

**PSYCHOLOGICAL PRACTITIONERS' CONCEPTUALISATIONS OF THE PROCESS
OF CHANGE IN CLIENTS WITH CHRONIC HEALTH CONDITIONS:
A QUALITATIVE STUDY**

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**A thesis submitted in partial fulfilment of the requirements of the
University of the West of England, Bristol for the degree of
Professional Doctorate in Health Psychology**

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Psychological practitioners' conceptualisations of the process of change in clients with chronic health conditions: a qualitative study

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Statement of Objectives

The objective of the research is to understand better, psychological practitioners' conceptualisations of the process of change in clients with chronic health conditions, through a qualitative investigation. Specifically, the research explores:

beliefs of health psychologists in independent practice concerning the means by which change can be facilitated in client health behaviours and cognitions that improve their experience of common chronic conditions,

beliefs of counsellors in independent practice concerning the means by which positive change can be facilitated in clients with common chronic conditions,

how the beliefs of a small sample of psychological practitioners from these backgrounds illuminate understandings of the process of client change,

how these practitioners beliefs may be modelled and understood and

what can be suggested from these outputs as useful future areas of research into practice and training improvements.

This research gratefully acknowledges that this study is based on the knowledge derived from existing published work detailed in the thesis Bibliography.

Assistance and encouragement from academic supervisors in the University of the West of England, specifically, Drs Diana Harcourt, Tim Moss and Mary Reid, have been invaluable. The views of the participants to this research lie at the heart of the study and I wish to express my gratitude to them for their contributions to this complex and perplexing area of study.

Statement of Collaboration

This research has been conducted by the author solely in his capacity as an independent psychological practitioner and as a student of the University of the West of England.

Guide to the Contents

This submission is a partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Professional Doctorate in Health Psychology. It contains three main elements comprising a Systematic Review, a Thesis and a Reflection on the process of training as a health psychologist. The remainder of the doctoral requirements lie in a separate Portfolio of evidence submitted to the University and externally assessed and passed in 2010.

The Systematic Review and associated appendices is presented here first and this was assessed and passed by the University of the West of England in 2008. This review was of the efficacy of randomised controlled trials (RCTs) of the use of hypnosis in the treatment of common chronic conditions. The outcome noted the weaknesses of the many small-scale RCTs of hypnosis relating to chronic health conditions and recommended much larger and better controlled studies. Unfortunately, it became clear that this recommendation was not capable of being implemented by the author, an independent researcher with no ready access to an institution with sufficient number of patients receiving hypnosis for chronic health conditions. This required the Thesis part of this submission for the Professional Doctorate in Health Psychology to change topic and necessitated a new and different literature review. The impact of this process is described in more detail in the Reflective Chapter that follows the Thesis. One non-central aspect of the Systematic Review that was capable of being researched came from noticing how the reviewed RCTs displayed many different presumed mechanisms by which hypnosis was thought to work. This prompted the author's research into exploring what health psychologists might believe about mechanisms of change when working face-to-face with patients and clients with common chronic conditions.

These ideas were developed into an exploration of the beliefs about the nature of the mechanisms of change in patients and clients with chronic health conditions as held by health psychologists and counsellors who work as independent practitioners alongside primary care. This research is described in the Thesis that follows the Systematic Review. The Reflections on the process of training as a health psychologist and the future direction of post-doctoral work by the author follows the Thesis.

Dedication

This research is dedicated to my wife, Bettina, without whose constant support, this work would not have been possible.

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**Professional Doctorate in Health Psychology, Department of Psychology,
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**A systematic review to determine the efficacy of hypnosis in the treatment of
common chronic conditions**

Paul Douglas Millar

Abstract

The purpose of this review was to establish if hypnosis has efficacy as an intervention in common chronic conditions. This review considers both the efficacy with which hypnosis improves symptomology and the hypothesised mechanism by which authors thought hypnosis was effective.

The search strategy interrogated published and unpublished randomised clinical trials identified through structured searches of MEDLINE (1966 to March 2006), EMBASE (1980 to March 2006), PsycINFO (1806 to March 2006), CINAHL (1982 to March 2006), AMED (1985 to March 2006), SIGLE (to March 2008) and The Cochrane Library. Hand searches made of the British Journal of Health Psychology, Contemporary Hypnosis and known centres of hypnosis study in the UK for unpublished papers (to March 2008). From the searches, 4579 papers were initially detected from which 40 papers with reports of RCT's emerged, with 11 meeting the inclusion criteria.

Selection criteria included all randomised clinical studies comparing hypnotherapy for the treatment of common chronic conditions with no treatment or other therapeutic interventions. Excluded were studies principally mental health in causation, addiction, non-chronic conditions, pain as the major symptom (unless IBS-related), asthma prior to introduction of inhaler medication and trials to improve coping with illness only.

All abstracts and studies were selected and evaluated for inclusion by two assessors with a third available for arbitration. Quality and data was assessed and extracted by the reviewer. The primary outcome measure was global symptom severity score. Secondary outcomes included individual symptoms, quality of life and psychological measures specific to trials and any unwanted side-effects.

11 RCT's of hypnosis as an intervention emerged from the search covering 4 chronic health conditions, asthma, eczema, irritable bowel syndrome and related conditions and obesity. The studies compared the efficacy of hypnotherapy to many different experimental conditions, psychoanalysis, placebo, biofeedback, supportive therapy, stress reduction, dietary advice, waiting-lists, conventional treatment controls and even the efficacy of different hypnotic styles.

Data were not pooled for meta-analysis due to methodological differences in study design and outcome measures. Hypnosis was found to be more beneficial than other psychological therapies or waiting list or conventional treatment controls in the common chronic conditions studied. Unwanted side-effects were not reported in any of the trials. However, the results of these studies should be interpreted with caution due to heterogenic data and weaknesses in methodological quality.

The methodological quality of the included trials was insufficient to permit firm conclusions about the efficacy of hypnotherapy for common chronic conditions. More research with high quality trials is needed and these with more conditions.

A systematic review to determine the efficacy of hypnosis in the treatment of common chronic conditions

Paul Millar, Professional Doctorate in Health Psychology, Department of Psychology, University of the West of England, Bristol, June 2008

Background

The purpose of this review was to establish if hypnosis is effective as an intervention in the psychology of health. It might be wondered why psychologists should concern themselves with a controversial intervention like hypnosis when more conventional cognitive-behavioural therapy (CBT) is available. That hypnosis is controversial is unquestionable, almost certainly through it being connected in the public and professional mind to the practice of stage hypnosis and media representations of a lurid nature (Waxman, 1989). CBT would likely make for a poor public display, but hypnosis as entertainment can often be encountered. Understandably, psychologists might shy away from this notoriety and a potentially useful intervention could be lost to the health professions as a consequence. Unhelpfully, there is no strong evidence base for the efficacy of hypnosis in health despite a plethora of individual case studies and anecdotal reports of successful interventions. To encourage the use of hypnosis as a therapy, the British Psychological Society (BPS) published guidelines and encouragement for its practice (Heap et al., 2001) that updates a much older similar plea, published by the British Medical Association for its use in medicine (BMA Psychological Medicine Group Sub-Committee, 1955).

The psychology and physiology underlying hypnosis is unclear (Palsson et al., 2002), but has been hypothesised as the cognitive modulation of some physiological processes that are normally thought to be under involuntary control, for example, in pain control (Rainville P. et al., 1997; Zeltzer L. et al., 1984; Dinges D. et al., 1997; Olness K. et al., 1987), endocrine function (Sugarman, 1996) or gastric fluid release (Stacher G. et al., 1975). Thus, hypnosis is thought to be effective in modulating the autonomic nervous system, in producing physiological responses triggered by visualisations of real triggers and cognitive-behavioural changes brought about by modifying perception of bodily functions through mental modelling and rehearsal (Gonsalkorale, 2006).

Purpose

In the UK, the principal text on medical and dental hypnosis has been revised and updated by a clinical psychologist and a general medical practitioner, with a substantial section devoted to hypnosis in psychological therapy (Heap & Aravind, 2002). Heap and Aravind lament that there is a dearth of systematic evidence among the plethora of case studies and hypnosis theory available in hypnosis literature and make a plea for more systematic approaches to support the approach's evidence base (ibid. pp 491-492). While there is a large volume of evidence on the use of hypnosis in psychology for issues focused on mental health, such as phobia, depression and anxiety, hypnosis is also of interest as an intervention suitable for physical health conditions (Lynn et al., 1993). There is, therefore, a good case for a systematic investigation of hypnosis in health.

The then President of the European Health Psychology Society's paper, "Is Cognitive Behaviour Therapy Effective for Changing Health Behaviours?" (Mitchie, 2005), raised the issue that health psychology is moving from studying psychological interventions in physical health to developing its own interventions based on the findings of this research. It is appropriate to test how much hypnosis can contribute as a cognitive therapy to physical health. A second justification for the review is awareness of those who suffer from health conditions who seek solutions not currently available in conventional medicine or who would prefer to seek forms of healing outside conventional pharmacology (Palsson, 2006). For example, it was reported that less than half of those suffering from IBS are relieved by current conventional treatment (Thompson et al., 1997), and psychological treatments have been shown to be effective in clinical trials. This review aimed to explore, systematically, just how effective hypnosis is, compared to other psychological therapies like cognitive-behavioural therapy or psychotherapy, in conditions where conventional medicine does not provide a total solution.

In the UK, common chronic conditions, such as IBS or diabetes, have been calculated as taking up 80% of general practice consultations, take up the majority of patient bed-days in hospitals, comprise two-thirds of emergency admissions and in the USA, consume 78% of all health-care spending (Department of Health, 2004). If psychological therapies offer a proportion of patients with chronic health conditions lasting relief from symptoms the benefits to individuals and to health care costs would make psychological interventions especially worthy of study.

This systematic review of hypnosis as a psychological therapy required a rigorous gathering together of all tests of hypnotic interventions and combining them into a broader understanding of the knowledge base. This has been done here employing randomised controlled trials (RCT's) of the effectiveness of clinical hypnosis in common chronic conditions. This review considers not just which conditions had been treated with hypnosis but the hypothesised means by which the authors thought hypnosis had been most effective.

Systematic searches of electronic databases found only limited occurrences of hypnotic interventions in health conditions. Outside the realm of mental health, randomised clinical trials were found for only 4 chronic conditions, namely, asthma, eczema, irritable bowel syndrome (and closely related conditions) and obesity. It was felt to be inappropriate to combine these conditions any further into larger groupings as they were so different in aetiology.

Nevertheless, the authors of papers investigating them have placed aspects of these conditions within the field of psychosomatic medicine, with the suggestion that some symptoms may be manifestations of underlying psychological processes, albeit expressed physiologically. Symptoms of mental ill-health are not by necessity associated with the chronic conditions of asthma, eczema, irritable bowel syndrome and obesity. However, these conditions are thought by the papers' authors to be at least partially caused by, or exacerbated by, psychological processes.

This made it appropriate to examine the efficacy of hypnosis in the treatment of chronic health conditions with a view to testing how appropriate it might be to include hypnosis in the range of interventions used in health psychology.

Objective

The objective of this systematic review was to determine the efficacy of hypnosis in the treatment of common chronic conditions with a view to assessing its applicability as a health psychological intervention.

Criteria for considering studies for this review

Types of studies

Randomized clinical trials of hypnosis for treatment of chronic health conditions were reviewed if they were published in the English language and met the inclusion tests as described below. The reason RCT's were selected was to ensure that the highest methodological standard of tests would be included in the review and that this might permit a meta-analysis to be performed. This would provide a more precise estimate of any treatment effect than that of any individual study (Egger et al., 1997).

Inclusion Criteria

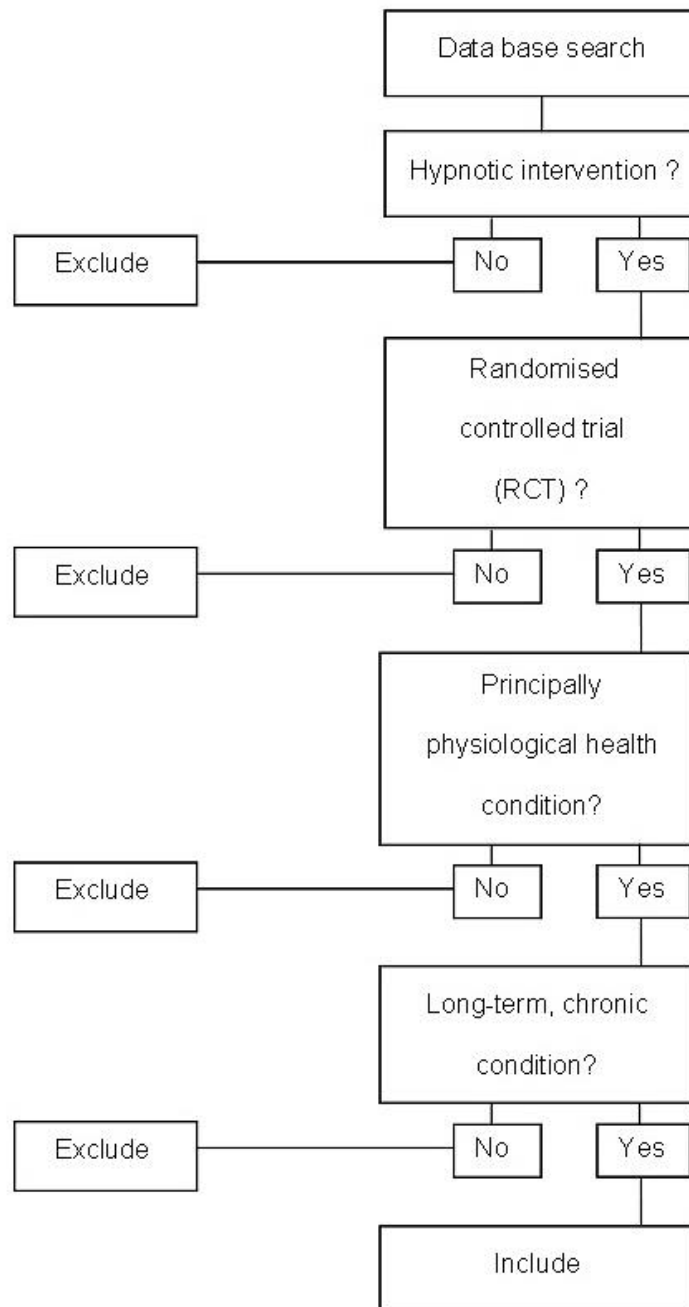
The common chronic conditions were selected as those which had a history of randomised controlled trials (RCT's) of hypnotic interventions. It is accepted that the rigor of hypnotic RCT's would fall short of some standards of blinding in RCT's, as hypnosis is an intervention that is difficult to disguise and, following the ethical guidelines of the British Psychological Society (BPS), should not normally be disguised (Heap et al., 2001). Thus, non-blinded studies were included. Chronic health conditions were defined as those that did not resolve themselves over a short period specific to each condition. Normally, chronic conditions are those which had become permanent or continued for many years and were refractory (unresponsive to standard medical interventions). Common chronic health conditions were defined as those which exist in substantial numbers in the normal population.

