Anne Marie Dewhurst

Professional Doctorate
in
Health Psychology

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Acknowledgements

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Lastly, to my amazing husband Sean, I promise that this is the last PhD I do. You have been a total rock throughout this whole process, and I love you with all my heart. We need a holiday.

This doctorate is dedicated to my darling mother Sheila Mary Dewhurst
(16th of March 1939- 24th of March 2025)

Portfolio Abstract

Anne Marie Dewhurst

Professional Doctorate in Health Psychology, 2026

This portfolio provides an overview of the work I have submitted whilst completing the Professional Doctorate in Health Psychology at the University of Staffordshire between 2022 and 2026. The work was conducted within my placement as a Health Psychology Lecturer at the University of Lancashire. Opportunities external to this placement were also sought to fulfil the requirements of the doctorate.

This portfolio is divided into the following chapters:

1. Professional Skills in Health Psychology
2. Research: From Design to Dissemination
3. Systematic Review
3. Consultancy in Health Psychology
4. Teaching and Training in Health Psychology
5. Health Psychology Interventions

In the following chapters I provide an overview of my development for each of the competencies of the Professional Doctorate in the form of research manuscripts, case studies and reflective commentaries. This portfolio presents a synopsis of the work I have undertaken including my development, learning and challenges that I have faced during my development as a Health Psychologist.

Introduction

This portfolio provides an overview of my completion of the Professional Doctorate in Health Psychology from September 2022 to January 2026 at the University of Staffordshire. Throughout this period, I was employed at the University of Lancashire as a Health Psychology Lecturer (0.8) and then in year 3 of my doctorate I reduced my hours to (0.6). Within this role I am responsible for leading and coordinating modules in Health Psychology at level 6 and 7, supervising students in the field of health psychology at level 6 and 7, providing pastoral and academic support and delivering lectures within the field of Health Psychology.

I completed four core competencies and received accredited prior learning for the research from design to dissemination and the systematic review.

Chapter 1: Professional skills in Health Psychology

The first chapter of my portfolio focuses on the professional skills in Health Psychology that I developed throughout the doctorate. I present a reflexive report of my development of competencies, and this is supported by excerpts from my reflective diary.

Chapter 2: Research: From Design to Dissemination

In order to demonstrate my competency in this area I applied for and received recognition of prior learning (RPL) for the research competency based on my PhD research. In this chapter I will present my PhD abstract followed by a brief outline of each chapter demonstrating the work completed.

Chapter 3: Systematic Review

For the purpose of demonstrating my competency in this area I applied for and received recognition of prior learning (RPL) for the systematic review competency, based on my PhD research. In this chapter I will present my systematic review abstract.

Chapter 4: Consultancy in Health Psychology

In Chapter 4 I present my case study where I designed a bespoke session for a group of lifestyle coaches in the community around behaviour change techniques and patient centred communication skills within the field of weight management. I provide an overview of the consultancy focusing on the identification of need, planning and negotiating the contract, establishing a working relationship, delivering and then evaluating the consultancy. This chapter also contains the contract which I developed as part of the consultancy process.

Chapter 5: Teaching and Training in Health Psychology

In chapter 5 I present a case study and evaluation of five teaching sessions which were all related to the theme of 'clinical communication within the field of Health Psychology'. The five teaching sessions were delivered to a variety of learners including foundation students, undergraduates, postgraduates and a range of health care professionals such as doctors, nurses and paramedics. The case study provides an assessment of training needs, the training programme structure and content, selection of training materials and assessment of learning outcomes. The evaluation focuses on the strengths and challenges of the training programme, sources of feedback, areas of development and self-reflection.

Chapter 6: Health Psychology Interventions

The final chapter of my portfolio includes two Health Psychology interventions. The first is a face-to-face intervention with one client and provides an overview of the assessment, formulation, implementation and evaluation of a psychological intervention around the menopause and weight management. The second is a remotely delivered intervention with one client and was devised to address weight maintenance, snacking behaviour and emotional eating. At the end of both case studies, I provide a reflective commentary which provides an overview of my experience delivering the intervention.

Table of Completion

Module	Date of completion
Professional skills in Health Psychology	January 2026
Research: from Design to Dissemination	Recognition of Prior Learning
Systematic Review	Recognition of Prior Learning
Consultancy in Health Psychology	January 2024
Teaching and Training in Health Psychology	June 2023
Health Psychology Interventions	January 2026

Chapter 1: Professional Skills in Health Psychology

Reflexive report

Background

This reflexive report will provide an overview of my professional development throughout my stage 2 training to become a qualified Health Psychologist. My placement involves working as a Health Psychology lecturer at the University of Lancashire within the Department of Psychology. I started this role in January 2017 and fulfilled most of my competencies within this. This role is multifaceted and includes teaching health psychology topics such as the role of health professional-patient communication and theories of behaviour change at both undergraduate and postgraduate level. Prior to starting my placement in 2017, I completed a PhD via research. Consequently, I was able to gain Accreditation of Prior Learning (APL) for the Advanced Research Methods competency. The initial sections of the report will focus on key reflections over the core competencies, and the following section will be reflections on key professional skills as outlined by (BPS; 2021) and the Health and Care Professions Council (HCPC; 2024).

Core competencies

Research

My PhD research initially comprised of a systematic review which was a thematic synthesis of physicians' experiences of discussing weight management within clinical consultations. I learnt that more specialist training for health professionals (HPs) around weight management was required which included knowledge and understanding of behaviour change techniques (BCTs) and ways to broach sensitive topics without damaging the doctor-patient relationship (Dewhurst et al 2017).

I also conducted two further qualitative studies. The first explored the views of HPs when discussing weight with patients and the final study focused on patients' experiences of discussing weight with their HPs. Overall, I found that patients desired a patient centred approach that displayed empathy and sensitivity. On reflection, I can now see how findings from my research have influenced my practice e.g. I became aware of the qualities that patients appreciated and needed when discussing weight with their HP. I was therefore keen to upskill myself in these areas and embarked on training in motivational interviewing.

Despite having completed a PhD before I began my doctorate, I was still aware that we are all 'works in progress' and the importance of honing my research skills. I enjoyed attending the doctoral seminars on research methodology and learning new techniques (e.g. Interpretative Phenomenological Analysis) from my lecturers and fellow trainees. I shared my knowledge around qualitative research with my peers and found I could help build their confidence and reassure them after sessions. Within my placement I was also asked to share my expertise in qualitative methods by delivering a training session to a group of researchers gaining valuable feedback from colleagues in the field of health psychology and presenting my research on weight management at a local university.

My research skills have also developed further since starting my placement e.g. I have worked as a qualitative [redacted] I have also undertaken several external reviews of grants, within the field of health psychology, as well as supervising at level 8.

Health Psychology Interventions

As part of my professional training, I delivered both a face to face (F2F) and a non-face to face (NF2F) intervention. Both clients were recruited within my placement via a university-wide menopause support page. For both interventions I was responsible for the assessment, formulation, intervention and evaluation. My F2F intervention focused on menopause and weight maintenance and the NF2F intervention on snacking behaviour, physical activity and weight management for menopausal women. I was initially nervous about delivering the health psychology interventions as it had been thirteen years since I had worked in a patient focused role. However, the skills I gained working for [redacted] (an NHS weight management service) conducting assessment and formulation, provided me with valuable expertise and I found both interventions extremely rewarding, gaining confidence as the sessions progressed.

On reflection although both interventions were effective for each client, I felt that the F2F intervention was the most successful. Firstly, the client was ready for change (e.g. the 'preparation stage' of the stages of change model (Prochaska & DiClemente, 1983) and she was focused, insightful, open and reflective. Secondly, being present with the client facilitated rapport and it was easier to gauge body language, mood and understanding (Irvine et al 2020). This was beneficial as I often found she studied the BCTs we discussed, began implementing them between each session as well as teaching her partner. During the last session, I arranged to meet my client in two months and then six months to check on her progress, both meetings were very positive. Unexpectedly, my client then emailed me 9 months later providing a detailed overview of her excellent progress and her continued weight loss.

In contrast, I delivered all the sessions via teams with my non F2F client and this sometimes acted as a barrier to communication (hindering verbal and non-verbal cues) potentially affecting the therapeutic alliance (Mohr et al 2012). Moving forward I would be keen to apply a 'hybrid' approach perhaps holding initial sessions in person and then moving to online. This ensures that individual sessions are tailored to the needs of the client which is always fundamental (Wentzel et al 2016).

Teaching and Training

Teaching is a substantial part of my role in my placement and prior to academia I was a teacher for 10 years, I therefore felt most confident with this competency. For my teaching competency I planned, designed and delivered a training programme of 5 sessions to a range of audiences around 'clinical communication within the field of health psychology'. I learnt a great deal such as not being reticent to gain feedback from students and that peer observation was not always congruent with your own personal perception of a teaching session. I became aware of ways to improve e.g. including tasks that can be omitted if timing is an issue. I have now implemented these into my lectures and have gained increased control when timing is challenging.

Aside from the sessions I delivered for this doctorate my teaching skills have developed in a number of positive ways. Firstly, I have taken on my first PhD student in the field of health psychology. Being a student again has reacquainted me with all the vulnerabilities you experience when you are learning and the guidance and mentorship you need to thrive. I have learnt from my supervision sessions how to supervise others, and I know these have enriched me as a supervisor, lecturer, a mentor and ultimately a health psychologist.

Secondly, I have been assigned a new module leadership role which focuses on the use of cognitive behaviour assessment and treatment planning in the field of clinical and health psychology. Fundamental to this is the development of students' confidence and problem solving in applying health and treatment planning using assessment and formulation. Conducting my own interventions using detailed assessment and formulation has provided me with an applied understanding of this process and 'live' 'in situ' examples to work with. These have undoubtedly enriched the teaching I conduct, helping create a more engaged learning environment (Su & Wood, 2012).

Consultancy

Consultancy was not something that I had done before e.g. delivering to an external client in the field of health psychology. I was fortunate to secure a paid opportunity to deliver a bespoke session on behaviour change training to a group of lifestyle coaches employed by a community leisure facility. I encountered a number of challenges both positive and negative. Firstly, I had to develop a contract, I found the legal terminology demanding and was undoubtedly out of my comfort zone. However, on reflection I gained valuable experience, and I would be less daunted by this task in the future.

Prior to delivering my consultancy I met with my client on multiple occasions to discuss what she needed and my area of expertise. In hindsight the importance of this relationship was paramount to the success of the consultancy. During these meetings we built rapport and trust and when I delivered my consultancy my client attended the session to support me, despite personal challenges of her own (Belkhodja et al 2012). It was apparent to me that many of the skills essential to good patient care such as empathy, effective listening and trust (Norfolk et al 2007) were relevant to consultancy and that the relationship building prior to delivery was as important as the delivery itself.

Working outside academia provided me with valuable insight into the delivery of health care interventions in the community. All the lifestyle coaches delivered weight management advice to clients but had received no formal training in BCTs and came from diverse backgrounds such as dancing and physiotherapy. As a health psychologist, it was important to work on the 'cliff face' in a community setting and it is something I would like to do more of in the future. However, there were some challenges; for example, the venue was noisy and the internet connection temperamental. In academia you are provided with reliable facilities to deliver your sessions, this was not something I anticipated sufficiently but will in the future. On reflection, the skills I gained working directly with the lifestyle coaches, particularly in behaviour change, were crucial when facilitating both my interventions. I was able to teach both my clients the key BCTs to help maintain their weight and in turn they used these techniques with their partners.

Professional competence

Reflection has been a key part of my development as a trainee health psychologist and something that I have enjoyed doing. I have always been a reflective person, but I found that using Gibbs' Reflective cycle (Gibbs, 1988) finetuned this process by providing more 'structure' and 'purpose' e.g. by reflecting in action and on action (Schon, 1983). I have also extended this by reflecting on the impact on others and self (Lavendar, 2003).

I also found reflecting with others beneficial. For example, we had doctorate teaching sessions where we shared challenging situations and sought opinions and perspectives from our peers. Consequently, this encouraged me to confide in my colleagues (Binks et al 2013) and is something I will make a more focused effort to do in the future.

Despite the benefits of reflection, especially in new or difficult situations (Mann et al 2009) there were times during my doctorate, and at present, when I found it too challenging to reflect as I was still trying to process the enormity of the situation (Nolen-Hoeksama et al 1993). In the last eighteen months both my parents and my [redacted] mother passed away in March 2025. I accepted that at this stage it was acceptable not to reflect but for several reasons decided to make some brief notes. Firstly, I know it can be therapeutic to write things down (Pennebaker & Graybeal, 2001) and secondly, I thought it may be helpful to reflect on these things on a deeper level when I felt better equipped to do so.

I also found it beneficial to read the reflections of others. Within my placement I was asked to assess a reflective practice assignment which were trainee associate psychological practitioners' reflections on their work experience in the NHS. These trainees used reflection to appraise their difficulties with clients and 'working through' this process helped them manage their own self-care (Fisher et al 2015). I also realised that I was preoccupied with reflecting when things went wrong, were emotional or challenging. Moving forward I need to also reflect when things work well, and feedback is positive. When I received a positive email from my intervention client outlining her continued progress I concentrated closely on what it was about the situation and sessions that made them successful. I know this will help my development, self-care and resilience as a health psychologist (Carmichael et al 2020).

Professional skills

Systems for Legal, Ethical and Professional Standards in Health Psychology

As a health psychologist, it is imperative to be familiar with and adhere to key guidelines to maintain legal, ethical and professional standards and to follow the HCPC (2024) and BPS (2017) codes of conduct. In my work placement I consistently undergo mandatory training in legal standards for example safeguarding and GDPR. As a lecturer I am responsible for reviewing ethics applications ensuring both undergraduate and postgraduate students adhere to BPS guidelines in the field of health psychology (BPS, 2021).

A key ethical situation I encountered was during the recruitment phase for my group intervention when it became apparent that one client had complex needs in comparison to the others. Eating disorders were not within my area of expertise and I suspected my client may have needed a safe space to discuss sensitive issues and a group setting would not provide this. It also may have posed problems for the other group members or threatened the client's privacy. After a gentle conversation we agreed that this intervention was not suitable for her and I signposted her to a relevant charity to provide interim support. I learnt that it is always important to reflect, especially when you feel an inner pressure to help a client. In these situations, it is critical to work within the limits of your knowledge and skill and to minimise risk for the client (HCPC, 2024).

[redacted] On reflection, I think it would have been possible to emphasise the severity of the situation whilst still protecting the student's confidentiality. It made me reflect on the personal information I receive in my work placement and potentially as a health psychologist in a multi-disciplinary team. It is vital to adhere to strict rules of confidentiality to protect your client and to make it clear from the onset how information about them may have to be shared with others, this is vital to protect client's privacy and dignity (HCPC, 2024).

Providing Advice and Guidance

I have provided advice and guidance to students, work colleagues, lifestyle coaches and clients. A situation occurred when I was asked for advice by a senior public health officer. She had been tasked with evaluating existing weight management services in her community and as a trainee health psychologist she was eager to know what aspects of weight loss interventions were effective.

I was able to discuss key factors that influence the efficacy of weight loss interventions such as the HP-client relationship, the sensitivity of the topic and any negative experience of clients with HPs prior to the intervention (Dewhurst et al 2016: Warr et al 2020). From personally delivering weight loss interventions, I was able to share my knowledge around the pertinence of specific evidence-based behaviour change techniques (BCTs) such as self-monitoring and goal setting as well as the utility of incorporating motivational interviewing (MI) techniques such as rolling with resistance and reflective listening (Barnes & Ivezaj, 2015). 'Upskilling' lifestyle coaches, who had received no previous training in BCTs or MI, may well prove cost effective and efficacious in the future (Dietz et al 2015).

In addition, I give advice to students on a regular basis within my placement. For example, a student contacted me as they wanted to pursue a career as a health psychologist. I arranged a meeting with them and spoke to them at length about the MSc in Health Psychology, the professional doctorate and conducting a research focused PhD. [redacted] on the MSc in Clinical and Health Psychology a role that involves providing advice and guidance. I am always keen to encourage students to achieve their goals and encourage the next generation of health psychologists.

Communication Skills in Different Contexts

Effective communication is fundamental to our role as health psychologists and is critical when working with patients, students, HPs and colleagues (Byrne & Curtis, 2000). As health psychologists our knowledge and understanding of psychological techniques can help us 'sharpen our lens' and communicate more effectively. These can include strategies such as person-centred care (Byrne et al 2024) MI (Miller & Rollnick, 2002) and understanding how patient beliefs can influence behaviour (Leventhal, 1998). As health psychologists we should be able to adapt the way we communicate to meet the individual needs of clients.

Within my placement I have had to alter my communication skills to specific student groups. For example, I teach an introduction to health psychology lecture at foundation level and focus on what health psychology is and provide a brief history. I also focus on skills a health psychologist may need such as healthy conversations skills which could be considered a 'light form of MI'. In contrast to MI (which I would teach to a more experienced audience) this is more practical, detailed and less complex (Hollis et al 2021). I am also mindful of the language I use so I avoid complex psychological terminology and integrate short activities to demonstrate the behaviour. In contrast I teach on a year 3 clinical and health psychology module which focuses on patient cues and concerns during clinical interactions. Students undertaking this module are familiar with advanced terminology, models of health psychology and are asked to critically analyse the research literature which we then discuss in the session. I therefore adapt my language accordingly and the tasks I choose to deliver.

I also tailored my communication when working with my consultancy client. For example, I utilised many of the techniques I use as a health psychologist such as goal setting and active listening (Appelbaum & Steed, 2003) as I know these are considered central to consultancy effectiveness (O'Driscoll & Eubanks,1993). I was also aware that my client was from a different organisation, with specific 'frames of reference' (Sutter & Kieser, 2019). I therefore spent time learning about the client's organisation and focusing on 'mutual communication connectedness' (Sutter & Kieser, 2019, p.271).

Finally, I was recently involved in an [redacted] which involved writing for a completely different audience. [redacted] are specific about what they need, e.g. they want applicants to be explicit about the research benefits to patients and the NHS. I had to develop an in depth understanding of what the [redacted] and an in-depth rationale and justification of the research design. I also had to make sure my writing style was clear and suitable for a wide range of reviewers.

Team Working.

As health psychologists we have a responsibility to bring our knowledge of communication to different teams, to work effectively with team dynamics and to manage with compassion and empathy (Kelloway & Barling, 2010). These amongst others, are fundamental aspects of team leadership. Within my placement I have a module leadership on the psychology undergraduate course and one on the master's in psychology conversion. Both involve leading and coordinating different teams, with colleagues of varying experience and in different subject areas. My role is to ensure a smooth and effective delivery of the module for both staff and students.

A situation occurred recently when I acquired the third-year module. I initiated a meeting with my colleagues to discuss the prospective year and to get to know my team members. Certain team members were not comfortable delivering certain lectures suggesting they would be happier teaching within the limits of their skill. In consultation with the team, I switched the lectures so both the clinical and health psychologists could teach in their area of expertise. I was also aware that members of my team had varying work commitments. Some were practising clinicians with busy external roles in the NHS and worked one day a week whilst others were full time members of staff. [redacted] In response I emailed the team promptly giving advanced notice of key deadlines and exam preparation and divided the work equally between my colleagues. I also made it clear that they could contact me if they were struggling with workload thus keeping open channels of communication.

[redacted] I have also learnt to set parameters with clients for example 3 months after my intervention had concluded my client emailed me to request a meeting about her progress and suggested we met up a local coffee shop off campus. On reflection, I felt it was more appropriate to meet her on campus, so we met at the university instead.

On reflection, when I was initially assigned these roles, I found it challenging but my confidence has grown over time. On a personal level I have reflected on my previous roles in different teams and tried to adopt the qualities and strategies of leaders that I have admired and respected (Meyer et a 2016). I know it is important to gain a holistic understanding of each team member (Engel, 1977) e.g. you need to understand the group's strengths and concerns to be an effective leader (Kahn, 2025).

Finally, I am also a member of multiple module teams, courses and support groups within my placement. Being a team leader has provided me with increased clarity e.g. I am now more aware of the key qualities I appreciate in my own team members 'organisation, empathy and flexibility' (Driskell et al 2006) and I try and emulate these as much as I can to help the team leader and my colleagues.

Service users and Carers.

In my work placement I frequently use feedback from service users (e.g. students) to inform change. This is conducted informally after teaching from staff-student liaison meetings and when students complete their module evaluation form at the end of each semester. When evaluating the module students provide detailed feedback about its content, areas they have found useful and aspects that could be improved and it is my role to respond to any changes required. During my doctorate some students suggested that written feedback was too lengthy (Bailey & Garner, 2010). According to Rae and

Cochrane (2008 p.217) quality of assessment feedback is critical, should focus on 'growth rather than grading' and is integral to student motivation and learning (Gibbs & Simpson, 2004). I therefore decided to move upcoming assessments to audio feedback. Each tutor had 3 minutes to record their feedback and identify key strengths and ideas for improvement which is viewed as good practice (Gould & Day, 2013). The response from students was very positive and they described it as more 'personal' and detailed. They enjoyed listening to the tutor's 'tone' of voice and suggested it motivated them more to make the changes required.

A further incident occurred when I used student feedback to adapt my teaching content. I was conducting an undergraduate seminar about BCTs. After the seminar, students commented that they found real-life scenarios useful and that working in groups gave them the opportunity to discuss and identify BCTs that were relevant. I therefore decided to adapt my teaching materials for a forthcoming lecture with public health students and contacted the course lead to identify which situations students found the most challenging. I then utilised scenarios that were relevant to them in their specific careers e.g. for GPs it was conversations around lifestyle change.

