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A portfolio submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Professional Doctorate in Health Psychology

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Abstract

Dipti Kishorbhai Mistry, Professional Doctorate in Health Psychology, 2023

This portfolio documents the work I have completed whilst undertaking the Professional Doctorate in Health Psychology at Staffordshire University between 2020-2023. The work was conducted alongside full-time employment in forensic mental health services within the NHS. Opportunities in other areas of the NHS trust and at Staffordshire University were also sought in order to fulfil the requirements of the programme.

This portfolio is divided into five chapters which represents the five core competencies of Health Psychology:

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

Throughout each of the chapters, I present evidence of my development in the form of research manuscripts, case studies and reflective commentaries. These outline both the work I have undertaken as well as the experience and knowledge I have developed in completing the work. Further details of the content of each chapter are provided in the introduction.

Introduction

In this portfolio I present the work I have conducted whilst undertaking the Professional Doctorate in Health Psychology at Staffordshire University between 2020-2023. My training commenced during the pandemic, with a significant proportion completed during this timeframe. Although I had training opportunities after the pandemic, the ongoing COVID-19 outbreaks remained a constant challenge, including some residual ways of working from the pandemic, in my place of work.

During the doctorate, I was employed within a Medium Secure Unit (MSU), where I mainly worked with female patients, although I had several opportunities to work with male patients. During the latter part of my training, I undertook a secondment to provide maternity cover at the National High Secure Healthcare Service for Women (NHSHSW). In both roles, I was the first Trainee Health Psychologist to work alongside other trainees and qualified psychologists from Clinical and Forensic psychology backgrounds.

Throughout the doctorate programme, my role involved providing trauma-informed care and treatment to adult patients diagnosed with long-term mental health difficulties (e.g., mental disorders, personality disorders and complex trauma) who were detained under the Mental Health Act (MHA; 1983, revised 2007) and have a forensic and offending backgrounds. Across both services, I was involved in a range of clinical activities which included delivering psychological interventions that were delivered in multi-disciplinary teams (MDT) to the highest standards of evidence-based therapeutic care and clinical expertise to provide quality service to patients in a secure environment.

Chapter 1: Professional Competence in Health Psychology

This chapter consists of a reflexive report of 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 needed to be a Health Psychologist. The second section focuses on how I developed on a range of key professional skills outlined by the British Psychological Society (BPS) and Health and Care Professional Council (HCPC). For example, communication skills in different context, giving health psychology advice and guidance to others and team working and leadership.

Chapter 2: Advanced Research Methods

Within this chapter, three research projects are presented. First is my systematic review which focuses on how adolescent use and experience social media for sexual and reproductive health information. This systematic review used a meta-synthesis approach. Secondly, my quantitative research study explored the impacts of Adverse Childhood Experiences (ACEs) on physical health outcomes of those admitted to medium secure mental health care. This research was a secondary data analysis using existing data to develop approximate ACE scores to understand health outcomes of this population. My final research project was my qualitative research study which explored the experiences of cervical screening in people nursed in forensic mental health services. This research utilised Interpretative

Phenomenological Analysis (IPA). Each research project is accompanied by a reflective commentary, outlining my rationale for decisions and my experiences of undertaking this work.

Chapter 3: Psychological Interventions

This chapter presents two case studies outlining the assessment, formulation, intervention design and delivery and evaluation of two psychological interventions. The first psychological intervention was an individual face-to-face intervention where I worked with a patient on their medically unexplained symptoms (Functional Cervical Dystonia) using Cognitive Behavioural Therapy (CBT). The second psychological intervention was a group intervention where I worked with four patients on improving their sleep which also used CBT. Both interventions are accompanied by a reflective commentary.

Chapter 4: Teaching and Training in Health Psychology

This chapter presents a case study and evaluation of a teaching and training programme that I designed and delivered on the theme "*Applied Health Psychology in Forensic Mental Health*". The programme compromised of five sessions that were delivered to two types of audiences: (1) health care professionals compromising of dietitians working in forensic mental health services and (2) psychology students at Staffordshire University. Sessions were taught in a combination of remote and face-to-face teaching as well as delivered to small and large group audiences. Sessions were evaluated using an amalgamation of self-reflection, student feedback and peer observation. The teaching and training case study is accompanied with a reflective commentary which outlines my strengths, challenges, and areas of improvement.

Chapter 5: Consultancy Skills

This chapter includes a case study of a piece of consultancy work I completed with the Safeguarding Team of the NHS Trust I was employed with while completing the doctorate. The Safeguarding Team initiated a project to understand self-neglect issues within the Trust, following a national analysis of Safeguarding Adult Reviews. I, therefore, consulted on a project exploring and understanding the clinical staff member's experience of working with patients who self-neglect their physical health. The project was titled "*Self-neglect: A Trust Wide Integrated Safeguarding Review**".*** Through this project, I identified, negotiated, and planned the consultancy opportunity which included developing a consultancy contract which was drafted and agreed with the Client. I also established a positive relationship with the Client, conducted and monitored the project and evaluated the consultancy opportunity.

Chapter 1: Professional Competence in Health Psychology

1.1 Reflexive Report

Background

This reflective report summarises my development of knowledge and skills throughout my Professional Doctorate training in Health Psychology. This report covers the professional guidelines I used to inform my development and learning, how I completed the required professional doctorate competencies, and how I developed the professional skills needed to practice as an applied Health Psychologist.

My placement was in forensic mental health services, where I completed most of my competencies. My training commenced during the pandemic, with a significant proportion completed during this timeframe. Although I had training opportunities after the pandemic, the ongoing COVID-19 outbreaks remained a constant challenge, including some residual ways of working from the pandemic. Following best practice guidance (Gibbs, 1988; Schön, 1983), I kept a weekly reflective diary and reflected on critical areas to aid my learning and development throughout training. This supported me in documenting this reflective report using Driscoll's Model of Reflection (1994, 2007).

Placement Overview

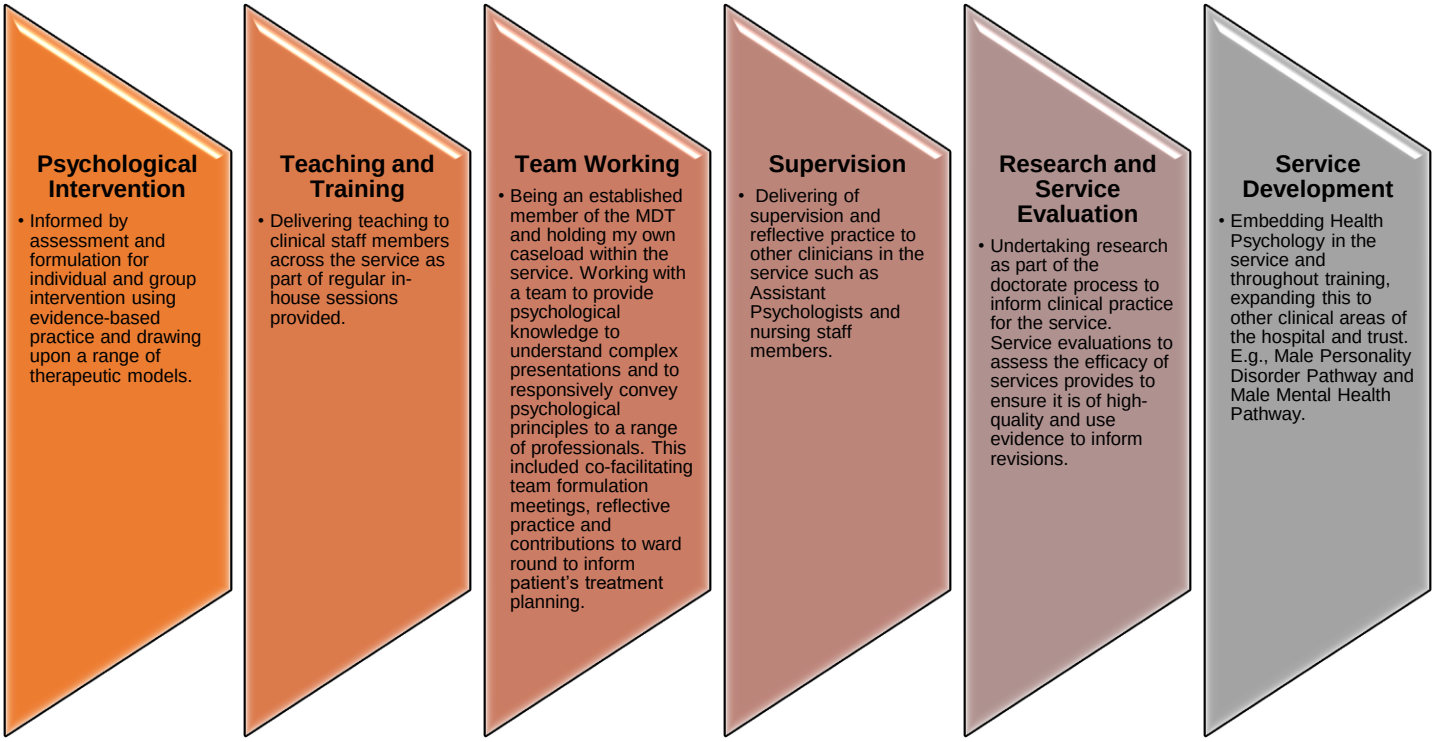
My placement was in a Medium Secure Unit (MSU), where I worked for several years as an Assistant Psychologist before becoming a Trainee Health Psychologist. I mainly worked with female patients, although I had several opportunities to work with male patients. During the latter part of my training, I took a secondment to provide maternity cover at the National High Secure Healthcare Service for Women (NHSHSW). In both roles, I was the first Trainee Health Psychologist to work alongside other trainees and qualified psychologists from Clinical and Forensic psychology backgrounds. Thus, I led and established Health Psychology within these services under supervision. I believe my success in embedding Health Psychology was due to the development I have undergone through my doctorate. This is exemplified by obtaining a qualified psychologist preceptorship role (NHS band 7-8a) in my final year of the professional doctorate.

My placement provides trauma-informed care and treatment to adult patients diagnosed with long-term mental health difficulties (e.g., mental disorders, personality

disorders and complex trauma) and forensic and offending backgrounds. Patients are referred to the services via courts, prisons and mental health hospitals and are detained under the Mental Health Act (MHA; 1983, revised 2007). Across both services, psychological interventions are delivered in multi-disciplinary teams (MDT) to the highest standards of evidence-based therapeutic care and clinical expertise to provide quality service to patients in a secure environment. This population are known to have experienced multiple Adverse Childhood Experiences (ACEs) and therefore are, known to experience more health inequalities relevant to Health Psychology. However, physical health can be overlooked in this setting due to competing clinical priorities, for example, clinical and forensic issues. This is despite evidence showing a significant need for healthcare for inpatients and the association between physical health and risks towards self and others (Bayo-Idowu et al., 2023; Long et al., 2014; Johnson et al., 2018; Kinnafick, Papathomas, & Regoczi, 2018; Meiklejohn, Sanders, & Butler, 2003).

My workplace contact was a Consultant Clinical Psychologist, and I also received clinical supervision from Clinical and Forensic Psychologists. My role encompassed a range of clinical activities and responsibilities (Figure 1) which broadened and developed throughout training. These developments allowed me to develop broader clinical and systemic experience and my ability to work autonomously.

Figure 1: Roles and Responsibilities on Placement



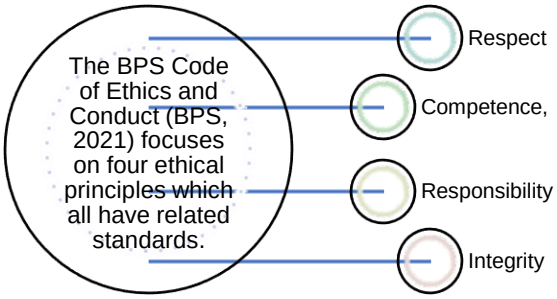
Professional Guidelines

The Health and Care Professions Council (HCPC) is the UK regulator for health and care professionals, maintaining a register of various professions, including Practitioner Psychologists and Health Psychologists. The HCPC sets standards that aim to regulate health and care professionals, including standards of conduct, performance, and ethics; standards of proficiency; standards of Continuing Professional Development (CPD); and standards relevant to education and training (HCPC, 2022).

Awareness and understanding of these standards were vital in my training to help me fulfil the training requirements and seek appropriate opportunities that align with the standards. This would enable me to register with the HCPC as a registered Practitioner Psychologist. An example included engagement with CPD opportunities throughout training, discussed later in this commentary. The HCPC places importance on regularly understanding and completing relevant, up-to-date activities related to clinical practice and service delivery.

In addition to the HPCP standards, my practice was also informed by the standards and guidelines set by the British Psychological Society (BPS). This included the BPS code of ethics and conduct (BPS, 2021), encompassing four principles (Figure 2), the BPS practice guidelines (BPS, 2017) and the code of human research ethics (BPS, 2021).

Figure 2: BPS code of ethics and conduct principles



1. ***Respect***

The principle of ***respect*** relates to the dignity of others by recognising their fundamental value. Respect-related factors, e.g., confidentiality, consent, and compassion, were critical throughout training. In a forensic environment, consent can be challenging, as patients are detained under the Mental Health Act (1983, revised

2007), where treatment can be provided without patient consent (e.g., medical, and pharmacological interventions under Section 62 of the MHA, 1983, revised 2007). Undertaking psychological interventions to reduce a patient's criminogenic risks is essential to support the patient to progress to other services, including reintegration into the community. This highlight concerns about the potential for coercive practices and the fundamental considerations for informed consent (Miles, 2016; Simms-Sawyers, Miles, & Harvey, 2020). Therefore, before completing any assessments or therapy with patients, I ensured patients were aware of their choice to engage and withdraw, enabling an informed decision about engaging in psychological work without applying pressure. Where appropriate, Staffordshire University consent forms were also provided to patients to ensure their informed consent was provided for clinical work to be used as part of my training.

Confidentiality within forensic settings is another vital consideration. Communicating information to colleagues (e.g., nursing staff members, documentation of clinical notes and external services) to support patients daily and for risk management is essential. However, I felt it was important to balance maintaining patient confidentiality while sharing appropriate clinical information. Therefore, I discussed with patients how the information would be shared and documented to preserve their dignity. Confidentiality would only be breached when patients made an unknown disclosure (e.g., about historical abuse or criminal activity) and information escalated. Before escalating their disclosure, I managed this by discussing with the patient the processes I would be required to take in the event of such a disclosure. This also allowed me to accept accountability for decision-making in these instances.

2. Competence

The second principle of ***competence*** highlights the need for specialist knowledge, skill, and experience to provide services. This principle supports engagement with CPD and working within professional limits. The latter was essential during my training as I was mindful of my competencies. Therefore, I engaged in incremental opportunities throughout training to develop my proficiencies to be a Health Psychologist while not practising outside of my abilities. This included only delivering psychological interventions within my skill and appropriate to my stage in training. In addition, working primarily with Clinical and Forensic Psychologists, I also needed to

ensure I undertook tasks relevant to Health Psychology rather than other areas of applied psychology while appreciating the likelihood of some clinical overlap. Throughout my training, I engaged in fortnightly clinical supervision to focus on my knowledge, skills, and developmental areas. This allowed me to recognise my strengths and limitations and reflect on aspects of my practice.

3.Responsibility

The third principle in the BPS code of ethics is ***responsibility***. Responsibility is closely associated with professional autonomy, appropriate and responsible use of knowledge and skills, and awareness of issues relating to power and control. As a staff member in forensic service, I was mindful of the different types of power I held (overt, discrete, and more subtle forms). In particular, the role of power and power dynamics in therapeutic relationships is readily cited within the literature (Boyd, 1996; Klovning, 2021) and is an area I regularly took to clinical supervision. An example of addressing possible power dynamics is highlighted in my psychological interventions one-to-one case study concerning seating positions (Richards, Hervey, & Wilson, 2021). I also ensured I practised responsibly and within my limits by being transparent with patients that I was a trainee, therefore not providing false beliefs about my abilities.

Furthermore, a significant aspect of working within the standards of responsibility included my practice being appropriate to my knowledge and skills and trying to reduce power imbalances through working within the principles of trauma-informed care (Office of Health Improvement & Disparities, 2022). An inherent aspect of trauma-informed care is patient safety and collaboration. As part of what is routinely offered to patients, I ensured they felt safe and involved in their care and treatment. This includes asking patients how they would like their therapy completed (e.g., appointment time and duration, therapy room, support in managing distress and joint preparation of end-of-treatment reports). My skills and abilities to collaborate with patients improved throughout training and became a fundamental part of my ongoing practice.

4. Integrity

The final principle is ***integrity*** which emphasises honesty, consistency, fairness and maintaining personal and professional boundaries. Maintaining professional boundaries is essential, especially within forensic services. A way in which I monitored

my professional boundaries, particularly with patients, was by using Hamilton's (2010) Boundary SeaSaw Model. This model is part of core training within my organisation. I routinely reflected, independently and in supervision, about my working relationship with patients and my boundaries to ensure I maintained my role as a "negotiator". (Hamilton, 2010). This suggests a caring and flexible practitioner rather than an abusive or pacifying practitioner, e.g., an exploitative or controlling or overinvolved practitioner (Hamilton, 2010). For example, I used this model to reflect on my therapeutic relationship with a patient and subsequent decision-making. Despite having a positive therapeutic relationship with the patient, they appeared to become over-reliant and attached to the relationship. Using the model allowed me to reflect, learn and be aware of the transferences and counter-transferences that can be present in therapeutic relationships with patients.

Furthermore, the BPS Practice guidelines (2017) provided the foundation to develop my skills to become a Practitioner Psychologist. The guidelines gave me a more informed understanding of the role of a Practitioner Psychologist that I could use and apply while on placement to develop my skills and knowledge. This included me being able to identify areas of strengths (e.g., psychology interventions) and weaknesses (e.g., consultancy) in my practice to allow me to develop skills, knowledge, and experience through the professional doctorate.

The final BPS document which facilitated my development during training was the BPS Code of human research ethics (2021), especially as I completed two research projects within the NHS for the professional doctorate. While each research project had challenges, this document provided me with a good overview of critical issues I needed to consider during the early stages of my research. For example, I paid attention to participants' dignity, privacy, and confidentiality. This was important as people nursed within forensic services have increased restriction levels and limited freedom, including their privacy. Therefore, I was mindful of maintaining participant confidentiality throughout the research and ensuring they were aware their participation was voluntary and would not impact other aspects of their care and treatment.

Professional Competencies

Advanced Research Methods

Research is essential in Health Psychology as it helps to understand the multi-faceted components of health, illness and diseases and healthcare systems to improve service, patient experiences, health promotion and service development (NIHR, 2022). My research interests are related to women's sexual and reproductive health and the impacts of psychological trauma on physical health and engagement in preventative healthcare. Therefore, to fulfil this competency, I completed a quantitative research project using secondary data, a qualitative research project using semi-structured interviews, and a meta-synthesis of qualitative research for my systematic review.

Quantitative Research:

I started my quantitative research earlier in my doctoral training to allow me sufficient time, as I recognised that quantitative research was not a strength of mine. I had discussions with the Senior Research Fellow on placement to discuss research opportunities and options available within the service. As I was interested in understanding the impact of developmental trauma on health, I designed a quantitative project to examine the relationship between ACEs and health outcomes using secondary data analysis. The data were collected during the ALACRITy study (Westhead et al., 2023), which investigated the outcome data of patients nursed in an MSU. I recognise the value in using existing data for secondary analysis for service benefit. For example, developing an understanding of how historical trauma can influence health outcomes of a large sample size that may have been overlooked in the original research due to different research objectives. Using existing data allowed me to learn more about and respond to the 'file drawer problem' where a dataset is not explored beyond the intended purpose and, therefore, there are missed opportunities to develop a further understanding (Laitin et al., 2021; Pasquetto, Borgman & Wofford, 2019). As a result, my suggestion of using the existing rich database to explore an issue of importance to the service was welcomed.

Although the primary research had received ethical approval, I was still required to obtain ethical permission for the secondary dataset analysis. Although I have completed several ethical applications for other research projects and service

evaluations, this was my first application for secondary data analysis. I found this process more challenging because:

(i) I needed a comprehensive understanding of the ethics process of the primary data collection to inform this approval,

(ii) access to the necessary information about the ethical approval and collection was not readily available and subsequently required several sources to be reviewed to gain a complete understanding, and

(iii) to understand the nature and format of the data to inform my research question and subsequent data analysis.

Starting my analysis elicited feelings of apprehension and anxiety. I have previously avoided access to support in supervision due to feeling embarrassed about difficulties completing and interpreting statistical analysis. I learnt from previous experiences the negative impacts of avoiding supervision and the importance of being transparent about my worries. This allowed me to be sufficiently supported throughout the analysis phase by my supervisor, allowing for timely checks on my assumptions and decision. This helped me incrementally build my knowledge, skills, and confidence. I found that the more I immersed and familiarised myself with the dataset, the more confident I felt in analysing and interpreting the data.

The outcomes of the findings helped provide an understanding of the health outcomes of participants with ACEs. The research helped identify those in MSU are at a higher risk of poorer health outcomes to inform the service to consider designing better-tailored health interventions for higher-risk patients.

Qualitative Research:

For my qualitative research, I was keen to approach the Women's Pathway clinical team to discuss valuable research opportunities. During our conversations, it became apparent that understanding patients' experiences of cervical screening was necessary due to the sub-optimal uptake within the service. Therefore, I began exploring existing research on this topic and population. Qualitative research is my preferred research methodology and an area I feel more comfortable with, particularly data collection and analysis. I found designing my research an enjoyable experience but recognised the challenges and barriers faced with obtaining ethical approval within an NHS setting. There were several challenges and obstacles that I had to overcome,

and these were regularly shifting my intended timescales. Despite this, I developed a vast knowledge base about completing NHS research, which included the required process and applications. As part of the ethical review process, I was required to attend a meeting with the Research Ethics Committee (REC). This process enabled me to justify my rationale for the research, which I felt was a positive experience and demonstrated my research knowledge.

Nevertheless, having not previously conducted Interpretative Phenomenological Analysis (IPA), I found this daunting, but I completed additional reading about this approach to develop my knowledge and skills. This was incredibly helpful with the analysis and write-up stage, and being supported by supervisors during this juncture also facilitated the process. In completing my qualitative research, I learnt to plan research in an NHS setting, including negotiating ethics processes, which required high levels of organisation and communication. This research also helped me develop skills in the clinical and practical implications of academic research as I have been able to approach senior staff about the results of this research, including recommendations for service development. Together, we are considering how to implement changes to inform clinical practice to improve the uptake of cervical screening for this population through policy development, better bespoke support for patients, education and learning opportunities, and staff training to enable a trauma-informed cervical screening process.

Given my preferences and skills in qualitative research, as well as the questions I am interested in answering, I envisage and hope to complete more qualitative research alongside clinical practice. This research project has provided me with essential foundational skills and knowledge to continue with qualitative research in the NHS as a Health Psychologist.

Systematic Review:

For my systematic review, I completed a meta-synthesis exploring adolescents' experiences of social media for sexual and reproductive health information. Although I had not previously completed a systematic review, I had conducted several literature reviews, and I was able to draw on these experiences. A key challenge I faced was accessing several full research papers despite contacting authors. Unfortunately, this impacted the quality of my review and draft submission. However, I worked with

supervisors to develop a plan to improve the review's quality and identify a realistic timescale to make amendments for submission. Despite the challenges, I completed the systematic review and produced a meta-synthesis of the findings. This was new to me, so I have gained several skills in writing a proposal, innovative ways of obtaining journal articles, organising, and managing papers and conducting and writing-up a systematic review and meta-synthesis.

Since completing this systematic review, I have had an opportunity on placement to conduct a rapid review of reflective practice models with colleagues. Within this review, we used Rayyan to manage the papers, a software I did not use for my systematic review. I found this software aided with managing the process and is something I would use in future reviews I complete. In completing the review for the doctorate and on placement, I have developed my knowledge and skills in systematic reviews and data synthesis. Completing a review with a team of people was another new experience, and it allowed me to share responsibilities and tasks, which felt less isolating through an overwhelming project. Conducting a review is something I imagine doing in the future alongside colleagues. For example, after completing my doctorate, I plan to undertake a Health Psychology review on trauma-informed gynaecological examinations within the service.

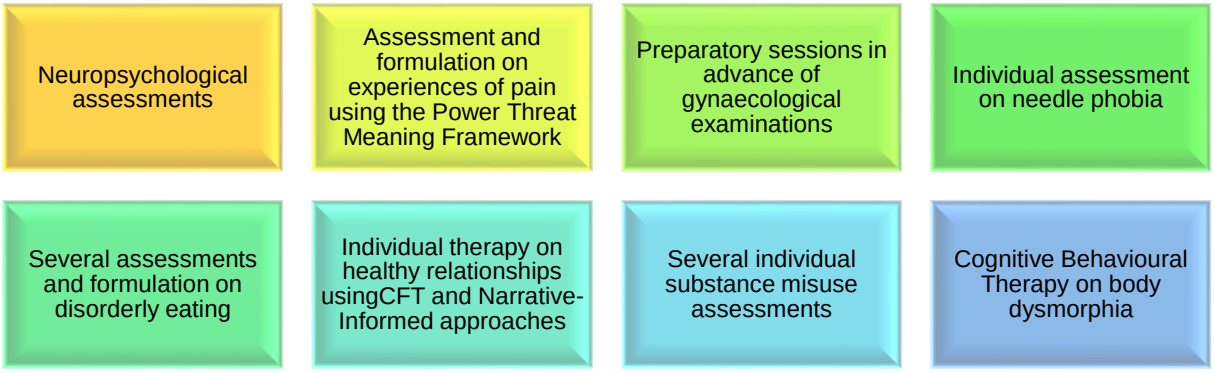
Psychological Interventions:

Health Psychologists often design, deliver, and evaluate psychological interventions at various levels. Before the professional doctorate, I had several years of experience completing psychological interventions. Therefore, this competency seemed the most familiar to me. As I was already working individually with patients, I was able to conduct psychological interventions based on client goals and a psychological formulation using a range of psychological models and approaches. However, having developed proficiencies in therapeutic skills to form a therapeutic rapport, these skills enhanced through training, and I developed a more comprehensive understanding of therapeutic endings to inform my practice.

During my training, I completed psychological interventions in various clinical presentations. My one-to-one case study included Cognitive Behavioural Therapy for a medically unexplained condition (Functional Cervical Dystonia), and I have since completed several psychological assessments and interventions (Figure 3). In

addition, for the non-face-to-face case study requirement of the Doctorate, I completed a group-based intervention using Cognitive Behavioural Therapy for Insomnia (CBT-I) for male patients in the Personality Pathway. I have also repeated this group intervention for the male psychosis ward. Other group interventions delivered throughout training include compassion-focused therapy, mental health psychoeducation, and a women's sexual and reproductive health group.

Figure 3: Examples of psychological interventions completed on placement.



Throughout the doctorate and on placement, with the above intervention, I have developed skills to complete more complex therapies with patients and use various psychological approaches. Before the doctorate, I was reasonably comfortable using CBT principles, which have strengthened through my Doctoral training. On placement, I have also had several opportunities to utilise other psychological techniques such as Compassion Focused Therapy, the Power Threat Meaning Framework, and Narrative Informed approaches, which have broadened my knowledge and application of psychological skills. My experience of Health Psychology models on placement has been amalgamated with other therapeutic approaches, allowing for an integrative approach that effectively meets complex patients' needs.

Consultancy:

Although I had not completed consultancy before my Professional Doctorate, I learned I could draw from my (transferable) clinical skills. These included my knowledge and application of Health Psychology, including psychological models, teamwork, planning, designing, and managing projects and interventions.

The focus of my consultancy for the professional doctorate was within the safeguarding team. The project was initiated following a national analysis of Safeguarding Adult Reviews (SARs) in England, which identified self-neglect as a significant factor in adult death (Preston-Shoot, Braye, Preston, Allen, & Spreadbury, 2020). Therefore, this was an important reason to understand clinical staff members' experience working with patients who self-neglected their physical health. An area that was novel to me was the development of a contract. It was beneficial having a taught session delivered by the University's legal team, which provided me with a template contract. In negotiating my consultancy, I learnt how to communicate clearly and fairly with the client and accurately represent our discussions in the contract. Getting the contract right helped to articulate the proposed work and timescale clearly. This meant the work was completed in a realistic timeframe and professionally. I regularly sought supervision when preparing my contract to ensure it was clear for all parties involved. Additional skills I gained from this process were mastering negotiation skills, which I previously struggled with.

Since this project, I have continued developing various consultancy skills. For example, when creating the contract, I learned how to write a transparent and fair document which was both useable and professional. I have recently used these skills when creating supervision contracts with new supervisees to ensure a clear and considered document is in place for the benefit of all parties. I also found that the skill of 'managing expectations' was an important skill to develop during the consultancy project, and I have used this in a variety of other contexts. For example, an external service approached our team to gain experience with how Health Psychology was implemented and requested assistance in identifying ways in which Health Psychology could be incorporated into their service, with a specific focus on the pain. As this did not have clearly defined parameters, my skills in setting boundaries and communicating allowed the external service's expectations to be managed appropriately.

Since completing my consultancy project, I have had other consultancy opportunities, such as the development of a CBT-I programme, Quality Improvement focusing on obesity and the implementation of a Women's sexual and reproductive health programme (Table 1).

Table 1: Continued opportunities and development of consultancy skills

Consultancy Opportunity	Description and Learning
CBT-I programmes	I was approached by a Clinical Psychologist to develop a CBT-I programme for patients with psychosis. Here I could understand and define the tasks while establishing the timeframe and resources available to complete the project and communicate about tasks I could not commit to. While developing a contract is recommended, this project did not utilise it as the consultancy was being completed within the same organisation as my placement and felt disproportionate. Despite this, I still thought that it was essential to maintain some form of a written agreement and follow the verbal discussion with an email. Therefore, I was able to transfer learning from my Doctoral consultancy experience to future opportunities.
Quality Improvement focusing on obesity	I have been a consultant on an obesity project within the service which formed as part of a Quality Improvement (QI) framework (NHS Improving Quality, 2014). This was a 'ground up' process which used a variety of professionals and service users to initially explore and understand a problem and implement change ideas to act as solutions. The project remains ongoing but focuses on reducing obesity within the forensic hospital, as overweight and obesity levels are high and contribute to other health inequalities (Johnson, Day, Moholkar, Gilluley, & Goyder, 2018). The initial stages of the project involved working with colleagues to establish factors within the service that contribute to patient obesity. I proposed using the COM-B model (Michie, van Stralen & West, 2011) to develop an organisation-based formulation to understand the issues, which would help inform intervention design. This allowed me to collaborate with colleagues and develop a broader understanding of the factors contributing to patient obesity within the service. Using the COM-B model (Michie, van Stralen & West, 2011) allowed me to demonstrate and apply my expert knowledge and maintain my understanding of this approach.
Implementation of sexual and reproductive health programmes for Women	Another opportunity was the development of a group intervention on Women's Health Education and Self-care, which I developed on placement. I extended this delivery by implementing this to the NHSHSW, a service within the same NHS Trust, following a request to support embedding it into their service. Here, I was able to develop further teaching and training skills and affirm the intellectual property rights of the programme to the founder service. I would have previously not had the confidence to discuss intellectual property rights with clients and likely avoided. I have since been approached by other organisations outside my NHS Trust requesting access to the programme, which is being discussed with the MDT in service.

Teaching:

The start of my doctorate saw significant challenges with COVID-19, resulting in my workplace postponing training opportunities for employees whilst they focused on patient care. As a result, I sought teaching and training opportunities in service capacities. I first delivered a three-session training package to dietitians working in forensic services, which was facilitated online. These teaching sessions taught me the importance of continuity among sessions and using Farrow's (2003) principles of LIGHT helped facilitate this.

Furthermore, I also delivered a session to BSc and MSc students at Staffordshire University. These were my first experience of academic teaching, which I initially found daunting. Since then, I have completed further teaching for MSc students on "Communication in Personal Protective Equipment" and "Applications in Health Psychology". During these sessions, I have developed the skills to communicate and teach different theories and models appropriately. My approach includes providing the information sequentially combined with examples to facilitate understanding of psychological models, which can be complex, with multiple components and overwhelming those without a psychological background. Within these sessions, I have developed good skills in theory-practice links. For example, clinical examples and case studies have demonstrated real-life applications, and I have regularly received positive feedback.

More recently, on placement, I have had several teaching and training opportunities (Table 2)

Table 2: Continued opportunities and development of teaching and training

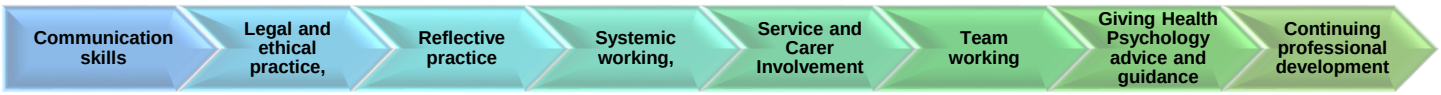
Placement Teaching Opportunities	Description and Reflections
Mandatory training	I regularly facilitate service-specific training on working with women in secure settings. This mandatory training, delivered to all new clinical staff members, has been valuable in maintaining teaching skills outside of professional doctorate competency.
Teaching on programme delivery	I have delivered a teaching session to colleagues within the NHSHSW on the theoretical backgrounds and facilitation of a treatment programme, Women's Health Education and Self-care. With the programme being new to the service, the session aimed to ensure learners understood the programme's content and felt competent in the delivery. Feedback from participants was positive. However, they felt a demonstration of delivering the group intervention would have been beneficial. If I were to provide the session again, I would consider including role play (in addition to the information shared on slides and through video) so that the participants could experience the process.

These teaching opportunities have provided me with a broader understanding of the theoretical aspects relevant to teaching. For example, developing my knowledge about different learning styles, Kolb's (1984) experimental learning cycle, and Bloom's (1956) taxonomy of educational objectives has informed my teaching practice and the importance of adapting my approach and tailing my design and delivery based on an assessment of learner needs. These have helped me develop alternative ways to write learning objectives and design and deliver sessions based on individual learning styles. The sessions have also developed my proficiency in online teaching while integrating technology into sessions. I have consistently struggled with time management. For example, I run out of time, resulting in the end of the session feel rushed towards the end or finishing much earlier than planned. However, I have improved my time management throughout training. However, ongoing monitoring of my time and practising timing beforehand in sessions remain a developmental need post-qualification.

Professional Skills:

In addition to completing the competencies discussed above, I developed various professional skills (Figure 4) to work as an effective Health Psychologist, as documented below.

Figure 4: Development of professional skills



Communication in different contexts:

Core to a psychologist's role is communication skills, including communication with patients, electronic communication, verbal communication, letter writing, report writing and dissemination of research findings (BPS, 2017). On placement, I have had several opportunities to develop my skills in all these areas. As a result, I feel that my skills in communicating with patients have developed in a variety of areas. This included:

- developing patient resources,
- collaborative psychological formulation,
- delivery of the therapeutic intervention, and
- end-of-treatment reports.

Here my communication was both written and verbal. Through training and on placement, it was important that my communication style was approachable and allowed patients to process the information in the context of their mental health difficulties.

Furthermore, my verbal communication skills were challenged and developed when working with higher-risk patients and completing psychological work through a locked door, with a small window allowing me to see the patient. This developed my skills in being precise, using simple language, and projecting my voice. It also developed my listening skills to respond to patients effectively. These experiences and the opportunities have enhanced my communication ability by working with people from various backgrounds. This included those with neurodiverse needs and different physical and mental health presentations. These experiences taught me about the

importance of diversity and enabled me to improve my clinical practice to become a more inclusive practitioner (Green et al., 2009).

Throughout COVID-19, my communication style with patients was challenged by the need to wear facemasks to manage infection control of the virus. The use of face masks when communicating with a patient with mental health difficulties can be challenging, resulting in patients:

- having trouble reading facial expressions,
- distrust or paranoia towards the therapist, disruptions in building connection,
- increased anxiety during therapeutic work, and
- easily misinterpreting information (Mehta, Venkatasubramanian, & Chandra, 2020).

This was further challenged when completing interventions in PPE alongside a translator . Therefore, I ensured I drew upon other approaches to compensate for my mouth being covered. This included using eyes, eyebrows, and appropriate body posture to communicate more effectively and improve patient comprehension, using head movement and voice inflexion in conversation, where possible, and using a clear mask to reduce visual sensory deprivation and aid with interpretation (Atcherson et al., 2017), wearing my name badge to facilitate trust and familiarity with patients.

<u>Development and Maintenance of Legal, Ethical and Professional Standards:</u>

Psychologists need to develop and maintain systems for legal, ethical, and professional standards (BPS, 2017; BPS, 2021; HPCP, 2021). I have had many opportunities to develop skills while working in forensic mental health services.

I was required to work within the legislation with forensic service patients detained under the MHA (1983, revised 2007). This included working within the principles of the MHA (1983, revised 2007), including:

(i) choice and autonomy,
(ii) least restrictive,
(iii) therapeutic benefit, and
(iv) treating people as individuals (BPS, 2019).

In addition to the MHA (1983, revised 2007), I was also required to work within the service's policies and procedures. This included accurate and timely documentation of clinical sessions, reporting of risk incidents, and safeguarding and appropriate information sharing (e.g., disclosures of unknown abuse or criminal activity). Alongside the MHA (1983, revised 2007), patients with a diagnosis of Intellectual Disability and autism spectrum disorder (ASD) are subject to Care Review Treatment (CRTs). Throughout my training, I have been involved in two CRTs for patients where I defended the psychological involvement and interventions, to a panel compromising of the lead/ chair, expertise clinician and expert by experience, for these patients by providing an evidence-based rationale.

Furthermore, as part of my qualitative research, a key consideration I had was protecting the anonymity of a minority participant (who identified as transgender). It was essential to be inclusive of their gender orientation while maintaining confidentiality. Therefore, I consulted with supervisors at the service and the Staffordshire University and equality, diversity, and inclusion leaders within the NHS trust on the most appropriate way forward. Following discussions, appropriate assigning pseudonyms and gender-neutral language was considered the most appropriate way forward in the absence of formal guidelines.

Finally, I also had the opportunity to participate in the services debrief process. This included working with clinical supervisors to support patients after witnessing an incident in the ward. I helped patients regain feeling psychologically safe while maintaining a trauma-informed approach to ensure patients were appropriately supported.

<u>Organisational and Systematic Issues:</u>

Working with a broader staff team within an MDT has allowed me to understand various organisational and systemic issues. This included understanding the differences in organisation and systematic working of an MSU and the NHSHSW (Table 3).

Table 3: Organisation and Systemic issues on Placement

Systemic/Organisation Issues	Description and Learning
COVID-19 and ways of working	On placement, COVID-19 caused significant systemic challenges, with guidance and ways of working regularly changing, which impeded the service's ability to provide consistency. This was also particularly complicated by the dissonance between the NHS and public restrictions. At times, I could only attend one ward a day to manage infection control of the virus across the service. This meant I had to complete all clinics for each ward in one day, which was exhausting. Although this situation was hard to prepare for, it was a shared experience between the psychology department. We collectively shared our experiences to find an appropriate approach to working that met service needs while maintaining our well-being.
Sub-optimal staff throughout the pandemic	Another organisation and systemic issue experienced were the implication of sub-optimal nursing staff levels. During the pandemic, various members of the psychology department, including myself, were redeployed to work on the ward to ensure patient safety. The need for ad-hoc cover continued, resulting in last-minute changes to the planned clinical activity of the day. Reduced nursing staff numbers, a national NHS issue, have resulted in less consistent support for clinical activities on the ward, e.g., group-based interventions. This has increased my caseload (e.g., more individual work), which reduced my capacity to ensure that I was adequately planning and reflecting upon my clinical sessions. While I do not feel this impacted my practice individually, the increased caseloads of the broader psychology department meant the quality of interventions delivered to the patients was negatively affected . While increases in caseloads and responsibilities are not a new concept within healthcare services (Bain & Baguley 2012), this and the increased clinical pressures are something I have observed more since starting in the NHS in 2014. As a psychology department, we reflected on managing workloads and maintaining high-quality psychological work. Therefore, the use of waiting lists was operationalised as a proactive solution. Furthermore, to monitor my practice and the quality of patient interventions, I regularly reflect on this matter in supervision and with the broader department.
Short nursing staff members	The depleted nursing staff numbers impacted the ward, causing a reduction in relational security and increased patient acuity levels, which has affected my practice. In these instances, I have had to offer more significant support to the broader nursing team and patients to make them feel psychologically safe and contained. While this has detracted me from aspects of my routine clinical practice and doctoral training, it has helped me develop my skills. This has included building and maintaining therapeutic relationships with staff and patients and being considered a reliable, experienced clinician in the service that can be consulted upon. It has also allowed me to develop my ability to exercise personal responsibility in complex situations in my professional practice.

Service User and Carer Involvement:

Service user and carer involvement is a core principle of trauma-informed care and an integral element of working within healthcare services (Rajabiyazdi et al., 2016). Throughout my training, I have engaged service users in various ways (Table 4).

Table 4: Reflections on Service User and Carer Involvement

Types of Service User and Care Involvement	Comments and Reflections
Teaching and Training	The involvement of service users in healthcare training is essential, allowing for teaching to be more applicable (Perry et al., 2012; Townend et al., 2008). While I had not directly involved any patients from the service in teaching sessions, I considered their contributions in other capacities. For example, in delivering a "communicating in personal protective equipment" session, I sought the patient experience of working with staff in PPE to include their voice in the training session.
Research	Another area I included service users within my doctorate was in research, as part of Patient and Public Engagement and Involvement (PPIE). For my qualitative research project, I had contributions from various sources during my research's planning and designing stage. I have learnt about the importance of service user contribution, which has benefited me in shaping my research and improving the quality and accessibility of my research documents. The lack of financial incentive and strain from the pandemic was barriers for voluntary services to engage. Therefore, ensuring research projects have sufficient money for PPIE is something I would consider for research grants in the future, as I value the importance of PPIE at all stages of the research. I have also included service user contributions in conference poster presentations . By including PPIE in a range of ways, I have learnt about the different forms of engaging in service user research
Clinical activities on placement	The final aspect I have included service users and carers is in the re-development of the service treatment model and several treatment programmes. For example, patient contributions to the programme name and content of a sexual and reproductive health group and patient's and carer's contributions, via focus groups, to the service's treatment model. These opportunities have allowed me to receive feedback on how approaches could use inclusive language to be more accessible to patients and care, especially the treatment model. These experiences broadened my experience and appreciation of service user involvement and enabled my colleagues and me in the service to make relevant changes while embedding health literacy principles.

Team Working and Leadership:

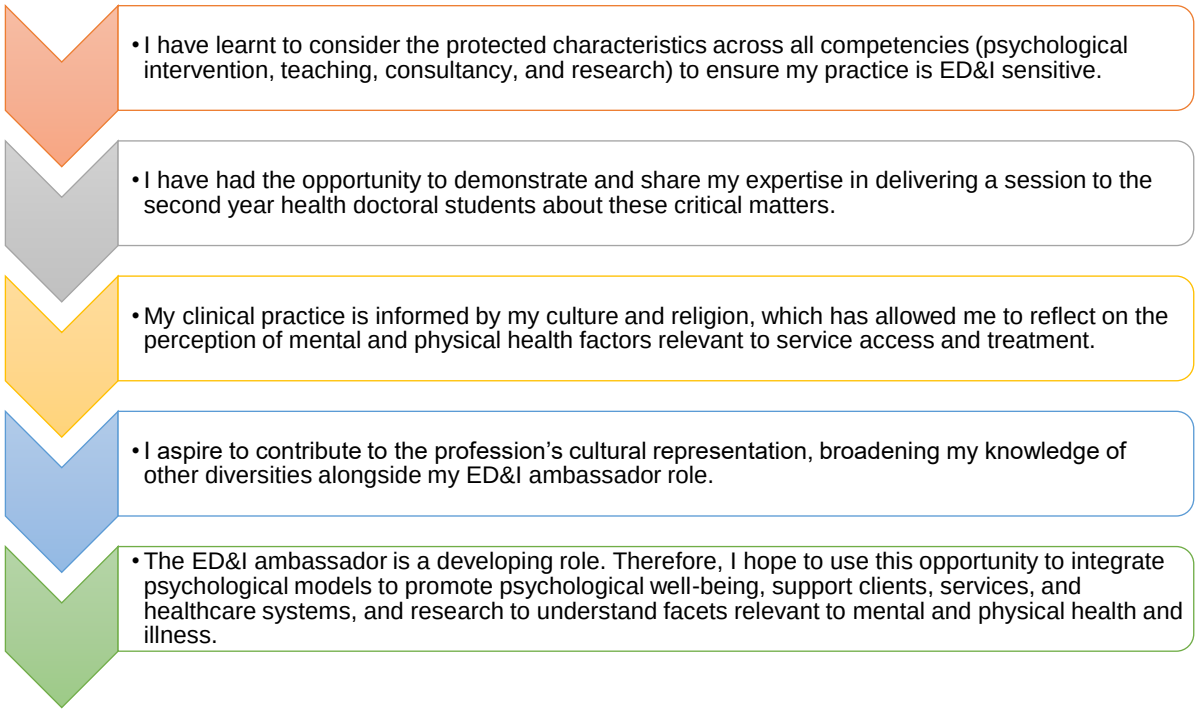
The role of a psychologist involves both teams working and leadership (BPS, 2017). The BPS suggests that "*contemporary leadership styles are generally more aligned to working with a team or system rather than being directive*" (BPS, 2017, pp. 15). I found this a valuable way of considering how psychologists can view leadership. When working at the NHSHSW, I was part of a wider psychology team of qualified psychologists, other trainee psychologists and assistant psychologists. Although not in a senior position, I was the only professional from a Health Psychology background. Therefore, I was depended on to provide guidance and support in embedding Health Psychology into the service. This involved additional responsibilities such as meeting attendance, supervision, reflective practice of others and managing my caseload. These responsibilities have further helped me work as an autonomous practitioner, especially in my final year of training.

In addition, I also developed skills in working in a team, especially in an MDT. Integrated as a clinician in the Women's Pathway clinical team, I had the opportunity to work with other professionals, Consultant Forensic Psychiatrists, Social Workers, Occupational Therapy and Nursing staff. On placement, I regularly attended ward rounds, Care Planning Review (CPA) meetings and core group meetings, offering a range of psychological recommendations and theories to help understand complex patient presentations or intervention recommendations. This included facilitating reflective practice sessions, disseminating psychological formulations, and working with colleagues to develop a team formulation. I worked collaboratively with colleagues and effectively communicated psychological principles to those without prior psychological knowledge. In addition, I presented a formulation during reflective practice, which was well received. I was subsequently asked to disseminate this at a team day to capture more nursing staff members. Through training, I have developed my ability to tailor and adapt my communication style when communicating psychological principles to the intended audience.

Furthermore, my leadership and team working skills are demonstrated through the Equality, Diversity, and Inclusion (ED&I) Ambassador position I hold in my workplace. This position is part of the broader forensic division. This involves working within the Trust values to provide support and guidance to the service, signposting, collaborating

with other organisations and championing ED&I matters. As a third-generation British Indian and Trainee Health Psychologist, I am passionate about ensuring ED&I in the profession, which has informed training (Figure 5).

Figure 5: Influences of ED&I on my practice



<u>Giving Health Psychology advice and guidance to others:</u>

At the start of training, I initially felt nervous about giving Health Psychology advice and guidance, mainly as it was a new form of applied psychology within the service. However, my confidence grew throughout training, evidenced by colleagues from my service and beyond actively approaching me for advice and guidance. This is in addition to service leaders recommending me to others.

Two situations where I gave Health Psychology guidance and advice was at a patient's CPA meeting where I made clinical recommendations which were both received differently:

- The MDT discussed a patient with a profound history of self-harm and periodically reported pain experiences. The self-harm and the pain were not considered separately, so I recommended a pain assessment, which was welcomed. This demonstrated the skills I have developed to communicate clinical recommendations confidently and effectively to other clinicians that are informed by my professional judgements on complex patient presentations.

- In another meeting, I suggested a pain assessment for a patient in the male service, but this recommendation was less well received. I learned the importance of building a case with a clear rationale for my advice, showing the reasoning and communicating the evidence-base which informed my recommendations.

In addition, I have also provided guidance and advice to clinical teams as part of reflective practice sessions. For example, two clinical teams approached me to facilitate a reflective practice session for patients with complex presentations (disordered eating and poor diabetes management). During these reflective spaces, I could provide staff with a reflective space to share their experiences working with patients with complex needs, using the Intersubjective Model of Reflective Practice for groups (Kurtz, 2019). This allowed reflecting on some of the challenges of nursing those patients while also integrating psychological principles and the COM-B model to develop shared formulations to facilitate their understanding. In giving health psychology advice and guidance, I have learnt about the importance of providing guidance in a non-judgemental and compassionate manner while integrating psychology models, as exampled above, in an approach that professionals without prior psychological knowledge can understand.

Throughout my training, I have been central in embedding Health Psychology into the service and the Women's Pathway MDT in the following areas:

- I wrote and delivered presentations to teams and departments,
- Being approached and advised about patient treatments and support with planning by a Consultant Psychiatrist,
- Women's health initiative from a Consultant Clinical Psychologist, including cervical screening, and
- I was approached for a secondment in the NHSHSW to embed Health Psychology.

Within these opportunities, my skills in communicating and providing Health Psychology advice and guidance have evolved as I have shifted across different identities in training. For example, going from Assistant Psychologist to Trainee Health psychologist and successfully obtaining a preceptorship Band 7-8a role upon

qualifying. This has enabled me to develop my confidence and capabilities to practise autonomously over time.

Personal and Continuing Professional Development as a Health Psychologist:

CPD is essential for psychologists to maintain and improve their professionalism and competence (BPS, 2017). The BPS (2017) encourages psychologists to engage in various types of CPD and apply the learning to professional practice.

Throughout my training, I have engaged in various short and longer-term CPD activities to support my learning. I have developed my proficiencies, skills, and knowledge in Compassion Focused Therapy at multiple junctures throughout my training. This has included attending training around the model more broadly and specific clinical presentations (e.g., eating disorder, psychosis, and pain management). I have also completed or am in the final stages of online training in other modalities, such as CBT, DBT ACT and Motivational Interviewing. Upon qualifying as a Health Psychologist, I recognise the need for CPD and have identified two areas for ongoing development (Table 5)

Table 5: Areas for future development

Areas for Development	Reflections and Comments
Supervision Training	I recognise my need to further develop my knowledge and skills in the delivery of supervision, as I will be regularly supervising Assistant Psychologists in my qualified position. Therefore, I will be completing Supervision and Clinical Leadership training programme for post-Doctoral students at the University of Leicester. I feel this will be a valuable developmental opportunity to support further.
Therapeutic Modality Training	I am exploring training opportunities to complete Eye Movement Desensitisation and Reprocessing Therapy (EMDR), which I can apply within my clinical practice when working with patients with physical and mental health conditions (e.g., trauma, pain, health phobias and anxiety). However, several accredited organisations have highlighted that Health Psychologists do not meet the eligibility criteria set by EMDR Europe, the National EMDR Association. I have found an organisation that recognises my volume of existing clinical experience and the appropriate EMDR supervision I would receive if trained in this modality. Therefore, I may be considered eligible. Although a frustrating position, it has provided me with valuable insights into the gaps in opportunities faced by Health Psychologists and my role to try and bridge these gaps I am soon to qualify. This has included notifying the Division of Health Psychology to encourage some change.

Conclusion

Completing the professional doctorate has been a valuable experience, both professionally and personally. It has provided me with core foundational skills and knowledge to practice as a Health Psychologist in the NHS. Throughout my professional doctorate, I have developed a great appreciation of reflection, both independently, in supervision and written. The opportunities provided on placement have been incremental in my development. Throughout my training, I have observed my confidence develop, and I have been given opportunities with increased responsibility and complexity to match the stage of my training. While I recognise areas for continuous development, I am keen to use the opportunities in my service and obtain CPD opportunities to develop my knowledge and skills and bridge gaps. In conclusion, I am enthusiastic to see what my future as a Health Psychologist will bring and how I will pave the way in forensic services.

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Chapter 2: Advanced Research Methods

2.1 Systematic Review Manuscript

How adolescents use and experience social media for sexual and reproductive health information: A systematic review and meta-synthesis.

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Abstract

Background:

Social media can be a valuable source of sexual and reproductive health (SRH) information for adolescents. Research to date has focussed on the impacts of social media on adolescents' SRH rather than conceptualising and understanding their experiences.

Aim:

This review aimed to synthesise qualitative evidence on (i) how adolescents use social media for SRH information and (ii) how adolescents experience using social media for accessing SRH information.

Method:

A systematic review and thematic synthesis of qualitative evidence.

Data Sources:

Seven databases (CINAHL Plus, ProQuest Dissertations, PsycINFO, PubMed, OpenGrey, Scopus, and Google Scholar) were searched between 2012-2022 for peer-reviewed papers published in English and research using qualitative methods.

Results and conclusion:

Ten studies met the inclusion criteria (adolescent aged 10-24 years, topic focused on social media and adolescent SRH, used qualitative methods and available in English). Participants ranged from 10 to 24 years of age and were recruited from social media, conferences, and local communities (e.g., schools and churches). Facebook was the most used social media platform, with Instagram and Snapchat also regularly reported in the studies. Through meta-synthesis, three themes were developed: "Motivation and intention to use online information"; "Social learning and exchange", and "Adolescent awareness and ability to assess resources".

Adolescents found it easy and convenient to access SRH information on social media. This allowed information to be accessed privately, away from parental supervision, which reduced feelings of embarrassment. Adolescents used social media for SRH, particularly around sexual behaviour and practice, as this was not readily available offline. The information accessed by adolescents allowed them to develop knowledge and understanding of sexual practices, behaviours, and romantic relationships. Social connectedness, reduced isolation, and sexual identity development were also highlighted as outcomes of social media engagement for SRH within the review. Adolescents' ability to recognise and respond to inaccurate information was also identified, impacting their sexual practices and romantic relationships. Therefore, information used to promote SRH on social media must be of high quality, evidence-based, and appropriate for the targeted age range of the population.

Introduction

Adolescence is characterised by rapid physical, emotional, and cognitive development (Erikson, 1966; WHO, 2023) between 10-24 years (Sawyer et al., 2018; United Nations, 2023). Within this period, social relationships become more significant as adolescents focus on developing their identity (Erkinson, 1994) and knowledge about health-related topics and behaviours as they transition into adulthood (Frech, 2012; National Academies of Sciences, Engineering, and Medicine, 2019).

Social media, defined for this review, is "*ubiquitous and intricately interwoven with the lives of people*" and includes web and mobile platforms allowing people to connect, share virtually, and co-create digital content such as information, messages, photos, or videos (Balt et al., 2023, p2). Adolescents most frequently use social media (Landry et al., 2015), meaning it can influence their social relationships (Livingston, 2008; Moreno, 2011) as the environment allows them to convey messages about their social identity globally and without being monitored by adults (Landry et al., 2017; Moreno & Kolb, 2012).

Given the ubiquity and popularity of social media, social media is considered a promising platform for delivering health information to adolescents (Lupton et al., 2021; Stockwell et al., 2012; Wong, Merchange & Morens, 2014). Specifically, there is a strong interest in using social media to disseminate positive sexual health information to adolescents (Condran et al., 2017; Hirvonen et al., 2021; Plaisime et al., 2020), as information on sensitive topics can be delivered discreetly to reduce adolescent's embarrassment (Farrugia et al., 2021).

Research has indicated interventions delivered via social media can increase sexual health knowledge, including condom efficacy, prevention of HIV and other sexually transmitted illnesses (STIs) and pregnancy (Aichner et al., 2021; Bull et al., 2012; Cassidy et al., 2019). Previous systematic reviews have found social media provides adolescents with easy access to information at a low cost and is a valuable strategy for promoting health interventions to adolescents (Park & Calamaro, 2013; Welch et al., 2016; Yang, 2017). Other systematic reviews have demonstrated mixed findings. For example, sexual and reproductive health (SRH) primary prevention strategies were ineffective in delaying sexual intercourse, improving birth control use, or reducing unplanned pregnancy in adolescents (DiCenso et al., 2002; Lameiras-Fernández et

al., 2021). In contrast, a meta-analysis found that sexual health promotion and risk reduction interventions delayed adolescents' initiation of sex and encouraged others to remove sex references from their public social media profiles (Guse et al., 2012). This appeared to influence psychosocial outcomes (e.g., condom self-efficacy) and increase adolescent sexual health knowledge; however, with only ten studies, this limits the generalisability of the findings. (Guse et al., 2012). However, another review found interventions increased adolescents aged 13-24, knowledge of preventing HIV and STIs and general sexual health knowledge (Wadham, 2019). While intervention outcomes improved with the frequency of intervention delivery and use of behaviour change models, findings were based on self-reports rather than objective behaviour change measures such as testing or service access (Wadham, 2019). Nevertheless, the variability in results across the years is unsurprising with the continuous developments in social media, including more features and functionalities, which will likely influence how adolescents use social media to access SRH information (Shaw et al., 2015).

Although social media platforms have several benefits, concerns about adverse health consequences have been highlighted. This includes the quality and accuracy of SRH information available and how adolescents engage with this, which reviews have sought to understand (Houlihan & Houlihan, 2014). For example, issues of trust in the social media platform, other users' behaviour, the quality of health content and adolescents' social identity are potentially essential influences on behaviour (Freeman et al., 2022). Adolescents' ability to recognise inaccurate information and question or appraise the quality of online health information is variable (Freeman et al., 2022).

This highlights the need to ensure that social media platforms share trusted SRH information which is high-quality and evidence-based, as up-to 80% of adolescents (N=5542) actively seek and access SRH information online (Mitchell, Ybarra, Korchmaros, & Kosciw, 2014). This was especially true for adolescents from sexual minority groups and those lacking access to alternative information sources (Mitchell et al., 2014). Given the benefits and risks associated with adolescent engagement in social media for SRH information, it is essential to develop a deeper insight into this population's experiences and influences on their knowledge.

Existing systematic reviews on social media and adolescents' SRH information have primarily focused on quantitative research, using meta-analysis or meta-narrative approaches (Guse et al., 2012; Saragih et al., 2021). Such reviews have demonstrated how SRH interventions delivered by social media in adolescence can increase engagement, be used as a preventative strategy, and be cost-effective (Park & Calamaro, 2013; Welch et al., 2016; Yang et al., 2017). Existing qualitative reviews have focused on how adolescents search for online health information and assess the credibility of the content (Freeman et al., 2022). Using qualitative studies, no published reviews have sought to understand adolescents' social media experiences for SRH information. Qualitative research ensures a rich exploration of acquired data while maintaining an in-depth understanding and experiences that may be overlooked in quantitative methods (Black, 1994; Pope & Mayes, 2020; Walsh & Downe, 2005). Thus, the proposed review can provide valuable insight into how adolescents experience using social media and how it influences their SRH knowledge.

This meta-synthesis draws together literature from qualitative studies to provide distinct analytical insights to generate new theoretical understandings of SRH experiences and knowledge for adolescents (Lee et al., 2015; Seers, 2012). Specifically, this synthesis seeks to answer the following review questions: (1) How do adolescents use social media for SRH information, and (2) How do adolescents experience using social media for accessing SRH information?

Method

This review was pre-registered with the International Prospective Register of Systematic Reviews (PROSPERO) database (registration number CRD42022357117).

Search Strategy

A systematic search of qualitative literature published between 2012–2022 was conducted using seven databases (CINAHL Plus, ProQuest Dissertations, PsycINFO, PubMed, OpenGrey, Scopus, and Google Scholar). Reference lists of included papers were searched for additional articles. This review focused on adolescents' subjective experiences of social media use for SRH information; therefore, the search strategy had keywords relating to adolescents, sexual health, reproductive health, and social media.

Study Selection

Studies were selected according to the criteria: sample, phenomenon of interest, design, evaluation, and research type (SPIDER; Cooke et al., 2012; Table 1).

[INSERT TABLE 1]

The first author screened all database searches and removed duplicate studies before screening titles and abstracts using the review's criteria. The first author retrieved and reviewed full papers and discussed with the second author, using the review criteria to ensure agreement. Where uncertainty remained, a third co-author was consulted.

Data Extraction

Data extraction, informed by Munro et al. (2007), was completed by the first author (supplementary information) with pertinent information summarised.

Assessment of Quality

The Critical Appraisal Skills Programme (CASP; 2014) qualitative checklist tool was used to assess the methodological strength and validity of results. This checklist contains ten questions tailored to qualitative research design to determine the primary sources' relevance and trustworthiness. Each study was assessed as 'low' (< four), 'medium' (five to seven) and 'high' (> eight) quality. The first author independently appraised each paper before discussion with co-authors.

Data Synthesis

Thematic synthesis (Thomas & Harden, 2008) of the key findings and conclusions was conducted by the first author in three stages: i) line-by-line inductive coding of the study's analysis section, including participant data (e.g., quotes) and discussion to ensure all relevant data was analysed to identify adolescents' experiences; ii) initial codes were organised into descriptive categories and iii) categories were interpreted to develop analytical themes. Themes were reviewed with co-authors to assess interrelationships, and conclusions were drawn to answer the research questions.

Results

Database searches returned n=2376 citations using the appropriate search terms. After screening (see Figure 1), duplicate articles were removed (n= 706), with n=1670

titles and abstracts screened (n=1643 excluded). Full papers (n=27) and reference lists (n=8) of included studies were screened for relevant literature. This review included 10 studies.

[INSERT FIGURE 1]

Study Characteristics

Table 2 summarises the studies included in the review. Studies were conducted in: Jordan (n=1); Brazil (n=1); Australia (n=2); Scotland (n=1); and the USA (n=5). One study completed in the USA also included a sample from Botswana (Cornelius et al., 2019).

Participants were recruited from the local community (n=3), conferences (n=1), social media (n=1) and flyers and posters (n=4). One study (Al-Shdayfat et al., 2019) used snowball sampling and provided no further details. The review covered topics such as general SRH (n= 4), sexuality and sexual identity (n=2), romantic relationships (n=1), HIV and STI testing (n=1), safe sex (n=1) and condom use (n=1). Four studies used Facebook specifically, whereas six considered social media platforms broadly. E.g., Facebook (n= 7), Instagram (n= 5), Snapchat (n=5), Twitter (n=3) and Tumblr (n=2).

The study's data collection approaches included individual interviews (n=2;), focus groups (n=7) and paired interviews (n=1). Individual interview sample sizes ranged between 30-96 participants, and the number of focus groups conducted ranged from 3-22. One study did not report the number of focus groups completed (Patterson et al., 2018). The total sample size in the review ranged from 19-96 participants, with one paper not reporting the overall sample size (Byron et al., 2013). This review included data from approximately 423 adolescents.

Participant's ages ranged from 13-24 (M=16.3yrs; SD=1.18). Participants mean age was reported in eight studies, and the standard deviation in five papers. Eight studies documented participants' gender as a mixed-gendered sample, and two included only male participants (Burns et al., 2021; Jones et al., 2019). Seven studies detailed participant gender as cisgender-male, cisgender-female, non-binary, transgender and non-identified. Two studies report participants' sexual orientation (Paceley et al., 2022; Patterson et al., 2018) as bi-sexual, pansexual, gay/lesbian, queer, and some preferred not to say. Five studies reported participants' ethnic backgrounds as White,

Aboriginal, African American, Southern African, Asian, Multiracial, Hispanic, other or preferred not state.