Exclusion Criteria

Conditions were excluded if they were short-term, self-limiting or acute. Self-limiting conditions, such as some infections, were excluded as they were thought to be normally resolvable over an expected time-frame. As with short-term and acute health conditions, this involves a variable time limitation that is specific to the health condition involved. Thus, a broken leg might take over a year to heal, following physiotherapy, but normally would be expected to heal over this time-frame for an otherwise healthy person. All mental health chronic conditions were excluded, although conditions with associated mental health aspects, such as with obesity and irritable bowel syndrome, were included as the mental health aspects were secondary to the main condition and were not necessarily present.

Also excluded were addiction conditions, considered to be principally issues of mental health (e.g. alcoholism, gambling), pain as a single symptom (e.g. migraine) and not a principal condition (e.g. pain in obstetrics or in palliative care, but included is functional abdominal pain, seen as part of the IBS spectrum of conditions) and chronic conditions with psychological disorders as a main component (e.g. anorexia or bulimia). Excluded too, were RCT's of hypnotic interventions aimed solely at coping with chronic conditions or not overtly directed at the symptoms. Asthma studies prior to 1980 were excluded as the introduction of inhalers as a first intervention significantly reduced emergency admissions from that time, rendering earlier studies anomalous to present-day conditions (Kohen, 1996). See Figure 1 for a diagrammatic summary of inclusion criteria.

Figure 1: Diagrammatic summary of inclusion criteria



Types of participants

Male and female participants undergoing medical interventions for significant health condition symptoms, as assessed by medical practitioners were eligible for inclusion in this review. No exclusion of children was made as the health conditions were not exclusive to adults and 3 studies did not identify the ages of participants, which justifies, to an extent, this inclusion of adults and children. Frequently, interventions for children and adolescents are excluded from reviews because they are thought to represent a different population from adults and may be treated in different social and clinical environments with parents present or by paediatricians rather than other medical practitioners. It is held here, that this distinction is not biasing if strict criteria ensure that reviewed RCT's can be said to have very similar interventions for both adults and children and that the psychosocial environment is not clearly different for adults and children in such interventions. While it is accepted that children may tend to have a stronger response to hypnosis than adults (Heap & Aravind, 2002), hypnotisability is an uncertain measure and varies substantially across populations, certainly between adults, and it may not always be defensible to differentiate between the psychological response to psychological interventions of children and adults via an arbitrary age cut-off at, for example, at 18 years (Hackman et al., 2000).

Types of intervention

Clinical hypnosis is the use of hypnosis as an intervention to treat symptoms, or to assist coping with symptoms, of a medical or mental health condition (Heap et al., 2001). The intervention is generally thought of as a cognitive process (Whalley & Oakley, 2003; Brown & Oakley, 2004) which if used as a therapy is called hypnotherapy. Here, clinical hypnosis and hypnotherapy is referred to as hypnosis for simplicity unless the distinction is thought essential to the context.

Hypnotic interventions are considered here to be biopsychosocial in their mechanism of action. Hypnosis is described in the reviewed papers as a complex intervention that affects the interactions between mental and physiological aspects of health. Hypnosis is also affected by the social context in which hypnosis occurs, the interaction between the hypnotist and the patient, empowered by commonly-held beliefs about the efficacy of hypnosis. Hypnosis is described as an intervention that affects respondents in many ways, "their state of mind, sense of self, self-schemas, memory, rumination and beliefs, but also the feedback between these factors and the good functioning of human physiology" (Webb 2007).

Hypnotic approaches vary but normally employ a set of verbal instructions or suggestions which are designed to produce an inwardly directed focus in the respondent. This is accompanied with imaginative processing which is designed to facilitate the psychological and physiological changes (Heap & Aravind 2002). This inwardly directed focus (traditionally referred to as “trance” in hypnosis) is often accentuated by the hypnotist’s suggestions of relaxation until the participant is barely aware of their surroundings and is comfortably and deeply relaxed. Once trance is induced, the focus of the hypnosis varied according to the psychological assumptions behind the therapeutic goal.

In the studies, gut-directed hypnosis directed feelings of warmth and relaxation towards the abdominal area in irritable bowel syndrome and its related conditions of functional dyspepsia and abdominal pain. Hypnosis inducing relaxation and calmness was used in asthma and eczema studies. Focusing on self-belief, motivation, education and stress reduction was the emphasis in weight control trials for obesity.

Types of outcome measure

The primary outcome measure was a change in the mean global condition severity, measured appropriately for each condition. Secondary measures were expected to include mean changes in individual symptom reduction, quality of life, participant assessments of change, validated questionnaire measures and measures of unwanted side-effects.

Search Methods for Identification of Studies

The aim of the Search Strategy was to systematically find peer reviewed RCT’s on hypnosis and its use in the treatment of chronic health conditions.

Electronic databases were chosen as the main focus of published studies. A detailed search strategy was developed which was tailored for each electronic database considered appropriate for the review. The data bases chosen were those most frequently selected for RCT’s, namely, MEDLINE (U.S. National Library of Medicine, 1950 to week 3, February 2008), CINAHL (Cumulative Index to Nursing and Allied Health Literature, 1982 to February Week 5 2008), AMED (Allied and Complementary Medicine Database, 1985 to February 2008), EMBASE (Elsevier Medical and

Biological database, 1980 to 2008 Week 09), PsycInfo (American Psychological Association psychological abstracts database, 1985 to February 2008) and the Cochrane Library of Systematic Reviews (February 2008) for citations for such studies (Pilkington, 2007; Hopewell et al., 2007).

Early search strategy testing found few RCT's of hypnosis use in chronic conditions and it was decided to adopt a high sensitivity, low specificity approach to find the largest number of studies at the outset. To achieve high reliability, this review utilised search strategies already developed for the identification of RCT's. The Centre for Reviews and Dissemination at York University (CRDYU) has developed search strategies for MEDLINE and CINAHL using OVID (Ovid Technologies) designed for high sensitivity in finding RCT's. (These strategies were originally designed to provide studies and reviews for the construction of the CRDYU database DARE, the Database of Abstracts of Reviews of Effectiveness.) (Centre for Reviews & Dissemination, 2007)

The search term "hypnosis" is stated to be effective in locating studies on hypnosis (Pilkington, 2007) and, following piloting, this was combined with "hypnotherapy", "relaxation", "imagery", "controlled" and "meta-analysis" in a search of the remaining databases, AMED, EMBASE and PsycInfo as shown again in Appendix A.

The Cochrane Library for Systematic Reviews (to March 2008) was searched using the keywords above and for all chronic conditions that emerged from the OVID database outcomes.

Grey literature searches used SIGLE (System for Information on Grey Literature in Europe, 1996 to March 2008), and a web-based search was made of the electronic libraries of known centres of excellence in hypnosis in the UCL London Hypnosis Unit and the University of Sheffield psychology department, seeking unpublished studies and theses (February 2008).

Hand searches were made of the Journal of Health Psychology, the main professional UK health psychology publication and also of Contemporary Hypnosis, the main publication of the UK health professional hypnosis journal. Electronic searches were made of journals derived from citations taken from papers found in the electronic search. These searches were to ensure that key publications not entered into OVID data bases had been fully searched for (all to March 2008). A detailed listing of the search strategy for each data resource is found in Appendix A.

From the searches, 4579 papers were initially detected featuring hypnosis and health from which 44 papers with reports or reviews of RCT's emerged, with 11 meeting the inclusion criteria. Appendix C lists the references to all studies included and excluded from this review, other citations from the review and Appendix D lists the excluded studies and reasons for exclusion.

Identification of trials for the Review

The titles and abstracts of all studies located by the searches were checked by a second reviewer to identify those likely to be evaluations of the efficacy of hypnosis for chronic conditions. Full papers were then obtained and double assessed by the author and the second reviewer to identify those that met the inclusion criteria. Differences were resolved through discussion and a third reviewer was available in the event of disagreement, but not required.

11 RCT's met the inclusion criteria. 4 chronic conditions emerged from the search, asthma, eczema, IBS related conditions and obesity. It is only considered possible to combine the outcomes of trials of such apparently diverse common chronic conditions in this review because of the assertion of substantial commonality in psychological causation.

Studies were then tabulated by design, results and the psychological hypotheses underlying interventions. The quality of the trials was assessed by examining the individual attributes of the trials rather than giving global quality scores. Quality assessment was made of the trials by participants, trial context, type of intervention, controls, prime effect measures, effect on symptoms and stated outcomes and hypothesised efficacy of intervention. Quality assessment was also made by follow-up, generation of the random allocation of respondents to trial conditions, allocation concealment, blinding and drop-outs. Data extraction was made by the author. Where clarification of data issues was not available from later studies that cited these primary studies, authors were contacted where traceable and requested to provide missing or additional information.

Initial condition severity measures were noted to be qualitatively mixed. IBS participants were assessed on several measures in addition to strict Rome Criteria, versions I, II and III (Rome Foundation, 2008) to unique experimental trial measures. Other studies had symptom severity ratings that permitted comparison through effect

sizes if not direct equality of severity effect. Outcome data was found to be similarly qualitatively mixed, comprising some continuous data, symptom decrease, asthma peak flows, emergency room visits, weight loss and some discrete and categorical data, reduced medication (unspecified), quality of life and well-being measures.

It would have been possible to compare different conditions' initial and outcome measures if there was equivalence of symptom measure scaling, such as eczema intensity, asthma bronchodilatory sensitivity, obesity measure or IBS global Rome scores. This would permit the strengths of the relationships between at least two variables in each of the trials to be calculated and a power prediction made of the outcome (Cohen, 1988). Unfortunately, the trials found were too heterogenous in methodology and initial and outcome measures for a meta-analysis to be done with confidence. Accordingly, the trials were assessed qualitatively.

Results

A positive outcome was found in most trials as is shown in Tables 1a and b below. With asthma, Kohen 1996 measured symptom severity as reported by participants. He reported that hypnotic relaxation therapy (intervention 1) and the alternative waking hypnosis (intervention 2) gave a significant improvement over a year in the intervention group (52% average decrease) compared to the control group (35% mean decrease). The principal outcome of the study, to reduce hospital emergency admissions was unproven, although symptom severity was reduced significantly. Ewer 1986 found the main outcome measure of lung function in bronchial hyper-responsiveness improved by 74.9% and self-reported asthma medication usage decreased by 26.2%.

In the irritable bowel syndrome and related conditions group, gut directed hypnosis was the main intervention. Calvert 2002 reported that the percentage improvement in dyspepsia symptom score at 73% compared to a smaller improvement, 34% for supportive therapy (counselling), a smaller improvement than the control and 43% for standard pharmaceutical treatment. Vlieger 2007 found with self-hypnosis, that 85% had improved in abdominal discomfort over the control's improvement of 25%. Whorwell 1984 reported positive changes for hypnosis with mean weekly scores in symptoms being significantly greater than control while a combination of psychotherapy and placebo medication did not produce a significant improvement. Galovski 1998's Composite Primary Symptom Reduction score for the hypnotic intervention group was significantly more improved than the control. Palsson 2002 also found IBS symptoms reduced more with gut-directed hypnosis than controls. Roberts 2006, interestingly,

found the intervention and control groups at 1 year had no significant differences, but that the intervention group reduced symptoms significantly faster than the control at 3 months with the control reaching the same level at the 12 month assessment. Roberts recorded a mean change from baseline of 13 points to 4.5 points in symptom severity compared to the control group at the 3-month timescale.

Sokel 1993 used hypnotic relaxation for exzema and had two result categories, area of skin affected and mean severity scores. Measures of skin area affected and redness were unchanged while severity scores after hypnosis showed significant improvement over 20 weeks compared to baseline for surface skin damage and lichenification (roughness) while the control showed no significant change. This outcome was stronger for girls than boys. Biofeedback results lay mid-way between hypnosis and control but the small sample size prevented differentiation of the interventions at significant levels.

In the obesity/weight loss group, both Stradling 1998 and Cochrane 1986 measured weight loss as the outcome of hypnotic realxation. Stradling 1998 found a significant weight loss of mean 3.8kg, while Cochrane 1986 reported that 2 different hypnotic approaches yielded losses of 17.8lb and 17.1lb with the interventions but little change for the control. Significantly, Stradling's team required weight loss to reduce sleep apnoea difficulties and failed to achieve a clinical result for that condition while still achieveing a result for weight loss alone.