During the doctorate I received positive feedback from service users during a group role play where they commented favourably on my communication skills. Throughout my mother's illness I liaised with multiple agencies, the local GP, the district nurses, carers and a charity that offered psychosocial support for patients with cancer. My mum's GP spoke to me face to face and said my care had been 'exceptional'. Being a carer altered my perspective as I was now on the 'the other side' and highlighted the importance of keeping open communication with many different agencies to help your patient. During both interventions I also shared the formulation with both my clients and was careful to listen attentively, amend with their input when needed and tailor the sessions as they progressed. Finally, I have actively involved service users in my research interviewing 25 patients on their experiences of consultations with health professionals. I have also been involved in Public and Patient Involvement groups where I used the perspectives of service users to inform the feasibility, design and the needs of the 'patients' (Rayment et al 2017). All these experiences involving service users and carers have helped me develop as a health psychologist.

Issues Associated with Equality, Diversity and Inclusion.

Within my placement, my institution has an Equality, Diversity and Inclusivity policy which covers the nine key characteristics of the Equality Act (2010). This ensures that both staff and students obtain fair treatment. As a trainee health psychologist, I adhere to this and have completed all relevant training on diversity in the workplace. I am committed to treating all people equitably, in particular, groups that encounter inequalities.

Part of my role is to design my teaching materials to suit the needs of students with a range of learning difficulties. For example, I taught a deaf student in my health psychology seminars. I liaised with the sign language interpreter and the student prior to the sessions to identify which strategies the student found the most helpful, ensured all the materials were available on blackboard a week in advance and all the videos were captioned. I also made sure my face was towards the student when teaching and kept my slides on for a longer period as it can be challenging for deaf students to study the visual aids and lip read at the same time (Lima et al, 2025).

I have also adapted my teaching style to be inclusive to students with attention deficit hyperactivity disorder (ADHD), making sure I incorporate activities such as frequent short quizzes rather than longer tests, varying my teaching methods and providing regular breaks (Álvarez-Godos et al 2023). I am also aware that some of my lecture material contains sensitive topics such as anxiety, weight management, patient cues and concerns and long-term health conditions. Although teaching students about a range of conditions raises knowledge of diversity and helps tackle stigma, I always place an advanced notice on the blackboard page and insert a slide at the beginning of the lecture warning students that some content may be sensitive. This ensures they are free to leave at any point or contact a member of staff if they so wish (Hulme & Kitching, 2017).

Finally, when designing both my interventions I chose to focus on women in menopause who work in the higher education sector. There is still much stigma around the menopause and a paucity of workplace assistance (Cowell et al 2024). I was therefore keen to foster open and inclusive conversations and support women with their weight, something that is often a major concern (Kracht et al 2022). I also researched the menopause extensively to ensure the strategies I proposed were suitable, and that I was aware of the challenges my clients might face e.g. setting realistic weight loss targets and equipping women with pertinent behavioural change techniques to achieve long term weight maintenance (Leitão et al, 2024).

Engaging in Continuing Professional Development (CPD).

Continual professional development (CPD) is now seen as a fundamental way to identify and develop key learning needs and skills (Karas et al 2023). The HCPC require that all health psychologists should continually strive to learn and develop (HCPC, 2022). During my time as a trainee health psychologist, I have taken part in both mandatory and self-directed training. Within my placement I have engaged in mandatory courses which include safeguarding, harassment and diversity in the workplace. I have also attended health psychology conferences and the interprofessional education day at Staffordshire University. I have pushed myself to engage in a number of professional activities within my placement, for example, I was asked to be an internal examiner for a [redacted] and I have conducted a grant review in the field of cancer screening. On reflection I can now see that I have been in a 'professional rut' and that reflection during my doctorate has helped me break this cycle. I have taken opportunities that prior to the doctorate I would have been hesitant to do so gaining further insight, confidence and knowledge in my subject area.

I have also been keen to 'upskill' myself and taken part in self-directed training such as a 3-day course on Motivational Interviewing in Cardiff led by Stephen Rollnick. I have used these skills in my placement, my consultancy and both interventions. I also enrolled on the Making Every Contact Count course for healthy conversation skills and have attended courses within my placement on anxiety, compassion focused therapy, mindful eating and panic disorder. I am also a member of the Psychological Professions Network in the Northwest of England and have attended two of their online conferences. Finally, I continually engage in reading and constant self-reflection as evidence suggests that this is a valuable training activity (Haarhof et al 2015) and can help maintain professional and ethical standards (Fisher et al 2015). In the future, I would like more training in Acceptance and Commitment Therapy as evidence suggests it is useful tool within the field of health psychology (Gundy et al 2011).

Organisational and Systemic Issues.

During my time on the professional doctorate there have been a significant number of organisational and systemic issues within my placement. [redacted] At present, I only have one fellow health psychologist and, in the year approaching 2026-27 there will only be me. I have seen former colleagues flourish in departments [redacted]. In the meantime, it is now more important than ever that I actively connect with health psychologists in other universities and forge new connections in the NHS and private sector.

I have also witnessed the dissolution of the Trainee Associate Psychological Practitioner course, the MSc in Health Psychology and the removal of several undergraduate modules in health psychology within my placement. [redacted] I find it very disheartening that students are no longer provided with a thorough grounding in health psychology and that the opportunities to encourage the next generation of health psychologists are slowly eroding. Without these platforms it will be a constant challenge to grow the profession.

I have also witnessed other systemic issues in different organisations including several in the NHS. For example, I enquired about a weight management post in an NHS trust in [redacted] After speaking to the Clinical Psychologist, she stated that the post was only available to Clinical Psychologists, although she did not understand why. She said that the commissioner was hesitant to advertise to health psychologists as he 'did not know very much about the health psychology doctorate course'. She asked me if I was willing to come and speak to the commissioner about the content of the doctorate, I agreed but nobody has contacted me since. Furthermore, a trust in [redacted] advertised a post as a weight management practitioner with a direct focus on using behaviour change techniques and motivational interviewing. When I inquired about the role, I was told the role was 'dietician led'. This was disappointing as I know weight management interventions are more effective when they are psychologically informed and we work together across disciplines (Moffat et al 2018). Health psychologists are ideally equipped to deliver weight management interventions and affect change. Disappointingly, there seems to be a long way to go.

Development as a Health Psychologist.

Prior to the professional doctorate I conducted a research focused PhD and then went on to work as a health psychology lecturer, consequently, most of my experience has been in the area of teaching and research. However, since starting my doctorate I have developed as a health psychologist in a number of significant ways. Firstly, I have performed both a F2F and NF2F intervention with different clients and enjoyed this immensely. I conducted a detailed assessment, formulation, intervention and evaluation with both clients over a significant number of sessions. I have implemented psychological BCTs 'in situ' and received positive feedback.

I have also further developed the 'softer skills' that are so pivotal when working with clients. A plethora of literature suggests that the success of any intervention is reliant on the therapeutic alliance (Lwin et al 2025) and working closely with clients has highlighted the importance of empathy and warmth (Nembhard et al 2023). In the future, I would be keen to conduct interventions with clients and work in a multidisciplinary team with other HPs. I now feel I have the confidence to do so.

I have also negotiated a consultancy opportunity with a client, been responsible for designing a contract, developed a training session and delivered this to a group of lifestyle coaches. Despite having no previous experience in this area, I now have the ability to work autonomously and would be keen to do so in the future.

Finally, I have also developed my existing skills as a health psychologist and feel more confident as a researcher and a lecturer. I feel 'practising' as a health psychology trainee has given me a new perspective as a lecturer as I can provide 'real world context'. I now feel more confident to teach HPs both in formal and informal settings.

Conclusion

I have enjoyed my time as a trainee Health Psychologist immensely and have witnessed significant change within my placement; on a personal level I have gained a unique perspective, as a carer looking in. Caring for my mother with cancer and my father with Alzheimer's, I can now see how my training frequently determined the decisions I made and has affected my overall development. As a health psychologist I understood the psychosocial impact of receiving a cancer diagnosis, so when no support was available to my mother and its necessity not even contemplated by the HPs we encountered, I was staggered. Care for cancer patients in the NHS is suboptimal with little attention paid to psychosocial support, the importance of patient centred care and the therapeutic alliance. In parallel there was little knowledge displayed around a biopsychosocial understanding of Alzheimer's, despite its potential to elucidate understanding of my father's condition, our family and the people that care for him. On reflection, I now realise more than ever that the biomedical model of health is still the dominant paradigm and that the need for health psychologists in the NHS, private sector and universities has never been greater. It is imperative that health psychologists play a key role in training health professionals and an active role in the NHS. I hope I can play a part in this in the future.

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Chapter 2: Research: From Design to Dissemination

In order to demonstrate my competence in this area I applied for, and received, recognition of prior learning (RPL) for the research competency and systematic review (see Chapter 3). My PhD focused on health professional-patient communication in relation to weight management and 3 qualitative studies were undertaken. The first was a systematic review and thematic synthesis of physicians' views and experiences of discussing weight management within routine consultations, the second was health professionals' experiences of discussing weight in patients with knee osteoarthritis and a final study focused on overweight/obese patients with knee osteoarthritis and explored their experiences of talking about weight with their health professional.

Thesis Abstract
Anne Marie Dewhurst
University of Manchester
30th September 2016

Degree Title: Doctor of Philosophy (PhD)

Thesis title: Health Professional-patient communication in relation to weight management

Background: Global obesity levels have doubled since 1980 and are expected to rise. It is associated with key health risks such as heart disease, some cancers and osteoarthritis and hence has considerable economic consequences for health care resources. Key policy guidelines recommend that all health professionals (HPs) should discuss weight management with their patients making every contact count. However, we know HPs find discussions about weight challenging due to lack of time, training and skills. Knee Osteoarthritis (KO) and obesity are inextricably linked and together with a rise in obesity levels and growing numbers of older citizens rates of KO are set to escalate. As obesity is the key modifiable risk factor for KO, discussions about weight are paramount. This thesis explored this relationship further from the perspectives of patient and HPs, focusing on KO as an exemplar condition where there is scope for improved weight management.

Methods: Utilising qualitative methods, three studies were undertaken. Firstly, a systematic review and thematic synthesis was conducted of published literature of physicians' views and experiences of discussing weight management within routine clinical consultations, not specific to KO. Secondly, HPs' experiences of discussing weight in consultations with KO patients through semi-structured interviews were conducted with 26 HPs. Interviews were audio recorded and analysed using TA. A final study recruited 25 overweight/obese patients with KO and investigated their experiences of talking about weight with HPs.

Results: Overarching themes were identified across the studies. Firstly, HPs are pessimistic about patients' desire to lose weight and their capacity to help them. Several factors lead physicians and HPs to be reticent to accept responsibility for discussions about weight. Within routine consultations and between HPs and KO patients, weight was viewed as a sensitive topic. Both HPs and patients recognized the difficult cycle of pain, reduced mobility and weight gain. Patients with KO desire patient-centred (PC) care but, despite HPs recognizing its value, they do not receive it. Both physicians and HPs lack communication skills in weight management.

Conclusions: The work undertaken in this thesis demonstrates that barriers preventing effective clinical interactions about weight identified in routine consultations still exist, even when two conditions such as KO and obesity are inextricably linked. Although HPs and patients hold similar understanding of these interrelationships and recognise the value of PC discussions, HPs struggle in effective behavior change talk. HPs expressed impatience with the efforts of their patients. To readdress this imbalance all consultations about weight should be PC. Both physicians and HPs were inadequately trained to discuss weight and patients' views supported this. HPs working with overweight patients should be trained in evidence-based behaviour change techniques and PC communication techniques to increase their confidence to support patients in weight management. Finally, health psychologists have the skills to both deliver and guide discussions about weight.

Outline of PhD thesis

Chapter 1 - Background: this chapter starts by providing a brief overview of my thesis and then focuses on obesity and the key guidelines. There is a brief outline of behaviour change techniques and the doctor-patient relationship.

Chapter 2 - Health professional-patient communication around obesity: this chapter provides a comprehensive examination of the most salient barriers to health professional patient communication around weight management focusing on health professional related barriers, health-system barriers and patient-related barriers.

Chapter 3 - Knee Osteoarthritis: this chapter provides a rationale for focusing this area of study on the field of knee osteoarthritis. It begins by explaining KO as a condition and its aetiology. It then explores the diagnosis of KO, symptoms and treatments. Key international and European guidelines for the treatment of KO are then discussed alongside the link between KO and weight management

Chapter 4 - General Methods: This chapter provides both an overview and extension of the methodologies that were chosen for the empirical work presented within the thesis. It also provides a summary of the key studies (aims and methods) within this thesis.

Chapter 5 - Physicians' experiences of discussing weight management within routine consultations: A systematic review and thematic synthesis. This chapter presents a thematic synthesis investigating physicians' views and experiences of discussing weight management within routine clinical consultations.

Chapter 6 - Health Professionals' views of discussing weight management with knee osteoarthritis patients: this chapter presents a qualitative interview study investigating health professionals' views of discussing weight management with knee osteoarthritis patients.

Chapter 7 - A qualitative investigation of perspectives of patients with knee osteoarthritis talking with health professionals about weight: chapter 7 presents a qualitative interview study investigating the perspectives of patients with knee osteoarthritis talking with health professionals about weight.

Chapter 8 - Discussion & Conclusion: this chapter presents a summary of the findings from across study 1, 2 and 3.

Chapter 3: Systematic Review

In order to demonstrate my competence in this area I applied for, and received, recognition of prior learning (RPL) for my systematic review. The following abstract provides an overview of my published systematic review and thematic synthesis of physicians' views and experiences of discussing weight management within routine consultations. This systematic review was published in the journal Patient Education and Counseling (Dewhurst et al, 2017).

Abstract

Objective: To systematically search and synthesise qualitative studies of physicians' views and experiences of discussing weight management within a routine consultation.

Methods: A systematic search of four electronic databases identified 11,169 articles of which 16 studies met inclusion criteria. Quality was appraised using the Critical Appraisal Skills Programme tool and a thematic synthesis conducted of extracted data.

Results: Four analytical themes were found: (1) physicians' pessimism about patients' weight loss success (2) physicians' feel hopeless and frustrated (3) the dual nature of the physician-patient relationship (4) who should take responsibility for weight management.

Conclusion: Despite clinical recommendations barriers remain during consultations between physicians and patients about weight management. Many of these barriers are potentially modifiable.

Practice implications: Improving training, providing clearer guidelines and placing a greater emphasis on collaboration between clinicians will help reduce barriers for both physicians and patients. In particular, more specialised training for physicians about weight management is needed to promote knowledge and skills in behaviour change techniques and ways to broach sensitive topics without damaging patient relationships.

Key words: weight management, patient-physician relationship, meta synthesis

Chapter 4: Consultancy in Health Psychology

Consultancy Case study

Section 1: Introduction

Consultancy can be defined as 'a formal relationship where one party seeks help from another, the consultant's role being to facilitate the process whereby both the consultant and client arrive at a mutually acceptable solution' (Earll & Bath, 2004 p.231). The British Psychological Society describe Health psychology consultancy as 'the use of specialist health psychology skills and knowledge to provide a service to an external business client, for example, public, private or third sector organisations' (BPS, 2015, p.37). The consultancy described in this report is a 90-minute bespoke training session on behaviour change techniques (BCTs). This was delivered to lifestyle coaches who were employed by a provider of leisure facilities. The report provides an outline of the consultancy process using the approach taken by Earll & Bath (2004) which focuses on the identification of the need for the consultancy, planning and negotiating the contract, establishing a working relationship with the client, evaluating the impact and consultant performance and finally a reflection and summary.

Section 2: The request and identification of the need for the health psychology consultancy

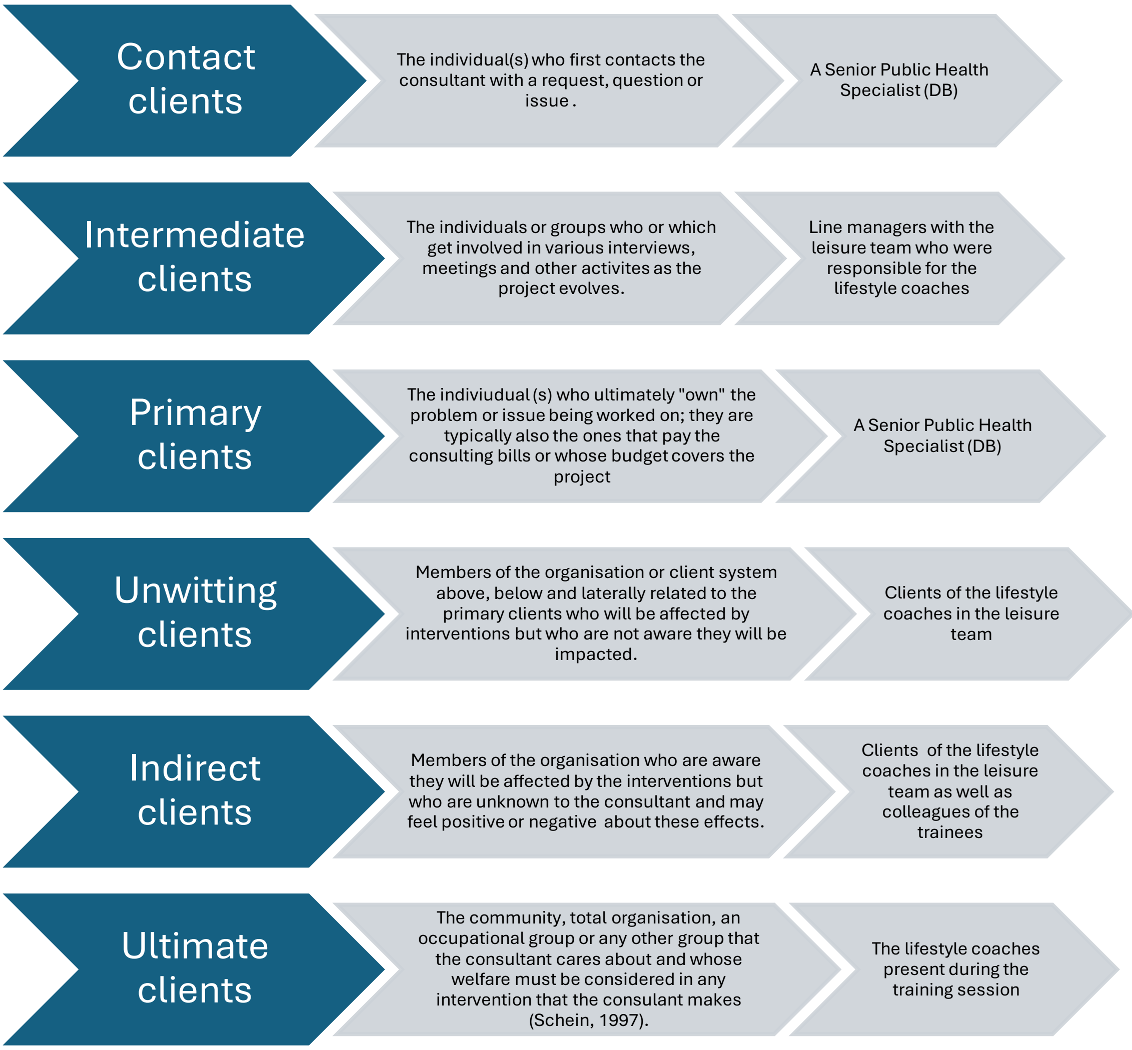
How the consultancy opportunity arose:

The consultancy opportunity arose by chance within my work placement. I was introduced to DB (the Client) a Senior Public Health Improvement Specialist based at a local county council. After a series of meetings and reviewing key documentation sent by DB. I noticed that many of the services were delivered by staff with various titles such as weight management coaches and exercise specialists. For the purpose of this assessment, I will identify them collectively as 'lifestyle coaches'. After extensive discussion with DB and subsequent meetings with managers of those services, it became evident that the lifestyle coaches had received no formal training in BCTs or patient centred communication skills. Consequently, DB asked me to deliver a bespoke session on BCTs to a group of lifestyle coaches.

The Client:

Within any consultancy process it is vital to provide a clear definition of the client (Appelbaum & Stead, 2003) as their role is pivotal (Schein, 1997). I followed the model by Schein (1977) (see Figure 1) which offers a simplistic overview of the six types of client. My 'contact client' (DB) was also my sponsor as she was my "main point of contact and facilitated access and permissions" (Earl and Bath p.234) to pertinent services. Earll and Bath suggest it is important to establish early on that your client has the authority to influence staff training and budget (Earll & Bath, p.234). DB was also the "Primary Client' as she was responsible for payment of the consultancy process. As the consultancy process progressed, I was introduced to my 'Intermediate clients' who were line managers within the leisure team and responsible for the lifestyle coaches within their specific teams. These 'intermediate clients' provided me with information about the different roles with their team and suggested further 'intermediate clients' (lifestyle coaches with the team) that I could then contact to discuss specific training needs. Finally, the 'ultimate clients' were my target audience for the intervention, the lifestyle coaches. Evidently, the consultancy process was interactive (Alvesson et al 2009) and encompassed a multitude of people rather than a single person (Arnaud, 1998).

