertheless continue to be valid and enforceable with the invalid or unenforceable parts severed from the remainder of this Agreement.

THIRD PARTY RIGHTS

37. The Contracts (Rights of Third Parties) Act 1999 shall not apply to this agreement and no person other than you and the Client shall have any rights under it. The terms of this agreement or any of them may be varied, amended or modified or this agreement may be suspended, cancelled or terminated by agreement in writing between the parties or this agreement may be rescinded (in each case), without the consent of any third party

WAIVER

38. The waiver by either Party of a breach, default, delay or omission of any of the provisions of this Agreement by the other Party will not be construed as a waiver of any subsequent breach of the same or other provisions.

IN WITNESS WHEREOF the Parties have duly affixed their signatures under hand and seal on this __________day of____________________,__________.

[redacted]

Name: [redacted]
Signature:

____

Mr. Michael Swift of (Staffordshire University)

Name:______________________________
Signature: ______________________________