Description of Review studies

A description of the 11 included studies included in the review is given below. The details of individual studies are contained in Appendix B, Characteristics of Included Studies.

Methods of randomisation, allocation and blinding

Studies were randomised with participants allocated to intervention and control groups. Allocation concealment and method of randomization were not adequately described for Kohen, 1996, Galovski, 1998, Cochrane, 1985 and Stradling, 1998. Allocation was blinded, but the method of randomization was not described for Ewer, 1986, Whorwell,

1984, Calvert, 2002 and Sokel, 1993. Adequate allocation and blinding by computer generated randomisation or sealed envelope took place for Palsson, 2002, Vlieger, 2007 and Roberts, 2006.

Study Participants

406 participated. The smallest study (Galovski, 1993) randomised 12 adults and the largest study (Calvert 2002) randomised 126 patients of ages unspecified. Overtly stated child studies were Sokel, 1993 (ages 5 to 15) and Kohen, 1984 (ages 7 to 12). 3 studies did not specify participant age, Ewer, 1986, Calvert, 2002 and Stradling 1988. No power calculations were given by any study to determine ideal sample size. Numbers invited were absent from 4 studies. 626 participants were enrolled onto all studies combined, 619 were randomised and 592 completed the tests. Calvert, 2002, Whorwell, 1984, Vlieger, 2007 and Cochrane, 1986 had few differences between invited, enrolled, randomised and completed numbers, suggesting missing or unexplained data. Whorwell 1984's participants were reported as having no withdrawals in correspondence with others (Webb A. et al., 2007). Withdrawals from studies were adequate when described, through wrong diagnosis of condition, illnesses during interventions and non-attendances after randomisation.

All but one study took place in a hospital or university setting, Roberts, 2006 was in primary care. All participants were recruited from patient groups, apart from Kohen 1996, (opportunistic) and Sokel, 1993 (unspecified).

Interventions

All used cognitive-behavioural approaches in hypnosis. This involved hypnotic suggestions aimed at changing beliefs and abilities to reduce anxiety and stress and to improve relaxation. For all conditions, special hypnotic suggestions were made to counteract symptoms, relaxation for asthma (Kohen, 1996, Ewer, 1986), gut-directed healing for IBS, functional dyspepsia and abdominal pain (Calvert, 2002, Whorwell, 1984, Galovski, 1988, Palsson, 2002, Vlieger, 2007, Roberts, 2006), soothing for eczema (Sokel, 1993) and de-stressing and dietary education for obesity (Stradling, 1998, Cochrane, 1986). These suggestions were made in hypnotic protocols of varying length and detail, often tailored to the individual's circumstances but details of these unique modifications were not given.

Whorwell 1984 compared hypnotherapy to psychoanalysis and placebo pill with no control. Sokel 1993 compared hypnosis to biofeedback with no control. Kohen 1996 compared two different hypnotic styles (traditional and waking) with a placebo control and no intervention. Cochrane 1986 compared two different hypnotic styles (with and without self-hypnosis) with a waiting list control. Auto-hypnosis is when a hypnotist performs the process directly with one or a group of participant(s), self-hypnosis is when a participant uses a recorded hypnotic medium or is self-trained to hypnotise themselves. Self-hypnosis permits repeated sessions at home while auto-hypnosis requires attendance at a special session with a hypnotist. Ewer 1986 compared hypnosis with placebo control. Calvert 2002 compared hypnosis with two controls, one of supportive therapy (counselling) and conventional treatment and second of conventional treatment only. Stradling 1998 compared hypnosis with stress reduction and dietary advice to hypnosis and dietary advice to dietary advice only and no control. Four studies (Galovski 1988, Palsson 2002, Vlieger 2007, Roberts 2006) compared hypnotherapy with waiting-list or conventional treatment controls.

Tables

Tables 1a to 1c below give a concise description of studies, including condition, participants, intervention type, controls, principal outcome measures and main statistical findings on effect on outcomes.

Table 1a Description of studies: RCT's assessing the effectiveness of hypnotic interventions in chronic conditions

Study	Condition	Participants	Intervention	Control	Outcome Measures
Kohen, 1996	Asthma	Children aged 7 to 12 64 invited 33 enrolled 33 randomised 24 completed	Intervention 1: Relaxation (self hypnosis). Intervention 2: Waking suggestion (no hypnosis).	Control 1: Attention placebo (conversation and games). Control 2: No intervention	Emergency room visits
Ewer & Stewart, 1986	Asthma	Patients 44 enrolled 44 randomised 39 completed	Intervention: relaxation mental imagery training (auto- hypnosis).	Control: Attention placebo (diary checking).	Bronchial hyper-responsiveness
Calvert, Houghton, et al, 2002	Functional Dyspepsia	Patients 126 invited 126 enrolled 126 randomised 149 completed	Intervention: auto-hypnosis and home self-hypnosis with audiotape	Control (1): Supportive therapy plus standard treatment Control (2): Standard Treatment	Medication use and consultation rate
Whorwell, Prior & Faragher, 1984	Irritable Bowel Syndrome	Adults 80 enrolled 80 randomised 80 completed	Intervention 1: Gut-directed auto, self-hypnosis Intervention 2: Psycho-analysis and placebo	Control: None	Well-being score and 3 IBS symptoms

Table 1b Description of studies: RCT's assessing the effectiveness of hypnotic interventions in chronic conditions

Study	Condition	Participants	Intervention	Control	Outcome Measures
Galovski & Blanchard, 1998	Irritable Bowel Syndrome	Adults 13 enrolled 12 randomised 11 completed	Intervention: Relaxation Mental Imagery training auto hypnosis).	Control: Symptom-monitoring waiting list.	CPSR Score: Composite IBS symptom score from diaries.
Palsson, Turner, et al, 2002	Irritable Bowel Syndrome	Adults 30 invited 30 enrolled 24 randomised 24 completed	Intervention: Gut-directed hypnosis (auto-hypnosis).	Control: Self-monitoring of symptoms.	Individual symptoms of IBS
Vlieger, Menko-Frankenhuys, et al, 2007	Functional Abdominal Pain and/or Irritable Bowel Syndrome	Children aged 8 to 18 Unknown number invited 53 enrolled 53 randomised 52 completed	Intervention: Gut-directed hypnosis (auto-hypnosis).	Control: Clinician and self-monitoring of symptoms.	Pain scores in IBS and FAP
Roberts, Wilson et al, 2006	Irritable Bowel Syndrome	Adults 101 invited 89 enrolled 89 randomised 81 completed	Intervention: Gut-directed hypnosis (auto and self-hypnosis) and conventional treatment	Control: Conventional treatment.	Quality of Life and medication

Table 1c Description of studies: RCT's assessing the effectiveness of hypnotic interventions in chronic conditions

Study	Condition	Participants	Intervention	Control	Outcome Measures
Sokel, Christie, et al, 1993	Eczema	Children aged 5 to 15 44 invited 44 enrolled 44 randomised 32 completed	Intervention (1): auto-hypnosis Intervention (2): Biofeedback	Control: No treatment, discussion only	Severity of surface damage
Stradling, Roberts et al, 1998	Obesity	Patients 60 invited 60 enrolled 60 randomised 46 completed	Intervention (1): Hypnotherapy, stress reduction, dietary advice. Intervention (2): As (1), No stress reduction Intervention (3): Dietary advice only	Control: none	Weight loss
Cochrane & Friesen, 1986	Obesity	Women 60 invited 54 enrolled 54 randomised 54 completed	Intervention (1): Group and individual auto, self-hypnosis and Intervention (2): As (1) No self-hypnosis	Control: Waiting list.	Weight loss

Table 2 below details each study's hypothesised explanation of the efficacy of hypnosis and classifies them into general psychological explanatory type, cognitive-behavioural (Calvert, 2002, Whorwell, 1984, Galovski, 1988, Cochrane, 1986), cognitive-behavioural and developmental (Kohen, 1996) and cognitive-behavioural and autonomic nervous system influences (Ewer, 1986, Palsson, 2002, Vlieger, 2007, Roberts, 2006, Sokel, 1993, Stradling, 1998).

Table 2a Conceptual details of RCT's assessing the effectiveness of hypnotic interventions in chronic conditions

Study	Chronic Condition	Hypothesised Explanation of Efficacy of Hypnosis	Classification
Kohen, 1996	Asthma	Hypnosis may undo a previously internalised negative cycle of behaviour and responses, (wheezing promotes anxiety which promotes wheezing which increases anxiety etc) alters maturation factors, psychosocial adjustment, issues of personal locus of control and mastery.	Cognitive-behavioural, developmental
Ewer & Stewart, 1986	Asthma	Autonomic arousal level reduced by hypnosis, reducing bronchodilatory sensitivity, hypnosis increases sense of well-being and reduces anxiety, stress and related psychosomatic symptoms.	Cognitive-behavioural, autonomic influence
Calvert, Houghton, et al, 2002	Functional Dyspepsia	Hypnosis produces positive effects on motor activity, sensitivity and acid secretion to improve symptoms	Cognitive-behavioural
Whorwell, Prior & Faragher, 1984	Irritable Bowel Syndrome	Hypnosis produces relaxation and this focused on intestinal motility	Cognitive-behavioural
Galovski & Blanchard, 1998	Irritable Bowel Syndrome	Hypnosis produces relaxation and this focused on intestinal motility, reduces distress of symptoms	Cognitive-behavioural
Palsson, Turner, et al, 2002	Irritable Bowel Syndrome	By changing focus of attention and/or changing beliefs about the meaning of symptoms, it produces a reduction in the sympathetic ANS activity linked to symptoms.	Cognitive-behavioural, autonomic influence

Table 2b Conceptual details of RCT's assessing the effectiveness of hypnotic interventions in chronic conditions

Study	Chronic Condition	Stated Hypothesised Basis of Efficacy of Hypnosis	Classification
Vlieger, Menko-Frankenhuys, et al, 2007	Functional Abdominal Pain and/or Irritable Bowel Syndrome	Hypnotherapy may relax gut motility, reduce psychological sensitivity to gut sensations, modulates gut pain via the cingulate cortex function, an area brain imaging suggests IBS sufferers differ from healthy controls	Cognitive-behavioural, autonomic influence
Roberts, Wilson et al, 2006	Irritable Bowel Syndrome	None overtly stated but referred to earlier work in tertiary settings as justification for this trial in primary care.	Cognitive-behavioural, autonomic influence assumed from references to earlier studies
Sokel, Christie, et al, 1993	Eczema	Hypnosis relaxed participants and reduces stress reducing eczemic stress reaction.	Cognitive-behavioural, autonomic influence
Stradling, Roberts et al, 1998	Obesity	Hypnosis relaxed participants and reduces stress, increasing control over behaviour, hypnotic learning can improve dietary knowledge and control	Cognitive-behavioural, autonomic influence
Cochrane & Friesen, 1986	Obesity	Hypnosis participants improve self-belief, motivation and improved decision-making	Cognitive-behavioural

Outcomes

A variety of principal outcomes were obtained from the papers and many studies measured several secondary types of outcome (see Table 1a/b). Health care use was used as an outcome in hospital admission frequency or consultation rate (Kohen, 1996, Roberts, 2006) and medication usage (Calvert, 2002, Roberts, 2006). Symptom measures were more common as measured outcomes, as in bronchial hyper-responsiveness (Ewer, 1986), various IBS symptoms (Whorwell, 1984, Galovski, 1988, Palsson, 2002, Vlieger, 2007) and surface area of eczema (Sokel, 1993). Quality of life was measured by various means (Whorwell, 1984, Roberts, 2006, Sokel, 1993) and obesity outcomes had a simple weight loss outcome (Stradling, 1998, Cochrane, 1986).

Methodological quality

Methodological quality was assessed with Jadad scores (Jadad A. et al., 1996) despite the practical difficulties of blinding hypnotic intervention. This does not disadvantage one study over another but does mean no study could achieve the highest rating of 5 points as double blinding cannot take place (patient and assessor) and hence the

highest Jadad score would be 3. Scores were, 3 points for Calvert, 2002, Whorwell, 1984 and Roberts, 2006, 2 points for Kohen, 1996, Ewer, 1986, Palsson, 2002, Vlieger, 2007, Sokel, 1993, Stradling, 1998, Cochrane, 1986 with the lowest score being Galovski, 1988, with 1 point. Unclear randomisation or allocation concealment explains the 1 point loss for all studies scoring less than 3 points and Galovski 1988's 1 point was due to its randomisation being inadequate as well as unclear.

Similar classification of studies by allocation concealment scored A – Adequate (Calvert, 2002, Whorwell, 1984, Roberts, 2006), B - Unclear (Kohen, 1996, Ewer, 1986, Palsson, 2002, Vlieger, 2007, Sokel, 1993, Stradling, 1998, Cochrane, 1986) and C – Inadequate (Galovski, 1988).

Performance and detection bias possibilities, where the investigator is also the unblinded hypnotist and assessor, are a danger in such research and lower their methodological standard (Galovski 1988, Whorwell, 1984, Roberts, 2006). All others had some assessor controls. Whorwell's detailed outcome data had been lost over time (Palsson et al., 2002), but its direction of effect was clear, it was replicated by Galovski 1993 with similar outcomes and was, thus, kept in the review. Detailed descriptions of each study's methods are in Appendix B, Characteristics of Included Studies.

Meta-analysis

Despite the differences between the health conditions assessed for hypnotic intervention efficacy, it would be technically possible to derive effect sizes from outcome measure results for all studies. However, the methodological differences in the construction of outcome measures and internal design were thought to be too great between the papers to permit the data to be combined for a meta-analysis.