Figure 1: An overview of the type of client relationships (Schein, 1997)



The consultant role:

The approach taken evolved as the consultancy process progressed. I Initially followed the approach of 'humble consulting' where I met with the client (DB) to 'figure things out' (Brady et al 2022, p. 864) accepting that I knew very little about the client's situation but eager to find out more (Schein, 1997). Schein (1977) suggests this is fundamental to both developing and maintaining the relationship. During this time, I met with DB six times and adopted the approach of being 'curious and committed' (Schein, 2016) as I wanted to find out what the client was focused on. During this process the Client sent me documentation outlining the weight management services under the remit of the council and a service evaluation (SE) of said services.

Identification of need:

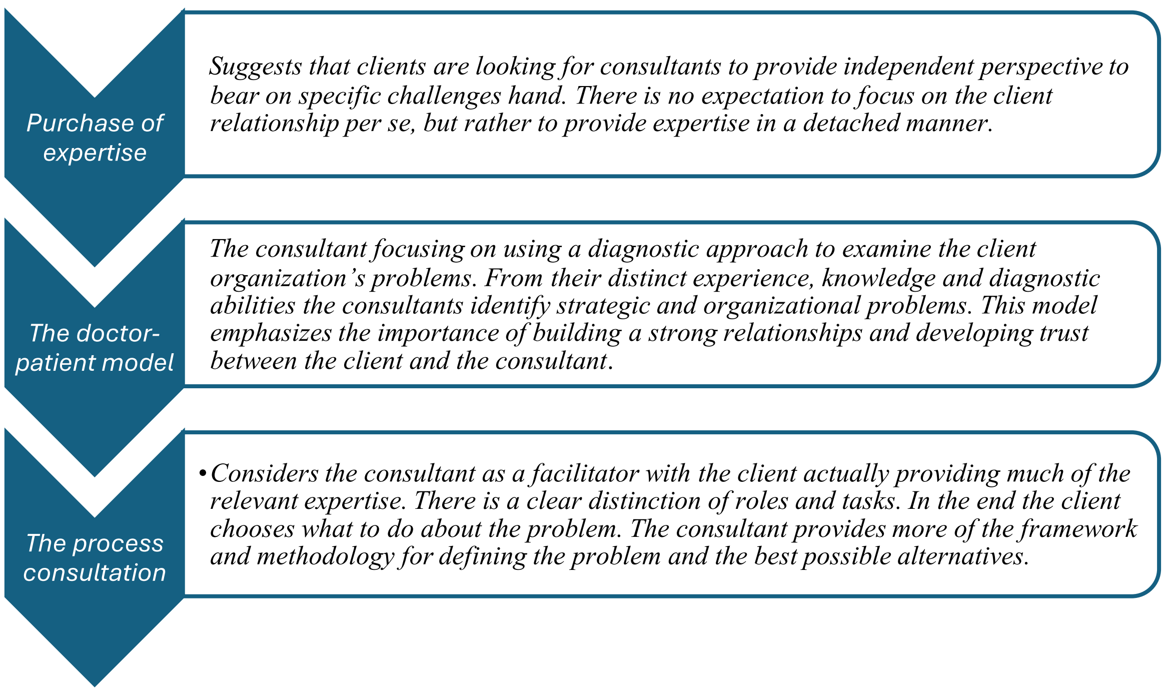
The identification of need took place gradually. During initial meetings with the Client we discussed the various types of roles that were responsible for delivering services around behaviour change in the council and it became evident that many of the lifestyle coaches had no formal training in BCTs. Further conversations with line managers supported this view. Furthermore, a recent external SE, given to me by the client, suggested a need for behaviour change training, particularly within underprivileged/deprived communities. Consequently, the SE indicated a training need and DB asked me if I could meet this need. I agreed and we targeted a service in a socially deprived area in the north of England.

Section 3: Planning and negotiating the contract.

Negotiating

I had seven meetings with DB over a six-month period. At the beginning, I adopted the role of a process consultant (Schein, 1988) (see Figure 2) where I focused on helping the client "to come to their own decision about the action to be taken to bring about change" (Turner, Robbins & Doran, 1996, p. 86). For example, the initial two meetings involved "dialogue" between the consultant and client (Turner, Robbins & Doran, 1996, p.86) where we discussed the needs of the service, and I adopted a 'not-knowing stance' (Anderson and & Goolishian, 1992). During the initial two meetings I followed Schein (Earll and Bath p. 237) by asking a series of open questions. In the second meeting I was given documents (an overview of the weight management services and a SE) to review. The third meeting was pivotal as after discussing the need for behaviour change training (as recommended by SE) the Client asked me to deliver 5 training sessions to leisure services in the north of England. I was hesitant to commit to this number of sessions. Firstly, my placement role and my commitment to the professional doctorate resulted in a limited number of hours to develop the deliverable. Furthermore, by overcommitting and then being unable to deliver, I risked damaging the client - consultant relationship, my credibility (Martinez et al 2016) and breaking the client's trust (Fullerton & West, 1996). Thirdly, I felt that it would be more practical and useful for me, and the Client, to deliver one pilot session where I could gain valuable feedback and adapt. Consequently, in the third meeting I adopted an open and honest stance with the Client (Fullerton & West, 1996; Kakabadse, 2006; Sharp & Hodge, 2011) and suggested that one bespoke pilot session would be more realistic and achievable than 5 and would ensure that future sessions were robust and tailored to the Client's needs. The Client was happy with this, although suggested that a 90-minute training session would be more appropriate than my original suggestion of 60 minutes. We then decided that a further meeting would be useful with different members of the lifestyle team (face to face) to discuss potential availability and training needs. A follow up (e.g. meeting 4) was then arranged via teams with a number of lifestyle coaches.

Figure 2: The 3 models of consultation according to Schein (1990)



During these initial meetings the Client also raised the topic of payment for the session. I thought it would be pertinent to spend time reflecting on this, so we agreed to discuss the fee in the next meeting. During this time, I was able to research the salary for a Trainee Health Psychologist in the National Health Service and calculated an hourly rate for my training development and delivery. I also allowed for other outgoings such as mileage for meetings and photocopying of key materials. I was fortunate that my Client agreed with the proposed budget of £500.00.

Planning

Planning is key to consulting success so during the first initial meetings the time frame for delivery was discussed with the client (Rynning, 1992). Earll and Bath (2004) suggest this is crucial to the output and affects whether you decide to accept the work and how you approach it. Initially, the Client was keen for the session to be delivered forthwith (e.g., late Spring, early Summer of 2023) but I was conscious that two months was not a realistic time frame and that the process would be lengthier than the Client anticipated. Firstly, I would need to have multiple meetings with the Client and intermediate clients (it may be a lengthy process to arrange these meetings) to ascertain key information. I would also have to read relevant documentation about the services, discuss these with my Client (Earll & Bath, 2004) have my contract approved prior to the training session and would need time to develop the bespoke session. This would be in addition to my work placement commitments. I therefore suggested to the Client that late summer was more realistic, and DB was happy with this. However, there was a delay over the summer period (due to the Client and Consultant taking leave) which meant as the meetings progressed, we decided that the original target of late summer 2023 was now unrealistic for a number of reasons. Firstly, the contract needed to be signed prior to delivery and this was going to be challenging during the late summer period as I was on leave and so were members of staff who needed to approve it. Secondly, I needed to meet with both managers and members of the leisure team prior to planning my session and the delivery. Finally, I needed to make revisions to my initial contract submission which caused a further delay. These circumstances, combined with personal illness resulted in the training session being delivered in November 2023 as opposed to late summer. I therefore arranged a meeting with the Client and explained the situation in detail (Belkohodja et al 2012) and was fortunate that DB was agreeable to the date being pushed back. Finally, although I was upset that there was a delay for the Client, I felt that the open and honest dialogue we had established from the onset as well as the good Client-Consultant relationship resulted in my client being understanding about the delay.

On reflection, I am aware that my client was understanding and that this may not always be the case. In the future, I would have to be prepared to negotiate with rigid clients and having the ability to do so is crucial within consultancy (Lubit, 2004). I am grateful that my client was amenable, but this does not mean I cannot learn from, reflect on and use strategies from previous experiences in my work placement or other roles to address problematic behaviour.

Finally, in addition to planning the meetings with the contact client and primary client (see Figure 1) I designed a 90-minute bespoke training session on BCTs. When I was planning the teaching methods and content of the session, I was mindful that opportunistic delivery of BCTs can be challenging for practitioners due to perceived low self-efficacy (Bull et al 2017; Keyworth et al 2019). Consequently, I began the training session by providing a solid rationale for the importance of BCT delivery (see Table 1) and designed exercises that would build confidence in the trainees using the concept of scaffolding (Van de Pol, 2010). For example, I identified 5 BCTs that would be applicable to lifestyle coaches (working in weight management or exercise referral) (see Table 1). I felt 5 BCTs was a suitable number to deliver in a 90-minute period (Mullan et al 2022) whilst being an adequate number to use with clients after the session. I then gave them exercises to problem solve in pairs so they could develop their skills gradually by problem solving together. When designing content, scenarios were tailored to their specific roles e.g. weight management and sedentary behaviour. I also used a variety of teaching methods to encourage active participation (Lujan & DiCarlo, 2006) such as pair work, group discussion and role plays using the BCTs (Analoui et al 2012). Table 1 therefore provides a step-by-step overview of how the key content was planned and the rationale behind the content.

Table 1: To provide an overview of the planning of the bespoke training session around BCTs.

Steps	Key Content within bespoke training session	Resources/rationale behind the chosen content
S1	90-minute training session to 6 lifestyle coaches	
S2	Established rationale for the delivery of a bespoke training session on behaviour change techniques (BCTs) to lifestyle coaches.	Making Every Contact Count (MECC) (Health Education England, 2018) and the National Institute of Health and Care Excellence (NICE, 2007) propose delivery of BCTs, plus HPs generally have low confidence when delivering these (Bull et al 2019, Keyworth et al 2019).
S3	Identified the BC Taxonomy and then identified 5 BCTs that demonstrate efficacy with weight management and physical activity	Michie's Taxonomy Howlett et al 2017 (systematic review) McGirr et al 2017 (systematic review) Samdal et al 2017 (systematic review) Schroé et al 2020 (randomized controlled trial).
S4	Exercise 1: Lifestyle coaches complete the charts in pairs to facilitate understanding of the 5 BCTs	Exercise 1: worksheet (Behaviour change exercise blank template) Exercise 2: worksheet (Behaviour change completed template).
S5	Exercise 2: Lifestyle coaches work in pairs to prepare a dialogue that incorporates 3 BCTs that are appropriate for the case studies.	To help lifestyle coaches with practical methods that work (Bull et al 2019). Active learning techniques such as group discussions about cases and tailoring scenarios help learners construct meaning from new information (Michael, 2006) and encourage deeper information processing (Bull et al 2019) (Craik & Tulving, 1975).
S6	Incorporate the BCTs with person- centred communication (PCC) Exploratory exercise to demonstrate how PCC can help both the facilitator and the client.	"The "what" and "how" of behaviour change" (The Scottish Government, 2010).
S7	Role play chosen on weight management so the lifestyle coaches can identify with the scenario and observe techniques that can help them deal with challenging interactions.	You tube video which shows an interaction between an overweight patient and their HP. The client is angry because he has been kept waiting.
S8	Introduction to PCC and provide lifestyle coaches with examples of PCC	Chosen as these are person centred techniques (Kaner et al 2013; Miller & Rollnick, 2012).
S9	Exercise 3: lifestyle coaches role play with each other now incorporating both the BCTs and a maximum of 2 patient centred techniques	Behavioural practice and rehearsal (8.1) BCT (Michie et al 2013).

S10	All lifestyle coaches are encouraged to practice the BCTs on themselves and their colleagues as evidence suggests that this aids proficiency in delivery with clients.	Behavioural practice and rehearsal (8.1) BCT (Michie et al 2013).

Section 4: Establishing a working relationship with the client and delivering the consultancy.

The strength of the relationship between the client and consultant is the "foundation stone" (Cope, 2010, p. 28) of the process. I therefore focused my efforts on building rapport and establishing trust, factors fundamental to the client-consultant relationship (Fullerton & West, 1996). I followed a development stage model as outlined by Stumpf and Longman (2000). After my first "chance meeting" with the client (Stumpf and Longman, 2000, p.125) and discussing our shared interests, we exchanged contact details. I then contacted the client and arranged to meet her in an informal setting. The first meeting between the client and consultant is pivotal (Kakabadse, 2006) and can help both the client and consultant feel relaxed, yet still maintain professional boundaries (Sharp & Hodge, 2011). The initial focus was for me to be a "ready receiver" (Stumpf & Longman, 2000) so I invested time listening to the client, asking open questions, and reflecting on key issues that were mentioned during conversation. These initial meetings also overlapped with the next "conversation stage" (see Table 2) where I gained knowledge around the different services under the remit of DB and started to conduct at "needs analysis" with the client.

In the second meeting the client provided me with key documentation about lifestyle change services as well as a recent SE that had been conducted by an external organisation. Reviewing this documentation, in conjunction with listening and reflecting, enabled me to identify "real and relevant client need" (Stumpf & Longman, 2000, p. 126). As the consultancy progressed, I arranged further meetings with the client and managers from the Leisure team as well as meetings with lifestyle coaches. Consequently the "needs analysis" stage took place over a four-month period and lasted longer than I initially anticipated. In the final stages of "engagement" I was able to offer a bespoke training session based on my competencies as a consultant (see Table 2).

Section 5: Evaluating consultancy impact and consultant performance.

My Client was distressed and needed to leave after the session, however, DB did provide some feedback at a later date. DB remarked that the session had 'upskilled' the group, that she was pleased with the standard, my level of communication, expertise and knowledge and would recommend me to other service providers. This was extremely pleasing.

Feedback from the trainees was gathered in multiple ways as this is the most effective approach to gather meaningful data (Mandouit, 2018). Post session, the group were asked to write down one positive aspect of the training and one item they would use in their role as a lifestyle coach. Pleasingly, many of them stated that knowledge around BCTs was beneficial to their role. Feedback was also gained via MS forms and emailed to me from the team leader. Overall, the comments were positive, especially considering the challenging circumstances, and lifestyle coaches mentioned the "interactivity" of the session. However, some members of the group did reflect on the problems experienced with the internet and that the session was a little rushed towards the end.

A number of things were positive during my consultancy. Firstly, my Client was supportive and attended the training session to introduce me and explain our consultancy journey. This was despite her own distressing personal circumstances. Furthermore, it was interesting to reflect on how my role as a Consultant evolved over time from my initial meeting with the Client in my work placement and being a "ready receiver" to delivering a training session and being the "sole vendor" (see Figure 3). I also enjoyed designing a session where the lifestyle coaches could benefit from "ready techniques' they could facilitate in their roles. Finally, I received positive comments from the trainees who found the session "enjoyable" and "engaging".

However, there were some challenging aspects, for example the internet was not functioning in the building when I arrived and despite arriving promptly it was an anxious time. My client also arrived extremely upset to the session and I made a decision that my Client came first. Consequently, my session started later than expected, and I rushed some of the key material at the end. There was also additional noise in the training room from an exercise class which was being held in the sports hall below. On reflection, all these variables had a considerable effect on the delivery of the session.

Moving forward I need to plan more effectively, e.g. checking the facilities in advance, asking about the reliability of the internet, the positioning of the training room and the timetable of activities around the room. In addition, it would be useful to bring printed copies of all the materials to the venue in case the internet fails on the day.

Figure 3: The Developmental Stage Model according to Stumpf and Longman (2000)

Stage	Objective	Means
Cold	"Ready receiver"	Show willingness to offer the prospective client something of personal or professional value
Conversation	Qualified vendor status	Knowledge of the company's situation, industry trends, and possible personal implications for the "ready receiver"
Needs analysis	Accepted proposal	Identify a real and relevant client need which the consultant is well qualified to address
First engagement	Differentiated vendor status	Superior performance, impact and working style
Enrichment	Preferred vendor status	Service provided, value added, the style or manner in which the service is provided, and the ability to connect to client's future plans
Sole vendor	Partnership	Demonstrate partnership value

Section 6: Reflection and summary

My initial experience as a consultant was rewarding and provided me with the opportunity to design and deliver a bespoke training session as an independent trainee health psychologist. I enjoyed the process of developing a relationship with the client from the initial meeting, identifying the needs of the client, designing the training session and the subsequent delivery and evaluation. We built a relationship of mutual trust and respect as the project evolved, resulting in the client being someone that I would be keen to work with in the future. I enjoyed liaising with a client external to academia, gaining insight into the delivery of health care interventions in the community. I also developed skills in contract building and planning the delivery using realistic time frames e.g. anticipating periods that can alter time frames dramatically. Finally, delivering this consultancy has given me the experience and confidence to deliver further sessions and I am eager to foster connections with both former and future clients.

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Consultancy Contract

CONSULTING AGREEMENT

THIS CONSULTING AGREEMENT (the "Agreement") dated this [date contract is signed] 2023.
BETWEEN:

[redacted]

(the "Client")

-AND-

Dr Anne Dewhurst of Staffordshire University, Stoke-on-Trent, Staffordshire, ST4 2DF

(the "Consultant")

1**. BACKGROUND:**

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

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

2. **SERVICES:**

2.1. The Client hereby agrees to engage the Consultant to provide the Client with services (the "Services") consisting of:

2.1.1. The design and delivery of one 90-minute bespoke training session on 'behaviour change techniques' to team members involved in lifestyle change within the county of [redacted]

3. **TERM OF AGREEMENT**

3.1. The term of this Agreement (the "Term") will begin on the date of this Agreement and will remain in full force and effect until the session has been delivered. It is subject to earlier termination as provided in this Agreement and it may be extended with the written consent of both Parties.

3.2. In the event that either Party wishes to terminate this Agreement prior to completion of the Services, that Party will be required to provide 10 days' written notice to the other Party.

4. PERFORMANCE

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

4.2. The Client will make herself available as practicable to answer any questions the Consultant may have to inform the delivery of the session.

4.3. The Consultant shall deliver the Services within the county of Lancashire at a location agreed upon with the Client.

4.4. The Client and Consultant agree to give reasonable notice to the other party for any period of holiday, sickness or other absence during which they are unable to perform their duties relating to the Services outlined in this Agreement or if this is to impact the Agreement in any way.

4.5. The Client will be responsible for ensuring that those people necessary for successful delivery of the Services are in attendance at events organised in order to achieve the Services.

4.6. If the Services, for which the Consultant has prepared and planned are cancelled with less than 2 weeks' notice, the Services will have been deemed to be complete and delivered successfully and paid for.

4.7. The Client will provide an evaluation of the Services delivered to the Consultant.

5. COMPENSATION AND REIMBURSMENT OF EXPENSES

5.1. The Consultant will be reimbursed a flat fee of £500.00 for the Services delivered.

5.2. This fee will include designing the session, travel, set up and delivery and any reasonable and necessary expenses incurred by the Consultant in connection with providing the Services under this Agreement.

5.3. Any expense claims submitted by the Consultant to the Client will be in accordance with the policies of [redacted]

6. LIABILITY

6.1. The Consultant does not accept liability for any action taken by those in receipt of the Services outlined in this Agreement.

7. CONFIDENTIALITY AND ETHICS

7.1. Confidential information (the "Confidential Information") refers to any data or information relating to the business of the Client which would reasonably be considered to be proprietary to the Client including, but not limited to, accounting records, business processes, and Client records and that is not generally known in the industry of the Client and where the release of that Confidential Information could reasonably be expected to cause harm to the Client.

7.2. 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.

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

7.4. The Consultant will comply with the British Psychological Society 'Code of Ethics and Conduct' (2021) and the Health & Care Professions Council Standards of Conduct, Performance and Ethics (2016).

8. INTELLECTUAL PROPERTY

8.1. It is envisaged that this work will involve the use of publicly available material, such as academic papers, information from public bodies such as the National Health Service, Office for Health Improvement and Disparities (OHID) or the National Institute of Health and Care Excellence. The Intellectual Property rights will remain with these original sources.

8.2. Any new material that is developed or produced under this Agreement, will be the sole property of the Consultant. The use of the Intellectual Property by the Client will not be restricted in any manner. The Consultant will provide the Client with electronic copies of all deliverables produced following delivery of the Services outlined in this Agreement.

8.3. The Consultant will be able to use any new Intellectual Property for the furtherance of any weight management research and practice for the ultimate health benefit of people in the United Kingdom and internationally.

9. RETURN OF PROPERTY

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

10. CAPACITY/INDEPENDENT CONSULTANT

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

11. NOTICE

11.1. All notices, requests, demands or other communications required or permitted by the terms of this Agreement will be given in writing and delivered to the Parties of this Agreement as follows:

11.2. Dr Anne Dewhurst, Psychology Department, Staffordshire University, Stoke-on-Trent, Staffordshire, ST4 2DF.

11.3. [redacted]

12. USE IN PROFESSIONAL DOCTORATE IN HEALTH PSYCHOLOGY

12.1. The Consultant is undertaking a Professional Doctorate in Health Psychology at Staffordshire University. The Client agrees that this contract, the content of the training session and a written reflective report of the consultancy will be submitted as part of the Consultant's qualification requirements.

13. MODIFICATION OF AGREEMENT

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

14. ASSIGNMENT

14.1. The Consultant will not voluntarily, or by operation of law, assign or otherwise transfer its obligations under this Agreement without the prior written consent of the Client.