Qualitative analysis approaches across studies included framework Analysis (n=1); Grounded Theory (n=3); Abridged Method (n=1); Discourse Analysis (n=1); Thematic Analysis (n=2); and Netography (n=1). One study (Al-Shdayfat et al., 2019) did not report their analytical approach.

[INSERT TABLE 2]

Quality Assessment

Using the CASP tool, nine studies were assessed as " high " quality and one as "low" quality (Table 3). The study assessed as low quality (Byron et al., 2013) had insufficient information to allow 7 CASP items to be scored (five were assigned as 'cannot tell' and two as 'no').

[INSERT TABLE 3]

All studies provided clear information, allowing for ratings to be assigned for: the appropriate use of a qualitative method (question 2), appropriate recruitment strategy for the research aims (question 4) and considered ethical issues (question 7).

Across studies, the relationship between researchers and participants (question 6) was the most poorly rated CASP item. One study (Cornelius et al., 2019) provided sufficient information to receive a score for this rating. Three studies gave insufficient information, resulting in a "cannot tell," and the remaining studies (n=6) provided no information assigned a "no".

Thematic Synthesis

Thematic synthesis generated three superordinate themes and seven sub-themes (Table 4). Superordinate themes included: "Motivation and Intention to use Online Information", "Social Learning and Exchange", and "Adolescent Awareness and Ability to Evaluate Resources".

[INSERT TABLE 4]

Motivation and intention to use online information.

This theme reflects adolescents' social media experiences in enabling them to access SRH information at ease and privately, reducing feelings of shame and embarrassment. Subthemes include the availability of information, concealed engagement and improving content for continued use.

Availability of information

This subtheme reflects the volume and accessibility of SRH information available to adolescents on social media as a reason for using social media. The synthesis demonstrates how adolescents are actively seeking information on social media and expect to find certain SHR information when searching online.

Adolescents use social media daily and are considered "*more computer-focused, and people are more motivated [to seek SRH information], because they have access to information" (*Participant quote, Aragão, et al., 2018*).* Social media provides adolescents access to multiple sources of information compared to alternative offline sources, such as books. Facebook, Instagram, Twitter, and Snapchat were repeatedly reported as "*the source for everything*" (Participant quote, Byron, et al., 2013) and accessing SRH information through social media was easy, convenient, and comprehensive and engaged a large audience:

> *"Adolescents emphasised the convenience and ease of access to Facebook, given that this form of communication is widely known and used among them, it facilitated learning about sexual and reproductive health in the context of adolescence"* (Author quote, Aragao et al., 2018)

Using social media to find information and develop their knowledge about SRH was easier and faster within adolescent's home environment due to advanced access to smartphones:

> *"Use social media and the internet because it is available easily at home, on smart phones, and I can use it any time. So it is easier than books or stories" (*Participant quote*,* Al-Shdayfat et al., 2019).

As information was readily available to adolescents on social media, this allowed for "*more practical [ways] to learn [about sexual health] because young people spend half the time on social networks"* (Participant quote, Aragao et al., 2018*).* Findings specifically highlighted how adolescents use social media as an "*effective tool to disseminate campaign messages [about sexual health] …[through] Instagram, Twitter, and Snapchat*" (Author quote, Jones et al.,, 2019), with Facebook allowing "*users to provide and seek information through groups, post, or direct messages*" (Author quote,

Cornelius et al.,, 2019). Therefore, a reason to use social media was to obtain SRH information.

Findings highlighted how social media could engage adolescents with sexual health promotion and learning in a straightforward and informative manner without the need for extensive searching:

> *"It's just right there and so convenient. I think it would allow more people to access the information that they need."* (Participant quote, Byron et al., 2013)

This ease of access was essential for reducing the cultural barriers adolescents from sexual and ethnic minority groups faced:

> *'I come from a pretty conservative family, and I would not feel comfortable asking questions about certain things.' (*Participant quote, Berger et al., 2021*)*

Adolescents from ethnic communities or rural areas had fewer opportunities to obtain information offline. Therefore, their motivation to use social media was to reduce these barriers and access relevant SRH information:

> "*Very effective way, especially in our community and our culture of being an African American. The main thing that we use now is social media…It's how a lot of people get their information…You're actually getting the information right then and there*" (Participant quote, Burns, et al., 2021)

Furthermore, the LGBTQ community "*preferred receiving information on sex, relationships, and sexual health from…social media, due to its accessibility*" (Participant quote, Cornelius et al., 2019). For ethnic and sexual minority communities, social media provided adolescents with SRH information, bridging gaps in their knowledge to inform practice.

The review highlighted how adolescents actively sought information on the menstrual cycle, pregnancy, puberty, sexuality and sexual identity and "*expect to find knowledge about masturbation, sexual relationship…signs, and symptoms of puberty' (*Participant quote, Al-Shdayfat et al., 2019). This demonstrates how adolescents intentionally use social media to obtain SRH information.

However, adolescents reported the "*sheer quantity of content available as a barrier to effectively seeking sexual health information online*" (Author quote, Patterson et al., 2018). The quantity of available information created practical barriers and obstacles for adolescents to find relevant and accurate SRH content, which may be deterring adolescents from using social media:

> *"Some participants overcame these barriers with some effort, while others abandoned their searches in frustration" (Author quote, Patterson et al., 2018)*

An alternative to overcome this is related to the experiences of advertising and campaigns. For example, "*Twitter…could be used to deliver short powerful messages…for disseminating facts [about HIV] to broad audiences…by incorporating the filter feature*" (Author quotes, Jones et al., 2019). Advertisements on social media allowed adolescents to obtain SRH information efficiently and accessibly without actively having to search for information themselves:

> *"Facebook advertisements were also considered worthwhile…because people don't really go looking for it unless it comes straight at them.*" (Participant quote, Byron et al., 2013)

Therefore, campaigns and advertisements on social media were considered attractive in effortlessly allowing access to SRH information and a reason to use social media.

Concealed engagement

This subtheme reflects adolescent reasons for using social media, including accessing SRH information discreetly and away from parents, which is essential in reducing embarrassment and shame.

Adolescents were concerned and feared others knowing of their engagement with sexual health content online which impacted how they used social media:

> "*I know people who have looked it up, but they find it really uncomfortable and have to delete their history and make sure they're home alone* "(Participant quote, Byron et al., 2013)

Concerns about others becoming aware of their searches, as above, influenced how adolescents engage online. For example, adolescents were less likely to like a page or share content with peers, were scared to use videos and erased or terminated searches following engagement, especially sexual health, due to potential embarrassment or stigma associated with this content.

Private and discrete daily use of social media was facilitated by activating social media settings to *ensure "limits on who can access information published in their profiles*" (Author quote, Byron et al., 2013). Hiding their identity, including using fake names which, was found to be significant "*when they [adolescents] are discussing risky health topics*" (Author quote, Burns et al. 2021):

> "*I think it's better if it's anonymous because I don't think everyone's really comfortable about talking about that kind of stuff [sexual health] with random [people]...It's something they want to keep to themselves*" (Participant quote, Byron, et al., 2013)

This shows the negative perception of engaging in sexual health content, and discretion allows adolescents to feel more comfortable with online content. Additionally, social media helped reduce experiences of embarrassment:

> *"I support it because one can get the great information without shame"* (Participant quote, Al-Shdayfat et al. 2019).

This private way of accessing SRH information on social media without shame and humiliation, as above, meant adolescents felt more comfortable, less embarrassed and a reason to use social media to access information.

Adolescents also reflected their parents are often "*embarrassed to talk to their children [about sexual health]" (*Author quote, Aragão et al. 2018) or adolescents feel "*that it was not safe to approach parents*" (Participant quote, Berger et al. 2021), especially around sex or gender identity. Therefore, social media allows access to information about SRH issues that otherwise were less discussed, away from parents and privately. This includes adolescents actively avoiding the social media platforms their parents use:

> "*Switching to Instagram in the United States is because their parents are on Facebook, but not Instagram*" (Author quote, Cornelius et al. 2019)

This suggests parental presence on social media sites may impact how adolescents obtain SRH information. However, other adolescents appeared less concerned about their privacy being compromised:

> "*...No one's going to go on a search engine and see that you've looked up herpes or chlamydia, or something"* (Participant quote, Byron et al. 2013)

Improving content for continued use

This subtheme reflects adolescents' suggestions for improving SRH content to enable further accessibility of information, enhance their social media experiences, and motivate ongoing use.

Adolescents recognised that different social media platforms would reach different demographics:

> "*…Twitter, IG [Instagram], or Snapchat would be better to reach [young] people. I think if you are trying to reach old people, or older than we are, then FB [Facebook]. I think they would see it better than we do. And getting a lot of people who have a lot of clout in the community…posting something out there or on their own website*." (Participant quote, Burns et al. 2021)

The above quote highlights the importance of information on platforms this population uses for accessibility. Furthermore, adolescents are aware of the influence of the person sending the message and people valued by the target demographic are more trusted and have a wider reach. Adolescents also identified the importance of the presentation of SRH content:

> "*The use of pop-up ads as ideal because each ad appears for a minimum of six seconds, an efficient means of allowing viewers to decide whether they wish to continue watching or "skip" the ad."* (Participant quote, Burns et al. 2021)

The brevity of advertisement was considered valuable in effectively delivering information. This is because it allows adolescents to access SRH information quickly, with the fleeting nature of the advertisements reducing the likelihood of being seen engaging with SRH content.

Adolescents felt the language used in SRH information was crucial as *"some of them (websites) were more detailed and more medical words…they don't know like big long words* (Participant quote, Patterson et al. 2018) and "*would not read the messages if they were too long*" (Participant quote, Burns et al. 2021). This increased adolescents' chances of disengaging from social media. Suggestions for improvement included "*messages lighter in tone may persuade more individuals*" (Participant quote, Jones, 2019), "*short and to the point*" (Author quote, Cornelius, 2019), which are "*kept… really simple"* (Participant quote, Byron et al. 2013):

> '*On Instagram or Snapchat or something I might—I'm just uh imma catch that, it's gonna catch my eye and everything*" (Participant quote, Jones, et al., 2019)

The emphasis on brief, attention-grabbing and visually engaging content was important in motivating and maintaining adolescent engagement with SRH content on social media. Varying the message format and an appealing information design was also essential, which could be facilitated by using captions and memes:

> "*I think the picture of the guy fishing; it's simple: 'Have you caught anything lately?' It's just one line and a picture. It has got a bit of comedy to it, it's not as serious*." (Participant quote, Byron et al. 2013)

As represented above, humour allowed for a relaxed and comfortable engagement, particularly when initially looking at SRH information. However, adolescents felt achieving a balance between the humour and the light tone of language was crucial in not undermining the content's significance.

Furthermore, using celebrities was identified as increasing engagement:

"*Funny YouTube videos featuring celebrities or politicians…"poking fun at them- selves" by talking about having STIs or going for a sexual health check-up*" (Participant quote, Byron et al. 2013)

While using celebrities, meaningful to the adolescents was seen as essential to entice this population to see a message, adolescents were more engaged when content "*focused on whether the messages or pictures seemed real to them*" (Participant quote, Cornelius et al. 2019). This was particularly relevant for ethnic groups who suggest content that was stereotypical to ethnic groups "*would not take the messages seriously* (Author quote, Burns et al. 2021). Therefore, emphasising information should incorporate diverse populations from various communities.

Overall, any changes made to motivate or maintain adolescent's use of social media for SRH information should incorporate adolescent's "*clear preference for sexual health information that did not implicate users and… outing their sexual health status or sexual activities*" (Author quote, Byron et al. 2013).

Social learning and exchange

This theme focuses on the interactions and engagement with other adolescents on social media, with subthemes representing a shared understanding and connection and educating and dissemination knowledge.

Shared understanding and connection

This subtheme highlights how accessing SRH information through social media can increase adolescents' social connections and reduce isolation.

Adolescents use social media to form connections, with platforms such as Facebook allowing its members to create online spaces for users to interact. This includes private groups to discuss and learn about SRH matters. The features of direct messaging helped form friendships online:

"*I do go on Facebook…Twitter… I've always done that though. I've always tried to look for more people who identify as LGBT, just because I feel like I'm so comfortable around them."* (Participant quote, Paceley et al. 2022)

For adolescents from sexual minorities (e.g., LGBTQ), social media was a space to find relevant information and connections with adolescents like themselves.

"We gravitate towards each other and the group is set up to be a safer space for everyone, it's a really nice space and you can talk about anything' (Participant quote, Berger et al. 2021).

These connections allowed for a shared understanding and development of sexual identity and reduced isolation adolescent experience:

> *"a really good tool for socially awkward people to not feel isolated"* (Participant quote, Berger et al. 2021)

Adolescents from the LBGTQ community found social media a safe space where they could seek and find support that's unavailable to them offline:

> *"Our community [LGBTQ] is more vulnerable [to discrimination] in the world so we're going to turn to social media for support with one another"* (Participant quote, Berger et al. 2021)

This demonstrates the protective elements that social media can provide adolescents when accessing SRH information, particularly content on sexual identity. Adolescents experience social media as favourable to discussing sensitive topics, sexual experiences, and sexual identity. It was felt "*without social media, [conversations] probably would not be so open, social media means that you're open to a whole lot of conversations that you weren't going to have face-to-face*' (Participant quote, Berger et al. 2021)

Nonetheless, complicated online interpersonal interactions were recognised and managed by adolescents:

> "*An advantage to establishing friendships online was that if it felt unsafe, emotionally or physically, it was easy to distance oneself from the other person, which would be more challenging in person*" (Participant quote, Paceley et al. 2022).

This ability to quickly terminate online interactions and connections with others was seen as a positive. However, problematic interactions on social media were also identified, including gossiping, discrimination and stigmatisation about sexual health and sexual identity, meaning adolescents cautiously engaged and shared content. While those who "*had experienced stigma in social media groups reported leaving and joining a smaller*" (Author quote, Berger et al. 2021), other adolescents terminated social media use leading to social isolation.

Educating and disseminating knowledge

This subtheme focuses on how the online environment facilitates the acquisition of SRH knowledge for adolescents. This includes how adolescents appear to be educating themselves and each other through interactions with learning informing their sexual behaviours and practices.

Adolescents felt they had insufficient knowledge of SRH issues and were using social media to access SRH information and resources to develop their understanding of sex, relationships, sexual health, and sexual identity. Their knowledge developed through group communications (e.g., commenting on posts) and sharing or creating resources and videos on social media:

> *"I was very self-taught; I watched a lot of YouTube videos. It taught me a lot about the myth about popping the cherry and the violence behind virginity, I learned most of my safe sex practices through there*" (Participant quote, Berger et al. 2021)

Although there was fear and embarrassment if others became aware they were using videos, some adolescents found this a positive tool for developing knowledge:

> "*I was able to clarify all issues…I know that having sex without a condom can bring several risks to my health. I hope you do not remove this group from Facebook* (Participant quote, Aragão et al. 2018).

This provides adolescents with opportunities to acquire knowledge with accurate information and to clarify their understanding, including "*getting them better educated for their own safety and protection [for sex]"* (Participant quote, Burns et al. 2021). This demonstrates how social media can help inform and harvest support for interventions to promote health information and behaviours for sexual safety. Especially as adolescents appear "*receptive to the idea of using social media for the delivery of safer sex information*" (Author quote, Cornelius et al. 2019).

Information around sexual identity was linked to accessing sexual health information:

> *"Lizzy was looking for sex education pertaining to her SGM [sexual gender minority] identity"* (Participant quote, Paceley et al. 2022)

Adolescents use social media to explore information and inform their knowledge and practices about sexual health, and sexual identity, especially those from the LGBTQ community.

Adolescents were motivated to continue using social media to develop their SRH knowledge. This population are already emersed in the digital world and experiences the online environment for learning as "*pleasant, contributing to an increase in their [adolescent] autonomy, seeking to know what is relevant"* (Author quote, Aragão et al. 2018) to them. In addition, adolescents emphasised the significant opportunity social media provides in independent learning and from others:

> *"They are multipliers of the knowledge acquired in the Facebook group, since they can pass on the information taught to their peers" (*Participant quote, Aragão et al. 2018)

This encompassed sharing information and receiving more information and explanation, including about sexual health and sexually explicit content, without shame. Subsequently, the acquisition of knowledge allowed adolescents to perceive that *"within a couple of weeks have been brought up to speed*" *(*Participant quote, Berger et al. 2021*)* and felt *"because we had never learned things…we can teach others, by interacting more with people* (Participant quote, Aragão et al. 2018*).* Therefore, this bridges their knowledge and demonstrates the benefits adolescent's experience.

Despite the favour of peer learning, the review highlighted issues such as misunderstanding information or stigma of adolescents sharing information and knowledge:

> "*even when you are posting things to educate people, there are still those other groups and individuals that may take it in another way*" (Participant quote, Burns et al. 2021).

Nevertheless, strategies to reduce stigma and maintain the value of shared knowledge by adolescents included "*private dissemination of sexual health information…sending a private message rather than messaging a public wall*" (Participant quote, Byron et al. 2013). This reduced concerns of associated stigma with specific content (e.g., sexual health and sexual practices) or other adolescents misinterpreting information while upholding peer learning.

Adolescent awareness and ability to evaluate resources

This theme encapsulates adolescent's interpretations of information and the impacts of misinterpreting on their knowledge and sexual practices and behaviours. Sub-themes include Interpretation and responding to information and Impacts of misleading portrayals of sex and relationships.

Interpretation and responding to information

This subtheme highlights adolescents' experiences and interpretations of SRH information being portrayed as inaccurate, inappropriate, misleading, or misused by

others. Adolescents also perceive the social media environment as encouraging certain behaviours, covering how adolescents maintain their online safety and information awareness.

The review highlighted the quality of SRH information can be inaccurate and inappropriate to the population age-range impacting how adolescents trust SRH information:

> *"Negative relationship representations were often questioned as potentially inaccurate or designed to keep audiences interested. However, media representations of positive relationships were also viewed with scepticism and sometimes assumed to be performed rather than genuine." (Participant quote, Kulkarni et al. 2019)*

Adolescents reported scepticism, particularly about sexual health and influences on sexual practices. The uncertainty of information about sexual practices stemmed from messages, pictures, and videos with "*actresses, actors, scenes, and dialogues did not seem realistic to them*" (Participant quote, Cornelius et al. 2019) or "*social marketing campaigns [on HIV testing] did not resonate with them [adolescents]"* (Author quote, Jones et al. 2019). Therefore, suggesting more "real-life" information would reduce scepticism.

Findings also showed how adolescents could misinterpret information about sexual practices and behaviours on social media. This misinterpretation appears due to adolescents taking "*it the wrong way because of their mindset."* (Participant quote, Burns et al. 2021), their "*lack of awareness of topics"* (Author quotes, Jones et al. 2019) or other adolescents undermining the information:

> "*There are a lot of clever people out there that can manipulate things really easily and in really funny ways and just turn things into huge jokes*." (Participant quote, Byron et al. 2013)

As highlighted above, others devaluing content through inappropriate use may negatively impact adolescents' understanding of SRH issues and practices. This could be managed through embedding humour into SRH content:

> *"Whereas if you are already making the jokes about it, people aren't going to take it and make jokes about it because it is already funny" (Participant quote,* Byron et al. 2013)

The use of humour, as identified in an earlier theme, reduces information being ridiculed due to the pre-existing light-hearted nature of the content. Adolescents also proactively managed inaccurate information and the negative behaviours of others when they recognised it. Their response included "*focusing on…free access to*

accurate information, silencing the haters, putting their partners' needs first, being a leader, and supporting…their own health" (Author quote, Burns et al. 2021).

Adolescents acknowledged that social media platforms provided them with a range of SRH information but were less likely to use *"information was mostly shared [by peers] via posts and comments*" (Author quote, Berger et al. 2021) due to not trusting the content. Instead, adolescents engaged in targetted SRH promotions, suggesting this population is aware of trustworthy online sources of SRH information. In addition, adolescents felt it was essential to be mindful of specific websites or social media where they could access relevant and accurate information and use "*the internet to find out about and access resources in or near their communities"* (Participant quote, Paceley et al. 2022). This would also combat accessing inappropriate information and reduce opportunities to receive incorrect information.

Adolescents remain motivated to use social media for SRH information despite concerns about their ability to appraise and misrepresent information. Further considerations included the appropriateness of the environment and content available:

> *"The majority of the participants supported initiating a website to provide them with the essential RSH [reproductive sexual health] information although some…are afraid that these sites are inappropriate for children who may accidentally open it"* (Author quote, Al-Shdayfat et al. 2019).

Whilst access to information without parents' knowledge allowed for privacy, parental and adult supervision could maintain adolescent safety, ensure accurate information, and manage unhelpful interactions (e.g., discrimination and bullying). The review highlighted the need for some oversight and regulation as it was considered that "*unmonitored internet use may place adolescents at significant risk of unreliable and incorrect information*" (Author quote, Al-Shdayfat et al. 2019):

> *'it is not good for teenagers to have this much authority…sometimes lines are crossed…the admin [group administrators] are still just teenagers like the rest of us, they usually just see it and…It just gets swept aside'* (Participant quote, Berger et al. 2021)

This emphasises the vital role of social media administrators in managing content available on social media and monitoring groups to combat concerning behaviours.

Impacts of misleading portrayal of sex and relationships

This subtheme focuses on how adolescents have been exposed to information about romantic relationships on social media when accessing SRH information, influencing their perception of romantic relationships and sexual behaviours.

The representation of romantic relationships included commitment, infidelity, abstinence until marriage and illustrations of sexual practices and behaviours. Adolescents reported, *"I feel like…their relationship is based on the media; you follow that exact image and [do] not have your own" and "you try to force that social media relationship…onto your relationship."* (Participant quotes, Kulkarni et al. 2019). This suggests adolescents replicate behaviours from online relationships offline.

The lack of commitment celebrities portray in relationships on social media suggests unfaithful behaviours are acceptable, which concerns adolescents. The review also highlighted how social media offered conflicting sexual behaviour depictions and expectations, with adolescents describing this portrayal as influencing their sexual practices:

> "*you're required to have sex" and lead males' partners to expect "a lady in the street and a freak in the sheets."* (Participant quote, Kulkarni et al. 2019)

As highlighted above, the portrayal of romantic relationships on social media was reported to influence adolescent sexual practices and behaviours. This included normalising being sexually active, dating multiple partners and unsafe sexual practices within relationships:

> *"Adolescence is a period of risk-taking and with significant peer pressure. Because we are followers… No one is thinking individually, so if everyone else is doing it [sex] so you just do it too."* (Participant quote, Cornelius et al. 2019)

In contrast, waiting until adolescents were ready was empowering views shared:

> "[*adolescents] did not express negative views about sexual activity, but rather appeared more supportive of sexual activity that occurred when adolescents were emotionally ready and preferred media relationships that promoted this message* (Author quote, Kulkarni et al. 2019)

The review also identified how the portrayal of romantic relationships influences adolescents practising safe sex:

> *"Because they aren't getting tested, they are just going around sleeping with people and getting infected."* (Participant quote, Cornelius et al. 2019)

The emphasis on multiple sexual partners and limited use of preventative healthcare (e.g., condom use), as noted above, suggests adolescents are avoiding engaging in

sexual healthcare, e.g., sexual health testing. This indicates the portrayal of romantic relationships may harm adolescents' sexual practices.

Discussion

This meta-synthesis sought to explore adolescents' experiences of social media for SRH information. Nine studies were identified and assessed to be high-quality. The themes identified represent the experiences and interpretations of participants in the included studies and captured three superordinate themes: “Motivation and Intention to use online information", "Social learning and exchange", and "Adolescent awareness and ability to evaluate resources".

Consistent with previous research, this review highlighted adolescents' use and experience of social media for SRH information because it is convenient, easy, and accessible (Park & Calamaro, 2013; Welch et al., 2016; Yang et al., 2017). For adolescents, accessing information was considered a practical way of developing knowledge. Privacy and discretion were important features as adolescents felt it was essential to access information without being seen by others, including parents. Privacy of the online environment further created an opportunity to access and learn about SRH topics without humiliation. This is consistent with previous research highlighting adolescent's concern about others knowing their access to online sexual health information (Bailey et al., 2015)

The review found that adolescents communicate, share, and express themselves on social media, allowing for an interactive experience facilitating their learning of SRH matters. Using social media for sexual health information promotion for adolescents has the potential to capture, target, and reach a large audience as technology is popular among this population (Plaisime et al., 2020; Selkie, Benson & Moreno, 2011). As adolescents actively seek information on social media about sexual behaviour and romantic relationships, this provides a reason to disseminate SRH information to adolescents via targeted social media interventions to facilitate learning (Wadham et al. 2019). Furthermore, adolescents suggested ways to improve and maintain social media use, including information on social media platforms frequently used by this population, integrating information into advertisements and using simple and engaging language while enabling privacy.

Adolescence is well understood as a pivotal developmental stage for identity formation (Boyd, 2014; Erikson, 1968). This population routinely finds it easier to express themselves online than face-to-face (Freeman et al. 2022; Smahel et al. 2020). Identity development and social connections were additional benefits this population experienced when using social media to access SRH information. Adolescents experienced greater social connections, and reduced isolation, allowing for shared space and experiences, especially for adolescents from sexual minority groups. Therefore, social media sites provide adolescent opportunities for individual and group identity exploration as this population negotiates relationships within and between different communities and social contexts online (Boyd, 2014; Freeman et al., 2022).

Relationships, sexuality, and sex are central to health and wellbeing, and adolescence is a period of learning and exploration, especially sexual identity (Kar et al., 2015; Mitchell et al., 2021). Therefore, it is essential to focus on the positive elements of sexual health education while adolescents access information and resources, allowing them to experience fulfilling, pleasurable sexual lives (Bleakley et al., 2009; Philpott, Knerr & Boydell, 2006). This is particularly relevant to adolescents, as highlighted that social media interaction allows them to develop their knowledge and behaviour around sexual practices by teaching themselves and sharing knowledge with other adolescents.

Research has found adolescents' ability to recognise and appraise the quality of online health information was inconsistent, identifying the need to improve skills to search and appraise sexual health information on social media (Freeman et al., 2018). This review highlighted factors such as scepticism, knowledge uncertainty, and recognition of the misportrayal or misrepresentation of SRH information. Adolescents in the review, could misinterpret information on social media (e.g., around sexual practices) or information appearing as not realistic, meaning information did not resonate. Consistent with previous research, concerns about social media providing inaccurate information may increase health-harming behaviours and discussions, especially without appropriate parental monitoring (Bailin et al., 2014; Houlihan & Houlihan, 2014). This influenced adolescent sexual attitudes and behaviours, e.g., pressure to have sex, partner's expectations about sex, multiple sexual partners, or unsafe sexual practices.

There is also the recognition that for sexual health information to be effective in engaging adolescents, the information on social media must be of high-quality and include evidence-based content (Wadham et al., 2019). Without this, there is the potential risk of social media contributing to spreading inaccurate information (Freeman et al., 2022). This review also demonstrated how adolescents intentionally used and accessed information on social media to evade parental and adult responsibility. However, with increasingly easy access to the internet, concerns about adolescent safety online (e.g., exposure to sexually explicit content and grooming) have been highlighted (Bailey et al., 2015). The review highlighted the need for appropriate social media content tailored to the adolescent population, which could be achieved by adult supervision and industry regulation.

Implications

Internet access in the UK is almost universal among adolescents at home or school (Mascheroni & Ólafsson, 2014; Odgers, Schueller & Ito, 2020). Thus, sexual health interventions can be made more freely available online. While this review only included one study completed within the UK, the themes highlighted the potential to use social media to disseminate SRH information and create targeted interventions for this population. With a volume of applications and programmes available for health problems, far fewer are available for sexual health or failed to attract user attention and positive reviews (Bailey et al., 2015). Therefore, social media is a feasible way to capture adolescents through digital interventions or health promotion campaigns (Chandra-Mouli, Lane, & Wong, 2015; Engel et al., 2019; Salam et al., 2016). This would enable SRH promotion of provided to adolescents to develop knowledge using accurate and appropriate information while encouraging engagement with sexual health services (Chandra-Mouli, Lane, & Wong, 2015; Engel et al., 2019; Salam et al., 2016).

Limitations

This review had several limitations and recommendations for future research such as only a small number of included studies, the wide age-range used, issues relating to the advance in social media developments and the impacts of the pandemic:

Limited number of studies:

This review captured studies completed in different countries, and with participants from different socioeconomic position and sexual orientations, as well as including a range of SRH issues. However, due to the small number of papers in the review, comparisons and a broader understanding could not be synthesised. Therefore, future research exploring adolescents understanding of their social media experiences relating to SRH information in the context of different participant backgrounds is recommended.

Wider age range of adolescents:

This review only included studies published in English and focused on adolescents aged 10-24. With the broad age range of adolescents, there may be a difference in social media experience and knowledge of SRH for younger and older adolescents. This may be because older adolescents are transitioning to young adults (Frech, 2012; National Academies of Sciences, Engineering, and Medicine, 2019).

Advances in social media:

The review included papers published between 2012-2022 which captured a considerable innovation in social media and social context (Hunter et al, 2019; Shaw et al, 2015), meaning social media had more functionalities than previous. This review recognises these advances in social media may influence how adolescents use social media for SRH information, with the abilities on social media constantly changing.

Impacts of the pandemic:

This systematic review was conducted following the COVID-19 pandemic but did not include any papers specific to COVID-19. The COVID-19 pandemic has increased interest in and understanding the online landscape's influence on health (Booth & Trauth, 2019; Li, Guan, Hammond & Berrey, 2021; Song et al., 2021). Therefore, a specific review considering social media and the impacts of the pandemic on adolescents' SRH would be recommended.

Conclusion

The findings from the review demonstrate the potential of social media to provide adolescents with access to information about SRH conveniently and privately. Future

health promotion practices and research should ensure the information on social media is accurate and of high, age-appropriate quality. This is mainly because adolescents intentionally wish to avoid adult supervision. Further research on understanding the influences of the pandemic on this population and their experiences of social media for SRH information is needed.

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Figure 1: Literature Screening Process

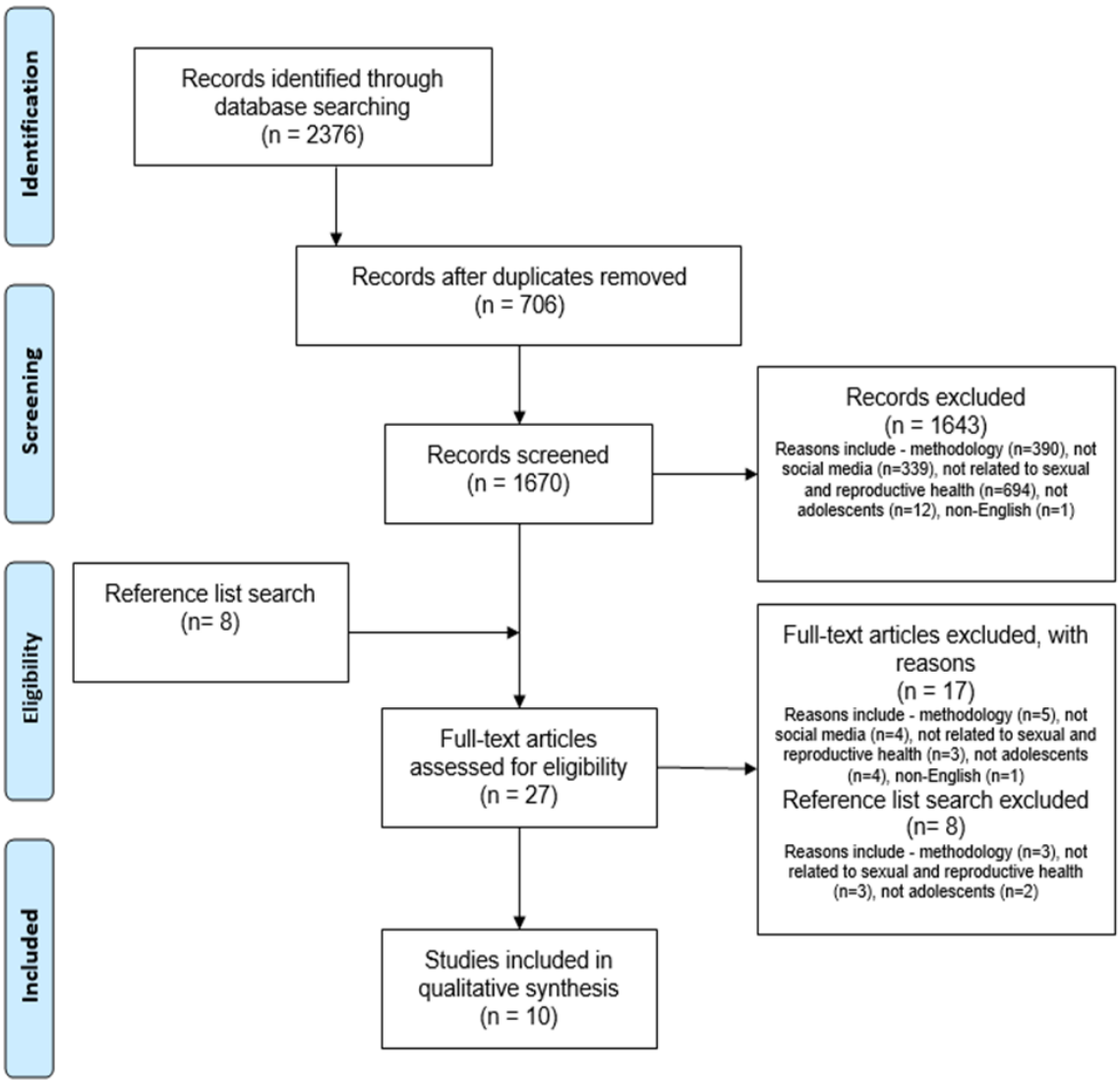


Table 1: Inclusion and Exclusion Criteria

	Inclusion for study	Exclusion for study
Sample	Adolescent was defined as those aged 10 to 24 years (Sawyer, 2018; The United Nations, 2023) and only studies reporting samples within this age range were included.	Adults aged >24 years Children aged <10 year
Phenomena of Interest:	Papers which focused on social media and SRH were included. Social media was defined and included web and mobile platforms and allows people to virtually connect, share, co-create, or exchange digital content. This might consist of information, messages, photos, or videos (Balt et al., 2023). E.g., Facebook, Instagram, TikTok, Snapchat, Twitter, YouTube). For this review, SRH focuses on reproductive health (e.g., managing menstruation) and sexual behaviours (e.g., contraception, planned and unplanned pregnancy, safe termination, and sexually transmitted diseases, including blood-borne illnesses). In addition to social media experiences, attention was also given to online sexual safety (e.g., sexting and picture sharing).	Studies that did not include the use of social media Studies not focusing on sexual and reproductive health issues.
Design	Studies that use 'Big Q' qualitative data generation methods (e.g., interviews, focus groups, diary methods, or social media content analysis) and data analysis approaches (e.g., grounded theory, thematic analysis, or framework analysis) were included (Willig, 2021).	Quantitative research studies Pre-existing systematic reviews or literature reviews
Evaluation	The review included data on adolescents' lived experiences or subjective perceptions of social media on SRH.	
Research Type	The review was limited to published, peer-reviewed studies using qualitative research methods. Finally, due to resources, only studies available in the English language were included in the review.	Book reviews, book chapters, conference proceedings, editorials, policy reports, and pre-prints were excluded. Studies not available in English

Table 2: Data extraction for included studies.

Author and Country/	Aim	Population	Topic	Analysis	Key Findings	Recommendations
Al-Shdayfat et al, 2019 Jordan	To explore how often adolescents spend on the internet and to explore adolescents' expectations and perspectives of using websites and social media for SRH information to gain knowledge.	**Age:** 15-19 years **Size:** N=40, Male and Female **Recruitment Site:** Snowball sampling technique **Data Collection: 8** Focus groups across North, Middle and South regions	Sexual and Reproductive Health	Not indicated	Adolescents supported web-based platforms to provide RSH information. They widely use online methods for RS information to develop their knowledge and skills. Access to RSH was considered quick and easy for adolescents, enabling SRH discussions without experiencing shame.	Recommendations to the government for developing a culturally sensitive website in Arabic language.
Aragão et al, 2018 Brazil	To understand the perceptions of school adolescents' use of Facebook social media in sexual and reproductive health learning, the Family Health Strategy	**Age:** 9th year of elementary school, mean = 15 years **Size:** N=96, Male (45) and Female (51) **Recruitment Site:** Public and Private schools **Data Collection:** Online environment via discussion forums, interviews and face-to-face meetings, Aug 2015	Sexual and Reproductive Health Learning	Netnography	Facebook contributed to sexual and reproductive health education in an interactive, playful, and practical way, reducing the embarrassment of adolescents conversing on the subject. It also brought adolescents closer to the health service by strengthening their bond with Health professionals.	Need for more health intervention for adolescents in public and private schools. For health professionals to recognise the value of the online environment and to promote SRH information.
4. Berger et al, 2021 Australia	To explore LGBTQ adolescents, use social media for exploring sexual identity and support from other LGBTQ peers.	**Age:** 14-17 years, mean = 16.17 years (std.dev = 0.99) **Size:** N=30, 4 Cisgender M, 19 Cisgender F, 4 non-binary and 3 transgender male **Recruitment Site:** As part of the Social Network and Agency Project (SNAP), recruitment via Facebook, Instagram, and peer referral. Flyers at the Family Planning clinics in New South Wales and one private school in Sydney.	LGBTQ Sexual identity	Thematic Analysis (Braun & Clarke, 2006)	LGBTQ adolescents use social media for identity, relationships, and wellbeing support. LGBTQ adolescents formed friendships and romantic relationships and gained information on sex, relationships, and sexual health from these groups. Social media is an environment where LGBTQ adolescents can connect, educate, and support each other, which may benefit this marginalised group.	Professionals and policymakers to be aware of the social media groups for LBGTQ adolescents and the information available to them (e.g., sex education). For professionals to support with managing online groups to minimise negative experiences or inaccurate information.

		Data Collection: Semi-structured interviews				
Burns et al, 2021 USA	To examine the current attitudes, norms and perceived controls related to social media influences amongst YAAMs adolescents.	**Age:** 18-21 years, Mean = 19.5 (SD-1.2) **Size:** N=41 African American males **Recruitment Site:** Prospective participants were recruited between May 2015 and August 2015 through a non-profit primary care clinic organisation located in Detroit, methods included flyers, social media, face-to-face discussions, and snowball sampling. **Data Collection:** 9 group-depth interviews. Used Goldman (1962) 13 steps to obtain elect information beyond the interpersonal level. The interview guide used the Theory of Planned Behaviour	Condom use	Thematic analysis	Participants demonstrated positive attitudes about using social media for condom use education. Social media sites were educational and engaging, allowing adolescents to seek out sexual health information related to condom use easily and being provided with educational content and creative advertisements. Adolescents disliked negative comments on social media.	Social media education may provide an opportunity for better engaging YAAMs in their health and can be if used by healthcare professionals.
Byron et al, 2013 Austrialia	To understand the potential of sexual health promotion via Facebook and other social media	**Age:** 16-22 years **Size:** not indicated, mix sex gendered **Recruitment Site:** New South Wales and Sydney **Data Collection:** Phase 1 – 22 focus groups in 2011 Phase 2 – 2 focus groups of returning participants from Phase 1. Discuss included hypothetical sexual health campaigns to develop strategies	Sexual health	discourse analysis	Adolescents were interested in using social media for sexual health information. Still, they were careful in presenting themselves online, highlighting concerns about privacy and the stigma associated with sexual health problems. Adolescents highlighted the importance of humour in sexual health messaging.	Information designed for social media needs to engage adolescents with sexual health information that can be incorporated into practices and with humour to reduce stigmatisation.
Cornelius et al, 2019 USA and Botswana	The study examined adolescents' mobile phone and social media usage and their perceptions of how safe sex interventions could be adapted and delivered via social media.	**Age:** 13-18 years **Size:** N=28 **Recruitment Site:** USA – schools, churches, and community Botswana – community site and schools	Safe sex intervention	Abridged method of analysis	Findings showed adolescents discussed peer pressure and connectedness with mobile phones and social media and had a general knowledge of STIs and HIV. Adolescents agreed that adaptation of risk reduction interventions for mobile phone and social media delivery was warranted, and they shared ideas for adaptation.	Provide consideration in using social media to meet the health promotion needs of adolescents and social media risk reduction intervention to reach at-risk

		Data Collection: 3 Focus groups, N=14 USA (2 focus groups), N=14 Botswana (1 focus group				adolescents with appropriate information.
Jones et al, 2019 USA	To assess any changes in attitudes towards HIV and HIV testing, ascertain awareness of HIV testing campaigns among young black men and the use of social networking sites to deliver HIV testing messages for social media marketing campaigns.	**Age:** 18-24 years, mean age = 19.6 (SD = 1.3) years **Size:** N=19, black/non-Hispanic and initiated sexually active **Recruitment Site:** Via email to college students at a public university in Atlanta, GA. The email included the study criteria, a post flyers with focus groups details and researcher's contact details **Data Collection:** 3 focus groups from September 2016 to October 2016.	HIV and STI testing	Grounded Theory	Findings indicated stigma and low-risk perception were discussed as barriers to HIV testing. HIV prevention, social support and new sexual partners were discussed as reasons for testing. There was a general lack of awareness of existing HIV testing campaigns. Messaging with a universal appeal and disseminated through Twitter, Instagram, and Snapchat may counter narratives of fear, stigma, and low-risk perception to increase HIV testing among young black men.	Social media may allow researchers and practitioners to send messages to young black men who engage in HIV risk behaviours and increase awareness of the campaign and the importance of HIV testing.
Kulkarni et al., 2019 USA	To explore how traditional and social media influenced adolescent expectations and attitudes about how and unhealthy relationships	**Age:** 13-17, mean =14.78 years **Size:** N=86, Male (33%) and Female (67%), Black, White, Hispanic, and Other **Recruitment Site:** Teen Media Literacy Conference (TMLC) in Charlotte, North Carolina **Data Collection:** Focus groups, N=9	sexual and romantic relationships	Constructive Grounded Theory Approach (Charmaz, 2006)	Findings showed adolescents' reflections on romantic relationships and how social media interact with relationship processes and perceptions. Adolescents are using social representations of romantic couples to clarify their romantic relationship expectations and desires. This included sexual practices within relationships.	Future teen dating violence prevention curricula should support adolescents' use of critical thinking, perspective-taking, and analysis to make relationship choices aligned with their values and preferences.
Paceley et al, 2022 USA	To explore youth's perception of ways they utilise social media and the internet as it pertains to their SGM identities	**Age:** 14-18 years, mean = 16 years **Size:** N=34, White (65%), African American (12%), Asian (3%), Latinx (3%) and Multiracial (17%). Cisgender F (53%), Cisgender M (26%), transgender (12%), questioning (9%). **Recruitment Site:** Online via social media	Sexual and Gender Minorities (SGM)	Grounded Theory Analytic Strategies (Stratus & Corbin, 1900)	Findings show adolescents use social media and the internet to establish a sense of community (access others, form relationships), express themselves (come out, vent), and access resources and information about sexual behaviour and sexual identity.	Intervention research may be interested in the way social Medi can be leveraged to facilitate interventions for improving wellbeing among adolescents. Also, practitioners may find it useful to engage SGM adolescents in

		Data Collection: Focus groups, Jan-June 2014				conversations about their social media use to establish points of sexual health risk.
Patterson et al, 2018 Scotland	To examine the key barriers and challenges faced by young people when accessing and using sexual health information online.	**Age:** 16-19 years **Size:** N=49 **Recruitment Site:** by gatekeepers within youth and community organisations, posters, word of mouth, social media posts, and snowball sampling **Data Collection:** areas in Scotland in 2014, paired interviews (25 interviews, 1 triad)	sexual health	Framework analysis	This study highlighted practical and socio-cultural barriers to engagement with online sexual health content. Practical barriers included difficulty filtering over abundant content; limited awareness of specific, relevant, trusted online sources, difficulties in finding locally relevant information about services; and challenges in navigating large organisations' websites. Socio-cultural barriers included fear of being observed; wariness about engaging with visual and auditory content; concern about unintentionally accessing sexually explicit content; and reluctance to access sexual health information on social networking platforms or smartphone applications.	For sexual health information providers and intervention developers to produce online information that is accurate and accessible, to increase awareness and promote sexual health information to adolescents in a sensitive manner.

Table 3: Summary of quality appraisal

Lead Author	Q1 Was there a clear statement of the aims of the research?	Q2 Is a qualitative method appropriate?	Q3 Was the research design appropriate to address the aims of the research?	Q4 Was the recruitment strategy appropriate to the aims of the research?	Q5 Was the data collected in a way that addressed the research issues?	Q6 Has the relationship between researcher and participants been adequately considered?	Q7 Have ethical issues been taken into consideration?	Q8 Was the data analysis sufficiently rigorous?	Q9 Is there a clear statement of findings?	Q10 How valuable is the research?	TOTAL	CASP Assessment
Al-Shdayfat 2019	**Y**	**Y**	**Y**	**Y**	**Y**	**N**	**Y**	**Y**	**Y**	**Y**	**9**	**High**
Aragão 2018	**Y**	**Y**	**Y**	**Y**	**Y**	**CT**	**Y**	**Y**	**Y**	**Y**	**10**	**High**
Berger 2021	**Y**	**Y**	**CT**	**Y**	**Y**	**N**	**Y**	**Y**	**Y**	**Y**	**8**	**High**
Burns 2021	**Y**	**Y**	**Y**	**Y**	**Y**	**CT**	**Y**	**Y**	**Y**	**Y**	**9**	**High**
Byron 2013	**CT**	**Y**	**CT**	**CT**	**Y**	**N**	**Y**	**CT**	**N**	**CT**	**3**	**Low**
Cornelius 2019	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**10**	**High**
Jones 2019	**Y**	**Y**	**Y**	**Y**	**Y**	**N**	**Y**	**Y**	**Y**	**N**	**8**	**High**
Kulkarni 2019	**Y**	**Y**	**Y**	**Y**	**Y**	**N**	**Y**	**Y**	**Y**	**Y**	**9**	**High**
Paceley 2022	**Y**	**Y**	**Y**	**Y**	**Y**	**N**	**Y**	**Y**	**Y**	**Y**	**9**	**High**
Patterson 2018	**Y**	**Y**	**Y**	**Y**	**Y**	**CT**	**Y**	**Y**	**Y**	**Y**	**9**	**High**

Table 4: Summary of themes across included studies

Lead Author	Theme 1: Motivation and intention to use online information			Theme 2: Social learning and exchange		Theme 3: Adolescent awareness and ability to evaluate resources	
	Sub-theme 1.1: Availability of information	Sub-theme 1.2: Concealed engagement	Sub-theme 1.3: Improving content for continued use	Sub-theme 2.1: Shared understanding and connection	Sub-theme 2.2: Educating and disseminating knowledge	Sub-theme 3.1: Interpretations and responding to information	Sub-theme 3.2: Impacts of misleading portrayal of sex and relationships
Al-Shdayfat 2019	X	X		X	X	X	X
Aragão 2018	X	X			X		
Berger 2021	X	X		X	X	X	X
Burns 2021	X	X	X		X	X	
Byron 2013	X	X	X	X	X	X	
Cornelius 2019	X	X	X		X	X	X
Jones 2019	X	X	X	X		X	X
Kulkarni 2019						X	X
Paceley 2022	X			X	X	X	
Patterson 2018	X	X	X			X	X

2.2 Systematic Review Reflective Commentary

Introduction

This reflective report focuses on planning, conducting, and writing up my meta-synthesis, which explored 'adolescents' experiences of social media for sexual and reproductive health information'. Within this reflective report, I discuss my strengths, weaknesses, and areas of development in the approach to the review as I work towards becoming a Health Psychologist.

Planning the review

Scoping review

Having limited experience in completing systematic reviews, I undertook some reading into the steps required to undertake a review. This included revisiting the teaching slides on the Professional Doctorate, engaging in broader reading on conducting a systematic review and reading examples of peer-reviewed published articles (Siddaway, Wood, & Hedges, 2019). The additional reading developed my knowledge and, alongside regular supervision, helped me to ascertain the processes I needed to complete a review. This made me feel better positioned to begin considering ideas for my review.

I found it challenging to decide upon a topic for my systematic review. I approached clinicians on placement to identify if any reviews would be clinically valuable to the service. Although ideas were suggested, these had a limited focus on health psychology. In supervision, it was recommended that it might be beneficial to complete a review using a population I had less clinical experience with to broaden my knowledge. Therefore, I began to scope and generate ideas for consideration for various topics I was interested in, e.g., perinatal health, virtual reality and health conditions, non-epileptic seizures, burns, and scars. Following this exercise, I identified the topic of sexual and reproductive health in an adolescent population as I had less clinical and research experience with this group. I felt this was a good decision as engaging in this take would broaden my knowledge and understanding of a different population in the context of an area, I am interested in.

I decided on my review topic and completed scoping searches to ascertain existing reviews. Several reviews have been conducted on adolescent sexual health in different settings (e.g., schools, local communities, social media and online more broadly) and timeframes (several years ago to more recently). During this process, I also recognised that definitions of the adolescent age range varied across the studies. Although previous systematic reviews had explored similar topics (e.g., social media for sexual and reproductive health information), most were meta-analyses and meta-narratives. Therefore, the scoping review informed the development of a proposal. As previous reviews have focused on quantitative studies, I felt developing a proposal for a review using qualitative studies would be beneficial. This strengthened my rationale to complete a meta-synthesis.

As part of my literature search, I searched PROSPERO to identify whether any relevant systematic reviews were currently being conducted. The reviews identified focused on adolescent sexual health but did not focus on social media experiences. This reassured me that my meta-synthesis would not be duplication. I learnt the importance of registering studies and checking protocol databases to ensure originality, especially since I have now experienced the volume of work required for a systematic review.

Writing the protocol

Writing a protocol took several months to complete. It was helpful having several people involved in the project, including researchers with experience in meta-synthesis, to offer support and guidance as I prepared the protocol. I have learnt having a review team of several researchers with different areas of expertise can increase the quality of the work as different viewpoints are discussed (Oliver, Dickson, & Bangpan, 2018). This matches my broader professional practice, where joint working and collaboration with other professionals outside my expertise can enhance the work produced.

An important area in my protocol was writing an appropriate search strategy. It is recommended that search strategies should include a balance of search terms that provide a variety of searches but avoid using too many different search concepts (Bramer et al., 2018; Higgins et al., 2019). I sought guidance from the University library service to help me develop my search terms. This is where I learnt about "Boolean".

Using a thesaurus to find alternative words (e.g., for adolescents) was helpful as I identified search terms I had not previously considered. I learnt there were different terms that varied across different backgrounds and cultures, including some variations in spellings, e.g., adolescents and young people. This was important as I was not restricting my searches to a particular country. However, I found balancing the different concepts and words challenging. Therefore, the feedback I received from my proposal (e.g., too many search terms) allowed me to refine my search terms to achieve a better balance. Here I learnt about the importance of having related terms for the topic and my research question, which was also achievable. This was especially important as I was leading this review, which included undertaking each stage alongside other clinical and academic commitments, and co-researchers were contributing by reviewing and checking to ensure the quality of the review was maintained.

Defining my protocol inclusion and exclusion criteria was another area I found difficult. Using the SPIDER format allowed me to ensure I was capturing a range of areas (e.g., study, population etc.) for my criteria. However, the feedback allowed me to recognise I was not always clear in my rationale about my criteria. This corrective feedback from my proposal allowed me to communicate my decision-making and rationale. I used other protocols and systematic reviews as examples to help share my reasoning for my review criteria and how best to communicate decision-making. Overall, this made me realise that having a more explicit rationale was one of the most important parts when developing a protocol to justify decisions and reduce any potentially biased perspective.

A key area in my review protocol was demonstrating the type of analysis I would be conducting. Having no experience in completing a meta-synthesis, I sought guidance from a supervisor with expertise in this area. Completing my reading helped me explain and understand the proposed analysis in my protocol (Bramer et al., 2012; Booth, 2016; Liamputtong, 2019; Mohammed, Moles, & Chen, 2012; Thomas & Harden, 2008). I struggled with how to manage the synthesising research with different epidemiological positions. I began to feel overwhelmed and was concerned this lack of understanding would impact my proposal. After seeking supervision, it was reflected that until papers are reviewed, it is not possible to know the epistemological positions of the studies entirely and if any conflicts arise in the review. I also learnt that it was

essential to document this in the proposal and state that the assumptions, methods, and epistemology of studies included within the review and my own during the review and synthesis of the findings will be clearly indicated. Therefore, promptly seeking guidance was important and avoided a delay in submitting the proposal.

After the protocol was complete, it was submitted and published on the PROSPERO website. PROSPERO is a database of health-related systematic reviews requiring registration before the review is conducted. No feedback was provided by PROSPERO, allowing it to be accepted and published immediately. This felt good, particularly as completing this submission was a much simpler process than my experiences of approval for other research competencies completed for the doctorate.

Conducting the review

Screening

In completing the screening of papers, I experience both successes and challenges. This helped me identify areas of research strengths and limitations to learn from (Table 1).

Table 1: Reflections and learning from the screening process.

Screening Stages	Comments/ Reflections:
Screening for papers	Searching papers from databases and screening these against my review criteria was straightforward but took longer than anticipated. I opted to use Excel, which was user-friendly, but the extensive database I created was sometimes overwhelming. I had been recommended a software (Rayyan) that could assist with organising the search. However, I felt that trying and navigating unfamiliar software was more challenging and would negate its benefits. Since completing this review, I have used Rayyan for a rapid review on placement, where I found it accessible and straightforward. Thus, it is software I would use going forward for future reviews.
Initial searches	My initial searches from my databases generated many papers, and using Excel had functionalities to remove duplications and add filter tabs helped with the screening process. I completed this stage while waiting for ethical approval or feedback on other research projects, which gave me a "break" from other aspects of the doctorate. Although the screening process was very time-consuming, I could dip in and out of, rather than fully immerse myself in, like other research projects. While this process was lengthy, I learnt the importance of keeping good records, which helped with the review's later stages.
Screening titles and abstracts	I continued to use Excel to screen journal titles and abstracts. I found several papers I was uncertain about as they appeared relevant to the topic area. However, essential information (e.g., participant age, time, social media, methodology etc.) was unavailable to help with my decision-making. Therefore, I learnt that keeping a record of this on my spreadsheet was essential to guide discussions in supervision and when reviewing the full article.
Full paper screening	When screening full text, I inputted my inclusion and exclusion criteria as filter tabs on my Excel spreadsheet. This process allowed me to adhere strictly to paper inclusion and maintain reasons for excluding papers. Discussions about paper suitability were had in supervision, with the Excel spreadsheet shared with my supervision to ensure agreement. Where there was further uncertainty about the appropriateness of the paper, this was shared with the third supervisor. For example, two articles met my review criteria on all domains but focused on sexuality and romantic relationships. In these instances, I was able to discuss with supervisors, and a third reviewer was able to support me with decision-making. I learnt the value of joint work in decision-making to facilitate a high-quality review.

An area where I faced difficulty was accessing the full papers for several studies. I contacted the NHS Trust library service to assist with access to limited success. I also contacted authors to access the complete article and drew upon my experience of contacting authors for other purposes, e.g., access to psychometrics. When contacting

the author, I needed to explain the reason for the contact and the purpose of the review, where possible. I also attempted to contact authors via email and ResearchGate. Contacting authors was highly challenging as, at times, I received acknowledgements of my query and, on other occasions, nothing. I was conscious of my busy doctorate and clinical schedule; thus, I only followed up the authors twice and unfortunately could not access the entire paper. In future, I will make more attempts and account for additional time in this part of the review. Therefore, I ended up omitting several papers from my initial draft review. This was disheartening and resulted in me excluding more papers in my review than I included. On reflection, I should have raised this with a supervisor before proceeding with the review to gain advice on how best to continue. Following feedback on my first draft, I was informed there are provisions for the University Library service to obtain access to full papers at a cost. Although not a resource I was aware of, I learnt about alternative ways to access papers which I can use in future reviews.

Data Extraction

Data extraction was completed by me and discussed and shared in supervision. The type of information to extract had already been agreed upon as part of the protocol, which eased this process. I found extracting information from each paper a variable experience. I observed that each paper had been written in different formats and styles; therefore, it was easier to draw out information in some papers than in others. In completing this stage, I found printing each paper and highlighting it easier than reading articles electronically.

I found the papers mostly provided clear information, which facilitated data extraction. This included information relating to the study's method, aims, key findings, application of results and the study limitations. I did note some variability in information. For example, where studies had a mixture of participants (e.g., gender, ethnicity, sexual orientation), some papers clearly described the percentage of each demographic, whereas others did not. Furthermore, an area where extracting information was less straightforward related to participant recruitment. For some papers, I found this information was documented in the method selection, providing transparent information about the recruitment process. In other articles, I noted that the information provided was limited, e.g., only reporting a snowball sampling. While further details would be interesting, I did not feel this significantly impacted the review.

Ultimately, I summarised the essential information extracted from the papers into a table for ease. After receiving feedback from my first draft, I recognised the information presented needed to be more concise. Being concise in my writing is a skill I am continuing to master. In addition, where papers focused on sexual health but were more implicit, this needed to be clarified in the summary table.

Quality Assessment

When undertaking a systematic review, it is necessary to evaluate the quality of the studies to ensure that included studies have sufficient credibility and address any sources of bias (Siddaway et al., 2019). Having limited experience in completing systematic reviews, I was keen to ascertain appropriate quality appraisal tools, particularly for meta-synthesis. Agreed in supervision, the CASPS was considered suitable as it had some validity (Hannes et al., 2010), a ten-question checklist for qualitative literature to allow systematic evaluation of the quality of the articles. I was familiar with this tool, having used this to complete a critical review assignment during my MSc. My prior experience with this tool comforted me, particularly as the broader systematic review process was unfamiliar and daunting.

In the quality assessing papers, I did not use assessments of methodological limitations as a basis to exclude published studies. Research suggests that excluding published evidence based on methodological limitations can detract from generalisability (Carroll & Booth, 2015). Instead, methodological limitations were recorded, assisting in the analytic statements generated through the review process. This appeared relevant for one paper where the quality was assigned as low. In future reviews, I would use this again, as excluding papers on this basis does not include all available research in the area.

I reflected on my ratings as quality assessment can provide insight into the confidence in study findings (Hannes et al., 2010). Initially, I felt my appraisal of the papers was too generous, with many of the papers being rated as high quality. I discussed my ratings and rationale for scoring in supervision to ensure accuracy. As I completed CASPS for each paper, I could also refer to evidence and my decision-making for each score. I, however, could have asked another reviewer to rate a portion or all of the studies. This would have allowed for a more robust method of quality assessment and something that I would do in the future.

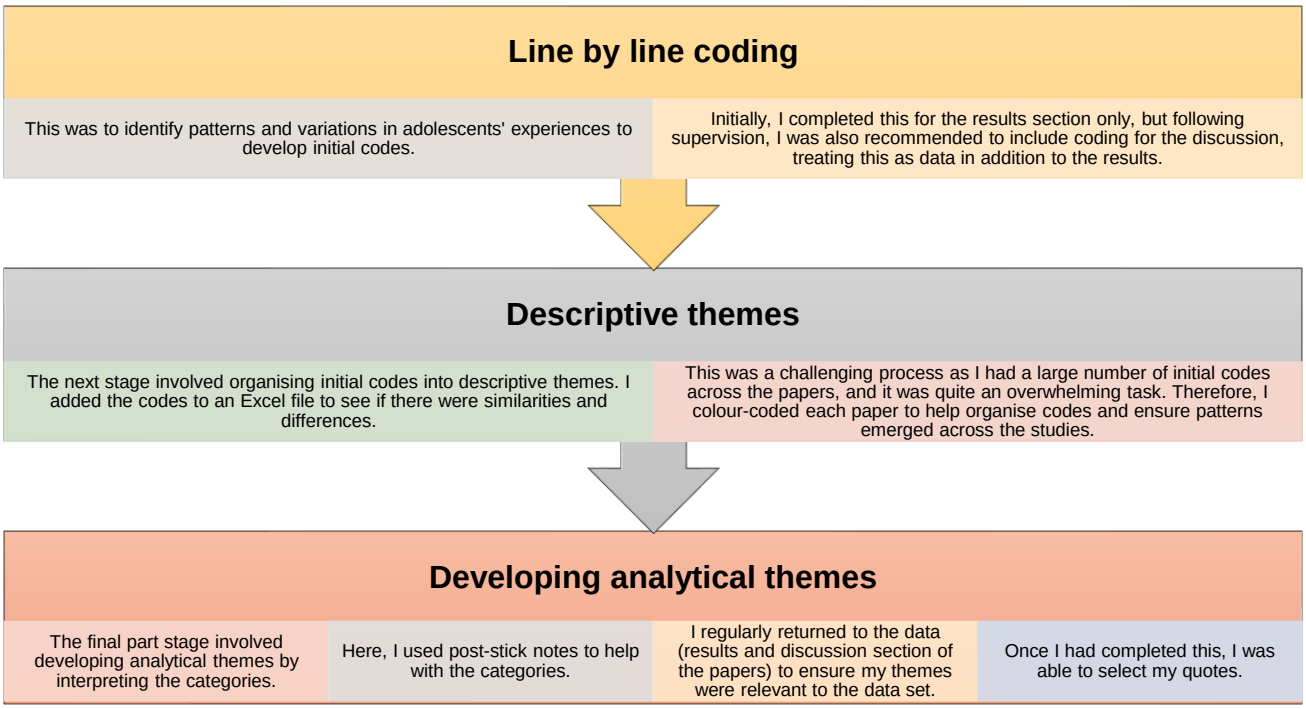
I found a challenging area in the quality appraisal related to question 6, "Has the relationship between researcher and participants been adequately considered". Several papers did not comment on or reference the relationships with participants or consider their reflexive stance. While it may be possible that the researchers had considered this in the study, as it had not been documented, I could not assign a rating. This hindered the study's overall quality rating score. In contrast, studies demonstrating the relationship between the researcher and participant had considered factors such as their professional background and prior relationship with the participants, allowing for straightforward scoring. The absence of this information in several papers has made me consider how I ensure I include the relationship (as a researcher) with participants in my qualitative research manuscript.

Analysis and Synthesis

Completing a meta-synthesis was entirely new to me, and therefore I undertook some reading in the area to prepare myself. I regularly had supervision to discuss the process to ensure accuracy and reassurance. I was nervous going into it but attempted to embrace the process, drawing upon my qualitative research experience and re-conceptualising as if it were qualitative research (e.g., ten transcripts rather than ten papers).

I completed my analysis using the process of Thomas and Harden (2008; Figure 1).

Figure 1: Reflections on the analysis process



Initially, I had two superordinate themes and seven sub-themes. However, following supervision and discussion after my first draft, these were reviewed to reflect three superordinate themes with seven sub-themes. I learned that although meta-synthesis was an unfamiliar approach, I attempted to draw on the process of my experience in the thematic analysis due to some of the similarities. Drawing upon this research experience provided comfort and guidance in using this analytical approach. Overall, I learnt that this type of analysis is not linear and requires much back and forth and, in the future, I would incorporate this into the timeframe when completing a review.