Discussion

The purpose of this systematic review was to establish if hypnosis was effective as a psychological intervention in the psychology of health and, if so, whether hypnosis should be brought back into the mainstream of psychological interventions.

The search of papers produced 11 RCT's meeting the inclusion criteria for hypnotherapeutic interventions for chronic health conditions. 4 chronic conditions had been sufficiently well studied to permit analysis: asthma, eczema, IBS related

conditions and obesity. The studies, unfortunately, exhibited a heterogeneity of outcome measurement which prevented a robust meta-analysis. Participants varied from children to adults with no obvious difference in ability to participate in hypnosis, although there were hints of children having a slight advantage over adults in speed and freedom of achieving the inner focus of trance.

Hypnosis was compared to several different psychological interventions with evidence of equivalence or superiority of efficacy, but the lack of sufficient controls rendered this evidence weakly substantiated. Nevertheless, all studies were performed in appropriate medical environments and were sufficiently well reported to permit a qualitative analysis.

Hypnotherapy had no untoward outcomes reported in any of the included studies and at least one beneficial outcome was reported in all studies. Even where there was no evidence of a long-term advantage (Roberts, 2006), hypnosis was associated with a speedier outcome than the control, which might provide useful information in applied settings. As the 11 studies were too diverse in methodology to state conclusively that hypnosis is effective as a psychological intervention, this does not imply, of course, that hypnosis is ineffective, but that no clear case has been made.

It was demonstrated, however, that hypnosis provided some benefits for participants across a wide range of common chronic conditions despite the mixed methodological quality of the studies. All the results point in the same direction, towards some measure of symptomatic relief. In asthma, a condition that affects a large number of people, both traditional and waking hypnosis suggest efficacy in reduction of the panic that can exacerbate symptoms thereby reducing emergency admissions (Kohen, 1996). Evidence of improved lung function through a hypothesised mechanism of control in the autonomic system was found in Ewer's study (1986), suggesting a positive association between hypnotic relaxation and autonomic function in asthma. The psychological explanation behind this is increased relaxation, confidence in coping and stress reduction stimulating physiological changes in the sympathetic and parasympathetic systems.

In the IBS symptomology group, hypnotic relaxation, altered focus, positive belief changes and distress reduction are also hypothesised to be linked to an autonomic influence (Calvert, 2002, Whorwell, 1984, Galovski, 1988, Palsson, 2002, Vlieger, 2007, Roberts, 2006). The single intervention versus control studies, Galovski, 1988, Palsson, 2002, Vlieger, 2007, Roberts, 2006, all found positive changes in symptoms

from hypnotic interventions of gut-directed hypnosis, with Roberts outcome indicating a faster response to hypnosis than conventional treatment. In comparisons of hypnosis to other psychological therapies, hypnosis appeared to be significantly superior to both supportive therapy (counselling) and psychotherapy. However, methodological objections arise that render this conclusion uncertain.

In eczema, Sokel, 1993 suggested that an autonomic effect led to improvement of symptoms via hypnotic relaxation and stress reduction, although it was thought that simple distraction via biofeedback had a similar result in preventing scratching itchy skin and permitting healing. Thus two psychological measures had significant outcomes in reducing symptom severity. Sokel emphasised a non-significant effect in that girls appeared to perform better at the imagery within hypnosis than did boys, possibly due to the gentle rather than active imagery employed. However, the small cell sample sizes prevented this suggestion to be validated.

In obesity weight-loss hypnotic trials, suggestions of stress reduction, confidence over self-control, motivation and improved decision-making were considered to provide the mechanism of action in weight reduction (Stradling, 1998, Cochrane, 1986). It should be noted that Stradling sought to induce weight loss to relieve sleep apnoea symptoms and found that although weight loss was achieved it was not clinically significant for that purpose.

In summary, hypnotic interventions in all of the trials of common chronic conditions proved effective to some extent. Of other psychological interventions, psychoanalysis, counselling and biofeedback, only biofeedback approached the efficacy of hypnosis in reducing symptoms. Varieties of hypnosis used appeared to have no effect on outcomes. No adverse effects were encountered and anecdotal reports suggested that hypnosis was pleasant and benefits in relaxation permeated other aspects of participants' lives. Unfortunately, these findings, as has been stated, are not sufficiently supported by methodology or sample size in the reviewed studies.

The mechanisms of efficacy, which emerged from the different hypnotic interventions in such apparently diverse common chronic conditions, were remarkably constant. The authors hypothesised that hypnosis can positively impact on coping with illness and that this, in some incompletely explained manner, has a biopsychosocial effect on participant physiology in "dampening down" the autonomic, sympathetic nervous system response. They also suggest that an increase in the parasympathetic system

response is directly associated with the practice of hypnosis, which in turn promotes self-healing in some manner.

Conclusion - Implications for research

High quality rigorous research is essential to validate the efficacy of hypnosis, and these reviewed studies do not provide sufficient methodological compatibility to perform a meta-analysis with confidence. However, for hypnosis to show a clear trend to efficacy, further well-designed studies with sufficient power are necessary to confirm any early promise. Common use of Consort methodological criteria is essential to permit hypnosis to be adequately assessed as a psychological intervention. RCT's comparing hypnotherapy to other alternative therapies in parallel studies should be considered to establish relative efficacies of different psychological interventions. Finally, participants in both control and hypnotherapy groups should be followed up at longer intervals to ascertain the long-term benefits of the intervention. Clinical cost-benefit analyses should be performed to establish the efficacy value of hypnosis in the psychology of health to permit it to be reasonably compared to other established approaches. Only then can the aim of this systematic review be achieved, which is to establish if hypnosis is effective as a psychological intervention in the psychology of health and whether it should be brought back into the mainstream of psychological interventions.

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Appendix A Search methods for Identification of Studies

The Review used the Centre for Reviews and Dissemination at York University's (CRDYU) search strategies for MEDLINE and CINAHL using OVID and which are designed for high sensitivity in finding reviews of RCT's. (These strategies were originally designed to provide studies and reviews for the construction of the CRDYU database DARE, the Database of Abstracts of Reviews of Effectiveness.)

MEDLINE - CRDYU Review search strategy: high sensitivity, low specificity

1. controlled.ab.
2. design.ab.
3. evidence.ab.
4. extraction.ab.
5. randomized controlled trials/
6. meta-analysis.pt.
7. review.pt.
8. sources.ab.
9. studies.ab
10. or/1-9
11. letter.pt.
12. comment.pt.
13. editorial.pt.
14. or/11-13
15. (SUBJECT TERMS INSERTED AS SHOWN ABOVE)
16. 10 not 14
17. 15 and 16

CINAHL - CRDYU Review search strategy: high sensitivity, low specificity,

1. meta analysis/
2. systematic review/
3. systematic review.pt.
4. (metaanaly* or meta-analy*).tw.
5. metaanal*
6. nursing interventions.pt.
7. (review* or overview*).ti.
8. literature review/
9. exp literature searching/
10. Cochrane*.tw.
11. Synthes*.tw. adj3 (literature* or research* or studies or data).tw.
12. (medline or medlars or embase or scisearch or psycinfo or psychinfo or psychlit or psychlit).tw,sh.
13. pooled analy*.tw.
14. ((data adj2 pool*) and studies).tw.
15. ((hand or manual* or database* or computer*) adj2 search*).tw.
16. reference databases/
17. ((electronic* or bibliographic*) adj2 (database* or data base*)).tw.
18. (review or systematic-review or practice-guidelines).pt.
19. (review* or overview*).ab.
20. (systematic* or methodologic* or quantitative* or research* or literature* or studies or trial* or effective*).ab.
21. 18 and 20

22. 19 adj10 20
23. or/1-17,21,22
24. editorial.pt.
25. letter.pt.
26. case study.pt.
27. record review/
28. peer review/
29. (retrospective* adj2 review*).tw.
30. (case* adj2 review*).tw.
31. (record* adj2 review*).tw.
32. (patient* adj2 review*).tw.
33. (patient* adj2 chart*).tw.
34. (peer adj2 review*).tw.
35. (chart* adj2 review*).tw.
36. (case* adj2 report*).tw.
37. exp case control studies/
38. exp prospective studies/
39. case studies/
40. animal studies/
41. "edit and review"/
42. (rat* or mouse or mice or hamster* or animal* or dog* or cat* or rabbit* or bovine or sheep).tw.
43. or/24-42
44. 43 not (43 and 23)
45. 23 not 44
46. (SUBJECT TERMS INSERTED AS SHOWN ABOVE)
47. 46 and 45

(Key to Ovid search terms: ab = words in abstract, hw = word in subject heading, pt = publication type, ti = words in title, tw = textwords, / = MeSH subject heading, * = truncation symbol, adj4 = adjacent (within four words))

For **AMED, EMBASE, PsycInfo**, a single search strategy was used, as shown below, which was derived from pilot testing to achieve the high sensitivity and low specificity required for the anticipated small numbers of research papers.

- 1 hypnosis
- 2 hypnotherapy
- 3 relaxation
- 4 imagery
- 5 controlled
- 6 meta-analysis
- 7 1 or 2 or 3 or 4
- 8 5 and 7
- 9 6 and 7
- 10 8 or 9

The Cochrane Library for Systematic Reviews (to March 2008) was searched using the keywords above and for all chronic conditions that emerged from the OVID database outcomes.

Grey literature searches used **SIGLE** (System for Information on Grey Literature in Europe, 1996 to March 2008), and a web-based search was made of the electronic libraries of known centres of excellence in hypnosis in the UCL London Hypnosis Unit and the University of Sheffield psychology department, seeking unpublished studies and theses (February 2008).

Hand searches were made of the British Journal of Health Psychology and Contemporary Hypnosis. These searches were to ensure that key publications not entered into OVID data bases had been fully searched for (all to March 2008).

Appendix B Characteristics of Included Studies

Randomised Controlled Trials (RCTs)

Study	Kohen, 1996
Methods	RCT, between group analysis. 100 participants were eligible for inclusion, 33 initially enrolled and 28 were randomised into 4 groups. Participants were randomly assigned to (1) Experimental (self-hypnosis, Relaxation and Mental Imagery (RMI)), (2) waking suggestion (no hypnosis), (3) attention placebo (no hypnosis or asthma discussion), or (4) control (no treatment). Allocation concealment and method of randomization were not described.
Participants	33 asthmatic children, 23 males and 10 females aged 7 to 13 years were recruited from pediatricians, GP's and allergy clinics and tested in a hospital setting. 28 participated, and 7 were randomly allocated to each group. Asthma was diagnosed by variety of physicians and its severity was not described. Participants were excluded if they had prior experience of RMI or were unwilling to accept randomisation.
Interventions	After enrollment, intervention (1) Relaxation Mental Imagery training (self hypnosis) in asthma control. Intervention(2) Waking suggestion (no hypnosis) in asthma control. Control (1) Attention placebo (no hypnosis or asthma discussion). Control (2) No intervention. Asthma diary kept.
Outcomes	Number of emergency room visits, psychological testing (not specified), school absenteeism, Pulmonary Function Tests (PFT's) (blindly assessed by clinician) and asthma severity (self-reported).
Notes	Some participants spontaneously developed coping strategies similar to hypnotic ones during trial. Small numbers of participants produced strong confounding factors that limit validity. Allocation concealment, B – Unclear
Study	Ewer, 1986
Methods	RCT, within and between group analysis. 44 participants were eligible for inclusion and enrolled with a drop-out of 5. 39 were randomised into 4 groups. Participants were split into 2 groups by high or low hypnotisability. Within both groups, randomly assigned to (1) Experimental (weekly hypnosis with relaxation and mental imagery, diary checks), (2) placebo control (weekly diary checks but no treatment). Allocation and lung methacholine challenge test to all participants blinded, method of randomization not described.

Participants	44 asthmatic adults were recruited from GP clinics and tested in a hospital setting. 39 fully participated and split into 2 groups by high or low hypnotisability. 7 men and 10 women were allocated to the low hypnotisability group. 8 men and 14 women were allocated to the high hypnotisability group. Asthma was described as existing and its severity was indicated by testing and pharmacological treatment. Participants were excluded if they had severe asthma, psychological conditions, specified medication, pregnancy or infection.
Interventions	After enrollment, intervention was relaxation and mental imagery training (auto-hypnosis) in asthma control. Control was no intervention. Asthma diary kept. Lung challenge test by methacholine in nebuliser.
Outcomes	Lung function tests for bronchial hyper-responsiveness (blindly assessed by clinician) and asthma medication usage (self-reported).
Notes	Some participants found the hypnosis reduced psychosomatization in other aspects of life.

Allocation Concealment, B - Unclear

Study Calvert, 2002

Methods	RCT, parallel analysis, stratified for gender, patients randomised to three experimental groups, hypnotherapy, supportive therapy plus placebo medication and standard treatment only. Patients tested at 16 weeks and 56 weeks. QOL tested as secondary measure. Patients and assessor were blinded. Investigator not masked. Randomisation not described.
Participants	UK. 126 patients divided into 3 groups: 32 patients to hypnotherapy, 48 to "supportive therapy" and placebo ranitidine and 46 to ranitidine 150 mg twice daily.
Interventions	Hypnotherapy induced using standard procedures. Tactile and visualisation methods were used to suggest that positive effects on motor activity, sensitivity and acid secretion could be achieved to improve symptoms. Patients had twelve 30minute sessions over 16weeks. Therewere two control groups, one received "supportive therapy" and placebo ranitidine the other did not have any "supportive therapy" butwas given active ranitidine 150mg twice daily.
Outcomes	At 56 weeks the total dyspepsia score was lower in the hypnotherapy group (median score = 0.6, interquartile range = 0.1 to 1.5), than the supportive therapy group (median score = 3.6,

interquartile range = 1.5 to 5.2) or the medical therapy group (median score = 2.9, interquartile range = 1.4 to 3.7).