15. ENTIRE AGREEMENT

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

16. TITLES/HEADINGS

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

17. GENDER

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

18. GOVERNING LAW

18.1. It is the intention of the Parties to this Agreement that this Agreement and the performance under this Agreement, and all suits and special proceedings under this Agreement, be construed in accordance with and governed, to the exclusion of the law of any other forum, by the laws of the Country of England, without regard to the jurisdiction in which any action or special proceeding may be instituted.

19. SEVERABILITY

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

IN WITNESS WHEREOF the Parties have duly affixed their signatures under hand and seal on [insert date when contract signed]

[redacted]

____

Dr Anne Dewhurst (Consultant)

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Chapter 5: Teaching and Training in Health Psychology

Teaching Case Study

Introduction

This teaching case study will detail how I planned, designed, and delivered a training programme consisting of 5 sessions to different learner groups, varying in size from 5 to 50 attendees. The learners included foundation students, undergraduates, postgraduates, and a range of health care professionals (HCPs) such as doctors, nurses, midwifes, paramedics and students training to be associate psychological practitioners. The training programme was conducted between February and June of 2023 (see Table 1). The teaching sessions were all related to the theme of 'clinical communication within the field of Health Psychology'. Teaching sessions focused on the biopsychosocial model of health and covered topics such as healthy conversation skills and the identification of cues and concerns within the health-professional patient relationship. A needs assessment informed the development of learning outcomes and the planning and delivery of the sessions. When planning the teaching sessions, I followed the model outlined by Van Diggele et al (2020) (see Figure 1) which focused on the key outcomes, the activity, and a summary of the key content to be addressed in each teaching session.

Table 1: Overview of teaching sessions.

Session and Date	***Title & delivery mode***	***Learner group, size & duration***	***Module/course***
Session 1 (S1) 7.2.2023	*Seminar support session on the biopsychosocial model of health/ formulation Mode: Face to face*	*Second year Psychology undergraduates Size: 5 students Duration: 1 hour*	*BSc Clinical Psychology module on Behaviour Change*
Session 2 (S2) 7.2.2023	*Lecture on Cues and concerns – the role of emotion in clinical communication Mode: Face to face*	*Third year BSc Psychology undergraduates Size: 30 students Duration: 2 hours*	*BSc Psychology module on Clinical Communication*
Session 3 (S3) 23.3.23	*Lecture on Introduction to Health Psychology: healthy conversation skills Mode: Face to face*	*Foundation year Psychology students Size: 35 students Duration: 2 hours*	*Foundation year students studying an Introduction to Health Psychology*
Session 4 (S4) (30.3.23)	*Lecture on Healthy conversation skills Mode: Face to Face*	*Health Care Professionals such as doctors, dentists and social workers and paramedics from a range of countries including Nigeria, India, Nepal & Pakistan. Size: 50 students Duration: 2 hours*	*Masters in Applied Public Health*
Session 5 (S5) (31.3.23)	*Workshop session to the Trainee Applied*	*Post graduate students Size: 20 students*	*Postgraduate diploma in Applied*

	Psychological Practitioners (TAPP) in Clinical Communication *Mode: Face to face*	*Duration: 2 hours*	*Psychological Practitioner*

Figure 1: OAS method for lesson planning and teaching 'Outcomes-Activity-Summary' (OAS) (Van Diggele et al 2020).

O *OUTCOMES* • *Consider the background knowledge of students* *Consider what you want the students to learn, understand, and be able to do by the end of the session* • *Establish your lesson goals and outcomes prior to the session* *Share the learning outcomes with students at the start of the session* • *Allow the students input towards the learning outcomes*
A *ACTIVITY* • *Design appropriate learning activities aligned with the outcomes* • *Plan the activities and how you will engage the learners* • *Plan the classroom environment and seating arrangements* • *Ensure students are active participants in the lesson* • *Ensure your lesson delivery is stimulating and you have the students' attention* • *Address students by their name, ask questions and get everyone involved to check their understanding* • *If clients/patients are involved, gain consent before participation*
S *SUMMARY* • *Ask students to identify one new point/knowledge/skill learnt* • *Summarise the content or skills covered* • *Complete the lesson with a take-home message and a self-directed learning task* • *Ensure the lesson finishes on time* • *Evaluate your own teaching and take on board feedback from students*

Assessing training needs

Pedagogical evidence suggests the importance of assessing learner needs (Pillay, 2002) to facilitate and maintain an environment that is learner focused (Dupin- Bryant & Du Charm-Hansen, 2005). For this I wanted to adopt a holistic approach so I followed the method outlined by Hartmann (2001) which states that teachers should reflect on the key aspects around their teaching such as "instructional goals, student's characteristics, needs, teaching strategies, materials and issues related to curriculum, instruction and assessment" (Hartman, 2001 p.149).

For S1 to S3 I had prior experience teaching on these modules so had consulted with the module leaders previously. However, I consulted other sources to assess current learner needs including the module handbooks which contained the learning outcomes, the assessment criteria and the key employability skills required. For S3 I was mindful that foundation students are sometimes unfamiliar and nervous about returning to education, and are often non-traditional learners (Askam, 2008). For this reason, I consulted with the S3 module leader again as well as colleagues who had conducted sessions with the same learner group, earlier in the semester. Consequently, it was suggested that students in S3 lacked confidence in the learning environment, so I adopted a more tailored approach, providing more support (Greenbank, 2007) and with an emphasis on enquiry-based learning (Wright, 2018).

As S4 and S5 related to formative assessment, I arranged a meeting with the respective module leaders as these were new cohorts that I had never previously taught. As S4 was not a course that was delivered within the School of Psychology, I was unable to access details (as I had no access to Blackboard) such as the number of students enrolled or the module handbook. For S5 this course was mainly delivered remotely via Microsoft (MS) Teams as students spent four days per week in clinical practice. However, I was able to consult with colleagues to assess any learning needs, access Blackboard and observe previous recordings of lectures via MS Teams. This was useful as it helped identify any learning needs specific to the course and learner group (Bell & Mladenovic, 2007). For S4 I was informed by the module leader that a range of HCPs would be present from different countries such as Nepal, Nigeria and India. Therefore, I discussed in advance which professions would be present, any language difficulties that I needed to be aware of, any possible cultural barriers and preferred learning styles (Hein & Budny, 1999). This is important as cultural sensitivity and being able to adapt your teaching style to the needs of the learners has been linked to student satisfaction (Zepke & Leach, 2005). In addition, the module leader also suggested that students in S4 had not received any previous lectures on behaviour change communication but were keen to learn these skills. I therefore consulted key documents to inform content such as the National Institute for Health and Care Excellence (NICE) and Making Every Contact Count (MECC) as these were established national initiatives to encourage HCPs to discuss behaviour change with patients.

Training programme structure and content

The content and structure of the training programme was determined by the learning outcomes and was also guided by Van Diggele et al (2010). This prompted consideration of key factors such as learner's previous knowledge, their session goals and what students needed to achieve by the end of the session (see Figure 1). For all the teaching sessions I followed a systematic approach and a structure outlined by Van Diggele et al (2020) for lesson planning and teaching (see Figure 1). However, both S1 and S5 were not formal lectures but workshop style sessions where I provided a brief outline of the session at the beginning, followed by a mixture of individual and group activity (Van Diggele et al 2020). I thought this was more appropriate as these sessions mainly focused on providing support for a coursework assessment. This assessment involved applying the biopsychological model of health to a chosen case study and producing a set of questions to inform a formulation. In terms of delivery, teaching methods informed the content. As S1 and S5 were workshop sessions, they were structured in a similar way. For example, they typically contained smaller numbers of students with a sharper focus on discussion, the exchange of ideas and role play. This informed the content as I adopted a more participatory/interactive method with the students (Ciobanu, 2018).

I also adopted a deep approach to teaching and learning (Asikainen, 2014; Biggs, 2003). For example, S1-3 were all university students, and the key aim was to prepare them for summative assessments at the end of the module. To achieve deeper learning, I utilised pedagogy that developed higher order critical skills (Asikainen & Gijbels, 2017). For example, I encouraged learners to work together collaboratively to engage with and question research literature (Robbins and Hoggan, 2019) and establish credibility (Mthethwa-Kunene et al 2022). The focus on deep learning was also pertinent with S4 and S5 as research suggests that deep learning can prepare students for the workplace (Lake & Boyd, 2015). In S4 and S5, learners were HCPs and trainee applied psychology practitioners, respectively, so the focus switched to embedding knowledge and practical skills around healthy conversation skills. I wanted to ensure that students had the opportunity to practice these skills in situ and observe their peers. Content was guided by evidence from various sources such as my previous research working with patients and health professionals (McLinden et al 2015) and examples from videos demonstrating clinical interactions between HCPs and patients. This was informed by knowledge of social learning theory which suggests that people learn by imitation and direct observation of role models (Bandura, 1971) and that observing target behaviour can increase performance (Woollard, 2010).

S1-5 was structured in line with Figure 1, for example, I provided a clear overview of the learning outcomes from the onset, I ensured that students had the opportunity to engage in multiple activities throughout the sessions and summarised the key points at the end of the lecture. Creating a clear and structured lesson plan is important for teaching and learning (Iqbal et al 2021) and can guide time management. It also ensures that a variety of different teaching activities and materials are utilised for the training programme (Chickering & Ehrmann,1996).

Although each session had a clear beginning, middle and end, the number of activities and length of activities sometimes varied in accordance with the size and needs and characteristics of the group. For example, in S2-4 I used regular quizzes at different time points to check learning and reduce lecturer talking time (Aljezawi & Albashtawy, 2015). In S1 and S5 these were used less as the sessions had a sharper focus on collaborative learning (Mthethwa-Kunene et al 2022). I also incorporated breaks into the sessions. For example, the sessions 2-5 were two hours in length and therefore it was important to schedule, so students were able to have classroom movement breaks. Regular breaks are beneficial for students and can increase attention and focus within the learning environment (Lynch, 2022). The learning environment also informed the structure and content, as sessions 1 and 5 were based in small teaching rooms where learners were seated around tables that encouraged informal discussion. In contrast, S2, 3 & 4 were lectures with larger numbers of students and held in lecture theatres. Therefore, a more didactic approach was adopted towards learning content (Berger, 1996).

Finally, in each session, I provided a summary of the content covered at the end. In S2-4 I asked students to write down one take home point from the lecture and one that needed further clarification. In S1 and S5, the groups were smaller, so learners were able to ask questions in a more 'spontaneous' way (Phillips, 2015) with a "mutual sharing of knowledge" (Phillips, 2015 p. 563) encouraging engagement and deep learning (Ryan & Ryan, 2013).

Selection of training materials

I used PowerPoint to provide a structure for the all the teaching sessions (S1- 5) but I adapted its use as appropriate to the characteristics of the group in which they were taught. For example, sessions 2, 3 and 4 were all formal lectures with key learning outcomes and summative assessment. It was therefore paramount that the material was available on blackboard prior to the teaching session to enable student preparation and engagement (Wanner, 2015). It was also accessible during the lecture (to provide an outline of key material) and afterwards to guide further study and exam preparation (Hill et al 2012). Research suggests learners prefer PowerPoint to facilitate their learning and that it is linked to increased retention (Apperson et al 2008). In contrast, sessions 1 and 5 adopted a formative assessment focus, were informal and workshop-based where the PowerPoint provided a more structural overview of the session rather than a 'content heavy' outline of key material. In sessions 2-4, I used PowerPoint throughout the lecture to provide detail and guide learning, whereas in 1 and 5 it was used to present a succinct overview of the session for the students, to facilitate the key learning activities and to provide learners with a summary at the end of the workshop, thus tailoring it to suit active learning (Wanner, 2015). I was also conscious that learners in S4 were international students with specific language challenges in comparison to native speakers in S1, 2, 3 and 5. Informed by Farrow's LIGHT model (Farrow, 2005) I therefore adapted my teaching materials ensuring that all materials, in particular PowerPoint guidelines, were simplified and clear (MacGregor & Folinazzo, 2018).

In all sessions I was keen to integrate blended learning, which is defined as the use of mixed modes of web-based technology to obtain an educational goal (Driscoll, 2002) and is linked to increased student performance and motivation (Vernadakis, 2011). In S2, 3 and 4 I adopted the method of self-paced instruction (Alammary et al 2014) where students selected the use of pertinent journal articles (accessible via Blackboard) and devised a set of questions to encourage critical thinking skills (Behar-Horenstein et al 2011). However, in S3 I provided additional guidance to learners by highlighting key areas within the article the students needed to focus on, thus simplifying the task. This is in line with scaffolding theory which suggests a strong link between task differentiation and increased emotional, behavioural and cognitive engagement (Acosta Gonzaga & Ranirez, 2022). As S1 and S5 were workshop based and student interaction was key, blended teaching methods were adapted to encourage collaborative learning and peer interaction. For example, both S1 and S5 were asked to watch you tube clips explaining the biopsychosocial model of health and then complete a peer driven formulation activity in smaller groups. Evidence suggests that small groups are linked to increased peer collaboration (Brindley et al 2009) and consequently deeper learning (Cleveland-Innes & Emes, 2005). Finally, in S4 and S5 I asked students to conduct role plays which were initially conducted in pairs before demonstrating a 'healthy conversation' with a willing volunteer. I adopted this technique as there is evidence that role plays, especially when observation is included (Rao & Stupans, 2012) can enhance communication skills and clinical competency (Rowe et al 2012). Finally, with the foundation students in S3 I selected a real time polling application named Veevox. This was to establish baseline knowledge (McDermott, 2022) and ensured learner anonymity as foundation learners sometimes report lower levels of self-esteem in comparison to learners who have begun their degree (Al- Harthy, 2020).

Assessing Learning Outcomes

Assessment is often defined as a form of testing or evaluation (Sambell et al 2012). The role of assessment is key to teaching and learning and can help provide the lecturer with an understanding of student ability (Fook & Sidhu, 2010). It is also a useful way to improve and support student learning and to increase student attainment (William et al 2004). However, to ensure that key learning outcomes were achieved, it was important that I selected the correct type of assessment (Fook & Sidhu, 2010) either formative or summative. Formative assessment is defined as “activities undertaken by teachers and students in assessing themselves that provide information to be used as feedback to modify teaching and learning activities” (Black and William, 2010, p.82). Formative assessment is often ongoing throughout the teaching session and module (Fook & Sidhu, 2010). In contrast, summative assessment, such as exams or portfolios, are normally developed to obtain a final grade and typically occur at the end of a module or semester (Dixon & Worrell, 2016).

In S1- 5 I mainly developed and utilised formative assessment techniques. These were pre-planned quizzes, question and answer sessions and pair work on a particular 'scenario', which I used at certain time points throughout the sessions. This was for several reasons. Firstly, to check learning of key concepts and theories throughout the lecture. For example, I wanted to ensure that students understood the key theories before we moved on to material in the latter part of the session that demanded more critical analysis (Gibbs et al 1987). Secondly, to increase student participation as learners often find formative assessment more informal (Dixson & Worrell, 2016) and evidence suggests it is linked with increased student motivation, communication and participation (Hernández, 2012; Marriot, 2009).

However, despite using similar formative assessment methods in S1-5 I did adapt these to suit the needs of the learners. For example, in session S3 I used more question-and- answer sessions to check student learning as I observed that students were struggling with one of the key models. I also asked students to answer quiz questions in pairs rather than individually to increase confidence levels and peer interaction. This was done spontaneously and linked to research by Cook (2009) who suggests that formative assessment can be either impromptu or planned. In contrast, in S2 and S4 I employed more graded questions within the quiz and more in-depth question and answer sessions. This was because S2 and S4 were higher level learners (see Table 1) and therefore questions that encouraged higher order thinking were key (Black, 2003).

Within S1-5 I also assessed learning outcomes in a more 'informal' manner e.g., the assessment technique was not planned prior to the teaching session. This was sometimes via impromptu question and answer techniques, triggered by observing body language in the classroom. I also tried to develop an atmosphere in the classroom that was conducive to discussion, so students felt comfortable asking questions and gaining feedback (Sambell et al 2012).

Finally, in S1, S2, S3 and S5 my formative assessment methods were not only developed to assess learning throughout the sessions but to develop skills that would be needed in the summative assessment. Examples included asking students to reflect on methodological differences in journals papers to develop skills in critical commentary. This is in line with research which suggests that ideally both formative and summative assessment should ‘complement each other’ (Dixon and Worrell, 2016, p. 157).

Conclusion

To summarise, there were many pleasing aspects throughout this case study. I gained positive feedback from students, both during, and at the end of sessions and enjoyed responding to questions that were raised. Both suggested that learners had the confidence to interact within the lecture environment. The area of clinical communication is a novel and niche topic, especially within the School of Psychology, so it was satisfying to learn that students recognised its value and its application to real life settings. It was also useful to reflect on the way I adapted sessions to suit the learning needs of the students as this is something I have done previously but in a less conscious and more ‘automatic’ way.

In contrast, the case study was not without its challenges as it was sometimes difficult to please every learner. For example, when gaining feedback, one student commented on an exercise I had developed suggesting it was too lengthy to complete, yet another suggested that it was a useful tool to build critical thinking. I also found poor attendance at lectures disheartening and frustrating, especially when I had spent considerable time preparing the materials. Consequently, I found myself adapting certain exercises in the sessions which sometimes affected the flow.

On reflection, I identified several key areas to improve. Firstly, despite preparing meticulously, I still had problems using ILT and on numerous occasions I reverted to verbal question and answer techniques rather than the use of teaching technology. I think further training in ILT would be useful. Finally, I found meeting all the lecture outcomes was occasionally challenging. This was sometimes because of protracted student discussion. I was also keen to promote engagement and included too many formative assessment tasks within the lecture. Moving forward I need to focus on providing a more effective time balance to ensure students are always prepared for their summative assessment.

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Evaluation and reflective commentary.

Introduction

This report provides an evaluation of a teaching programme on clinical communication within the field of health psychology delivered between February and June of 2023. Sessions were delivered to a variety of students and levels including foundation, undergraduate, postgraduate, health care professionals (HCPs) and trainee applied psychological practitioners (TAPP) students. In the context of teaching, evaluation is defined as 'student's judgment of teaching quality' (Diseth, 2007; p.186) and provides valuable information about the strengths and limitations of lectures, seminars and workshops (Diseth, 2007). Providing regular evaluation of teaching is central to student-centred learning (Trinidad, 2020) as well as sustaining teaching excellence (Tomas et al 2022). It is also linked to greater accountability, and improvement in the Higher Education sector (Ballantyne, 2000; Lundberg, 2022; Tomas et al 2022).

To evaluate my teaching programme, I adopted a holistic approach, gaining feedback from multiple sources, ensuring a rigorous and structured approach (Hounsell, 2003). Methods of feedback were adopted to suit the characteristics of the learner group (Williams & Brennan, 2004) for example as S1 and S5 contained smaller group numbers, verbal feedback was obtained at the end of the session. Conversely S2, 3 and 4 were larger groups so written evaluation (S2 & 3) and Microsoft forms surveys (S4) were more suitable (Hoon et al 2015). Feedback provided useful information regarding both the strengths and limitations of the sessions (Diseth, 2007). I found the methods of feedback adopted encouraged different levels of completion, for example in S2 I gained written feedback at the end of the session and only received a fifty percent response rate. Consequently, I adopted a different method in S4 and used a Microsoft teams survey where students could respond quickly and anonymously using a QR code on their phone at the end of the session. This improved the response rate significantly, the comments were equally as rich, and collation was easier (Mijic, 2010).

Secondly, I engaged in a process of continuous self-evaluation and personal reflection throughout the teaching programme based on Gibbs reflective cycle (Gibbs, 1988). This is perceived as essential to good teaching practice (Lundberg, 2022). Finally, in S3 and 4 I gained peer evaluation from teaching observations. Both observers were colleagues within my department, were course leaders, and one was a senior fellow of the Higher Education Academy (HEA). Furthermore, both were experienced in delivering teaching and training and were therefore well placed to offer constructive feedback. This aligns with research by Abbott et al (1989) which suggests that feedback and training from expert teachers increases teaching performance. Both provided me with written and verbal feedback (post session) to discuss the strengths and limitations of the session. Research suggests the benefits of peer observation are multifactorial including improving teaching and learning, increasing confidence and collegiality in departments (Bell and Mladenovic, 2007) and prompting self-reflection (Englin & Priest, 2014). Furthermore, colleagues are often more cognizant of teaching competency than learners and can advise more effective options for teaching and learning (Keane, 2015). In addition to the formal feedback methods, I also captured 'incidental feedback' by observing body language and levels of student participation (Hounsell, 2003). This is important as student feedback informs teaching quality (Harrison et al 2022). I will now discuss the strengths, challenges and areas of improvement based on the feedback I received from these multiple sources focusing on both similar and contrasting views throughout.

Strengths of the training programme

Regarding strengths the following key themes were identified from the multiple sources of feedback. These were, sessions were interactive and supportive, gaining relevant applied skills and the use of interactive learning technology (ILT) as a teaching and learning tool. I will address each one in turn discussing the similarities and differences across the feedback received.