Writing up the review

Before preparing my manuscript, I identified a range of possible journals to which the review could be submitted (e.g., Journal of adolescent sexual health, BMJ Sexual and reproductive health, Sexual and reproductive health matters, and Journal for adolescent research). I was initially leaning towards preparing my manuscript for the Journal of adolescent sexual health however noted in the author's guidelines did not lend itself well to meta-synthesis (e.g., word count and type of review). Therefore, I prepared my manuscript for the Adolescent reproductive health and well-being journal, which I felt better catered to the specifics of this review.

Having had limited experience writing systematic reviews and no prior experience in meta-synthesis, I found this task extremely challenging. Given the pressures of the final year of the doctorate, I attempted to manage my time by completing the write-up in sections. For example, while still conducting my review, I made a start on drafting my introduction. At various junctures in completing my review, I prepared the method, data extraction, and quality assessment of the review, including a summary of my search outputs in an adapted PRISMA diagram. Taking this approach allowed me to detail aspects in the write-up while they were fresh in my mind. I also found it helpful as it allowed me to feel less anxious about the process and demonstrate that I was making realistic progress towards my goals.

I found writing the results and discussion sections of the review particularly challenging. This was partly due to the time pressure of the first draft, alongside some personal challenges, which added additional pressure and stress. Nevertheless, I attempted to draw upon my experience of writing qualitative studies to help with this write-up. However, the feedback I received after reviewing the first draft was

disappointing. Several areas required a great deal of improvement, and although this knocked my confidence, I immediately sought supervision about the best way to proceed.

Amendment after the first draft

As noted earlier, the feedback from my first draft was not as expected, requiring significant revisions. This included a broader review to enhance the quality. The feedback was extensive and disheartening, given the volume of work I had completed. Still, it was beneficial as it allowed me to make revisions at this stage rather than submitting to fail the competency. The feedback and meetings with supervisors allowed for explicit instruction and areas for improvement constructively. I felt I had a clear plan of how to proceed, which included using my Learning Support System and requesting an extension (Table 2).

Table 2: Reflections following draft feedback.

Areas for improvement and revision	Comments and Reflections
Reviewing initial searches	The first aspect of the revisions included revisiting my initial searches. Initially, I had included searches from the Staffordshire Library database that yielded many searches that were duplicates. I learnt this was unnecessary as the University uses the same databases I had included in my review. While frustrating, I recognised my unhelpful thoughts and felt it was essential to continue with areas of the review that were within my control. As I had organised my papers into an Excel spreadsheet, I was able to remove these papers easily.
Screening and selecting papers	After that, I completed the stages of the review as previously discussed. This time, I sought supervision more closely to ensure I was responding to the feedback received from my draft. This was primarily related to decisions I had made around the timeframe of paper searches and the definition of adolescent, which impacted the quality of my review. Therefore, with co-authors, I learnt to discuss the reasons for excluding papers from the review. For example, not relevant to sexual and reproductive health, the adolescent age range is not well defined, and the methodology. It was positive my rationale was shared, which gave me confidence in my abilities which had been knocked. Working closely with supervisors was a positive experience, despite the circumstance. I learnt the importance of drawing upon their expertise and discussing to check and affirm decision-making.
Completing the meta-synthesis	I also sought closer supervision related to data synthesis. Like my qualitative research, I met with supervisors to discuss my themes to ensure agreement and refinement. Having felt I had developed a good familiarity with the papers and the data, I knew what quotes were amongst the dataset and which would represent the theme appropriately. I had further meetings where I could present my themes and some extractions. This process allowed for clarification and refinement as a group of researchers. I found this process beneficial in strengthening my rationale and justification for the developed themes, especially as I was conscious of my previous feedback and limited experience with meta-synthesis. Furthermore, an issue I encountered was that some quotes needed context to ensure the extracts made sense. Therefore, selecting and using a quote in the most suitable place requires attention to detail.

In preparing my manuscript, I was nervous based on my previous feedback. I recognised my unrelenting standards schema was being triggered, and I was moving between avoidance (e.g., procrastinating) and compensating (e.g., perfectionism) in my core beliefs. From the doctorate to date, I have learnt the importance of recognising unhelpful thoughts and developing skills to combat them. This included making a list of tasks I must complete for the review and taking these in stages to ensure they were manageable and less overwhelming. In addition, being transparent with supervisors

at the University and on placement about my worries and learning needs allowed me to be sufficiently supported. This enabled accommodations to meet my learning needs, including additional time, which assisted with writing my manuscript.

Conclusion

Overall, I found this a highly challenging piece of research to complete. While aspects of the review played to my strengths (e.g., reviewing papers, coding, and generating themes), I found managing a large output and the write-up difficult. I found the time-consuming nature of completing the review difficult. However, I acknowledge it is likely to have felt this way due to the pressures of the doctorate alongside working in a clinical role. Despite this, I have developed various skills, such as time management, organisational skills, greater abilities to use Excel, innovative ways to search and obtain access to journal articles, and how to complete a meta-synthesis from completing this review. I have also developed a broader understanding of the process required for a robust review. This helped with completing a rapid review with colleagues on placement.

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2.3 Quantitative Research Manuscript

The impacts of Adverse Childhood Experiences on physical health outcomes of those admitted to Medium Secure Mental Health Care: A Secondary Analysis of data

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Abstract

***Purpose*:**
This study aimed to explore Adverse Childhood Experiences (ACEs) and health outcomes of patients admitted to the UK Medium Secure Unit (MSU).

Methodology:

Secondary data was analysed from a retrospective longitudinal study (N=864) of patients admitted to an MSU between July 1983 and June 2013. Outcome measures included the Adverse Childhood Experiences Questionnaire, demographic information, morbidity, obesity, head injury, history of substance misuse, history of self-harm, history of suicide and mortality data.

Findings*:*

The study included 864 participants, with N=179 had experienced no ACEs, N=488 experienced 1-3 ACEs, and N=199 experienced ≥4 ACEs. A Chi-square test of association showed a significant relationship between ACE scores (≥4) and morbidity ($X^2(2, N=864) = 9.978, p = .007$) and mortality ($X^2(2, N=864) = 7.150, p = .005$). A one-way ANOVA highlighted participants with ≥4 ACE scores had poorer physical health outcomes than those with none or ≤3 ACE scores ($F(2, 861) = 3.578$, $p = 0.028$). A Pearson Chi-square test of association showed a significant relationship between ACE scores (≥4) and a history of substance misuse ($X^2(4, N=864) = 43.64, p = .001$), history of self-harm ($X^2(4, N=864) = 52.87, p = .001$) and history of suicide ($X^2(4, N=864) = 26.85, p = .001$). Two linear regressions including ACE scores, gender and ethnic background as predictors accounted for 0.9% of the variance in Physical Health Outcomes index scores and 17% of the variance Health Harming Behaviours index scores. ACE scores significantly predicted the Physical Health Outcomes index score ($\beta = 0.21$, 95% CI [0.00, 0.42]) and Health Harming Behaviours index scores ($\beta = 0.242$, 95% CI [0.198, 0.285]). Ethnic background ($\beta = -0.496$, 95% CI [-0.695, -0.297]) and gender ($\beta = -0.317$, 95% CI [-0.543, -0.091]) only predicted Health Harming Behaviours.

Originality*:*

The current study showed a link between ACE scores, mortality, physical health outcomes, and health-harming behaviours. These findings have implications for a) identifying those in medium secure mental health care settings at higher risk of morbidity and mortality and b) designing better-tailored health interventions for patients at higher risk.

Keywords:

Trauma, adverse, childhood, ACEs, medium secure, health outcomes, morbidity, health behaviours, mortality

Introduction

Adverse Childhood Experiences (ACEs) refer to traumatic events occurring before 18 years of age, such as different types of abuse and neglect, parental mental illness, substance misuse, parental separation, parental criminality, and domestic violence (Felitti et al., 1998). Prolonged exposure to ACEs has been shown to impact children's neurobiological, social, and emotional development (e.g., emotional and conduct childhood difficulties) and can increase individual's risks to health and social harms in adulthood (Asmundson & Afifi, 2019; Berens, Jenson & Nelson, 2017; Felitti et al., 1998; Finkelhor, Shattuck, Turner, & Hamby, 2013; Ford, Bellis, Hughes, Barton & Newbury, 2020). ACEs have been shown to predict poorer adulthood outcomes, such as poorer physical and mental health outcomes and offending behaviours (Cronholm et al., 2015; Felitti et al., 1998; Hughes et al., 2017; Monnat & Chandler, 2015). In addition, the ACE-Q has provided significant epidemiological evidence regarding the link between ACEs and adult mental and physical illnesses, and the higher the ACE score (≥4), the greater the likelihood that a person will develop one or more of the following health problems: ischemic heart disease; cancer; chronic bronchitis or emphysema; hepatitis or jaundice; skeletal fractures; diabetes; smoking, sexually transmitted diseases; or depression (Felitti et al., 1998).

Those in the criminal justice system are known to have experienced higher levels of ACEs compared to those in the general population (Baglivio et al., 2014; Carnie, Broderick, Cameron, Downie & Williams, 2011; Ford et al., 2020; Scottish Government, 2018; Wolff & Caravaca-Sánchez, 2019). This is important because increased ACE exposure (≥4) is associated with adverse behavioural, health and social outcomes, including poorer physical health, such as obesity, heart disease and cancer (Bellis et al., 2014); increased likelihood of engaging in health-harming behaviours, such as substance use and self-harm (Fernandes et al., 2021; Grummitt, Barrett, Kelly & Newton, 2022; Wan et al., 2019); increased and repeated use of services, primary care use, and hospitalisation (Hargreaves, Mouton, Liu, Zhou, & Blot, 2019); the decreased likelihood of engaging in health-promoting behaviours, e.g., sexual safety, exercise, healthy diet (Bellis et al., 2014); reduced educational attainment, unemployment (Liu et al., 2013); and continued involvement in violence

and offending behaviours (Ford et al., 2019; Mair, Cunradi & Todd, 2012; Taillieu, Davila, & Struck, 2020).

Previous research on ACEs and adulthood outcomes has provided helpful insight into adults' physical and mental health outcomes, criminality, and to a lesser extent, health-promoting behaviours. Existing evidence also suggests that a higher prevalence of ACEs in prisoners is associated with poorer physical and mental health outcomes as well as being a strong predictor for violent behaviours, problematic substance misuse and prolific offending (Baglivio & Epps 2016; Baglivio et al., 2014; Ford et al., 2020; Hughes et al. 2017). Therefore, the evidence related to health and re-offending outcomes in the prison population is concerning. However, much of the existing evidence is primarily based on American studies. Given the differences in social, political, economic, population and forensic contexts between America and the UK, a better understanding of the British context is needed.

This research aims to broaden the understanding of the exposure to and impact of ACEs in patients detained in England's Medium Secure Units (MSU). An MSU is an inpatient service for adults receiving treatment and care for complex mental health problems who have also been in contact with the Criminal Justice System, thus posing a severe risk to themselves and others (NHS England, 2021). Previous research has examined several outcomes related to this population and setting (Coid et al., 2016; Kasmi, Duggan, & Völlm, 2020; Maden, Rutter, McClintock, Friendship, & Gunn, 1991). For example, studies conducted by Davies et al. (2007) and Westhead et al. (2023) on the Arnold Lodge Admission Cohort Reconvictions and Intervening Treatment (ALACRITy) study provided data and insights into the outcomes of mentally disordered offenders admitted to one MSU over 30 years, examining admission characteristics, offending types, histories reconviction rates, readmission rates, morbidity, and mortality rates. However, associations between ACEs and adulthood physical health outcomes within this population have yet to be explored. Therefore, this research intends to examine the association between ACEs and adulthood physical health outcomes in psychiatric patients admitted to an MSU by further analysing data collected in the ALACRITy study (Davies et al. 2007; Westhead et al. 2023).

The current study addresses two primary research questions (1) what is the prevalence of ACEs within patients admitted to MSU, and (2) what is the relationship between the number of ACEs and mortality and morbidity rates of patients? In addition, secondary research questions look to (3) assess if there is an association between the number of ACEs and history of suicide attempts, history of self-harm and history of substance misuse, (4) if there is a difference for individuals who have experienced more ACEs have poorer physical health outcomes than those who have experienced fewer ACES, and 5) to understand how ACE scores, and demographic factors (gender and ethnic background) predict physical health outcomes and health-harming behaviours in patients admitted to MSU.

Method

Design

A retrospective longitudinal design was used to examine secondary data collected in the ALACRITy study of admissions to an MSU between July 1983 and June 2013 (Westhead et al., 2023). Data were analysed to identify the prevalence of ACEs' and their impact on mortality, morbidity, physical health outcomes and health-harming behaviours in those admitted to the MSU.

The ALACRITy study (Westhead et al., 2023) obtained identifiable data from clinical paper records and follow-up data from several sources. This included patient clinical records (paper files and electronic records) for patients admitted to the service between July 1983 to 2013. Information retrieved from follow-up data included reconviction, readmission to psychiatric care and mortality collected from medical records. This included electronic files, Police National Computer (PNC), Nexis Database, Google (e.g. obituary), NHS Digital for Hospital Episode Statistics (HES) data, Care Pathway Approach (CPA) reports from other hospitals, and Office of National Statistics (ONS). The participants' demographic details regarding offending risks, readmission rates and outcome data are detailed in the original study (Westhead, 2023).

Participants

Nine hundred and nine participants were identified from the ALACRITy study database of patients admitted to an MSU between July 1983 and 2013 via the Trust's Applied Information Department. (Westhead et al., 2023).

A power analysis was completed to consider the sample size required for analysis using a medium effect. GPower version 3.1.9.7 (Faul, Erdfelder, Bunchner & Lang, 2009) indicated that a minimum of 111 participants would be required for a correlational analysis to detect an effect size of r = 0.30 with a power set at .95 and alpha set at a level of .05 (Cohen 1992).

For the current study, all 909 participants were considered, and n=864 were deemed eligible as existing data (i.e., childhood and family history information) allowed completion of the Adverse Childhood Experiences Questionnaire (ACE-Q; Felitti et al., 1998) to create an approximate (researcher, rather than participant determined) ACEs score.

The demographic details of the final sample are documented in Table 1. The sample included 85% male and 79% white participants. The most common (41 %) mental health diagnosis was psychosis-related (e.g., Schizophrenia, delusional disorder), and 27% had a Personality Disorder diagnosis. A portion of the sample (7%) had other mental health diagnoses, such as mood disorders. In comparison, details of a formal diagnosis were unavailable for 25% of the sample due to the participant's admission to the hospital for assessment, meaning they had a working diagnosis (e.g., yet to be established).

[INSERT TABLE 1]

Measures

The following data were retrieved from the ALACRTIy study database:

Demographic Information:

Demographic information included gender, ethnic background, and mental health diagnosis. Gender was recorded as male or female, and ethnicity was recorded as white or non-white. Mental health diagnosis was recorded as: Psychosis-related; Personality Disorder; Other diagnoses; or missing/ undiagnosed.

Adverse Childhood Experiences

The ACE-Q, developed by Felitti et al. (1998), is a 10-item measure intended to assess ten types of childhood adversity across three domains: abuse, neglect, and household challenges. ACE items include emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, mother treated violently, household substance abuse, household mental illness, parental separation, and imprisoned household member. This questionnaire was designed to measure the occurrence of adverse experiences experienced by an individual before the age of 18 years. The questionnaire provides statements, e.g., "While you were growing up, during the first 18 years did…", offering a Yes or No response ("yes" responses are assigned 1 point, "no" responses are assigned 0 points). Overall scores for the assessment are determined by summing responses. An ACE score of 0 suggests that the person reported no exposure to childhood trauma. An ACE score of 10 indicates that the person reported exposure to a range of childhood trauma. The ACE is a reliable, valid, and economical screening tool for retrospective assessment of adverse childhood experiences (Wingenfeld et al., 2011) and has adequate internal consistency; Cronbach's alpha = .88 (Murphy et al., 2014). ACEs scores amongst the sample were categorised into 0 ACEs, low ACEs ranging from 1-3 and high ACEs ≥4 (Bellis et al., 2014).

Health Outcomes:

Morbidity is defined as the presence of a physical health condition. This included illnesses such as diabetes, disease of the respiratory system, a blood born virus, high cholesterol, disease of the gastrointestinal system, epilepsy, high blood pressure or other conditions such as asthma. Scores were assigned 1 if an illness was recorded or 0 for no documented illness.

Obesity was defined by the ALACRITy study (Westhead et al. 2023) as a recorded Body Mass Index (BMI) above 30.0. Scores were assigned 1 if obesity was recorded or 0 if no obesity was recorded.

Head injury was defined by the ALACRITy study (Westhead et al. 2023) and recorded as either a traumatic or acquired head injury in childhood, adulthood or at an unspecified time. Scores were assigned 1 if an injury was present or 0 for the absence of an injury.

A Physical Health Outcomes Index was created by summing scores for the presence of (1) a physical health condition using morbidity data, (2) a head injury and (3) obesity, meaning participants could have a score ranging from 0 to 3. Of the participants in the sample, 65% had no physical health outcome, 30% had one condition, and 5% had two conditions. No participants had all three physical health conditions. A Pearson's Chi-square test of association was run to test the relationship between ACE scores and the presence of physical health conditions, head injury and obesity. The three variables were significant and therefore were combined to create a "Physical Health Outcomes" index score as a variable.

Health Behaviours:

History of Substance Misuse was defined by the ALACRITy study (Westhead et al., 2023) as a history of substance misuse, including participants who had engaged in harmful use of substances or had been diagnosed with dependence before admission. A history of substance misuse did not include alcohol use or alcohol dependence. The most reported substance used by participants was regular cannabis use. Scores were assigned 1 if a history of substance misuse was recorded or 0 for an absence of a substance misuse history.

History of Self-harm was defined by the ALACRITy study (Westhead et al., 2023) as having engaged in self-injurious behaviours either prior to their admission into service, during admission or upon discharge from the hospital. Scores were assigned 1 if a history of self-harm was recorded or 0 if this was absent.

History of Suicide Attempts was defined by the ALACRITy study (Westhead et al., 2023) as those who engaged in self-harming behaviour and made life-threatening attempts (most commonly using a ligature) was also referred to as life-threatening self-harm in the ALACRITy study (Westhead et al., 2023). Scores were assigned 1 if life-threatening self-harm was recorded or 0 if this was not recorded.

Health Harming Behaviours Index was created using a combined score of the presence of a (1) history of substance misuse, (2) a history of self-harm and a (3) history of suicide attempts, meaning participants could have a score ranging from 0 to 3. Of participants in the sample, 11% had no health-harming behaviours, 21% had one health-harming behaviour, 25% had two health-harming behaviours, and 43% had all three health-harming behaviours. A Pearson's Chi-square test of association was run

to test the relationship between ACE scores and the presence of a history of substance misuse, a history of self-harm, and a history of suicide attempts. The three variables were significant and therefore were combined to create a variable known as the "Health Harming Behaviours" index score as a variable.

Mortality:

Mortality included whether participants were deceased or living. This included whether the circumstances of death were related to natural causes, unnatural or open verdict and suicide. Natural causes included conditions such as cancer, heart or cardiovascular-related and respiratory. Unnatural death included circumstances such as mental or behavioural disturbances and overdose. Open verdicts and suicide were considered deaths resulting from a drug overdose or poisoning, jumping from a height or in front of a moving object and hanging.

Procedure

Data collection for the original study was completed by the ALACRITy research team (Westhead, 2019). Data for participants in the initial 20-year cohort (July 1983 - 30th June 2003) had already been collected and was available in an existing database at the MSU (Davis et al., 2007). Clinical records were available at the MSU and were used to collect the admission data for the additional ten-year contemporary cohort (1st July 2003 - 30th June 2013). When combined, data was available for a 30-year cohort (Westhead et al., 2023). Clinical records for the contemporary cohort of patients were available from a combination of paper-based and electronic files from the Medical Records Department. Multiple data sources were used to obtain follow-up outcome data (reconviction, readmissions to psychiatric care, and mortality). This included information from clinical records in the medical records department at the MSU. Outcome data were collected from the Ministry of Justice (MoJ) for Police National Computer (PNC) for reconviction data and NHS Digital for readmission and mortality data. NHS Digital obtained mortality data from the Office for National Statistics (ONS). Data on readmissions to secure and general psychiatric hospitals was obtained from NHS Digital (formerly the Health and Social Care Information Centre). Finally, mortality data were also collected from NHS Digital, which obtained the data from the Office for National Statistics (ONS;).

The ACE-Q was used as a proforma and completed using existing information about participants from the ALACRITy database, which included participants' childhood history data up to 19 years. Therefore, relevant variables from the ALACRITy were used to obtain approximate ACE scores ().

Questions 1, 2, 3, 6, 8, 9 and 10 of the ACE-Q were answerable using the data available. Information relevant to questions 4 and 5, and 7 was not collected in the ALACRITy study, and therefore, alternative data was available and used to obtain approximate ACE scores. For questions 4 and 5, which refer to neglect within the ACE-Q, data on "institutional care" was used as a proxy to answer this item on the ACE-Q. The decision to re-code this item was due to research indicating the most common reasons for a child being placed into institutional care are due to neglect, abuse, family breakdown and a parent's or child's illness or disability (Become, 2020; NSPCC, 2020). For questions 4 and 5, if a child was placed into care as a child, a score of 1 was allocated for each question. If not indicated as present, a score of 0 was assigned, and the item was omitted if the information was missing.

For question 7, which refers to "Household Challenges", specifically domestic violence, on the ACE-Q, information about a participant's family history was used. This included a family history of mental illness and substance misuse to answer this item. The rationale for using this method of scoring for this item is based on the "Toxic Trio" Theory (Brandon, 2009; Brandon et al., 2012). This indicates a triangulation between domestic violence, substance misuse and mental illness in the family home, thus exposing the child to these adversities. Therefore, for each participant, if it was indicated that there was a family history of mental illness and substance misuse, a score of 1 was used. If one or both were absent, a score of 0 was used, and the item was omitted if the information was missing.

In sum, the ACE-Q was completed for the 909 participants in the database. For participants where data was available for > 7 items, this allowed for a score to be assigned based, and these participants were included in the final dataset for secondary analysis. Participants were removed from the dataset for secondary analysis when >5 items could not be assigned a score due to missing data.

To ensure the accuracy of the ACE-Q scoring, 10% of the sample (N=90) was second coded by the fourth co-author (services Senior Research Fellow). The selection of

participants for the second coding was completed using a random sampling method and Excel software [random.org] to identify cases based on Excel lines rather than participant ID. The double coding checked the scoring of ACE scores from the original data, which included checking missing values for participants that would not allow assigning an ACE score. Discrepancies were identified in 12% of cases (11/90); therefore, all scores within the database were re-checked to ensure accuracy.

Analysis

Data were screened in two parts to assess missing values. Firstly, missing data were assessed for the entire ALACRITy database, which consisted of N=909. Secondly, missing ACE-Q scores were examined. 5% of the data had five or more items missing, preventing the calculation of an ACE score, and leading to the removal of 45 participants and 864 participants remaining in the final sample.

Descriptive analyses were conducted to identify the prevalence of ACEs within this sample and to summarise their demographic characteristics (e.g., gender, ethnic background, and mental health diagnosis).

A Pearson's Chi-square analysis was completed to understand the associations between the number of ACEs (0 ACEs, low between 1-3 ACEs and high ≥4 ACEs) and mortality and morbidity. A further Pearson's Chi-square analysis was completed to understand the associations between the number of ACEs and history of suicide attempts, history of self-harm and history of substance misuse.

Research suggests those with ≥4 ACES are at an increased risk of poorer health outcomes than those with 0 or 1-3 ACEs (Bellis et al., 2014). To examine the differences between those with low ACEs and high ACEs and poorer health outcomes, a one-way ANOVA with ACEs (IV) scores amongst the sample were categorised into 0 ACEs, ACEs ranging from 1-3 (low ACEs) and ACEs ≥4 (high ACEs) to examine the physical health outcomes (DV) using the Physical Health Outcomes index score. Levene's test was used to check the homogeneity of variance assumption, which was met.

Finally, two multiple linear regressions were conducted to examine whether ACE scores and demographic factors (gender and ethnic background) could predict

participants (1) Physical Health Outcomes index scores and (2) Health Harming Behaviour index scores.

Ethical Permission

The ALACRITy research obtained permission and ethical approval from several governing organisations (REC:15/EM/0378), which were made via the Integrated Research Application System (IRAS). This allowed for all the necessary information needed to submit multiple applications to the relevant organisations. Ethical approval for the current study for secondary analysis included ethical approval from Staffordshire University's Research Ethics Committee and the local NHS Trust of the participating research site where the data was initially collected and currently held.

Results

Prevalence of ACEs

Table 2 illustrates ACEs' prevalence rates (research question 1) among patients admitted to MSU. Of the N=864, 20% had no ACEs, 56% had a score between 1-3 ACEs, and 24% of the samples had ≥ 4 ACEs. The individual differences in ACEs among gender, ethnic background and mental health diagnosis were examined. 21% of male participants had no ACEs, compared to 14 % of females. Male participants had more scores between 1-3 ACEs, 57%, compared to 30% of female participants. However, 30% of female participants experienced ≥4 ACEs compared to 22% of males. 19% of White participants were recorded as having no ACEs, compared to 28% of ethnic minority participants. 59% of White participants experienced 1-3 ACEs, and 25% experienced ≥4 ACEs, compared to ethnic participants who experienced more ACEs between 1-3 ACEs (58%) but fewer ≥4 ACEs (14%). For participants with a mental diagnosis of psychosis, 25% had no ACEs, 61% had experienced 1-3 ACEs, and 14% had ≥4 ACEs. For participants diagnosed with Personality Disorder, 8% had no ACEs, 50% had experienced 1-3 ACEs, and 42% had ≥4 ACEs. Of participants diagnosed with other mental health conditions, 25% had no ACEs, 57% had experienced 1-3 ACEs, and 18% ≥4 ACEs. Finally, for participants who did not have a diagnosis, 31% had no ACEs, 58% had experienced between 1-3 ACEs, and 11% had experienced ≥4 ACEs.

[INSERT TABLE 2]

Consequences of ACEs on health outcomes

A Pearson's Chi-square test was conducted to examine the association between ACE scores (0 ACEs, 1-3 ACEs (low), and ≥4 ACEs (high)) and morbidity and mortality of participants (research question 2). The analysis showed a significant association between ACE scores for morbidity and mortality (Table 3). This suggests that participants who experienced more ACES (≥4 ACES) were more likely to have a physical illness (morbidity) $X^2(2, N=864) = 9.978, p = .007$ and die (mortality) $X^2(2, N=864) = 7.150, p = .028$ than those with 0 or 1-3 ACEs.

[INSERT TABLE 3]

Research suggests those with ≥4 ACES are at an increased increase of poorer health outcomes than those with none or ≤3 ACES (Bellis et al., 2014). A one-way ANOVA was conducted to examine differences in Physical Health Outcomes index score between those who have more ACE scores (as defined as ≥4 ACEs) and those who have fewer ACE scores (as defined as ≤3 ACEs) (research question 4). Levene's test had a significance value of $p > 0.05$, and therefore, the homogeneity of variance assumption was met. There was a significant main effect of the ACE score category on the Physical Health Outcomes index score ($F(2, 861)= 3.578$, $p < 0.05$). The test for multiple comparisons found that the mean value of Physical Health Outcomes index scores significantly differed between those with ACE scores of 0 or 1-3 and ≥4. Therefore, those with higher ACE scores had poorer physical health outcomes (M = 1.27; SD = 0.60) than those with lower ACE scores (M = 1.04; SD = 0.69).

Consequences of ACEs on health behaviours

A Person's Chi-square test (Table 3) was conducted to examine the relationships between those who have higher ACE scores (as defined as ≥4 ACEs) than those who have fewer ACE scores (0 or 1-3 ACEs) and a history of suicide attempts, history of self-harm and history substance misuse (research question 3). The findings highlighted a significant association which suggests that participants who experienced more ACES (≥4 ACEs) were more likely to have had a history of suicide ($X^2(4, N=864) = 26.85, p = .01$), history of self-harm ($X^2(4, N=864) = 52.87, P = .01$) and history of substance misuse ($X^2(4, N=864) = 43.64, p = .01$).

Two multiple linear regressions were conducted to examine whether ACE scores and demographic factors (gender and ethnic background) could predict the participant's (1) "Physical Health Outcomes" index score and (2) "Health Harming Behaviours" index score (research question 5).

Among the participants, ACEs were negatively correlated with gender $r(864) = -.74$, $p = 0.030$, and ethnicity $r(864) = -.151$, $p = 0.001$ and positively correlated with Physical Health Outcomes index score $r(862) = .078$, $p = 0.022$ and Health Harming Behaviours index score $r(862) = .375$, $p = 0.001$. There was also a positive correlation between Physical Health Outcomes index score and Health Harming Behaviours index score $r(862) = .183$, $p = 0.001$. For all other variables, there was no correlation (Table 4).

[INSERT TABLE 4]

A model examining predictors of Physical Health Outcomes index score was significant ($F(3, 860) = 2.648$, $p = .48$, adjusted $R^2 = 0.009$) and accounted for 0.9% of the variance in Physical Health Outcomes index score. The ACE scores significantly predicted the Physical Health Outcomes index score ($\beta = 0.21$, 95% CI [0.00, 0.42]), showing that individuals with higher ACE scores reported experiencing poorer Physical Health Outcomes index score. Ethnic background and gender were found not to be a significant predictor of poorer Physical Health Outcomes index score; ethnicity ($\beta = - 0.078$, 95% CI [-0.174, 0.017]) and gender ($\beta = - 0.019$, 95% CI [-0.128, 0.089]).

A model examining predictors of Health Harming Behaviours index score was significant ($F(3, 860) = 59.273$, $p < .001$, adjusted $R^2 = 0.171$) and accounted for 17% of the variance in Health Harming Behaviours index score. The ACE scores significantly predicted the Health Harming Behaviours index score ($\beta = 0.242$, 95% CI [0.198, 0.285]), showing that individuals with higher ACE scores also reported engaging in more Health Harming Behaviours. Furthermore, ethnic background was found to be a significant predictor of more Health Harming Behaviours index score ($\beta = - 0.496$, 95% CI [-0.695, -0.297]), meaning that white ethnic participants had more Health Harming Behaviours index score relative to other ethnic participants. Similarly, gender was also a predictor of more Health Harming

Behaviours index score (β = - 0.317, 95% CI [-0.543, -0.091]), meaning that male participants had more Health Harming Behaviours index score than female participants (Table 5).

[INSERT TABLE 5]

Discussion

This study assessed relationships between approximate ACE scores and physical and mental health outcomes among patients admitted to MSU across a 30-year period. Findings suggest that participants with more ACEs had poorer health outcomes and that ACEs were associated with a history of self-harm, history of suicide attempts and history of substance misuse. In addition, findings highlighted ACEs were associated with mortality outcomes in the sample.

The current study found that the prevalence of one or more ACEs among the sample was high, with only twenty percent having no documented ACEs. Among the sample, only one-quarter of the participants had experienced approximately four or more ACEs. Previous research has found nearly 90% of those in the UK criminal justice system experienced one or more ACEs, with 50% experiencing multiples (≥4) ACEs (Ford et al., 2019). Similarly, other previous research has found nearly half of those within custody have experienced multiple (≥4) ACEs (Baglivio et al., 2014; Wolff & Caravaca-Sánchez, 2019). This research shows similar prevalence rates of one or more ACEs among the sample but fewer multiple (≥4) ACEs than in previous research. However, current findings should be interpreted cautiously, given the proportion of missing data and the need to substitute variables to obtain a researcher, rather than participant, derived score based on secondary data.

Previous research has highlighted that ACEs predict poorer adulthood outcomes, including the development of physical health illness or disease before age 70, such as heart disease and cancer, and increased likelihood of engaging in health-harming behaviour, such as illicit substance misuse (Cronholm et al., 2015; Bellis et al., 2014; Felitti et al., 1998; Liu et al., 2013; Mair, Cunradi & Todd, 2012). The current study also found a difference between ACE scores and developing a physical health condition. Furthermore, the current study found participants with an ACE score of greater than four had poorer physical health outcomes than those with none or lower

ACE scores (0 or 1-3). This supports previous research that individuals who have experienced a higher number of ACEs (≥4) are at increased risk of poorer adulthood outcomes, increased alcohol or substance misuse, obesity, inpatient hospital care, chronic health conditions and imprisonment (Bellis et al., 2014).

In addition, previous research has found a higher prevalence of ACEs and a positive association between ACEs and a history of substance misuse (Leza, Siria, López-Goñi, & Fernandez-Montalvo, 2021). Furthermore, prisoners who have experienced multiple ACEs are substantially more likely to have a lifetime history of self-harm or suicide attempts (Ford et al., 2020). The current study, like previous research, also found a significant association between ACE scores (none, low, high) and a history of substance misuse history of self-harm, or a history of suicide attempts. Consistent with previous research, this study predicted a difference between ACE scores and the mortality rates of those in the sample. Previous research has found that those with four or more ACEs were at increased risk of premature death before the age of 75 years (Bellis et al., 2014; Brown et al., 2009; Bryan, 2019).

The current study found ACE scores predicted Physical Health Outcomes index score (as measured by the index score including obesity, head injury and a physical illness) and Health Harming Behaviours index score (as measured by the index score of history of substance misuse, history of self-harm and history of suicide attempts). However, gender and ethnic background only predicted Health Harming Behaviours index score and did not predict Physical Health Outcomes index score.

This research found that those participants who experienced more ACEs had poorer Physical Health Outcomes index score, with gender and ethnic background having no role to an individual's physical health outcome in this sample. Previous research has found those from ethnic backgrounds are likely to have experienced a higher proportion of adversity and subsequent poorer physical health (Giano, Wheeler, & Hubach, 2020; Sacks & Murphey, 2018; Zhang & Monnat, 2022; Wheeler, Daire, Barden & Carlson, 2018). Furthermore, the role of ACEs and gender in predicting adulthood outcomes has been noted in previous research, with females more likely to experience poorer physical, emotional and psychological health adulthood outcomes, including experiencing somatic illness (Alcalá, Tomiyama, & von Ehrenstei 2017; Fang et al. 2016; Haahr-Pedersen et al, 2020;

Turner et al, 2020; Vaswani, 2018). These findings may not have been replicated in the current study due to the sample being disproportionately white and male when previous research which has included participants with samples that are more balanced in gender and ethnic background.

Although the linear regression highlighted the impact of participants experiencing ACEs on physical health outcomes, its contributing role was noted to be a small effect, suggesting other factors, such as age, may offer a better understanding of physical health outcomes. Although the age of the participants in the sample is unknown, it is possible that participants may have been relatively young at the point of data collection, which would help to understand the small variance. Research has found that those who have experienced more ACEs are more likely to experience poor physical health through developing an illness or disease before age 70 (Bellis et al., 2014). Therefore, if obtaining this information now (ten years later), participants may present with more significant health conditions.

Furthermore, this research also found that those participants who experienced more ACEs had engaged in more health-harming behaviours. Findings from this study are consistent with previous research highlighting ACEs significantly increase an individual's risk of engaging in health-harming behaviours, including repeated self-harm, substance misuse and increase risk of attempted suicide (Cleare et al, 2018; Friestad, Ase-Bente, & Kjelsberg, 2014; Levenson, 2016; Levenson, & Grady 2016).

In addition, the current study highlighted gender and ethnic background in predicting Health Harming Behaviour index score. This means that white ethnic individuals had more Health Harming Behaviour index score relative to other ethnic groups, and male individuals had more Health Harming Behaviour index score than female participants. Previous research has found that those from ethnic backgrounds are likely to experience a higher proportion of adversity (Giano, Wheeler, & Hubach, 2020; Sacks & Murphey, 2018; Zhang & Monnat, 2022; Wheeler, Daire, Barden & Carlson, 2018) and engaged in more health-harming behaviours, especially substance misuse compared to white-groups (Grella, Stein, & Greenwell, 2005; Johnson et al, 2023). Furthermore, previous research has also documented gender differences, including female experiencing a higher prevalence of ACEs and substance misuse from adolescent years into adulthood for this population

(Karamanos, Stewart, Harding, Kelly, & Lacey, 2022; Shurtliff, 2020) and a more extensive history of self-harm in females nursed in an MSU (Baker, Wright & Hansen, 2013; Holden, Stables, Brown & Fotiadou, 2022; Ribeiro Tully, & Fotiadou, 2015). However, possible findings may not have been replicated here due the disproportion number of non-white and male participants, in the sample was disproportionate.

Finally, while the linear regression highlighted the prevalence of ACEs, gender and ethnic background all played a role in Health Harming Behaviour index score it would be more beneficial to explore other factors alongside ACEs (such as duration of childhood adversity, onset age of childhood trauma) to understand Health Harming Behaviour index score amongst individuals within MSU than only considering an individual's gender or ethnic background (LaBrenz et al., 2019; Lee & Chen, 2017).

Strengths and Limitations

A strength of this study is that it examines a cohort of participants admitted to an MSU over 30 a year period using a secondary data analysis approach. This allowed for a large sample of participants to be examined. Using retrospective longitudinal data also allowed for understanding how the study population's characteristics have changed.

This study has several limitations. This study relied on an existing data set generated for the ALACRITy research project (Westhead, 2023); therefore, some variables of interest were unavailable. For example, the age of participants was not recorded and, therefore, could not be used when attempting to explain some of the current study's findings. Previous research has highlighted the relationship between ACEs and premature death and increased health risks before the age of 70 years (Bellis et al., 2014; Brown et al., 2009; Bryan, 2019). Therefore, the participant's age at the data collection point may have limited exploration of the potential link between ACEs and mortality and morbidity.

Furthermore, the current data set had a range of missing data, including the inability to score items within the ACE-Q, with two items substituted within the ACE-Q to contribute to the ACE scores. The original researchers suggested this may be due to how this information in clinical records may have been documented, with reporting styles changing over the years (Westhead, 2023). Therefore, the missing data is likely

to be an under-representation of the developmental experiences of the sample. This highlights the likelihood that the approximate ACE scores and subsequent findings in the current study may not represent the patient population within an MSU or those within the service within the last ten years. The latter is essential as the endpoint of the original data collected was 2013. Despite this, the current study used a large sample and reliable substitutions based on previous research and theory to understand ACEs, which has begun to demonstrate some of the health outcomes of this population.

Implications for future research

The findings have contributed to understanding the health needs, outcomes, and status of those detained in secure settings. Ongoing research efforts to understand the current level of developmental adversity and its links to health-harming behaviours and health outcomes of those with a criminogenic background are recommended, especially since the data collection ended in 2013. Therefore, ongoing research into this area from a service perspective is recommended, and this would allow a more comprehensive and complete understanding of ACEs within the population, particularly as the reporting of this information is recognised to have changed over time (Westhead, 2023). Therefore, having a broader understanding would enable a better consideration of how ACEs differentiate amongst those admitted to MSU and influence health outcomes within this population sample. If ACEs are linked to poorer health outcomes, this will allow the service to be responsive to patient health needs.

Conclusion

The current findings demonstrated that individuals with more ACEs had poorer health outcomes. Health outcomes were better understood when combined with other factors, such as ethnicity, rather than standalone. Furthermore, health-harming behaviours, including a history of self-harm, life-threatening self-harm, and substance misuse, were a better predictor of ACEs than ethnic background. Overall, ACEs are a crucial risk factor for poor outcomes, which services should consider in reducing the health inequalities of their patient group. This study highlights the need for further research into ACEs and the health outcomes of those nursed within secure settings, which would inform early service interventions to address the impacts of ACEs.

Disclosure of interest

DM is employed by [XXX]. The first author (DM) received funding from [XXX] to complete a Professional Doctorate in Health Psychology, where this analysis formed part of her work and contributed to her doctoral portfolio.

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Table 1: Demographic characteristic of participants N=864

Gender	Ethnic Background	Mental Health Diagnosis
Males n =737	White n= 685	Psychosis related n = 355
Females n =127	Non while n = 179	Personality Disorder n = 233
		Other diagnosis n= 214
		Missing or undiagnosed - 62

Table 2: Prevalence of ACEs

ACE scores	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
ACEs	N=179	N=192	N=160	N=136	N=87	N=60	N=25	N=10	N= 15
prevalence	20%	22%	19%	16%	10%	7%	3%	1%	2%

ACEs	**0 ACEs**	**Low ACEs (1-3)**	**High ACEs (≥4)**
Gender			
Males	21%	57%	22%
Females	40%	30%	30%
Ethnicity			
White	19%	59%	25%
Non-White	28%	58%	14%
Diagnosis			
Psychosis	25%	61%	14%
Personality Disorder	8%	50%	42%
Other	25%	57%	18%
Undiagnosed	31%	58%	11%

No Outcome/ Behaviour	**0**	**1**	**2**	**3**
Physical Health Outcomes	N=564 65%	N=259 30%	40 5%	0 0%
Health Harming Behaviours	N=99 11%	N=184 21%	N=208 25%	N=373 43%

Table 3: The differences in ACEs, mortality morbidity, history of substance misuse, history of self-harm and history of suicide attempts.

	df	N =	Chi-square static value	Sig.	X^2
ACE scores					
Morbidity	2	864	9.978	.007	Sig
Mortality	2	864	7.150	.028	Sig
ACE scores					
Substance misuse	4	864	43.64	.001	Sig
Self-harm	4	864	52.87	.001	Sig
Suicide	4	864	26.85	.001	Sig

Table 4: Correlation among variables

	ACE Score	Gender	Ethnicity	Physical Health Outcomes	Health Harming Behaviours
ACE score		-.074 *p=0.030**	-.151 *p=0.001**	.078 *p*=.022*	.375 *p*=.002*
Gender	-.074 *p*=.030*		.019 *p*=.584	-.018 *p*=.597	-.114 *p*=.001*
Ethnicity	-.151 *p*=0.001*	.019 *p*=.584		-.066 *p*=.054	-.207 *p*=0.001*
Physical Health Outcomes	.078 *p*=.022*	-.018 *p*=.597	-.066 *p*=.054*		.183 *p*=0.001*
Health Harming Behaviours	.375 *p*=.001*	-.114 *p*=.001*	-.207 *p*=0.001*	.183 *p*=0.001*	

Table 5: Summary of linear regression for (a) Physical Health Outcomes index scores and (b) Health Harming Behaviours index scores (n=864)

	B	SE	Beta	Sig.	95% Confidence Intervals	
					Lower Bound	Upper Bound
ACE scores *	0.021	0.011	0.068	0.047	0.000	0.042
Gender *	-0.019	0.055	-0.012	0.726	-0.128	0.089
Ethnic background *	-0.078	0.049	-0.055	0.109	-0.174	0.017
ACE scores **	0.242	0.022	0.346	<0.001	0.198	0.285
Gender **	-0.317	0.115	-0.086	0.006	-0.543	-0.091
Ethnic background **	-0.496	0.101	-0.154	<0.001	-0.695	-0.297

*Physical Health Outcomes index score model ** Health Harming Behaviours index score model

2.4 *Quantitative Research Reflective Commentary*

Introduction

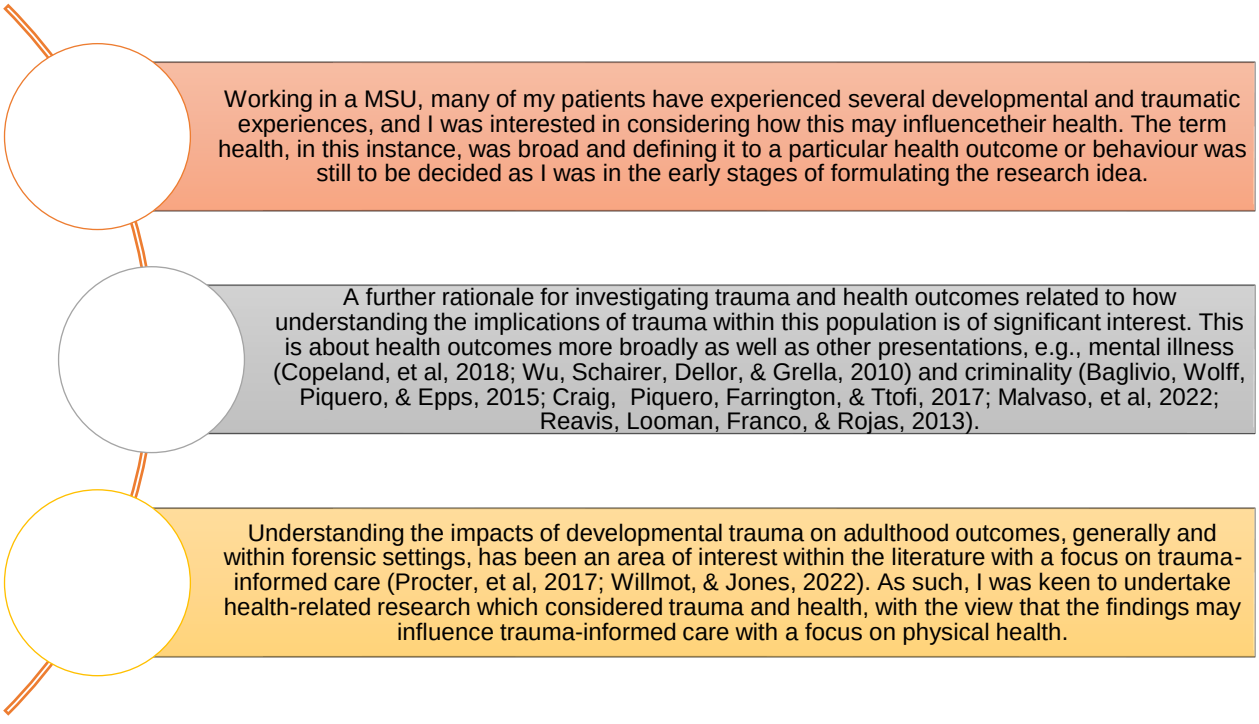
This reflective report accompanies my manuscript, which explores Adverse Childhood Experiences (ACEs) and health outcomes of a cohort of patients admitted to one Medium Secure Unit (MSU) over a 30-year period. Within this reflective report, I discuss my strengths, weaknesses, and areas of development in the approach to the research design, ethical approvals, analysis, write up and dissemination. I also discuss my experiences and development as I work towards becoming a Health Psychologist.

Rationale

I started planning my quantitative project early into my training due to not feeling confident in quantitative research methods. In addition, I was also conscious about having enough time and opportunity to collect data from a sufficiently large sample. I was interested in several topics, but I was keen for the research to be of value to my placement in an inpatient MSU. My placement experiences and interests led me to focus on health outcomes and trauma-related concepts.

Throughout my applied career to date, I have developed a strong interest in understanding the influences of developmental trauma and adverse experiences and how these impact an individual's health (Figure 1).

Figure 1: Areas of research interest



Working in an MSU and with a clinical population, I wanted my research to focus on an applied setting with a patient population. I recognised several factors to consider and challenges to overcome in undertaking research with this population and NHS setting. This included the comprehensive ethical review process, trauma sensitivity for this population and factors relating to participant recruitment (e.g., consent, capability, mental health status etc.). A solution to the potential recruitment issues was to obtain and use routinely collected patient data which would not require participant/ patient consent. However, this would require a further ethical review within the Integrated Research Application System (IRAS) process from the Confidential Advisory Committee (CAG). After seeking advice from other researchers who have experienced this process, I learned that seeking approval could be lengthy. This included sometimes taking over twelve months and needing further research training to apply for permission.

Following several discussions with the Senior Research Fellow within my service, an opportunity arose to consider using existing data from previous research. This approach would allow me to complete applied research within a clinical population while minimising possible difficulties relating to data collection and ethical approvals. For example, ethical approval/governance had already been obtained for these projects. In addition, a further reason for using secondary data is related to the benefits of the service. The dataset in question had been collected for another project, a recent PhD ALACRITy study (Westhead, 2023). It was felt that these large and rich databases were being under-utilised, and therefore, there was an opportunity to examine them further for the benefit of the service. As is often the case once a particular research project is completed, in a busy practice environment like the NHS, the clinicians and researchers move their focus to the next project. Here, I had the opportunity to reflect and consider the Open Science movement and the file drawer problem where a dataset is not explored beyond the intended purpose, and therefore there are missed opportunities to develop a further understanding (Laitin et al., 2021; Pasquetto, Borgman& Wofford, 2019). As a result, my suggestion of using the existing rich database to explore an issue of importance to the service was welcomed.

I recognise that undertaking quantitative research is not my research strength. Therefore, starting a quantitative project was anxiety provoking. I was keen to commence this soon into commencing the doctorate to allow me sufficient time to

progress and complete the research. Having the time was essential to me, having not conducted quantitative research since my master's. After several discussions with the Senior Research Fellow about possible research ideas, including a secondary data analysis, I opted for this approach. I felt completing a secondary analysis would make good use of existing data within the service while also broadening my research experience, having never previously conducted a secondary data analysis.

Design

During the research design process, I familiarised myself with the PhD thesis and reviewed the ethical approval documents for the original project. I couldn't access the original dataset, as ethical approval only allowed the original research team to access this information. I knew that the ALACRITy data was a large dataset with a range of variables and a cohort of over 900 participants spanning 30 years. To supplement my research design process, I also reviewed published peer-reviewed journals on my research topic, enabling me to identify the key questionnaires and variables to consider.

Nevertheless, I began developing my research questions and rationale after establishing the variables within the dataset and understanding how these were coded or scored. I established my primary and secondary research questions and subsequently developed hypotheses to test. Despite not having done this for several years, I felt my knowledge of quantitative research slowly returned once I had started.

Power Analysis

When considering my research's sample size, I knew the existing dataset had a large sample. Despite this, I was advised to complete a power analysis to strengthen my proposal and as a method of good research practice. Conducting a power analysis was not something I had done for several years and something I found challenging. I initially felt unsure of how to approach this, which affected my confidence, and although the process was being explained, I continued to struggle. I noticed my confidence was knocked, and I began questioning my ability to complete the course and this project. For a while, I was trapped in a period of catastrophising. This became a barrier in seeking support and guidance as I did not want to expose my inabilities or bring my suitability for training into question. After supervision with the module lead, I understood and completed an a priori analysis, despite previous research not reporting

the effect sizes within their papers. After completing the power analysis, I felt somewhat proud of my abilities. I also learned the importance of recognising unhelpful thoughts, developing skills to combat them, and seeking prompt support and guidance from others.

Ethical Approval

From previous research experiences, obtaining ethical approval from the NHS could be incredibly challenging. For this study, several factors (e.g., different guidance on which documents to complete, in-house processes not being explicit, and waiting on others to review documents) were vastly frustrating and delayed the overall approval process. This was partially due to my own unfamiliarity with the process and expectations of what was required. I met with the Trust's Research and Innovation team to discuss my project and the ethical review process. They clarified things for me, which was invaluable because it gave me a clear direction on what was required for approval and who I needed to liaise with. I learnt here to follow up discussions with an email which allowed me to share my knowledge with others and refer to the information in case of any confusion about the ethical review requirements in the future.

Another component of the ethical approval process involved obtaining research site approval. This involved sharing my research proposal in a presentation to the Trust's Academic Forum. I had previous experience presenting to this group which I found consistently challenging. This was because when I was asked many questions at the time, I interpreted them as critical rather than supportive or curious. However, on this occasion, I found the experience significantly less adverse. This experience was both different and pleasant as the presentation was delivered on Microsoft Teams, which felt like talking into a black void as I could not see anyone's faces.

Nevertheless, what made my experience more positive was my mindset and approach. I entered this presentation with more experience and knowledge and actively invited the audience to provide feedback and engage in a Q&A. I also tried not to internalise the questions and comments as personal criticisms. In addition, I felt that my position as a trainee Health Psychologist undertaking a Professional Doctorate impacted the audience's perceptions of me and the presentation. I was probably

considered more serious and competent than when I had previously presented as an Assistant Psychologist or MSc student.

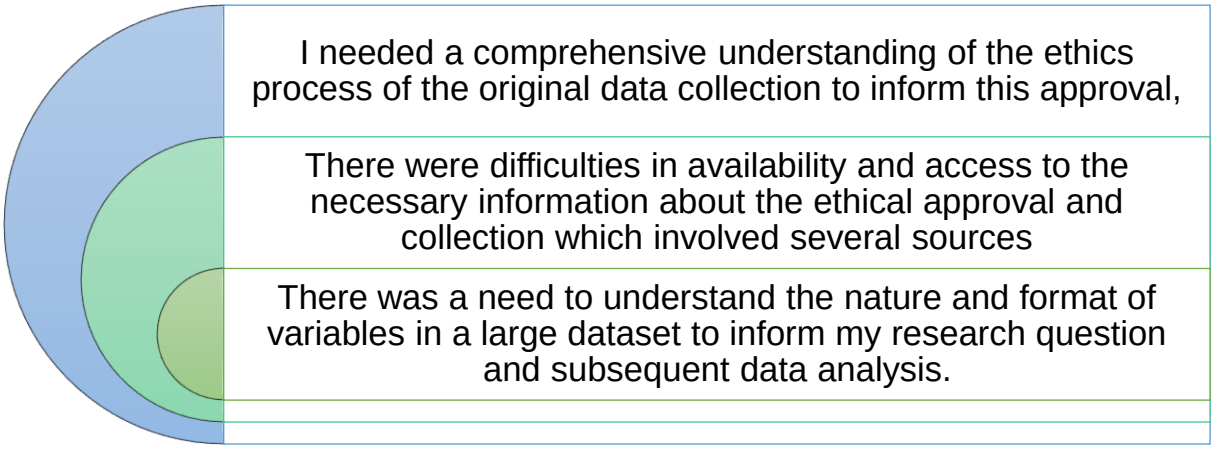
Preparing an application

As part of my research proposal, I had to highlight the types of analysis I would be conducting. At this juncture, I felt like all my previous knowledge and experience of quantitative research methods had disappeared, and I struggled with understanding what analysis I needed to complete. In part, I also believe my dyslexia and confidence were barriers. After taking some time away from the proposal and being less emotionally driven, I could return to my proposal. I was reluctant to seek supervision because I believed that being on a doctoral training programme, I ought to be able to understand and run statistical analyses.

With hindsight, I can see that my high expectations (e.g., my unrelenting standards schema) can lead me into a cycle of avoidance and negative thinking. When I receive feedback on work that I am unsure of or anxious about, I can make assumptions that the feedback confirms that I should be doing better. Consequently, I can find it hard to ask for help. However, I communicated my feelings through my monthly report, which allowed my supervisor to understand my experiences and approach me so we could overcome the issues together. Following supervision, I felt much more reassured about my abilities. I then felt more able to request supervision with the module leader to address my comments on the proposed analysis. I learnt from this experience that although I do not feel confident in quantitative research methods and the process makes me quite anxious, avoiding it only increases my uncomfortable feelings. Therefore, I recognised the need to seek support sooner or communicate my feelings earlier rather than letting them build up and become more problematic or increase my avoidance drive.

In drafting and preparing my ethics application, despite having completed a range of applications for various research projects and service evaluations, this experience was different as I had not prepared an application using secondary data, and I found this process harder (Figure 2).

Figure 2: The challenges I experienced.

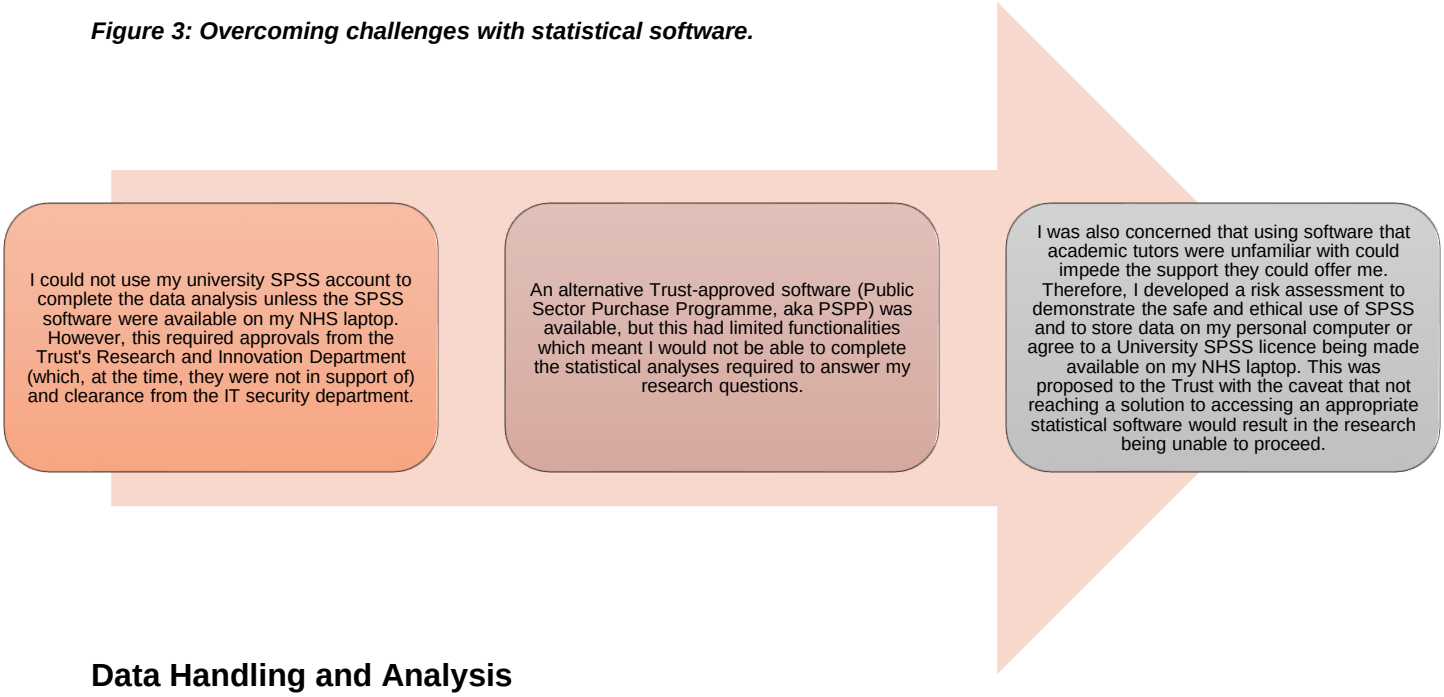


Writing the ethics protocol of research involving secondary data analysis was a new experience and did not require specific information such as study design and participant recruitment. Instead, I needed to include all the necessary ethical approvals already gained as supporting information. As I relied on others (e.g., researchers of the original data set) to provide me with relevant information and evidence for original approval, I needed to communicate clearly. Being precise about the information I required and the rationale as well as providing reasonable timescales for this information, was vital in completing my protocol promptly. My skills are of being assertive and explicit developed.

Statistical Software

A further ethical consideration was that I could not share the data outside of my placement to ensure I was working in alignment with the IRAS ethical approval of the original study. A challenge in completing this research was ensuring I had access to appropriate statistical software to analyse the data, as the data could not be shared or taken outside of my placement due to information governance. Initially, SPSS was unavailable to use. An alternative Trust-approved software (Public Sector Purchase Programme, aka PSPP) was available but had limited functionalities. However, the process I undertook (Figure 3) to challenge the statistical software issue meant I was successful in having SPSS downloaded onto my NHS computer for me to continue with the study. This was a significant shift for the research department within the Trust and taught me about the need to appropriately challenge with evidence and solutions and highlight the impact that insufficient software can have on research. My ability to be assertive and persistent certainly developed.

Figure 3: Overcoming challenges with statistical software.



Data Handling and Analysis

As noted, through my reflective commentary, I felt that quantitative research was my weakest competency, mainly due to my dyslexia. This mean working with a large volume of numbers, handling numbers, complicated terminology, procedures, and interpretation became easily overwhelming for me. Therefore, I felt anxious and apprehensive when entering the data analysis and handling stage. Being transparent about my worries and learning needs allowed me to be sufficiently supported by academic tutors who helped accommodate my learning needs by slowing the pace and breaking each aspect down so that it was manageable. Factoring plenty of time for this part of the project was something I had prepared for in advance.

I felt okay coding and deriving ACE scores from the data, as the task did not feel challenging. However, it was difficult to avoid getting confused, given the volume of data. My second checker for my ACE scoring identified some differences in scores. Addressing these discrepancies was essential for the study's analysis. I was pleased that I built this into my project to ensure reliability, which I would repeat in the future.

Although my analysis could be considered straightforward (e.g., chi-square, ANOVA, and regression), it had been several years since completing these, and I had always collected primary data. Nevertheless, I sought close supervision and guidance throughout the analysis phase from my supervisor, mainly as the University had a change in module lead. Having learnt from previous experiences of the impacts of avoiding supervision, my supervisor and I agreed that I would carry out the analysis in

stages so that I could pause and consult at regular intervals as part of supervision. This was extremely useful because it allowed me to make timely checks on my assumptions and decisions and helped me incrementally build my knowledge, skills, and confidence. I found that the more I immersed and familiarised myself with the dataset, the more confident I felt in analysing and interpreting the data.

Overall, it was a positive learning opportunity to complete quantitative analysis as part of a mandatory competency of the course. Without it, I would have likely avoided using a quantitative research methodology. Furthermore, building my confidence was helped by having appropriate software, which I was already familiar with from previous academic studies. Without this, I would have likely found this stage additionally challenging. Although I needed to refresh my knowledge and skills in using SPSS and running the analysis, I could sufficiently achieve this by referring to familiar textbooks or utilising videos to run and interpret my analysis.

Writing up

I found the process initially daunting in writing up my findings, having not written quantitative research for many years. At first, it felt like I had forgotten how to write the study. However, after reviewing some published papers, I was able to use these as a template for headings while also drawing upon my experience of writing qualitative research studies. Writing the methods section was challenging as I was not involved in the original research study and data collection. As a result, I had to refer to the original research thesis to obtain this information. It was also helpful that I contacted the original research team members to get the information required to complete this section of my write-up.

Completing the results section was another aspect of the write-up that I found most challenging. This was difficult, mainly due to my lack of recent experience writing a quantitative project. I also found writing up a research project with some findings demonstrating smaller variance (e.g., linear regression) difficult. This made it harder to consider the study's possible recommendations and clinical implications. The feedback from my first draft provided a balance in areas I completed well and areas that needed additional focus. Specifically, the feedback helped with areas I could consider or expand upon to strengthen my points about recommendations and clinical

impacts. Clear feedback helped highlight areas for improvement and boosted my confidence in the process rather than increasing my anxiety.

When commencing the study and the write-up, I did not have a journal in mind. Given the study's topic and population, I was undecided whether a health (psychology) focused journal would accept the paper or whether a journal with a greater forensic focus would be more appropriate. I identified journals catering to both (e.g., the Journal of Forensic Practice, Journal of Mental Health, and Journal of Trauma Stress). I recognised the need to review author guidelines and discuss suitable journals with academic tutors and placement colleagues. However, in future, I intend to find a possible journal before preparing my manuscript, as I could utilise the author's guidelines to structure my write-up.