Notes Allocation concealment, A – Adequate

Study Whorwell, 1984

Methods RCT between groups study. Intervention (1) was auto-hypnotherapy followed by self-hypnosis with tapes of the auto-hypnosis. Intervention (2) was psychotherapy plus a placebo tablet. Control was no treatment. Randomisation by sealed envelope. Experimenter was physician to patients as well as intervention 1 and 2 performer.

Participants 30 participants invited (26 Females, 4Males; aged 24 to 53 years). All patients had IBS for at least 1 year and had not responded to any therapy (mean = 6 therapies per patient). All patients under care of experimenter

Interventions Gut focussed hypnotherapy (Intervention 1) versus psychotherapy and placebo (intervention 2).

Outcomes Primary outcome measures were frequency and severity of abdominal pain and abdominal distension. These were given a score of 0=none, 1=mild, 2=moderate and 3=severe. Bowel habit and general wellbeing were also recorded and abnormality expressed on a similar 0 to 3 scale. The data for 7 days were totalled and the scores analysed separately with a repeated analysis of variance. Post therapy comparisons were made by means of a Tukey multiple comparison test and were adjusted for pre-treatment levels.

Notes Data not available for analysis as data on unreadable older formats or lost.

Allocation concealment, A – Adequate

Study Galovski, 1998

Methods RCT cross-over design with 13 adults with diagnosed irritable bowel syndrome (IBS). Blinding of trial allocation was unclear. 1 participant dropped out and 1 other excluded, both as inappropriate respondents. Repetition of Whorwell's 1984 study (UK) in USA.

Participants 13 adults with diagnosed IBS aged from 23 to 58 years interviewed, one excluded because of mental health condition. 12 subjects (10 females, 2 males) were matched into 6 pairs. One member from each pair was initially assigned to the intervention or control group

and then control group crossed over. All participants were independently diagnosed with IBS by their gastroenterologist or physician.

Interventions	After enrollment, intervention was hypnotherapy and control was symptom monitoring with cross over after 6 weeks.
Outcomes	Composite primary reduction score (CPRS) devised comprising diarrhoea reduction score + constipation reduction score, divided by the number of primary symptoms present (2 or 3)). Diarrhoea reduction score = average pretreatment diarrhoea ratings minus average posttreatment diarrhoea ratings divided by average pretreatment diarrhoea ratings.
Notes	Rome criteria used for diagnosis of IBS by a physician was derived from Webb A., et al, 2007. Allocation concealment, C – Inadequate

Study Palsson, 2002

Methods	RCT, cross over design. 24 participants with irritable bowel syndrome (IBS) divided into 2 groups of 15, each divided into intervention (hypnosis) compared to control of symptom self-monitoring. Control crossed over to hypnosis after 4 months (end of group 1 intervention). Allocation and concealment by computer generated randomisation (from Webb A., et al, 2007).
Participants	24 participants diagnosed with IBS by own physician (IBS Rome 1, refractory to standard medical therapy, exclusion of organic disease), 15 females and 9 males, with a mean age of 39.1 years were recruited and tested in a hospital setting. 5 additional participants dropped out for varied reasons and 1 excluded for mental health issues.
Interventions	After enrollment, the immediate intervention group received gut-directed hypnotherapy while the control group had self-monitoring.
Outcomes	Central symptoms of IBS, abdominal pain, abnormal bowel movements, bloating.
Notes	Allocation concealment, B – Unclear

Study Vlieger, 2007

Methods	RCT, between group analysis. 53 participants aged 8 to 18 years, with either irritable bowel syndrome (IBS) or functional abdominal
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pain (FAP) were recruited and were randomly assigned to gut-directed hypnosis (Manchester protocol) or standard medical care. Allocation and concealment by computer generated randomisation, plus pain diaries, scored blindly.

Participants 53 participants aged 8 to 18 years with IBS (n=22) and FAP (n=31) were recruited and diagnosed from gastroenterology clinic and tested in a hospital setting. Initially, 28 were randomly allocated to hypnotherapy and 25 randomly to standard treatment but 1 Intervention participant dropped out and 1 Control participant transferred to intervention group by parental request. Participants were excluded if they had medication, disease, mental health issues. No information on initial numbers invited to participate.

Interventions After enrollment, intervention was gut-directed hypnotherapy adapted to each participant's interests with no fixed protocol. Control, standard medical treatment plus supportive dietary, stress and emotional therapy.

Outcomes Central symptoms of IBS, abdominal pain, abnormal bowel movements, bloating.

Notes Younger children responded more strongly than older ones, suggesting differential suggestibility by age. No difference was made between IBS and FAP.

Allocation concealment, B – Unclear

Study Roberts 2006

Methods RCT between groups non-cross over analysis. 81 respondents randomly allocated to either an intervention of gut-directed hypnosis, tailored to participant plus conventional treatment or to a control of conventional treatment only. Allocation concealment and method of randomization by sealed envelope, externally supervised.

Participants 101 participants were initially recruited from 24 general practices in UK. 89 initially enrolled and 81 met the selection criteria of adults aged 18 to 65, consisting of 68 female and 12 male, mean age 41/6 years. IBS diagnosed by own GP at least 6 weeks prior to study using local GP criteria of uncertain commonality. Excluded fell outside the age range or had conditions in addition to IBS.

Interventions After enrollment, intervention group received 5 weekly sessions of gut directed hypnotherapy in addition to their usual conventional treatment, control group received only research clinic assessment and follow up questionnaires and were managed with usual conventional treatment by their general practitioner.

Outcomes	IBS-specific quality of life (QOL) measure (8 dimensions) and a symptom score derived from Rome 2 criteria (3 dimensions of pain and bowel behaviour). Outcomes recorded at 3, 6, and 12 months post randomisation.
Notes	Rome criteria not used for selection but outcome measured on limited criteria from Rome 2. Allocation concealment, A – Adequate
Study	Sokel, 1993
Methods	RCT, parallel analysis, hypnotherapy, biofeedback and discussion control. 44 children aged 5-15 years randomised to each group. Participants not blinded, outcome assessor blinded to which treatment each child was receiving and separate from the psychological treatments. No randomisation method stated. Dropouts differed significantly between conditions, 13 dropouts from the 44 initial participants but no reasons given. Very small samples in each condition with substantial drop-outs.
Participants	44 children with poorly controlled atopic eczema (despite standard treatment), duration of condition unstated, enrollment criteria unknown. 12 withdrew from study, reasons unclear. Small sample size in each condition after withdrawals, with sex bias evident in dropouts that differed from each condition (Control, 5 of 8 boys left, 7 of 8 girls stayed, Biofeedback, all boys stayed, 1 of 4 girls left, Hypnotherapy, 7 of 9 boys stayed, 5 of 9 girls stayed)
Interventions	Intervention 1, Hypnotherapy focused on reducing itching through guided imagery face-to-face with a clinical psychologist. 4, 30-minute sessions. Intervention 2, Biofeedback relaxation via skin conductance. 4, 30-minute sessions. Control, Discussion with eczema diary with parental assistance. 4, 30-minute sessions.
Outcomes	(a) Mean % of body coverage for (i) erythema (ii) surface damage (iii) lichenification. (b) Mean severity score for (i) erythema (ii) surface damage (iii) lichenification.
Notes	No difference between groups at start but dropouts changed balance at outcome measure. Allocation concealment, B – Unclear

Study	Stradling, 1998
Methods	RCT, parallel study, three conditions over 18 months. 60 respondents randomly allocated to 3 conditions with no control. Randomisation not described. Allocation concealment not made clear. Initial interventions were individual, all later ones were group interventions.
Participants	60 participants recruited from sleep apnoea patients at a university sleep unit, comprising 49 males, and 11 females, ages unstated. 14 dropped out (25%) – no explanation. Inclusion criteria, Body Mass Index (BMI) over 30kg/m ² . Exclusion criteria – none made clear.
Interventions	Intervention (1), 16 participants, auto and self-hypnotherapy with stress reduction. Intervention (2), 15 participants, auto and self-hypnotherapy. Intervention (3), dietary advice only. Outcome measured after 18 months.
Outcomes	weight loss
Notes	Allocation concealment, B – Unclear
Study	Cochrane, 1985
Methods	RCT, parallel study, three conditions over 4 weeks. 60 respondents randomly allocated to 3 conditions, hypnosis with audiotape, hypnosis and no treatment. Randomisation not described. Allocation concealment not made clear and intervention groups met during procedure. Hypnosis was partly in groups, with partial individual hypnosis.
Participants	60 females recruited by newspaper advertisement. 54 aged 20-65 (no males). 6 dropped out – no explanation. Inclusion criteria, weight 20% above “ideal “weight as defined by Metropolitan Life actuarial data (1960). Exclusion criteria were medical problems contraindicating weight loss, enrolment in another weight loss program simultaneously.
Interventions	Intervention (1), 17 participants, hypnotherapy using group and individual auto-hypnosis, lecture and hypnotic audiotape for home self-hypnosis. Intervention (2), 17 participants, group and individual auto-hypnotherapy and lectures as (1) but no audiotape. Control, 20 participants, waiting list. Outcomes measured after 6 months.
Outcomes	weight loss
Notes	Allocation concealment B – Unclear

Appendix C - References to included, excluded and other citations

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Appendix D Characteristics of excluded studies (33)

Study	Reason for exclusion
1. Anbar 2004	Non RCT. not controlled
2. Andrews 1990	Non RCT. not controlled
3. Brown 2007	Non RCT. review
4. Edwards 1985	Non RCT. not controlled
5. Ewen 1992	Non RCT. case studies
6. Flammer 2003	Non RCT. review
7. Forbes. 2000	RCT. study of hypnotic methodologies
8. Gholamrezaei 2006	Non RCT. review
9. Gonsalkorale 2003	Non RCT. survey of responsiveness
10. Gonsalkorale 2005	Non RCT. review
11. Graci 2007	Non RCT. sleep disorders
12. Gruzelier 2002	Non RCT. review
13. Halley1991	Non RCT. review
14. Houghton 2002	Non RCT. not controlled
15. Huntley 2002	Non RCT. review
16. Hyman 1989	Non RCT. analysis
17. Johnson 1996	Non RCT. analysis
18. Kirsch 1996	Non RCT. analysis
19. Morrison 1988	Non RCT. small sample uncontrolled
20. Naito 2003	RCT. not relevant, poorly controlled
21. Noeker 2000	Non RCT. exploration of process
22. Ost 1987	Non RCT. descriptive
23. Read 1999	Non RCT. descriptive
24. Simren 2006	Non RCT. exploration of process
25. Smith 2006	Non RCT. uncontrolled
26. Soo 2004	Non RCT. review
27. Soo 2004	Non RCT. review
28. Spanos 1988	Non RCT. uncontrolled
29. Tschugguel 2003	Non RCT. uncontrolled
30. Van Kuiken	Non RCT. analysis
31. Webb 2007	Non RCT. review
32. Wilson 2006	Non RCT. review
33. Yung 2001	Non RCT. not relevant

**Psychological practitioners' conceptualisations of the process of change in
clients with chronic health conditions: a qualitative study**

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**A thesis submitted in partial fulfilment of the requirements of the University of
the West of England, Bristol for the degree of Professional Doctorate in Health
Psychology**

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Psychological practitioners' conceptualisations of the process of change in clients with chronic health conditions: a qualitative study

Paul Douglas Millar

Abstract

A qualitative exploration was conducted of the conceptualisations of the process of change held by 10 independently employed health psychologist and counselling practitioners who work with clients with chronic health conditions in a context parallel to primary care. The health psychologists were in their early careers while the counsellors were older and had practiced longer. A thematic analysis of responses to semi-structured interviews found commonalities in intervention beliefs among the participants from the two professions, sharing two overarching themes of “Change can be prompted by expert techniques” and “Providing love and safety lets change happen”. These themes were believed to facilitate an end-state of healthy change in the patient/client. The health psychologists appeared to believe that techniques based on theories and evidence provided an appropriate basis for intervention while the counsellors appeared to believe that an eclectic mix of relational theory and selected techniques were sufficient to support their approach. The health psychologists and counsellors approached their clients/patients with different objectives, with the health psychologists focused on improved outcomes while the counsellors focused on the quality of the therapeutic relationship. A sub-theme of “Frustrated by lack of therapeutic skills” was derived from some of the health psychologists who believed that a lack of training in relational skills inhibited the quality and possibly the efficaciousness of face-to-face interventions whereas the counsellors appeared more confident in their practice and exhibited no similar frustration with their approach. It is suggested that the expert procedures in the Trans-Theoretical Model of behaviour change could provide the basis for additional relational training for health psychologists as this model derives from psychotherapeutic change theory and practice. Further research should be carried out to explore and test the utility of combining health psychological theory and evidence with relational approaches in health interventions in clients/patients with common chronic conditions.

Psychological practitioners' conceptualisations of the process of change in clients with chronic health conditions: a qualitative study

Introduction

This study is a qualitative exploration of the beliefs about the mechanisms of change held by health psychological practitioners and counsellors in independent practice when conducting interventions with people with common chronic or long-term conditions. A secondary focus is given to considering to what extent these practitioners feel confident in applying their understandings of the process of change when working one-to-one with people with chronic health conditions.

Health psychology is considered to be especially suited to the study and amelioration of the adverse and complex expression of long-term health conditions due to the multidimensional view of health that underpins its theories, training and practice (Marks et al 2005, Michie and Abraham 2004, Ogden 2007, Taylor 1990). The amelioration of these complex health factors is hypothesised to happen through some form of change and this change is envisaged here is a movement from one state of health cognitions and behaviour to another that improves a client's quality of life and well-being. There are, however, multiple competing models of explanations about the processes of change that underlie psychological interventions (Hagger 2009). This multiplicity appears to be represented in a two-fold manner, firstly with theorists and practitioners exploring issues around promoting and improving these different models, exploring their intervention effectiveness in target populations or developing one model in preference to another. Recent examples of this kind of individual model-based research can be found for the Transtheoretical Model (Armitage 2009, Prochaska 2008), the Theory of Planned Behaviour (Ajzen 2006), the Theory of Reasoned Action (Hale 2007), and Perceived Self-efficacy in the adoption and maintenance of health behaviours (Schwartz 2008).