Theme 1: The sessions were interactive and supportive

Learners across S2, 3 and 4 suggested they "*liked the interactivity*" of the sessions and in S4 suggested "*it was very informative and interactive*". In S2 they also enjoyed the "*opportunity for interactive discussion*" and that "*lots of questions and quizzes to get you thinking made the lecture more interactive*" "*helped the information sink in*" and "*varied interactive activities kept in interesting*" and in S4 that "*it was a very informative and interactive session*". This is important as both student-student and lecturer-student interaction encourages deep learning and is key to achieving the required learning outcomes (Cleveland - Innes & Emes, 2005). Feedback also suggested that learners found the learning environment supportive for example in S2 "*your ability to listen to students and understand their point of view was very accepting and helpful in understanding other's perspectives in context of content*" and one learner in S2 suggested "*I never put my hand up and did quite a bit today*" and in S4 "*I was happy to be part of today's session*". This is key as evidence suggests student motivation to learn increases when the lecturer builds a supportive learning environment (Abualrub et al 2013). Correspondingly, feedback from learners aligned with my personal reflections in S2 and S4 as I was happy with the level of learner interactivity and my ability to make students feel comfortable in the learning environment. I felt learners seemed engaged as there were lengthy question and answer sessions. There were also examples of incidental feedback from learners as some approached me after the sessions and commented that they found the use of role plays useful. Finally, feedback from peer evaluation suggested I tried to "*break up the session by providing variety*" and "*engage the class in interaction*". This is important as the ability to engage and develop learner rapport improves teacher effectiveness (Alam & Ahmad, 2016; Strong et al 2011).

Theme 2: Student's gained relevant applied skills:

Some learners across the sessions commented on the usefulness of the applied techniques such as healthy conversation skills and SMART goals. They suggested that the "*session on healthy conversation was very interesting and helpful for me personally being a doctor. SMARTER will be remembered*" (S4) and that the "*the content was useful for my personal and professional life*" (S4). Conversely, although some learners in S2 and S3 suggested it was "*enjoyable, and I will use some of the tips in my own career*" and "*I loved the healthy communication, useful in all branches" (S3)* there were noticeably fewer comments made by learners regarding the usefulness of applied skills. This may be because S2 and S3 were undergraduate learners and therefore found applying skills to specific careers more challenging. In comparison, the learners in S4 were HCPs and were able to make more explicit connections to their chosen careers. This concurs with research that many graduates, especially HCPs, are keen to access social skills training at university as they typically gain interactive skills in the workplace (Tynjala et al 2006). Furthermore, role play is more effective to develop communication skills than traditional didactic methods (Rao & Stupens, 2012). Future sessions with undergraduate learners, suggests a need to highlight the utility of performance-based skills as many psychology undergraduates enter the helping professions (Reich et al 2022).

Some of my personal reflections also concurred with feedback from learners and peers. For example, I noticed that learners in S2 appeared more engaged when I provided them with examples from my previous role working for an NHS weight management service with some suggesting it was useful "*when the lecturer related to their own experiences'*. I did this by discussing powerful interactions I had experienced with patients. For example, one patient suggested that when his health professional broached the topic of weight it was "*like a smack in the mouth from his best friend*". I also provided an example of a clinician adopting a biomedical model of health with a patient as opposed to a biopsychosocial approach, demonstrating the importance of adopting a holistic approach with patients. Feedback from my peers also aligned with my reflections as it was suggested that "*the use of personal stories and discussion of her own interests enhanced this further and made it engaging*". Evidence suggests that the use of stories helps promote learning, engagement and memory (Easton, 2016).

Theme 3: The use of ILT as a teaching tool

Learners were generally positive about the use of Interactive Learning Technology (ILT) within sessions with some suggesting this was the area they enjoyed the most. Tools they found engaging included "*intermittent quizzes to recap*", and "*videos and veevox*" (S2). In S4 comments were more specific for example "*the videos reinforced the knowledge gained*" and " *helped to change the level of listening*" (Abykanova et al 2016). However, this was sometimes in contrast to my personal reflections as during several sessions the ILT failed and I transitioned to oral question and answer techniques, with students using pen and paper to answer the quiz questions. I was disappointed that after meticulous preparation this made me appear unprofessional and ill-equipped to the learners. In contrast, peer feedback was positive suggesting the problem was handled "*quickly and professionally*" and that switching immediately to paper and pen ensured "*students didn't miss out on that bit of learning*". Surprisingly, there was no negative feedback from learners either. This could suggest that students preferred face to face learning techniques in contrast to virtual learning (Griffin and Howard, 2017) or were confident that learning outcomes were met despite the difficulties with technology.

After observing a colleague use ILT successfully (Engin & Priest, 2014) and the level of engagement obtained from learners I decided to use Veevox (a polling platform) to assess prior learning in S2. This was because I had observed how students were reticent to answer questions in front of their peers in S1. Veevox proved to be a useful tool to identify the baseline of knowledge at the beginning of the session (Hailikari et al 2008). Learners also remained anonymous, this was useful if they were shy or underconfident about contributing in sessions and provided an unobtrusive method to gain an overview of their peer's knowledge and ideas. I also noticed that learners in S2 struggled with the timing of tasks and that relying solely on audio instructions from me was problematic. Students were potentially focused on the task content rather than the amount of time they had to complete it. I therefore included a PowerPoint countdown timer in S3 which ensured learners were provided with a visual cue as this can improve learning (Brown & Manogue, 2009).

Challenges of the training programme:

I identified several challenges across the training programme which related to building critical skills and timing and pace. I will now address each one in turn discussing the similarities and differences across the feedback received.

Theme 1: Building critical skills

Learners in session 2 commented on a journal paper task I developed where they were asked to identify methodological variations between articles with the aim of developing critical skills. Although the feedback was sometimes positive, and some learners found the task beneficial commenting "*spending time reading research papers was useful*" and provided "*good encouragement of critical thinking*" and "*we were guided towards finding the answer ourselves*" there were also negative comments with some suggesting that the articles were a *"little too long*" "*took away from active learning*" and would be more effective "*out of the classroom or in a seminar setting".* After the session I reflected on the feedback and realised that the article was too lengthy and needed to be adapted for future sessions. For example, in session 3, I still wanted students to focus on the methodological differences in the article to build critical skills (Azar, 2005) but adapted the task by highlighting relevant aspects of the paper, to reduce reading time for learners. I also asked the learners to work in pairs as research suggests a link between scaffolded teaching and student engagement (Griffin & Howard, 2017). Interestingly, my peer observer did not specifically mention this exercise, so I decided to discuss the changes I had made with her after the session. She suggested that the task should be adapted to meet the individual needs of the learners. This made me think about the importance of adaptation and differentiation to the learner, both when preparing learning materials and in situ (Pozas et al 2020).

Theme 2: Timing and pace

Another key challenge I faced with sessions was timing and pace. In S1 and 5 the sessions were more flexible, whereas S2 was a 'content-heavy' lecture. Feedback from learners suggested they sometimes struggled with the "*time constraints for tasks*" and that the pace "*was fast so sometimes hard to make notes".* One learner commented that I "*wish we could have completed the slides as it was interesting*". This was something I realised during the session and was disappointing. On reflection, and in my eagerness to include a variety of interactive learning tasks, I had used too many. I had also tried to cover too much material and was unable to provide a succinct overview at the end of the session. Finally, realising that I needed to speed up midway through the session I increased my pace resulting in some students suggesting that I needed to "*slow it down a little*". Consequently, in S3 and S4 I adapted some of the teaching materials so learners would find tasks easier and quicker to complete (encouraging pair work and differentiation of tasks) and removed some tasks completely. Instead, I referred learners to these specific tasks at the end of the session, providing them with the option to complete these in their own time, thus encouraging self-directed learning (Topale, 2016). This improved the following sessions with peer feedback suggesting that session 3 *"was nicely paced and finished on time"*.

Key improvements:

Overall, some key improvements are necessary. Firstly, I need to ensure more exact timings around the different learning activities to ensure all the key learning outcomes are achieved (Azar, 2005). Planning a two-hour lecture, factoring in different levels of group participation, and allowing adequate breaks for students can be challenging. However, on reflection there are techniques I can use to address this in future. These include, speeding up and adapting some of the learning tasks in situ by moving from independent to pair work as utilised in S3 (Rich & Hannafin, 2009). In addition, including tasks that could be 'omitted' if timings are challenged. This would ensure key learning outcomes are achieved as learners could complete these activities post session, thus encouraging independent learning (Azar, 2005).

Secondly, I need to improve my own skill and confidence when implementing ILT, as well as being mindful of the skills of learners. On reflection, I have made progress as I now incorporate ILT techniques in sessions more frequently. This was partly due to the rapid switch to online learning during the Covid 19 pandemic and observing the utility of ILT when observing my peers. However, I am sometimes frustrated that despite meticulous levels of preparation issues can still occur, even from room to room. I therefore need to be prepared to transition to paper copies or templates on PowerPoint to ensure a rapid switch if technical difficulties occur, as in S3. On reflection, this was simple to facilitate as the group was small, but I was mindful that in larger groups, where students are less likely to answer questions in front of their peers, technical issues may disadvantage learners. Finally, learners akin to lecturers have varying ILT abilities and therefore, I should choose the simplest version of the task, and this should be as user friendly as possible (Simamora et al 2020).

Thirdly, I need to evaluate my teaching sessions more frequently, especially when delivering new sessions. I found the feedback obtained from peers and learners encouraging and thought provoking and suggestions resulted in useful changes to both existing and future teaching materials (Ballantyne, 2000). This was particularly useful when combined with self-reflection and peer observation as this encouraged me to reflect at a deeper level, adopt novel teaching strategies and refine existing ones (Englin & Priest, 2014). Finally, addressing the needs of students when they have contrasting opinions, for example, some learners in S2 found the journal paper interesting but some suggested it was too lengthy. In S3 I adapted the task, so it included more guidance and was a little shorter but still focused on developing critical skills. Moving forward I need to be prepared to modify tasks to meet the individual needs of learners in teaching sessions.

Conclusion

Overall, I found delivering the sessions an enjoyable process. I particularly enjoyed S4 with the HCPs as they responded enthusiastically to the healthy conversation skills training and its application to their specific roles working with patients. It was also reassuring that my personal reflections, for example, aspects that I felt needed to be improved after the sessions, were consistent with learner feedback. Moving forward, this has given me confidence to change and adapt my teaching post reflection. Conversely, peer observation feedback was not always congruent with my own perceptions as I was concerned that when the learning technology failed it had made me appear unprofessional and unprepared. My observer commented that this was not the case as I transitioned to "paper" versions which were equally as relevant ensuring students did not miss out. Thus, contrasting feedback demonstrates the need to employ a holistic approach when evaluating, using self-reflection, incidental feedback as well as learner and peer feedback (Smith, 2008) to improve teaching practice. This is because feedback sources are often qualitatively different (Griffin and Howard, 2017) and understanding the needs of individual learners is often gained from contrasting viewpoints and nuances in feedback. Finally, this is the first time I have delivered sessions using a 360 perspective throughout (Hunukumbure et al 2017) highlighting the benefits of receiving feedback from multiple sources as well as observing my peers in practice (Engin & Priest, 2014).

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Chapter 6: Health Psychology Interventions

Face to Face Case Study

Introduction

This case study provides an overview of the assessment, formulation, implementation and evaluation of an individual face to face psychological intervention around the menopause and weight management. Considering the link between weight gain and the menopause an advert was placed on the women's network team page at the [redacted] in January 2024 advertising the services of a trainee Health Psychologist. I received a response from a client who had entered the menopause, gained weight and was keen to receive support. The client was assigned a pseudonym and will be identified as 'Sheila'. She attended a total of six face to face sessions over a period of 16 weeks. The menopause is defined as the 'time between onset of menstrual irregularity and 12 months after the final menstrual period' (O'Neill & Eden, 2020, p. 175). Common menopause symptoms include hot flashes and weight gain (Chiu et al 2020) with 20 percent of women gaining more than 4.5kg (Yuan et al 2023). This is associated with an increased risk of cardiovascular disease and certain cancers (Kapoor et al 2017). Furthermore, women face additional barriers to weight management and exercise such as reduced energy and motivation (Kracht et al 2022). Thus, a number of women are interested in exercise and weight management support during menopause.

Assessment

Assessment is a core competency (Bull and Dale, 2022) and is used to help health psychologists assimilate pertinent information (with formulation) so the client and psychologist can develop a mutual understanding of the problem and tailor the intervention appropriately (Johnstone and Dallos, 2013). In session 1 (S1) I gained consent for the intervention, introduced myself as a trainee Health Psychologist and explored client expectations. Exploring client expectations around commitment and goals can have a positive effect on the therapeutic alliance and treatment outcomes (Patterson et al 2013). In addition, we agreed the purpose and duration of the sessions and discussed confidentiality and its limits (Martindale et al 2009). We also spoke about my need to have a communication skills observation reassuring her that this would be in one of our later sessions and that alternative, less intrusive methods of assessment were available if she did not feel comfortable with an observer in the room.

In S1 I adopted a clinical interview format guided by Motivational Interviewing (MI) focusing on open questions, affirmations, reflective statements and summaries (OARS) (Miller & Rollnick, 2012). The essence of MI is fundamental to intervention planning and is both compassionate, collaborative and empathic (Miller & Rollnick, 2012) with the aim of promoting self-compassion in clients (Pastore & Fortier, 2020). This is an essential prerequisite for consultations (Byrne et al 2024) around weight (Cox et al 2011). S1 (as with all sessions) was guided by the client, and I focused closely on client expectations and motives (Miller & Rollnick, 2012). I was also mindful that these sessions were not in a 'clinical setting' and was unable to access key documents such as hospital records. I therefore spent more time with the client prior to S1 exploring the client's clinical history with a focus on being "insight- oriented" (Ryum & Kazantzis, 2024).

Finally, evidence suggests that empathy, warmth and the quality of the therapeutic relationship are more effective predictors of good client outcomes than the individual techniques used (Kelley et al 2014). Consequently, I arranged an initial 30-minute session (prior to S1 & S2) to meet with Sheila to listen to her story and build rapport gently. This was to help Sheila feel at ease and to provide her with the opportunity to ask any questions about the upcoming sessions. Secondly, I placed Sheila at the heart of the session using the biopsychosocial approach as a framework to develop a set of open questions and a guide for my treatment plan (see Figure 1 for a summary of the questions asked during S1 & 2).

I initially planned S1 as an assessment session and S2 to provide an overview of the formulation. However, in S1 I wanted to explore slowly and sensitively and to be guided by Sheila, giving her time to discuss all areas of the biopsychosocial (BPS) model (Bull & Dale, 2022). Consequently, not all areas of the BPS model were explored so S2 was also a second assessment session. At the end of S1 I had asked Sheila to reflect on the questions we had explored for 'homework' so I began S2 by asking Sheila to consider those areas as client reflection is linked to increased patient insight and awareness (Watson, 2012). Providing Sheila with this time was important as in our initial meeting she emphasised the need for a holistic understanding of her weight. At the end of the session, I gave Sheila a food diary to complete.

Biological:

Sheila is 51 years of age, menopausal and waiting for an assessment for autism. She was diagnosed with Polycystic Ovary Syndrome (PCOS) in her twenties. Sheila is on Hormone Replacement Therapy (HRT). Sheila stated that she used more insulin than normal (hyperinsulinemia), due to PCOS, and has high testosterone levels. Although Sheila does not have diabetes, weight loss and exercise can help address hyperinsulinemia (Marshall & Dunaif, 2012). She weighed 84 kilos at the start of the intervention and had a Body Mass Index (BMI) of 30.1 and is concerned about her weight 'creeping up'.

Psychological:

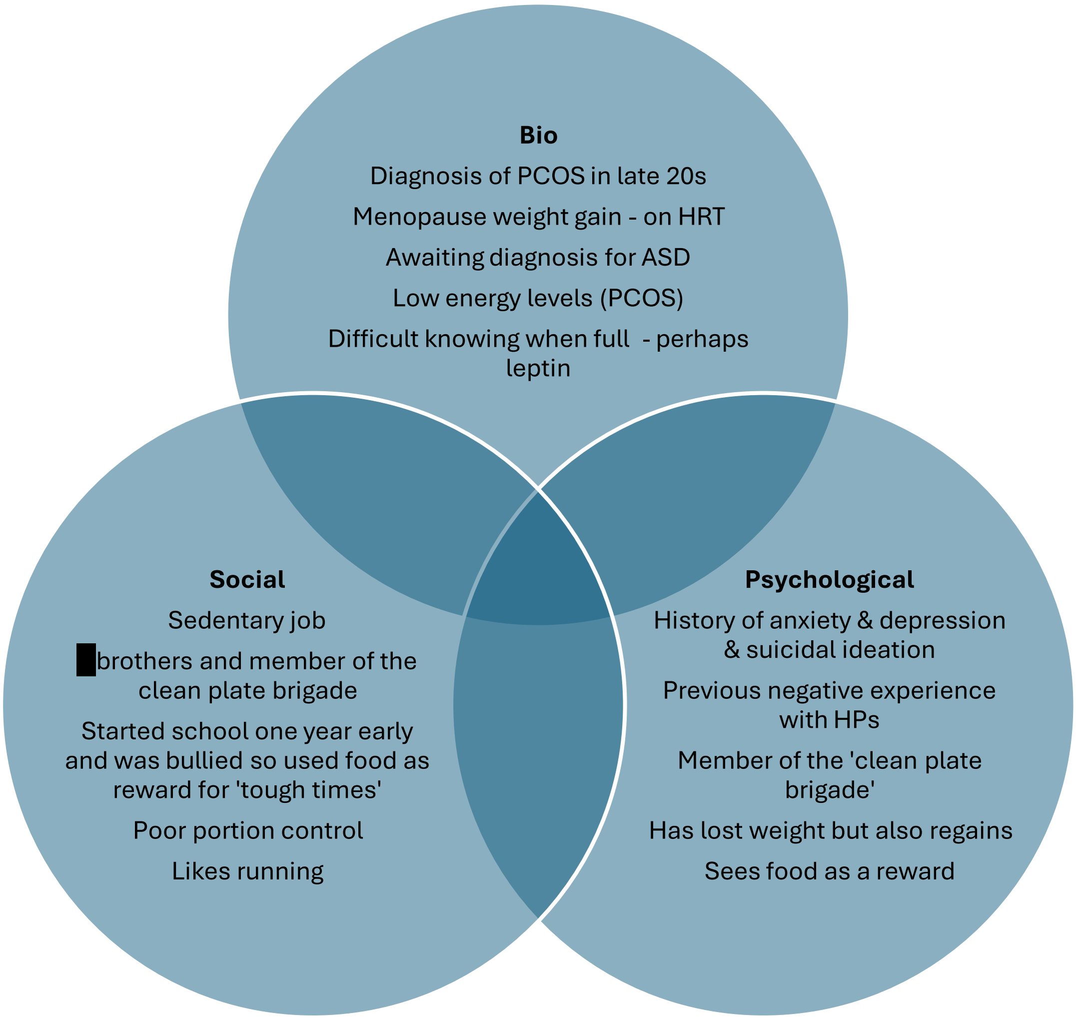
Sheila has experienced previous negative encounters with health professionals (during her struggle to receive a PCOS diagnosis). She has suffered from anxiety, depression and suicidal ideation, and the onset of the menopause has exacerbated this. Sheila had received previous psychological input but was 'told what to do and not listened to'. HRT has been helpful for her mental health. Sheila had a 9-month break from work 10 years ago with her mental health and has since changed to a 4-day week. Sheila has an emotional link with food that dates to early childhood e.g. she attended high school a year early, but this led to bullying and using sweet snacks and desserts as a source of comfort and reward.

Social:

Sheila does most of the cooking as her partner has Attention-deficit hyperactivity disorder (ADHD). If her husband cooks, they always get a takeaway. Sheila has a pudding after lunch and her evening meal. Previous attempts at weight loss with slimming world and fasting diets were successful but she has always regained the weight she has lost. Sheila admits that her portion control is poor. She enjoys exercising but often feels fatigued which is a barrier to lifestyle change.

Figure 1: An overview of the questions asked during S1 & S2 using the Biopsychosocial model as a framework.

Figure 2: The Biopsychosocial model of Health including key information from my client (Engel, 1977).



<u>Formulation</u>

Formulation involves piecing together the information gathered in the assessment so an intervention can be 'tailored accordingly" (Forshaw, 2022, p.117) and enables the Health Psychologist to work in a "psychologically informed way" (Forshaw, 2022, p.118). In S1 and S2 I used principles of MI and gathered information sensitively and gradually, framing my questions around the biopsychosocial approach (Engel, 1980) (see Figure 2 for a summary).

In S3 I used the knowledge I gained from these questions to share the formulation with Sheila, and we agreed the shared goals (Dale & Bull, 2007). I presented the 5 Ps formulation diagram (Kuyken et al 2009) and explored the presenting problem, predisposing factors, precipitating factors, perpetuating and protective factors

(Kuyken et al 2009). I was mindful that the 5Ps involved exploring past situations and experiences, and that although some clients find formulation beneficial to their overall understanding of their problem, some experience anxiety and worry (Redhead et al 2015). Consequently, I adopted a sensitive approach at all times and Sheila guided the session.

The 5Ps was adopted as it provides a holistic summary for the client and can develop the therapeutic alliance (Mc Tiernan et al 2020). Secondly, there is evidence that the 5Ps helps to focus on the client's difficulties as well as identifying areas for the intervention (Gonzales-Wong & Peters, 2023). Thirdly, formulation was a collaborative process and helped inform the outcome measures I chose to select (Harper & Spellman, 2006). For example, in S3 Sheila had returned her food diary prior to the session. I was therefore able to identify areas for change such as the reduction of snacks/desserts at lunchtime (see Table 2). However, I did not suggest the specific targets for Sheila, moreover, she always decided on a target that was achievable for her, e.g. she suggested replacing lunch time snacks with fruit every other day (see Table 1 & 2 for examples). Finally, formulation was an opportunity to see if Sheila agreed with everything I had said, would like anything changing or adding and for us to agree on shared goals (Redhead et al 2015). The next section explains how the formulation led to the design of the specific intervention.