Dissemination

I have prior experience in disseminating research and findings. Before commencing the study, I completed a poster presentation of the research proposal to the Trusts "Trent Study" Conference, 2021. Preparing a poster presentation for an ongoing project was another new experience, particularly as I did not have information to include in the results or discussion section. However, I searched for examples of academic posters and noted a breadth of approaches, including those that presented case studies, proposed research ideas and reflections. This opportunity broadened my experience preparing a poster presentation and encouraged me to be more creative, flexible, and versatile. In presenting at the conference, I also learnt that sharing my proposed research with professionals in the field was vital in keeping them up to date with planned research. This was because many were interested in knowing "what was out there" and remaining up to date with findings when available.

At the time of writing, I am communicating the findings to the service via the clinical governance forum. I am engaged in discussions relating to sharing the research outcomes with patients. This has also allowed me to recognise the importance of disseminating research to different audiences and using appropriate format and language to enable the audience to understand the study's findings.

Conclusion

Undertaking this quantitative research was challenging, partially due to not completing quantitative research for several years and my confidence in my abilities. Having conducted this research, I feel more confident with quantitative work, and I am pleased that I have had the opportunity to complete a secondary data analysis as a new experience in quantitative research. I am keen to maintain and build on the skills I have developed during this experience. I now have the confidence to engage in future opportunities to participate in quantitative research as an Applied Health Psychologist.

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2.5 *Qualitative Research Manuscript*

"People might find it difficult because you don't even have to be a survivor of abuse to be worried about smears" - The experiences of cervical screening in people nursed in forensic mental health services.

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Abstract:

Introduction:

People nursed within forensic services are commonly known to have a complex trauma history. Research has found the experience of childhood trauma, especially sexual abuse, to be associated with an increased risk of various physical and mental health problems. This includes cervical cancer. Research indicates this population are less likely to attend preventative assessments, such as cervical screening. Little is known about the experiences of cervical screening for this population. This study aimed to understand the experiences of cervical screening among inpatient people, in a forensic service, with a trauma history in the context of their reproductive history.

Method:

Qualitative semi-structured interviews were conducted with people detained within the Women's Pathway across two NHS secure services (N=8). Interviews were audio-recorded, transcribed verbatim and analysed using Interpretive Phenomenological Analysis (IPA).

Results:

Two superordinate themes were developed, which captured experiences: (1) Internal Conflict and (2) Manufacturing Control. Internal conflict captured how cervical screening beliefs had been shaped and influenced by earlier experiences. These experiences created inner struggles and conflicted views about the importance of cervical screening, which produced individualised barriers to engagement. Manufacturing control represented how individuals employed strategies to feel in control and psychologically ready to engage in cervical screening. Strategies included engaging in learning and peer support to build a sense of empowerment which acted as a facilitator to engagement.

Conclusion

The results identify people's experiences within forensic mental health services and how these influences or hinders cervical screening uptake. The findings demonstrated the need for individuals to be psychologically ready, in control and feel safe to engage in cervical screening to minimise the potential of the examination to remind or re-enact aspects of their trauma history. The research identified several systematic factors that may be useful for clinicians in forensic mental health services to consider that might increase an individual's perception of safety and promote the uptake and ongoing engagement with cervical screening in this population.

NB: This research involves participants who are Cis-Gender Women. However, the findings are also applicable to those who identify as transgender and non-binary.

Introduction

Cervical cancer affects approximately 570,000 people with a cervix globally and 3,152 in the UK annually (Wilding et al., 2020; WHO, 2023; Cancer Research UK, 2023). High-risk human papillomaviruses (HPV), a prevalent virus transmitted through sexual contact, are associated with most cases of cervical cancer, causing cell changes in the cervix, leading to cancerous cells if untreated (Cancer Research, 2023). In the UK, effective primary (HPV vaccination) and secondary prevention (screening for and treating precancerous lesions) approaches can prevent most cases (WHO, 2023).

The HPV vaccination programme, introduced in 2008, is offered 12-13 years in schools and administered in two doses up to 12 months apart (NHS, 2019). The HPV vaccination uptake was 83.9% for two doses in 2018/19 (Public Health England, 2019) but dropped to 67.3% in 2021/22 due to the closures of schools through the pandemic (UK Health Security Agency, 2022). The NHS cervical screening programme (NHSCSP), introduced in 1988 (Public Health England, 2020), assesses the health of the cervix to detect high-risk HPV and saves approximately 4,500 lives annually in England (Peto et al., 2004). The NHSCSP, or screening here-on-in, is offered to cisgender women aged 25–49 every three years and those aged 50–64 five yearly. Despite the effectiveness of screening at reducing cervical cancer incidences, screening uptake dropped to below the 80% attendance target (NHSCSP, 2018, Public Health England, 2017), with barriers including worry, embarrassment, appointment convenience, and pain (Waller et al., 2009; Wilding et al., 2020). Efforts to increase NHSCSP uptake have improved attendance, with 3.5 million people attending 2021/22, compared to 3.2 million the previous year (NHS Digital, 2021; NHS England, 2023). This shows focusing on understanding barriers to non-attendance can inform and improve engagement (NHS Digital, 2021; NHS England, 2023). This highlights the continued need to increase uptake, particularly for inpatients in forensic services.

Patients in forensic settings commonly have experienced (i) complex trauma histories (Clarke, Williams, Siddal & Lewis, 2023), (ii) adverse sexual health-related experiences and (iii) reduced use of healthcare services. Survivors of abuse, or survivors hear-on-in, often have had more lifetime sexual partners (Dickerson et al., 2004); have experienced coercive sex (Coverdale et al., 1997, 2000); are less likely

to use contraception (Alspaugh, Barroso, Reibel, & Phillips, 2020; Govender, Naidoo, & Taylor, 2020), have unplanned pregnancies (Shah & Sachdev 2006); engaged in health-harming behaviour while pregnant (Mosack et al., 2010; Cadman et al., 2012) and experienced pregnancy and birth complication (Tarasoff et al., 2020). Consequently, survivors also experience health issues, e.g., vaginal bleeding, urinary tract infections, sexually transmitted diseases, painful intercourse, and chronic pelvic pain (Latthe et al., 2006; London et al., 2017; Farrow et al., 2018). In addition to the above experiences, survivors are identified as at increased risk of cervical cancer due to early exposure to HPV and precancerous lesions from sexual abuse, with the prevalence of HPV infection and cervical cancer in imprisoned women higher than the general population (Escobar & Plugge, 2020). In addition, these experiences mean this population are less likely to attend preventative screening assessments (Aggarwal, Pandurangi & Smith, 2013; Farrow et al., 2018; Gesink & Nattel, 2015; Werneke, 2006), with survivors reporting their trauma history being a contributing reason for NHSCSP non-attendance (Graham, 2018). This suggests an opportunity for healthcare services, e.g., targeted healthcare programmes in UK prisons (NICE Guideline, 2016), to engage this population in these settings to provide NHSCSP (Martin et al., 2008; Plugge & Fitzpatrick, 2004).

Research has explored the barriers to NHSCSP for survivors. The procedure can parallel past trauma, e.g., the position, penetration, exposure and vulnerability, the lack of control, and the language used, like "open your legs" or "it'll be quicker if you relax" (Graham, 2018). This may evoke Post Trauma Stress Response (PTSD) responses in this population (Ackerson, 2012; Cadman et al., 2012; Robohm & Buttenheim, 1997). This includes individuals experiencing overwhelming emotions, memories, distress, shame, embarrassment, feeling powerless (Cadman et al., 2012, Farrow et al., 2018), dissociating and reverting to a childlike voice (Bates, Carroll & Potter, 2011; Robohm & Buttenheim, 1997) during the examination. Furthermore, as reported by survivors, receiving non-routine invasive examinations may cause individuals to experience psychological distress and lower self-efficacy in communicating their preferences for obstetric care (Stevens et al. 2017). Therefore, this population declines routine assessment to avoid trauma symptomology, which increases their risk of developing preventable diseases (Bibbins-Domingo et al., 2017; O'Laughlin et al., 2021).

Moreover, opportunities for clinicians to be aware of patients' traumatic histories are improved within forensic services than in community settings, where rates of unprompted disclosures are low (Farrow et al., 2018; Watson, 2016). Thus, forensic services are well-positioned to deliver trauma-informed gynaecological care to improve outcomes (DeMaria et al., 2022; Grillo et al., 2021; Kirkner, Lorenz, & Ullman, 2021; Quinn, 2022). It is, therefore, essential to understand forensic patient's experiences of NHSCSP within the context of their trauma history to inform practice.

Research suggests that childhood trauma, especially sexual abuse, is associated with an increased risk of physical health problems, including cervical cancer. Therefore, this population's attendance at NHSCSP is essential. However, personalised narratives and an in-depth understanding of their experience of NHSCSP including contributing factors are limited. Therefore, gaining insight and interpretation of first-hand experiences could improve screening attendance in forensic services. The research's primary objective is to understand the experiences of NHSCSP in inpatients in forensic services with trauma history in the context of their reproductive history. Specifically, this research sought answer: (1) 'what are people's experiences of NHSCSP in a forensic setting?' and (2) 'how have experiences of trauma influenced these experiences?'.

Method

Design

A qualitative study using semi-structured interviews was conducted with people in inpatient forensic services. Considering the sensitivity of participants' trauma histories, individual interviews were considered the most suitable approach than other methods, e.g., focus groups (DeJonckheere, & Vaughn, 2019). This allowed to obtain a detailed and personal exploration of the participant's perspective of NHSCSP.

Setting

Participants were recruited from the Women's Pathways of two NHS hospitals. This included the National High Secure Healthcare Service for Women (NHSHSW) and a Medium Secure Unit (MSU), which encompassed participants from the Standard MSU and Women's Enhanced Medium Secure Service (WEMSS). All participants were detained under the Mental Health Act (1983, revised 2007) and were over 18 years.

Participants

A total of eight people participated (Table 1). Five from the MSU (three from the WEMSS service and two from the standard MSU) and three from the NHSHSW. The first author conducted interviews between December 2022 and January 2023. Participants ranged from 27-54 years (mean age was 36 years), and on average, had been in secure services for 13 years, 2 months (ranging from 3-31 years), and in their current service for 8 years 4 months (ranging from 2-30 years).

[INSERT TABLE 1]

Six participants were offered their first NHSCSP while in a secure hospital. All participants were invited to their screening in the last 24 months; two had declined. All participants had a trauma history.

Procedure

Participants were recruited through a purposive sampling. Clinical teams identified possible participants using the study's criteria, and those considered suitable were provided with an invitation letter.

Participants were approached by a member of the research team to review the Participant Information Sheet and reviewed again after 48 hours to establish their consent to participate. If in agreement, informed written consent was obtained.

The first author completed demographic sheets using inpatient files capturing each participant's history (e.g., trauma experience, history of gynaecological examinations including cervical screening) that informed the interview. This allowed to obtain sensitive information, with consent, without participants needing to directly disclose this to the researcher. Missing information were completed with the participant prior to the interview.

Face-to-face semi-structured interviews, recorded using an NHS-approved encrypted Dictaphone, were completed with each participant, ranging from 26 to 65 minutes. One participant's original interview did not save onto the Dictaphone and was repeated with their consent.

An interview guide, using the Theoretical Domains Framework (TDF; Cane, O'Connor & Michie, 2012; Michie et al., 2005) informed the interviews. The TDF, an integrative

framework synthesises psychological theories and consists of fourteen theoretical domains that cover factors reflecting the physical and social environment, individual motivation, and capability, each representing several related theoretical constructs. The TDF has been applied to various behaviours to inform intervention design, including the uptake of cervical screening (Stuart & D'Lima, 2020).

A debrief was completed by the researcher after each interview, and each participant also met with their psychologist to discuss any experienced emotional impacts of the interview.

Ethical Approval

The research received approval from the Health Research Authority, Research Ethic Committee [REC: 22/WS/0120] and Staffordshire University. The local NHS Trust of the participating research sites also provided study approval.

Analyses

The interviews were digitally audio-recorded and transcribed verbatim. Data were analysed using Interpretative Phenomenological Analysis (IPA; Smith 2004, 2009). This was the most appropriate analytic approach as 'double hermeneutic' aims to ideographically examine how participants interpret lived experiences of personally significant experiences (e.g., past experiences of trauma and gynaecological care) rather than a priori scientific constructs (Smith et al., 2009). Table 2 summarises the IPA process used, as outlined by Smith et al. (2009).

[INSERT TABLE 2]

The robustness of the analysis process was assured through reflexivity and regular bracketing conversations (LeVasseur, 2003), with co-authors focusing on the process and development of themes. In acknowledging the "double hermeneutic" (Smith et al. 2009), researchers considered their potential assumptions about the data informed by their prior experiences. This included the researcher's gender, age, professional background and previous knowledge of participants. The lead author kept a reflexive diary of (interview content and their emotional responses) observations throughout the data collection and analysis for discussions with the co-authors.

Results

Two master superordinate themes were developed from the data: 1) Internal Conflict and 2) Manufacturing Control (Table 3), with sub-themes that considered participants' experiences and the factors influencing their NHSCSP attendance. Pseudonyms are used throughout.

[INSERT TABLE 3]

Internal Conflict:

This theme encapsulates how past trauma experiences have shaped beliefs about screening. This is illustrated through two subthemes representing influences of earlier experiences and the importance of screening role models. This theme shows how previous traumatic experiences and understanding the value of NHSCSP can create a personal tug-of-war experience for individuals, which can be a barrier to screening uptake.

Influences of earlier experiences:

This subtheme focuses on foundational experiences of gynaecological examinations in influencing beliefs about screening and engagement with healthcare professionals. Participants' early experiences of gynaecological examinations before hospital admission included those following sexual traumas. Participants reflected on how this shaped their assumptions of NHSCSP. This included the procedure re-enacting their trauma, thus influencing non-attendance forensic hospitals. For example, Flo described their experience of screening as an adolescent after being removed by social services from their abuse:

> *"… I had that smear test it was the first smear test…I didn't really think much of it. I just went there with the staff [social workers]. So, you know, you obviously don't do these things when you're younger… she clamped it open and she took this scrape [sample from cervix], and this water came out, and at first…I didn't suspect anything as I'd never been that before. I've never been aware of anything. And then obviously as the years went by, and I learned about miscarriage…and I thought to myself…I thought oh my god, they've given me a ummm, they've given me a miscarriage…I thought to myself oh no, I lost a baby…I thought I'd had; they'd given me an illegal, an illegal miscarriage. Then that why, it probably contributed to the reasons why I wouldn't want to go smear" (Flo, 3, 115-129)*

Flo repeatedly emphasised their lack of knowledge before the examination, stating, "*don't know these things*", which was a shared experience of other participants. The circumstances of the test, combined with Flo's lack of understanding, appear central in developing their fear and sense of regret as represented by "*oh my god, what have I done*". Although Flo was unsure if they were pregnant, this contributed to their perception the examination caused a miscarriage and was harmful to the body. Such

foundational experiences are core to shaping future beliefs and engagement in NHSCSP.

NHSCSP, anticipation and actual, being a reminder of historical distress and trauma, was a significant barrier within the participant's narrative. For Lois, the association between screening and sexual trauma was evident by their use of the term "*self-explanatory":*

> *"It's pretty much self-explanatory…it's painful, it's triggering, erm contaminated and it just makes it makes you feel dirty as well because all I've known is from the first experience that someone was gonna go down and was when I was 7 and that's always gonna be that experience and that's always what's gonna stick inside my head" (Lois, 9, 385-387)*

Bailey similarly shared beliefs about the links between screening and historical trauma, with specific elements such as the position and the pain, triggering their trauma:

> *"Just that the pain because when I had erm sex first it was really, really painful and I…and he [abuser] just carried on and carried on and carried on and then when I had smear test and I got pain up there and it just triggers something in your head…" (Bailey, 5, 189-192)*

For Georgina, the speculum elicited distress reminding them of *"negative experiences of being abused as a kid and that and having things inserted into me" (Georgina, 7, 249)*. For both Bailey and Georgina, specific aspects of the screening were associations with historical traumatic experiences, contributing to their beliefs that screening is painful, uncomfortable and intrusive. These beliefs become a barrier to future engagement in NHSCSP.

Furthermore, Paige declined their recent NHSCSP due to concerns the examination would trigger their trauma symptomology:

> *"Just from a past trauma…I used to suffer from really bad flashbacks and dissociation…and my main fear was that if I was to have a smear, I'd have a flashback or dissociate…but kind of there's a chance that I might lash out and hurt someone... I don't kind of want to do that, so that's one of the major barriers it's in the way" (Paige, 2, 60-64)*

Paige's concern was the vulnerability precipitating aggression. This vulnerability was similarly shared by Flo that *"it just puts you in a really vulnerable position…. because obviously this area is exposed and it's a bit, bit unpleasant." (Flo, 5, 213-214)* which elicited feeling unsafe. Flo and Paige's anticipation of triggering their trauma was significant barrier and why they declined their NHSCSP invitation.

Further NHSCSP barriers related to participant's distress caused by other gynaecological examinations unrelated to cervical screening, including the relationship with the clinician performing the procedures:

> *"Having an abortion, that whole thing affected me quite badly…the reaction to that first doctor who said no I'm not going to do...it did put me off having anything to do with any GP or anything…" (Melissa, 8, 334-336)*

> *"… I put something in there [vagina] and the doctors said next time use ice. And I thought, like, erm, and stuff like that can completely put you off as well. When people say stuff like that" (Bailey, 3, 124-126)*

The interaction and dynamics between doctor and patient are crucial in preventative healthcare, where power dynamics are present. Bailey experienced clinicians shaming them for healthcare decisions by using the phrase "*stuff like that*" and Mellissa by using the word "reaction". This demonstrates how a clinician's unhelpful and judgemental comments can have residual impacts on an individual's ability to engage in future examinations or with healthcare professionals.

In addition, participant's foundational experiences elicited feelings of worry and mistrust towards the screening process and clinicians:

> *"I suppose like you want it done but you don't want it done. You don't want to go with people and your worried about something happening…want a female nurse because if she were going to do anything, she would be less inclined to" (Juliet, 3, 96-98)*

Distrust, suspiciousness and personal tensions were reflected in Juliet's use of "*I want it*" but was "*worried*" about the clinician completing the test. Embarrassment, humiliation, and self-consciousness were also influenced by earlier incidents and represented in the inner conflict participants experienced:

> *"I think there is the embarrassment there and...obviously self-conscious and worry...I think everyone is a little self-conscious. I think that's because it's an intimate area and strangers in it" (Ashley, 4, 167-169)*

> *"Quite embarrassed…just because the whole process of it because obviously it's different to being in a relationship and actually having sex and stuff because that's kinda of, not normal but that's what happens in a relationship…" (Paige, 4, 153-157)*

For Ashley, they emphasised feeling uncomfortable by repeatedly using the term "self-conscious". Alternatively, Paige felt insecure, focusing on it being "*not normal*" to expose themselves outside sexual activity. While the associations with trauma and foundational experiences in engaging in NHSCSP are recognised, a few participants conceptualised it differently. Mellissa, who did not report historical sexual abuse, described a sense of disconnection from their past to enable NHSCSP uptake:

> *"It comes back to that thing, we're don't take it personal, we understand that it's a procedure and these are the reasons why this procedure needs to be done. And it's in your best interest at the end of the day… you don't really want to be doing these things unless they have to…" (Melissa, 7, 295-298)*

Although NHSCSP uptake is incredibly challenging for many participants, the emphasis on it *'not being personal'* allowed Melissa to engage. Bailey also shared the therapeutic process in separating screening from their trauma as *"afterwards, I thought it was alright because I'm not scared to have it done anymore"* (Bailey, 5, 207). Therefore, engaging in NHSCSP allowed them to overcome personal challenges stemming from foundational experiences to feel safe rather than re-enacting historical distress.

Importance of cervical screening role models

Although past experiences were barriers to participants engaging with NHSCSP, several acknowledged the health benefits and importance of attending. This theme highlights individual beliefs about the value of NHSCSP, including how others influence and shape their views, combined with personal tension creating barriers to screening uptake.

Participants recognised engagement in NHSCSP was essential for their health and "*that you kind of need it doing, to save your life" (Paige, 10, 419).* However, participants felt it could be detrimental to their mental health:

> *"I do think it's important…but to be honest with you, it's not really something that I'd happily wants… I don't think it's a good thing for me [mental health], but I do think it is important" (Flo, 7, 276-278)*

How beliefs about NHSCSP and its value are developed differed across generations and through personal experience. Juliet, 41, reflected, "*I think probably younger ones don't realise how important it is today. So… they choose not to go even though; obviously, everyone should have it done" (Juliet, 7, 251-252).* Whereas Ashley, 31, shared how their understanding and perspective of screening shifted:

> *"…I think it's only the last few years that I've realised actually how important it is and that and that's like having a scare with one of mine coming back positive. It made me realise" (Ashley, 1, 15-17)*

Juliet's emphasised on screening uptake was based on generational experiences and understanding, whereas Ashley's value changed after receiving results from abnormal cells.

Family members appeared to fulfil a valuable role in shaping the views on screening by communicating and helping participants understand the importance of NHSCSP and prompting uptake. Ashley explained, "*my family have always told me how*

important it is to have it done, so it's kind of like stuck with me. If they hadn't… [I] would have probably just brushed it aside" (Ashley, 8, 342-344). In addition, Melissa shared that their engagement in screening was "*dependent on whether your mum has done it [screening]*" (Mellissa, 11, 474) and "*I had my mum there to support me*" (Mellissa, 11, 238). Ashley and Mellissa reflected on their mother's influences in providing messages about the importance of NHSCSP and modelling behaviour. This was also represented by Juliet, a mother, role-modelling their daughter:

> *"To be safe and get tested because she's important to me. I want to make sure she hasn't got anything wrong with her. If you have to go and catch it quicker" (Juliet, 8, 285-286)*

In contrast, Georgina shared:

> *"I knew it as a youngster and my mum went for it. But no one mentioned smears to me before...bearing in mind my mum was having cervical cancer tests. So, my sister didn't mention it to me, my dad didn't mention it to me and so it was [paused] not really talked about" (Georgina, 2, 69-72)*

Georgina's repetition of "*didn't mention*" suggests a lack of open communication about screening in the family home, which may have impacted their views and uptake. Similarly, Paige shared, "*I haven't really done anything about smears*" (Paige, 2, 47), with their beliefs stemming from the "*hearsay*" of others:

> *"...Some of the reasons why I've been put off having a smear is because people say it hurts. People say obviously they can bleed a lot… it's from hearsay and ...it kind of puts you off and it makes you think, like, can I put myself through that? (Paige, 5, 227 – 230)*

As an adolescent, Paige's admission to mental health services reduced their opportunity to learn about NHSCSP at home. This was a common experience for other participants who were also admitted to mental health services from a young age. Paige's hesitation and lack of engagement in NHSCSP shows the impact of absent or limited opportunities to engage in open discussions to inform correct beliefs about the importance of screening.

Manufacturing Control

This theme captures the participant's need to feel in control to feel psychologically safe during the NHSCSP process. Sub-themes include facilitating empowerment, psychological readiness, learning, knowledge and having a shared experience. This theme illustrates how services create a sense of safety while individuals implement strategies to feel empowered and in control. This theme highlights, in the absence of

this, the detrimental impacts on participants' mental health, recovery and risk, which can contribute to feelings of disempowerment and powerlessness about screening.

Facilitating Empowerment

This subtheme represents the importance of empowerment during the NHSCSP process to feel safe. Empowerment refers to the process an individual experiences to be stronger and in control of their circumstances to engage in screening. Facilitating empowerment is closely related to feeling and being in control during the screening process.

Disempowerment is a common experience for survivors and those in forensic settings (Baker, 2017). Therefore, facilitating control through an examination process, which can re-enact their trauma, is essential to reduce an individual's sense of vulnerability. Participants said how "*I like to be in control of things"* (Juliet, 8, 313) and how control and choice are recognised through engaging and declining NHSCSP.

Participants reflected on the control they held in declining their NHSCSP invitation, which created safety and facilitated empowerment:

> *"It makes me feel better and I'm glad because I don't feel pressured. Because the big thing for me as well as control...so, while I'm not having it done, I'm in control, but then when I do feel like I'm ready to have it done, again I'm in control. That's, that's a biggie for me." (Paige, 6, 257-259)*

Paige identified not being psychologically ready to accept their examination but did not feel "pressured" to engage as represented by the repeated use, this facilitated "control". Furthermore, declining a screening to feel safe was influenced by participant's previous behaviours towards staff and perceptions of how this may influence staff's behaviour towards them:

> *"…If I am behaving horrible and kicking off and causing bother and being umm [pause] risk towards others and…obviously then I'm not going to go because obviously I'm not safe...obviously, they'll being thinking I've been treating people like absolute crap so why should they not do the same back. So, I'd just say no." (Flo, 9, 373-378)*

Another significant feature within the participant's narrative was the option of changing their mind to feel safe, in control and empowered. Flo described their experience of knowing they could terminate the screening:

> *"I'd say stop before I was like properly exposed...It would probably be me not going for that test rather than get there, because I think once you're there, you're halfway through, you might as well get on with it the rest of it. Whereas if you just say don't want to go, then you don't have to go; I don't have to go" (Flo, 3, 107-110)*

Flo's use of "stop" emphasised consent to terminate the screening, which was indicated as a vital form of empowerment. For participants, stopping had not always

been respected "*because of our past abuse...and obviously wanting people to stop and...they didn't, so that's always in the back of my head" (Paige, 2, 85-86*). However, this option is not known by everyone, as experienced by Georgina:

> *"I had another one here and that was with a women doctor, it was many years ago, and it wasn't a good experience. It was an invasive experience because I wasn't ready, I wasn't prepared, and I didn't even have a chance to refuse." (Georgina, 10, 358-360)*

Georgina's inability to refuse an examination suggests stopping was either not an option or they did not feel empowered to stop, as highlighted by their use of "*chance*". This resulted in feeling a lack of control of their situation, likely reminiscent of prior abuse.

Furthermore, during the examination, familiar nursing staff as chaperones were necessary for participants to feel in control and not feel alone during a vulnerable procedure. Lois illustrated two experiences of staff support during their screening:

> *"…but the fact is, I [was with] …well two people I didn't know. But when I came back, I had a one to one with "staff member X…she wasn't happy, so she made a complaint to "staff member X"…it does have an impact on your mental health…" (Lois, 10, 446-451)*
>
> *"I went with a member of staff, and I got on very well with her...she kept tapping me on the shoulder to let me know that she was still there, and I was crying all the way through the procedure" (Lois, 3, 134-136)*

Lois' comparison of experiences shows the detrimental impacts on their mental health due to unfamiliar and insufficient staff support. However, when supported by a staff member with an established therapeutic rapport, despite "*crying all the way through*", it still allowed them to continue the examination.

As demonstrated in an earlier theme, participants' experience of NHSCSP as trauma re-enacting. Therefore, the choice to be physically supported by staff to regulate their distress was reflected by Lois above and Flo:

> *"…sounds silly but a chaperone and that don't mind you, holding their hand and squeezing a bit of support...I kind of think in my head I really want to hold someone's hand right now. But I'm aware that it might have been done at this age. But I think that I'd be ideal to have someone that you can just hold on to" (Flo, 11, 475-479)*

When supported by staff members during their examination, Flo shared their benefits, such as grounded and emotionally regulated, from being "touched" by staff members. Physical touch within forensic services is uncommon due to boundary blurring and risk. However, patient choice to be touched with their consent facilitates control and empowerment during screening.

Other control and empowerment mechanisms include a choice of equipment, position, and adaptive coping skills, during the examination. Lois shared learning about alternative positions to have their screening which enabled them to feel in control and reduced their sense of vulnerability while detaching from trauma reminders:

> *"…I don't lie on my back or my belly because of trauma. So, if I knew that I could do on the side, I think it would have been okay, so now if in future, when I do need them, I know I don't have to go back to trauma. I know I can have it laying on my side…" (Lois, 14, 630-634)*

Empowerment was also facilitated by controlling and choosing the environment in which their NHSCSP was completed. Participants emphasised having the test on the ward "*would basically contaminate my room*" (Lois, 12, 613) and "*trigger memories." (Bailey, 7, 310).* Thus, leaving a negative association with the environment. Participants felt examinations off-ward would allow a sense of safety and privacy:

> *"I think it's better being off the ward personally…if I did have a smear, and it was done in the clinic [on ward], for me that would stick out in my head thinking, oh I was in here when I had this done as well on the ward it's not very private…so that staff will come in not knowing that someone's having that done. So, I think it's more personalised having it done at the meds centre [off-ward]." (Paige, 5, 199-203)*

Additionally, participants felt NHSCSP increased their perception of vulnerability because *"you've exposed yourself"* (Flo, 7, 299), creating a sense of disempowerment. Therefore, preserving dignity was essential. Incorrect equipment and processes interfere with maintaining dignity and can cause feelings of being "*contaminated… and makes you feel dirty"* (Lois, 9, 386). Georgina shared how their dignity was maintained, which reduced feelings of embarrassment:

> *"I've got a bit embarrassed about stripping off and having my body shown. But they were very understanding, and they shut the curtains so you can get undressed…until you say you're ready. I stripped off, I sat on the bed, put a blanket over me and then they asked can we come in now and I said yes, I'm ready. Then they did the examinations…" (Georgina, 8, 276-280)*

Clinician's role in completing the examination was central to how in control and empowered participants felt to engage. Bailey highlighted the importance of a female conducting the screening: "*if you've got a male doctor, you want a female doctor, you've got the right to say that"* (Bailey, 11, 477), with an emphasis placed on the choice to request a change. Alternatively, Juliet focused on whether the person made them feel safe rather than gender: "*sometimes you can just meet someone… [you] automatically know something about that person [clinician], I do not like them*" (Juliet, 3, 145). Paige focused on the importance of being treated with respect:

> *"…I'm not saying I want a fantastic relationship to like on speaking terms kind of thing. But it's, you know that just from coming introduce themselves…I understand your concerns and your worries and stuff like that…" (Paige, 7, 301-305)*

In contrast, Flo highlighted a situation unique to patients in forensic services. Having an NHSCSP screening completed by professionals seen daily makes it awkward, whereas going to an external hospital, outside forensic services, was perceived as 'more dignified' by some participants:

> *"we see these people these people day-to-day and…Like I said if you just go to the hospital, they don't, you're just another person to them, I just suppose you're just another person to them but the staff here it's just a bit raw; I don't know if it's more dignified." (Flo, 6, 235-239)*

Paige's preference for knowing the clinician and having the opportunity to build a therapeutic relationship with them was significant. Flo's prominence of the word "raw" suggests seeing the staff daily increased their vulnerability and embarrassment. This symbolises the importance of choice and individual preferences to feel safe, in control, and empowered with screening. Therefore, collaborative discussions between patients-clinician are essential for participants to feel in control and empowered during the process:

Six participants had their first NHSCSP while in forensic services, and this was their only experience with screening. Autonomy was substantial within the participant's narrative. Although not currently available in forensic services, participants preferred the opportunity to engage in self-administered NHSCSP:

> *"I'd do it because I'm doing it myself…you thought if I needed to stop, if it were hurting or it makes me remember things, I can stop it myself. I mean, I'm in control. But yeah, I think there's been a lot of people that have been willing to do it themselves." (Paige, 9, 392-395)*

Participants suggested this approach would facilitate control as Paige emphasised, "I can stop it myself", allowing for a greater sense of psychological safety, empowerment, and independence in preventative healthcare.

Psychological Readiness

Creating a sense of safety through feeling in control enabled individuals to feel empowered to engage in NHSCSP. This sub-theme focuses on the importance of participants feeling mentally prepared to engage in screening. Psychological readiness includes examination at the right timing in participants' recovery that does not compromise their progress or adversely impact their mental health, which can facilitate ongoing engagement in preventative healthcare.

Common among participants' narratives was the importance of being in the right "*frame of mind*" (Lois, 6, 270) to engage in NHSCSP. Georgina illustrated two experiences symbolising the importance of psychological readiness:

> *"Then they kept trying to coax me to go up and…said you've got an appointment and I wasn't even ready, and I didn't even know it was on that day…I said I can't I'm not ready, I'm not prepared...and they just tried to coax me to go and I said no, no." (Georgina, 5, 156-159)*

> *"But I think they also need to be assessed, mentally assessed so if someone isn't right themselves and then they don't go ahead and do it themselves, the smear test. But I would do it, definitely yeah." (Georgina, 13, 459-461)*

Georgina's comparison of experience shows the lack of readiness and being "coax" to engage despite repeatedly saying "no". However, when psychologically assessed by members of their multi-disciplinary team and at the correct juncture in their recovery allowed for screening uptake. This highlights the significance of others' understanding patients' readiness and respecting them when they are not ready for their screening.

The significance of historical trauma was closely related to psychological readiness and feeling prepared to engage in screening:

> *"If I was...having flashbacks again, then I would become unsettled…and I obviously then there's the concern about hurting other people if they stop me from hurting myself. So, it's just like, trying to keep myself stable but I fear that I have the smear, and something goes wrong, then that I feel like all the progress that I've made is just completely" (Paige, 3, 98-102)*

> *"My mental health can go down pretty quick because if I'm taking you back to a place of serious trauma, and that literally throw me off all the progress that I have made. But self-harming as well, you can have a go at doing that and…with like self-harm or aggression or mental health worries…" (Lois, 3, 441-446)*

Paige and Lois reflected on how being unprepared can cause a deterioration in their mental health. For Paige, this included increased risks towards others and Lois to themselves, both compromising their progress. The significance of association with historical trauma and appropriate stage in treatment is shared by Flo's interpretation of readiness to screening uptake:

> *"…I think the trauma, how that's affected and where we are in treatment and how we look at things yeah, because obviously people look at things in different ways. I think if people relate it to trauma and getting it wrap up in their brain, then it could possibly de-stabilise you…" (Flo, 9, 402-206)*

Furthermore, the value placed on advanced planning allowed individuals to feel psychologically ready to engage in NHSCSP. Flo shared the benefits of developing a plan beforehand to help reconceptualise the screening from a negative into a positive manner:

> *" I think I just need to grow on the feelings inside the actually they are trying to help, they're not doing anything wrong. They're trying to help and I think it's just about being compassionate ..I think I could value from growing on my*

> *thoughts, the positive thoughts about it, you know, rather than just trying to bury the negative one all the time" (Flo 5, 219-223)*

Flo's emphasis on "*grow*" suggests their attempts to mature and develop inner emotions. This reflected the importance of the intentions of NHSCSP, shifting from negativity to more helpful ways of thinking. Preparation for psychological readiness included independent planning and collaboration with staff members, as exampled by Paige:

> *"I spoke to my named nursed about it I and when I did this booklet, I did put that in there [concerns]. But obviously like I said, I've never went as far as sharing the booklet with the meds centre staff because I didn't like, follow up kind of thing". (Paige, 2, 73-75)*

However, it appeared that independent planning for Paige, using the resources provided by the service, was insufficient in feeling prepared to proceed with an examination. In contrast, Lois shared their experience of individualised and collaborative preparation with clinicians within the service, which allowed them to engage:

> *"I didn't know how I was going to be… but I thought when "staff member X" said I am taking you, I thought she was the person to go with...And she was just very like, gradually, talking and saying I can do this, and we will do that, if you need this, if you need help or if you need a shower. Literally prepared the whole thing." (Lois, 16, 706-713)*

Lois emphasised the value of joint planning through "talking", being "gradual", reassurance and at the pace of patients. NHSCSP invitation processes can inhibit effective preparation methods. For example, "*unless you tell the staff I've got an appointment booked…they won't really know. So, you need to literally need to come forward first and say I am worrying about this"* (Ashley, 6, 266-269). However, improving current processes by ensuring nursing staff are aware of patient appointments is necessary. This creates opportunities for individuals to become psychologically ready, develop a sense of safety, rapport with staff and personalises the process:

> *"Just basically have someone come down and be like your smear is due whatever and just go through the form with you...trying to encourage you but at the same time, be understanding if I say look I can't go through with it because this, this and this" (Paige, 5, 188-190)*

As described by Paige, existing processes felt impersonal and support in preparing was actively being sought. Ashley emphasised the "*need for good communication…it more comfortable and more at ease…to help prepare"* (Ashley, 4, 151-154) is essential in developing individualised support to ensure psychological readiness for screening

uptake. Georgina reflected on how a compassionate and personalised approach involving planning and preparation helped them feel in control and psychologically ready:

> *"This time was very helpful, the people and the advice…if you want me to come down to the wards and talk to you, I'll come talk to you. If you want to go up there, sit and have a drink and talk about your smear and that and if you don't want to have it done you can go back down to the ward until you find a better place in your mind to have it done." (Georgina, 3, 80-84)*

The experience of NHSCSP preparation for psychological readiness can facilitate uptake. Successful and safe uptake provides participants with "*a sense of achievement"* (Paige, 7, 284) and "*not scared to have it done anymore"* (Bailey, 5, 207). This is a powerful process in reconceptualising historical distress associated with screening and facilitating future uptake:

> *"Kind of probably put me at ease like thinking after everything that's happened to my past that I kind of have been strong enough to go through something I have never been strong enough to go through." (Paige, 7, 291-293)*

Learning, knowledge and having a shared experience

Participants' previous histories and experiences were core in allowing for psychological readiness and creating a sense of safety to facilitate empowerment and control in NHSCSP uptake. This sub-theme focuses on the power of learning about cervical screening and the mutual experiences and support participants receive from their peer group.

Participants reflected on the role of peers and peer support within the ward environment. Some found peer support supportive, whereas others felt "*I wouldn't ask for peer support…I wouldn't think that would make it any better" (Flo, 11, 470)*. Nonetheless, peer support was experienced as valuable in motivating and encouraging each other with screening attendance. Georgina and Ashley shared their experiences of being inspired by others or encouraging others:

> *"My friend went…"patient x" said, go, it doesn't hurt, go have some gas and air…you'll be fine, and I thought, right, I'll go and I went and…it was fine" (Georgina, 2, 39-42)*

> *"…like now when I hear people saying, oh no I don't want to go. Now I tend to be like no you need to…you kind of pass it on [laughs]. But like talk to me and then I so it comes in like the support." (Ashley, 8, 353-358)*

Georgina initially hesitated to engage, but their peer's reassurance about the pain motivated their screening uptake. In contrast, Ashley assumed the role of encouraging

others by emphasising the importance of the examination. The benefit of shared experience in supporting and promoting engagement is recognised. However, balancing how peers help and "*encourage each other without overstepping"* (*Mellissa,* 11, 489) is essential, as not all participants wanted others to know or "*didn't want to talk" (Lois, 12, 529)*. Participants shared ideas on how to support peers who are reluctant to engage in screening uptake:

> *"I think you should make a book with other patients that have had this smear test and how it's gone and if there is other patients coming in from a different hospital or somewhere else and they can read it and see it's not actually that bad and have it done" (Bailey, 12, 84-487)*

Bailey described sharing positive experiences of NHSCSP uptake, with Melissa similarly highlighting mutual understanding as the key to encouraging others, emphasising "*someone who was more relative*" (*Melissa, 4, 142)*. Ultimately, "k*nowing that everyone is going through it, all-female staff, patients…" (Bailey, 8, 346-347)* allowed patients to experience empathy and a shared experience. This supported their engagement as they felt others understood and were not alone.

Furthermore, participants wanted to develop their knowledge and learn together about NHSCSP, especially as some participants had limited opportunities to learn about screening before their hospital admission. This caused incorrect understanding and perceptions, including which part of the female anatomy is tested. This contributes to embarrassment and non-attendance:

> "*Never even thought that it doesn't go near that area [womb]...that changes everything really*" (Flo, 4, 172-174).

Information and resources about NHSCSP across the services were variable. Participants emphasised services needing to create opportunities to learn about NHSCSP, as currently, "*judging on information I've got which isn't [laughs] a lot is…I think there should be a bit more information available because I don't actually know a lot really" (Flo, 14, 620-622)* or *"some of the information [in the service] wasn't completely easy to read*" (Paige, 4, 178). Therefore, participants highlighted how information and resources, to be accessible, should use simple language using "layman terms", be patient-friendly, and include "colour" and "pictures" to make it eye-catching by having patient involvement. This reinforces a shared experience and peer support.

Participants across both services highlighted new learning initiatives, including increased promotion of NHSCSP, booklets, and group-based educational learning that were considered an optimal opportunity to learn together in a safe environment:

> *"in like the group…Like people get embarrassed when you say that a word like that vagina and stuff like and they don't want to come to groups because of it. But you…use slides and then talk about it, a little laugh and joke about it. But at the same time, be serious and like people like feel free to ask any questions. And if we do you or if you still want to talk about it before if we do we can before we move on. So, it really helps because people don't understand it" (Bailey, 5, 220-226)*

Bailey reflected on group-based learning, emphasising humour when learning, which allowed for a "*free*" and welcoming space to ask questions. This approach to learning is essential.

Participants reflected that individuals come into forensic services from early adulthood, often from other mental hospitals. In addition, participants also develop coping skills in their current hospital, which they take to other services, including the community. Therefore, supporting patients to build their knowledge of NHSCSP is core:

> *"Basically, when people come in. So, people come here at the age of 18, and I just feel like the more people know about stuff like this, then sometimes the easier it can be for them. Like I say, mentally preparing themselves" (Paige, 9, 384-386)*

As highlighted by Paige above, it emphasised the need for early intervention and education rather than waiting until the age of an NHSCSP invitation. Early interventions would allow individuals to feel sufficiently supported, psychologically prepared and establish a sense of safety while working through their concerns, especially those relating to their trauma. This would offer the best opportunity to improve screening uptake for this population.

Discussion

This study aimed to explore the personal narratives of people within forensic settings about how their trauma history has influenced experiences and perceptions of NHSCSP. Eight semi-structured interviews were completed and analysed using IPA, which captured these experiences in two superordinate themes: "Internal Conflict" and "Manufacturing Control".

The theme of internal conflict highlighted how participant beliefs about screening had been influenced by experiences of past trauma, including experiences of gynaecological examinations and NHSCSP. This was often related to screening re-

enacting past distress and was at odds with their beliefs about the value of engaging in screening. These factors contribute to inner struggles and conflicted views, affecting NHSCSP uptake. Manufacturing control illustrates how participants navigate and employ strategies which support psychological readiness and empowerment to engage in screening. The consequences of feeling disempowered and not psychologically ready in the NHSCSP process can harm individual mental health, recovery, risk, and future engagement.

The theme of internal conflict supports previous research, which found the process of screening paralleled historical trauma while increasing vulnerability and eliciting a lack of control in survivors (Graham, 2018) and are experiences are shared by participants in the current study. Previous research identified survivors were concerned about experiencing PTSD responses, intrusive thoughts, dissociation and emotional distress during the examination (Ackerson, 2012; Bates, Carroll & Potter, 2011; Cadman et al., 2012; Farrow et al., 2018), which was evident within the narratives of participants in this current study.

Many participants recognised the importance of NHSCSP uptake. However, barriers included the examination triggering past trauma, intrusive, embarrassing, perceived harmful to their body and making them feel self-conscious. This is consistent with previous research conducted with survivors (Robohm & Buttenheim, 1997; Cadman et al., 2012, Waller et al., 2009; Farrow et al., 2018). Survivors also reported experiencing invasive nonroutine examinations causing psychological distress (Stevens et al. 2017). The current study indicated similar experiences for participants encountering other gynaecological examinations after self-harm, sexual assault, or pregnancy. These experiences also reflected unhelpful interactions with healthcare professionals, increasing individual distress and contributing to participants' perception and subsequent engagement in screening (Farrow et al., 2018; Watson, 2016).

The theme of manufacturing control is consistent with previous research. Integral to individuals establishing control were psychological readiness for screening and the importance of a safe and containing environment and process. This aligns with research highlighting the importance of compassionate care from healthcare

professionals when working with survivors to improve the NHSCSP uptake (Gesink & Nattel, 2015).

Participants highlighted the importance of empowerment and feeling in control at all stages of the screening process. Facilitating empowerment has been acknowledged when providing trauma-informed gynaecological care (DeMaria et al., 2022; Grillo et al., 2021; Kirkner, Lorenz, & Ullman, 2021). The role of control and feeling safe is core in screening uptake, as historically, control was often removed from this population. This theme highlighted how cervical screening triggers memories of past trauma and increases a sense of vulnerability. Therefore, control and choice are core to successful and continued screening uptake. This can be provided through a choice of position, speculum size, not feeling pressured to engage, engaging at an appropriate stage in recovery, and having the power to terminate the examination. Such processes address power imbalances within NHSCSP (Gesink & Nattel, 2015).

Clarke et al. (2023) highlighted, using clinicians' reports, the prevalence of historical sexual abuse, in patients in a forensic hospital, suggesting professionals within the current services readily know the participant's background. However, clinicians may be less familiar with participants' reproductive health history, and this research highlights these individual narratives are core in screening. As this information is crucial to inform NHSCSP uptake (Quinn, 2022), additional ways in which clinicians could begin to develop their existing knowledge of participants' reproductive health backgrounds is an area of development.

The final component of trauma-informed gynaecological care involves professionals offering targeted, individualised, and holistic approaches (Raja et al., 2015). Within this, support from familiar staff members is essential. The current study highlighted the role of regular staff members as chaperones for patients, having the opportunity to form relationships with the healthcare practitioners and the appropriate environment to perform the examination mirrored previous research (Gesink & Nattel, 2015). Participants also considered having opportunities to prepare in advance, receive peer support and develop their knowledge as essential in increasing self-efficacy to engage in NHSCSP.

Clinical Implications

The current study highlights the narrative experiences of NSHCSP of those nursed within forensic services, a notably underrepresented population. Findings provide valuable and crucial recommendations to inform existing clinical practice to increase screening uptake in this population. This includes policy development, individualised support plans, education and resources and staff training.

Policy Development:

As participant experiences of NHSCSP may differ across services, and as they transition between services, a formalised Forensic Division Policy and local service procedures with user involvement are recommended. This would support trauma-informed processes for planning and monitoring screening. The policy would enable the coordination of physical health, clinical, and nursing teams to reduce ad-hoc appointments and ensure effective trauma-informed screening.

Individualised Support Plans:

Individualised screening support plans collaboratively developed by patients within the service are recommended. This would allow individual preparation before the examination, facilitate choice and empowerment, and increase self-efficacy and uptake. The importance of choice and collaboration during NHSCSP has been identified as critical by survivors (Cadman et al. 2012). Therefore, each plan should aim to capture the individual's broader reproductive history, their treatment stage to ensure readiness, choices of speculum, position of the procedure, environment, time, ways of coping and communication of feedback about results. This aims to minimise distress, re-enacting trauma, fear, and anxiety during the examination. This could be extended to include other gynaecological examinations where appropriate.

Education and Resources:

The Royal College of Obstetricians and Gynaecology (2019) recommends access to reliable and clinically age-appropriate information on women's health, including on NHSCSP. Therefore, recommendations to develop and embed educational resources about screening are made. A group-based learning environment, a new initiative in each service, would allow for peer learning and support. Accessible resources should be provided for individuals and, where possible, prepare them for examinations in

other settings, e.g., the community. Resources should include service-user involvement to ensure it meets the needs of those within the service.

Staff Training:

Nurses have reported feeling anxious about the potential of screening causing harm and distress to survivors, thus requesting support and training to provide sensitive care to this population (Walker & Allan, 2014). As participants value staff support, specialist training is recommended so staff feel equipped to offer adequate, trauma-informed support to survivors during screening (Cadman et al., 2012). Clinical supervision is also recommended to increase staff confidence in providing safe and sensitive practice for survivors (Walker & Allan, 2014).

Limitations and future research

People in secure services are a hard-to-reach population and therefore underrepresented in research. Although this research included two national services, the study only captured participants from two services across two levels of security. Recognising that these findings may not be transferable to those within other medium or low-security levels is crucial.

This qualitative research allowed for the identification of a range of views. However, participation bias is likely because people more open to discussing their experiences are more likely to participate in research. Participants in the study were all Caucasian and primarily identified as female. Further research in forensic services on ethnic minorities, transgender participants and those with neurodiverse needs is recommended.

Conclusion

The research highlights the NHSCSP experiences of people nursed in forensic services with a trauma history, with themes of Internal Conflict and Manufacturing Control. This paper highlights critical issues for mental health services, and those working with this population must acknowledge and consider their patients lived experiences and how this can inform NHSCSP uptake. This study adds existing research exploring the experiences of a population that, to the researcher's knowledge, has not been investigated previously. Pursuing this research area is hoped

to invite further research to develop recommendations, inform clinical practice, improve patient experiences, and increase screening uptake.

Disclosure of interest

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Table 1: Sample Characteristics

Participant	Age	Gender Orientation	Cervical Screening status	Last Cervical Screening	Gynae Examinations	Trauma History	Duration in current service	Duration in services	Mental Health Diagnosis
Lois	33	F	Accepted ◊	2022***	Y- after sexual assault	Physical, Sexual & Emotional abuse	4 years	17 years	Emotionally Unstable Personality Disorder
Bailey *▲	32	F	Accepted ◊	2022***	Y – self-harm	Physical, Sexual, Neglect & Emotional abuse	7 years	18 years	Emotionally Unstable Personality Disorder
Melissa **	46	F	Accepted	2022	Y – STI, Birth, Routine medical	Termination of pregnancy & abusive intimate relationship	2 years	3 years	Schizophrenia
Juliet	41	F	Accepted	2022	Y - Birth	Physical, Sexual & Emotional abuse & abusive intimate relationship	3 years	3 years	Schizoaffective and Emotionally Unstable Personality Disorder
Flo *▼	31	F	Declined	2021***	Y – after sexual assault, routine medical	Physical, Sexual, Neglect & Emotional abuse & Abusive intimate relationship	2 years	11 years	Schizophrenia and Post Traumatic Stress Disorder (PTSD)
Ashley	31	M	Accepted	2021***	/	Bullied by others, termination of pregnancy & Abusive intimate relationship	8 years	9 years	Emotionally Unstable Personality Disorder
Georgina **	54	F	Accepted ◊	2022***	Y – Self-harm	Physical, Sexual &Emotional abuse & Abusive intimate relationship	30 years	31 years	Emotionally Unstable Personality Disorder
Paige*▪	27	F	Declined	2022***	/	Physical, Sexual, &Emotional abuse, miscarriage & Abusive intimate relationship	10 years	12 years	Emotionally Unstable Personality Disorder

*HPV Vaccination Eligible; ▪ HPV Vaccine accepted; ▲HPV vaccine not offered; ▼Unable to recall HPV vaccine offered; ** Peri-menopausal; *** first smear in services; ◊Previously refused cervical screening

Table 2: IPA Process

Steps	Description of the analytic process
1. Initial Coding	Each transcript was read at least twice, facilitating immersion in the data. The analysis involved attending to each case, line-by-line annotations (exploratory coding) identifying descriptive, linguistic, and conceptual aspects (e.g., certain of own knowledge, repetition of they, hesitation, uncertainty, done by others) to develop an in-depth understanding of individual accounts (Smith et al., 2009).
2. Experimental statements	Codes were grouped to form experimental statements
3. Personal experimental themes (PETs)	Connections across the experimental statements were then searched for to form personal experimental themes. This allowed for broader superordinate themes and subordinate themes to be developed. The idiographic approach of IPA aims to offer insights into each participant's narrative, and therefore, analysis was completed for each case in turn.
4. Group experimental themes (GETs)	Once all transcripts had been individually attended to, exploring how the themes connected across participants was undertaken to develop master superordinate themes (group experimental themes). This allowed identifying convergence and divergence within the data.

Table 3: Overview of themes

Master Subordinate Themes	Sub-Themes
1. Internal Conflict	Influences of earlier experiences Importance of cervical screening role models
2. Manufacturing Control	Facilitating Empowerment Psychological Readiness Learning, knowledge and having a shared space

2.6 Qualitative Research Reflective Commentary

Introduction

This reflective report focuses on the processes undertaken and decisions I made in designing, ethical approach, data collection, analysis and write up of my qualitative research. Within this report, I also reflect on my growth in experience and competence as I completed my qualitative study exploring the experiences of cervical screening for people with a trauma history within forensic services.

Rationale

I completed my qualitative research while working on placement within the Women's Pathway of a Medium Secure Unit (MSU) and National High Secure Healthcare Service for Women (NHSHSW). The research idea arose during a treatment planning meeting when the MSU multidisciplinary team (MDT) noted that the uptake of cervical screening amongst the female forensic population was suboptimal. The NHSHSW, while designing my research, also expressed a shared concern about the limited uptake of cervical screening of patients within their service. This was of particular concern because this population is at higher risk of cervical cancer than community populations (Escobar & Plugge, 2020). Addressing the need to develop a deeper understanding of forensic populations' cervical screening experiences became my research's focus.

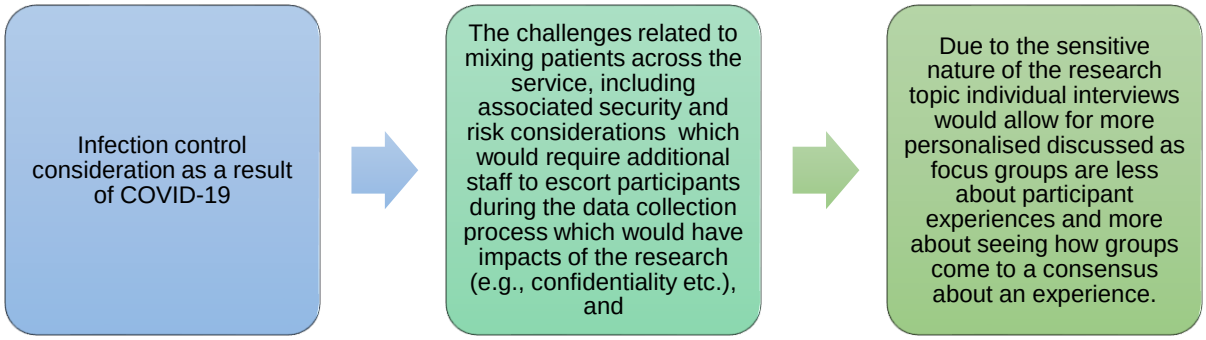
To focus my research question, I reviewed the current literature on cervical screening in survivors of abuse, those with mental health difficulties and female offenders to understand the existing research. Previous research in the area has focused on quantitative research methods. This included a range of research highlighting the increased risks of cancer and gynaecological issues for victims of sexual assault, which included barriers to cervical screening. However, I could not identify research focusing on female offenders or those within mental health services. This, therefore, provided a strong rationale for qualitative research and strengthened the need to understand the experiences of this population. To do this, I completed semi-structured interviews with people in two forensic services to understand their experiences and how their trauma history has influenced their experiences.

Working clinically in both services, I developed excellent knowledge and understanding of the context. This helped me with the practical elements of designing, planning, and completing the research, e.g., obtaining appropriate ethical approvals and making data collection more achievable.

Design

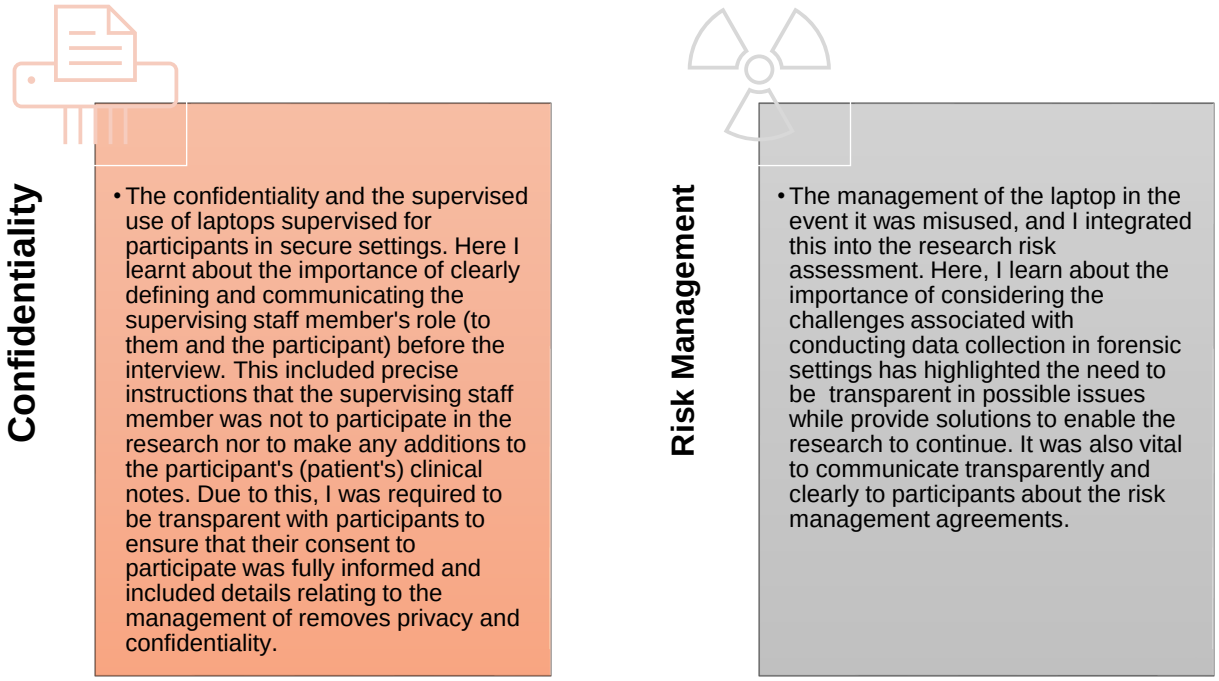
Individual semi-structured interviews were selected as the data collection method as I wanted to explore participants' first-hand experience of cervical screening, and individual semi-structured interviews were opted for over-focus groups (Figure 1).

Figure 1: Rationale for semi-structured interviews



Another consideration in my research design, especially with data collection, was the impact of COVID-19. While the position of the pandemic was improving, I felt it was essential to have a contingency plan in place to ensure I could continue with data collection if there were an outbreak of COVID-19. The COVID-19 contingency plan included virtual interviews rather than face-to-face. However, given the secure hospital setting from which participants were recruited, participants would require supervised access to use laptops which generated two key ethical considerations (Figure 2).

Figure 2: COVID-19 ethical considerations



A core aspect of my research design and preparation of research documents included Patient and Public Engagement and Involvement (PPIE). The Health Research Authority (HRA, 2023) defines public involvement in research as "*done with or by the public and not to, about or for them. It means that patients or other people with relevant experience contribute to how research is designed, conducted, and disseminated*". I included several different PPIE methods (Table 1).

Table 1: Use of PPIE

Organisation	Rationale	Comments
Jo's Trust	I approached Jo's Trust, a charity organisation that focuses on cancer and has previously worked with survivors of abuse.	My initial contact with the organisation was to discuss and establish what involvement and contributions they could provide to the research. I had anticipated to engage this organisation to help design my research but was also open to suggestions and ideas of other types of engagement. However, due to the service strains caused by the pandemic, they could not offer support at the current time.
WISH charity	Alternatively, the WISH charity, which supports women with long-term mental health needs that have contact with the criminal justice system, was also contacted.	Similarly, to Jo's Trust, the charity was experiencing significant strain due to the pandemic and was operating at a reduced level. This meant they were unable to offer any involvement in the research.
Public Involvement Coordinator	I worked alongside the public involvement coordinator who was able to support public involvement in my planning stage. This provision was with the Institute of Mental Health, based at Nottingham University.	This involved supported me with public and service user engage by inviting people on an existing distribution list to “engage”. The results of this included delivering a focus group to discuss my ideas and plans and to receive feedback . Although the focus group attendance was smaller than anticipated, the comments and feedback highlighted additional considerations.
Patient Involvement Group	This included working with service users across the NHS trust of the participating research sites.	It was not possible to engage them in earlier part of the research design as I had to progress with preparing research documents and applications. This was to minimise delaying aspects of the professional doctorate. Therefore, the patient involvement group involved service users from one NHS trust reviewing all participant-facing documents. I also found this group had already accessed and received the relevant research training, which is an essential factor in PPIE .

In my approach to selecting PPIE involvement, I needed to include providers with existing structures in place and the involvement of people in forensic settings. It was not possible to use patients within the existing research sites as it is recommended that clinicians do not use their patients or likely participants in PPIE to reduce potential bias and conflict of interest (Hoddinott et al., 2018). Therefore, I approach two charity

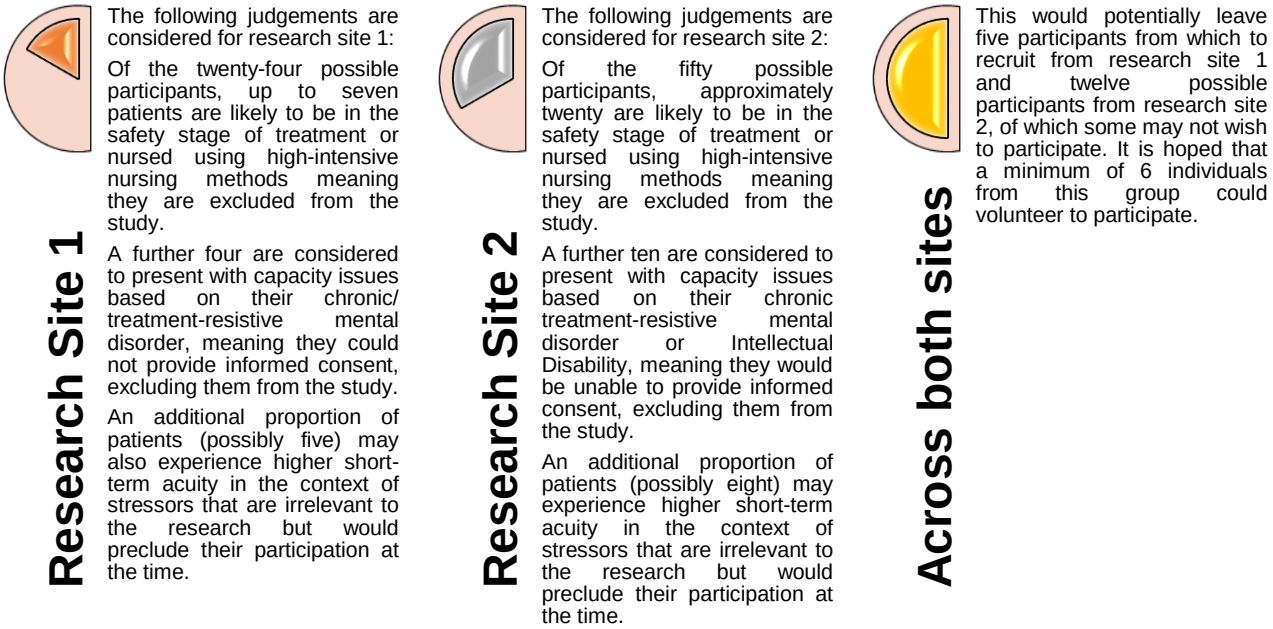
organisations. This was because well-established charities and organisations have the existing infrastructure to provide meaningful contributions to research projects, ranging from informal discussions to partnership research approaches that can include co-production (Hoddinott et al., 2018). Neither service could support due to service strains caused by the pandemic. However, I learnt about the importance of networking and connecting with organisations. Although these services could not help, PPIE is essential for disseminating research, so their involvement could be revisited.