A second strand of substantive effort is simultaneously underway to examine the extent to which these models, theories and associated interventions display commonalities or may be combined or integrated into more effective or a smaller number of approaches. Recent examples of this collating and integrative tendency can be found in Abraham and Michie's (2008) development of a taxonomy of change methods, Bonetti et al's (2010) exploration of how theories relate to practice, Godin, et al's (2008) study of the

relative benefits of cognitive theories, Hagger and Chatzisarantes's (2009) combination of planned behaviour with self-determination and Pressau et al's (2010) combination of goal theory with planned behaviour.

There is at present no consensus view emerging as to whether seeking commonalities or general agreement over a dominant model is the way forward for practitioner psychologists in health. Perhaps, under the circumstances, it is reasonable for health psychologists to adopt a critical open-mindedness to the potential for multiple paradigms to address problems in health research (Hagger 2009). This suggests that at present, psychologists working in the field of health may choose from one of many explanatory models or select from syntheses or combinations of models when applying their health interventions. The present study explores how psychological practitioners resolve this complexity and develop their own working models when delivering health interventions.

A systematic and critical review of the dominant health behaviour change models currently in use in the UK was conducted by consultants for NICE (2006) and this is briefly summarised in Table 1. While not covering all models present in health psychological literature such as those listed by Hagger (2009), they exemplify their conceptually overlapping and often differentially operationalised nature. The authors concluded that the Theory of Reasoned Action and the Theory of Planned Behaviour can both predict health related behaviour with greater effect than the Health Belief Model and that the Trans-Theoretical Model is also superior to the Health Belief Model but often poorly and incompletely operationalised with weak predictability of its stages concept. Nevertheless, the authors concluded that the Trans-Theoretical Model was insufficiently tested in its Processes of Change and that there was potential for it to be developed into a more effective behaviour change procedure, albeit without the need for what the authors thought was the overstated benefits of the stages of change.

Table 1: Brief summary of evaluation of the main health psychological models evaluated by the National Institute for Health and Clinical Excellence (NICE)

Model, type, main author	Main hypothesis of change	Limitations
<p>Health Belief Model (social-cognitive, Rosenstock and others)</p> <p>Clients have a set of core beliefs about threat, susceptibility and severity of illness, perception of barriers to threat avoidance and beliefs of effectiveness of prevention or threat reduction influence health behaviours.</p>	<p>Behaviour change prompted by training client in perceptual cues in raising awareness of threats or impact of illness symptoms and promoting belief in ability to change (self-efficacy). Raising awareness of role of psycho-social context of lifestyle to promote or inhibit change.</p>	<p>Emphasis on client's rationality in behaviour change and less emphasis on social and emotional influences. Weak internal logic and poor predictive power as operationalised.</p>
<p>Theory of Planned Behaviour or Reasoned Action (social-cognitive, Ajzen and others)</p> <p>Clients have set beliefs and attitudes towards health behaviours that can be mediated by social and subjective norms. Perceived behavioural control with above attitudes and beliefs leads to behavioural intentions then action.</p>	<p>Clients' beliefs elicited regarding health behaviour, normative beliefs and past experience in health behaviour. Changes in both beliefs and behaviours suggested to clients in a manner similar to CBT.</p>	<p>More logically consistent than the health belief model but difficult to state if outcomes reflect the model or the strategies based on it. No clear mechanism of action implicit in the model and applications produced only limited improvements.</p>
<p>Trans-Theoretical Model (psychotherapeutic, Prochaska and DiClemente)</p> <p>Combines a variety of theories drawn from psychotherapy structured around 6 stages of change linked to different theoretical 'Processes of Change': Consciousness Raising, Dramatic Relief, Self and Environmental Re-evaluation, Social and Self Liberation, Counter Conditioning, Helping Relationships, Reinforcement Management and Stimulus Control. This battery of processes and accompanying internal procedures borrowed from therapies improves decision-making and self-efficacy to complete the stages to termination of the unwanted health behaviours.</p>	<p>Clients helped through the 6 stages of change (including cycles of slipping-back, succumbing to temptation, and returning to the effort of change) from unawareness of problem to terminating unwanted health behaviours using a wide range of experiential, cognitive-behavioural and psycho-therapeutic procedures linked to the processes of change. Provides a plausible model that is readily understood by clients.</p>	<p>Interventions using this approach often fail to incorporate the wider range of processes of change, rendering the model untested in full. The cycle of change stages is not well evidenced in practice. The model is generally untested in its entirety.</p>

Table 1: Brief review of major health psychological models. Source: NICE, 2006, Behaviour Change: Review 4 - Models: A Review of the use of the Health Belief Model (HBM), the Theory of Reasoned Action (TRA), the Theory of Planned Behaviour (TPB) and the Trans-Theoretical Model (TTM) to study and predict health related behaviour change, NICE, London

Individual, face-to-face or one-to-one health interventions

The research focuses on the intervention context of 'one-to-one' or 'face-to-face' health interventions that take place in primary care and independent practice. In one-to-one interventions, health psychologists working with people seeking a positive outcome from their problematic health issues come up against the problem of matching evidence-based paradigms with the client's unique individuality. This requires psychological practitioners to adapt empirically-supported programmes to suit individual treatment plans in a manner that respects the individual while remaining faithful to the generality of the empirically-verified intervention. It is a difficult task to balance general evidence of effectiveness against individual circumstances and this requires the practitioner to bring the diversity of conceptual and evidenced approaches in a dynamic manner to the circumstances unique to their client or patient (Marks et al 2005). These challenges are, however, thought to be within the competence of health psychologists when assessing and working with the client's issues (Belar and Deardoff 2008, Nikcevic et al 2006, Persons 2008).

In primary care settings, health psychologists may work with patients with long-term health conditions using interventions based on their models, theories, evidence base and practitioner experience (Taylor et al 2007, Ogden 2007). Health psychologists bring their knowledge of patterns of health and psychology to focus on understanding client health cognitions and behaviour, using observation skills to discover helpful and unhelpful patterns that may be constructively adapted to improve quality of life in tailored interventions. This may be through guidance on coping strategies and behaviour change to manage the condition to optimal levels of functioning, supportive education to provide knowledge of the condition to improve treatment adherence or through awareness-raising to help clients avoid aggravating contexts in their life and their environment. Working one-to-one with a client requires the development of a relationship of collaboration and confidence to support the unique psychologically-based treatment regime developed for each client in one of the many ways listed by Abraham and Michie (2008). A small number of psychological practitioners also work in independent settings, alongside primary care, but outside the intervention preferences of formal health agencies. In independent work, practitioners are required to maintain the same professional standards and ways of working of their colleagues in the NHS or similar agency settings (HPC 2009a) and face the same challenges of formulating interventions from assessments based on health psychological paradigms to suit the individual circumstances of their clients.

Translating from general health and psychological evidence to the individuality of the patient is a common challenge in all walks of medicine as well as in the psychology of health (Bassler et al 2008) and guidance to practitioners can be given by employing health agencies or from many widely-available computer-resourced guidance such as Clinical Knowledge Summaries (NICE 2010). Independent practitioners, by the nature of their self-employment, must necessarily develop their own intervention philosophy, approaches and techniques with guidance from open source clinical resources and from their own professional and training agency guidance and recommendations. Guided by practitioner training, supervisors, professional bodies and regulatory agencies such as the Health Professions Council, independent competent psychological practitioners working on a one-to-one basis with patients or clients are encouraged to develop their own understandings of practice knowledge and preference for models and related assumptions about mechanisms of change (BACP 2009, BPS, 2009, HPC 2009a). Practitioners are expected by their professional and regulatory bodies to retain their professional competence, to conduct lifelong professional learning through continuous professional development, seek guidance and knowledge from professional journals, to attend clinically educative conferences and workshops and to be reflective about their professional practices, knowledge and performance to retain and augment their skills. Independent psychological practitioners are, therefore, not anticipated to be idiosyncratic in their beliefs about psychological processes and intervention protocols. They were considered to be a suitable population for the purposes of this study as they can be expected to be accustomed to considered personal reflection on their professional performance and intervention approaches, independent of any potentially biasing influence from employing agencies. It was anticipated that such practitioners can be expected to be comfortable in expressing their independently considered intervention beliefs and to be a suitable population to assist in the pursuit of the research objectives here.

It was stated above that chronic health conditions are a suitable work area in which to explore health psychological interventions, as such conditions can create long-term and potentially complex wellbeing issues for those affected and that this group would be likely to benefit from psychological aid. It is also appreciated that there are many health practitioners other than health psychologists working with patients with common chronic conditions, especially in primary care. Health psychologists have been acknowledged to be a rare presence in primary health care (Ogden 2007). In 2006, the UK Division of Health Psychology estimated that around 29% of its c.1100 members were involved in direct clinical work, mostly in secondary care, and expressed concern that primary care is insufficiently represented in health psychology with an unstated

small minority of its members in that setting (BPS-DHP 2006). In primary care, the specialist psychological practitioner most likely to be encountered by patients with chronic health conditions is a counsellor, normally in or attached to a GP clinical setting. Many other health staff provide some measure of psychological support in primary care but the main specifically psychologically trained practitioner found in GP settings is counselling (NHS 2009). The professional organisation Counsellors and Psychotherapists in Primary Care (CPPC) estimate that 4,500 counsellors worked in primary care in England in 2005 (CPPC 2005). While the present number of counsellors in GP settings is unknown, it was thought that in 2009 “around half” of all GP surgeries in England had counsellors in or attached to them (NHS 2009, BACP 2009). While these numbers are quite imprecise, considering that there were 8,230 GP practices in England in 2007 (The Information Centre 2009), it is evident that at present, counsellors are likely to outnumber health psychologists in primary care by a very considerable margin. The BPS Division of Health Psychology (BPS-DHP 2006) aspires to their members having a higher profile in primary care clinical practice and notes that most of its clinical members already work with chronic health conditions in secondary care. With knowledge that health psychologists currently work in some numbers with chronic conditions in secondary care, this suggests that this study is timely in its focus on psychological practitioner beliefs about ‘what works’ for patients with chronic conditions alongside primary care settings.

Considering that counsellors seem likely to form the majority of psychological practitioners in primary care and that health psychologists are being encouraged to extend their work into this area, it seems appropriate to explore how both sets of psychological practitioners view the mechanisms of change in interventions with primary care or similar patients. The Division of Health Psychology and others have recently explored how health psychologists can work more closely with, among other healthcare locations, primary care health staff in one-to-one care (BPS 2007). To facilitate this close working between health psychologists and clinical staff in patient health interventions, the Division of Health Psychology adapted its Stage 2 training in 2009 for practitioner psychologists to better equip its new trainees in face-to-face health intervention skills (BPS-DHP 2009). This research may provide useful material to aid understandings of the intervention beliefs of psychological practitioners who are in practice but have not undergone this training route, and how these beliefs may compare to those of other practitioners working in interventions with patients and clients.

The significance of interventions for chronic health conditions

By their nature, long-term health conditions require long-term management of symptoms with both positive and negative psycho-social consequences for patients and family, friends and colleagues. Chronic diseases have accompanying psychological and social consequences that demand some psychological adjustment from patients, families and carers (Danoff-Burg and Revenson 2005, Department of Health 2004 and 2009, Fournier et al. 2002). Unfortunately, Petrie and Revenson (2009) suggest that psychological practitioners providing interventions for people with long-term health conditions face considerable challenges due to limited data on effective intervention, because psychological interventions designed specifically for chronic conditions have a relatively short history and because of the complex psychosocial issues involved in the necessity to adapt across multiple areas of life. There is also a growing interest from psychologists and others for better understandings of how a wide range of socio-economic and psycho-biological factors are also thought to predispose to chronic conditions and whether this as well as the conditions themselves can be affected by psychological interventions (Mansfield et al 2011, Marmott et al 2010, Wardle and Steptoe, 2005). Many health behaviours, such as smoking, obesity, lack of physical activity and unhealthy nutrition, underlie the development of chronic disease and follow the social gradient of wealthier to poorer communities (Marmot et al 2010). This again emphasises the importance and the complexity of the multi-dimensional factors that practitioner psychologists must consider when conducting interventions for chronic ill-health and highlights that these factors manifest themselves in unique ways in individual patients (Mansfield 2011).

In addition to the need for psychological interventions, the prevalence of common chronic health conditions is increasing and, with the decreasing threat of infectious illness, they have now been described as dominating the pattern of disease in the western world (Petrie and Revenson 2009). It has also been accepted for some time that people suffering from chronic or long-term health conditions are likely to suffer from more than one long-term illness and are an increasing proportion of the population. In England, long-term conditions present in one in three of the population and in people aged over 60 years, 60% have been recorded as having a chronic condition. As a consequence, this patient group represents a large and growing demand on psychological health service resources as the UK population becomes proportionately older, especially in the 'oldest old' of 85 years and older (Department of Health 2009, ONS 2010). This suggests that there is likely to be a growing demand for chronic condition interventions in the psychology of health and that a fuller

understanding of practitioner beliefs about 'what works' for chronic conditions might aid the future education of practitioners who will be involved and for those who commission their services.