Designing the intervention

Reflecting on my initial sessions with Sheila, the intervention was designed around building the therapeutic alliance (using the key principles of MI e.g. empathy, reflection and compassion) as Sheila had experienced negative consultations with health professionals. I also included psychoeducation which involved talking through the formulation with Sheila emphasising the importance of gradual weight loss with a focus on healthy eating (e.g. healthy sources of protein and carbohydrates and foods that promote satiety). Combining MI and psychoeducation has been proven effective (Barnes et al 2018).

Finally, when completing the formulation four behaviour change techniques (BCTs) were selected from the behaviour change taxonomy with an initial focus on weight loss (Michie et al 2013) and presented to the client in S3. These were 1.2. problem solving (reaching for food- identify triggers that urge client to eat unhealthy food). 2.1. self-monitoring (giving client a food diary). 8.7. graded task (e.g. swap pudding for yoghurt) or (increase daily number of steps gradually) and 12.1 restructuring the physical environment (giving client portion plate).

These BCTs were chosen as they had proven efficacy with weight management interventions (see Table 1) and could be implemented around the completion of a food diary. Finally, four BCTs was a pertinent number to deliver in the remaining number of sessions without overwhelming the client.

However, in S3 when Sheila and I discussed the formulation, and she described cycles of weight loss and weight gain it was evident that Sheila was good at losing weight but found maintenance challenging. I therefore revisited the formulation and the focus of the intervention shifted from weight loss to weight maintenance. At this point I reviewed the relevance of the chosen BCTs but continued with them as these were also deemed effective for weight maintenance.

Table 1: Examples of BCTs used within sessions and their corresponding evidence base.

Sessions	Behaviour Change Techniques (BCTs)	Some examples used with Sheila.	Evidence base for weight maintenance
3	2.3. Self-monitoring 8.7. Graded tasks	Gave client food diary to complete daily between each session. Asked client if she could substitute high calorie desserts after lunch (she suggested how many) with a piece of fruit or yoghurt to start making gradual changes.	Jolly et al 2011 Awoke et al 2023. Butryn et al 2007. Burke et al 2009. Carraca et al 2021 Cavero-Redondo et al 2020.
4	1.2. Problem-solving	Asked client to identify triggers that urge her to eat unhealthy snacks (e.g. using food as a reward when sad) and to think about other strategies to manage this e.g. client suggested using much smaller portions.	Stubbs et al 2011. see above

	8.7. Graded tasks	Asked client if she could substitute desserts after dinner with a piece of fruit or yoghurt.	
5	12.1. Restructuring the physical environment	Client kept unhealthy snacks on her desk at work so we discussed how we could address this. Client suggested moving these to the staff kitchen at the end of the corridor. Gave client portion plate and asked her if she could use it for her evening meals. Client also said that she would use it to prepare her packed lunch.	Jia et al 2022 Rigby et al 2022 Vargas- Alvarez et al 2023
6	1.2. Problem-solving	Asked client to think about strategies to help at work when no healthy food choices are available. Client suggests purchasing healthy foods and placing in the cupboard at work.	see above

Outcome measures

Outcome measures are used to assess the impact of an intervention (Smith, 2015) and in weight management interventions focus on measurable factors such as Body Mass index (BMI), weight and mean change in cholesterol (Mackenzie et al 2020). However, as this intervention was only 6 sessions, focusing on some of the outcome measures used in large scale interventions was not appropriate. A key outcome measure chosen was to measure weight in kilos pre and post intervention rather than BMI. Sheila was familiar with this measurement, and it was a more realistic measurement of weight loss (as opposed to BMI) in only six sessions.

The second outcome measure used was the food diary given to Sheila after sessions 2, 3, 4 & 5. Sheila completed this daily, either for a 7-day period or for a 14-day period (depending on the gap between our sessions) and returned them prior to our next session. Sheila also made notes reflecting on food choices as there is evidence that this can facilitate behaviour change (Zepeda & Deal, 2008). This was useful as I could monitor the impact of the intervention throughout the sessions in detail (e.g. the BCTs such as problem solving, graded tasks and self- monitoring) and also at the end of S6. I also monitored attendance and perceived preparedness in all sessions. Finally, I gained qualitative feedback from the client after S5 and S6.

After the process of assessment and formulation in S1 and 2 it was evident that my client showed signs of emotional eating. I had hoped to use the Dutch Eating Behaviour Questionnaire for assessment of restrained, emotional and external eating (van Strien et al 1986). However, after a significant amount of research and emails I received a response from the publisher saying that the DEBQ was only licensed for large scale research purposes in the United Kingdom and therefore I could not use it.

Implementing the intervention

I had 4 intervention sessions with Sheila (S3-S6). Gaps between each session were 2 weeks, however there was a longer gap between S4 and 5 due to client illness. MI and psychoeducation were used in all the sessions as well as four BCTs which were incorporated into sessions 3, 4, 5 and 6 (see Tables 1 & 2 for an overview of the BCTs used). For example, in S3 I introduced the BCT 'problem solving' provided Sheila with a definition and gave her specific examples in relation to weight management (e.g. identify triggers when she may want to snack). In S5 I introduced the BCT 'restructuring the physical environment' and provided Sheila with a portion plate. We discussed how this could be incorporated into her lifestyle using the BCT problem solving so BCTs were gradually built into the sessions. This format was repeated whenever I introduced a new BCT.

Table 2: Overview of the 6 sessions

Plan & dates of the session	***Techniques used***	***Overview of session delivered***	***Targets set***
Initial meeting (30 minutes via MS Teams)			
I spoke to the client for 30 minutes via teams and she seemed very motivated and keen to work on her lifestyle e.g. weight and exercise. The client stressed that she would like a set of tools that she could work with after the six sessions had been completed e.g. an action plan for the future. She mentioned that she has been looking for a holistic approach to weight management.			
Session 1			
22.2.24 Assessment	*Biopsychosocial (BPS) model used to frame questions & using MI (collaborative, empathic and promoting self-kindness).*	*Gathering a holistic understanding of the patient using a BPS model*	*Reflect on the session and the key things we discussed.*
Session 2			

7.3.24 Assessment	*Biopsychosocial model used to frame questions & using Motivational Interviewing (MI)*	*Gathering a holistic understanding of the patient using a BPS model*	*Client asked to complete food dairy for following week* *Client asked to provide weight*
		Session 3	
21.3.24 Formulation overview and BCTs	*5Ps* *BCT 1.2 Problem solving (using food diary)* *Reflective listening*	*Formulation overview with client e.g. I presented the 5Ps to Sheila.* *Explained the BCT Problem solving* *We then discussed the completed food diary and identified targets for change in a collaborative way.*	*1.To replace lunch time snacks/desserts with a piece of fruit every other day* *2. To replace full English with beans on toast* *3. To move sweets, chocolates from desk and replace with fruit*
		Session 4	
4.4.24 BCTs	*BCT 1.2 problem solving* *BCT 2.3 Self - monitoring* *SMART goals* *BCT 8.7 Graded task*	*1. Recap problem solving BCT and discuss how client has got on with the changes,* *2. Think about other options for your food diary e.g. mid afternoon and evening meal (using problem solving)* *3. Introduce New BCT - self monitoring* **Did not complete all the key things as the client was upset*	*1.To replace evening desserts with a piece of fruit every other day* *2. To replace afternoon snacks with a piece of fruit*
		Session 5	
8.5.24 BCTs	*BCT 12.1 Restructuring the physical environment* *BCT 2.3 Self - monitoring* *BCT 1.1 Goal setting* *BCT 1.2 Problem solving*	*1. Explored the food diary from previous 2 weeks e.g. positive changes, things the client found hard and areas to work on in the next week.* *2. Introduced the portion control plate and provided psychoeducation around this.* *3. Introduced the option of exercise (as the client had mentioned this in her food diary).*	*1.To use the portion control plate every night for her main meal* *2. To carry on completing the food diary* *3. To walk for 15 minutes twice a week at lunchtime and every other day in the evening.*
		Session 6	
16.5.24	*BCT 12.1 Restructuring the physical environment*	*1. Explored the food diary from previous 2 weeks e.g. positive changes, things the*	

	BCT 2.3 Self - monitoring *BCT 1.1 Goal setting* *BCT 1.2 Problem solving*	*client found hard and areas to work on in future* *2. Explored the exercise goals from the previous weeks e.g. positive changes, things the client found hard and areas to work on in future* *3. Explored the portion plate* *4. Client provided weight at the end of the intervention* *5. Maintaining progress plan, what has the client learned, what was most useful, what can I continue to do to prevent setback.*	

The implementation went well, and Sheila was punctual, focused and only missed one session due to illness. She rearranged this session promptly, despite being on leave. Sheila quickly obtained a good understanding of the BCTs and integrated them accordingly. She also completed all her food diaries and sent them to me promptly before each session. This made preparation for our sessions straightforward as I had time to read through her food diary and identify areas to address. However, Sheila did find the completion of the diary time consuming stating that the 'external analysis' during our sessions was more useful than completing the diary.

Ending the intervention

At the end of S6 I used the relapse prevention plan and asked Sheila what she had learned, found the most useful, and what she could continue to do to prevent any future setbacks (see Table 2). As this was our last session, I wanted to provide Sheila with as much reassurance as possible, so she would remain confident about maintaining her progress alone. Consequently, we talked through the changes she had made collaboratively, and things she could do to prevent future setbacks (see Figure 3). Evidence suggests that engagement from both parties and giving your client time and space is key to ending the therapeutic alliance (Veron & Schweitzer 2023). We also agreed a future session later in summer.

Evaluation

This case study will now focus on evaluating in three ways: feedback from the patient, outcome measures and observations from my work placement supervisor.

Patient feedback

At the end of S5 & S6 I spent time discussing with Sheila how she had found the process, what she had learnt, what things were the most useful and what she could do to prevent any future setbacks. I thought it was important to focus on the client's experiences as well as the outcome measures as there is evidence that the 'personal story telling' of the client is equally as beneficial to the intervention (Simmons-Mackie, 2001). See Figure 3 for an overview of the key comments reported from Sheila.

Figure 3: A qualitative summary of client feedback at the end of S6.

What have I learned?

- To be kind to my 'future me' they might be hard choices now but I will be grateful for them later on e.g. better knees, avoid diabetes.
- Small changes can make a big difference.
- Healthy swaps are better than not being able to have something at all.
- I'm really good at losing weight.
- To disconnect emotion from eating.
- I have a more healthy psychological connection with food.
- I have shifted from using food as a reward to using the absence of food as a reward.

What was the most useful?

- To know that nothing is 'off the record' .
- The portion plate.
- I feel more in control of my eating habits.
- I know what hungry feels like.
- I can still say no to some foods without feeling deprived.
- The external analysis when 'stuck'.
- Felt somebody wanted to understand me rather than 'handing out solutions'.

What can I continue to prevent a setback?

- The portion plate - I will use this for lunch and dinner.
- Maintain the mindfulness and the awareness.
- I will monitor my weight but now know how to make changes if it starts to increase.
- My shopping habits have changed and I have become more intentional about my choices.
- If I fancy a treat e.g. a flapjack I will now cut the flapjack into 8 small pieces to control my portions.
- I now have healthy food such as fruit within reachable distance at my desk rather than crisps, sweets and chocolates.

Outcome measures

The following graphs outline the changes made by Sheila over the 6 sessions in relation to the outcome measures of weight loss, dessert consumption and numbers of steps taken which were measured at a time points S1 to S6 for weight loss and steps and time points S3 and S6 for dessert consumption.

Figure 4: To demonstrate weight loss progression over the 6 sessions

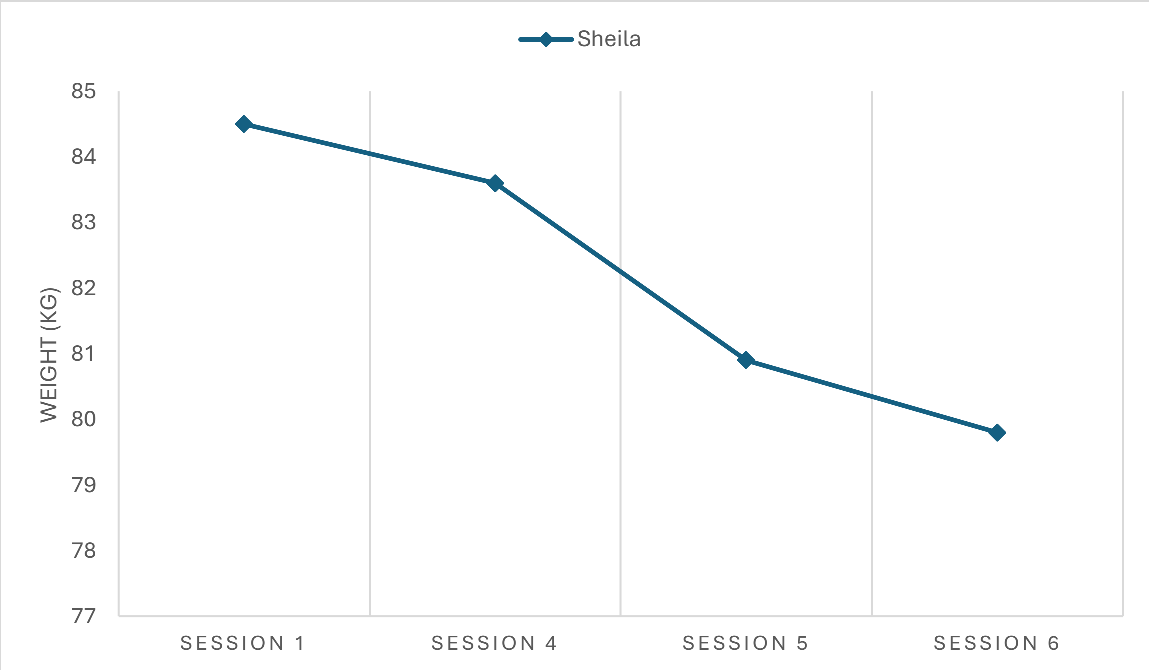


Figure 4 demonstrates a reduction in weight from 84.5 kg to 79.8 kg which is a loss of 4.7kg. This equates to a 5 percent reduction which is defined as a clinically significant marker for disease reduction e.g. cardiovascular disease and lipid profile (Swift et al 2016; Williamson et al 2015).

Figure 5: Self-reported dessert consumption from sessions 3 to 6.

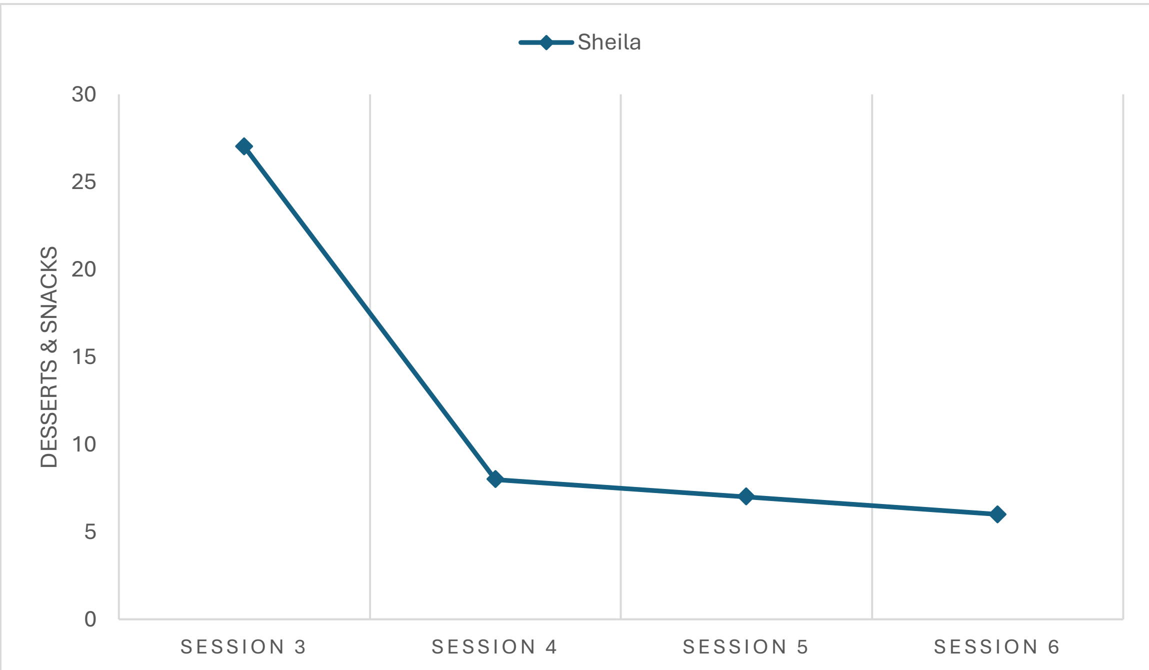
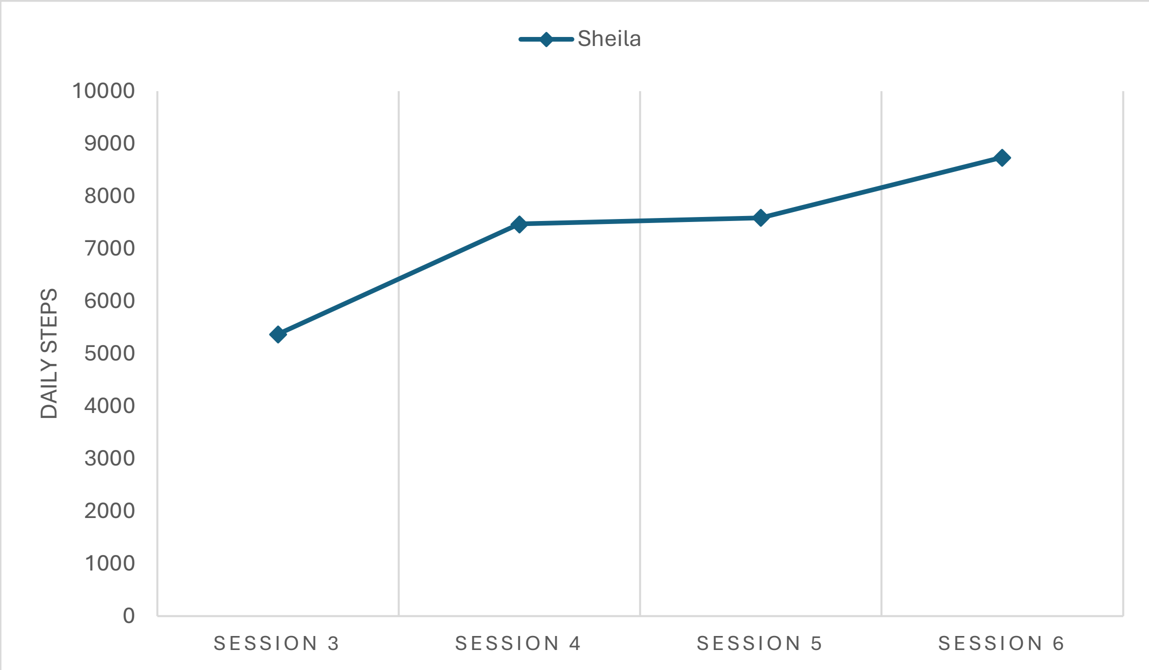


Figure 5 provides an overview of the reduction in dessert/high calorie snack consumption for healthier options.

Figure 6: Average numbers of steps taken from sessions 3 to 6.



Finally Figure 6 provides an overview of the number of steps per day as the sessions progressed.

My observations.

Sheila responded well to the intervention. She lost nearly a stone in weight, increased her step count and decreased her dessert consumption. I also noticed some other shifts in behaviour. For example, as the intervention progressed and her understanding and use of the different BCTs developed, her confidence grew in her ability to manage her weight.

There was also a shift in her energy. For example, in S1 & 2 Sheila mentioned that she was often fatigued and found the mental effort of planning meals overwhelming. This had prevented her from making lasting changes in the past. However, this altered as the sessions progressed and I noticed that she began planning what to purchase at the supermarket in a more habitual way using 'less mental energy'.

My workplace supervisor also noted some positive aspects of the intervention. He mentioned that Sheila displayed 'learned insights and increased self-management' and that the portion control plate had 'inspired really creative approaches to using this'. Perhaps one of the most important shifts was that Sheila had learnt to be kinder to herself and to accept and recognise the fluctuating changes in her eating.

Conclusion

I found this process incredibly rewarding. I enjoyed building rapport with Sheila and having the time to listen and gain a holistic understanding of her situation. I know from my time working in weight management that this is what patient's desire the most but rarely receive. I am grateful that I had a client that was motivated to change and insightful. She was also very reflective, and during discussions it was clear that this helped her 'process' some of the changes that she needed to make. Finally, I am confident that using the principles of MI and appropriate BCTs helped my client to make lasting and meaningful changes to her weight and her behaviour around eating and exercise. At the end of S6 we arranged to meet in 3 months’ time so we could discuss Sheila's progress and I could provide support.

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Face to face Case Study- reflective commentary.