The involvement of a Public Involvement Coordinator at the Institute of Mental Health and Patient Involvement Group in the participating sites of NHS Trust gave me invaluable feedback to inform my research. Here I learnt to appreciate and consider the perspective of public members with varying perspectives outside of the NHS and clinical practice. In addition, receiving patient feedback was vital to me. I learned that although I attempted to use lay language and incorporate visuals, but this was not always accessible to individuals. As such, it allowed me to make changes, and this input is something I would use in future research.

My final consideration when designing my research, and a cause for concern for me, was having an appropriate sample size. Given the sensitive nature of the topic and the population (those with fluctuating mental health difficulties to provide informed consent), I wanted to ensure I had a suitable sample size for qualitative research. Guidelines for sample sizes in qualitative research have been recommended based on the research question and associated analytic approach (Guest, Bunce, & Johnson, 2006). Smith, Flowers and Larkin (2009, pg 56) suggested "*there is no right answer to the question of sample size" when using Interpretative Phenomenological Analysis (IPA)."* Single-participant studies have been justified, providing they can generate a particularly rich or compelling case (Smith, 2004). However, Clarke (2010) has identified three participants as the default sample size for undergraduate or Masters-level IPA studies, whereas four to ten participants are advised for professional doctorate research. When planning my research, I had one research site: my placement. However, another service within the same NHS Trust was also interested in the study and requested I consider them as an additional research site. This was a positive experience as the research topic was also considered necessary in other areas. Therefore, partway through planning and designing my research, I had to consider including an additional research site to increase my potential pool of

participants. My consideration of sample size was based on clinical knowledge of the service (Figure 3) while guided by my research question and data analysis approach, as Guest et al. (2006) recommended. Therefore, I opted for a sample size of eight.

Figure 3: Sample size decision making



Ethical Approval

To complete the research, I had to balance ethical procedures from Staffordshire University, the NHS Research Ethics Committee (REC), the Health Research Authority (HRA), and local NHS approval. Working out the order to pursue the different permissions, addressing requests for amendments, and liaising with all committees was a mammoth task. Obtaining ethical approval for this project was an incredibly long process which I found highly frustrating at various junctures (Table 2).

Table 2: Ethical Approval Process and Reflections

Ethical Approval Body	Description of Process and Reflections
Research Site Approval	To obtain initial approval for each research site, I presented my proposal to clinicians in the service. This included the Clinical Director, a Senior Research Fellow, and Women's Pathway MDT, who were in positions to authorise service approval. Although nerve-wracking, I found the presentation to be a pleasurable experience. I felt confident in conveying the rationale and proposed methods and answering questions. The experience allowed me to develop my communication skills, presentation delivery, research knowledge, and passion for the project. However, a long wait in obtaining research site approval from each service delayed my progress to the next ethical approval stage.
Staffordshire University	I submitted paperwork for a full ethical review for Staffordshire University, which underwent an Independent Peer Review Process. Completing the documentation for submission took longer than anticipated due to the simultaneous preparation of all my research documents and PPIE engagement. Nevertheless, the minor amendments and feedback from the panel were almost congratulatory, commenting on the quality of the documents submitted. I felt that taking the time here was essential and assisted me in obtaining subsequent approvals needed for the research. I also learnt that despite the time taken to complete the research documentation and ethics forms, taking the time helped later, as only a few amendments were required.
NHS Ethics	After that, I had to seek ethical approval from the Research Ethics Committee (REC) and Health Research Authority (HRA) using the Integrated Research Application System (IRAS). This process took several months, and I had to overcome several obstacles, barriers, and delays. Such as: • Obtaining required signatures - Ensuring I had the necessary signatures to submit my application. Although this sounds like a simple task, staff sickness and trouble identifying who the appropriate signatory was caused delays. In addition, any amendments to the ethics form resulted in all existing being lost and therefore needed “re-signing”. • Organisational Information Agreement - This is a written agreement between the NHS Trust and Sponsoring organisation (Staffordshire University) - it was with the University for several months. It ended up with the legal department of the University. Despite seeking to understand the delays, limited feedback was provided, which left me feeling incredibly frustrated and concerned about completing the project within the timeframe. My clinical supervisors on placement had some significant concerns about these delays impacting the research and my training and were very

close to intervening to seek an update. However, I reflected that all the delays were beyond my control, and I learnt that it was okay to feel what I was feeling and to take these to supervision. Here my resilience and persistence, while being tested, also developed. In future situations, I need to understand expectations and requirements more clearly than "learning as I go" to minimise hold up. This may have helped manage the delays better.

- HRA document change - The HRA committee (via the REC board) requested language changes to the participant information sheet. However, these had not been communicated to me. The REC had provided a favourable opinion of my application, so I was frustrated about the delays. It was only when I directly contacted the HRA that I learned of their requested amendments. After several emails with the REC, I sought an update. It transpired that the individual managing my application within the HRA was unwell and absent from work, and an alternative employee was not processing my application. Once this miscommunication was identified, the HRA team could act on the matter and clarify their amendments. I learned that there were set language templates I should have used. I made the revisions, and final approvals were granted.

Nevertheless, as part of the ethical approval process, I attended a REC board meeting which was a positive learning opportunity. I sought support from clinicians and previous trainees beforehand to help me prepare for the meeting. This meeting gave me the experience of understanding the research review process and enabled me to consider various research issues and solutions. I found it interesting that although I answered the questions from the panel, I would still be expected to provide a formal written response following the meeting. Although I was keen to give an immediate response, with hindsight, reflecting on their questions and discussing my written response to the panel with my supervisors allowed me to provide a more considered response.

Local NHS Trust Approval	The final approval I sought was from the local Trust in the format of Confirm and Capability. This process appeared straightforward, as I could use the HRA template to seek approval. Although the Trust raised a few queries, these were responded to with little concern or delay. Overall, the approval process was long, complicated, and challenging; I learnt a lot about the process and the issues faced when completing research in the NHS, which has prepared me for future applications.

Data Collection - Participants and Recruitment

My planning, which included regular communication and contact with key clinicians in the service, made collecting data straightforward. One of my research sites was my core workplace, so I took a greater responsibility in approaching participants. Although also clinically involved at the second research site, this was to a lesser extent, and therefore, I used my onsite supervisor during the recruitment process. This was incredibly useful in saving time and project management. Ultimately, I completed my data collection within six weeks and felt euphoric as this timeframe exceeded my expectation and allowed me to "make up" for delays in ethical approval.

As mentioned, I worked clinically in both services while completing this research. I was, therefore, in a position where I knew of some of the participants from previous clinical interactions, known as a 'dual relationship' (Braun & Clarke, 2013). As this was unavoidable, I communicated my two roles with participants and the importance of maintaining a distinction where possible. For example, discussions about research and clinical matters took place separately. I was conscious of my dual relationship, e.g., participants feeling compelled to engage due to a pre-existing relationship or assumed knowledge based on the clinical experience of working with them (Braun & Clarke, 2013). In this position, I was also mindful of my boundaries in having multiple roles (as a researcher and clinician for participants). I considered how the participants might have felt being approached by me and engaging in the research. Maintaining professional boundaries and separating roles was necessary, leading to several reflections about different dimensions (Table 3).

Table 3: Decision-making model for therapists regarding dual relationship dilemmas (Gottlieb, 1993)

Dimension	Description	My approach and reflections
Power	The power levels in professional relationships depend on the amount of vulnerability required of the participant and the amount of influence maintained by the researcher/therapist. A relationship low in power includes fewer hierarchies, e.g., someone the same as you. In this stance, another peer/ participant. High-power relationships involve one person having influence over another who is more vulnerable. E.g., participants/ patients Vs researchers/therapists.	In maintaining my boundaries during the recruitment and data collection processes, I was mindful of the power dynamics within the relationship. By nature of their mental health status and detention, patients within secure service are classified as vulnerable adults. Therefore, in entering the research process, I was aware of the power dynamics. This included my existing relationship (as a therapist) with the patient and now as a researcher. To balance the dynamics, I attempted to empower participants through the process. They were provided with the necessary information in a standardised manner. However, empowerment and control were facilitated in considering their participation, including the time needed to decide. I felt my ability to achieve this was good, as several participants did not wish to receive further information beyond the initial invitation letter (e.g., the participant information sheet). This was ultimately respected, allowing them to feel in control of the situation. During the data collection, maintaining a balance of power and providing participants with choice and empowerment was also facilitated. I attempted to do this by ensuring participants knew they could skip questions they did not wish to share or stop participation at any point without providing a reason. Participants were informed of this during the recruitment process and were again reminded before the interview.
Duration	This dimension refers to the amount of time and period of contact with the participant.	Reflecting on my relationship with participants, I considered this before data collection. I had an existing relationship with participants and with an established therapeutic rapport. This, I believe, worked to my advantage. For example, participants were familiar with me and likely aware of how I would engage them in the interview. For some participants, the contact duration spanned several months to several years. I believe this established knowledge allowed participants to: (i) enquire and ask questions about the research and (ii) have the confidence to decline engagement in the research.

		Furthermore, although therapy sessions are distinctly different to research interventions, the Socratic nature of asking questions is similar. As such, the familiarity of my compassionate, gentle, and sensitive approach would facilitate engagement in a sensitive research topic.
Termination	This dimension focuses on the professional relationship ending before the next relationship begins. Also, the termination of the professional relationship has an agreed end date, and no further professional contact is expected.	Considering my endings with participants, this was made explicit before data collection and as part of the recruitment process. Participants were informed that my role as a researcher was time-limited and my role as a clinician in the service would continue after the research interview. To help manage the roles distinctly. It was agreed that I would not complete direct clinical work (e.g., therapy) with the patient (participant) during a data collection period. The timing of data collection (e.g., near the Christmas period) also lent itself well as during this juncture clinical activity such as therapy is reduced. This allowed them and me to have a clear role and to minimise blurring. The termination of the research relationship was clear, and participants knew that no contact about the research would occur after the interview, except if they wished to withdraw the data. Psychologists in the service offered post-interview support. While I am aware that I am a psychologist in the service, to help reduce the blurring of roles, this additional support was provided by the lead psychologists of the services.

I had experience collecting qualitative data, including individual semi-structured interviews and focus groups. In addition, my clinical background in delivering therapy and using Socratic questioning allowed me to complete the research interviews confidently, as I could draw upon these skills. I was mindful, given my dual role, the semi-structured process of the interview would be a different experience for both participants and me and therefore, I discussed this with participants beforehand. I also found that using a semi-structured guide allowed me to remain focused on the research topic and enabled some flexibility based on the participant's narrative. This was important as it enabled me to ask additional questions and the interview to flow and feel conversational, allowing for a more natural experience.

One participant interview did not save on the recording device during my data collection. This was an incredibly frustrating process, but there were several options available to me;

(i) invite participants to re-interview,
(ii) approach other identified participants for their consent, or
(iii) end data collection as a sufficient sample had been recruited.

Following a discussion with my supervisor, I invited the participant to re-interview, which they accepted. In re-completing the interview, I was mindful of the respondent's burden, e.g., the length of the interview, the amount of effort required for the respondent, and the frequency with which the respondent is interviewed (Bradburn, 1978). In addition, I was also mindful of respondent fatigue. Therefore, I monitored for signs such as the participant becoming bored, tired, or uninterested in the interview and performing or responding differently than previously (Jeong et al., 2023). While alternative responses were expected during the interview, I also attempted to monitor the participant's level of engagement, and there was no evidence of anticipated responses or pre-prepared answers.

Data Analysis

The data was transcribed using a mixture of audio transcription by hand and a dictation feature on Word. When the dictation function was used, the transcription was checked by relistening to the recording and amending any errors to ensure accuracy. Although checking the transcription was time-consuming, it was more time efficient than my previous transcribing experience. Nevertheless, I also found listening to the interviews

beneficial as it allowed me to familiarise myself with the data as part of the analysis process.

IPA was adopted due to the idiographic stance over other form of qualitative analysis I had no prior experience using IPA as an analysis methodology, so I conducted some broader reading to develop my knowledge (Pietkiewicz & Smith, 2014; Smith, Flowers & Larkin, 2009), which included revisiting the materials from a teaching session on the Professional Doctorate. This allowed me to understand the different stages of IPA better and complete the analysis sequentially. Familiarising myself with the data was essential through reading and rereading the transcripts. This helped me achieve the exploratory comments of descriptive, linguistic, and conceptual commentary. This was an incredibly demanding and psychologically taxing process. I underestimated the time required to complete this stage and the cognitive fatigue I experienced. In the future, I would organise my time differently to allow more time during this phase, incorporating self-care to manage fatigue. After that, I made my exploratory statements, which felt like a more familiar process to other qualitative analysis forms. Having developed a greater familiarity with the data, I felt comfortable sharing my initial interpretations with supervisors to ascertain their insight. This also allowed me to check my accuracy in IPA, given my limited experience with this approach.

The next stage in my analysis was developing personalised experience themes, including creating a table of themes for each transcript. This was another new experience, and I was initially unable to appreciate the benefits of this stage until I progressed to the group experimental theme stage. Here I valued and recognised the collective themes across all the transcripts and key distinctions amongst participants. I had further meetings with my supervisors, where I could present my themes alongside illustrative extracts from the data. This process allowed for clarification and refinement as a group of researchers. I found this process beneficial in strengthening my rationale for the themes, mainly as I was conscious of my lack of IPA experience. My experience working with multiple researchers was valuable due to each person's different clinical and research backgrounds which provided alternative, unique, and shared perspectives to the analysis and interpretation of the data. This is an approach I would be keen to use in future qualitative research.

I found it somewhat overwhelming when selecting suitable extracts for my analysis. This was due to the volume and richness of the data and wanting to do the research justice. Having developed familiarity with the dataset, I instinctively knew which quotes would represent the theme appropriately. An issue I encountered was that some quotes could be used to illustrate more than one point; therefore, selecting and using a quote in the most suitable place was essential. This required selecting extracts and observing how they fit with the narrative of the theme. I gave myself several options for participant extracts and made selections based on how they read within the manuscript. Feedback from drafts also helped with this process as I learnt that taking an idiographic stance allowed participant extracts to fit better in the themes.

Furthermore, the language used within the quotes sometimes reflected the language used within forensic services. Therefore, for lay individuals, it was unlikely to make complete sense. Having worked in a forensic hospital for several years, I have gained a good understanding of the environment (to facilitate understanding of the processes) and the unique language used. This helped me understand specific words used during the interviews and how to reflect this within the analysis to ensure it would suit a non-expert audience.

Dissemination

I consciously decided to use gender-neutral language when describing my participants. This was prompted by one participant who identified as a transgender male. Whilst I was keen to be inclusive of their gender orientation, I had concerns about whether the transgender participant's anonymity would be sufficiently maintained as the only minority participant. Following discussions with onsite and academic supervisors and Equality, Diversity, and Inclusion (ED&I) leaders within the NHS Trust and the University, I used gender-neutral pseudonyms. A participant-driven approach could have been used on reflection, which may have facilitated rapport-building between the participant and me (Allen & Wiles, 2016). In summary, I learnt the importance of inclusive language to all participants and the ethical considerations that arise when minorities are included within a sample.

Before preparing my manuscript, I identified a range of possible journals to which the research could be submitted (e.g., Journal of Women's Health, British Journal of Cancer, and Journal of Trauma Nursing). Although these journals would suit this

research, they did not lend themselves well to qualitative research. For example, the author's guidelines either emphasised quantitative study or had a limited word count for qualitative research. Therefore, I felt the Psychology and Health Journal would be suitable, and I prepared my manuscript using the publisher's guidelines. I felt this journal catered to the specifics of my research, including the research outcomes being of interest to the audience.

In addition to the manuscript, I plan to disseminate findings to each service for clinicians and patients in the service:

> **Summary for Clinicians:** This will include presenting the results at the service's clinical governance meetings and producing an executive report. This will summarise the participants' experiences of cervical screening and shed light on the barriers and facilitators of engagement for this population. The results will also include recommendations for how the research findings can improve clinical practice. This report will be made available to the service clinicians and Research and Innovation Department and published on the local NHS Trust intranet.
>
> **Summary for patients in each service:** Discussions on how these findings could be presented include a summary using lay and easy-read language and are yet to be finalised. A suggestion of presenting the results as a leaflet has been discussed and felt to be appropriate and accessible for the intended audience. To generate more ideas of how to present the findings, I intend to invite the participants and other patients in the service to share opinions on how they would like research to be summarised. Involving participants and patients across the service in this process is essential, as they have in-depth knowledge in the area and can advise on how the research might impact their health and health care beyond an academic and clinical audience (Hoddinott et al., 2018).

I have since been approached by an animation service (Science Animate) interested in creating a video summarising the findings. This service has developed research animations for the National Institute of Health and Research (NIHR). While this video is associated with a significant cost, funding options are being explored. However, I feel that this approach would produce a research summary in an accessible manner

for the intended audience that includes less clinical jargon and meets the health literacy needs of those in the service. Critical areas in dissemination I should capture include the voices of people in the service about cervical screening and how individuals can be supported better to engage in preventative healthcare. It is hoped that this summary will also include PPIE involvement. I look forward to sharing the research outcomes with different individuals and working with them to consider the practical implications of the findings. In future projects, particularly in writing applications for research grants, I recognise the need for building in funding to support the dissemination of research.

In addition to producing and disseminating reports, I will aim to present the findings at conferences, including a poster presentation at a Women in Secure Care conference and a Staffordshire University conference. This will ensure it reaches a variety of professionals both within academia and clinical practice to inform clinical practice and improve patient uptake of preventative healthcare.

Conclusion

Overall, I have found this project enjoyable and rewarding to complete. Improving patient engagement in preventative healthcare is an area of vital importance to me. Therefore, being able to conduct research with applications to clinical practice has been fulfilling, and I hope I can continue with similar projects in the future. Although IPA has been a new experience, completing this project under supervision is beneficial. The research skills I have gained from design to application within the NHS have provided me with the competencies and knowledge for future research in the NHS as I become an applied Health Psychologist.

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Chapter 3: Psychological Interventions

3.1 Individual Face-to-Face Case Study

Introduction

This case study describes a psychological intervention, which I implemented at a Medium Secure Hospital across eighteen sessions. The patient, who will be called "*Mr. Bailey*", was referred to the Psychology Department for Cognitive Behavioural Therapy (CBT) by his Neurologist after receiving a diagnosis of Function Cervical Dystonia (FCD) in November 2020.

FCD is a neurological movement disorder characterised by continuous or intermittent muscle contractions that cause involuntary abnormal, often painful, repetitive movements in any region of the body (National Institute of Neurological Disorders and Strokes, 2021). It is diagnosed when tests that normally establish the cause of these symptoms are negative and appear to be triggered by psychological or psychiatric factors (Dystonia UK, 2020). FCD can occur at any age but typically, symptoms are first experienced during midlife (late 30–the 40s) and progress gradually often reaching a plateau over a few months or years (National Institute of Neurological Disorders and Strokes, 2021).

Mr. Bailey is a 48-year-old male of Afro-Caribbean descent. He has presented with symptoms of FCD since 2014. Mr. Bailey has been under mental health services and the criminal justice system since the late 1990s. Mr. Bailey also has a primary mental health diagnosis of Schizoaffective Disorder with co-morbid Personality Disorder.

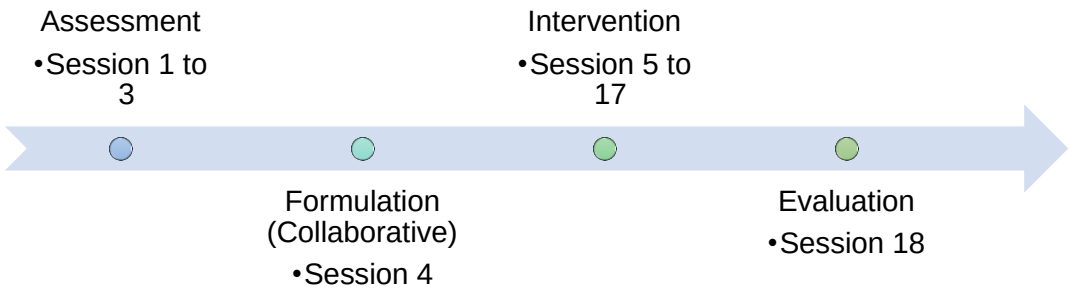
Like many patients with FCD, Mr. Bailey presents with a consistent twisting of the neck and experiences chronic pain. His neurologist referred Mr. Bailey for individual CBT as a first-line intervention before pursuing Botox injections. Individual therapy, specifically CBT, is considered appropriate for patients presenting with physical symptoms as these can be related to psychological distress. The association between chronic physical illness and psychiatric disorder is long-established, which further emphasises the suitability of CBT (Evers 2002; Larcombe 1984; Greer 1992; Sharpe, Sensky Timberlake, & Sharpe 2001). Thus, CBT aims to examine and adapt beliefs about health and physical symptoms, reduce stress, and increase coping with symptoms (Dystonia UK, 2020; Geraghty, & Scott,

2020; Halford & Brown, 2009; Kent & McCillan, 2009, 2020; McAndrew et al, 2019; Scott, Crawford, Geraghty, & Marks, 2022).

At present, there are no recommended National Institute for Clinical Excellence (NICE) guidelines for the appropriate psychological treatment of FCD. However, CBT interventions have been offered as an evidence-based therapy for psychological disorders in adults experiencing persistent physical symptoms and Medically Unexplained Symptoms (MUS; Hoffman et al, 2012). Such interventions have been shown to reduce the intensity and frequency of somatic symptoms and improve functioning in somatising patients (Jones, & de C Williams, 2019; Knotts & Cox, 2014; Scott et al, 2022).

Published IAPT guidelines for MUS on the length of treatment for a CBT-based intervention, suggest “high-intensity interventions” which can be characterised as weekly sessions for a duration of twelve to twenty weeks (Geraghty, & Scott, 2020; Husain, & Chalder, 2021; IAPT, 2014; Knott & Cox, 2014; Scott et al, 2022; Shafran, Myles-Hooton, Bennett, & Öst, 2021). Through discussion with my supervisor, it was agreed that a twelve-week intervention would be an appropriate starting juncture, however, this was extended due to the patient need for a longer assessment process (see Figure 1 for therapeutic timeframes).

Figure 1: Therapeutic Timescales



The processes of assessment, formulation, implementation, and evaluation are discussed within this case study. The case study is accompanied by a reflective report and a supervisor’s report to assess communication skills .

Assessment

My assessment was conducted over three sessions. The aim was to establish an overview of Mr. Bailey’s difficulties, decide if CBT were an appropriate approach, and

develop a collaborative working CBT formulation that would help me to develop an intervention plan (Halford, J., & Brown, 2009; Redhead, Johnstone, & Nightingale, 2015). I used three primary assessment techniques (self-report questionnaires, clinical interview, and observation) because multiple assessment methods have the potential to offer a more complete picture of the behavioural, cognitive, physiological, and emotional aspects of a problem (Hawton, Salkovskis, Kirk, & Clark, 1989).

Observation

Behavioural observation was used as an assessment method and throughout therapy. It was a method of examining Mr. Bailey's overt behaviours and presentations. For example, noticeably Mr. Bailey could be seen to have a profound twist of his neck to the left. He was observed to use compensatory strategies (e.g., placing his hand on to face) to align his neck straight. He self-reported pain and found others seated to his left less painful and eased the twisting to his neck. The use of observation and seating arrangement (including the process of how this changed) is discussed within the therapeutic relationship section of this case study.

Self-report Questionnaires:

Mr. Bailey completed five questionnaires at the start of the assessment to obtain a quantifiable understanding of his presentation. These questionnaires were again administered upon completing the intervention to serve as a measure of change (Table 1).

Table 6: Questionnaires completed by Mr. Bailey

Measure	Synopsis	Rationale
The Cervical Dystonia Impact Profile (CDIP-58) Cano, Warner, Bhatia, Thompson, Fitxpatric & Hobart (2004).	The Cervical Dystonia Impact Profile (CDIP-58) is a 58-item questionnaire that assesses the health impact of CD. The CDIP-58 includes eight scales: • head and neck symptoms (6 items), • pain and discomfort symptoms (5 items), • upper limb activities (9 items), • walking (9 items) • sleep (4 items), • annoyance (8 items), • mood (7 items), and • psychosocial functioning (10 items).	I used this measure to develop a broader understanding of the health impacts of Cervical Dystonia. The scale: • evaluates the health impacts of Cervical Dystonia • and measures the quality of life in patients with Cervical Dystonia (Cano et al, 2004; Albanese et al, 2013). • is sensitive to detecting statistical and clinical changes • and has sound psychometric properties - good reliability (Cronbach's alpha $\geq$ 0.92, test-retest intraclass correlations $\geq$0.83; Cano et al, 2008)
The Perceived Stress Questionnaire (PSQ) Levenstein, et al (1993).	The Perceived Stress Questionnaire (PSQ) is a 30-item questionnaire that was developed to assess stressful life events and circumstances that trigger or exacerbate disease symptoms.	The measure was designed and recommended for use in clinical settings. I used the PSQ to develop a broader understanding of stressful life events and situations that could influence Mr. Bailey's condition/symptoms. The PSQ has sound psychometric properties - an internal consistency ranging from .90 to .92 and test-retest reliability of .82.
Brief-COPE Carver et al., (1989)	The Brief-COPE is a 28-item self-report questionnaire designed to measure effective and ineffective ways to cope with a stressful life event. The scale can determine someone's primary coping	I selected this measure as it is often used in healthcare settings to ascertain how patients are emotionally responding to a circumstance.

	styles with scores on the following three subscales: • Problem-Focussed Coping • Emotion-Focussed Coping • Avoidant Coping	The scale is useful in counselling settings for formulating the helpful and unhelpful ways someone responds to stressors. The responses from the measure were incorporated into the patient's case formulation. The measure also provides insight into a range of facets of coping (e.g., Self-distraction, Denial, Substance Use, Behavioural disengagement, Emotional Support, Venting, Humour, Acceptance, Self-Blame, Religion, Active Coping, Use of Instrumental Support, Positive Reframing, and Planning) that would inform the selection of intervention techniques.
The McGill Pain Questionnaire, MPQ (Melzack 1975)	The McGill Pain Questionnaire (MPQ) is a 78-item questionnaire that measures the sensory, affective, evaluative, and miscellaneous components of pain (Melzack 1975).	I selected this measure to assess both the quality and intensity of subjective pain by understanding what words best describe the patient's experience of pain as well as where in the body the pain occurs for the patient. The measure also has sound psychometric proprieties - validity, and test re-test reliability, r= 0.95 (Ferraz et al., 1990; Melzack and Katz 2001).
The Brief Illness Perception Questionnaire, IPQ (Broadbent et al, 2006)	The Brief Illness Perception Questionnaire (IPQ) is a 9-item questionnaire that assesses cognitive representations of illness (Broadbent et al 2006).	I selected this measure to develop a broader understanding of the patient's cognitive and emotional representation of their illness. This measure is theoretically driven and was selected as it covers both cognitive representations of illness, illness comprehensibility as well as causes of illness. This measure was particularly attractive as the general word 'illness' can be replaced by the name of a particular illness such as asthma (or Cervical Dystonia). The word 'treatment' in the treatment control item can be replaced by a particular treatment such as 'CBT' The measure has sound psychometric properties - good test-retest reliability (Pearson correlations 0.24–0.73) has been demonstrated (Broadbent et al 2006)

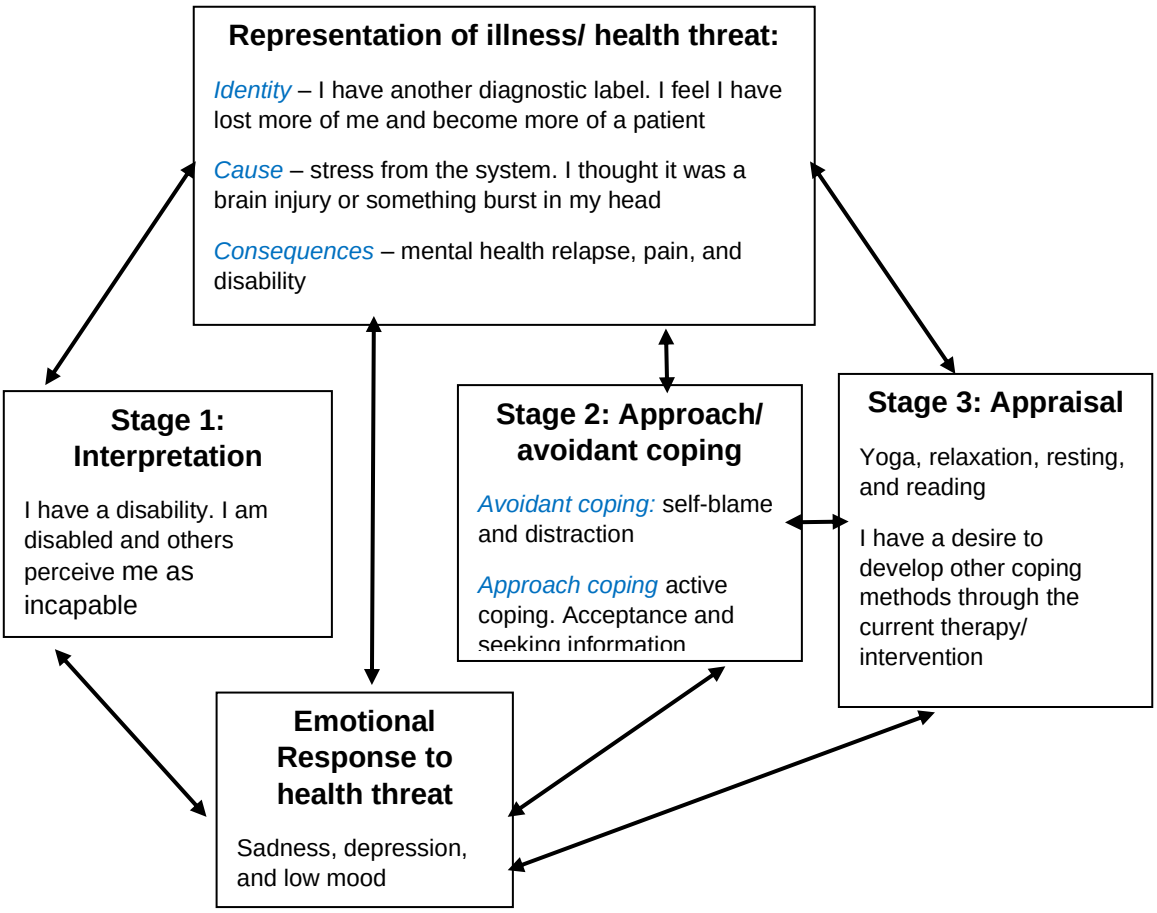
Clinical Interview:

I used a clinical interview during the first session to establish the possible triggers for his condition, a timeline of Mr. Bailey's symptoms, and factors that may contribute to the maintenance of his symptoms. The questions which guided this element of the assessment were developed from Morgan, Eccles, and Greasley's (2021) qualitative research on the experiences of living with dystonia and CBT for physical illness.

As part of my assessment, I also integrated Leventhal's Self-regulatory Model (SRM, 1980) of illness behaviour which has been effectively applied to understand the health outcomes of MUS (McAndrew et al, 2019; Moss-Morris,2011). The SRM is useful because it provides a framework for understanding how individual symptoms and emotions experienced during a health threat or diagnosis influence a person's perception of illness and guides their subsequent coping behaviour (Benyamini & Karademas, 2019; Browning et al, 2009; Diefenebach & Leventhal, 1996; Leventhal, Hudson & Robitaille, 1997).

In integrating the SRM into my assessment, I was able to explore how Mr. Bailey processed his illness threat by developing an understanding of what the illness is and what it means to him (e.g., its causes, its consequences, how long it will last, and whether it can be cured or controlled). Understanding this illness representation allowed me to formulate Mr. Bailey's personal experience (physical symptoms and emotions), social influences, and/or interaction with healthcare providers (Figure 2).

Figure 2: Mr Bailey Assessment based on the SRM



Formulation

There is no universal definition of a case formulation. However, the term formulation refers to both the process of sense-making and the explanation arising from this process, while integrating psychological theory to understand a patient's difficulties (Division of Clinical Psychology, 2011; Eells, 2007; Johnstone & Dallos, 2013). Within CBT, the formulation is considered essential to effective therapy representing theory, research, and the specific details of a patient's case, while seeking to understand complex and interacting problems to inform and guide intervention (Birdsey, 2020; Butler, 1998; Dudley & Kuyken, 2013; Jacqueline, & Lisa, 2015; Pearson, 2012; Redhead et al, 2015). Persons (2012) advocates the use of the case formulation approach in CBT, which benefits from being principle-driven rather than protocol-driven, and helps clinicians address various issues that are overlooked in protocol-inform.

Formulation Approach:

A Longitudinal CBT Formulation (Beck et al, 1979) was adopted for conceptualising Mr. Bailey's presentation. This approach was taken as a longitudinal CBT formulation that extends the current understanding by linking the client's current thoughts, feeling, and behaviours to their past experiences, using principles of CBT. This in turn provides an evidence-based hypothesis on where difficulties came from, what triggered them, as well as what maintains them (Birdsney, 2020; Beck et al, 1979; Jacqueline & Lisa, 2015; Redhead et al, 2015). The information gathered from all three assessment approaches was used to inform the formulation which allowed to identify triggers, beliefs, thoughts, feelings, behaviours, and physical sensations relating to FCD.

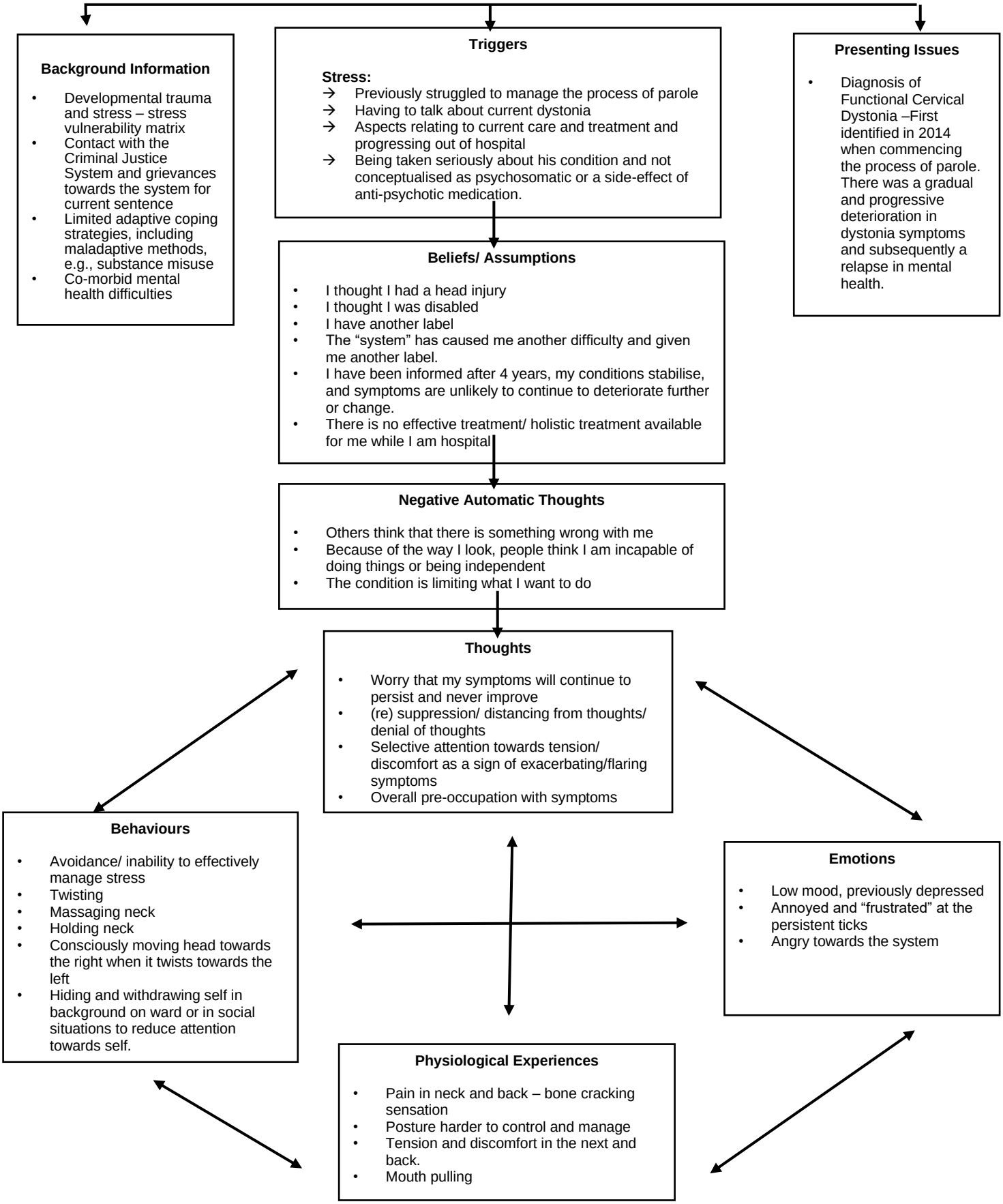
Within CBT, formulation often involves the development of a cyclical diagram (Figure 3) or narrative formulation to demonstrate the links between how different aspects and his FCD. This represents the interrelationships between different aspects of a patient's difficulties (Kuyken, Padesky, & Dudley, 2009), including maintaining factors, (Greenberger & Padesky, 1995) and underlying psychological mechanisms related to historical experiences (Persons, 1989). Within NHS Mental Health Trusts, it is recognised that patient involvement should be at the core of services and there should be "no decision about me without me" (Department of Health, 2012; Evan, 2020). CBT formulation involves 'collaborative empiricism' whereby a patient and therapist work together towards a shared understanding of the patient's problems (Beck, 1995), with the process being dynamic and revised transparently through interactive discussions with the patient (Antaki et al, 2005; Bennett-Levy et al., 2004).

Communication and Collaboration of the Formulation:

Mr. Bailey has prior experience in both collaborative and top-down case formulation as a part of previous therapeutic interventions around his mental health or offending. He requested that I draft the initial formulation for this intervention before collaboratively reviewing it with him to ensure revisions, amendments, and clarifications could be made. This process allowed me to demonstrate my understanding of the narratives he provided during the assessment sessions as well as his perspective of the therapist as an "expert". In session 4, we began to work through the different components of the formulation before the diagrammatic formulation (Figure 3) was reviewed. The use of a diagrammatic formulation also

allowed to demonstrate areas the intervention would focus on (e.g., perpetuating factors).

Figure 3: Mr. Bailey's Formulation



Intervention

Intervention Design:

The intervention design and planning were informed by the case formulation (Figure 2) which describes the mechanisms that cause and maintain Mr. Baileys FCD symptoms. Here, it was important for me to obtain Mr. Bailey's consent to proceed with the recommended treatment plan or a revised treatment plan. This was especially relevant as Mr. Bailey commenced sessions by requesting all symptoms be eradicated. The likelihood of this happening was unrealistic, but evidence suggests patients are not willing to proceed with treatment unless they have confidence that the therapist truly understands their difficulties and will provide treatment that addresses them (Wampold, 2015).

Consequently, it was important for me to manage Mr. Bailey's expectations of the treatment outcomes while re-establishing consent as it was ethically necessary and clinically relevant. For example, it may prevent non-adherence to the goals and interventions of treatment and set the stage for revisiting that process if treatment fails (Blease, 2015; Geraghty, & Blease, 2018; Marcinow et al, 2021; Schaeuffele, Schulz, Knaevelsrud, Renneberg, & Boettcher, 2021). Thus, the therapeutic aims were to:

- Increase recognition of the impacts of stress on FCD symptoms, and
- Understanding how thoughts, feelings, and behaviours impact coping and symptom maintenance.

A mixture of psychoeducation about stress and acceptance as well as behavioural and cognitive interventions was planned (Table 2).

Table 2: Mr Bailey's Intervention Plan

Session No	Focus	Overview
5-6	Psychoeducation of stress	Information about stress and the effects on the body. Exploration of stressors for Mr. Bailey while exploring the Stress Vulnerability Matrix (Zubin & Spring, 1977), existing strategies, and maladaptive behaviours. Further exploration of how stress affects mental health and physical health.
7-9	Behavioural Interventions	To identify activities that Mr. Bailey finds stressful and activity-provoking due to his FCD. Exploring how thoughts and feelings effects behaviour and engagement in activities. To increase activity and scheduling of activity while integrating stress-reduction strategies, e.g., progressive muscle relaxation. An exploration of avoidance or resistance to part-take in activities.
10-12	Cognitive Restructuring	To explore cognitive distortions and focus on addressing inaccurate or dysfunctional beliefs and maladaptive thoughts about FCD. To decrease health-related worry/ symptom pre-occupation. To focus on fact-checking thoughts.
13– 14	Promoting Acceptance	To focus on promoting acceptance, reconceptualising condition, and adjustment to illness.
15-16	Relaxation training	To promote additional coping strategies with the introduction of relaxation techniques and grounding techniques that can be employed at heightened states but to maintain stress management
17	Consolidation	An opportunity to reflect on the intervention and summarise key points of learning.
18	Therapeutic Endings	To bring the intervention and therapeutic relationship to a close. An opportunity to consider “what happens next”, re-referral, and the process of booster sessions. This also included re-administrating psychometric measures to inform an evaluation of the intervention.

Intervention delivery and techniques:

I incorporated several cognitive and behavioural techniques which I explain in Table 3. The intervention was delivered as planned, with each session the traditional therapeutic hour in duration.

Table 3: Intervention techniques used with Mr. Bailey

Intervention Techniques	How it was used	Observations
Psychoeducation	This was used in the earlier sessions to discuss the role of stress, the personal meaning of stress, and how this is linked to the biopsychosocial model (Engel, 1977). The sessions on stress also focused on inventing Mr. Bailey to explore and discuss categories of stress – acute, episodic, or chronic and consider his stress within these terms. The sessions on stress also focused on the stress vulnerability model along with the stress vulnerability bucket (Zubin and Spring, 1997). Here, worksheets were used at Mr. Bailey's request, and, where possible, these were provided in advance to facilitate understanding, preparation, and independent reflection before the session. The use of worksheets allowed Mr. Bailey to consider the different types of stressors he experienced and the impacts this has on these thoughts, feeling, and behaviours which impact on coping with his FCD and symptom maintenance. These sessions on stress informed proceeding sessions. Psychoeducation around Mr. Bailey's FCD was not completed as he felt he had received the necessary information from his neurologist. He	***Effective*** **–** Mr. Bailey had limited understanding of the concept of stress and therefore focus on increasing his knowledge of stress (pressure and demand and how to manage these) which helped him to understand the stress and the types of stressors he experiences/ experienced. Here, Mr. Bailey was able to consider his most difficult stressor, which is his current sentence, and has had limited contact with family. He does, however, feel more relaxed/able to cope with the stressors relating to his children as they are older and contact with them has resumed. He reported having previously managed through "psychological self-harm" (fantasising by inflicting harm on self but not engaging in the behaviour). As noted earlier in the case study, Mr. Bailey reported the most significant stressor and precipitator of his FCD related to his parole hearing. He further explained during these sessions that he also, more relevant when in prison, became stressed by others' behaviour (and can hold grudges) which was in conjunction with parole hearing stressors. This tension built up and manifested in the body rather than through forms of aggression (which historically was an issue). Thus, Mr. Bailey's interpretation was that his tick became an anger management strategy, as his symptoms would not impact his parole hearing or progression in the same way that aggressive acts would. This would also indicate an element of protectiveness. During these sessions, we also incorporated the Stress Vulnerability Matrix and bucket. For example, using the analogy that you carry around with you which gradually fills up when you experience different types of stress. If you are experiencing a high amount of stress, the bucket will soon fill up. The size of the bucket varies from person to person and can change on a day-to-day

	reported having been provided with a prognosis of his FCD, possible further deterioration and other treatment options post psychological therapy. He was allegedly informed that after 4 years there is no further deterioration of the condition.	basis. Mr. Bailey was able to recognise the stressors of the "system" and wanting more control and autonomy and how over time this "filled" his bucket in addition to needing more adaptive coping skills to reduce/ manage stress levels. Previously, Mr. Bailey has thought about wearing a neck brace to manage his symptoms and this would also enable him to keep his neck straight. He felt this would also reduce his experiences of pain. He reported regularly others do not consider him to be in pain as he does not always present "in pain" and therefore finds this invaliding and as though others do not understand him. As sessions progressed, Mr. Bailey recognised that his symptoms, namely tick and twisting of the next subsided. He felt having the opportunities to discuss his stressors contributed to a reduction in symptoms. He wanted more skills to maintain the reduction in symptoms – considered stress reduction strategies and explore existing strategies. Through the intervention, Mr. Bailey was also granted escorted community leave which provided him a sense of freedom and marked progression. With a reduction in symptoms, Mr. Bailey also felt less "noticed" by others.
Activity Scheduling and Graded Assignments	Activity scheduling and graded task assignment aim to enhance functioning and steadily increase pleasurable or productive experiences. In the sessions, Mr. Bailey was supported and asked to identify situations that he finds anxiety-provoking or highly stressful. He was then supported to discuss how these situations influence his symptoms, with a particular focus on situations and experiences he perceives increase his symptoms of FCD. After	***Effective*** **-** graded exposure to activities and activity scheduling allowed Mr. Bailey to begin to facilitate control over his FCD. He developed additional insights into situations that he found least stressful and anxiety-provoking to ones that he found the most heightening – following the completion of the hierarchy. This then allowed for the low arousing situations/ activities or easy-to-perform tasks to be addressed first. This included attendance at ward-round and access to the community. There were some unrealistic or impossible to address e.g., involvement of the system. Overall, the activity scheduling and graded task techniques involved obtaining a baseline of activities during a day or week, rating activities on the degree of mastery and/or pleasure, and then collaboratively designing

	completing this, these were placed into a hierarchy.	changes that will reactivate the patient, stimulate a greater sense of enjoyment in life, or change patterns of isolation or procrastination. These techniques help patients re-establish daily routines, increase pleasurable activities and deal with problems and difficult issues by increasing problem-solving. Over time, within the graded task assignments, Mr. Bailey was able to create manageable steps to help overcome procrastination and anxiety-provoking situations, while integrating some simple relaxation tasks (e.g., progressive muscle relaxation). Focus then began to shift to exploring his thoughts, feelings, physiological experiences, and behaviour alongside activities.
Behavioural Experiments	Behavioural experiments are also used to help patients gather evidence against the use of 'safety behaviours' (Salkovskis, 1996), which are avoidance and escape behaviours. Within the cognitive model, safety behaviours reinforce anxiety as they make disconfirmation of dysfunctional assumptions and negative automatic beliefs impossible. Using Mr. Bailey's formulation and through guided questioning, he was encouraged to identify his current activity schedule. This then informed a discussion around other activities and exploration and identification of activities he no longer engages in or avoids. This informed a discussion to establish whether this was due to beliefs that these activities make his symptoms worse. After establishing activities that Mr. Bailey avoids or engages less in due to	***Less effective*** **–** Mr. Bailey was able to identify activities (e.g., attending the gym) that which felt helped manage symptoms of his FCD and mental health. He however would repeatedly decline to attend the in-house gym stating the facilities exacerbated his symptoms. A behavioural experiment would allow the patient to gather evidence to discount the predictions that something terrible will happen and that the safety behaviour of avoidance is necessary to remain safe. However, Mr. Bailey, over time, stated his non-attendance was due to feeling "exposed" and conscious. There was an evident dissonance in his perception of exercising helping his symptoms and his non-engagement in the behavioural experiment. It is also recognised that completing behaviour experiments was challenging in an artificial environment like a secure hospital.

	perceptions it would “flare” his symptoms, a schedule/plan was collaboratively developed whether he would identify a day/ time to engage in an activity. This would then be evaluated in the subsequent sessions to assess whether his symptoms (objectively or perceived) did increase.	
Cognitive restructuring	In the session, Mr. Bailey was invited as part of a discussion to firstly identify automatic thoughts and dysfunctional beliefs, and cognitive distortions relating to his FCD. The use of a worksheet facilitated this. After identifying thoughts and beliefs, Mr. Bailey was invited to reflect on how this affected his mood/ emotions. To support Mr. Bailey in modifying automatic thoughts and dysfunctional beliefs and cognitive distortions he was supported to consider the evidence for and against assumptions.	***Somewhat effective*** **–** Mr. Bailey demonstrated a good understanding of cognitive distortions as this is an area, he was familiar with having explored this as part of other interventions. Mr. Bailey was provided a list of cognitive distortions and was invited to engage in a discussion about which appeared to be more prominent and relevant to his FCD. He was able to provide evidence that supports/does not support his assumptions. When exploring Mr. Bailey’s assumptions relevant to avoidance of particular activities (which were attempted to be addressed during behavioural experimentation) he appeared more reluctant and dismissive in these discussions. It is possible that this may have been him feeling criticised, shamed, or felt as though his experiences were invalidated. During these sessions, there was also a focus on symptom pre-occupation and worry - Cognitive restructuring or reframing. Mr. Bailey was supported to identify objectively his thoughts, and any inconsistencies between perception and reality and begin to replace destructive thinking with supportive thinking. This was noted to be relatively effective, e.g., checking thoughts of “I have a brain injury”

Facilitating acceptance and control	Facilitating acceptance and control drew upon the concept of radical acceptance and focused on adjustment preserving functional status (Stanton et al, 2007) while also being adaptive.	***Effective*** **–** Mr. Bailey was able to engage in a discussion that accepting and adjusting to his FCD remains an ongoing process and felt progress would continue as he reintegrates back into the community. The process of acceptance and facilitating control was observed throughout the entire intervention. Mr. Bailey, over time, was able to understand that his FCD was not a disability but a condition. He also recognised that when in the community he would have a greater sense of control of himself and his FCD than he does at present ("in the system"). Mr. Bailey felt more comfortable within himself and at ease and in less distress/ pain through developing acceptance of his FCD as well as developing strategies that were perpetuating aspects of his presentation. We also integrated/explored Morris-Moss' (2013) adjusting to chronic conditions model in a session.
Relaxation Training	Progressive relaxation training and breathing exercises were used to reduce levels of autonomic arousal related to anxiety. These techniques aimed to help manage distress and anxiety associated with his FCD. In sessions, Mr. Bailey was guided through different breathing exercises, image exercises, and progressive muscle relaxations. He was firstly guided through with me reading a script to him before practising this himself.	***Effective*** **-** Further introduction to relaxation techniques and grounding techniques that can be employed at heightened states to maintain stress management. These were introduced to Mr. Bailey as stand-alone sessions but at times were integrated into the end of another session. For example, he was introduced to 4-7-8 breathing to help manage stress, tension, and anxiety. In sessions, Mr. Bailey was guided through exercises that helped him develop an understanding and independent application outside of sessions. He had the opportunity to discuss these in the session, practice, and subsequently review the experience the preceding week.

Therapeutic Relationship and Endings

The term therapeutic relationship is a widely used concept that refers to an exchange between therapist and client with the goal of sharing intimate thoughts and emotions to facilitate change (Okamoto, Dattilio, Dobson, & Kazantzis, 2019). The therapeutic relationship encompasses several interpersonal processes such as empathy, rapport, agreement of shared goals, and collaboration (Horvath, Del Re, Fluckiger, & Symonds, 2011; Rickard, Hevey, & Wilson, 2021). The therapeutic relationship has been emphasised as a critical element in both psychotherapies (Labouliere, Reyes, Shirk, & Karver, 2017; Wilmots et al, 2020) and in clients with persistent relational problems and/or Personality Disorders, like Mr. Bailey, where collaboration difficulties can be experienced (Okamoto et al, 2019). Within the therapeutic relationship with Mr. Bailey, there were two significant factors which appeared to influence the development and maintenance of the relationship overcoming ambivalence, and seating arrangements.

Overcoming Ambivalence

Initially, when Mr. Bailey was referred for this psychological intervention, he openly expressed ambivalence about how therapy could assist with his physical health condition. In addition, he had previous experience of therapy regarding his mental health and offending behaviour, but he was unfamiliar with Health Psychology as a profession, having only worked with Clinical or Forensic Psychologists. Overcoming this uncertainty firstly required me to explain the purpose, role, skills, and experiences of a Health Psychology. Secondly, it required me to explain the linter-links between mind and body and how psychology can assist with this process. This almost facilitated "getting him on board" to proceed with sessions.

Seating Arrangements

The other factor pertinent to the development of therapeutic alliance is related to seating arrangements. Mr. Bailey struggled to sit face-to-face because of his symptoms (neck twisting to the left and pain). Therefore, to reduce his discomfort and facilitate rapport and engagement we commenced therapy by sitting in a side-by-side position. Jobes (2012) states side by side seating arrangement moves away from client perceptions of the "clinician-as-expert" to restore power imbalances. A power imbalance favouring the therapist is considered an unavoidable aspect of the therapeutic relationship across all therapy modalities (Harrison, 2013); however,

reducing this imbalance is crucial to the therapeutic process (Cooper, 2009). The seating arrangement may communicate information about the nature of the therapy relationship to clients and may increase or reduce the power imbalance (“Role Power”; Proctor, 2002). As sessions progressed, Mr. Bailey reported a reduction in symptoms and increased levels of comfort. This enabled me to sit face towards Mr. Bailey, in what would constitute a more traditionally therapeutic position (Richard et al, 2021). For Mr. Bailey resuming a traditional therapeutic position was his request to demonstrate symptom reduction rather than creating a power imbalance.

The therapeutic ending is also considered an important part of the therapeutic process and as significant as the beginning and middle of therapy (Reiter, 2022). Within CBT, the planning the end of therapy is established from the start of the intervention and is an ongoing process, culminating in the final sessions with a review of treatment and introduction of relapse-prevention skills (Cully & Teten, 2008). Ending the therapy appropriately is particularly important since patients with Personality Disorders and historical attachment difficulties may experience feelings of abandonment or rejection at the end of the therapeutic relationship. Therefore, treatment termination is recommended to be completed in an empowering and thoughtful way by recognising and normalising their fears, assuring them safeguards are in place (e.g., emergency resources, booster sessions), and encouraging them via reminders that the purpose of CBT is self-management of symptoms. As such the ending of the intervention focused on the following areas (see Table 4):

1. Summarising the sessions and reviewing what was learned (Cully, & Teten, 2008; Kazantzis et al., 2017),
2. Relapse prevention planning (Antony, Ledley, & Heimberg, 2005; McKay, Abramowitz, & Taylor, 2010), and
3. Booster sessions (Cully, & Teten, 2008).

Table 4: Therapeutic Endings

Ending	Rationale/ definition	How I completed this
Reviewing what was learnt.	Within therapy, summarising areas covered by therapy is an important termination and transition process allowing the patient to maintain progress (Reiter, 2022).	I used the final two sessions to start to summarise the areas covered within therapy, whilst also focusing on termination and transition for Mr. Bailey to maintain the progress achieved and to prevent regression. The final session focused on reviewing and recording the different cognitive and behavioural skills Mr. Bailey learned through the intervention. Here, I used Socratic questioning to elicit this list (e.g., "What have you learned as a result of our time together? Is there anything particularly meaningful to you about your time in therapy?"). From this, I was able to understand the benefits Mr. Bailey experienced from therapy and was able to disseminate this to members of his clinical team so that he could be supported to continue to access these skills.
Relapse Prevention Planning	Within CBT, it is recommended that Relapse Prevention Planning is completed where possible (Antony, Ledley, & Heimberg, 2005; McKay, Abramowitz, & Taylor, 2010) as patients can often express concerns about their inability to manage their difficulties without the aid of therapy.	Mr. Bailey was invited to engage in this process to consider possible stressors or difficulties that could exacerbate his symptoms or condition in the future (e.g., parole board hearing). However, Mr. Bailey was reluctant to engage in this process. He noted that future ongoing stressors relate to his current detention and future stressors, or difficult situations are unlikely when discharged from services.
Booster Session	Within CBT, booster sessions can be scheduled approximately one month following the end of treatment and then as needed thereafter (Baggs, & Spence, 1990). These sessions serve to review how a patient is progressing with self-management of their symptoms and stressors, refresh skills learned in therapy, discuss questions, or concerns the patient might have about the transition, and review treatment goals and maintenance of treatment gains.	Mr. Bailey was not offered any booster session at the end of the intervention. However, the process of re-engaging with myself was available to him. He was aware that I can receive regular feedback about his progress from his Named Psychologist within the service or he could request to meet with me again via his clinical team. This is a routine form of practice within the service. Although not a booster session in its traditional form, an additional meeting with Mr. Bailey was arranged in December 2020, following the identified treatment need to support members of his clinical team (about his condition as well as members of his family in understanding his condition.

Evaluation

Within a therapy context, evaluation refers to a process of gathering data to determine what, if any, changes occurred (Kennerley et al, 2016). The evaluation of this intervention was divided into:

1. Outcome evaluation,
2. Process evaluation,
3. Impact evaluation, and
4. Intervention evaluation.

Outcome evaluation:

Outcome evaluation refers to intervention results and determines whether intended outcomes (increase understanding of impacts of stress on symptoms and increase understanding of thoughts, feelings, and behaviours contribute to coping and symptom maintenance) were achieved from therapy. To assess this, I used outcome tools (psychometric assessment) to assess Mr. Bailey's change throughout the intervention. These questionnaires were completed pre- and post-therapy and summary scores are in Table 5.

Table 5: Psychometric Data and Interpretation

Measure	Pre-Therapy Scores	Post-Therapy Scores	Interpretation
Cervical Dystonia Impact Profile (CDIP-58)	Head/ Neck - 27 Pain/ Discomfort- 21 Upper limb – 10 Walking - 18 Sleep -16 Annoyance - 25 Mood - 18 Psychosocial Functioning 18 Total = 153	Head/ Neck - 12 Pain/ Discomfort -10 Upper limb - 10 Walking - 11 Sleep 4 Annoyance - 8 Mood - 7 Psychosocial Functioning – 14 Total = 76	The CDIP-58 provides breakdown scores to assess the health impact of CD as well as an overall score. Higher scores indicate greater health impacts. Mr. Bailey's scores on the CDIP-15 demonstrate a 56% reduction, suggesting a decrease in impairment. Of most significant reduction is in his scores/impairment with his head and neck twists and pain and discomfort. These appear to have reduced the most which was the primary area he reported experiencing discomfort at the commencement of therapy.
McGill's Pain Questionnaire	Words Chosen – 8 Pain Intensity - 20	Words Chosen – 5 Pain Intensity - 16	There is no total MPQ score. However, the simplest method is to calculate the number of words chosen and totalling rate of the presence of pain (in part 4 of the questionnaire) between 1-5 as least painful or most painful. Mr. Bailey's experiences of pain, as measured by the MPQ, reduced after therapy. He selected a few words after post-intervention and reported a reduction in his experiences of pain intensity. These scores in isolation and when considered together suggest a reduction in pain. While no specific interventions attempted to address Mr. Bailey's pain, but it appears this was a secondary gain from therapy.
The Brief Illness Perception Questionnaire	Consequences - 7 Timeline - 6 Personal Control -5 Treatment Control - 6 Identity -6	Consequences - 4 Timeline - 6 Personal Control - 7 Treatment Control - 3 Identity - 4	The Brief IPQ gives an overall score which represents the degree to which the illness is perceived as threatening or benign. Higher scores represent a more threatening view of the illness.

	Coherence- 6 Emotional Representation - 6 Concern – 7 Total = 49	Coherence - 2 Emotional Representation - 2 Concern – 3 Total = 31	Mr. Bailey's overall scores reduced by 63% after therapy suggesting he views his FCD as less threatening. His scores are noted to have consistently reduced across all domains. This would suggest Mr. Bailey developed alternative methods of coping with illness to allow him to identify with the illness, feel less concerned, and have greater views of treatment control. In addition to the CBT techniques developed, the understanding developed around stress may also have contributed to a reduction in scores. However, the findings also suggest Mr. Bailey perceives less control after therapy. The reasons for this are unclear/ unknown.
Perceived Stress Questionnaire	0.49	0.27	PSQ scores range from 0-40, with low measured between 0-13, moderate stress as 14-26, and high perceived stress between 27-40. Mr. Bailey's experiences/ perception of stress that may serve as triggers or exacerbate his symptoms, as measured by the PSQ, were also reduced after therapy. While post-intervention scores remain in the higher perceived range, these are reduced considerably through treatment. A further examination of the scores notes Mr. Bailey's therapy felt more rested, calmer, and felt as though fewer demands were placed on him, which he interpreted as a reduction in stress. Furthermore, it is important to consider that Mr. Bailey's perceived stress scores may be contributed by other persistent (or acute stressors) e.g., the stress experienced from being in the system that he consistently spoke about throughout therapy.

Brief-COPE	<u>Avoidant Coping:</u> Denial - 2 Substance Use -2 Venting - 2 Behavioural Disengagement - 2 Self-distraction - 3 Blame- 2 **Total = 13** <u>Approach Coping:</u> Active coping - 6 Positive reframing- 5 Planning - 6 Acceptance - 6 Seeking Emotional Support - 4 Seeking Information Support -6 **Total = 35** Humour - 2 Religion - 6	<u>Avoidant Coping:</u> Denial - 2 Substance Use -2 Venting - 2 Behavioural Disengagement - 2 Self-distraction - 3 Blame- 4 **Total = 15** <u>Approach Coping:</u> Active coping - 6 Positive reframing- 5 Planning - 6 Acceptance - 6 Seeking Emotional Support - 4 Seeking Information Support - 6 **Total = 35** Humour - 5 Religion - 4	The Brief-COPE provides summed scores for each scale. Higher scores indicate greater utilisation of that coping method. When assessing Mr. Bailey's method of coping, using the Brief-COPE, indicated his primary coping was "Approach Coping" and these scores remained stabled through therapy. However, there was some small observed change in his "Avoidant Coping" scores which increase a marginal increase in self-blame. It may be possible that an increase in this domain was Mr. Bailey developing insight into the contributors of stress to his illness.

From the five different measures completed pre- and post-intervention, Mr. Bailey demonstrated an improvement in all scores after therapy which would suggest the intervention was effective. While Mr. Bailey coping scores (as measured by the Brief-COPE) remained largely unchanged, with a slight increase in avoidant coping skills, his experiences of pain and perceived stress reduced. Therefore, it is likely that the skills developed (and maintained pre-existing skills) from the current CBT intervention. This allowed Mr. Bailey to increase his understanding of the impacts of stress on symptoms and increase his understanding of thoughts, feelings, and behaviours that contribute to coping with symptoms.

Process Evaluation:

Process evaluation is a term used to help establish the reasons for an intervention's effectiveness (Biliunaite, Kazlauskas, Sanderman, & Andersson, 2021). Process evaluation was completed through receiving regular clinical supervision for monitoring the quality of the delivered intervention as well as an assessment of Mr. Bailey's experiences of the therapeutic work (Copper, 2021); this is discussed in greater detail in my reflective report.

Furthermore, process evaluation also refers to how clients are experiencing the therapeutic work. Throughout the intervention, I regularly sought Mr. Bailey's feedback on activities and approaches to ensure they suited his style and were meeting his needs. He was receptive and open to the therapeutic approach and at the end of the intervention provided a summary of his experience in therapy (Table 6).