A great number of different interventions have been described by psychological practitioners for those with chronic conditions but it is sometimes difficult to know the finer detail of what these were with sufficient detail to replicate them (Dombrowski et al 2007, Michie et al 2009, Riley et al 2008). The complexity of many interventions appears to be reduced to brief and inconsistently-described reports in the literature (Michie et al 2009) yet some generalities can be made for many chronic condition psychological interventions. In health psychological literature, longitudinal investigations of chronic health conditions have involved understanding the complex interplay between the contextual factors of socio-economic variables, gender, culture and ethnicity and the personal processes of adjusting linked to personality, cognition, resilience, risk appraisal and the presence of supportive others (Stanton et al 2007).

How such complex factors are operationalised varies by how the conditions are assessed and monitored. For example, a recent meta-analysis of interventions for non-cancerous lower back pain (Hoffman, Papas, Chatkoff, Kerns 2007), which they described as a very common chronic condition, explored interventions across a wide range of factors including those targeted at pain intensity, emotional functioning, pain-specific disability, health-related quality of life, participant ratings of global improvement, health care utilization, health care provider visits, pain medications, and employment/disability compensation status. 205 effect sizes from 22 studies were pooled in 34 analyses in which Hoffman noted that cognitive-behavioural, self-efficacy and regulatory protocols were found to be effective as well as other multi-disciplinary approaches that included psychological components. Drotar (2006) discusses a wide range of protocols for intervening with distressing childhood and adolescent chronic health conditions such as asthma, diabetes, cancers and cystic fibrosis. Drotar emphasises that emotional and coping skills training is required not only of the children burdened with long-term illness but also for their parents and carers who are stressed and anxious and also require understanding and support via cognitive-behavioural and learning coping strategies. Drotar's emphasis is on the complex social components of health psychological interventions, where the health of the carer is critical to the health of those affected. In addition to the complex cognitive-behavioural and social contextual factors surrounding chronic illness, health psychology looks at adherence to protocols by the person with the chronic health condition (Ogden 2007). Much of this work is educational, informing about the nature of illness in understandable ways

including checking that patients' understandings of the specifics of the illness and its behavioural components are fully understood to increase the client's knowledge about their condition. Psychological support also includes monitoring to ensure that the learning is effective, that it increases their self-efficacy in taking control of the situation and that behaviour in the patient's and patient's family, for example, remains appropriate to their wellbeing. This allows the client to develop skills to manage their condition in the wider context in which they live their life. This educative and monitoring role has been a mainstay of health psychology for many years (Ogden 2007, Taylor 1990). Perhaps the most comprehensive and exhaustive list of what is both envisaged and undertaken in health psychological interventions, much of which relates to common chronic conditions, is in Abraham and Michie's suggested taxonomy of health psychological interventions (2008). This list attempts to systematise multiple descriptions of a huge variety of psychological protocols that are available to the practitioner psychologist.

The literature covering these complex factors relating to chronic health conditions shows the richness and challenge that these long-term health conditions pose to psychological practitioners. Exploring how psychological practitioners conceptualise the mechanisms and processes of change in patients with such conditions is clearly appropriate and timely. Literature on the mechanisms and process of change was explored in the current study to see how much is known about how this links to practitioner practice in interventions.

Review of literature on psychological practitioner beliefs and practice

Introduction

A substantial literature is available from researchers advocating or testing a wide range of health psychological models and approaches but very little is available that explores the personal and professional beliefs of independently practicing psychologists who may be unaffiliated to any one model. Searches of literature databases related to psychology (PsycINFO, Medline, AMED, PubMed, PsycEXTRA), thesis, dissertation abstracts and the psychological journals produced a very short list of studies of independent psychological practitioner beliefs and practices. Those found mostly related to clinical and counselling psychology (Hansen 2006, Gallagher 1991, Gore-Felton 1999, Jorm, 1997, Jorm 2008, Keiffer 2001, Motter 2007, Pope 1987, Schwartz 2009, Wodrich 2004) and a smaller number of educational psychology studies (Cushman 2004, Foreman 2009, Potenza 2003, Wodrich 2004). No studies specifically relating to the practitioner beliefs of independently practicing health psychologists were found.

Review

The Cochrane Library of systematic reviews was searched in June 2009 (and repeated in October 2010 for new additions) for systematic reviews relating to beliefs concerning the mechanisms behind psychological interventions for chronic or long-term physical conditions. 24 systematic reviews relating to mechanisms of change were found and a general trend of review quality improvement (using Cochrane Library assessments) was noted from earlier to later studies. Of these reviews, 9 were rejected as being related to mental not physical health, were still provisional or considered by Cochrane reviewers to be weak and/or unreliable. The remaining 15 reviews were explored for evidenced beliefs and theories that appear to relate well to chronic health condition interventions (Bauman et al 1997, Connelly et al 2007, Hampson et al 2001, Hansell and Bonnet 1999, Hettema et al 2005, Hoffman et al 2007, Irwin et al 2006, Jacobsen et al 2007, Knight et al 2006, Lackner et al 2004, Linden et al 2007, Lubans et al 2008, Marshall and Biddle 2001, Nezu et al 2001, Steed et al 2003, Tulloch et al 2006). All the reviews were subject to reservations by the Cochrane reviewers and none gave convincing explanations of the underlying mechanisms of action because of weaknesses in the methodologies of the reviews, choices of studies or in their conclusions. (Some recent reviews were pending in the Cochrane Library and their contribution was unavailable for use here.)

The rationale behind inquiring into practitioner beliefs about mechanisms of change is that beliefs about 'what works' can be expected to affect practitioners' psychological intervention behaviours and choices (Hagger 2009, Michie et al 2008). It is believed that knowledge of the mechanisms and process behind interventions is fundamental to their being delivered effectively (Fishbein et al 2001). However, it is generally accepted that there is some diversity in health practitioner models and approaches and it is appropriate to know whether this diversity is an asset or a problem for independent practitioners when they hope to deliver psychological interventions. An open-minded approach has been suggested for practitioners, to use this diversity inventively to address the diversity of individual client challenges (Hagger 2009).

A diversity of professional opinions concerning explanations, models and theories of mechanisms of change is not unique to psychological circles and similar diversity can also be found in other areas of health, for example in the field of health practitioners' beliefs concerning how best to manage back pain (Buchbinder et al 2007), how to deal with death and bereavement (Saunderson and Ridsdale 1999) or whom and when to immunise (Taylor et al 2007). Further examples include doctors and nurses having different attitudes towards reporting critical incidents (Kingston et al 2004), physicians concerned about over-dependence on clinical guidance rather than professional judgement (Eccles et al 2009, Woolf et al 1999), wide variations among healthcare professionals on attitudes and beliefs about the need for quality improvement (Eccles et al 2009), GPs beliefs about men seeking medical advice affecting their treatment (Hale et al 2010) and physicians ascribing health behaviours to patients with lung cancer without real knowledge (Marteau and Riordan 1992). Non-evidenced beliefs, expectations and attitudes of health professionals are known to have some impact on the professionals' choice of treatment, the quality of care and patient outcomes (McGee 2007).

In psychological literature, there are similar findings that suggest that practitioner beliefs, attitudes and expectations may affect aspects of interventions. For example, patient drop-outs are said to be regularly underestimated with unknown impacts on measuring the effectiveness of long-term psychological interventions (Pulford et al 2007). There appear to be wide differences reported in how psychologists read, understand and react to psychological texts concerning their patients (Addis and Krasnow 1999) and there is evidence to suggest that where health practitioners and patients differ in their beliefs about the efficacy of psychological interventions it consequently impacts on their effectiveness (Jorm et al 1997).

The corpus of evidence on the complexity and variety of models and theories of health behaviour change suggests that there is an incomplete knowledge of the action that health psychological interventions may play in such change (Hagger, 2009, Abraham and Michie 2008, Ogden 2004). Interventions based on such models and theories also display an inability to explain much variance in health behaviour (Michie, Rothman and Sheeran 2007, Rothman 2007) and while health researchers can agree on the behaviours requiring modification they disagree on the causal models that link variables to the desired behaviour change (Fishbein et al 2001). In this context of a considerable choice of competing theories, models and beliefs about the nature of behaviour change and uncertainty about the nature of their effectiveness, it is appropriate to explore just what psychological practitioners actually do believe 'works' when they work with clients and patients with chronic or long-term health conditions, especially if it is accepted that such beliefs affect the likelihood of the interventions being delivered effectively (Fishbein *ibid*).

It is also known that psychological interventions for those with chronic health conditions are often carried out by a wide variety of health professionals other than psychologists, such as psychiatrists, counsellors and psychotherapists, social workers, nurses, arts, drama or music therapists, occupational therapists, or alternative and complementary therapists, each having their own their own knowledge and assumptions of therapeutic action (Department of Health 2007a, Kahana et al 2008). Considering the potential for a wide variety of different kinds of psychological intervention available, Abraham and Michie (2008) have found that many psychological interventions do vary widely in range and type even though they are designed to target similar health conditions with similar target populations. Abraham and Michie (2008) suggest that apparent differences in approach might disguise substantial commonalities and effectiveness or even a possibility that different interventions have similar outcomes. The theoretical bases of many psychological health interventions are thought to have substantial conceptual overlaps despite displaying apparent differences in language and approach (Abraham and Michie *ibid*, Hagger 2009).

Unfortunately, Abraham and Michie (*ibid*) also stated that the descriptive language of methodologies employed in evidential reporting was so inconsistent that it would be difficult for practitioners to compare and contrast evidence without an agreement on common descriptors of intervention protocols. Abraham and Michie (*ibid*) fear that this lack of clarity might lead to ineffective or incorrect interventions being carried out

despite the practitioner believing that they had correctly applied the recommended protocols.

Psychological practitioners working in the field are the ones who must use their professional judgement on what aspects of the competing theories and approaches they should apply to which situations. According to Fishbein et al (2001), practitioner understandings from evidence-based approaches have direct and immediate importance to their clients and patients as they materially influence the intervention that will be offered. There are clearly problems for health psychologists designing health behaviour change interventions due to “the plethora of potentially relevant theories, many with overlapping constructs, and the lack of guidance as to how to select theories and apply them to intervention development” (Michie 2008 p 65).

Health psychologists, however, are expected to deal with the uncertainties described above as a competent practitioner. During the process of registration with the HPC, health psychologists categorised much of their applied nature in discussions with the HPC to define professional training and standards (BPS 2006, HPC 2009a, 2009b). Among the considerable number of professional competencies describing the role of a health psychologist listed by the HPC are some directly relating to a practitioner’s knowledge and understanding of change mechanisms and process. Health psychologists are expected by the HPC to be able to practise as an autonomous professional, exercising their own professional judgement and be able to contrast, compare and critically evaluate a range of models of behaviour change when designing and delivering interventions. This acknowledges that there is range and variety of different models to be considered. The HPC also expects health psychologists to be able to use psychological formulations with clients to facilitate their understanding of their experience and to be able, on the basis of such a psychological formulation, to implement psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client (HPC 2009a). It is clear that the HPC uses terms such as “psychological therapy or other interventions” in a general manner, indicating that the health psychologist has to critically evaluate models, theories, evidence, alongside the client’s “presenting problem” and the unique psycho-social makeup of the client.

The health psychologist is expected to “exercise their own professional judgement” of the most appropriate means of delivering an appropriate intervention. This professional judgement would normally involve beliefs and critical evaluations of evidence, theories and models “appropriate to the presenting problem” (HPC 2009a).

Roth and Fonagy (1996) suggest that to achieve this task, the psychologist has to have a good understanding of what may facilitate change and hold internal working models of “what works” and be able to explain this to the client in a manner that facilitates the desired change. From this regulatory description of competencies, agreed by the professional body with the regulator (BPS 2006, HPC 2009b), it is clear that it is the practitioner who must use their own judgement on the multiple, competing and overlapping models, theories and evidence when faced, one-to-one with the unique reality of an individual client. This judgement is not a computerised mechanical one without possibility of variance, but one derived by an individual qualitative understanding based on a complex balance of training, experience and belief in “what works”.

Exploring mechanisms of change and the process of change in clients is not, of course, restricted to health psychology, as other psychologies also explore these processes as part of their own intervention research. However, despite considerable research into the process of change and mechanisms of change, there is a general consensus, that the deep mechanisms of change in clients remain largely unknown or unexplained (Elliott, 2010, Hagger 2009, Kazdin 2009, Michie et al 2008, Sniehotta, 2009). Kazdin (2007), writing about counselling and psychotherapeutic work, for example, exemplifies this common theme from the literature, namely, that evidence is more robust as to what therapeutic interventions do but without any good explanation as to how they actually work.

“There has been enormous progress in psychotherapy research. This has culminated in recognition of several treatments that have strong evidence in their behalf. Even so, after decades of psychotherapy research, we cannot provide an evidence-based explanation for how or why even our most well studied interventions produce change, that is, the mechanism(s) through which treatments operate” (Kazdin 2007 p 1).

Kazdin (2007 p 23), like Hagger (2009), points to the strengths of considering multiple complex approaches, in that they provide a diversity of interventions for the diverse populations encountered in psychology; “The complexities are critically important to understand because the best patient care will come from ensuring that the optimal variation of treatment is provided”. This philosophical position is echoed in counselling literature by Elliott (2010 p 9), who subscribes to a ‘systematic methodological pluralism’ in approaches to client issues, that that brings ‘all available methodological tools to bear on the problem’. In health psychology, Michie (2008)

gives her more gloomy analysis that much of the literature on health psychological intervention is inconsistently described, potentially confusing and insufficiently served with guidelines as how to incorporate theory into interventions. Abraham and Michie (2008) have aimed at elucidating some of this confusion by suggesting a taxonomy of behaviour change techniques used in interventions. Their aim is to develop a standardised vocabulary of intervention components to eliminate some of the uncertainty about what is meant in intervention descriptions and thus improve knowledge of what was actually done and how it was facilitated. At present they describe the content of the evidence base that is meant to guide psychological practitioners as to “what works” as being difficult to identify accurately and hence, difficult for practitioners and researchers to know just what the evidence really means. Their work seeks some commonalities in this endeavour as well as suggesting integrative intervention descriptions that can cross theoretical and model boundaries:

“Thus, a range of behaviour change technique definitions is required to comprehensively relate effectiveness to intervention content across behavioural domains, thus illuminating when and how content matters to effectiveness” (Abraham and Michie 2008 p 380).