Below you will find some of my key reflections during my one-to-one intervention. Despite being nervous at the beginning of this competency, I found the one-to-one intervention an incredibly enjoyable, rewarding and interesting experience. In hindsight I was not anxious about the process of building rapport with the client or working with someone on a one-to-one basis, but I was concerned that I possessed the skills necessary to design an effective intervention and was extremely mindful of the responsibility I had to my client. To help manage this I used my regular supervision sessions with my supervisor as well as Emma and Mark (my workplace supervisor) to manage this. It had been 12 years since working as a lifestyle coach in the field of weight management, a job that I enjoyed immensely, but I knew that working as a trainee Health Psychologist would be different and my expectations of myself were now much higher.

I had an initial meeting via MS Teams with Sheila and was excited to get started. Sheila was very focused from the beginning and ready for change. She was invested in the process from the start, never late, always arrived prepared with her food diary, had clearly reflected between sessions on the different techniques we had discussed and always responded quickly to any communication about her sessions. In hindsight this was not something I expected. In my previous role as a weight management coach, clients often did not attend their appointments and were often reluctant to engage, sometimes because they had had negative experiences with health professionals (e.g. they had been dismissive about their weight loss struggles, felt judged or treated them insensitively) and sometimes because they had been referred by a health professional but were not necessarily ready for change themselves. In hindsight this taught me the power of 'not assuming' and moulded the way I approached my sessions with Sheila. You can never assume that somebody is or is not ready for change so I was keen to adopt a patient centred approach, demonstrate empathy, warmth and sensitivity and that the two of us would work collaboratively on the targets Sheila wanted to achieve.

Sheila was very open about her past struggles with her weight which made the process of formulation easier than expected. Sheila's willingness to discuss all aspects of her life including both her past and present relationship with food helped my confidence too as I felt trusted, consequently, I became more relaxed as the sessions developed. I enjoyed building rapport with Sheila, listening to her 'story', watching her confidence grow and seeing her understanding and perceptions towards food develop when she realised that making small but sustainable changes could contribute to lasting change.

Not all my sessions with Sheila were straightforward and I sometimes had to adjust the focus of the session to suit the needs of the client. In S1 and S2 Sheila was very open about her previous frustrations with weight and her constant cycle of weight loss only to regain the weight she had lost months later and sometimes even more. This was something that she had mentioned frequently in S1 and S2 and was a constant source of upset. At the beginning of S3 we discussed the formulation in detail using the biopsychosocial model. My intention was to raise the specific BCTs we were going to focus on, but Sheila was emotional, so I decided to pause, and Sheila guided the session. Once again, Sheila discussed her frustrations with dieting and had even prepared graphs from the previous 5 years which provided an overview of her weight loss journey. What appeared clear to me was that Sheila was excellent at losing weight and I told her so. On reflection, stepping back from the session was the right thing to do. It gave Sheila the time and space to discuss and reflect on the formulation. It was a pivotal moment in the intervention as Sheila remarked '*I am really good at losing weight I just need help to maintain'*. It was at this point that we moved the focus to weight maintenance rather than weight loss. This enforced the power of a patient centred approach.

One of the most salient moments of the intervention was in S5 when I had my clinical skills assessment and was observed by my work placement mentor (WPM). I was nervous about being assessed and worried that it may cause disruption to the dynamics that I had developed with Sheila in sessions 1-4. At the end of the session my WPM asked Sheila what she had learnt, were the sessions what she expected and to describe techniques and knowledge she had gained from the sessions. I felt very proud when I sat listening to Sheila as she began to describe some of the shifts she had experienced during the intervention. Sheila started by discussing how she *'had learnt to be kinder to her future me'*, to disconnect emotion from eating and that small changes can make a difference. She also mentioned that swaps are better than not being able to have something at all and that she still ate foods she enjoyed (e.g. a flapjack) but now

divided them up into smaller pieces. Knowing *'nothing was off the record'* had helped her make gradual changes that could be sustained. She now knew that if she did gain weight, "*I could make swaps and changes to help this".* Sheila also mentioned that throughout the process "I *had never told her once that she couldn't eat anything*".
On a practical level Sheila mentioned the utility of the portion plate and that she would use it frequently as well as using it to measure her lunch that she takes to work. Her [redacted] had also now ordered one and they had also bought 'portion cutlery' to help address portion control. [redacted] was also asking her for dietary advice. Sheila also mentioned that she was now focused on her *'future me'* and had switched from using the consumption of high calorie food as a reward to using the non-consumption of food as a reward (e.g. she accepted that these would be hard choices now but she would be grateful for them later on in life as she would have better knees, be able to run up hills and mountains and avoid diabetes). She also mentioned shopping 'mindfully' for healthy food options that she now placed in the cupboard at work for times when she forgot her lunch or was hungry during the day.

I also obtained feedback from my WPM after the session. He mentioned that I had demonstrated an empathic approach and that there was a clear collaboration of nature. We also discussed that I had explored lots of useful tools and coping approaches with Sheila and the balance of dialogue was excellent. I was really pleased with the feedback and listening to both comments from Sheila and my WPM created a shift in my confidence. I found the session reassuring, and it was beneficial to have another opinion from a valued colleague. I realised the power of supervision and how discussions with your peers can be so useful.

In hindsight, seeing the changes Sheila has made, as well as the feedback from my WPS have helped me grow in confidence and develop as a trainee Health Psychologist. It was excellent to observe the quantitative changes in Sheila e.g., she lost nearly a stone in weight, but it was the qualitative shifts that were the most powerful to hear. I knew these were the changes that would help Sheila maintain her weight in the long term. Furthermore, I realised that although the stages of assessment and formulation are key, important shifts are made when the client has time to develop a holistic understanding of their weight. As Sheila said in her final session " *I felt like somebody wanted to understand me rather than hand out solutions".* I felt very lucky to have an insightful client like Sheila. I know from my time working as a lifestyle coach that this is not always the case and that in the future, I will need to adapt my style to suit the needs of individual clients as not everyone will be in the same stage for change. I also learnt that the rapport you build with the client is fundamental to the process and is often superfluous to the techniques you use. Finally, at the end of S6 I would have been happy to carry on with my sessions as I still felt there was so much to do. However, my client insisted she was happy to 'run free'. Sheila emailed me after the final session, and we arranged a session in August to discuss her progress. She said that she had been looking for someone for the past 5 years to adopt a holistic understanding of her health and take a psychological approach, this seemed a perfect opportunity for a trainee Health Psychologist.

Nonface-to-face Case Study

Introduction

This non face to face (NF2F) bespoke intervention was conducted via MS Teams to provide my client (Nina) with support and guidance around weight management. I initially planned to offer a group weight management (WM) intervention and so advertised to potential clients through my work placement on the women's network, specifically the menopause support page. There is limited research focusing on menopause in the workplace (Verdonk et al 2022) yet women desire increased support (Hardy et al 2017) and techniques for self-management (Dennis & Hobson, 2023). Menopause is linked to metabolic and body composition changes resulting in increased levels of anxiety, poor sleep and weight gain (Fenton, 2021). Furthermore, increases in weight during menopause are linked with cardiovascular disease, certain cancers and osteoarthritis (Hurtado et al 2024). I therefore conducted assessments with 5 clients in January 2025 who were all at different stages of the menopause but had reported weight gain or/and an intention to develop healthy eating habits during the menopause. However, due to personal circumstances I had to take an interruption in my studies. When I returned in May 2025 only one group member was still available to take part in the group intervention. The remaining group member was happy to participate in a NF2F intervention. I conducted 7 sessions with Nina, a 59-year-old female, focusing on snacking behaviour, mindfulness-based stress reduction (MBSR) to address emotional eating and behaviour change techniques (BCTs) to facilitate weight maintenance. This case study will provide a detailed overview of the assessment, formulation, delivery and evaluation and reflection of the intervention.

Assessment Session 1, 2 & 3.

Prior to session 2 in May 2025, I had already met with Nina via MS teams in January 2025 (S1). However, I was keen to provide further assessment sessions as I was conscious that both the circumstances and needs of my client may have changed in the preceding months. Prior to S2 I gained consent and in S2 & 3 I used the biopsychosocial (BPS) model of health to gain a holistic understanding of Nina (Barlow, 2013) and as a framework for my questions. The BPS model is a flexible and practical way of providing a clear overview of a client's needs (Gask, 2018) and can help guide formulation (Bull & Dale, 2022). In contrast to my F2F intervention the assessment stage was longer; I was conscious of the physical distance from my client, so I focused on building rapport, active listening skills and building a collaborative relationship (Ribeiro et al 2020). Evidence suggests that the bond between the person delivering the intervention and the client is more important than the content of the intervention (Chopra et al 2021) so these initial conversations were key. I used motivational interviewing (MI) techniques with Nina focusing on open questions, affirmations, reflective listening and summarising (Miller & Rollnick, 2012). MI was chosen as it is a way of evoking and encouraging lifestyle change as well as reinforcing discussion and supporting self-efficacy (Rollnick & Miller, 1995). It also has proven efficacy with WM interventions in females (Suire et al 2020).

After S2 I sent Nina a food diary and asked her to complete this during the week and return before S3. This was so I would have time to study the diary and identify any areas for dietary change. In S3 Nina completed the Salzburg Emotional Eating Scale (SEES) (Meule et al 2018). These provided baseline measures for the intervention.

Formulation

The 5Ps model was chosen as it enables the clinician to gather a detailed overview of the client's past and present experiences (Cox, 2020). It is also key to effective treatment and recognises the uniqueness of individual clients (Johnston & Dallos, 2013). S3 started with an overview of the 5Ps model and how I had applied this to Nina (see Figure 1). I talked through the formulation with Nina making sure this was an accurate summary of our discussions and if there was any information she needed adding or removing. The process of formulation can help the client make sense of their experiences (Chadwick et al 2003) ensuring a collaborative interaction between the client and practitioner (McTiernan et al 2021). Throughout this session I noticed that my client was quieter than normal so I ensured the session was slower and focused on kind communication as this can help patient anxiety and increase client engagement (Greco et al 2025).

Towards the end of the session, we focused on goals and the key areas for the intervention, and this was led by Nina. Firstly, we addressed the issue of weight as Nina had lost weight successfully in the past but had always regained. She had also lost over a stone since January 2025 and was still losing over a pound a week.

However, she was not confident that she could maintain her weight loss once she had reached her goal weight. We therefore decided that one focus of the intervention would be on learning strategies for weight maintenance in preparation for reaching her goal weight at the end of summer. Weight maintenance would focus on a number of different BCTs (Michie et al 2013), top tips (Beeken et al 2012; Cleo et al 2017) and increasing physical activity. We also discussed the issue of snacking, as it was evident from the food diaries that Nina sometimes opted for high calorie snacks and alcohol in the evening, and that this may contribute to future weight gain (Barrington et al 2019). Addressing this could also help with both weight loss and maintenance. Furthermore, the results of the SEES scale (see Figure 3) suggested that Nina was more likely to snack and overeat when she was feeling sad, angry or anxious. The intervention would also focus on tools to help with emotional eating e.g. mindfulness techniques. After discussion, Nina stated that she was happy with this plan and was keen to move forward.

Figure 1. Summary of the 5Ps model for Nina

Predisposing factors: (what made me vulnerable in the first place)

Sedentary role at work [redacted]

Childhood 'clean plate brigade'.

Client is post-menopausal- women experience a decrease in metabolic rate and a loss of muscle mass which increases vulnerability of weight gain and obesity/changes in adipose tissue (Lovejoy et al 2009).

Client is taking HRT to help with sleep & hot flushes and this has been effective.

[redacted]

No advice given on weight maintenance.

[redacted]

Protective factors: (positive things that I have got going for me)

Insight into own behaviour and self-belief to change.

[redacted]

Has lost weight previously with slimming world but regained. Has lost 1 stone [redacted] *but would like help to maintain weight.*

Very sociable person and likes walking with others and will take the initiative and go out by herself.

Prepares own meals from scratch and can choose healthy options such as yoghurt, soup, pasta etc.

Problem areas: weight gain & maintenance, [redacted] in the evening & weekends, understanding triggers & eating habits. Moods affect her eating patterns & behaviours.

Precipitating factors (triggers for the most recent event)

Onset of menopause (linked with weight gain).

Have noticed weight creeping up and would like to address it.

[redacted]

Perpetuating factors (things that keep the problem going)

Have been previously successful with [redacted] *and lost weight but has always regained so focus is on maintenance.*

Snacking behaviour when home from work in the evening and at the weekends.

Skips meals and reaches for unhealthy snacks at night [redacted]

Access to high calorie foods at home.

Portion sizes & sedentary job.

Finding time to plan a variety of meals as sometimes bored with food choices.

[redacted]

Post menopausal

Goal/Intervention areas:

Build therapeutic alliance (especially as online intervention).

Psychoeducation (share formulation, promote the benefits of gradual weight loss being more effective, snacking behaviour - there is evidence that snacking in the evening is associated with higher BMI (Barrington et al 2019) also around eating in the evening and distraction).

BCTs from behaviour change taxonomy that are primarily associated with weight maintenance:

1.2 problem solving (reaching for food- identify triggers that urge client to eat unhealthy food) (relapse prevention)

1.3 goal setting (lose one pound per week)

1.4 action planning

2.1 self-monitoring (give client food diary and ask her to complete before each session).

2.2 feedback on behaviour - provide this by discussing the food diary at the beginning of each session.

8.7 graded tasks (ask my client to gradually build exercise e.g. walk for 30 minutes and then ask her to increase this week by week)

Increase physical activity to help with weight maintenance (Awoke et al 2021)

10 Top tips to help with weight maintenance (Beeken et al 2012)

Tools to help with emotional eating e.g. some mindfulness exercises will be delivered in each session (Bays, 2017)

Designing the intervention

The initial sessions (S1 & 2) with Nina were focused on building rapport and implementing the fundamental techniques of MI. This was for several reasons. Firstly, motivation plays a crucial role in weight maintenance so drawing on the client's motivation whilst utilising person-centred strategies such as active listening, asking open ended questions and rolling with resistance (Suire et al 2021) was key. Secondly, Nina was sometimes reluctant to address her snacking behaviour, so this method seemed appropriate to facilitate change. Furthermore, there is evidence that MI is an effective tool for weight loss maintenance, especially when used as an adjunct to BCTs such as self-monitoring (Simpson et al 2015).

I also included psychoeducation around snacking behaviour as there is evidence that people snack to reward themselves when stressed (Gillebaart et al 2022). Snacking in the evening is associated with weight gain so it may be more appropriate to elect foods that prevent hunger and consume these in the afternoon. Snacking can contribute to weight loss if the correct snacks are consumed (Prapkee et al 2023).

From discussions with Nina, it was apparent that she was losing weight successfully with Slimming World, but she expressed concern about regaining weight when she had reached her goal weight. As this had happened frequently in the past, she was eager to break the cycle. We therefore agreed to focus on weight maintenance. The BCTs selected were 1.1 goal setting, 1.2 problem solving, 1.4 action planning, 2.2 feedback on behaviour, 2.3 self-monitoring and 8.7 graded tasks. All had proven efficacy with weight maintenance (see Table 1). We also decided on 5 further sessions to provide Nina with sufficient time to learn and utilise all the techniques we had explored and decided weekly sessions were pertinent as this improves patient adherence and outcome measures (West et al 2021).

Finally, when discussing Nina's food diary in our initial sessions, she described 'blowing out' several times a week on high calorie snacks and an inability to control this. I therefore asked her to complete the SEES scale (Meule et al 2021). Results suggested a connection between Nina's eating behaviour and feelings of sadness, anxiety and anger. When researching emotional eating, I identified a plethora of literature on the effectiveness of mindfulness in addressing emotional eating (Sarto et al, 2019; Torske et al 2024). Thus, using both BCTs and mindfulness seemed appropriate techniques to address this.

Table 1: Examples of BCTs and mindfulness techniques used with Nina

Session	Behaviour Change Techniques (BCTs) & other techniques	Some examples used with Nina	Evidence base
1	Motivational Interviewing	Asked open ended questions, listened reflectively & expressed empathy, summarised, affirmed and elicited self-motivational statements. "In what ways does your weight concern you?" "What's good and bad about your current eating?"	Miller & Rollnick, 2022
2	Motivational Interviewing	Building optimism & self-efficacy "What strengths do you have that would help you make a change?" "When you have made a significant change before how did you do it?"	Miller & Rollnick, 2022
	2.3. Self- monitoring	Nina was given a food diary to complete after S2 and asked to complete this on a daily basis from S3-S7. I asked her to return this to me the day before our weekly session.	Ramage et al 2013 Sainsbury et al 2017
3	2.2 Feedback on behaviour	During each session we would discuss the food diary. This would involve praise for making good dietary choices and physical activity (PA) as well as highlighting areas such as skipping meals and the choice of high calorie snacks.	Awoke et al 2022 Sniehotta et al 2019
	Motivational Interviewing (MI)	Aspects of (MI) were also adopted during all the sessions e.g. I focused on eliciting the client's own motivation rather than 'telling the participant' what to do.	Simpson et al 2015 Suire et al 2020
4	1.1. Goal setting	After looking at the food diary Nina and I discussed improving levels of physical activity. Nina enjoyed walking and I was eager to agree on a realistic target. Nina suggested increasing her walking from 30 minutes to 40 minutes per day.	West et al 2011
	8.7. Graded tasks	After reviewing the food diary together Nina agreed to replace just one of her weekly snacks with a healthy option e.g. a donut for a yoghurt. This was then increased as the sessions progressed.	Howlett et al 2019 West et al 2011

	Mindfulness eating	Results of the SEES scale (see Figure 3) suggested a clear link between Nina's eating behaviour and feelings of sadness, anxiety and anger. Evidence suggests that practising mindfulness can decrease emotional eating. An introduction to mindfulness was conducted, what mindful eating is as well as key questions to reflect on when eating. This was followed up with a basic mindful eating meditation exercise e.g. the raisin exercise.	Katterman et al 2014 Kristeller & Hallett, 1999) Lattimore et al 2019 Sarto et al 2019 Torske et al 2024 Bays, 2017
5	1.1. Goal setting Mindfulness technique: 'Slow it down'	At the beginning of the session Nina and I discussed increasing levels of physical activity again. Nina suggested increasing her walking from 40 minutes to 50 minutes per day. This focused on the importance of chewing your food (15-30 times before swallowing) and having a hunger 'appestat'. We also focused on the 20-minute biological feedback loop. This was then followed by 'Tips to slow it down". Nina was encouraged to implement this.	West et al 2011 Bays, 2017
6	Mindfulness technique: 'The right amount' 1.2 Problem solving e.g. relapse prevention 1.4 Action planning	We focused on the teaching of Oryoki 'just enough' and to be aware of eating just enough to feel satisfied and that eating everything on your plate can be bad for you. We then discussed tips to implement this. I encouraged Nina to identify specific triggers that may increase the urge to drink more alcohol or consume high calorie snacks and develop strategies to address this. From the food diary it was evident that Nina often skipped meals and then snacked on crisps and chocolate later in the evening. Nina planned to eat 3 meals a day at regular time slots.	Bays, 2017 Byrne, 2002 Pederson et al 2018
7	Top Ten Tips for weight maintenance	Nina and I went through this in our last session, and all the material was also sent to her. These tips provided a structured guide for Nina and covered many of the strategies such	Beeken et al 2012 Cleo et al 2017

		as increasing PA and mindful eating that we had employed in the previous sessions.	

Outcome measures

Outcome measurements are important as they help the clinician assess the level of progress the client has made since the beginning of the intervention (Hatfield et al 2007). Traditional outcome measures in WM normally focus on body mass index (BMI). This was measured with Nina in S2 and S7. Nina was keen to focus on BMI as she was aware of some of the key health benefits if her BMI moved from the obese (>30) to the overweight category (25-30). Consequently, as the intervention was only 7 weeks, I was keen to manage her expectations as she was unlikely to lose a significant amount of weight in that time period.

The second outcome measure focused on emotional eating. This was assessed using the SEES (Meule et al 2018). A number of self-report measures were available however the SEES was deemed beneficial for several reasons. Firstly, the scale was the first to assess the difference between varying emotions and between increased/decreased food consumption because of these emotions. Secondly, it demonstrated an internal reliability of >0.70 (Meule et al 2018). Nina completed this after S3 and S7.

The third outcome measure used was the food diary that Nina completed after S2,3,4,5 and 6. Nina completed this on a weekly basis and returned to me the day before our session. This enabled me to monitor snacking behaviour (e.g. high-density snacks, alcohol consumption and timings of meals). I was also able to identify her use of BCTs as well as any qualitative comments that may identify a connection between her moods and eating behaviour.

Finally, in addition to outcome measures it is important to note that I planned to ask Nina to provide qualitative feedback on her experience of the intervention as this can provide a more in depth understanding of participants' experiences (Rortveit et al 2020).

Implementing the intervention

Over the 6 weeks, I had 4 intervention sessions with Nina (S4-7). All sessions were conducted via teams and lasted for 60 minutes. I prepared a PowerPoint for each session which provided a visual overview of the key things we would address. However, I remained flexible with this in case Nina wanted to explore any specific aspects further. We often began by discussing her weight loss from Slimming World and I always provided positive encouragement (2.2. Feedback on behaviour). We also discussed the food diary from the previous week, identifying any areas she was struggling with. In the initial sessions (3 & 4) I explained the BCTs individually and provided visual examples on the PowerPoint. However, as the sessions progressed, I encouraged Nina with tailored examples e.g. we discussed the use of completing a food diary for self -monitoring and its link to weight maintenance. I encouraged her to develop her own action plans (1.4) and to problem solve (1.2) (see Table 1.)