Table 6: Mr. Bailey's feedback

Working with Ms. Mistry and Cervical Dystonia
Working with Ms. Mistry to learn and better understand and manage Cervical Dystonia for the last 18 weeks has been an excellent experience for me. We have managed to identify the underlying stressors of the condition and I have learned to live with the condition a lot better because of the work we have done together.
Dipty is a competent, confident, and capable trainee Doctor whom I found it a pleasure to work with, she was well resourced and had a good basis of knowledge that allowed her to deliver her treatment in a professional and caring manner.
All in all the experience of working with Dipty has been a very enjoyable and rewarding one.
Mr. Baliey"

Impact Evaluation:

Impact evaluation is used to measure the immediate effects of an intervention and how the intervention objectives have been achieved (Anderson & Ozakinci, 2018). The immediate impact of the intervention was observed through three domains highlighted (Table 7).

Table 7: Impact evaluation of Mr. Bailey

Impact Evaluation	Immediate Effects
1. Mr. Bailey's Narrative	Mr. Bailey reported through the course of the intervention that he was experiencing a reduction in pain and an increase in quality of life. Although Mr. Bailey continued to experience symptoms relating to his FCD, he felt that from developing skills and techniques from CBT he had an improved way of coping and had adapted to living with his chronic illness.
2. My observations	At the commencement of therapy, Mr. Bailey was observed and reported experiencing a significant twist of his neck towards the left. This was both uncomfortable for him to maintain himself straight on during therapy as well as painful. To allow for Mr. Bailey to be comfortable during therapy, I seated myself to the left of him (where his neck naturally twisted towards). The immediate effect of the therapy showed Mr. Bailey's neck twisting appeared less and caused him less discomfort, particularly to aligning straight on. As the sessions progressed, an immediate effect allowed the seating position to be more of a traditional therapeutic seating arrangement (straight on).
3. Observations from the clinical team	The final immediate effect observed relates to observations made by members of the clinical team. While the changes to Mr. Bailey's symptoms were subtle. A therapist in another treatment intervention commented: *"It was also observed that Mr. Bailey's cervical dystonia appeared to demonstrate slight improvements, with him appearing more able to address his peers face-on, with a somewhat lessened tendency to direct his head towards the left."*

Intervention Evaluation:

My evaluation of the intervention process was based on my self-reflective observations, during the sessions and reviewing the audio recordings after each session which were also reviewed within clinical supervision as for routine processes for trainee psychologists in the service. These observations capture the strengths and weaknesses of myself as a therapist as well as the intervention which are documented within my reflective diary (Table 8).

Table 8: Intervention Evaluation

Strengths	Weaknesses
• My communication skills to discuss/ explain psychological concepts and complete therapy using Personal Protective Equipment (PPE) • Ability to be sensitive to patient's condition and curious when asking questions • Ability to build and maintain a therapeutic rapport • The timing and duration of sessions and intervention were appropriate • The formulation was collaborative and evidence-based • Intervention met patient goals • Ability to implement CBT techniques • Working with a complex patient with co-morbidities • What intervention techniques worked well – 4-7-8 breathing exercises, psychoeducation around stress, cognitive strategies to manage worry and develop control and acceptance over the condition	• Not an expert in FCD • Socratic questioning/ techniques – could have made further enquires at times to understand the patient's difficulties • What intervention techniques were less effective – behavioural techniques, e.g., graded exposures and this was partly due to the challenges of behavioural exercises in a controlled and restricted environment. Some situations were not possible to change, e.g., contact with the criminal justice system.

Conclusion

This was an individual CBT-informed intervention for a gentleman with a recent diagnosis of FCD. My approach demonstrated a range of strengths and weaknesses at all junctures in the assessment, formulation, intervention, and evaluation stages. Overall, the intervention demonstrated positive outcomes for the patient in reducing their experiences of pain and

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3.2 Individual Face-to-face Reflective Commentary

Introduction

This reflective report accompanies my one-to-one psychological intervention case study which focuses on Cognitive Behavioural Therapy (CBT) for Functional Cervical Dystonia (FCD). Within this reflective report, I discuss my strengths, weaknesses, and areas of development in the approach to the assessment, formulation, intervention, and evaluation of the intervention. Within this reflective report, I also discuss my experiences and development as I work towards being a Health Psychologist.

Assessment

The purpose of the assessment was to gather information about the patient's clinical presentation and presenting difficulties, to begin to develop a therapeutic rapport, and to orientate Mr. Bailey to the therapeutic model. Having worked with Mr. Bailey previously, I was aware of his condition and that his FCD had been understood as a psychosomatic symptom in the context of his mental disorder. Nevertheless, I was mindful when commencing the assessment that I had no foundational experience and knowledge of FCD and therefore I felt nervous and apprehensive before starting the intervention. However, after undertaking some preliminary reading to build my knowledge and utilising supervision, I felt more informed and assured in my abilities to proceed.

Within CBT (Marzillier & Marzillier, 2013), three common forms of assessment (clinical interviews, self-monitoring/diary methods, and psychometric measures) are used, which informed my assessment approach. Starting with a clinical interview allowed me to re-establish a working relationship with Mr. Bailey and provided a good foundation on which to build therapeutic rapport. I believed my combined assessment approach, integrating CBT and the Self-Regulatory Model (SRM; Leventhal, Meyer, D., & Nerenz, 1980) as a standalone assessment session strengthened my assessment approach. Having used CBT assessment approaches before, the inclusion of the SRM provided me with a thorough understanding of Mr. Bailey's presentation as well as specific elements relevant to illness representation which in turn informed his case formulation. I believe the specific insights into his illness that the assessment provided allowed Mr.

Bailey to feel validated and as though I understood his condition. I believe this also contributed to the development and maintenance of the therapeutic rapport.

Self-monitoring is another recommended CBT assessment technique used to establish an activity (listing and rating daily activities) or a record sheet for documenting negative thoughts. Mr. Bailey was invited to engage in this process and a clear rationale for the use and benefits of this method was provided. However, his previous experience using this technique was that he found it too demanding. In the interest of tailoring the assessment to Mr. Bailey's needs and taking on board his opinion, self-monitoring was not adopted. This demonstrates my flexibility in understanding and working collaboratively with a client.

Throughout the assessment, establishing a good therapeutic alliance with Mr. Bailey was essential, with the emphasis being placed on collaboration. As part of the orientation of the CBT model, assessing Mr. Bailey's expectations of therapy was crucial to ensure his goals were realistic to achieve. Initially, Mr. Bailey's therapy goal was for all his symptoms to be eliminated. Having developed my knowledge of FCD, combined with my existing experience of therapy for Medically Unexplained Symptoms (MUS), I recognised this may not be entirely possible, and ensuring that he was aware of this was crucial. Therefore, providing him with a more balanced and realistic possible outcome was important. For example, he may experience a symptom reduction or alleviate the distress associated with the condition. I believe Mr. Bailey having a more measured understanding of the possible therapeutic outcomes influenced the current intervention and the therapy gains.

Formulation

The process of formulation is discussed within my case study. The concept of collaborative formulations has been much debated. In some instances, collaborative formulations are thought to help clients to understand their problems which in turn can allow them to feel accepted and understood, allow for an emotional shift and enable clients to move forward (Challoner, & Papayianni, 2018). Alternatively, collaborative formulations may provide little explanation as to why this has been proposed, what this brings to the therapeutic endeavour, and how this may affect the client-therapist relationship. As a Trainee Health Psychologist, I feel collaborative formulation provide an avenue to importantly demonstrate that the patient's opinion is valued, and as a

practitioner I will work with patients to find a way to address their issue(s). Although emphasis is routinely placed on formulations being collaborative, this process of benefitting clients is an under-researched area and rather much of the literature focuses on benefits to the practitioner and does not see formulation as necessarily needing to involve the client (Challoner, & Papayianni, 2018). This is something I am subsequently conscious of.

Despite the varied perspectives and evidence-base available in the collaborative formulation approach, I felt it was important for Mr. Bailey to be invited into the process. I was mindful of the possible power dynamics in me being positioned as an “expert”, especially as Mr. Bailey repeatedly in sessions described feeling disempowered by his experiences in the criminal justice system. I was keen for Mr. Bailey to be part of the formulation process in a capacity he felt comfortable with, to minimise reinforcing concerns about power and expertise noted within the literature (Challoner, & Papayianni, 2018; HCPC, 2018).

To find a workable mutual approach, it was important for me to communicate why emphasis was being placed on a collaborative formulation. Although Mr. Bailey was initially focused on moving to the intervention itself (e.g., fixing his problem), he engaged with the process after I explained the reasoning for collaborative working. I feel this enabled him to understand the precipitators and maintenance factors for his condition. This made me feel satisfied that my continued efforts, despite initial resistance were worthwhile. As such, if met with a similar clinical encounter, it would be important for me to “preserve” as collaborative formulation can form part of an intervention.

Intervention

CBT is a well-evidenced intervention that has been applied to a range of mental health and physical health conditions, and as such, I employed techniques embodied within the model, as discussed in my case study. Table 1 discussed techniques I feel were most effective and challenging to implement.

Table 1: Reflection on Therapeutic Intervention Techniques

Areas of Focus	Reflection and Learning
Therapeutic Intervention Success	Things that worked well for Mr. Bailey were those designed to focus on acceptance and adjustment preserving functional status (Stanton, Revenson & Tennen, 2007) while also being adaptive. Mr. Bailey was actively engaged when guided through each exercise and subsequently appeared able to apply and use these exercises outside of sessions to help him manage his distress and pain. Mr. Bailey found the 4-7-8 breathing exercise the most effective, accessible, and time efficient. He reported using this regularly to manage his stress, tension, and anxiety as well as integrate within other therapeutic sessions across his wider treatment in the hospital. He was also able to consider how these exercises could be employed as he re-integrates back into the community and meets with additional challenges. In addition, Mr. Bailey was able to understand that his FCD was not a disability but a condition. It was a rewarding feeling to observe Mr. Bailey's perspective and stance shift on how he views his condition. However, he felt when in the community he would have a greater sense of control of himself and his FCD than he does at present ("in the system"). This was a challenging assumption to try and overcome and felt to be beyond the scope of this intervention. While it would have been good to try and work through this with Mr. Bailey (if he consented to it), I was mindful of my competencies as a Trainee Health Psychologist as well as the defined therapeutic aims of this intervention.
Therapeutic Challenges	The most challenging techniques to deliver in a secure hospital environment were behavioural experiments designed to help Mr. Bailey gather evidence against the use of his 'safety' / avoidance behaviours' (Salkovskis, Clark, & Gelder 1996). It was not always possible to overcome the challenges, which was somewhat frustrating, but adaptations were made to suit the limits of the secure environment. For example, we explored situations (on-ward group activities) within the service where Mr. Bailey may be subtly avoiding and explored methods to gradually increase his exposure or engagement within these constraints. This was rewarding to know I can be adaptable within the environmental limits. In addition, during the intervention, Mr. Bailey was granted escorted leave into the community. This was an exciting experience to be able to optimise this opportunity to employ behavioural experiments.

Evaluation

Overall, I believe dividing my evaluation process into four components allowed me to consider my strengths and weaknesses (Table 2).

Table 2: Appraisal of the evaluation process

Evaluation Method	Strengths of the approach	Weaknesses to the approach/learning points
Outcome Evaluation	• The use of psychometric measures allowed for a quantitative assessment of change through the intervention. • I used measures alongside other forms of assessment to inform formulation rather than as a standalone method.	• Although this did not occur, the use of psychometrics can lead to false-negative results due to testing anxiety. This is therefore a possible limitation of my approach that I was aware of.
Process Evaluation	• I was able to discuss in clinical supervision how my intervention was progressing. • I utilised an audio-recording session which allowed for treatment implementation to be monitored. This was particularly useful as I am not formally trained in CBT and therefore recognised the limits within my competencies. • I was able to obtain client feedback which provided insights into their experience of therapy.	• I did not objectively assess how the client was finding the therapeutic work. I could have completed this using an independent person to gather his feedback/ thoughts. • By me gathering his feedback he may have felt the need to provide positive feedback (eager to please).
Impact Evaluation	• I completed this using three elements (patient narrative, my observation, and clinical observations) which offered variety. • I observed symptom reduction (less twisting of the next) throughout therapy. This was a positive feeling for me to overtly see the changes. However, I was conscious it may have been an association developed in therapy. • The patient was able to provide their narrative. This relied heavily on the patient's narrative on change rather than a direct behaviour change (that was either observed by others, e.g., the nursing team). I feel this aligns with more of my Social Constructivist approach and may have been helpful as a method of monitoring the intervention effects.	• I could have requested more direct observations from members of the clinical clean to monitor the effects of work throughout therapy. • The patient's narrative may have been influenced by an eagerness to please.
Intervention Evaluation	• The use of audio recordings allowed me to assess my competency in delivering therapy	• My observations are subjective

Therapeutic Approach and Endings

The term “Therapeutic Alliance” is a widely used concept encompassing several interpersonal processes such as empathy, rapport, agreement of shared goals, and collaboration (Horvath, Del Re, Fluckiger, & Symonds, 2011). There were two significant factors that I believe were important and influenced the development of a therapeutic alliance (Table 3)

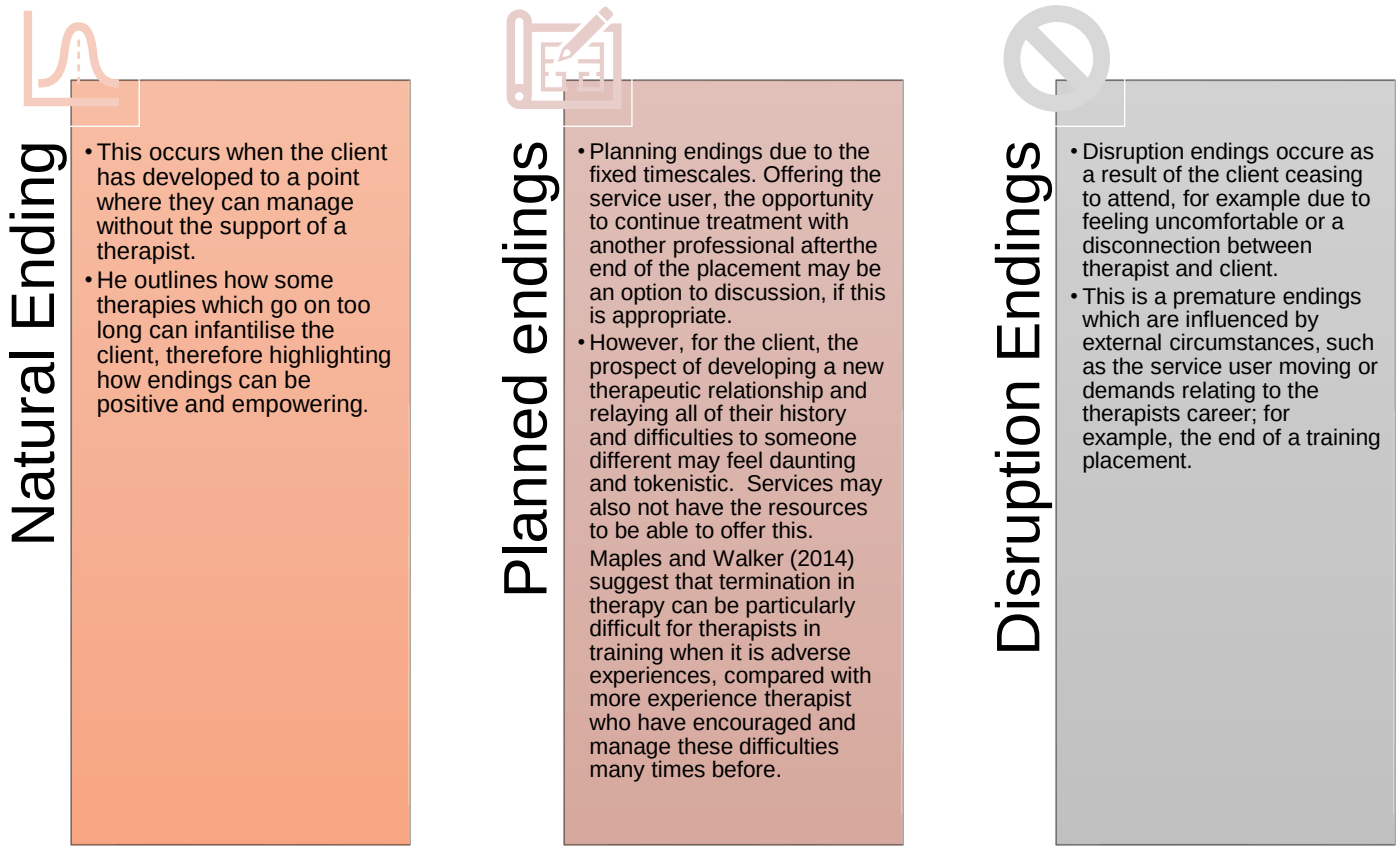
Table 3: Reflection on Therapeutic Alliance

Influencers in Therapeutic Alliance	Reflection and Learning
Overcoming ambivalence	I feel my ability to overcome Mr. Bailey’s ambivalence to engage with a Trainee Health Psychologist by explaining the background of a Health Psychology and my purpose, role, and skills was satisfying was positive and rewarding feeling. I was also able to demonstrate the inter-links between mind and body and how psychology can assist with this process was good. This I believe allowed Mr. Bailey to “get him on board” and is something I have continued to use in other clinical work due to the successes here.
Seating arrangements	My consideration of seating arrangements, I believe was another contributing factor in facilitating therapeutic alliance. As noted in my case study, seating arrangements, particularly sitting side-by-side with the patient can reduce power imbalances and the perception of the therapist as the expert (Wright & Jones, 2012; Harrison, 2013). Reducing power imbalances and perceptions of the therapist as an expert were secondary benefits and rather seating arrangements were discussed and implemented to enable Mr. Bailey to feel physically comfortable during sessions given the nature of his symptoms (neck twisting). Despite, recognition of the above, seating arrangements with Mr. Bailey, as therapy progressed, the position changed to a traditional seating arrangement. This was not to evoke power imbalance or to demonstrate me as an “expert” but rather an active process in therapy that allowed him to demonstrate a reduction in symptoms, pain, and discomfort. I completed the review and changes in seating arrangements following collaborative discussions with Mr. Bailey. This partnership aligns with the principles of CBT collaboration (Kazantzis et al., 2017), but was central in ensuring the therapeutic rapport was maintained and not ruptured as often individuals with Personality Disorders can have difficulties in collaboration due to historical and persistent relational problems (Okamoto, Dattilio, Dobson, & Kazantzis, 2019). Overall, I am delighted with myself to have practiced in a seating arrangement that I am less familiar with and to work “outside my comfort zone” to accommodate the patient's needs.

While I feel I developed and maintained a good therapeutic relationship with Mr. Bailey, an alternative approach to monitoring the quality of a therapeutic relationship is using a formal assessment. A useful tool for tracking the quality of the relationship is the Revised Helping Alliance Questionnaire (HAq-II), which is a 19-item self-report scale; it can measure the alliance from either the patient or the therapist's point of view (Luborsky et al, 1996; Rickard, Hevey, & Wilson, 2020). Although this measure is commonly used at the beginning of therapy when therapy is challenging or has a poor start, the measure can provide the therapist with useful information about the patient's perception of the alliance. Whilst it was not felt that the beginning of therapy was challenging, using a formal assessment would have provided additional information to understand Mr. Bailey's perception of the therapeutic relationship. This information would have bridged the gap in my perspective of therapeutic rapport by providing an objective and patient-centred insight into the therapeutic relationship which may have confirmed or reflected an alternative viewpoint to my experience of working with Mr. Bailey.

Furthermore, the Department of Health (DOH; Curvis, 2019; Roth & Pilling, 2007) provides best practice guidelines that emphasise the importance of therapeutic endings within CBT and as part of a therapeutic alliance. The guidelines highlight that engaging with this process is an essential part of managing the therapeutic relationship, offering specific advice on discussing the ending early on within therapy, and reviewing how the client might manage post-therapy. Wittenberg (1999) further described three types of therapeutic endings (Figure 1).

Figure 1: Types of therapeutic Endings



The therapeutic intervention logically concluded meaning a natural ending with Mr. Bailey. As part of therapeutic endings, review and (re)referral are an important method to provide patients choice, empowerment, and reassurances that additional support is available if required. Mr. Bailey was familiar with this process, and I feel offering him a review / re-referral was possible to accommodate as my placement was not ending soon. In the event, my placement was soon to end or a more structured time-limited placements (like for trainee psychologists) I would have planned for this at the beginning of the therapeutic endeavour (e.g., knowing who may offer him a review/ re-referral to allow him to be informed as part of the current therapeutic ending).

Professional Development

Throughout this individual case study, there were three areas of professional development which I have demonstrated and reflected on (Table 4).

Table 4: Professional Development Reflections

Areas of development	Reflection
Documentation and Clinical sharing of information	The HCPC guidelines, standard 10, require the psychologist to "*be able to maintain records appropriately*". During this intervention, I was required to make entries on Mr. Bailey's "RIO" records as per hospital policy. However, this system, would not align with his medical record or the external general hospital in which the Neurologist referred him for psychological therapy. Clinical records not aligning made me feel uncomfortable. Therefore, following a discussion with my supervision we explored options (e.g., notifying/writing to our in-house GP, contacting Mr. Bailey's neurologist, or a summary for his inpatient hospital records only). To overcome this challenge and to ensure, my practice allowed me to maintain clear and accurate clinical records I wrote to Mr. Bailey's neurologist. This included a letter acknowledging the referral and an end-of-treatment letter in the interest of appropriate information sharing.
Communication style	HCPC standard 2, highlights psychologist needs to "*communicate appropriately and effectively*". Specifically, psychologists must "*meet service users' and carers' language and communication needs*". Mr. Bailey indicated, and it was observed, that his head would twist towards the left. Therefore, he found sitting straight on (in traditional therapeutic arrangement) uncomfortable which in turn impacted his ability to communicate and engage in therapy. Consequently, to meet Mr. Bailey's communication needs in this scenario, it was agreed that I would sit to the left of him to allow him to feel more comfortable and to facilitate discussion. As the therapy progressed, Mr. Bailey found his symptoms were less pronounced allowing him to sit face-on with me, at which juncture seating arrangements were revised. Being able to adjust my practice to accommodate Mr. Bailey's communication needs was rewarding. It also demonstrated to me that I could practice manners and seating positions outside of the "traditional therapeutic arrangements" as this was not something I have not done previously. Another communication consideration noted was the intervention was completed during the COVID-19 pandemic when NHS staff were legally required to wear PPE. In this instance, the intervention with Mr. Bailey was completed while wearing face masks. To ensure effective communications, I utilised active listening and regularly para-phrased back to Mr. Bailey. I also ensured each session and regularly throughout the session, that Mr. Bailey could hear and understand me. To compensate for the physical barrier placed by facemasks I used open body language, facial expression (eye more so), and explicit language to effectively communicate. The intervention with Mr. Bailey was completed several months (>6 months) into

	wearing PPE. Therefore, I felt comfortable and assured in my communication skills compared to earlier in the pandemic when practising in PPE was novel and uncomfortable.
Training, Observation, and Supervision	The following intervention was completed using a CBT model. Although I have not had formal competency training in CBT, I read the necessary CBT resources (e.g., Beck 2020 – Cognitive Therapy: Basics and Beyond, and Kinsella, & Moya, 2021 - CBT for Long-term Conditions and Medically Unexplained Symptoms: A Practitioner's Guide) to further my knowledge, application, and skills. I was also receiving clinical supervision (which included reviewing some of my audio recordings) throughout to bridge the gap and advance my knowledge of the CBT model. Supervision also provided me with opportunities beyond a formative exchange and a chance to discuss and reflect on sessions, the patient's responsivity, my affect, anxieties, and my overall approach to the intervention. I, therefore, developed further recognition of the value and need for clinical supervision. Furthermore, with the use of my reflective diary after each session, over time my anxiety of not having worked with this presentation previously, reduced, and I was reassured of my competency in delivering the intervention.

Conclusion

Completing this intervention has broadened my current knowledge and experience in delivering CBT interventions and applying these to a physical health condition. This intervention provided me the opportunity to reflect and consider components in an individual intervention that I have previously not considered (e.g., the value of formulation, collaboration, and power dynamics in therapy). Completing this intervention has also enabled me to further consider the interlinks between mental health, trauma, and physical health. I remain keen to continue focusing on developing trauma-informed approaches and practices throughout my health psychology training as well as post-qualification.

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3.3 Group Intervention Case Study

Introduction

My placement is at a Medium Secure Mental Health Hospital, which offers patients a breadth of psychological interventions to address clinical and forensic issues.

The prevalence of insomnia in patients with Personality Disorders (PD) is between 50-93% (Provencher, Lemyre, Vallieres & Bastien, 2020), compared to 10-30% of the general population (Randall, Nowakowski, & Ellis, 2018). Within forensic psychiatric patients diagnosed with PD (Anti-Social Personality Disorder and Borderline Personality Disorder), lower sleep quality and higher insomnia scores have been associated with increased impulsive behaviours, aggression, and suicidality, affecting decision making, risk-taking behaviours, and behavioural inhibition (Anderson, 2018; Randall et al., 2018; Van Veen, Karsten, & Lancel, 2017). Therefore, addressing sleep difficulties in psychiatric patients may enhance the treatment of both sleep disturbance, maladaptive personality traits, accelerate their general treatment response, and increase remission rates to their primary disorder (Manber, 2008; McCall, 2010; Provencher et al., 2020; Veen et al., 2017).

This case study provides a summary of the face-to-face group psychological sleep intervention I delivered to four inpatients. I present the different stages of my intervention - the referral and assessment process, the process of developing a group formulation, intervention design and delivery, and the evaluation method.

Referral and Assessment

<u>Identification of Need</u>

The care stream's Lead Psychologist, clinical and nursing team identified patients with sleep difficulties at night and reduced daytime functioning based on their 24-hour observations. Their scoping exercise indicated a clinical need to support patients to address their sleep difficulties. Four patients were identified with sleep difficulties, and I was asked to design an intervention to address this clinical presentation.

The rationale for using CBT-I as a Framework for the intervention.

Among offenders, insomnia is common and often not a treatment priority (Dewa et al., 2017). Untreated insomnia is problematic because sleep disturbances are identified as symptoms of mental disorders and impact overall care and treatment (Kallestad et al., 2012; Morin & Ware, 1996). Interventions to addressing insomnia have typically employed sleep hygiene and sedative-hypnotic medication (e.g., sleeping tablets). However, evidence shows sleep hygiene alone is ineffective, and hypnotic medication is associated with risks (Dewa et al., 2017; Koffel, Koffel & Gehman, 2015; National Institute of Care and Excellence Guidelines, 2021). Psychological interventions provide durable treatment gains; therefore, following the National Institute of Care and Excellence Guidelines (NICE, 2021), CBT-I (a combination of behavioural intervention, cognitive therapy, and relaxation training) is recommended as the first-line intervention for insomnia.

CBT-I is an evidenced-based approach, as effective over five to eight sessions in individual and group therapy, self-administered, computerised, and brief sleep treatment (Buysse et al., 2011; Koffel et al., 2015; Troxel, Germain & Buysse, 2021; Navarro-Bravo, Párraga-Martínez, Andrés-Pretel, & Rabanales-Sotos, 2015). Completing the intervention in a group has been as effective as individual therapy (Biggs et al., 2020; Tasca, Mcquaid, & Balfour, 2016). A group CBT-I intervention was considered most appropriate due to changes in psychology provisions at the hospital through COVID-19.

Assessment of Patient Suitability

The assessment process was completed in three stages:

(i) An introductory meeting,
(ii) Individual clinical interviews, and
(iii) Psychometric assessments.

An introductory meeting was arranged between each patient, their Lead Psychologist, and I. This meeting served as an initial consultation to assess suitability, motivation and ensure mental health co-morbidities were optimally managed (NICE Guidelines, 2021). The first stage in therapy is conceptualised as a collaboration and trust between the patient and therapist, where goals are exchanged. Done effectively, this facilitates

a therapeutic rapport and the completion of therapy (Ardito, & Rabellino, 2011; Hartley & Strupp, 1983). Therefore, the initial consultation, alongside a clinician known to the patients, was essential in developing therapeutic alliance (Ardito, & Rabellino, 2011; Hartley & Strupp, 1983). All patients confirmed sleep difficulties and impacts on daily functioning, with some describing experiences of previous interventions as ineffective. All patients consented to the intervention and were assessed by me.

The second stage involved individual assessments in gathering qualitative information about patient's sleep disturbances. I used an adapted version of The Insomnia Interview Schedule (Morin, 1993) to structure my assessments. Using a semi-structured interview provided me with a good foundation and template to complete an assessment but flexibility in seeking additional information based on patients' responses. Table 1 provides key issues identified by patients.

Table 1: Synopsis of patient assessments

	Patient 1: (Mr. Jones)	**Patient 2: (Mr. Davis)**	**Patient 3: (Mr. Brown)**	**Patient 4: (Mr. Smith)**
Age	37	33	47	40
Core sleep issues at night	Waking regularly through the night.	Difficulties with sleep onset – taking several hours to fall asleep. Experiences of nightmares.	Difficulties with sleep maintenance, e.g., waking through the night and unable to return to sleep.	Experiences of hallucinations, paranoia, and nightmares at night.
Unhelpful Thoughts & Inaccurate Cognitions	Intrusive thoughts before bed – can be ratty, irritable, judgemental, and intolerable. These need to be processed before bed or can interfere with sleep.	Worry about falling asleep, e.g., worries about having a nightmare or reminders of historical trauma.	Do not look forward to going to bed due to persistent poor sleep. Ruminate when awake through the night whether to return to sleep or not. Self-blaming thoughts, e.g., Am I doing something wrong?	Feeling a lack of control over own sleep
Maladaptive Behaviours	Compensating on missed sleep – going to bed earlier than planned.	A lack of wind-down routine before bed.	Excessive caffeine intake.	Napping through the day, limited to 45 minutes.
Impacts on daytime functioning	Daytime fatigue, resulting in falling asleep in the day and communal areas. Reduced productivity.	Feeling unrefreshed in the morning. Struggling to concentrate and falling asleep in communal areas.	Daytime fatigue. Negative impacts on mood – feeling more sombre and distant.	Daytime fatigue is exacerbated by antipsychotic medication. Reduced productivity

The final assessment stage used psychometric measures to obtain a baseline score for each patient. Table 2 provides a list of the psychometric measures used and the

rationale. These measures focused solely on assessments of sleep. The patient's mental health symptoms, anger, or impulsivity were not measured due to differences in patients' mental health symptoms and diagnosis as well as an absence of problematic impulsive behaviours amongst patients.

Table 2: Psychometric Assessment

Measure	Number of items	Synopsis of measure	Rationale
Pittsburgh Sleep Quality Index (PSQI) Buysse, Reynolds, Monk, Berman & Kupfer (1989)	10	Measures sleep quality and patterns over the previous month. High scores indicate poorer sleep quality.	To quantifiably understand a patient's sleep experience, quality of sleep, and sleep pattern as a method of measuring change.
Dysfunctional Beliefs and Attitudes Sleep (DBAS) Morin, Vallières, & Ivers, 2007)	16	An assessment exploring sleep-related cognitions such as faulty beliefs, worry, and attentional bias, which clinical and research evidence suggest can perpetuate or exacerbate insomnia. High scores indicate greater inaccurate beliefs and attitudes about sleep.	To develop a better understanding of maladaptive beliefs about sleep, which maintain sleep difficulties and inform understanding cognition when addressing cognitive components in the intervention.
Sleep-Related Behaviours Questionnaire (SRBQ) Ree & Harvey (2004)	32	An assessment designed to measure safety behaviours employed to cope with fatigue or to improve sleep. Higher scores indicate greater maladaptive and compensatory behaviours.	To understand behaviours patients, engage with to manage the impacts of tiredness or to improve their sleep. Understanding sleep-related behaviours provide insight into the maintenance behaviour for sleep problems.

The group size was a core consideration in facilitating group formation and interaction. Optimal group size is dependent on the target population and type and duration of therapy (Biggs et al., 2020). A consensus group size between five to ten members allows for group formation and cohesive functioning, with fewer than five members

thought to have fewer interactions, attendance, and group image (Anderson, 1993; Biggs et al., 2020; Cohen & Rice, 1985; Fulkerson, Hawkins, & Alden, 1981). Nevertheless, four patients were considered appropriate for the following reasons:

(i) The implementation of a pilot intervention,
(ii) COVID-19 impacted the service and the need for social distancing in the group, and
(iii) Systematic reviews of group-based CBT-I indicate a group size no fewer than four and no larger than six patients (van Straten et al., 2018; Koffel et al., 2015).

Formulation

The formulation process involved:

(i) Individual partial formulations,
(ii) Collaboration and reformulation, and
(iii) The construction of a group formulation.

A case formulation is the essential and starting point of all therapy and is vital in individual and group therapy. It increases the therapist's empathy for a patient through the understanding offered by the formulation and guides the therapist through the intervention (Elles et al., 2005; Johnston & Dallos, 2013). Common themes amongst the definitions of formulation (Table 3) consider the process as a hypothesis of a person's difficulties which draws upon psychological theory.

Table 3: Definitions of Case Formulations

"formulation is… a provision explanation or hypothesis of how an individual comes to present with a certain disorder or circumstances at a particular point in their time." (Weerasekra, 1996, pg 4)
"*Psychological formulation is the summation and integration of the knowledge acquired by this assessment process that may involve psychological, biological, and systemic factors and procedures. The formulation will draw on psychological theory and research to provide a framework for describing a patient's problem or needs, how it developed and is being maintained."* (Division of Clinical Psychology, 2011, pg 6).

The process of constructing a formulation

I completed partial formulations for each patient, informed by individual assessments. I recognised it was impossible to offer an intervention that sufficiently addressed each formulation due to differences in each patient's presentation. However, completing individual formulations allowed identifying common themes that informed the group intervention.

Spielman, Caruso, and Glovinsky's (1987) "3P's Model" was adopted to conceptualise sleep difficulties by understanding patient's predisposition, precipitating, and perpetuating factors contributing to the development and maintenance of insomnia. This approach has successfully formulated sleep disturbances for prisoners (Hassan, Edge, Senior, & Shaw, 2013; Randall et al., 2018; Singleton et al., 1998; Toler, 1978). This model was considered applicable to the current population (all patients have previously resided in prison and currently in a forensic hospital – an environment resembling prison).

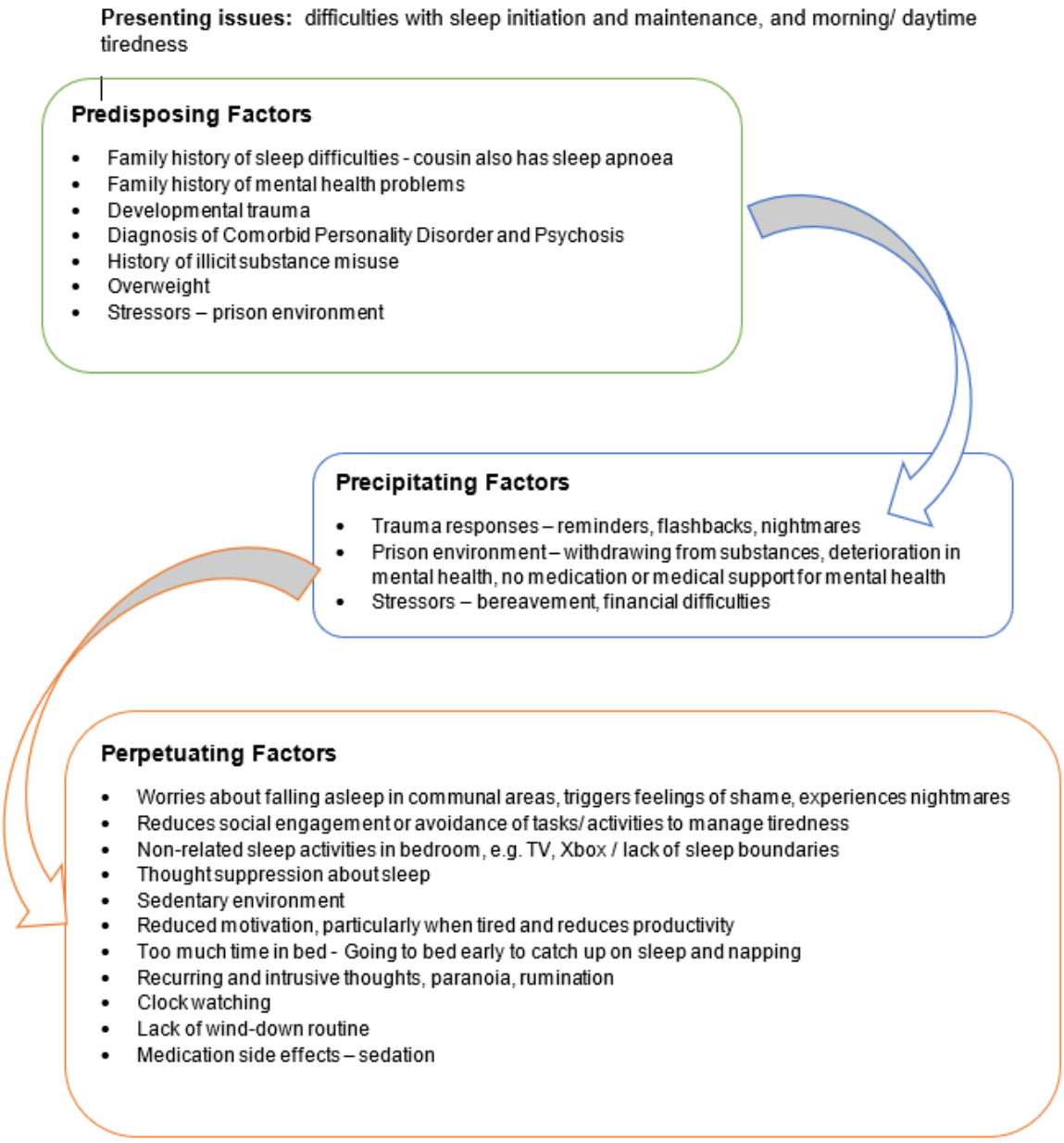
Collaboration and Reformulation

Reformulation was completed during session three of the group. Although patients have previously co-developed formulations for clinical and forensic issues, providing patients familiarity with the 3P's model was important. As a group, patients formulated a case study before completing their diagrammatic sleep formulation. Each patient and I then reviewed the formulation they developed alongside the partial formulation. These were then combined into a formulation for each patient. This offered a dynamic and collaborative process, allowing each patient to offer contributions to ensure relevancy and accuracy into their existing partial formulation (Division of Clinical Psychology, 2011).

Group/ Presentation of formulation

Presented diagrammatically (Figure 1), the final stage involved collating individual formulations into a group formulation (Barlow, 2015; Division of Clinical Psychology, 2011). This "*provides a basis for understanding, assessing and determining what is going on in a group from the group-as-a-whole and the individual member perspective*" (Brown, Spender, & Dlin, 1990, Pg 72).

Figure 1: Group Formulation



Overall, my formulation indicated the intervention should offer a flexible approach, appropriate for patients with chronic sleep difficulties and mental health difficulties.

Intervention

This stage involved applying the aims, selecting, and applying intervention techniques while utilising the group process and promoting experimental learning. The intervention aims were:

1. To educate patients about sleep problems,
2. To help patients identify factors contributing to and maintaining their sleep difficulties, and
3. To help patients implement skills to improve their sleep-related difficulties.

In keeping with Group-Based Behaviour-Change Interventions (GB-BCIs), a co-facilitator and I delivered the intervention, which provided education, practice, psychological change processes, and techniques to improve sleep (Borek, Abraham, Smith, Greaves, & Tarrant, 2015; Borek et al., 2019).

Intervention Design

The intervention was designed from the group formulation and focused on maladaptive behaviours, unhelpful and inaccurate cognitions, and sleep-promoting behaviour changes. Considered an evidence-based approach for group intervention, components of CBT-I were adapted (Edinger & Carney, 2014; Murawski, Wade, Plotnikoff, Lubans, & Duncan, 2018; Perlis, Jungquist, Smith & Posner, 2006). This provided me with a foundation for designing my intervention, identifying deliverable intervention techniques, and crucially considering patient needs and mental health co-morbidity (Waters, Ree & Chui, 2017).

Table 4 shows the intervention content and structure.

Table 4: Intervention Overview

Session No	Focus	Objectives
1	Introductions to the programme	An overview of the programme, therapeutic rules, and therapeutic contracting. An introduction to sleep difficulties and sleep diaries emphasises the importance of self-monitoring of sleep through the group to assess the effectiveness of intervention techniques. Sleep diaries are considered essential in CBT-I to monitor the effectiveness of intervention techniques (Anderson, 2018; Carney et al., 2012). Therefore, a minimum of three recordings per week was negotiated with patients to monitor the effects of the intervention (Carney et al., 2012).
2	Understanding Sleep - Psychoeducation	Information on basic facts about sleep and insomnia, e.g., circadian rhythm versus sleep pressure.
3	Formulation	To identify predisposing, precipitating, and perpetuating factors contributing to sleep difficulties for acute presentation and chronic sleep problems. The process of collaboration and reformulation of partial formulations.
4	Sleep Restriction/ Sleep Compression	To enhance overall Sleep Efficacy (SE) and to dedicate time in bed for sleep. To identify the duration of time spent in bed awake and asleep and subsequently adjust and restrict time in bed to ensure periods in bed are devoted to sleeping.
5	Stimulus Control Therapy	To identify and improve cues for bed and bedroom for sleep and reduce cues for activities in bed or the bedroom that interfere with falling or staying asleep. The aim is to develop a stronger association between sleep and sleep-related stimuli in bed/ bedroom.
6	Sleep Hygiene	To identify and implement changes in daily and night routine and overall habits that contribute to poor sleep patterns, to develop alternative practices that promote sleep.
7	Cognitive Components	To focus on addressing inaccurate or dysfunctional beliefs and maladaptive thoughts about sleep and decreasing sleep-related worry.
8	Sleep and Mental Health	To explore the role of mental health symptoms and experiences (nightmares, intrusive thoughts, hallucinations, and paranoia) which interfere with sleep and alternative coping methods. To also consider the sedation side effects of medication on inhibiting and promoting sleep and methods of maximising daytime energy.
9	Relaxation and Mindfulness and Group Ending	To explore techniques to support relieving tension, the ability to manage worry that may interfere with sleep and let go. Also, reflections on the group as a process and bringing the intervention to an end.

Intervention Delivery and Techniques

I incorporated several techniques specified in the Behavioural Change Technique Taxonomy (BCT; Michie, Atkins & West, 2014). Table 5 demonstrates how the BCT was integrated into the intervention.

Table 5: Employed Behaviour Change Techniques

Sessions	S 1	S 2	S 3	S 4	S 5	S 6	S 7	S 8	S 9
Education		✓						✓	
Commitment	✓								
Self-monitoring		✓		✓	✓	✓	✓		
Associative Learning					✓				
Behavioural Practice and Rehearsal				✓	✓	✓		✓	✓
Restructuring of physical environment						✓			

In delivering the intervention, evidence shows describing different components to patients advances their understanding of the intervention content, application, and facilitates behaviour change (Duncan et al., 2017; Michie, Johnstone, Francis, Hardeman & Eccles, 2008; Murawski, Wade, Plotnikoff, Lubans, & Duncan, 2018). Table 6 describes how each technique was used and my observations about their utility and effectiveness.

Table 6: Description of Behaviour Change Techniques and Observed Effects

Intervention Techniques	How it was used	Observations
Commitment	Used in session one, where patients were asked to affirm how they were committing to behaviour change. Activities to assist with commitment focused on group formation where patients identified amongst themselves rules, expectations, and behaviours to the intervention, which indicated a commitment to behaviour change.	***Effective*** – Commitment to intervention and behaviour change is a technique often integrated into other aspects of the patient's treatment programmes. They were able to identify methods that indicated a commitment to the intervention (e.g., attending regularly, on time for the sessions, completing out-of-session practice, etc.). They also identified barriers to commitment to behaviour change (e.g., previous unsuccessful attempts, demands from other aspects of their treatment).
Education	The use of education was to provide factual information about sleep. Information about sleep was delivered using psychoeducation information about sleep and videos to support understanding the sleep-wake cycle, sleep pressure, and the circadian rhythm. Educational techniques were also used when exploring the impact of sleep on mental health and methods of coping.	***Effective*** – Although initially, patients found psychoeducation confusing, after further explanation, their understanding improved. They recognised the need for different coping strategies in the day compared to the night and were receptive to learning new methods. Experiential learning is the process of learning through experience (Felicia, 2011). Patients were engaged in an applied approach to learning both in and between sessions, which emphasised the importance of learning new coping skills through experience. The term "out of session practice" was used instead of the term "homework" to highlight the patient role in the process and reduce potential associations with the student-teacher concept.
Self-monitoring	This technique was introduced early into the intervention to monitor and record behaviours as part of a behaviour change strategy. Self-monitoring was completed using sleep diaries to assess and monitor the effectiveness of CBT-I techniques (e.g., restriction/ compression therapy,	***Somewhat effective***- The uptake and utility of self-monitoring were variable. All patients had used self-monitoring in the form of diaries in other therapeutic interventions and found the process tedious or onerous in the context of other therapeutic demands. However, half the patients consistently used sleep diaries and observed changes in their sleep, which motivated them to continue implementing the CBT-I principles and monitoring behaviour changes.

	stimulus control therapy, sleep hygiene, and cognitive components) and changes within patient sleep.	
Associative Learning	The session on Stimulus Control Therapy (SCT) focused on developing an improved association between bed and sleep and considering what changes and adjustments could be made to enhance sleep cues. As part of group discussions, patients identify behaviours and activities in their bedroom they associate with being awake and behaviours that promote sleep, including activities patients, may engage with if waking through the night.	***Effective -*** One patient who had previously completed SCT shared their experience of this technique and how developing this understanding of association can improve sleep. This motivated other group members to reflect on prompts and cues that may interfere with sleep to adjust practices to improve the association for behaviour change (sleep). The bedroom environment is the only place where patients have privacy and independence from the communal areas of the ward. Subsequently, patients engage in behaviours in their bedrooms that inhibit sleep. Nevertheless, they developed a better understanding of behaviours at night that inhibit or promote sleep (e.g., changing the type of music listened to, sitting in a chair to watch TV rather than a bed).
Behavioural practice and rehearsal	On more than one occasion, this technique was utilised to practice and rehearse skills developed in the group to support behaviour change.	***Effective -*** The uptake of this technique varied amongst patients and each session, with some patients practising more than others. Those who consistently and engaged in practices outside sessions had more significant behaviour change outcomes. Sleep compression therapy – one patient made the recommended adjustments in sleep and wake times, and an improvement in sleep-efficacy scores was observed. Sleep hygiene – one patient struggled with sleep onset and practice, and having a wind-down routine reported an improved sleep onset time. Cognitive restructuring – although patients did not explicitly report having engaged in practising this technique, dysfunctional beliefs about sleep were observed to be reduced at the end of the intervention.

		Relaxation - all patients were familiar with the concept and relaxation methods, with some patients already using relaxation techniques regularly.
Restructuring of the physical environment	This technique was adopted as part of sleep hygiene to support patients in identifying daily and night routines and habits that contribute to poor sleep. There was also an exploration on maximising daytime energy and managing fatigue. Patients considered how they are currently managing their fatigue, what activities they are not participating in, and methods to improve daytime functioning. There was also an exploration of the patient's existing bedroom environment and daily routine inhibiting sleep, which informed a discussion around changes in their bedrooms or daily routine to facilitate behaviour change.	***Somewhat*** **-** The uptake of this was variable as patients were content with the daily routine, which in part, was dictated by the ward's overall treatment model. One patient had previously engaged in sleep hygiene and found this approach entirely ineffective, and thus, did not wish to make any changes. Another patient utilised this approach to establish a wind-down routine to facilitate a consistent sleep-time and observed changes in sleep onset.

Group Formation and Process

In therapy, dynamics between patients and amongst patients and therapists are essential for a successful group as it provides patients with a belonging, connection, and maintains focus (Ezhumalai, Muralidhar, Dhanasekarapandian, & Nikketha, 2018). Key features in the current group included establishing group bond, engagement, and patients exchanging ideas. Existing familiarity amongst patients enabled them to listen to each other, provide feedback, and enhanced their willingness to share thoughts and emotional states. In addition, group identity, high morale, and loyalty were observed through patient-supporting each other via problem-solving and applying skills developed through the intervention. Finally, the intervention ending was important. Patients had the opportunity to reflect on the ending process and terminate tasks.

Evaluation

Evaluation is the process of understanding what changes have occurred through the Intervention (Department of Business Innovation & Skills, 2011) and was divided into evaluating intervention outcomes and intervention process.

Evaluation of Intervention Outcomes

The intervention outcomes were evaluated using psychometric measures (completed pre-intervention, post-intervention, and six weeks post-intervention) and sleep diaries to monitor change.

Overall, post-intervention findings indicate (Table 7 and Figure 3) that all patient's SE increased, with one patient's SE score marginally below the recommended guidelines (Edinger & Carney, 2014; Perlis et al., 2006; Reed & Sacco, 2016). All patients' sleep quality improved (as measured by the PSQI), and inaccurate cognitions about sleep reduced (as measured by DBAS). A reduction in sleep-related behaviours (as measured by SRBQ) was observed in all but one patient whose SRBQ score increased by 12%.

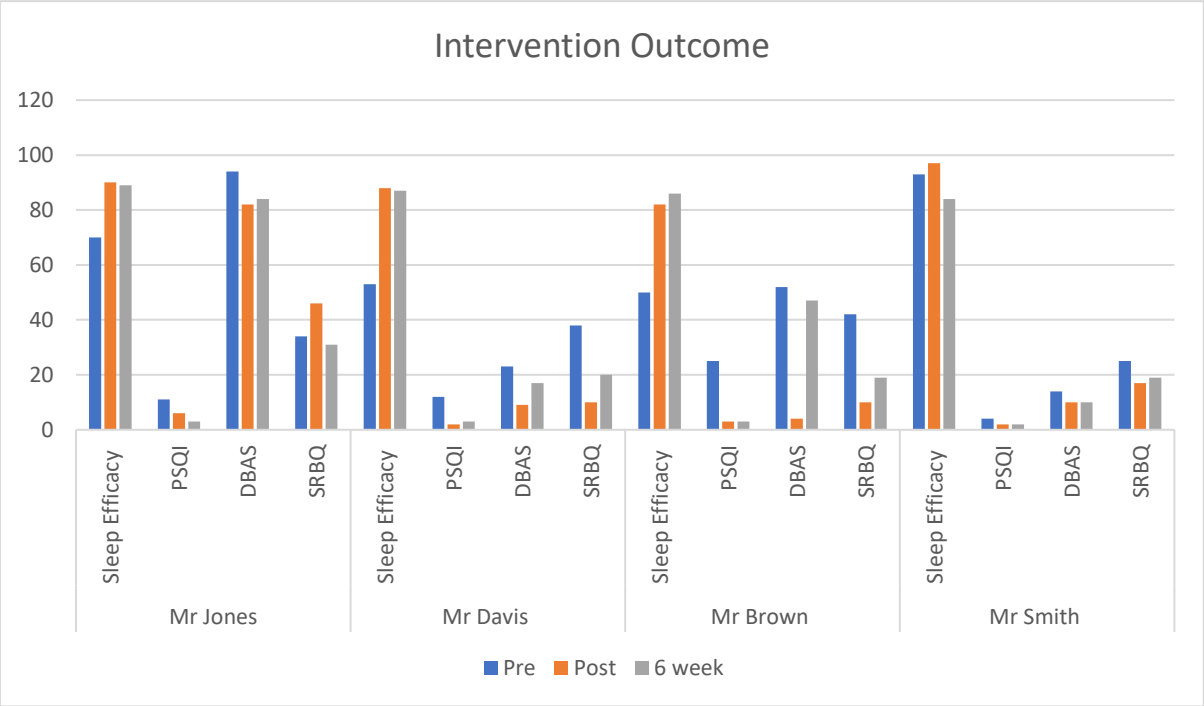
The longitudinal follow-up highlighted maintenance in SE and sleep quality, noting a minimal reduction in percentage than immediately after the intervention. DBAS and SRBQ scores increased, but scores were not as high as pre-intervention. These

outcomes may have increased as relapse prevention planning was not completed within the intervention.

Table 7: Summary of Intervention Outcomes

	Mr Jones				Mr Davis				Mr Brown				Mr Smith			
	Sleep Efficacy	PSQI	DBAS	SRBQ	Sleep Efficacy	PSQI	DBAS	SRBQ	Sleep Efficacy	PSQI	DBAS	SRBQ	Sleep Efficacy	PSQI	DBAS	SRBQ
Pre-Intervention	70	11	94	34	53	12	23	38	50	25	52	42	93	4	14	25
Post Intervention	90	6	82	46	88	2	9	10	82	3	4	10	97	2	10	17
6-week post Intervention	89	3	84	31	87	3	17	20	86	3	47	19	84	2	10	19

Figure 3: Intervention Outcome



Sleep diaries were used to assess sleep quality and the effectiveness of the intervention. The completion of sleep diaries amongst patients significantly varied. Two patients consistently completed these, and intervention success showed improved SE, sleep onset, and reduced sleep maintenance difficulties. The other two patients struggled to complete diaries, finding the process strenuous alongside other treatment demands. This made it difficult to assess and evaluate the intervention's impacts.

Evaluation of the Intervention Process

Evaluation of the intervention's strengths and weaknesses (Biggs et al., 2020) was completed through in-session patient feedback about the processes they found effective or ineffective (Table 8), and an end of treatment form. The evaluation was informal to avoid placing additional demands on patients who had already expressed the burden of completing a sleep diary alongside other therapeutic demands.

Table 8: Strengths and Weaknesses of Intervention

Strengths	Weaknesses
• The facilitators had good communication skills to explain concepts and skills in the intervention. • The use of worksheets was excellent and engaging. • The timing and duration of sessions were appropriate. • The facilitator's knowledge of intervention was good. • Visual examples using flip chart were accessible in understanding the information (e.g., using a clock diagram to calculate sleep-efficacy score) • The formulation sessions, with the use of case study, was engaging • Partial formulation represented a good understanding of clinical difficulties, and patients subsequently felt heard during the assessment	• Video clips were too confusing, intellectualised, and complicated. • The accent of the individual in the video clip was hard to understand • The therapeutic aims were not apparent at the beginning of the group • Sleep diaries were too demanding and boring • The psychoeducation session on sleep was overwhelming with the technical information presented • The last-minute cancellation of sessions or moving of room was disruptive but unavoidable.

Summary

This pilot sleep intervention was delivered to four patients in an inpatient forensic hospital. My approach demonstrated a range of strengths and weaknesses at all junctures of assessment, formulation, intervention, and evaluation. Overall, the intervention improved in patient's duration and quality of sleep while reducing maladaptive beliefs and behaviours. The evaluation of the intervention provided valuable insights into methods that were helpful and areas for revisions for future delivery of this intervention.

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3.4 Group Intervention Reflective Commentary

Introduction

This reflective report accompanies my group intervention case study, which focuses on a sleep intervention. I discuss my strengths, weaknesses, and areas of development at all junctures of assessment, formulation, intervention, and evaluation. I also discuss my professional developments from completing this intervention as I work towards being a Health Psychologist.

Assessment and Formulation

Assessment

I completed individual assessments as only four patients were identified for the group. This allowed me to build a therapeutic relationship with each patient, which is core in improving patient assessment, expected treatment outcomes, and compliance (Crits-Christoph, Rieger, Gaines, & Gibbons, 2019; Corner, 2019; Elliott, Bohart, Watson, & Murphy, 2018). In developing a therapeutic rapport, I was warm, affirming, and understanding of all patients' experiences. Using open-ended questions, reflection, and paraphrasing to demonstrate active listening (Ntshuntshe, Gqeba, & Gqeba, 2020; Taukeni, 2020) enabled a transition from "small talk" to formal assessment. This reaffirmed a "client-centered approach" in facilitating a therapeutic relationship for optimal treatment compliance and outcomes (Jones, & Wright, 2017; Moreno-Poyato et al., 2019; Tishby & Wiseman, 2018)

Individual assessments however were time-consuming and only appeared viable due to a "pilot intervention" involving four patients. Individual assessments with a standard group size of five to ten patients (Biggs et al., 2020; Cohen, Cecil, & Rice, 1985; Fulkerson, Hawkins & Alden, 1981), would increase workload and time constraints. These are linked to fewer therapeutic outcomes, resulting in inadequate consultation time and flawed communication methods (Crits-Christoph et al., 2019). An alternative approach may involve patients completing a self-report assessment or dividing assessments amongst co-facilitators dependent on their knowledge, competencies, and clinical supervision.

Psychometric assessments provided a helpful baseline assessment of patients. I found the Beliefs and Attitudes about Sleep (DBAS) and Sleep-Related Behaviour Questionnaire (SRBQ) beneficial in understanding perpetuating beliefs and behaviours which helped with constructing partial sleep formulations. However, each measure's content was not thoroughly reviewed to ensure relevance and applicability for the current population. I recognised this when administrating the PSQI (question 10 relates to bedroom partner) did not apply to patients in a forensic setting due to lone sleeping arrangements. Fortunately, this item did not contribute to the final score. Nonetheless, it highlighted my need to explore the suitability of measures before administration.

Formulation

The process of formulation, as described in my case study, was completed in three stages.

Strengths in my approach were completing individual formulations and collaboration and reformulation. Individual formulation guided a broader group formulation and intervention design. This process identified distinct differences in patients, which I felt were essential as forensic psychiatric patients present with a range of complex clinical presentations and mental health co-morbidities. This allowed making treatment recommendations to patients' clinical team for issues that could not be addressed in the group. My process of reformulation was robust as it invited each patient to offer contributions and collaboration to their partial formulation. Completing this process in a group setting allowed patients to share experiences and offer peer support which would have been absent outside of this format.

Despite strengths in my formulation approach, limitations included:

- Inaccessible language
- Not disclosing the group formulation to patients, and
- Insufficient information about the intervention aims.

I felt the "3P's Model" (Spielman, Caruso & Glovinsky, 1987) was simple, accessible, and applicable for patients having successfully formulated prisoners insomnia (Randall, Nowakowski, & Ellis, 2018; Sharma & Andrade, 2012). However, I observed the 3P's language was inaccessible to patients. I was pleased patients felt

comfortable, due to an established rapport, seeking clarity about the model. I then converted the terminology to a more 'lay-friendly' format. This made me conscious of my assumptions about what is and is not accessible language and be more mindful of health literacy (Nutbeam, 2000; Nutbeam & Kickbusch, 2000).

I independently developed the group formulation to maintain the confidentiality and sensitivity of individual formulations. Furthermore, I did not provide patients with important information about the intervention beforehand due to developing my knowledge of CBT-I and BCT. This contributed to patient ambivalence about the intervention. Clear communication of therapeutic aims minimises patient doubt, contributes to interpersonal relationships, increases compliance, and provides a positive experience of therapy (Heinonen, & Nissen-Lie, 2020). In the future, communicating key themes from the group formulation which the intervention intended to address would provide patients with clear therapeutic aims, maintain confidentiality, and minimise patients' ambivalence.

Implementation

Intervention Design

Three core factors informed my intervention design:

- Alignment with the Personality Pathway Programme structure,
- The CBT-I model, and
- Group formation.

I was limited to providing my intervention within the twelve-week programme structure. While initially not concerned with the time limits, factors such as co-facilitators annual leave or COVID-19 impacts resulted in session cancellations. Subsequently, I felt pressured to ensure the intervention was completed in this timeframe.

The intervention content was founded on the CBT-I model, which offers a manualised, evidence-based approach with a logical and coherent structure. This structure provided me a sound basis to tailor my intervention, informed by the formulation, and incorporated BCT to deliver my first sleep intervention. Necessary adaptations were considered in the design and delivery of the intervention, as when CBT is delivered rigidly, dynamics in the therapeutic relationship, treatment compliance, patient needs, and outcomes are neglected (Beck, Rush, Shaw, & Emery, 1979; Okamoto, Dattilio,

Dobson, & Kazantzis, 2019). Therefore, my flexibility and tailored intervention design were excellent in matching patient need.

Research suggests group process and formation with fewer than five members have limited interactions, attendance, and group image (Cohen, 1985; Fulkerson, 1981; Holt et al., 2019). Therefore, I designed initial sessions to facilitate group formation, but patients found these sessions “dragged out”. Revisions in future intervention design hope to find a balanced approach that promotes group processes (ensuring patients understand the reasoning behind activities, without over-emphasis of sessions feeling “long-winded") while acknowledging group formation as a continuous process through therapy.

Intervention Techniques

The use of evidence-based techniques from CBT-I and BCT was a strength. However, self-monitoring (sleep diaries) was the least effective technique as two patients struggled to complete these alongside other treatment demands. Unfortunately, I did not address the ongoing obstacles or find a solution with the patients, allowing this technique to be more effective. In a future intervention, considering the principles of COM-B (Michie, Atkins & West, 2014) to formulate and overcome the difficulties in using sleep diaries as a self-monitoring method.

My intervention used different modalities to deliver the content. Discussions and worksheets were an asset to facilitate patient learning and share experiences. Videoclip was a creative method of disseminating knowledge earlier in the intervention. However, patients found these confusing, often seeking additional explanations. I retrospectively recognised using this modality to manage my anxiety about my knowledge. However, I was reassured when I effectively translated the information from videos for patients who found it valuable and accessible.

My intervention incorporated mindfulness-based techniques as an emerging area (Kim, 2021; Ong & Sholtes, 2010; Wang et al., 2018). I included these knowing patients are familiar with mindfulness, having completed this module of Dialectic Behavioural Therapy (DBT; Linehan, 1987; Linehan, Cochran, & Kehrer, 2001). I felt this was valuable to demonstrate extending mindfulness from other aspects of their treatment in the hospital.

Coping with nightmares was explored with patients. Specific evidence-based approaches to address nightmares, e.g., Imagery Rehearsal Therapy (Augeda et al., 2013; Aurora et al., 2010), were not used due to the interlinks between patients' nightmares and developmental trauma. In addition, these evidence-based approaches require specialist knowledge and training amongst Psychologists, which are outside my current level of expertise. However, I introduced patients to these techniques to increase their knowledge so they could discuss this with their clinical team.

Evaluation

Overall, my approach to evaluating the intervention was valuable. It identified therapeutic strengths and weaknesses and allowed me to distinguish which areas patients appeared to be responding positively to and less effective areas. Contributing to this process was patient feedback during or at the end of sessions - evaluating the intervention's effectiveness on an individual level (Biggs et al., 2020).

Psychometric assessments were used to evaluate at a group level. This preferred approach of mine was simplistic, time-efficient, and effective in gathering data on treatment outcomes. However, this solely relied on patient engagement and feedback. Actigraphy measures (wearable activity watches) provide objective recordings of sleep difficulties (Dietch & Taylor, 2019; Mitchell et al., 2019; Sheaves et al., 2018). However, could not be used as the technology of the devices does not comply with the security requirements of forensic services.

An alternative evaluation method of my intervention is the Behaviour-Change Intervention Checklist (GB-BCIs; Borek, Abraham, Smith, Greaves & Tarranta, 2015; Borek et al., 2019). This provides a practical tool in designing and assessing the quality of group-based intervention across four domains: intervention design, intervention content, group participants, and group facilitators.