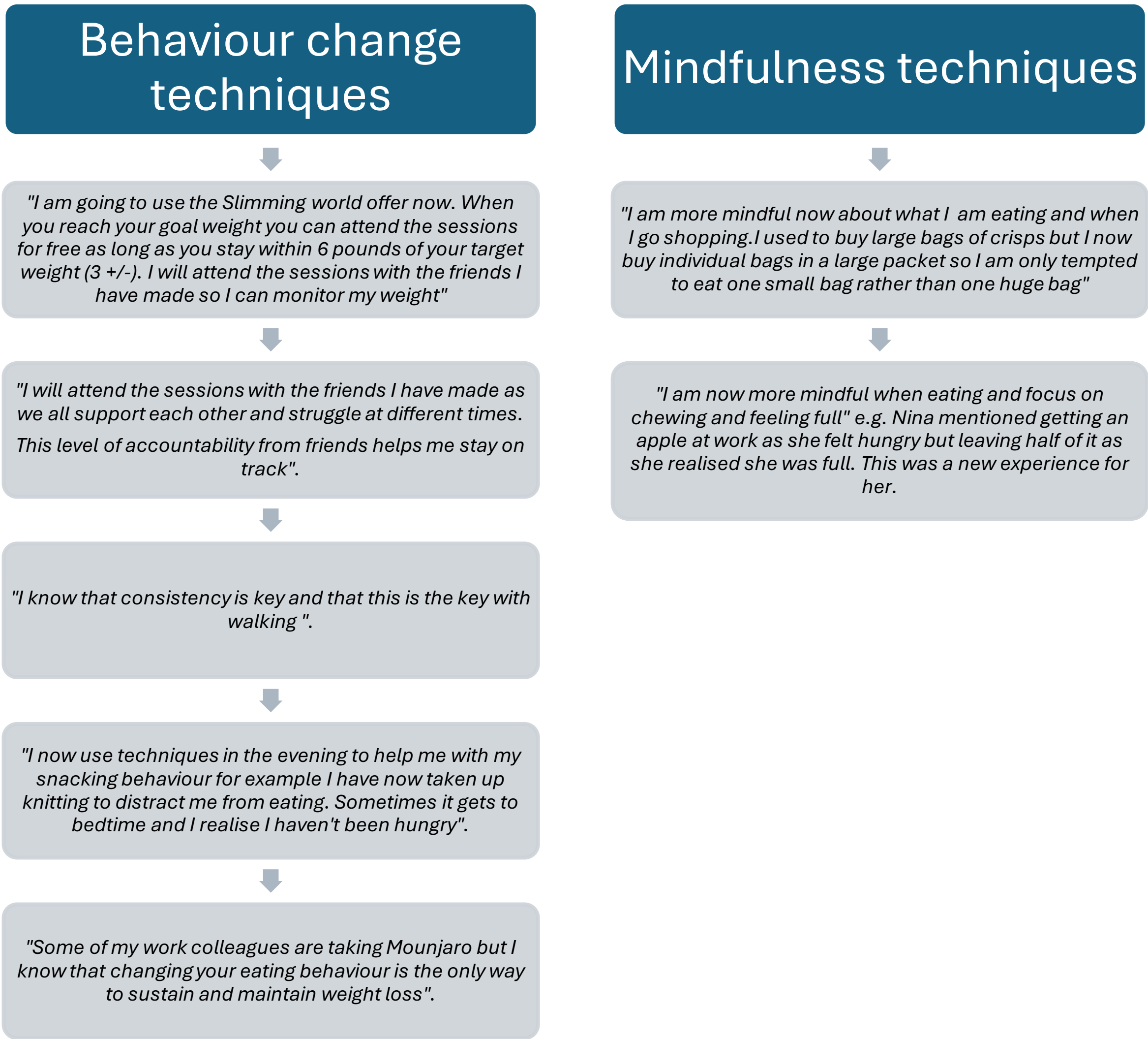
S4, 5 & 6 also included specific mindfulness techniques. I began by explaining what mindful eating was and its benefits in relation to emotional eating. In our first session we carried out a basic task called the 'raisin exercise' (Bays, 2017) with S5 & 6 focusing on chewing and the 20-minute feedback loop. We discussed ideas of when and how these techniques could be implemented into Nina's daily life and she was keen to adopt these methods.

Evaluation

I used three sources of feedback to evaluate the success of the intervention, the participant feedback, participant outcomes measures and self-reflection.

<u>Participant feedback</u>: I obtained verbal feedback from Nina at the midpoint of the intervention in S5 and also S7. I was eager to know what Nina was finding beneficial or if there were any aspects that needed clarification e.g. to change or add. I also sent Nina an evaluation form immediately after S6 (Hardavella et al 2017). I felt this was necessary as I was conscious that there may have been comments she was happier to provide in a form rather than face to face in our session. Written feedback also gives the client longer to reflect on aspects they found beneficial or areas they would have liked changing. See Figure 2 for an overview of the feedback from Nina after S6.

Figure 2. A qualitative summary of the techniques used by Nina for weight maintenance.



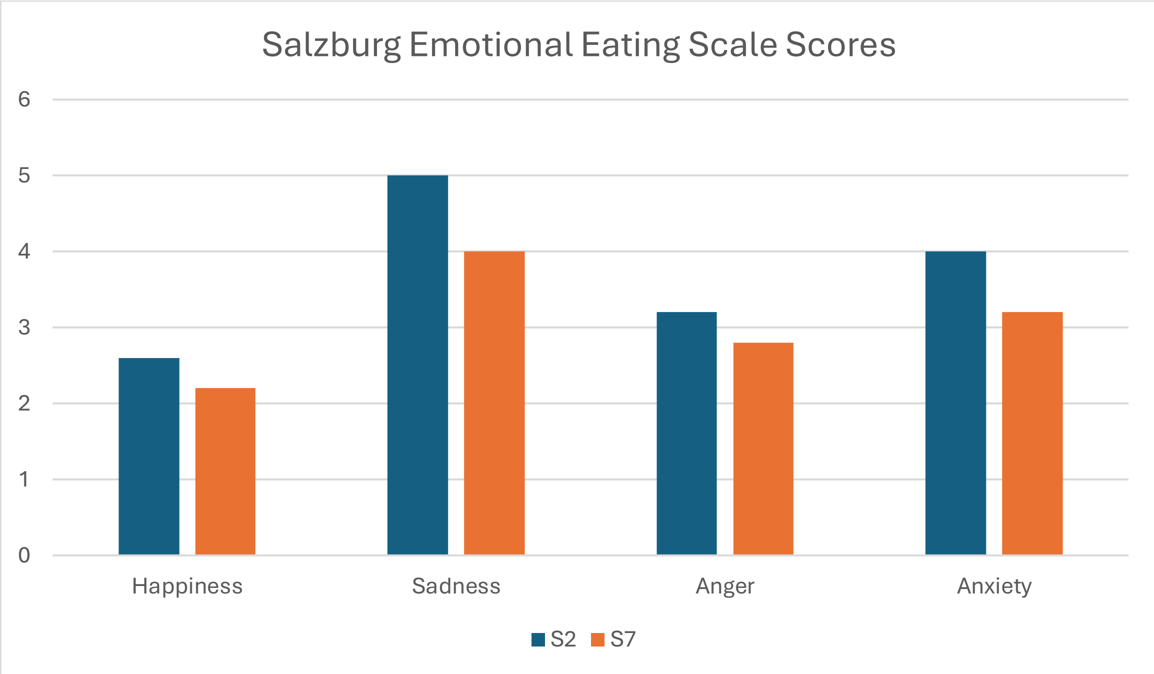
<u>Participant outcomes</u>:

After S2 and S7 I obtained results of the key outcome measures: the SEES scale, snacking behaviour choices and weight loss/maintenance.

The SEES scale & Emotional Eating

Results from S2 and S7 (see Figure 3) demonstrate a clear reduction in the association between eating behaviour and sadness, anger and anxiety. For example, the sadness score had reduced from 5 in S2 to 4 in S7, the anger from 3.2 in S2 to 2.8 in S7 and anxiety from 4 in S2 to 3.2 in S7. Although sadness and anxiety were still >3 there was a decline in the score. Anger was 2.8 and was now in the 'eats the same as usual bracket'.

Figure 3: Mean subscale scores on the Salzburg Emotional Eating Scale after S2 and S7



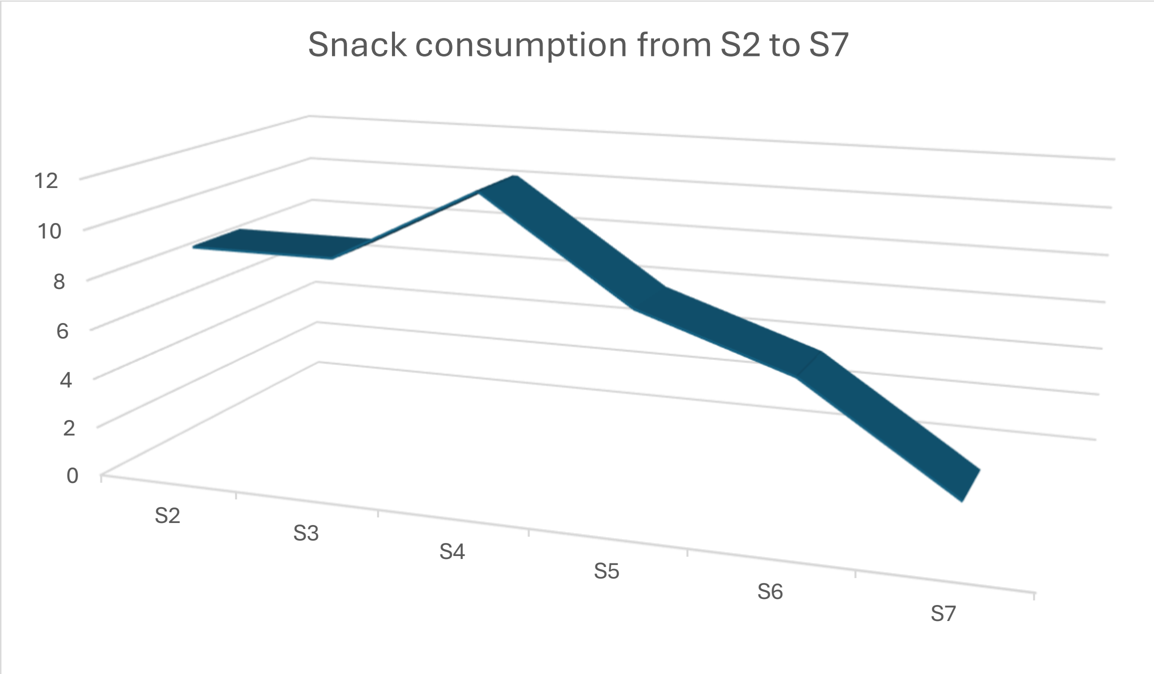
Nina completed the above scale in S2 and S7. Mean scores were calculated for each subscale and were interpreted as follows: someone who eats less when experiencing these emotions (scores < 3), eats the same amount as usual (scores = 3) or eats more when experiencing these emotions (scores > 3).

In S2 Nina scored above 3 on sadness, anger and anxiety, indicating that these emotions tended to lead to her over-eating. By S7 it was evident that all scores had decreased to the point where anger was now no longer associated with emotional eating. Anxiety had clearly reduced to a point where it was nearly at the desired level and although sadness was still associated with emotional eating it was trending in the right direction.

Snacking Behaviour Choices

In terms of Nina's snacking behaviour, Figure 4 demonstrates a clear jump in snacking behaviour in S4. Nina had skipped several meals during the day which had caused her to snack on unhealthy options late at night. However, from S4 onwards there was a clear reduction in amount of/number of snacks consumed.

Figure 4: Graph to demonstrate the numbers of snacks consumed from S2 to S7.



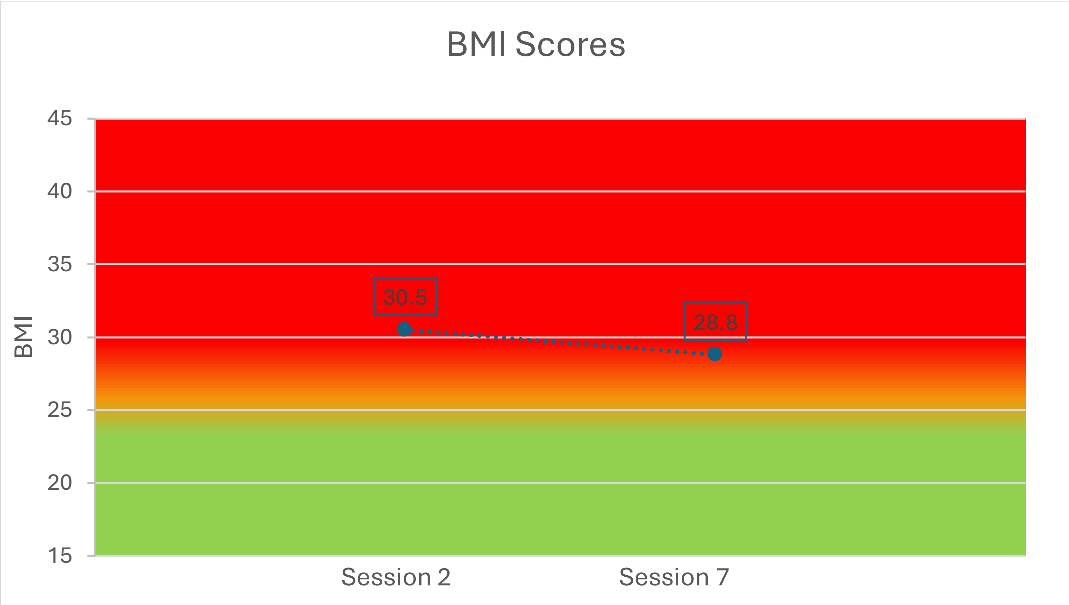
** snacks include items such as crisps, biscuits and alcohol drinks*

Weight Loss/Maintenance

The final outcome measure was weight loss/maintenance. Nina's BMI was calculated in S2 and was 30.5 which according to the World Health Organisation (WHO) put Nina in the obese category. In S7 Nina's BMI was calculated at 28.8, demonstrating Nina had moved from the obese category into the overweight category (see Figure 5). This has key benefits such as a reduction in susceptibility to cardiovascular disease and some cancers (Dikaiou et al 2021).

Nina was also doing slimming world and had been losing a pound a week prior to the intervention. However, during the intervention her weekly weight loss often increased resulting in her meeting her goal weight earlier than expected. This suggested the intervention had added benefits.

Figure 5. To demonstrate the reduction in Body Mass Index (BMI) between S2 and S7.



<u>Self-reflection</u>: In general, the sessions went well and I enjoyed delivering them. My client was engaged, attended every session, was happy to attend a session when she was on leave and sent her food diary to me prior to each session, without prompting. Nina reached her weight loss goal earlier than expected and reduced her snacking behaviour. However, in hindsight, I did try and cover too much in sessions 1 & 2, perhaps because I was unsure about the quantity of information I could cover in a one-hour session via teams. However, as the sessions progressed, I realised that Nina was very open to discussion, and I adjusted to her pace and the content I planned for each session was more appropriate. If I was running behind, which happened in most sessions, I focused on the key aspects that I needed to cover. On reflection I felt my experience was different to my F2F intervention. At the beginning I was conscious that I needed more time to build rapport with the client, so I elongated the assessment process which ensured I gained a holistic understanding of my client. However, I felt that my client took longer to 'open up' and was more resistant to change and I wondered if this may have been a result of the physical distance between us. For example, there is evidence that the absence of visual clues from a client may affect the therapeutic alliance (Irvine et al 2020). Furthermore, discussions around weight and eating behaviour are very sensitive and clients need reassurance, compassion and empathy (Warr et al, 2020). In future, it may be useful to devote the first half of S1 to building

rapport with a clear focus on techniques such as reflective listening, verbal validation and consistent eye contact (Al- Khafaji & Al-Samarrai, 2025).

Conclusion

This NF2F intervention was conducted over 7 sessions and was devised to address weight maintenance, snacking behaviour and emotional eating. The results were encouraging as Nina demonstrated a decline in snacking behaviour and a decrease in emotional eating e.g. results from the SEES revealed a reduction in scores for sadness, anxiety and anger. My client also continued to lose weight throughout the sessions and expressed confidence that she would be able to maintain her weight once she had reached her goal. My experience conducting the intervention was very positive, my client was engaged, never missed a session and was prompt with her feedback. When she was asked what she would have changed about the sessions she said that she would have liked them to have been longer, this was pleasing.

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None Face to Face Case Study - Reflective Commentary.

When I first met Nina, she was [redacted] post menopause and had gained 2 stone in the past two years. She had started taking HRT in the last year and this had improved her quality of life significantly. However, she was struggling with her weight and was keen to develop long term strategies that would help her both lose and maintain her weight. She was attending slimming world but was frustrated with her pace of weight loss which was slow in comparison to other members. I was keen to explore possible reasons for this.

I started this intervention with Nina as a more confident health psychologist. My face-to-face (F2F) intervention had been an extremely positive and enjoyable experience and had given me the opportunity to deliver my first intervention in a person-centred way, thus building my confidence in preparation for my none face to face intervention (NF2F).

However, delivering a NF2F intervention raised its own challenges. Firstly, I was concerned about being reliant on technology due to potential technical issues. I use MS Teams on a frequent basis in my workplace, so was aware of the possible pitfalls and the stress this can cause. I therefore ensured I made contingency plans with my client, and we were fortunate that this was never a problem. On reflection I know that technology is used more frequently now to deliver interventions, especially in the NHS since Covid. When delivering interventions in the future I would perhaps need to spend longer with clients helping them with technological aspects to build their confidence and navigate the systems. I was also fortunate to have a client that was solely reliant on her work-based internet which was fast and reliable. This may not always be the case.

Perhaps my most significant concern was that it would not be possible to build sufficient rapport online and this would affect the depth of the therapeutic relationship and ultimately the success of the intervention. This is especially key in the initial sessions where there is an increased likelihood that you may miss visual cues/ body language. To address this, I spent longer in the assessment and formulation sessions than I did during my face-to-face session so I could get to know my client. I listened hard and was mindful to demonstrate that I was fully engaged with her using clear signals e.g. making increased eye contact, nodding frequently and summarising what my client was telling me on a frequent basis.

As a consequence, I think I sometimes let Nina [redacted] and our discussions [redacted]. She was [redacted]

I also spent a considerable amount of time reflecting on certain sessions with Nina. [redacted] On reflection I found this information very sad and was keen to demonstrate empathy to my client and that I cared. I had faced a similar situation with my face-to-face client but felt that there was something about being in the same room as your client that helped convey my concern more effectively. I also asked myself would my client have confided in me earlier if the sessions had been F2F. This may have provided me with the benefit of gaining important information earlier, but it is not something I know. In the future I will have the confidence to interject earlier.

[redacted]

[redacted]

In order to address this, I found some of the techniques I had learned studying motivational interviewing very useful. I asked Nina open ended questions exploring the pros and cons of making changes and any internal conflicts that she may be feeling regarding this change. I was also keen to encourage Nina (to build self-efficacy) and use other techniques such as rolling with resistance and developing discrepancy. On reflection these techniques were useful as they not only moved the focus to Nina, but they maintained positive dialogue between us, at a time when it is easy to meet barriers. As a health psychologist I know change has to come from within and maintaining the relationship with your client is key to positive outcomes. Finally, it was also useful to have input from my lecturers who suggested useful strategies when clients are resistant to change. This demonstrated the importance of asking colleagues for advice and guidance, especially when you encounter challenging situations.

On a positive note, there were a number of beneficial aspects around the NF2F intervention. Firstly, my client had a very busy full-time job and an active social life. Having the sessions online enabled us to meet on a weekly basis, which kept the momentum of the intervention going, and, because she did not have to travel, enabled her to fit sessions in, even during her busy periods at work.

On reflection I found the confidence to ask Nina midway through our sessions what she was enjoying, finding useful and asked her for written feedback too. Her comments were positive [redacted] In future I think it may also help to ask for feedback more frequently. This may have provided a more in-depth critique and allowed Nina increased time to reflect and take on board the utility of the changes and techniques that she had made.

In our final session Nina mentioned that some of her [redacted] had decided to take the weight loss drug Munjaro as they wanted to lose weight for summer weddings as they had not left themselves enough time to lose weight 'the traditional way'. Nina had participated in the office discussion and had outlined the limitations of taking a weight loss drug. She suggested they would be unable to take Munjaro for life and stressed the importance of changing their eating behaviour and adopting behaviour change techniques in order to sustain and maintain their weight loss. I felt proud that she had the confidence to discuss this and the insight to mention these factors to her colleagues.

In her last session Nina mentioned [redacted] and I was delighted that she had shared this with me. She had also lost ten percent of her weight at slimming world, and she was excited about being able to maintain her weight loss using the techniques she had learnt during the intervention. She mentioned that she had found the sessions very useful, and I felt that this was a positive way to finish.

Finally, both interventions highlighted areas for future development as I noticed some key patterns when discussing weight with clients, notably, they are often self-critical and lack self-compassion. I would therefore be keen to receive some training in compassion focused therapy (CFT) as this focuses on 'motivational shifting' and has proven effective in increasing levels of self-compassion and self-efficacy in individuals with obesity. Being able to integrate aspects of CFT into any future interventions and dialogues would be beneficial and I know it is something I would benefit from learning about.