Summary and Professional Development

This intervention contributed to my experience of delivering group interventions, considering components in group therapy (e.g., group processes and group formulations), and allowing me to apply several behaviour-change techniques used within Health Psychology. It was vital for me to receive feedback from patients and the co-facilitator to highlight good practice and developmental needs as I progress through

training. I attended a two-day training event alongside literature reading and regular clinical supervision to further my knowledge, application, and skills. This intervention increased my interest in sleep interventions, advanced my understanding of the CBT model, and offered a reflective opportunity on sessions, the patient's responsivity, and my intervention approach. I am motivated to continue delivering and embedding sleep interventions into the service, emphasising the benefits of physical health and wider treatment outcomes for patients. As I progress to qualifying as a Health Psychologist, I endeavour to develop trauma-informed modalities in sleep intervention.

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Chapter 4: Teaching and Training in Health Psychology

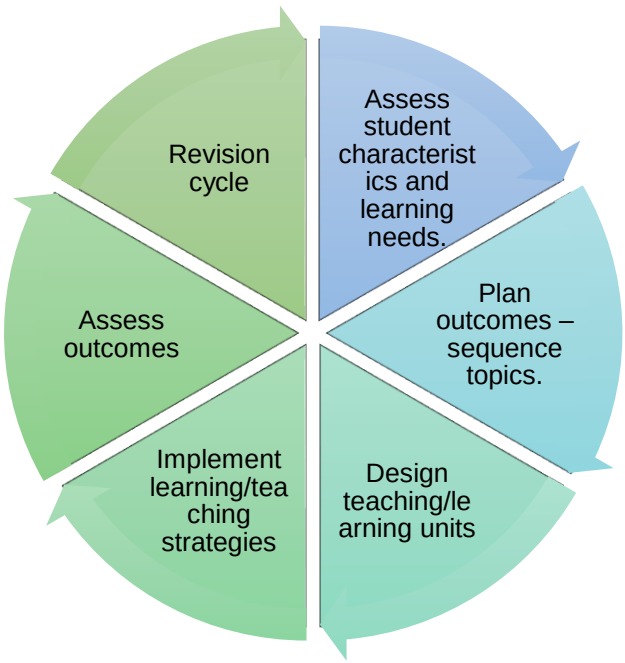
4.1 Teaching and Training Case Study

Introduction

This case study describes five teaching and training sessions I delivered across different learner groups. In this case study, I discuss the process of planning, designing, delivering, and evaluating these sessions. The overarching theme of this teaching programme was "***Applied Health Psychology in Forensic Mental Health***". Participants were either healthcare professionals (dietitians) working in Forensic Services or academic students and sessions were delivered in a variety of small and large group settings either face to face or online (Microsoft Teams; MS Teams).

When planning a teaching programme, Stefani (2009) suggested a systematic approach (Figure 1).

Figure 1: Stefani's (2009) Systematic Approach to teaching



Therefore, this case study is structured to address the relevant stages in the teaching process:

- Assessing and identifying training needs,
- Design of session structure and content,
- Selection and creation of teaching materials, and

- Assessment of learning outcomes.

This case study is also accompanied by a reflective report, observer feedback, and relevant appendices evidencing the planning, designing, delivering, and evaluation of the teaching programme.

Assessment and Identification of Training Needs

The process of finding teaching opportunities was identified using a variety of ways. For example, completing teaching and training needs analysis within a healthcare professional forum, being approached by teaching staff, and expressing my interest to teach an audience. Table 1 summarises each of the teaching opportunities which I completed, how the teaching opportunity arose, and provides a brief synopsis of the assessment of needs.

Table 1: Summary of Teaching Sessions

Session	Audience	No of attendees	Identification of teaching	Needs analysis	Delivery method	Topic Overview
1	Dietitians	46	Attended group supervision where dieticians identified opportunities to develop their understanding of working with complex patients. offered	Group discussion to identify areas of development – a list of possible topics was emailed. Duration – to be decided by me	MS Teams	Overview of psychological principles and assessments
2	Dietitians	36			MS Teams	Trauma and Substance Paralleling Behaviours
3	Dietitians	23			MS Teams	Case Formulation, Behaviour change, and CFT.
4	MSc Students	8	Approached by lecturer	Discussion with lecturer in supervision about the requirements Duration – allocated 1hr slot	MS Teams	MSc and beyond
5	BSc Students	31	Expression of interest to the module leader	Email correspondence with the lecturer Duration – allocated 1.40 hr slot	Face to face	Illness Cognitions

Training Needs Assessment

I assessed the learning needs in a range of different ways, including being informed by the module leader of the student's learning requirements, reviewing module handbooks where relevant, and attending a group supervision session to identify teaching need(s), gather thoughts, and later requested feedback.

When assessing the learning needs of healthcare professionals (dietitians) I attended a group supervision space where the learners highlighted several gaps in their knowledge when working with complex patients in forensic services. It was important for me to understand the learner's needs further as this would inform the content of the teaching sessions (e.g., focusing on appropriate clinical matters relevant to the audience that were within my competencies). The learners collectively made a list of topic suggestions before re-inviting me to another group supervision to discuss this further.

This approach differed when assessing the needs of academic students undertaking undergraduate (BSc) and postgraduate (MSc) courses. In both these instances, I had several discussions with the module leaders to understand the purpose of the sessions, how my sessions related to the wider module, and if the session contributed to any module assessment. For one session, I was provided a copy of the module handbook (Illness Cognition) which informed me that my session contributed to a summative assessment within the module. For the MSc students, I was a "guest speaker" and the session formed part of the careers and employability programme within a wider module which considers core issues in Health Psychology.

When understanding the needs of the learners, it was also important for me to establish the audience/student characteristics. This included their existing knowledge of the area, application to professional practice (relevant for healthcare professionals only), and any learning/ developmental needs of students (e.g., dyslexia). For all learner groups, my needs analysis informed me that participants had limited knowledge of the topic areas which guided the planning of my sessions. Furthermore, when understanding the learning needs of students, I only completed this for my final teaching session (Illness Cognitions) after recognising this as oversight for previous sessions.

Theoretical Underpinnings

The theoretical underpinnings of my teaching sessions were based on Kolb's (1984) experimental learning cycle which comprises four different stages of learning from experience: Concrete Experience, Reflective Observation, Abstract Conceptualisation, and Active Experimentation. The use of Kolb's experimental learning was facilitated across all sessions and Table 2 describes how each stage of learning was utilised.

Table 2: Application of Kolb's (1984) Experimental Learning Cycle

Learning Stage / Phase	Description of Phase	Application within Sessions
Concrete Experience (doing/ having an experience)	Learners begin their concrete experience either by completing a new experience or reimaging an experience that has already occurred. Here, learners engage in activities or tasks with the key to learning including involvement.	As noted by the learning needs analysis, students were broadly unfamiliar with the topic areas that were scheduled for the teaching sessions. Therefore, I intended to initially present a new learning experience for most learners. I, therefore, ensured this phase was structured to allow participants to become actively involved in the teaching session to facilitate their learning. As involvement is key, learning through reading or watching is not considered sufficient. Therefore, I ensured this phase, within sessions, was well structured to promote this. In doing this, I believed these allowed participants to be actively involved in the teaching to facilitate learning. As such, I used a range of methods and activities that were a combination of passive and active techniques: - Lecturing / disseminating information - Case studies - Videos - Skills practice - Quiz These approaches were also relevant to my teaching audience as it intended to facilitate an acquisition of knowledge (e.g., theoretical models). For example: - Session 2: For this healthcare teaching session, I utilise videos to communicate and support clinicians in understanding trauma. - Session 3: For my healthcare teaching, I demonstrated to participants how to complete activities and exercises using compassionate focused approaches by inviting them to participate while I am demonstrating (e.g., compassionate colours script, safe place imagery). - Session 5: For my BSc students, I used lecturing slide methods and a PowerPoint presentation that was integrated with a case study and clinical example when teaching on the theoretical model of illness.

Reflective Observation (reviewing/ reflecting on the experience)	After engaging in concrete experiences, the learner reflects on the task/ experience. During this stage in the learning cycle, learners ask questions and discuss their experiences with others.	This phase commences after the first stage is complete. In sessions, I attempted to support participants in a process of reflection where they began to consider the activities undertaken in sessions and show their experiences in structured ways. Communication at this stage is vital as it allows learners to identify any discrepancies between their understanding and experiences. For example: In all my healthcare teaching sessions and BSc, after learners were provided with theoretical information learners had the opportunity to consider it in small groups (due to the large nature of the group) before sharing this with the wider group. During these discussions, I attempted to support learners with any thoughts or feelings that they occur during the experience. In session 1, after providing information on theoretical concepts learners were asked to apply these concepts to a case study within their breakout groups. Similarly in session 2, learners were introduced to a treatment model (Livesey's Treatment Stage Model, 2000) and asked to identify how this model can be applied within their profession and what dietetic techniques/ interventions they could use in each stage of treatment. Finally, in session 3, participants were provided with information on behaviour change techniques and introduced to the behaviour change cards to explore how these strategies would be applied within clinical practice. While encouraged to consider the application of these cards broadly to their practice, learners were also guided with a case study. During this session, learner described understanding the content (thoughts/ cognitions) but feeling inexperienced (feelings) in applying some of the content to their clinical practice. A similar approach was taken for my BSc students (session 5) where learners were provided with a theoretical model/concept on illness cognitions and later a case study. Learners then had the opportunity to discuss in smaller groups how to apply the model before sharing their thoughts with the wider group. During this session, I also presented to learners how I applied the theoretical model to this case/ clinical example. In session 4 the arrangements were slightly different. After phase 1 (where students were provided an overview of my background and the Professional Doctorate in Health Psychology), learners then had the opportunity to discuss with me as a wider group. This method of group discussion and communication allowed learners to safely share

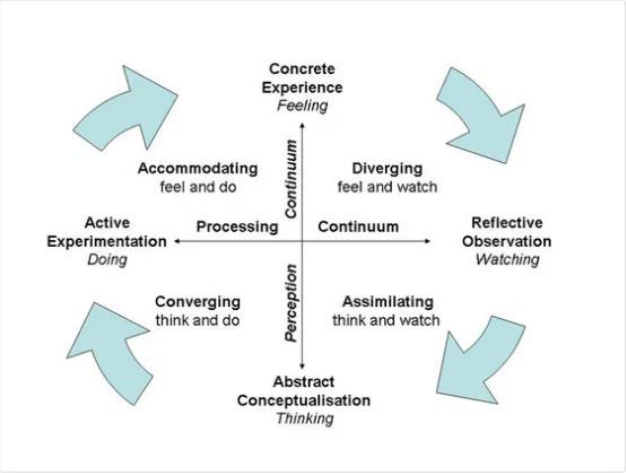
		their thoughts or feelings that they occur within the experience. It was particularly well due to the small and intimate nature of the learner group.
Abstract Conceptualisation (concluding/ learning from experience)	In this stage, reflection gives rise to a new idea or modification of an existing abstract concept e.g., the learner has learned from their experience.	This stage involves learners starting to make sense of events and teaching content. In this stage of learning, I attempted to support participants to take a step back and critically consider where possible, concluding the application to "real life". This area was about learners initially working alone before sharing their conclusions with the wider group about what they learned. The aim here was to allow learners to conclude the experiences by reflecting on their prior knowledge, using ideas with which they are familiar, or discussing possible theories with their peers. For example: In Session 1: (dietitians) the learners developed their knowledge of the Biopsychosocial model and how to apply this to disorderly eating and obesity. Initially, learners considered the application of the Biopsychosocial independently before sharing this with the wider group (as a prompted discussion). Here, learners reflected that although a "new" theoretical concept was introduced to them, they felt the underpinnings are something they routinely draw upon in practice. E.g., they consider the patient's biology, and psychological and social circumstances but do not name it in this manner. Therefore, learners reflected a need to explicitly state the use of this model in their practice, following their session. E.g., I am using the "Biopsychosocial Model" with patient "X" as they felt this would subsequently enhance their demonstration of evidence-based practices within their services. In Session 4 (MSc students): the students were able to reflect on the content of the session (e.g., careers development after MSc in Health Psychology). They were able to reflect independently before discussing and reflecting as a group at the end of the session. E.g., how to integrate the career development information from the session to their own developmental/ career pathway. Other ways in which I supported learners in this step included: - Asking and helping the learners to summarise what they had learned into concise statements - Helping learners with connecting the conclusions reached and integrating them into a theoretical model presented in the teaching session - Ensuring, within the timeframes possible, that learners who wanted to contribute and share insights had the opportunities to do so.

Active Experimentation (planning/ trying out what you have learned)	The learners apply the newly developed knowledge to themselves or within clinical practice.	In this stage, the focus was on supporting learners to begin to apply the learning by concluding new experiences. A focus within my sessions was to support and allow learners to put their acquired knowledge into practice. This included demonstration and ensuring that the information is retained in the future. For example: - Session 2 (dietitians): After providing learners with the understanding of a theoretical model (Livesey's, 2000, Treatment Stage), the learners were then asked in small groups to consider dietetic interventions they could use with patients in each stage of treatment. I then collated and combined the ideas and suggestions from each group into one document that became a shared resource for all learners. - Session3 (dietitians): I guided learners through several compassion-focused exercises that they could use with patients that were experiencing trauma-symptomology or found interventions relating to their diet or eating particularly triggering their mental health. After demonstrating to the learners, they were then able to discuss how they use the exercises within their practice while sharing short resources/information to support them in remembering the information in the future. In this session also, I provided learners with information on case formulation (definition, purpose, and utility) and demonstrated how to complete a 5P's formulations. Learners then had the opportunity to complete a formulation based on a case study. - Session 5 (MSc Students): the learners/ students were supported to apply the learning as part of their assignment. Learners were presented with a clinical example and then shown how they could use the knowledge from the session in a clinical example. This mirrors their assignment where they were asked to apply a theoretical model from the module to a clinical case study.

Learning Styles

Kolb's (1984) experimental learning theory sets out four distinct learning styles, which are based on a four-stage learning cycle, with individuals tending to prefer a particular learning style. Kolb (1984) recognised a variety of factors that influences an individual preferred style, e.g., social environment, educational experiences, or the basic cognitive structure of the individual. Nonetheless, it is felt that the learning style preference is a product of two variables/ separate choices (*Processing Continuum* **-** how we approach a task or *Perception Continuum* - our emotional response, or how we think or feel about it), presented within the axis in Figure 2.

Figure 2: Kolb's (1984) Learning Styles



While it would be ideal to know what everyone's learning style is when delivering teaching and training sessions, this is also unrealistic. Therefore, Kolb (1984) recommends that stimulus of all types of learning styles to one extent or another should be incorporated in teaching and training sessions. Table 3 indicates how I attempted to include and consider each learning style for my teaching audience.

Table 3: Application of Kolb's Learning Style

Learning Style	Definition	How I used it in my session
Diverting Learning Style	This learning style takes a creative approach where learners prefer to watch rather than do and tend to gather information and use imagination to solve problems.	Across my teaching sessions, I attempted to offer learners a space to share an idea, e.g., in group discussions. This also allowed learners to listen (open-minded) and receive feedback where possible.
Assimilating Learning Style	This learning style takes a reasoning approach where learners prefer a concise, logical approach when being presented with new ideas and concepts.	During my teaching sessions, I offered learners resources in advance sessions (e.g., PowerPoint slides and case studies) which included clear and logical explanations of theoretical models and other teaching information. This provided individual independent time to prepare for sessions.
Converging Learning Style	This learning style uses a problem-solving approach to learning. Learners prefer technical tasks, can solve problems and will use their learning to find solutions to practical issues.	Within my teaching sessions, I attempted to provide learners the space to explore practical ways they could use the learning from the session within their practice or studies. I provided learners with resources and practical exercises as well as using activities such as quizzes.
Accommodating Learning Style	This learning style is adaptable and initiative. Learners prefer 'hands-on,' and rely on intuition rather than logic.	In my teaching session, I attempted to offer learners practical, and experiential approaches and opportunities. I drew upon activities that promoted independent discovery and discussion that supported deeper questioning, e.g., “what if?” or “why not?

Learning requirements for healthcare professionals

A key difference between the two audiences (healthcare professionals and academic students) was ensuring the teaching sessions for the healthcare professionals were relevant to their role, and practice, and delivered in a manner that matches their experience (Bullock, David, Lockey & Mackway-Jones, 2008). Therefore, this informed how I designed and delivered my teaching sessions for dietitians. While it was important for the academic student's sessions to be relevant to their role, there appeared to be less of a requirement for the sessions to draw on applied-practice links. As such, I designed my sessions to ensure the sessions for dietitians focused on clinical credibility which is a core foundation for effective teaching within medical settings (Bullock et al, 2008).

For the sessions designed for practicing healthcare professionals, I ensured the evidence gained in the classroom was transferrable to clinical practice. This was to support learners in clinical situations while I was also being aware of contemporary healthcare realities (e.g., challenges of working in forensic services, the pandemic, remote working as a few examples), so students can combine the theoretical with their clinical practice (Cardwell, Hillel, Gray, Davis, & McKenna, 2019).

In addition, educators with clinical credibility are considered to produce clinicians who are better equipped, and confident to deal with the ever-changing complexities of patient conditions and comorbidities (Cardwell et al, 2019). Therefore, from the beginning of the session, I felt it was important for me to demonstrate my current clinical abilities (and the limits of this as a Trainee Health Psychologist), sound evidence-based knowledge, and how this is integrated into my practice and patient outcomes.

Another importance when teaching healthcare professionals included consideration of the different approaches, e.g., "clinical teacher", employed by the university, to the "preceptor", an employee of the health care setting and transient to the university (Leonard McCutcheon, & Rogers, 2016). While I recognise, that I did not fit in entirely with these approaches, it would appear I align more with an employee of a healthcare setting. Therefore, it was important for me to demonstrate how the dietitians could acquire psychological-informed knowledge and skills in their profession, particularly

as healthcare settings can provide rich and challenging environments for students (Cardwell et al, 2019).

The final consideration I had for healthcare professionals was the use of the training as part of the Continued Professional Development (CPD). CPD is a requirement for all healthcare professionals registered with the Healthcare Professional Council (HCPC). Before informing learners that they could use the session(s) as evidence, I sought guidance from teaching staff from the university and course leaders.

Training Programme Structure and Content

Biggs and Moore (1993) propose that deep learning can be achieved by actively considering how the knowledge in a session is structured, providing an environment in which the motivations of the learners can be cultivated, opportunities for interaction are provided, and ensuring the inclusion of a diverse range of learning activities.

Approach to designing and planning.

The approach to designing and planning my teaching sessions and defining my learning outcomes was influenced by the type of session I was delivering. Two styles were used across my sessions:

- Creative and experiential for healthcare professionals (teaching and learning by experience and through the dynamics of a group process)
- Didactic approach for academic students (which involved a lecture-style approach consisting of information dissemination and interactive activities)

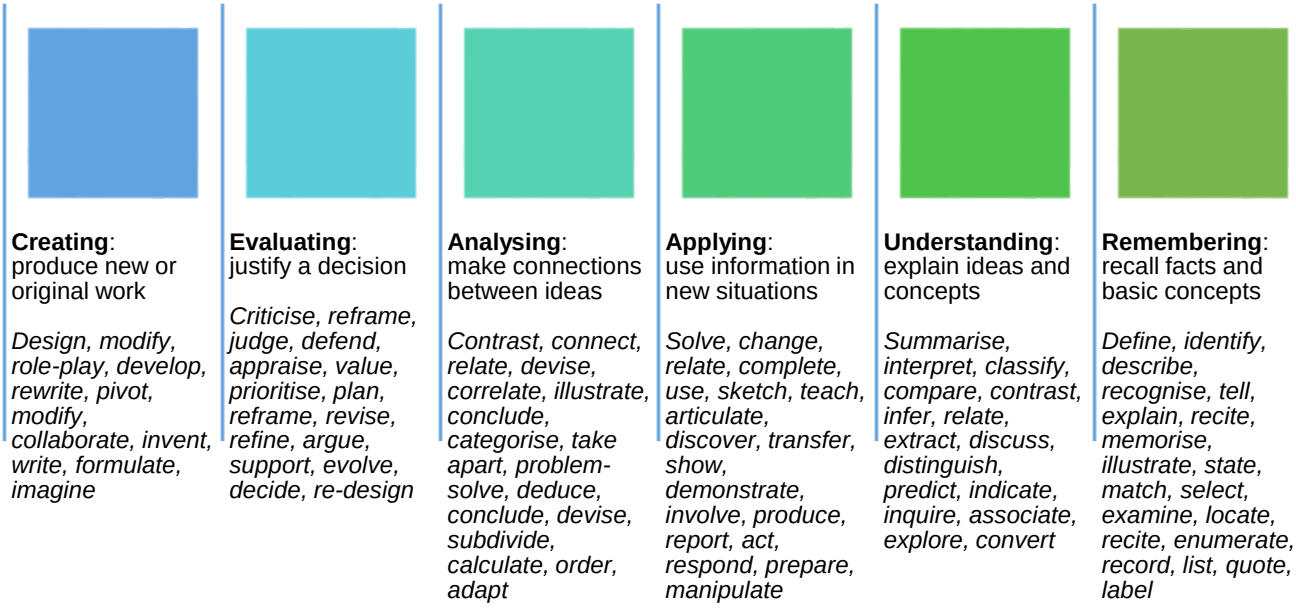
There was some variation in the use of these approaches across my learner groups based on the size of my teaching group and the format of learning. Although my healthcare professional sessions captured a “large” teaching size, the use of online teaching allowed for creative and experimental learning as dynamic group processes and interactivity could be easily promoted (e.g., using breakout rooms). Whereas a didactic approach was more applicable when teaching academic students, irrespective of the size of the group and delivery method. The dissemination of information using a lecture-style approach appeared due to the type of content (for MSc students – my experience/ career development) and the face-to-face teaching for BSc students (large teaching group) made it challenging to promote similar group processes during activities.

Learning Outcomes

A learning aim represents a teacher's intention to provide learners with a thorough grounding in the basics of a subject area, whereas a learning outcome is concerned with the student's achievement (Fry, 2007). Butcher et al. (2006) suggest that learning outcomes provide scaffolding for those learning, allowing the group (of learners) to ask any questions if unclear and to have clear expectations from the session. In addition, learning outcomes are required by professional bodies and provide the most direct indicators of the intended level and depth of a programme of learning (Race & Pickford, 2007). Developing learning outcomes for teaching sessions and defining these aims and outcomes allows for the provision of guidelines and a common understanding between those delivering and the learners.

In developing my learning outcomes for each teaching session, Bloom's Taxonomy (Figure 3) was used to identify, and the level of competence required with appropriate terms such as 'evaluate' and 'apply' (Bloom et al., 1956). The information that I acquired about the needs of my learners, showed a need for deep learning. As qualified health professionals, it was important that my participants not only gained more knowledge about a subject but also demonstrated an understanding of how to apply this to their practice, within their professional boundaries. I felt these principles were equally relevant to academic students that I was teaching (e.g., how to use the content for their career development or summative assessment). Therefore, I selected a small number of meaningful and memorable learning outcomes (e.g., 2-4 learning outcomes) for each session (Kennedy, 2006).

Figure 3: Bloom's (1956) Taxonomy



Teaching Activities and Strategies

Biggs and Moore (1993) suggest that teaching strategies should aim to promote deep learning. This can be facilitated by offering a well-structured knowledge base that encompasses a motivational context, learner activity, and interaction with others.

Well-structured knowledge base

The lesson plans for each session focused on a particular area within health psychology (eating, health psychology careers, and illness cognitions) with a practical application in both clinical and academic sessions relevant to the learner group (Table 4). I combined my knowledge and expertise in these areas by drawing upon relevant publicly available resources and material, while also integrating my reflections, to demonstrate how participants could apply the content of the sessions within their roles. Information used in the sessions was shared with the learners. Resources were appropriately referenced, and recommendations and signposting were also made available to those that wanted to explore the subject area in further detail.

Table 47: Teaching Session Plans

Session No	Session Content	Session Aims	Summary of Tasks	Materials Required
1	• Introduction and application of the Biopsychosocial model • Exploration of when healthy eating becomes disorderly eating – meaning of food, developmental model, and cognitive model • Eating behaviours and stigma • Psychometric assessments	• To understand the difference between overeating and underrating • To understand the application of the Biopsychosocial Approach to disorderly eating and obesity • To consider the role of obesity when working with patients • To consider when eating becomes disorderly eating • The role of assessments with patients	• Group exercise and discussion	• PowerPoint Slides • Case Study “Lucy” • Biopsychosocial Model worksheet
2	• Understanding trauma, how it relates to obesity and taking a trauma-informed approach within clinical practice • Introduction to substance paralleling behaviours, assessments, and functions.	• To develop a basic understanding of trauma and how this influences obesity • To understand ways of and when working with patient’s trauma • To understand substance paralleling behaviours and its relevance to eating patterns	• Use of videos, case studies, application of treatment model, and quiz • Groups experiences and discussions throughout.	• PowerPoint Slides • Trauma and Brain Development video • Adverse Childhood Experiences video • Case Study “Sophie” • Poll Quiz • Blank Treatment Model • Case Study- “Peter”, “Jean”, “Lawrence” and “George”

3	• Working through an assessment, formulation, intervention, and evaluation approach. • Exploring compassion-based approaches and their utility	• To understand a case formulation and how this informs intervention planning • To explore intervention techniques • To develop compassion approaches when working with patients who experience guilt and shame • To understand methods of evaluation	• Use of case studies, completing a formulation, and exploring intervention techniques using the Cards for Change. • Groups experiences and discussions throughout. • Understanding, practising, and considering the application of compassion-based exercises	• PowerPoint Slides • Case Study – “Hannah”, “Lesley”, “John” and “Sam” • 5 P’s Formulation template • Cards for Change • Attention Exercise • Soothing Rhythmic Breathing Exercise • Compassionate Colours Exercise
4	Careers develop talk based on my own experiences	• To provide an overview of opportunities after MSc in Health Psychology • To provide an overview of the Professional Doctorate in Health Psychologist	• Presentation of my journey • Q&A at the end	• PowerPoint Slides
5	To understand and analyse how individuals use illness cognitive and make sense of illness Theoretical underpinnings of the Self-regulatory model and its application to coping Presentation of clinical example	• An introduction to illness cognition • An introduction to the Self-Regulatory Model and its application to coping with illness	• Menti.com activity on illness • Group discussion on a clinical example based on information presented	• PowerPoint Slides • Menti.com • Case Study • Clinical Example

Motivation to learn.

Motivation is considered to play a core role in the overall learning experience (Race & Brown, 1998) and subsequently I wished to establish the motivation of the learners. For my sessions with healthcare professionals, motivation was assessed within their group supervision space. Learners had previously expressed an appetite for teaching sessions and appeared keen when presented with a draft outline of what the sessions could cover. Here, motivation was also assessed by their engagement in the process, attendance (due to the voluntary nature), and overall participation in the sessions. In determining the motivation of academic students, I had discussed with both module leaders who indicated that students had been well engaged in the module thus far, particularly as the modules for both sessions were specialist Health Psychology modules (for MSc and BSc students).

As students presented as driven and motivated, my aim for the sessions were to ensure teaching strategies encouraged deep, rather than surface learning. This allowed for the content to be directly and practically relevant to learners in their roles (Saljo & Marton, 1976). Therefore, I ensured my teaching plans included a range of activities (e.g., group discussions, demonstration, practice, quizzes, and case studies) aimed at encouraging the learners to actively engage with the subject matter (Table 5).

Table 5: Activities that promoted engagement.

Session Number and Audience	Activities that promoted engagement
Session 1: Dietitians	• Group-based discussion around issues related to disorderly eating staff had been observed in their clinical practice. • Drawing upon their clinical experience and patient group to consider the Biopsychological Model and as a way of understanding eating with the patient group • Use of case study "Lucy" • Information on possible psychometrics that could be drawn upon to inform their assessment • Opportunity at the end to consider how the content of the session can be integrated into their practice
Session 2: Dietitians	• Using videos on trauma and Adverse Childhood Experiences (ACEs) to deliver content and demonstrate the links to obesity and health outcomes • Case study – one case was used throughout the first part of the session to consider trauma and trauma-informed approaches. Another set of case studies was used during the second half of the session when considering functions of substance paralleling behaviour. This provided a variety of examples. • Livesey's (2000) treatment model and learners were encouraged to consider approaches they could use with patients in each stage of treatment. • A quiz on the treatment model to assess their understanding of the treatment model • Quiz on assessing
Session 3: Dietitians	• Demonstrating to learners the process of assessment, formulation, intervention, and evaluation approach. • Inviting learners to refer to session 1 where we look at psychometric assessments and the biopsychosocial model to inform the "assessment phase". • Discussion around types of formulations, e.g., individual and teams' formulations and their role and contributions as dietitians. • Case study to complete a formulation in a group. • Recommending resources on the formulation to promote ongoing learning after the session. • Introducing intervention techniques, e.g., the COM-B model and Cards for Change. • Learners were invited to use the Cards for Change to consider techniques that could be used for the formulation they had completed. Asked learners to think about the formulation complete and what techniques could be used for the case study. • Compassion-Focused Approaches – on how to work with patients experiencing shame and guilt.

	• Provided learners examples and demonstration of several different Compassion Focus Exercises exercises/ approaches. • Inviting them to practice so they can experience what it is like to do before asking patients to engage. • Recommending some accessible Compassion Focused resources for ongoing development.
Session 4: MSc Students	• Allowing for discussion and questions at the end of the session (although a standard part of the session), students were able to ask questions in the chat throughout
Session 5: BSc Students	• Using menti.com to consider what health meant to the learners before thinking about ill-health • Taking learners through the illness cognition model and a case example developed from research • Providing then a clinical case study – asking learners to apply the model before I demonstrated how it was used in clinical practice.

Selection and creation of learning material

It is recommended that the information provided, both verbally and in written format, during teaching sessions needs to be related and linked to the learning outcomes and should be delivered in a consistent style throughout each teaching session/ across modules (Farrow, 2003). When developing the materials for the teaching sessions, which used strategies to promote deep learning (Biggs & Moore, 1993), I ensured these were evidence-based information. This would subsequently inform my session material to allow me to convey psychological knowledge to learners who have different levels of prior psychological knowledge. In my sessions, I used a variety of power-point presentations, videos, case studies, and clinical examples from the patient's work I completed to demonstrate the theory-practice links. Therefore, the selection and creation of learning material were informed by Farrow's (2003) 5 principles of teaching material, referred to as 'LIGHT'. Within my teaching sessions, the principles of "LIGHT" were applied in several ways (Table 6).

Table 6: Application of Farrow's (2003) Principles of LIGHT

Principles of LIGHT	Definition	How I used it
Links	The materials used should have a direct link to session content.	I ensured that all the teaching materials were directly relevant to the topic/ clinical matters of the session and the audience. All information presented (e.g., theoretical models, videos, case studies, exercises, and clinical examples) was also directly linked to the information I was providing to learners.
Intelligibility	The teaching material should be easy to understand and learn from.	All teaching material developed was easy to read and understand. I minimised the use of technical language or jargon as this would have disinhibited learners in understanding the content. I ensured, where possible, that the information presented was concise, and simple, and avoided the use of overly long sentences that would be overwhelming and difficult to. During my teaching slides, I also used diagrams to present information to allow these to be more “eye-catching”. This was particularly useful for presenting technical theoretical models which allowed for information to be presented in an accessible and creative manner. I also ensured that the PowerPoint slides were not too ‘text heavy’ and supplemented and expanded on the information verbally. However, I retrospectively recognised that during my Illness Cognition (BSc) session, there were some slides with too much information which I discuss further in my reflective report. I also presented the case studies in an accessible manner and used appropriate language for the audience so that they could meaningfully engage in the tasks. Throughout all sessions, I ensured that the font I used was legible and in a size that was easy to read. I also ensured it was consistent throughout the session.
General Style	To use a consistent style throughout the teaching material.	I ensured that I used a consistent style throughout my teaching sessions. This was particularly important for my healthcare professional sessions as it was a series of sessions. I felt consistency and uniformity were important as it demonstrated continuity among sessions and allowed learners to focus on content rather than style.
Highlighting:	Highlighting information/content helps to emphasis important issues or pivot points.	Where appropriate, I attempted to emphasise important phrases or content within the session. I did this by using diagrams, italics, or bold. It was important to not overdo this as it reduces the usefulness of the technique and hides the pivotal points being made about the content

Targeting	To ensure that the training programme and teaching materials are targeted at what students need to learn.	Targeting relates to the training needs and assessment outcomes and therefore I ensured that the teaching materials were relevant to the audience. An example of how this was achieved was ensuring the resources used applied to my audience (e.g., the use of relevant theoretical models, clinical examples, and case studies). While it was not possible to use service users in my session (which I discuss in my reflective report), I incorporated case studies representing clinically relevant matters relevant to the audience. For example, for my healthcare professionals, I used a range of case studies across all sessions presenting relevant psychological elements to eating behaviours. In addition, during my Illness Cognition session for BSc students, I demonstrated a clinical example of using the Self-Regulatory Model to demonstrate its application and support students with their assignments.

Teaching Techniques: Learning Activity and Interaction with Others

A variety of teaching techniques (Table 7) were used in each session to facilitate deep learning, promote interaction among learners, and provided opportunities for learning activities. Within the session, I set students' tasks using clinical and theoretical models where students were required to apply what they have learnt to a specific situation. This enabled students to apply knowledge and practice skills they had learnt amongst themselves. For example, during dietitian's session 2, participants were introduced to a clinical treatment model and were then asked to consider specific dietetic interventions that they could draw upon when using this model.

Table 7: Teaching Techniques Used

Session No	Teaching Techniques	Effectiveness of Techniques
Session 1:	• Introduction to Theoretical Concepts and models (including applying these to practice).	**Effective** - Learners were to reflect on the theoretical concepts provided (e.g., the Biopsychosocial Model) and how this was an access approach they could employ. Some felt it was something they use to could explicitly label this as the approach being used.
	• Use of case studies to consider theoretical concepts	**Effective** – Learners found the case study helped bridge the gap between theoretical consent and application. The case study was commented to be a "relatable" example.
	• Information on psychometric assessment and the utility	**Okay** – Learners were curious about psychometric assessment and felt there would be some benefit. However, the effectiveness of this could have been enhanced if I provided some complete examples of psychometric assessments.
	• Group-based discussion and an opportunity at the end to consider how the content of the session can be integrated into their practice	**Excellent** – group experiences and the discussion became reflective and peer support space where they could share learning amongst each other.
Session 2:	• Multimedia (e.g., Videos on trauma and ACEs).	**Good** – Learners found the content accessible and simple to understand. It was reflected the content communicate technical information on trauma using straightforward language.
	• Case studies - one focusing on trauma and another example on substance paralleling behaviour	**Excellent** – learners found the case studies were an again relatable example. It allowed them to consider complex concepts (e.g., trauma and substance paralleling behaviours) in simple and non-intimidating manners. Learners reflected this allowed them to consider a trauma-informed approach while feeling contained and working within their professional boundaries and competencies.

	• Applying a treatment model to consider dietetic approaches they could use within each stage of treatment.	**Excellent** – Although each group thought of similar suggestions across each of the treatment stages when collated together there were some distinct differences. This promoted an exchange of ideas and learning amongst the group.
	• Quiz on assessing understanding of the treatment model	**Good** – this affirmed to learners that they understood the model. Also allowed for questioning and clarifying.
	• Further case studies to consider functions of substance paralleling behaviours	**Excellent** – group experiences and the discussion became reflective and peer support space where they could share learning amongst each other.
	• Case studies in understanding and practising case formulations	Excellent – The use of the case study and information on formulation allowed the learners to conceptualise complex clinical presentations. Having the opportunity to practice formulation allowed learners to feel more confident in reading formulations prepared by a psychologist in their services. It highlighted the need for collaboration and teamwork where learners were able to reflect on how this might be achieved within their services.
Session 3:	• Applying the Cards for Change to the completed formulation	**Good** – Learners felt this was particularly found the cards a useful tool to draw upon. However, did not have sufficient time in the session to become accustomed to the cards.
	• Being guided and practising Compassion Focused exercises.	**Good** – Learners reflected that there were a lot of exercises, and some felt easier than others to employ. Some leaners also expressed some concern if they utilised the strategies within their practice/ session they may undertake work beyond their competencies or “trending” on the professional toes of others in the service.

Session 4	• Presentation of information	**Excellent** – learners reflected that they were able to see the journey I went on before commencing Health Psychology training. It later allowed them to reflect on their career pathway. They were also able to compare my presentation to other "guest speakers" from the session.
	• Q&A at the end of the session	**Excellent** – this complimented the presentation of information well and provided a relaxed environment to ask questions.
Session 5	• Use of Menti.com	**Good** – a simple and relaxed opening task where participants were well engaged.
	• Presentation and group exercise of theoretical model and application to a clinical example based on research	**Good** – It allowed learners to consider how to apply the model before being provided with an example
	• Presentation of application of the theoretical model in clinical practice	**Excellent** – Learners saw a real-life application of a theoretical model within clinical practice. It intended to support learners with their assignments and feedback suggests this was successful.
	• Providing then a clinical case study – asking their thoughts before I presented/ discussed how I utilised it	

Bligh (1998) suggests that lectures can cause students to be passive, disengage from the material, and have low attention levels. Therefore, interaction amongst the learner groups was important as it facilitates collaborative learning and allowed for greater and more meaningful engagement, particularly in larger learner groups (Race, 2007). This was further facilitated by encouraging student-led discussions and group activities (in breakout groups for sessions facilitated virtually). The interactive activities were combined into the teaching sessions in a non-threatening manner and fostered engagement without fear in students (Race, 2007).

Another learning activity that promoted engagement amongst learners was the use of case studies. The use of case studies to introduce patient narratives is recommended, particularly in healthcare teaching as it can provide a powerful learning tool which can facilitate the integration of knowledge and theory with context and complexity (Benner, 1992). I found that the use of case studies (with dietitians) allowed them to apply the learning from the session to a clinical example. In addition, the use of the case study (during the illness cognition session) demonstrated to the students how to apply theoretical models in clinical practice as a Trainee Health Psychologist. This also served to support them with their end-of-module assessment. During my session with MSc students (MSc and Beyond), students were directed to a resource that contained case studies of health psychology practitioners and their career journeys. As the use of case studies appeared to be well received by both health professionals and learners and in small and large group settings, it is an approach I am likely to continue to employ in future sessions.

Assessing learning outcomes

The purpose of evaluating whether learning outcomes have been achieved serves to improve future teaching sessions and outcomes for learners (Wilkes & Blign, 1999). The achievement of learning outcomes is often completed in the form of assessment, which forms an integral part of teaching and learning. Assessment can be described as any process that appraises an individual's knowledge, understanding, abilities or skills" (Quality Assurance Agency for Higher Education, 2018). Furthermore, how students are assessed essentially affects their learning, especially in an academic setting. Good assessment practice is designed to ensure that students have demonstrated and achieved the intended learning outcomes which influence the

grades of modules and courses (QAA, 2018) and accuracy is required if a student challenges what is perceived as an unfair judgment. (Fry et al, 2007). Within healthcare professionals and clinical settings, achievement in intended learning outcomes aims to improve outcomes for patients with whom the healthcare professional works (Morrison, Boohan, Jenkins, & Moutray 2003). Furthermore, QAA (2018) indicates assessment of learning can be completed either formatively (assessment of developmental purposes which is designed to help learners learn more effectively by providing them feedback) or summative (the extent of a learner's success in meeting the assessment criteria which is usually achieved through a mark contributing towards a course, module, or award).

Having had discussions with the healthcare professionals within their group supervision space and module leaders for the academic students, I was aware in advance of the session that learners had limited knowledge of topic areas for each session. Therefore, in each teaching session and with the different learner groups, I incorporated several evaluation and feedback elements to assess students' understanding while also reviewing my performance as a teacher/ session facilitator which is summarised in Table 8.

Table 8: Methods of Assessments Used

Learner Groups	Methods of Assessment	Notes
Dietitians (Healthcare Professionals)	• No formal assessment method was used	
	• Engagement and understanding were assessed in breakout groups and when feeding back to the wider group	**Good** – the feedback after group activities allowed those from other groups to contribute and learn from
	• Applying learning to case studies, formulations, treatment models, etc engagement in discussions, and feedback from case studies to demonstrate learning from content provided to them	**Excellent**– allowed to see how learners understood and applied the content. The feedback after group activities allowed those from other groups to contribute and learn from
	• Small quizzes were completed during sessions.	**Good** – helped to assess learners' understanding of the content and provided an opportunity to clarify understanding
	• Considerations for teaching healthcare professionals – e.g., CPD and learning outcome are possibly integrating aspects into practice.	
MSc Students	• "Guest" session for the students and not contributing to a summative assessment (mark for the module)	
	• Assessed through their engagement in discussion and Q&A	**Excellent** – Learners appeared to have listened to the content and consider this for themselves based on the personal questions they were asking. Appeared well engaged in the session and Q&A, suggesting an effective session
	• Student feedback	

		Excellent – the feedback from learners was positive. They had indicated they were able to intergrade the learner from the session to their career development. This was feedback was voluntary and not actively sought.
BSc Students	• End of module assessment to complete a case study using a theory covered in the session and therefore the content was relevant to the summative assessment.	**Poor** – I am unaware of any of the students using the models from my teaching as part of their assessment. I have not requested to know this information from the module leader.
	• Small group exercises where they were asked to apply the theory using a clinical example	**Okay** – Some goods were better and more actively engaged than others. As it was face-to-face and in the lecture room I could not walk around to sit with groups. This is easier in a workshop setting or breakout room
	• Feedback form of their perception of understanding – used a confidence ladder (Cook, 2019) within the feedback forms I sought from learners at the end of sessions.	**Good** – A simple and effective way to assess how learners felt about the content. However, it is not an objective measure though.

Summary

This case study describes a series of five teaching sessions delivered to different learner groups. My approach demonstrated a range of strengths and areas for improvement at all stages of the teaching process, including assessing and identifying training needs; designing session structure and content; selecting and creating teaching materials; and the assessment of learning outcomes. In delivering these sessions, I developed skills in teaching single sessions and a series of sessions in a

variety of different teaching formats, face to face and virtually, in a motivating and engaging manner. These sessions have provided me with fundamental skills in Health Psychology in the process of planning, designing, and evaluating teaching sessions.

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4.2 Teaching and Training Reflective Commentary

Introduction

As discussed in my case study, Stefani (2009) suggests a systematic approach is useful when planning a teaching programme. Within the approach, assessment of outcomes is highlighted which can include the evaluation of teaching sessions. This reflective report accompanies my case study and is presented alongside my observer feedback forms.

Evaluation encourages teachers to learn about the effectiveness of their teaching, enhance the quality of future teaching sessions and develop skills as teaching professionals which is relevant for Health Psychologists who teach within the clinical practice (Butcher, Davison & Highton, 2006; Boerebach, 2015). I evaluated my teaching sessions through a combination of self-reflection, peer observation, and participant evaluation forms, as multiple methods of feedback are recommended (Hoon, Oliver, Szpakowska, & Newton, 2015; Hounsell, 2008; Shute, 2008).

In this reflective report, I also discuss the strengths, weaknesses, and areas for improvement including the learnings for each teaching session. Here, I also discuss how feedback I received has informed the development of content and delivery of future sessions and enhanced my teaching skills as I work towards qualifying as a Health Psychologist.

Sources of Feedback

Each of my teaching sessions incorporated feedback and evaluation at three levels:

- feedback from participants,
- observer feedback, and
- self-reflection (Table 1).

The learning points for each session are integrated throughout the report.

Table 1: Sources of Feedback for Teaching and Training Sessions

Sources of Feedback	How and why I used sources of feedback
Participant Feedback	The use of student-generated feedback to improve teaching is a well-established method of assessing teaching sessions (Hoon et al, 2015). Therefore, for all teaching sessions, I felt it was important for participants to be able to share their experiences of the session and provide feedback. I designed online forms using a combination of quantitative and qualitative methods. It was important for me to ensure the feedback was tailored to the teaching audience and therefore I asked specific questions relevant to the students. For example, about how the content can be improved, my style, and what aspects of the session were found to be helpful (Hoon et al, 2015). Although there were similarities in the design of the feedback forms, there were some noticeable differences amongst each student group. Furthermore, I used qualitative-based questions as this allowed for students to provide further comments behind this feedback, suggestions for improvement, and appraisals of me as a teacher (Basow and Martin 2012; Berk 2012; Buckley, Archibald, Hargraves, & Trochim 2015; Lattuca & Domagal-Goldman, 2007). As noted earlier, I sought feedback through online methods. This was felt to be both practical (particularly as most sessions were delivered through junctures of the pandemic) and allowed for flexibility and convivence for participants to complete at their convivence (Anderson, Cain, & Bird 2005; Gakhal, & Wilson, 2019; Stowell, Addison, & Smith 2012). Online feedback also aligns with several higher education sectors and institutions that have moved away from paper-based feedback surveys to assess the quality of teaching (Gakhal, & Wilson, 2019; Moskal, Stein, & Golding 2016; Treischl & Wolbring 2017). I felt this was particularly relevant to the academic sessions I taught. The process of obtaining feedback was at the start of all sessions, I requested that participants took some time to provide me with feedback at the end of my session. I used this opportunity to emphasise that their assessments would inform my practice and changes to teaching and learning (Gakhal, & Wilson, 2019; Tucker 2014) and be included within my portfolio. This strategy ensured that most participants provided me with full and considered evaluation responses. I found using online surveys allowed for a quick turnout of results (Crews & Curtis, 2011) which enabled me to understand student feedback relatively instantly after sessions were completed. This prompt turnaround was useful as each set of feedback could be used to inform my proceeding teaching sessions (including reflections and learning points), despite audiences being different. After each session, I collated the participants' feedback into summary documents. I noticed students provided comprehensive comments on qualitative questions which are thought to have been contributed by using online surveys, compared to paper-

based, (Burton, Civitano, & SteinerGrossman 2012; Fike, Doyle, and Connelly 2010). Therefore, this is an approach I would use again in the future.

Observer Feedback

Peer observation of teaching can be defined as a "*collaborative, developmental activity in which professionals offer mutual support by observing each other teach; explaining and discussing what was observed; sharing ideas about teaching; gathering student feedback on teaching effectiveness; reflecting on understandings, feelings, actions and feedback and trying out new ideas"* (Bell & Mladenovic, 2008, pg 3). Two main purposes of peer-observation having been identified: development and performance management (Bell & Mladenovic, 2008; Peel, 2005). The use of peer-observation has been recommended within a practice to provide performance feedback and improved teaching practice as a necessary component of any training programme (Coninxa, Kreijnsb & Jochems, 2013; Rose & Church, 1998). In addition to being considered a requirement of training programmes, several benefits of peer observation have been noted in the literature, e.g., improvements to teaching practice, development of confidence to teach and learn more about teaching, the transformation of educational perspectives, more respect for the approaches of colleagues and integration of tutors/colleagues into the department (Allen 2002; Bell, 2005; Bell & Mladenovic, 2008).

I used observer feedback for all sessions, using the same observer-feedback form, an online templates form accessed through my university. I found that this worked well as it provided me with a combination of rating scales and qualitative feedback (Thampy, Bourke, & Naran, 2015). Furthermore, it is recognised that students' experience of receiving narrative feedback is more beneficial than quantitative in the development and improvement of teaching sessions (Eastwood, Davies, & Rees, 2021). I also used this form throughout as I felt it covered most aspects of my teaching, resulting in highly detailed feedback from my peers which I could implement in future sessions (Scheeler, Ruhl, & McAfee 2004; Newman, Roberts, & Frankl, 2019), and to monitor comments from session to session.

Utilising observer feedback for each session was important to me as I wanted to gain as much peer feedback as possible during these teaching sessions, as this offers an objective form of feedback on my teaching performance (Morrison, 2003). This was especially regarding my inexperience within this area, I did not want to miss anything out of a form. Being provided with feedback is effective for enhancing performance (Coninxa et al, 2013; Codding, Skowron, & Pace 2005).

I used two approaches to receiving observer feedback:

- Retrospective Observation: Sharing recordings of sessions (that were completed via Microsoft Teams) with either academic or clinical supervisors to comment on. This was beneficial as it allowed for feedback to be provided around their commitments, rather than needing to be present for sessions.

- In moment observation: Module leaders for two sessions being present (either on Microsoft Teams or during the face-to-face session).

In all observations, observers had the feedback forms in advance and were able to provide detailed feedback that supported me in developing my skills as a teacher. This allowed me to receive feedback for each session promptly, and in advance of the next session, to improve subsequent sessions.

While I recognised the value in receiving feedback, observation was not common to me and did elicit some anxiety. Anxiety during peer observation is common with some students having been noted to prepare more than usual (Eastwood, Davies, & Rees, 2021). I found myself feeling more anxious for sessions where my observers were present, but this eased, and I felt comfortable as the sessions progressed. This is thought to have been contributed by a positive peer-observer relationship (Eastwood et al, 2021).

Self-reflection

Finally, I used self-evaluation to reflect on my teaching experience after each session using a guided reflection schedule (Kolb's, 1984, 'What, So What, Now What' model). Self-reflection is considered an essential requirement to improve and enhance a teacher`s performance, and it is recommended to be included in the evaluation processes of teachers conducted by educational institutions (Alena, Danka, & Henryk, 2019). Reflective teaching is defined as looking back at the teacher's teaching which includes thinking and rethinking one's performance before, during, and after class activities (Artzt, Curcio, Gural & Thomas, 2015). Reflective teaching practice allowed me as the teacher to have the opportunity to review their unit designs and implementation process and improve their performance by having awareness and rethinking my strengths and weaknesses (Yurtseven, & Altun, 2018; Zahid, & Khanam, 2019).

Using reflective teaching helped me to affirm my accomplishments and highlight opportunities for further improvement of my teaching practice. I utilised self-reflection immediately after each session as the information and experience were fresh in my mind. Furthermore, as all sessions were recorded this allowed me a later opportunity to watch the recording to see if my reflections had changed or to capture areas that I may have missed but were important to reflect on. Where possible, I tried to complete my reflections, initially, without looking at the peer-observation feedback forms. This allowed me to gauge my initial reaction to each session. I then summarised all the feedback and noted down how I could improve future sessions by focusing on what I had learned and what I would change (Quinton & Smallbone, 2010; Wain, 2017). For each new teaching session, I would recap previous feedback and make appropriate changes to my sessions.

Using my different sources of feedback, I have reflected on my teaching strengths, weaknesses, and areas for improvement which are detailed below.

Strengths and Successes

Slides / presentation of information:

I endeavoured to align my slides with the audience and the content of the topic I was delivering where possible, as I thought this would improve the consistency of the session or modules (Farrow, 2003). I believe consistency for the dietitian's sessions was key as it demonstrated a continuation of sessions, whereas sessions with academic students were standalone sessions. As discussed in my case study, I utilised evidence-based information and a variety of different methods to present the learning material which was informed by Farrow's (2003) principles (e.g., LIGHT). While a strength of mine was my ability to convey information creatively, accessibly, and in a format that encouraged engagement (e.g., use of a diagram, simple language and using patient quotes), a drawback is noted from my session on illness cognition. Feedback from students felt that some of the slides had too much information which made it difficult to understand and process. In the future, I would simplify the slides. I would also look to supplement information presented verbally through additional handouts/worksheets. This was requested and highlighted by participants in their feedback, as handout can to support with conveying in more detail the theoretical knowledge of psychological models.

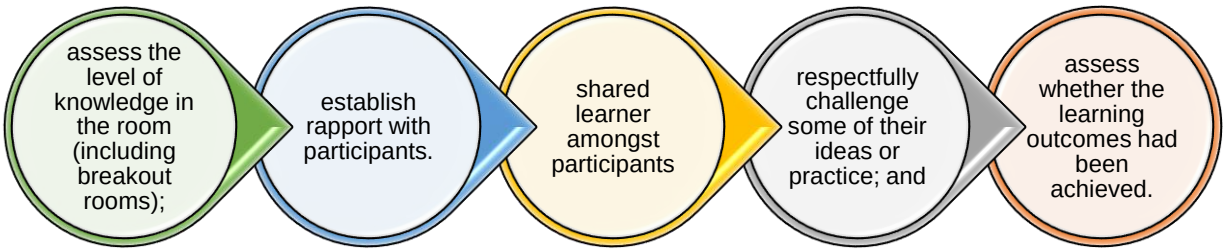
Interactivity – breakout room and using case studies:

The use of learner activities has many benefits over and above simply delivering teaching content (Deighan, 1992). Throughout all teaching sessions I used a range of interactive strategies to engage the learner, with positive of this note in my observer feedback:

> "*A strength of this teaching was the wide range of interactivity. This included the use of case studies (which worked very well in aiding understanding) that the participants were asked to reflect on, small group exercises, quizzes, videos, large group discussions etc."*

I used breakout groups for all healthcare professionals teaching sessions and small group activities for my BSc module. The use of breakout rooms and small group activities provided several learning benefits and opportunities for students (Figure 1).

Figure 1: Benefits of Breakout Rooms and Small group activities



Participant feedback, particularly from my healthcare professionals found this forum allowed "*sharing experiences with others, use case studies to apply knowledge from the tools*". While a greatly positive experience, and an approach I am likely to use again. It was important for me to allocate sufficient time for breakout activities for students to get the most out of them, as some participant feedback highlighted "*some of the breakout room activities maybe require a bit more time to fully explore the subjects*".

Another interactive strategy that I used, was to incorporate case studies. The use of case studies to introduce patient narratives is recommended, particularly in healthcare teaching as it can provide a powerful learning tool to facilitate the integration of knowledge and theory with context and complexity (Popil, 2011). I found using case studies was helpful for me as a facilitator to communicate theoretical models, demonstrate application and engage participants with the content. I noticed that the use of case studies (with dietitians) allowed them to apply the learning from the session to a clinical example and make theory-practice links ("*The case studies were very appropriate and useful to put theory into practice*…"). Whereas the use of the case study (during the illness cognition session) demonstrated to the students how to apply theoretical models in clinical practice as a Trainee Health Psychologist. This also served to support them with their end-of-module assessment. As using case studies appeared well-received, it is an approach I am likely to continue to employ in future sessions.

Theory-Practice links:

Before sessions commenced or in advance of the introduction of new models, I established participants' foundational knowledge. For example, with the dietitians I

ascertained their understanding of Compassion Focused Therapy as a model and similarly with undergraduate students I sought to understand their existing knowledge of the Leventhal's Self-regulatory Model (SRM, 1980). Broadly, most participants had no prior knowledge or had limited experience/ confidence with the models. I reflected that many psychological models can be quite complex, and intimidating to those without a psychological background, and the model has multiple components within. Therefore, I went through each stage sequentially and provided worked examples for each component. I also regularly sought participants' understanding throughout the sessions, however, acknowledge that students may not want to speak out if they did not understand something (Abdullah, Bakar, & Mahbob, 2012). I was pleased that I had managed to successfully explain this complex model, that this was observed within my observer-feedback (Table 2) and that I had enthused students to seek opportunities for learning more about this theory to continue to use it in their studies.

Table 2: Observer feedback on the use of psychological and theoretical models

"Dipti presented psychological information on topics such as formulation in an accessible way to participants that don't have a background in psychology. I think it was helpful providing an example of a formulation to aid understanding."
"It was good that you involved the participants to practice some skills from mindfulness and other CFT exercises. If possible, in the future it might be helpful to pre-record to the slide the scripted exercises. I think this would be helpful when disseminating the slides after the sessions. *I think there was a lot of information on CFT for the participants to digest in a short period of time. This was presented well although I am not sure if someone without any previous experience of CFT to process."*

To facilitate theory-practice skills, I used clinical examples and case studies as discussed above. Initially, I wanted to have service users' part of the session. For the dietitian sessions, a particular service user, with disorderly eating, had been considered suitable to participate in the virtual session alongside the service's Peer Support Worker. However, at short notice, they were unable to contribute as their mental state had deteriorated at the time the session was scheduled. For the illness cognition session, it was logistically too challenging to have a service user (from a secure service) attend campus. Although the inclusion of a service user would be beneficial, in the future, I could explore their addition by using a video of a patient to demonstrate a clinical example. Nevertheless, I chose to present a clinical example from my workplace following a discussion with the module learner. I felt doing this

would be both interesting for the students and I hoped it would support them with their assignment, which is consistent with participant feedback which I am pleased about (Table 3).

Table 3: Participant feedback on the use of a clinical example

"The real-life application was particularly interesting and was helpful to understand the content further and was also beneficial for our assessment."
"Real life scenario was really beneficial in seeing how Health Psychology can be used in the real world."

Communication skills:

Participant evaluation suggests that my communication style helped to create a motivational context (Biggs, 2003), although some during the illness cognition session felt I spoke too fast for them to follow the information. Although I was concerned, that I might come across as inexperienced, stumbled over my words, or spoke incoherently, the feedback largely indicates that I was perceived as a credible, passionate, and natural teacher (Table 4). This feedback was largely consistent with my observer feedback (e.g., "*the use of repetition and paraphrasing was good*" and "*I liked how Dipti stopped sharing the screen so that she could be more engaged and present with the participants*"). Although they noted my need to be more assertive and clearer when providing instructors.

Table 4: Participant Feedback on Communication Style

"The facilitator's explanations were very clear and they answered questions well; making the information relevant to our profession"
"Really interactive and knowledgeable. Friendly and really helpful when answering questions anyone had, didn't use language too complicated so I could really understand her work and recognise her passion. Great stuff!"
"The information was presented clearly so it was easy to understand, and it was done so in an engaging way. It wasn't rushed and there were several opportunities to ask questions if we needed to…."
"I thought the presenter was clear and concise, the content was very accessible and explained really well."
"Have confidence in yourself because you are a natural speaker and would love to have a lecture from her again."

In addition, I supplemented my verbal communication by incorporating media (e.g., video clips) to convey information about developmental trauma (session 2). This served to facilitate emotional connection during the learning experience which is

particularly important for healthcare professionals as its thought to minimise stagnation and boredom (Pedersen, 2018). I observed during the sessions (through verbal feedback from students) that the video clips engaged the learners and helped facilitate their knowledge about trauma in an accessible manner as they commented during the session.

Increase knowledge and integration of learning:

My learning outcomes related to the acquisition of declarative knowledge (knowing about things) and functioning knowledge (knowing how to apply declarative knowledge;Biggs, 2003). Interactive and group exercises provided some evidence that these outcomes were achieved as I was able to assess whether they understood and were able to apply the material I had covered. For example, in session 3 I introduced dietitians to case formulation and encourage them to develop a formulation based on a case study they were provided. When each group presented their formulation, I was able to assess their understanding and integration of their knowledge.

In addition, quantitative feedback from participants demonstrated agreement across all participants (and sessions) that my learning outcomes were achieved. Table 5 represents qualitative feedback from participants who showed new knowledge they had acquired and how participants integrate the learning from the sessions into their areas, e.g., clinical practice or academic studies. The feedback provided from participants appears consistent with the observations I made throughout the session. It was a rewarding feeling knowing students felt they were able to apply the learning as this meant I add to address the teaching aims and objective while providing them the abilities to integrate the learning.

Table 5: Participant feedback on integrating learning.

"Attended all 3 sessions, have found there's been a lot of detailed information and resources to take in which have been very useful and will now need go through them in my own time to work out which ones I can incorporate in my own practice. Also to liaise with psychology and perhaps attend team formulation however this dependant on time."
"Thanks Dipti for the very informative training and insight into Psychology related tools that can be transferable in Dietetics. I intend to use the 5 P's approach and the COM-B"
"Thank you so much for your honesty and personal reflection of your wins and your challenges - I learnt so much and went home and got out my planner!"
"… The real-life application was particularly interesting and was helpful to understand the content further, and was also beneficial for our assessment."

Challenges

Needs Analysis:

As noted in my case study, my training needs analysis was completed by either attending a reflective practice session for the dietitians or liaising with the module leaders for my academic sessions. Although not highlighted by others, following a self-reflection alternative approach would have been to use a survey to establish learners' training needs. I felt that a survey for the dietitians would have been especially helpful as they were a large audience, and this approach may have provided a greater opportunity to identify developmental and training needs which may not have been captured during the forum. Furthermore, with the MSc student, I may have been able to understand their career aspirations or if there were specific elements of the Professional Doctorate, they wished for me to cover. This was following participant feedback requesting "*more information on the application process*".

In addition to training needs, for future sessions, it would also be important for me to know if participants had any learning needs (e.g., dyslexia). Although I discussed this with the module leader for session 5, this was not consistent across all my sessions. To ensure it was completed sensitivity, I asked participants to contact me directly or include this within the training needs analysis.

Time Management and Pacing:

As my teaching sessions (for dietitians) were due to last for 3 hours, I needed to be able to appropriately pace myself and the delivery of the content (Ramsden, 2003). For session one, I was initially worried that my nerves would result in the pace of the session being fast, including me rushing through tasks. Although nerves did strike during this session, that was also noticed in my observer feedback and self-reflection, for future session sessions I was able to slow down. I also worked on using all the allocated space (e.g., asking participants to feedback after group discussions) and had a better understanding of how long tasks and activities would take. As my confidence grew across the series of teaching experiences, I started to incorporate intentional pauses for reflection into my virtual teaching (Ryan, 2012). It was positive that my conscious attempts to address my pacing and learning from experience were noticed in my observer feedback (Table 6). I will continue to do this in future sessions, as it helped to elicit student discussion, and stopped me rushing through the content.

Table 6: Observer feedback on time management and pacing.

"Her pace of talking was good and there was just the right amount of repetition – in that it aided learning without feeling repetitive"
"Dipti was briefed to provide a 30-minute presentation on the topic of 'The MSc and Beyond'. Dipti demonstrated excellent time management and completed the presentation within this time frame. The delivery was well paced and covered a lot of interesting and valuable, content, especially given the career stage of the students."

For my only face-to-face session, I did finish earlier than scheduled, despite me and the module tutor being concerned that there would be too much information and the session may run over. While I feel as though I developed a better understanding of the timing of tasks for virtual sessions, I feel I was still learning this for face-to-face sessions. For example, I would allocate 20 minutes for a task but after 15 minutes the room would become quiet which signalled a natural point to resume. Developing my skills in face-to-face teaching appears to be an ongoing developmental need of mine.

The feedback I received from participants across all sessions regarding the pace was variable. For the dietitian sessions, where I and observer feedback noted a fast pace, feedback was consistently felt suitable and similarly for the BSc session. For example, *"It wasn't rushed and there were several opportunities to ask questions if we needed to"*. On the other hand, other students felt the pace was too fast. Although partly related to my teaching delivery and the experience of pace, I feel may be related to student learning styles due to the mixed feedback within and across sessions. While, I have developed several skills in time management and pacing of sessions, across virtual and in-person teaching, this remains an ongoing area of development for future teaching sessions.

Assessment of learning outcomes:

Assessing whether learning outcomes had been met was a challenge and I found this especially for teaching sessions 1-4 as they did not contribute to any formal assessment methods (e.g., exams, coursework, etc). For session 5, students were asked to complete a summative assessment that involved using a theoretical model covered across the module. On reflection, although some of the strategies to assess learning were successful, alternative approaches could be used in the future, dependent on the learner group, group size, and mode of delivery (Figure 2).

Figure 2: Alternative methods of Assessment

Dietitian Sessions:

- I used less formal assessment (e.g., engagement and discussion in breakout groups, applying learning to case studies and other theoretical models, quiz's) methods which made it feel less "official"
- Alternatives include:
  - Mind maps (e.g., menti and using before and after a topic to identify a baseline and any changes
  - More quiz's/ polls (e.g., Kahoot in addition to MS polls)
  - Sharing of reflections
  - I could have attended another reflective practice space to assess ongoing use and integration of the sessions.

MSc Session:

- Again, used informal methods as I was a guest speak. I am not sure other ways in which I could have assessed feedback within this circumstance.

BSc Session:

- There were a range of assessment methods that were led by myself as well as a standard of the module.
- The end of module assessment to complete a case study using a theory covered in the session. I could have sought feedback from the module leader to see if any students utilised the theories covered in my session and their knowledge/ application of this.

Although I found the assessment learning outcomes of students tricky to evaluate, I may have been more critical of myself. Observer feedback highlights a range of methods that I employed throughout the sessions to assess the learning outcomes of students (Table 7). Therefore, I learned that although the summative assessment approach is important, other methods such as obtaining regular feedback from participants are equally important and likely to be more applicable for learner groups outsides of an academic setting and within clinical practice.

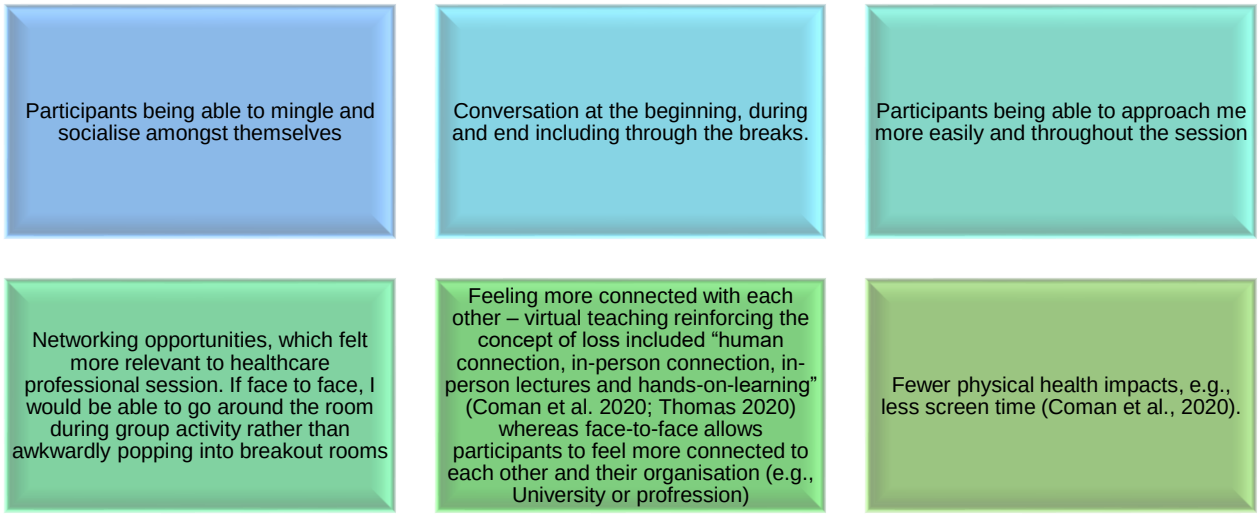
Table 7: Observer feedback on assessment of learning outcomes

"Dipti regularly sought feedback from the participants."
"The topic of focus was of interest to the students, and they appeared to value Dipti's honest reflections in relation to her career journey. It was clear that some of these reflections really resonated with the students, especially in relation to experiences in completing an MSc."
"It was also great that you checked in with student understanding to make sure they were following."
"Students seemed really engaged and it was great that you checked on their understanding throughout"

Virtual Teaching / Use of Technology:

The use of technology in teaching has powerful potential to support teacher learning (McKenney & Vissche, 2019). Most of my sessions were completed using Microsoft Teams, due to the pandemic and government guidelines. Outside of this usual way of living, I had several reflections on things that may have been different if the sessions were facilitated face-to-face (Figure 3).

Figure 3: Limitations of using technology for teaching sessions



An area that I found most challenging with using technology was establishing rapport amongst learners. Research suggests the first teaching session is essential for developing rapport with/ amongst students, making them feel safe and secure, and for setting the tone (Howe, & Watson, 2021). I reflect that for all my sessions I did not engage my participants in any opening activities/ icebreakers. This is likely to have had the most impact on the dietician sessions, as academic students were well into their module teaching, and rapport amongst each other was likely to have been established by the module leader.

Within my healthcare profession teaching session, I also did not set guidelines around cameras on or establish other methods of building rapport amongst learners. Participant and observer feedback (Table 8) suggests that learners were better engaged when cameras were on. For forthcoming sessions, I would consider how I could engage students, virtually, to develop rapport amongst themselves (e.g.,

introduction/ getting to know the activities and guidelines on-camera use, particularly during small group activities to promote engagement and learning).

Table 8: Feedback on the use of cameras

Participant feedback: *"Ground rules- people should be encouraged to have mics and cameras on in the breakout rooms so that they are likelier to participate"*
Observer feedback: *"Dipti tried to engage the participants throughout the training, with varying success. I thought that the engagement of the participants was a lot better when their cameras were switched on following a group task. I think it would have been reasonable to suggest the participants have their cameras on throughout the teaching as this might have increased engagement at other times in the training."*

Teaching was a new experience for me, including virtually. Being from a technology-driven generation I felt relatively comfortable using this to teach, despite my inexperience. However, I did experience some technical difficulties. For example, during session 3 with the dietitians, I had difficulties with internet connection which resulted in me feeling flustered and starting the session late. Experiences in technical issues are commonly reported as challenges in online teaching and can contribute to reduced student satisfaction with sessions (Garrison Anderson, & Archer, 2001; Howe, & Watson, 2021). However, the feedback I received was that despite the delays and technical issues learners remained engaged and satisfied with the session.

The pandemic dramatically altered teaching to online learning and has forced teachers to critically re-evaluate teaching strategies (Howe, & Watson, 2021). Although one of my sessions was facilitated face-to-face, I continued to employ technology in my sessions to facilitate learning, e.g., menti.com as it recognised the interactive benefits. I feel that teaching online still allowed to me present myself in a personable, warm, and friendly manner which appears consistent with my observer feedback (Table 9).

Table 9: Observer feedback on individual characteristics

"Dipti has a very engaging and natural teaching style. This extends to her use of gestures and movement. This is despite the session being delivered online as this can sometimes be hard to get across. Dipti was able to ensure that content was delivered clearly and adapted and repeated information where necessary."
"Nodding to give participants encouragement when giving feedback felt supportive."

Imposter syndrome:

During my teaching sessions, particularly because of my inexperience in teaching, I felt nervous and was experiencing imposter syndrome which is found to be common among doctoral students (Nedegaard, 2016; Rivera, 2021; Wilkinson, 2020). In my sessions I was keen to reflect on my competencies appropriately e.g., dietitians training in Compassion-Focused Therapy (CFT) does not certify them as CFT practitioners and for my BSc teaching, I reflected to students I was not an “expertise” in illness cognitions. While I felt this was as important to highlight my professional competencies, observer-feedback from the session discouraged this for future sessions as it could students may feel the teaching is disingenuous which could impact engagement. Therefore, for future sessions, I need to find a balance when making appropriate disclaimers about my competencies and what this provides for participants in a training session.

Areas for Improvement

My independent reflection, combined with participant and observer feedback provided me with several learning points for future sessions (Table 10).

Table 10: Area of learning for future sessions

Developmental Areas	For future sessions
Ways to increase activity / (group) engagement	• Establishing guidelines for camera use in virtual teaching – requesting these be turned on during breakout group activities and when asking questions if learners do not want these on for the duration of sessions. • Feedback from learners – requesting learners' feedback on each specific point of the activity and breaking it down this way.
Session content	• Ensuring the information on slides is concise and not too much • Utilise handouts, especially for theoretical models in face-to-face sessions, to supplement slides and to use alongside activities. This allows for easier access and for learners to refer back. • When introducing and demonstrating/practicing skills (e.g., mindfulness and CFT exercise) pre-record these to a slide for the learner to be able to refer back to after the teaching session. • - Ensure the volume of content is not too much for one session. Maybe breaking this down into smaller sessions or providing learners with a pre-recorded presentation (e.g., covering theoretical concepts) in advance of the teaching session.
Communication and Pacing	• Practicing the teaching session in advance to grasp the timings and pacing. • Being assertive but clear with instructions. Therefore, only providing one set of instructions at a time not multiple instructions as this is confusing to the participants
Professional disclaimers	• Being transparent about professional boundaries and competencies but using appropriate expression to convey this. E.g., not a certified CFT therapist, rather than an "expert".

Summary

My experience in designing and delivering teaching sessions across different learner groups was invaluable. I have developed skills in virtual teaching, and have learned interactive exercises (especially case studies, group activities, and multi-media) serve several functions and are an essential feature of a quality learning experience. I have worked on improving the pace of my sessions and utilising all the allocated time. Although initially nervous in delivering sessions, I relaxed into this role and felt confident in my ability. I have also discovered that, across singular or multiple teaching sessions, it is possible to achieve a range of learning outcomes associated with the acquisition of new knowledge and skills. These sessions have provided me several learning and reflective points that will inform future teaching opportunities for me within my workplace. I have also continued to seek further teaching opportunities, across

different groups, I am broadening my experience of more face-to-face teaching sessions which was limited in my current sessions due to the pandemic. Nevertheless, these experiences, have provided me with teaching skills and abilities, and foundations that I will continue to develop my competencies.

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Chapter 5: Consultancy Skills

5.1 Consultancy Skills Case Study

Introduction

In this case study, I discuss the completion of my consultancy project with the Safeguarding Team (ST). The ST is part of a larger NHS Trust that is part of my workplace. Within the ST, there is the "Making Safeguarding Personal" (MIP) Steering Group which manages several projects exploring significant safeguarding areas in the Trust to provide better staff support and improve patient care across organisations.

In January 2021, I was invited to consult on a project within the MIP. The MIP Steering Group had initiated a project to understand self-neglect issues within the Trust, following a national analysis of Safeguarding Adult Reviews (Table 1). The focus was to understand the safeguarding challenges that arise across organisations in adult patients. I, therefore, consulted on a project exploring and understanding the clinical staff member's experience of working with patients who self-neglect their physical health. The project was titled "***Self-neglect: A Trust Wide Integrated Safeguarding Review".***

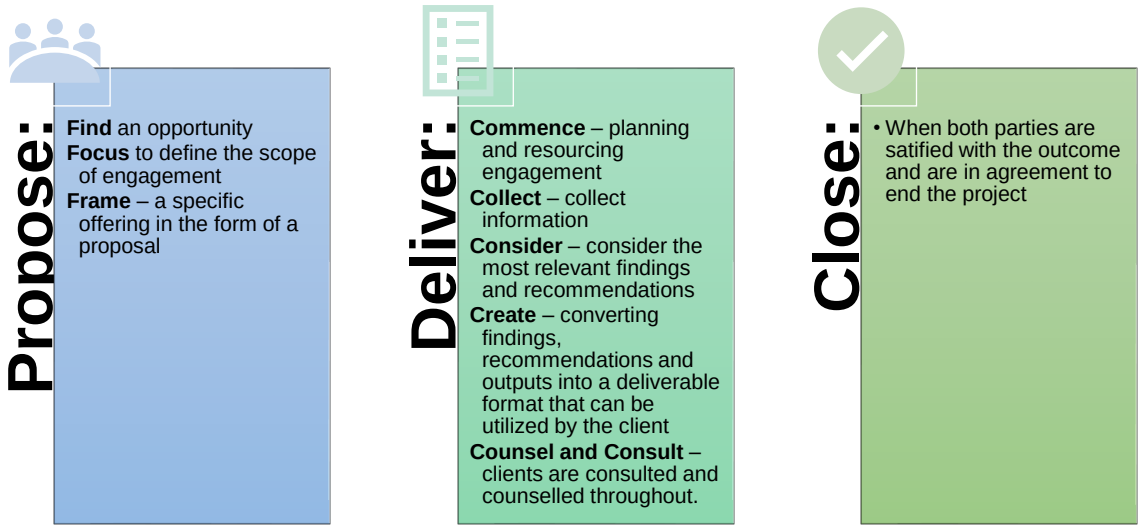
Table 1: Background Information on Project

Background Information to Consultancy Project
• The project was initiated following the first national analysis of Safeguarding Adult Reviews (SARs) in England (Preston-Shoot, Braye, Preston, Allen, & Spreadbury, 2020). • The review was funded by the Care and Health Improvement Programme and supported by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). • The purpose of the review was to identify priorities for sector-led improvement. • The review also built on published regional thematic reviews (between 1 April 2017 and 31 March 2019). • The analysis focused on specific types of abuse and neglect. The analysis bridged a significant gap in the knowledge base about adult safeguarding across all types of abuse and neglect. • In summary, the SARs review found that self-neglect was a significant contributing factor to adult death within this safeguarding review.

Consultancy is defined as "*a two-way interaction, a process of seeking, giving and receiving help*", with consulting aimed at aiding a person, group, organisation, or larger system in mobilising internal and external resources to deal with problem confrontations and change efforts" (Lippitt & Lippitt, 1975). After reviewing different

consultancy models, I selected Newton's (2010) three core stages and nine steps of client-centric consulting (Figure 2) as it provides a coherent structure and focuses on a process consultation approach by placing value on the Consultant-Client relationship (Block, 2011; Earl & Bath, 2004; Newton, 2010). This approach provided me with a clear structure to complete my consultancy and allowed me to work collaboratively with the Client to understand their needs, ideas, and vision which was important to achieving positive consultancy outcomes (Newton, 2010; Schein, 1999). This approach also maintained the project ownership with the Client, which was key for me due to my limited prior experience in offering consultancy. I also felt it was important for the Client to maintain responsibility as this can increase the prospect of outcomes and recommendations being accepted and implemented at the close of the engagement (Newton, 2010).

Figure 4: Newton's (2010) Consultancy Model



This report summarises my approach and reflective experience in consultancy. I discuss how I proposed, negotiated, delivered, and closed (including evaluating) my consultancy as well as developed, and maintained a constructive and productive relationship with my clients.

The Proposing Stage:

According to Newton (2010), the first stage of a consultancy process is concerned with finding, focusing, and framing the consultancy offer.

Finding the Consultancy:

In this instance, finding the consultancy work was simple as the Client (Clinical Safeguarding Associate) in the ST approached me directly. The initial discussion focused on me providing "*health psychology advice and guidance*". However, there then appeared to be an opportunity for greater involvement and consultancy within this project.

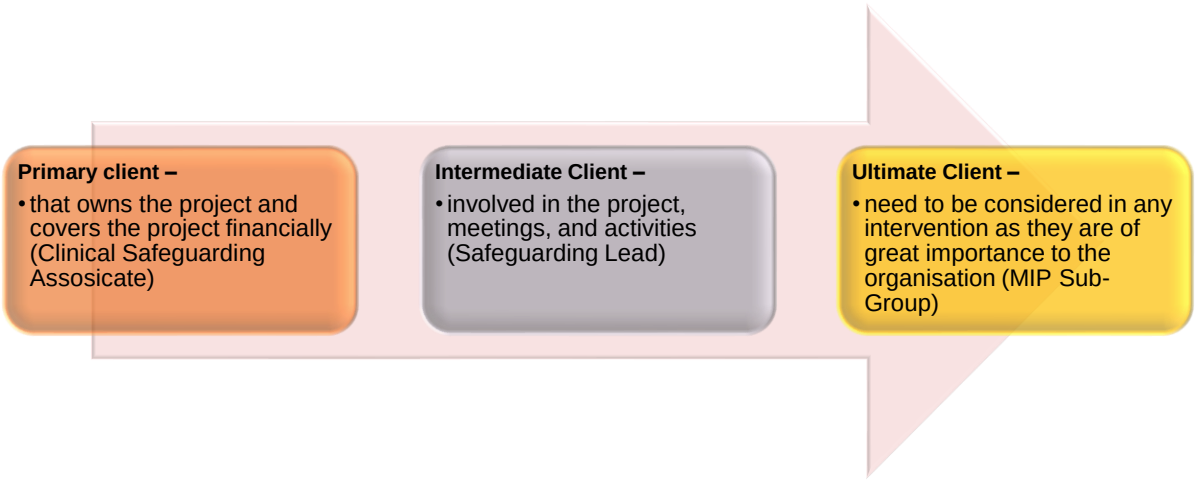
The Client and I have an existing working relationship, from working within the NHS, and was familiar with my practice, knowledge, and expertise as Trainee Health Psychologist. Thus, the Client had confidence in my abilities to consult on this project. As the consultancy project was outside my workplace, the agreement was sought from my line manager to be released for a dedicated period, to fulfil the consultancy, before any further discussions were had.

Focusing the Consultancy

The MIP Steering Group had identified a need to better understand self-neglect within the Trust and had actioned the current project to form as part of a Quality Improvement Project (QIP). Using email, a "kick start meeting" (via Microsoft Teams; MST) was arranged between the Client, Safeguarding Lead (another project member), and I to further establish the needs and requirements of the project.

During this meeting, we confirmed the different roles of the people involved in the project. Using Schein's (1997) classification, here I was able to establish the types of Clients involved in the project (Figure 2). At this juncture, it was important for me to establish a working relationship with the Clients and to begin to pitch, negotiate, plan, and manage the consultancy. Having an existing relationship with the Primary Client facilitated this, but it was essential for me to develop a working relationship with the Immediate Client. I feel my approach of being accessible, and friendly and maintaining open channels of communication enabled a working relationship.

Figure 2: Types of Clients



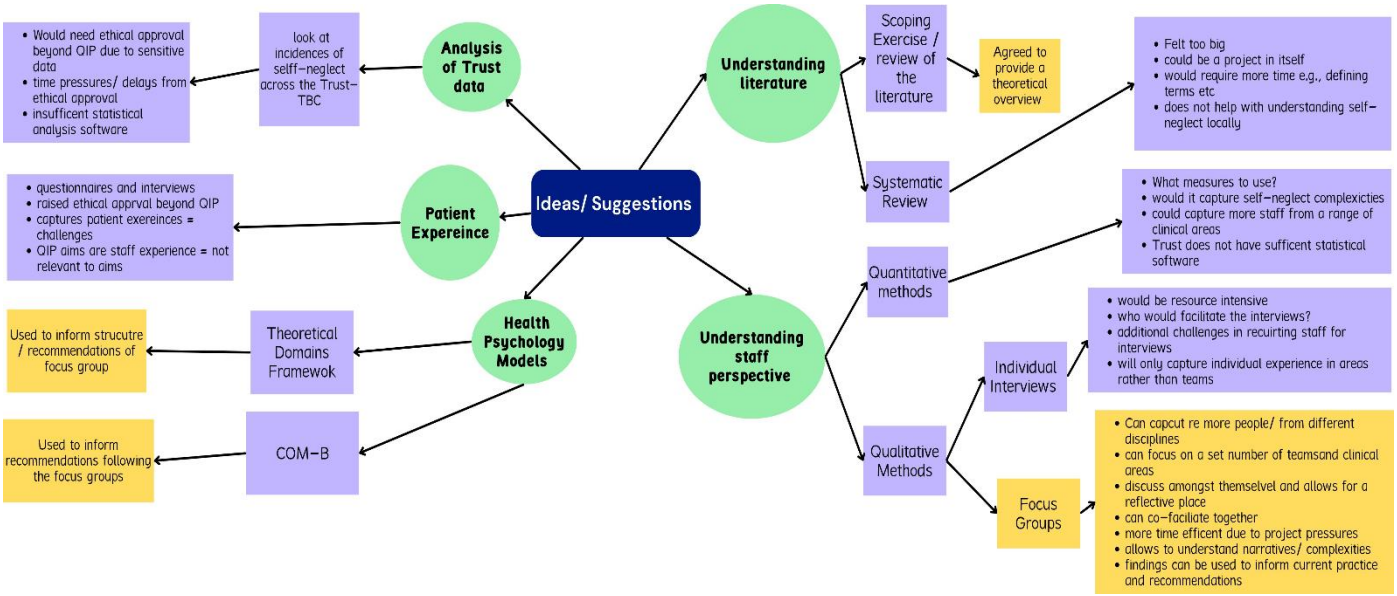
Having established the need for a QIP, it was necessary to focus the consultancy through dialogue with the Clients. During the meeting, the aim was to discuss the SARs review (the Client had shared the report before the meeting) and to consider how this impacted the NHS Trust. The high-level objectives of the consultancy project (e.g., to broaden the understanding of self-neglect on physical health and the safeguarding facets across the Trust) were established by the MIP Steering Group, including the clients, and were not negotiable. However, I was able to pitch and negotiate, in meetings, with the Clients to focus on the consultancy project ideas that might be achieved realistically. It was mutually agreed between the Clients and I (after my suggestion) that the project would focus on understanding staff members' experiences of working with self-neglecting patients, including the safeguarding complexities that arise across different clinical areas in the Trust. Here, I was also able to recommend and negotiate the project focuses on limiting the number of services, (maximum 10), due to the large Trust/ organisation.

Focusing on the consultancy allowed me to fully understand the outcomes and targets the Clients were committed to achieving. Throughout the meeting, obtaining information about project parameters was important to me, particularly given other commitments of all parties involved and the different competencies and professional backgrounds. Having established timescales (completion by March 2022) and there being no available budget to ascertain the viability of the project, this provided me an opportunity to negotiate the terms that would allow both Clients and I to mutually benefit.

Framing the Consultancy:

The aspects of framing the consultancy were completed alongside the Clients. I took an active role in the decision-making process when proposing, negotiating, formulating, and finalising ideas during follow-up meetings that would be of benefit to the QIP. I made a range of suggestions (e.g., literature reviews, conducting focus groups, and using appropriate theoretical models to inform the project). Here, I felt confident in discussing the suggestions, demonstrating both benefits and challenges and how these would address the project aims (Figure 3). Agreed in the meetings, the consultancy objectives would concentrate on understanding a) psychological models of self-neglect and b) staff members' experiences of working with self-neglecting patients that would inform developing learning support and guidance for staff members.

Figure 3: Project Suggestions and Ideas



Thereafter, I generated a draft contract and relevant actions. However, the scale of the project was too demanding alongside other commitments. I, therefore, recommended the need to establish more detailed timescales, roles, and responsibilities that would be included in the contract. As such the QIP was divided into four stages (information gathering, consultation, analysis and reporting, and production stage), with the name of each phase and tasks mutually decided to allow the project to be more manageable. Taking an active role in the decision-making

process allowed me to develop my confidence in negotiating and assuming certain roles and responsibilities based on my knowledge, and expertise alongside other commitments to fulfil project tasks. This then informed the Contract and Working Agreement Conditions Document and for Client Consent Form, which explicitly indicated tasks, individual roles, and responsibilities.

Creating a contract was a novel experience for me which I found challenging. Having not prepared a contract previously, I relied heavily on resources provided by the University. Within contract writing, I learned the importance of needing to be explicit, transparent, and detailed which allowed roles and responsibilities to be clear while also including causes that protect both the Client and I from any liability. Going forward, this experience in contract writing has provided me with a good foundational template that I could use for future consultancy projects.

The Delivery Stage:

Newton (2010) suggests the delivery of a consultancy project typically involves five steps; commence, collect, consider, create, counsel, and consult.

Commence Delivery:

Having established timeframes with my Clients and within the Working Agreement, I created a Gantt Chart to support tracking and meeting the QIP requirements. Due to my limited prior consultancy experience, I did not have an existing model of planning, documenting, and monitoring the consultancy, therefore, the Gantt Chart allowed for this. I found this document was an important point of reference to monitor and review my progress, identify any reasons for the delay, and ensure all parties were able to track the overall progress of the consultancy. To ensure I was meeting my deadlines, I maintained regular contact (via email or MST) with my Clients which permitted me to both keep accountability and autonomy throughout the project. In addition, the consultancy felt manageable to complete having already established four phases in earlier meetings.

Collecting Data:

The process of collecting data for the QIP (e.g., a literature review and recruitment of staff members and conducting focus groups) appeared straightforward as roles and responsibilities were already established (Table 2).

Table 2: Consultancy Data Collection

Task	Brief	Learning Points
To understand the psychological models of self-neglect.	I completed a literature search to establish existing literature using available peer-review journals and books. I utilised the library resources at Staffordshire University and the NHS Trust to facilitate this process before preparing my literature review.	Completing a search for the literature review was a familiar process. I felt comfortable completing this and accessing the library resources. This was due to completing similar processes as part of current and previous academic studies. As such, I felt comfortable and confident in this task and the processes.
Focus Group	For the focus groups, the clients were responsible for the recruitment of staff members to participate in the focus groups. The Primary Client was also responsible for completing the QIP form which provided the necessary ethical approval for the project, including the completion of focus groups and analysis of the data. I prepared the materials associated with conducting the focus groups. This included developing a participant information sheet, consent form, and a draft of the focus-group schedule. Both the clients and I were responsible for co-facilitating focus groups. The Primary Client was responsible for chairing each focus group (e.g., introductions, conclusions, and time management) and I was responsible for asking the pre-arranged questions (and downloading and deleting the recordings upon completion). The Immediate Client was responsible to ask to follow-up questions based on participant responses. The Primary Client was also responsible for organising administrative support to transcribe the focus groups.	Drafting the focus-group schedule was another familiar process. I have utilised the Theoretical Domains Framework (TDF; Michie et al, 2005) to inform the interview scheduled previously and therefore could draw upon this experience. The Clients and I, then re-affirmed the schedule in advance to conduct the focus groups and established roles. This was a particularly useful process as it allowed me to explain some questions in the scheduled and allowed all to be familiar with the schedule before the focus groups. This is a process I would complete again when jointly preparing for focus groups. In conducting the focus groups, having established roles and responsibilities, made this process organised and allowed focus groups to be completed with ease. This is a process I would use in future projects.

The data collection phase provides a good example of process consultation (Schein, 1987) because the Clients and I worked collaboratively to achieve the consultancy objectives. This was a pleasant experience as we had defined responsibilities and each person to complete their tasks.

Considering Data:

This step involved synthesising the literature and analysing the focus group data to begin to address the initial aims and objectives of the QIP (Table 3).

Table 3: Considering the Consultancy Data

Data	Action and Reflection
Literature Review	In offering evidence-based literature on self-neglect, I chose to summarise the findings from peer-review journals which included systematic reviews. This summary provided an outline of key models and theories relevant to self-neglect which is summarised in the final report.
Focus Group Transcription	Regarding the focus group data, there were some significant and unforeseen delays in commencing data analysis (e.g., the duration of time to transcribe the focus groups had been underestimated). I had recommended overestimating (e.g., 7 hours per focus group) the allocated time to transcribe each focus group based on previous experience. However, due to competing demands of administrative support, the initial proposed time was felt to be inflated and thus, the adjusted time allocated (e.g., 3 hours per focus group) to transcribing the focus groups was felt to be sufficient. After the first transcript was transcribed, it was recognised the allocated time was not achievable. Following a discussion between the Clients and I, further administrative support was sought by the Primary Client (their responsibility) to minimise further delays to the project. Helpfully, I was provided with regular email updates from the Clients (and administrative support) about the progress and competition of each transcript. Knowing when each transcript was prepared, I was then able to proceed with analysing each transcript in turn.
Focus Group Analysis	The analysis stage involved using Braun and Clarke's (2006) Thematic Analysis. Completing the analysis was divided into different stages where I completed initial steps individually before working with the Clients on defining themes and sub-themes and selecting participant quotes. There was a further delay at this stage as I had contracted Coronavirus and my workplace had several COVID-19 outbreaks resulting in my being re-deployed to support the nursing compliment. This meant I could not consistently dedicate time to this project, as documented in the Working Agreement. As per the Working Agreement, both Clients updated and were accepting and understanding of the situation. In retrospect, I recognised having not considered or included a clause in my Working Agreement to cover unforeseen circumstances (including impacts relating to the Coronavirus) or illness, which would be necessary for future contracts. Given these delays, it was verbally agreed with my Primary Client a contract extension of two weeks would be made to allow for the completion of the QIP. This was later formalised in my placement meeting alongside academic and workplace supervisors. A follow-up email was sent to the Primary Client to document the written agreement of an extension. While

	mutually agreeing to an extension of the contract was straightforward, agreeing on an appropriate time extension was more challenging. I felt two weeks would be sufficient to complete the tasks, however, the Primary Client was keen to not add a timescale. While I found it uncomfortable to be assertive, this was eased as the extension had to be agreed alongside my workplace line manager (as they were releasing my time to fulfil the project requirements). Having prior experiences in qualitative analysis (including Thematic Analysis, Braun, and Clarke, 2006) and research methods provided me with a good level of experience in analysing the focus groups. However, I refreshed my knowledge of this analytic approach by reviewing material from a teaching session I had previously attended as part of my Professional Doctorate training. I also shared information (e.g., videos and slides) on Thematic Analysis (Braun and Clarke, 2006) with my Clients to bridge their knowledge and verbally demonstrated the different stages I undertook (e.g., showing how and why I had coded the data as I had). While completing analysis collaboratively was challenging at times (e.g., took longer than anticipated) due to their limited experience in this area, the joint-working was beneficial. This was because multiple individuals with different clinical backgrounds offered alternative perspectives to the data.
Recommendations	After analysing and preparing a report which summarised the focus group findings, my Clients and I arranged a further meeting to discuss recommendations. I suggested recommendations to be constructed using the COM-B model (Michie, van Stralen & West, 2011), focusing on staff capability, opportunities, and motivations to raise issues relevant to patient self-neglect. I again shared information (including a free training session) on the COM-B Model and Behaviour Change wheel, to support their knowledge due to their unfamiliarity. Instead of sharing self-directed information, I could have presented the model using PowerPoint slides and including multi-video available. This would have provided an engaging and hopefully effective overview of the model. This approach would have also allowed me to demonstrate how the model could be applied to the focus group findings.

Creating Deliverables:

The creation step involved the development of a final report that was credible, useable, and accessible to the MIP Steering Group. The report structure had been agreed upon with the Clients, in the Working Agreement and I used the Trust corporate template to ensure the correct letter-headed paper was applied. The length of the report was important for me. Therefore, I ensured the report was concise, capturing the key summary points of the project. I was also keen to minimise the use of jargon and summarising the recommendations in clear, simple, and accessible language which also included general readability of the COM-B model, which I felt confident in doing.

The report provided a literature review of self-neglect models, an introduction, design, methodology (including how the focus groups were conducted), results of the focus group, discussion, and recommendations. The recommendations were jointly prepared by my Clients because of their expertise in safeguarding principles and could implement the recommendations, going forward. In contrast, my knowledge and contributions focused on shaping recommendations in the context of the COM-B model (Michie et al, 2011) in a behavioural science manner. In addition, the Primary Client prepared the discussion but was only able to complete this after the contract end date (before the closing meeting) due to other commitments which was frustrating. While jointly preparing the report was largely uncomplicated, I recognised each author had a different writing style. Therefore, we had to ensure the language and style were consistent throughout.

The final report also included an executive summary at the beginning and relevant appendices. In table 4, I also provide some examples of how my approach to writing the final report was consistent with guidance in the consultancy literature.

Table 4: Reporting Findings: Guidelines within the Consultancy Literature and my Approach

Guidance in the literature	My Approach
To avoid being/ using judgmental language and for change to be sustainable, findings must be presented in a non-threatening way (Cope, 2010; Block, 2011).	It was important for me to convey the findings of the project appropriately, which reflected the challenges, obstacles, and barriers of staff members when working with self-neglect as well as the positives. Although the project captured staff from several services, it remained important for me not to communicate/ make generalised assumptions or interpretations about the findings from the focus group.
To keep messages brief and simple. Therefore, it is important to avoid long and complicated language in reports (Block, 2011).	It was recognised that the readers of the report are unlikely to be familiar with the COM-B model (Michie et al, 2011). Therefore, to ensure understanding an explanation of the model was provided within the appendix.
Remain solution-focused – the Consultants have a responsibility to suggest solutions to problems that they uncover (Block,2011).	Throughout the project, I worked closely with both clients. When making recommendations based on the focus group findings, it was useful doing this alongside the clients as they were able to make suggestions on the most effective way in which the recommendations could be implemented and sustained.
Offer a well-balanced analysis. It is important to focus on strengths as well as weaknesses. Reporting formats need to achieve the appropriate balance of diagrams versus text (Newton, 2010).	Within the analysis of the focus group, I highlighted the strengths and successes of staff members. These successes were then used to inform recommendations.
Check and quality assure the final product. Deliverables must be checked, and quality assured before handing over to clients (Newton, 2010).	At each stage of preparing the document, versions were shared with the Clients. They were able to offer their thoughts on improvements and structure (particularly for lay readers). These were integrated into the final report.

Counselling and Consulting

The Clients were consulted and counselled throughout. In addition to the deliverables, the outcomes of this work can be viewed from the perspective of the different Client types involved, including my own as a (trainee) Health Psychology Consultant. From the perspective of the Primary and Immediate Client, they both developed their knowledge of the TDF (Michie et al, 2005) and COM-B model (Michie et al, 2011) and how to apply these models. Both Clients also developed their knowledge in conducting focus groups and analysing the data using Thematic Analysis (Braun and Clarke,

2006). In addition, Newton (2010) suggests several components involved in the counselling and consulting phase (Table 5).

Table 5: Newton (2010) counselling and consulting phase

Counselling and Consulting Stage	Process and Reflections
Presenting findings	A draft of the final report was shared with both Clients via email, and both were content with the document but had some recommendations during a workstream meeting. My Primary Client felt the introduction read as 'anti-medical' and requested some of the languages be softened. Here, I was able to convey the literature on self-neglect models criticises the medical approach to self-neglect. Nonetheless, I agreed to provide a balanced approach and suggested stipulating in the report the information presented is based on the existing literature rather than a personal stance for other readers. Another recommendation made, by the Immediate Client, was to include a brief and simple summary of COM-B (Michie et al, 2011) in the appendix of the report to support readers when interpreting the recommendations which informed using this model. Newton (2010) also highlights the importance of how the findings and recommendations are discussed and presented to the client, e.g., with clarity, confidence, and assertiveness. Having jointly considered the findings and recommendations with my clients, I felt capable to present these with transparency, clarity, and assurance. This appeared to gain their acceptance that recommendations presented were logical and non-contested. I then worked with the Clients to refine these to allow the recommendations to be easily implemented upon completion of the project.
Refining deliverables based on Client feedback.	
Making final Client recommendations	
Agree on the client's next steps.	Section 3.3.4 in the Working Agreement indicates presenting the findings and recommendations to the wider MIP and other relevant individuals across the NHS Trust. However, as the QIP has already overrun, and a further extension was not possible an alternative approach was agreed to enable this. It was agreed with the Primary Client, my line manager, and I that this could be fulfilled on a meeting-by-meeting basis (e.g., "add on work"). This would involve the Primary Client making contact, via email, in advance to discuss attending a meeting. The agreement is then sought from my line manager to formally attend the meeting. I have reflected on the impact of this if I were acting as an independent consultant and concluded that I would need to charge the Client for singular work.

The Closing Stage:

A successful end in a consultancy project is one in which both the Clients and Consultant are satisfied with the outcomes and agree the consultancy is complete (Newton, 2010). Newton (2010) suggests closing a consultancy is simpler when the deliverables are specified from the outset. Within the Contract and Working Agreement, the identified roles, and responsibilities for me were clearly defined, and therefore closing the contract occurred with no issues. After making the relevant amendments to the report, a final version was shared with the clients and saved on the shared working space. A final meeting was agreed upon in May where the next steps were discussed, feedback was sought from the Client and the consultancy formally ended. The final meeting took place beyond the two weeks extension due to the Easter break and annual leave of the Clients. As this meeting occurred much after the contract end date, it meant the report could not be formally finalised until this juncture (particularly as the Client had an outstanding section to complete) and receiving feedback from my clients was delayed.

A checklist is also recommended to ensure the consultancy engagement has been closed appropriately (Newton, 2010). This was a useful resource given my limited prior experience in completing and ending a consultancy project. It helped me ensure I had fulfilled all the relevant tasks required and is a resource I am likely to use drawn upon again.

Establishing and Maintaining a Working Relationship

The core of the Client-Consultant relationship to the successful delivery of a consultancy project is widely recognised (Block, 2011; Earl & Bath, 2004; Newton, 2010), with the relationship seen as the "*foundation-stone that supports the entire project*" (Cope, 2010, p.4) but critical generating future work opportunities. Block (2011) suggests the consultant is working on two levels when relating to clients: content level (referred to as the analytic or technical part of the discussion) and relational level (which is about generating a trusting and mutually respectful alliance).

As noted earlier, I had a pre-existing working relationship with my Primary Client. Subsequently, I felt it was important I maintained this relationship, not only to enable the facilitation of this consultancy but also to convey a positive representation of my practice. Through the working relationship, we both reflected on and overcame the

difference in academic requirements of completing consultancy e.g., with Health Psychology training and Forensic Psychology training (their background). With the Immediate Client, I had no previous contact or working relationship with them. Therefore, it was important for me to be welcoming, warm, approachable, and professional.

In addition, to both my Client's rapport has been identified as essential to the maintenance of a working relationship (Nelson & Economy, 2008). Therefore, to develop rapport between my Clients and me, I attempted to empower my Clients, ensuring they were in a joint-working relationship which I believe was further re-affirmed with my process consultation approach in which the Client remains responsible for the project but I as the consultant provide them assistance and help (Schein, 1999).

I also sought to develop and maintain a trusting working relationship which is represented in Table 6.

Table 6: Application of Cope's (2010) Definition of TRUST

Relationship attributes	Examples
Truthful	My contract with the ST was a non-commercial one, in that I was providing a consultancy service with no charge attached. I however was using my time within my employed role within the same NHS Trust. Subsequently, it was important for me to be transparent about the realistic time and timeframes I could dedicate to the project, being mindful of existing employment and academic commitments that occurred simultaneously.
Responsive	In establishing the recommendations from the focus groups, I worked alongside the clients. I was able to make recommendations based on the findings of the focus groups and align these within the COM-B Model (Michie et al, 2011) principles. Rather than imposing recommendations, working alongside the clients allowed the recommendations to be realistic and in line with what is likely to occur after the project is complete. For example, I was made aware that each recommendation would be implemented into another QIP when the findings are shared with leads in the organisation and ST. Therefore, recommendations needed to be realistic and achievable.
Uniform	I ensured that there were regular opportunities to review the progress of the consultancy and agree on the next steps. It was agreed earlier in the project that while no formal minutes of our meeting would be taken, summarises and actions would be shared via email, and everyone would take responsibility for managing their actions/ tasks. Therefore, after certain meetings and after completing actions, I would provide my clients with an update, usually via email. In between meetings, when I received emails from my Clients, I always responded promptly. I was also transparent around junctures where my commitments were more intense or when I was on annual leave, which would mean I was less available.
Safe	When preparing the report, it was important for me to convey the findings of the project appropriately. It was core for me to communicate the challenges, obstacles, and barriers of staff members when working with self-neglect as well as the positives. Communicating the difficulties can be exposing to services. Therefore, I was keen to demonstrate this in a non-blaming or critical manner and rather a balanced, constructive way.
Trained	During the initial stages of finding and focusing on the consultancy, I seized the opportunity as I felt confident that I could make valuable contributions to the project. I felt assured in my qualitative research abilities, particularly having recently refreshed my knowledge during a Professional Doctorate teaching session. I was also certain that any difficulties that may occur during the analysis and interpretation section could be discussed with my academic supervisor to provide a robust assessment of the qualitative data if required. A deficit that I recognised within myself from the outset was the gaps in knowledge Safeguarding. This related particularly to terminology. However, I was able to routinely ask my clients to clarify. This knowledge gap was a further reason why I worked with the clients when making recommendations following the staff focus groups.

In my working relationship, I was also realistic in my expectations. For example, I was aware all parties had other commitments, so each would have to prioritise and manage their own time for the project accordingly. Therefore, we discussed during earlier workstream meetings about suitable and pragmatic timescales to complete tasks and respond to emails and requests. This was particularly important when we experienced delays in the QIP and we were mutually, without any issues, able to arrange meetings to re-group and re-focus on the project.

Throughout the entire consultancy project, the use of technology was valuable in completing tasks and maintaining contact. Due to the nature of the pandemic, it was agreed that all services would be provided virtually. While this did not cause any difficulties in meeting the deliverables or developing and maintaining a working relationship with the Clients, I recognise this may have been different in person. For example, it may have been harder to meet in person, particularly as everyone was based in different geographical locations. Therefore, future consultancy projects that involve face-to-face contact and engagement may present me with different experiences in developing and maintaining relationships with the Clients as well as the entire running of the consultancy project.

Evaluation

The process of evaluating consultancy is to ascertain whether the negotiated and agreed requests and aims were addressed. Specifically, clients would expect the quality of the work and operational findings/ results that can impact the likelihood of the consultant gaining further work (Stumpt et al, 2000). To understand the client's experiences of my consultancy, I developed a client feedback form for both Clients. This included information on Client satisfaction, the Consultant's performance throughout the process, and the output itself, as well as evaluating whether this has had an impact on service development and the client's learning (Earll & Bath, 2004).

Client feedback indicates they felt I was enthusiastic, and committed to project timescales, and knowledgeable of Health Psychology related research, theories, and approaches and demonstrated how these may apply to issues of self-neglect. Before the consultancy ended, the Clients shared the positive impacts of the QIP thus far. To remain updated about the consultancy impact, during the closing meeting, the clients suggested (and I agreed), that they could be approached to request receive updates

about the dissemination, impacts, and use with the NHS Trust. This was important to see:

- How lead clinicians and decision-makers in the NHS Trust were responding to the report,
- The influences the project was having on those teams involved and the wider trust, and
- What resources and recommendations were being implemented based on the findings.

Summary

This reflective report is a summary of my experiences of consulting on a QIP in the ST within one NHS Trust. The experience of consultancy was new to me and an area that elicited feelings of uncertainty. From this process, I have developed my skills in all areas of proposing, delivering, and closing a consultancy piece. I have particularly developed my proficiencies in negotiating and contract writing; an area in that I had no prior experience. I have learned about the importance of being explicit and detailed in my contracts and the future would also include a clause to account for sickness and unforeseen circumstances. I have also learned to monitor, deliver, and close a piece of work. This project has also enhanced my abilities to work inter-professionally.

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5.2 *Consultancy Contract and Working Agreement*

Dear [redacted]

Consultancy Agreement

(The Agreement) dated:

[redacted] of [redacted] Safeguarding Team, [redacted]

(The "Client")

AND

Dipti Mistry of Staffordshire University, Stoke-on-Trent, England, ST42DE

(The "Consultant").

1. BACKGROUND

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

1.2 The Consultant is agreeable to providing the services to the Client based on the terms and conditions set out in this Agreement.

1.3 This consultancy work will be written up as a case study for the Consultant's Professional Doctorate in Health Psychology at Staffordshire University. A consent form with more information, is to be completed by the Client if agreed, and is provided as a supplementary document to this Consultancy Agreement.

1.4 The Consultant will be contracted to contribute to the *"Self-neglect: A Trust Wide Integrated Safeguarding Review*" Project within [redacted], Safeguarding Team. The aim of the project is to develop a broader understanding of staff members, within [redacted], experiences of working with patients who self-neglect and the potential safeguarding issues when working with patients who self-neglect. This project will be coordinated and led by the "Client", a Clinical Safeguarding Associate. Other members involved in the project include a Safeguarding Specialist Practitioner.

2. TERM

2.1 The term of this Agreement (the "TERM") will begin on the date this Agreement is signed and will remain in effect until 31.03.2022, which is the agreed end date for the provision of the service.

2.2 This Agreement is subject to earlier termination, as provided in the Agreement or further extension, by which written consent of both parties will be obtained.

3. SERVICES

3.1 The Consultant will use their best endeavours to promote the interests of the Client unless prevented by ill health or accident. The Consultant will devote a minimum of 3 hours per week, (equivalent to 12 hours per month) and a maximum of 7.5 hours per week, (equivalent to 30 hours per month) to complete the agreed services for the Client, until the end date of this Agreement (31.03.2022). The Consultant will provide these services alongside existing Professional Doctorate, and employment commitments.

3.2 The Client hereby agrees to engage the Consultant to provide services (the "Services") consisting of 4 stages (Information Gathering, Consultation, Analysis and Reporting, and Production) each with specific deliverables. The anticipated milestones for each stage are:

- Information Gathering Stage: beginning on the date this Agreement is signed to 30.11.2021.
- Consultation Stage: beginning 01.09.2021 to 30.09.2021.
- Analysis and Reporting: beginning 01.10.2021 to 30.01.2022
- Production Stage: beginning 01.02.2022 to 31.03.2022

3.3 These milestones are a guide and for reference only. The Consultant is not bound to delivering evidence of these during the Term. This excludes the final Milestone, by which time the Services are to be delivered. The Milestones will act as a guide for the discussion of progress and content.

3.3.1 Stage 1: “Information Gathering Stage”:

- *Literature Review:* The Consultant will undertake a review of the literature to identify:

a) the psychological models of self-neglect, and

b) how self-neglect relates to physical health conditions, as identified within “Analysis of Safeguarding Adult Reviews: April 2017- March 2019”.

Deliverable Outcome: to produce a written report summarising a literature review on the psychological models of self-neglect and how self-neglect relates to physical health conditions for the [redacted] Safeguarding Team.

3.3.2 Stage 2: “Consultation Stage”:

- *Quality Improvement Plan (QIP) ethical approval*: The project will require QIP ethical approval from [redacted] to:

a) conduct focus groups with clinical staff members working in a range of services within [redacted], and

b) submit the services and outcomes outlined in this Agreement as part of the Consultant's consultancy competency for the Professional Doctorate in Health Psychology at Staffordshire University.

c) As part of the ethical approval process, the Consultant will develop the Participant Information Sheet and Consent Form for the focus groups. The Consultant will produce a draft set of focus group questions in collaboration with the Client and Safeguarding Specialist Practitioner during a Workstream meeting. The Client will confirm and finalise these questions prior to the focus groups commencing. The Client, as lead for the project, will submit these documents as part of the overall QIP ethical approval to receive the permissions within [redacted]

Deliverable Outcome: to develop a Participant Information Sheet and Consent Form and draft focus group questions in collaboration with the Client and Safeguarding Specialist Practitioner. These documents will be provided to the Client.

- Delivery of focus groups: The Consultant will co-facilitate, with the Client and Safeguarding Lead Practitioner, up to seven focus groups with the following teams across [redacted]: Tissue Viability Team; Substance Misuse; Intellectual and Developmental Disability Services; Forensic Complex Cases; Child and Adolescent Mental Health Service; Adult Mental Health Team; and District Nurses.

a) Identifying focus groups: Focus group participants will be recruited from seven teams, as identified above, across [redacted]. The aim is to capture and identify patients' self-neglecting presentations and the potential safeguarding issues faced by staff members when working with patients who self-neglect from a range of clinical services within the Trust. These teams will be identified via: i) recent incident reports highlighting self-neglect and ii) services who have sought support from the Safeguarding Team around experiences of working with self-neglect. In both cases, teams will be approached by the Client or Safeguarding Specialist Practitioner about possible participation in the focus group.

b) Confirmation of roles in conducting the focus groups: The focus groups will be co-facilitated by the Client, Consultant and Safeguarding Specialist Practitioner via Microsoft Teams. The Client will chair all focus groups and will be responsible for initial introductions, obtaining informed consent, time management and debriefing the participants. The Consultant will co-facilitate

the focus group discussions and ask the pre-designed questions. The Consultant will also be responsible for recording and downloading (and deleting after download) the interviews via Microsoft Teams. The Safeguarding Specialist Practitioner will also contribute to this discussion by asking any follow-up questions or further prompts during the focus groups based on participant responses. The focus groups will explore experiences of working with patients who self-neglect, experiences in communicating safeguarding issues to senior colleagues about patients who self-neglect; and the practical and clinical issues and legal considerations associated with patients who self-neglect.

Deliverable Outcome: to co-facilitate the focus groups by taking the role of asking the proposed questions to participants and recording, downloading and deleting all interviews.

3.3.3 Stage 3: "The Analysis and Reporting Stage":

- *Transcription of focus groups*: The Client will be responsible for transcribing the focus groups from audio data from the Microsoft Teams recording. Administrative support will help to ensure there are no spelling or grammatical errors in the transcripts. The Consultant will save the download recording of each focus group onto the 'Self-neglect and Neglect WG' shared file to enable to the Client to transcribe the data. The Client will save all the transcripts in the 'Self-neglect and Neglect WG' shared file which is accessible to the Consultant, Client and Safeguarding Specialist Practitioner only. Saving the transcripts in this shared file will allow the Consultant to access the transcripts for analysing the focus group data.

- *Analysis of focus groups*: Thematic Analysis (Braun and Clarke, 2006) will be used to analyse focus groups data using a deductive approach. From the five steps in Braun and Clarke's (2006) Thematic Analysis, the Consultant will conduct the first three steps:

  (i) read and re-read the data,

  (ii) complete open coding using phrases, sentences or parts of sentences that held one meaning related to the participant's experiences, and

  (ii) apply meaning units and sentences with similar content and will generate initial codes.

The final two steps will be completed by the Consultant, Client and Safeguarding Specialist Practitioner collaboratively during a Workstream Meeting:

(iv) organising codes into categories and sub-categories based on similarities and interplays within the text in its entirety, and

(v) generating themes from the sub-categories and selecting participants' quotes to represent the categories.

Deliverable Outcome: the focus groups will be analysed using a Thematic Analysis approach. The Consultant will lead on the first three steps of Thematic Analysis and will then complete the latter two stages in collaboration with the Client and Safeguarding Specialist Practitioner during a Workstream Meeting.

- *Reporting findings*: A report of the findings from the first three stages (information stage, consultation stage and analysis stage) will be used to produce a written summary in a peer-review journal format.

a) Introduction: The Consultant will be responsible for writing up the 'Introduction' section, which will be informed by the literature review completed in the "Information Gathering Stage".

b) Methodology: The 'Methodology' of the focus groups will be completed by the Consultant, Client and Safeguarding Specialist Practitioner. The Consultant will complete the design and materials section of the 'Methodology'. The Client and Safeguarding Specialist Practitioner will complete the participants and procedure section of the 'Methodology'. A working document will be saved on the 'Self-neglect and Neglect WG' shared folder to allow the Consultant, Client and Safeguarding Specialist Practitioner to write each section separately.

c) Results: The Consultant will complete the Results section using the analysis of the focus groups.

d) Discussion: The Client will prepare the Discussion.

e) Agreement of order of authorship is as follows: first author – Consultant, second author -Safeguarding Specialist Practitioner and third author – Client.

Deliverable Outcome: to co-prepare a report in a peer reviewed journal format. The Consultant will complete the Introduction (using the review of literature conducted in the Information Gathering Stage), the design and materials sections within the Methodology, and the focus groups' Results.

3.3.4 Stage 4: "The Production Stage":

- *Supporting learning and guidance:* The outcomes from stages 1, 2 and 3 will identify recommendations for learning and development to inform guidance and education support for clinical staff members in [redacted]. This stage will take two phases:

a) The Consultant, Client and Safeguarding Specialist Practitioner will attend up to four meetings with Departmental Leads in the Trust (e.g., legal team, Mental Health Capacity lead as examples) to discuss the findings from the focus groups which will help inform recommendations to identify support, learning and guidance for staff members within [redacted]. The Client will present the report produced from the 'Analysis and Reporting' stage to Departmental Leads, which highlights the findings from

the focus groups. These meetings will take place via Microsoft Teams. The Client will be responsible for arranging proposed dates and times for the meetings with Departmental Leads. The Client will inform the Consultant of proposed dates and times of the meetings and the Consultant will endeavour to attend, subject to existing employment commitments within the Trust and the Consultant's University commitments.

b) The Consultant will provide a written list to the Client, via email, of recommended resources to support learning and guidance (e.g., educational material, information guidance, leaflets, posters, and recommendations for training as examples) for staff members within [redacted]. The Consultant will not be involved in the development of the learning and guidance resources.

Deliverable Outcome: The Consultant will attend up to four meetings with Department Leads in the Trust to discuss the findings of the focus groups to inform recommendations. The Consultant will provide a list of recommendations, via email, to the Client of resources to support learning, development, and guidance for staff members within [redacted].

3.4 **Attendance of Meetings:**

3.4.1 *Workstream meetings:* Throughout the "project", the Consultant will attend monthly workstream meetings (via Microsoft Teams) with the Client and Safeguarding Specialist Practitioner to discuss the project's progression. The Client will be responsible for organising these meetings with the Consultant and Safeguarding Specialist Practitioner. These meetings will be arranged between the Consultant, Client and Safeguarding Specialist Practitioner's existing employment commitments within the Trust and the Consultant's University commitments.

3.4.2 *Making Safeguarding Personal (MSP) Working Group:* The MSP Working Group holds bi-monthly quality improvement plan meetings. The current project is embedded into this group and will need to provide feedback regarding the project's progression. The Client or Safeguarding Specialist Practitioner will provide feedback on the services and deliverables to the MSP Working Group quality improvement plan. The Consultant will provide the Client with a written summary via email on a bi-monthly basis about the progress of services provided, as documented in this Agreement. The Client will incorporate this feedback into a broader summary about the project's progression, in which the Client or Safeguarding Specialist Practitioner will feedback at the MSP Meeting.

3.5 The Consultant will assume the responsibilities and provide the services over minimum of 3 hours per week, equivalent to 12 hours per month and a maximum of 7.5 hours per week, equivalent to 30 hours per month, concluding at the end of this Agreement (31.03.2022). The services within this Agreement will be

provided, alongside the Consultant's existing employment in the Trust [ ] and the Professional Doctorate.

3.6 Should the Client require assistance or information about the project outside of the Workstream Meetings, the Consultant will ensure availability is made on reasonable notice (minimum of 48 hours). This is subject to no existing conflict with the University and employment commitments.

3.7 The Consultant is to declare any conflict of interest from the onset.

4. COMPENSATION AND REIMBURSEMENT OF FEES AND EXPENSES

4.1 The Consultant will receive no direct payment from the Safeguarding Team for providing services to this specific project. The Consultant's salary will continue to be paid by the Consultant's existing employer within . This has been agreed between the Client and the Consultant's line manager.

4.2 The Consultant will be reimbursed for all reasonable expenses incurred in providing the services, or those expenses agreed in advance as necessary for the proper performance of the services. This will include reimbursing the Consultant in attending necessary training, workshops, webinars, travel, and purchasing academic papers for the literature review (3.3.1) that may support with providing the services outlined in this Agreement. All reimbursement claims for expenses are to be made directly to Expenses Department. It will be the Consultant's responsibility to make an expense claim. It is the Client's responsibility to provide the correct budget code to the Consultant to enable expenses to be claimed.

5. CONFIDENTIAL INFORMATION AND ETHICS

5.1 Confidential information refers to any data or information relating to the business of the Client which would reasonably be exclusive 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.

5.2 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 authorised by the Client or as required by law. The obligations of confidentiality will apply during the term of this Agreement and will survive indefinitely upon termination of this Agreement.

5.3 All written and oral information and material disclosed or provided by the Client and participating staff (from the focus groups) to the Consultant under this Agreement is Confidential Information. This is regardless of whether it was provided before or after the date of this Agreement or how it was provided to the Consultant.

5.4 All documents, transcripts of focus groups or any data (including copies) provided to the Consultant are to be maintained or stored electronically on [redacted] computer systems or in a locked filing cabinet on [redacted] premises. These premises are either [redacted] (the Consultant's day-to-day base) or [redacted] (location of the Safeguarding Team) until the end of the terms in this Agreement.

5.5 The Consultant will comply with the British Psychological Society 'Code of Ethics and Conduct' (2018) and the Health & Care Professions Council Standards of Conduct, Performance and Ethics (2016).

6. GENERAL DATA PROTECTION REGULATION

6.1 All information collected, processed, or held as part of the service will be in accordance with General Data Protection Regulation (GDPR, 2018).

6.2 The Consultant will ensure upon completion of the focus groups, via Microsoft Teams, these recordings are downloaded and saved in the 'Self-neglect and Neglect WS' shared folder. The Consultant will immediately delete the Microsoft Teams recording from Microsoft Stream, after download, to ensure these recordings cannot be accessed by an unauthorised individual. Upon completion of the transcribing of the focus groups, the Client will be responsible for deleting these recordings from the shared folder.

6.3 The Consultant consents to the Client making such information available to [other companies in its group] those who provide products or services to the Client (such as advisers), regulatory authorities, governmental or quasi-governmental organisations and potential purchasers of the Client [or other companies in its group] or any part of its business.

6.4 The Consultant will comply with the Client's data protection policy when processing personal data relating to any employee, worker, customer, Client, supplier, or agent of the Client.

7. INTELLECTUAL PROPERTY

7.1 The Consultant hereby assigns the Safeguarding Team, within [redacted], all existing and future intellectual property rights (including, without limitation, patents, copyright, and related rights) and inventions arising from the services for the Client.

7.2 The Consultant irrevocably waives all moral rights under the Copyright, Designs and Patents Act 1988 (and all similar rights in other jurisdictions) which have or will have in any existing or future works.

7.3 The literature review (section 3.3.1) will involve publicly available material, such as academic papers, information from public bodies (e.g., National Health Service or Public Health England) and information in the public domain from health literacy organisations. The Intellectual Property rights will remain with these original sources.

7.4 The qualitative data collected from the focus groups with staff members within [redacted] under this project and Agreement will be the sole property of the Safeguarding Team in [redacted]t. The use of the Intellectual Property by the Consultant will not be restricted for the purposes of the project and Agreement.

7.5 The Consultant will provide the Client with electronic copies of all deliverables produced outlined in this Agreement. The Consultant is to save all electronic copies in the 'Self-neglect and Neglect WG' shared folder. The Intellectual Properties will remain with the Safeguarding Team. However, the deliverable outcomes, findings and any resources developed solely by the Consultant or with the Client and Safeguarding Specialist Practitioner will be available for other services within the [redacted]

7.6 The Client agrees that all deliverable outcomes as indicated in this Agreement are available to the Consultant to submit as part of the Consultant's Professional Doctorate in Health Psychology at Staffordshire University.

7.7 The Client agreed that the Consultant's contributions to the services provided in this Agreement will be appropriately acknowledged in the future.

8. LIABILITY

8.1 The Consultant does not accept liability for any action taken by those in receipt of the services outlined in this Agreement.

9. TERMINATION

9.1 The Client may at any time terminate the Consultant's engagement with immediate effect with no liability to make any payment (other than in respect to any accrued fees or expenses at the date of termination) if:

9.1.1 The Consultant is in material breach of any of obligations under this Agreement; or

9.1.2 As a result of illness or accident, after notice in writing, the Consultant wilfully neglects to provide or fail to remedy any default in providing the services.

9.1.3 Any delay by the Client in exercising their rights to terminate shall not constitute a waiver of those rights.

10. RETURN OF PROPERTY

10.1 Upon the expiry or termination of this Agreement, the Consultant will return any property, documentation, records, or confidential information to the Client.

11. OBLIGATIONS ON TERMINATION

11.1 The Consultant shall return any of the Client's property in their possession, and any original or copy documents obtained by the Consultant while providing the services shall be returned to the Client. This can occur at any time on request by the Client and in any event on or before the termination of this Agreement.

11.2 At the end of this Agreement, the Consultant will save all documents, transcripts of focus groups or any data (including copies) provided to the Consultant and any deliverable outcomes onto the 'Self-neglect and Neglect WG' shared folder. The Consultant will irretrievably delete any information relating to the business of the Client [Safeguarding Team, [redacted]t] that is stored electronically or as a hard copy elsewhere (e.g., NHS encrypted memory stick or a locked filing cabinet on [redacted] premises, either [redacted] (the Consultant's day-to-day base) or [redacted] (location of the Safeguarding Team).

12. DISPUTE RESOLUTION

12.1 In the event a dispute arises out of or in connection with this Agreement, the parties will attempt to resolve the dispute to the best of their abilities through friendly consultation. If the dispute is not resolved within a reasonable period, then any, or all outstanding issues, may be submitted for consideration to an independent mediator, who will pass judgement and mediate a resolution to the dispute.

13. ADDITIONAL CLAUSE FOR INFORMATION – PROFESSIONAL DOCTORATE IN HEALTH PSYCHOLOGY

13.1 The Consultant is undertaking the Professional Doctorate in Health Psychology at Staffordshire University. There are several competencies that must be achieved to receive the Qualification in Health Psychology (QHP):

The QHP (Stage 2) involves a minimum of two years of supervised practice (or part-time equivalent) as a Trainee Health Psychologist. During which time a Portfolio of Competence demonstrating how the five competencies underpinning the qualification have been achieved" (Qualification in Health Psychology (Stage 2) Candidate Handbook, 2018).

13.2 The competencies are:

- Professional Competence in Health Psychology
- Psychological Interventions
- Advanced Research Methods
- Teaching and Training
- Consultancy

13.3 This Agreement is in support of the Consultant achieving the 'Consultancy Competency'. As such, this Agreement will provide an opportunity for the Consultant to demonstrate this competency and for the Client to benefit from the Consultant's expertise.

13.4 As part of the Consultant's training in the Professional Doctorate in Health Psychology, this consultancy work will be written up as a case study for the Professional Doctorate in Health Psychology at Staffordshire University.

13.5 As part of the Consultant's training in the Professional Doctorate in Health Psychology, the Consultant will receive regular supervision from an academic supervisor from Staffordshire University. This will include comments and feedback to indicate the Consultant has demonstrated the required competencies for training.

13.6 At the end of this Agreement, the Client will provide written feedback to the Consultant about their experiences of the services provided by the Consultant. This feedback will be included within the appendices of the Consultant's case study for the Professional Doctorate in Health Psychology.

14. AMENDMENTS AND VARIATION

14.1 This Agreement may only be amended by a document signed by both the Consultant and the Client.

14.2 Any amendments or modifications of this Agreement or additional commitments or outcomes assumed by the Consultant or requested by the Client must be mutually agreed upon and negotiated upon first.

14.3 Agreement to amendment roles, responsibilities or outcomes of the Consultant will only be binding if evidenced in writing signed by each Party.

15. THIRD-PARTY RIGHTS

15.1 The Contracts (Rights of Third Parties) Act (1999) shall not apply to this Agreement, and no person other than the Consultant 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.

16. GOVERNING LAW

16.1 This Agreement and any dispute or claim arising out of, or in connection with, it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

17. JURISDICTION

17.1 The courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this Agreement or its subject matter or formation (including non-contractual disputes or claims).

I hereby acknowledge receipt and accept the contents of this Agreement.

Signed ..... [redacted]..... Date ..... 20.08.2021.....

[CLIENT - [redacted], CLINICAL SAFEGUARDING ASSOCIATE]

For and on behalf of

[SAFEGUARDING TEAM, [redacted]]

Signed ..... [redacted]..... Date 20.08.2021

[CONSULTANT – DIPTI MISTRY]