By Abraham and Michie (*ibid*) stating that health psychology currently lacks a means of separating context from content in intervention reports, it leaves the practitioner, at least at the present time, to rely on their professional judgement as to “what works” and how when dealing with clients.

Review conclusions

The literature on health psychological models and their effectiveness contains very little on independent psychological practitioner beliefs and no published material on independently practicing health psychologists. There seems to be a general acceptance by recent reviewers of health psychological literature that the underlying mechanisms of change, despite substantial inquiry, remain somewhat unclear and uncertain. While models and theories provide testable hypotheses that may provide evidence of an associative nature between client change and proposed mediators of change, this complex and ambivalent literature does not as yet appear to provide clear or unambiguous guidance on the effectiveness of specific models for psychological practitioners in face-to-face interventions. This literature, especially, does not appear to clearly separate intervention effects from the influence of their delivery contexts. While the BPS specifically requires health psychologists to understand and be

competent in interventions based on several competing models and approaches (BPS-DHP 2009), there appears to be no published research that explores what health psychologists, unaffiliated to specific employer-recommended protocols, models or procedures, actually believe 'works' in day-to-day practice. This is not surprising considering the very small numbers likely to be working in independent health psychology practice in the UK. It is on this knowledge gap that this qualitative study focuses, namely exploring what the small number of independent health psychological practitioners believe about 'what works' in mechanisms of change in clients with chronic conditions, comparing these beliefs with those of counsellors who have been working in this area for some time, understanding better what they both believe about the effectiveness of their interventions and providing suggestions for potential future directions in health psychology training and research.

Comparing health psychologists to psychological professions currently established in primary care

It was evidenced above that health psychology represents a relatively new and minor presence in primary care yet is skilled in working with chronic health conditions and has aspirations to have a stronger presence in that setting (BHP-DHP 2006, Ogden, 2007). If health psychologists believe that they are well suited to practice in primary care and can make a useful and beneficial contribution in that context, it may be useful to compare what they can offer to an area where psychological interventions already take place. Health psychologists are trained in health promotion, health behaviour change, management of chronic conditions, equipped to give expert psychological advice on health and illness and to research and advise on health matters (BPS 2007, 2009). The areas of health psychological expertise explored here are skills and practice in psychological intervention with patients and clients with common chronic conditions.

Medically-trained health professionals are reported to have only a minor part of their training dedicated to psychological factors in medicine, that training is mostly in mental health rather than in psychological components of health and that there is limited opportunity to put into practice many items in the curriculum such as the psychological components of health (Blakshi et al 2003, Royal College of General Practitioners 2010). Counsellors, by comparison, describe themselves as a psychological profession (BACP 2010a), and can be found in many primary care settings as previously described. Of the many different kinds of health practitioners listed above as working psychologically in primary care (Department of Health 2007a, Kahana et al

2008), counsellors were considered to be the most appropriate profession to compare with health psychologists. It is accepted that the term 'counsellor' covers a group of professionals with a wide range of different trainings and approach (BACP 2010c) and this is discussed in more detail below and in the section on Participants.

Psychological practitioners likely to use intervention styles very close to or identical to those used in health psychology, such as clinical, counselling and other psychologists affiliated to the British Psychological Society, were not selected, as it was thought that any contrast between the intervention styles may be too minor to provide much learning about any different ways or philosophies of working with similar client populations. The wide availability of counsellors in GP settings also suggests that it would be beneficial to explore comparisons with this group before psychological practitioners likely to be less frequently encountered there.

Counsellors working in primary care are recognised by the BPS as psychological professionals and this permits two different psychological approaches to health conditions to be studied if counsellors are considered alongside health psychologists (BPS 2006). Counselling is thought suitable for being involved at all levels of psychological care for people with chronic health conditions (Elliott and Johnson 2008). This contribution is recognised in the NHS where people with common chronic health conditions may be advised to seek psychological interventions from counsellors to deal with their quality of life and daily functioning (NHS 2009a). As has been noted above (NHS 2009, BACP 2009), in the UK, counsellors linked to primary care are the commonest specialist psychologically-trained practitioner likely to be encountered by a patient, being present in approximately half of all GP practices. This suggests that the NHS recommendation to consider seeing a counsellor for psychological guidance related to health conditions is reasonable and realistic although, in recognition of half of GPs not having counsellor colleagues, the NHS suggests seeking private counselling if none is locally available.

The term "counsellor" describes a psychological practitioner who may come from one of many diverse and different theoretical orientations to be accredited by the British Association of Counsellors and Psychotherapists (BACP) or the United Kingdom Council for Psychotherapy (UKCP) (BACP 2010a, UKCP 2010). Here, the terms "counsellor" and "psychotherapist" are considered to be synonymous if the participant is accredited with either body and advertises themselves as a counsellor. While this labelling appears to be a highly controversial area within therapeutic circles and not entered into here, it is claimed that there is no discernible difference between them in

normal counselling practice (BACP 2010a, b). The specific training and philosophical adherence of the counsellors participating in this study is given in the “Participants” section below.

Selecting counsellors as a comparator to health psychologists anticipates that the two disciplines may approach interventions with clients with common chronic conditions in a different manner. Counsellors may aim to focus their skills on the therapeutic relationship between the counsellor and client to help the client develop self-knowledge, self-esteem and the ability to take control of his or her own life (BACP 2010c). This is a common theme in counselling based on a belief that, among other features of counselling, healing requires a trusting relationship between therapist and client for change to take place. These characteristics of counselling are considered in much greater depth in the general discussion below. These aims appear to relate well to some similar health psychological goals discussed above, of seeking to increase the client’s knowledge about their condition, increase their self-efficacy to cope with the condition and to develop skills to manage their condition in the wider context of their life (Ogden 2007). Putting it very simply, the main difference in therapeutic approach between the professions appears to be that health psychologists may prefer to focus their interventions on evidence-based psychological models, techniques and education while counsellors may prefer to focus their work on the quality of the therapeutic relationship as the key elements of facilitating change.

Selection of independent versus NHS practitioners

This research focused on the beliefs of independently employed health psychologists and counsellors working outside the NHS. Independently employed practitioners were selected for this research as it was thought that they would be more likely to have beliefs representative of their individual reflective thinking than those working within corporate health care settings such as the NHS. Major health agencies such as the NHS and its contractors can be expected to have their own ‘in-house’ belief sets (e.g. CBT or counselling only) or preferred logics of intervention or procedures (e.g. time-limited therapy) that may restrict practice ideas to those of employer-preferred approaches (NHS 2009a,b, Hansen et al 2002). Thus, practitioners may be restricted in their choice of, or style of approach to practice that might introduce a bias to their own personally and freely arrived at beliefs about ‘what works’. This issue is specifically addressed in NHS advice to patients and they are informed that, consequently, they may prefer independent practitioners for counselling and therapy

(NHS *ibid.*). Independent health and counselling psychological practitioners are members of their own professional bodies and are accredited as being competent to work independently and developing their own understandings of psychological theory and practice (BPS 2009, HPC 2009a, BACP 2009). Thus, to avoid any potential employer intervention belief bias or bias brought about by the acceptance of limited therapies, independent professionals working outside the NHS were selected and considered as being more likely to work within their own preferred belief-set of 'what works' in psychological interventions for chronic conditions.

The British Psychological Society Centre for Outcomes Research and Effectiveness suggests that patients seeking counselling (among other psychological therapies) for psychological help in managing their health conditions can consider seeking practitioners outside the NHS if they wish to avoid lengthy waits for NHS appointments or to avoid the limitations of NHS short-term or time-limited therapy (NHS 2009b). This supports the view held here that independently working counsellors and health psychologists are appropriate practitioners to interview to explore their conceptualisations of the processes and mechanisms of change in health interventions.

A consequence of limiting participants to non-NHS employment, however, is to reduce the potential participant pool to very small numbers, especially in the field of health psychology. A practical outcome of this sample choice was that while finding participant counsellors in non-NHS employment was straightforward due to their large numbers, it required a UK-wide search to locate sufficient non-NHS health psychologists to reach saturation of responses. A second consequence of limiting the research to non-NHS participants is the unquantified factor of the reasons for practitioners operating outside the NHS. While some participant health psychologists mentioned the difficulty of finding NHS work as a health psychologist as a reason for undertaking private practice, others sought practical intervention experience in addition to full-time working in higher educational institutions. It was not explored in this research, and consequently unknown, if a participant bias has been introduced here by selecting a non-NHS practitioner population.

Novice versus expert issues

As an accidental outcome of the sampling process, it was noted that the health psychology participants were earlier in their careers than the counsellors. Table 2 shows that the mean years of practice length is 6.0 years for health psychologists and 12.4 years for counsellors. As health psychology is a recent arrival among the

psychologies (Ogden 2007) and certainly a much younger psychological discipline than counselling (Cooper 2008), this finding may not be wholly unexpected. Nevertheless, this factor might, as a consequence, mean that any qualitative differences between the groups could be due solely to novice/expert differences. Research suggests that novices have a need for more formal guidance on intervention procedures, while experts seek contextual information specific to clients rather than procedures. Novices have been found to be less assured than experts in both assessing and understanding client needs and display differences in hypothesis generation and testing, diagnostic reasoning, organisation of relevant knowledge, the proportion of correct diagnoses, use of data-driven reasoning strategies and diagnostic planning (Daley 2000, Cuthbert et al 1999, Norman et al 2006). The following analysis is, therefore, not intended to give a closely-matched comparison between health psychologists and counsellors working with chronic health conditions in a quantitative 'like-for-like' comparison, but comparing 'what is found out there' among a convenience sample of psychological professionals dealing with clients with common chronic conditions. Along with substantial differences in training and approach between the groups, potential novice/expert differences require to be considered in the analysis.

Practitioner terminology

Psychologists and counsellors sometimes were found to use different terminology for their service users, their 'customers'. The literature found here that the terms 'client' and 'patient' are often used interchangeably by both health psychologists and counsellors and the terms here are also used interchangeably without intention of bias or discrimination. It is appreciated that this terminology may be a sensitive issue for some practitioners and service users, as the term 'patient' can be seen to suggest a passive role while 'client' may be used to suggest a more active participation by the service user (Deber 2005, Naseem et al 2001). No debate is entered into here about power relationships between practitioner and client/patient although it is assumed that most service users may approach practitioners in an expectation of specialist knowledge and expertise that impacts on the quality of the exchange. Here, the terms are used by the author to indicate close equality of meaning as seen in the casual usage of both terms found in the interviews or is used to reflect the terms used in the literature or by the participants.

The choice of a qualitative over a quantitative approach

A qualitative method is said to be appropriate when exploring complex uncertainties that require better understandings in depth rather than in volume and where in-depth descriptive accounts are thought necessary to elicit personal beliefs, perceptions, interpretations and meaningful understandings (Smith 2008). There can be little doubt that there are complexities of beliefs, interpretations and understandings surrounding how each psychological practitioner conceptualises mechanisms of change for a client when they practise autonomously, exercising their own professional judgement. As just one small part of a long extensive list of what is expected of psychological professionals, the HPC requires them to understand the dynamics present in health professional – client relationships:

be aware of the characteristics and consequences of non-verbal communication and how this can be affected by culture, age, ethnicity, gender, religious beliefs and socio-economic status,

be able to choose and use a broad range of psychological assessment methods appropriate to the client, environment and the type of intervention required and

be able to work psychologically across a variety of different contexts using a range of evidence-based and theoretical models, frameworks, and psychological paradigms (HPC 2009).

This synopsis of HPC practitioner standards gives a glimpse of the dynamic complexity of professional work required of an individual practitioner in a face-to-face intervention. It confirms that such activity may be as much an art (judgement, reasoning) as a science (evidence and method) as each practitioner's understandings affect operationalising theory and evidence with a client. Psychological interventions are seen to be done by 'scientist-practitioners', seeing clients as individuals with complex adaptive systems and intervening with their own professional creativity, knowledge, understandings, intuition and experience (Kennedy and Llewelyn 2001, Lane and Corrie 2006). When exploring what it is that psychological practitioners do and think about their work, it is assumed here that they are the competent professionals specified by the HPC and their own professional standards and are aware and reflective about their work (BACP 2009, BPS 2009). The practitioners are expected to have explicit general aims about their own style of practice which are shaped to the specific contexts and individuality of their clients. Practitioners' judgements are subject to their own

reflective practice as a normal part of their professional activity and it is this process that is tapped into by the qualitative method, inviting expressions of these personal reflections for analysis.

A quantitative approach would provide useful information on the scale of any similarities and differences in change beliefs between health psychologists and counsellors, requiring a representative sample of the two professions of sufficient size to be statistically accurate. Such a survey would provide a simpler but quantifiable data set, reflecting measurable differences in assumptions concerning the nature of behaviour change and permit predictions about change beliefs to be made of all health psychologists and counsellors. It may be necessary to suggest simple broad categories of belief to prevent fine gradations of lists of beliefs to make the questionnaire unwieldy. The qualitative approach used here seeks to understand contexts, meanings of beliefs, unconstrained personal and unique expressions of opinion that would not be feasible to code quantitatively without the risk of losing the rich complexity of expression sought here. No broad generalisations can be made from this study but it is hoped that a set of personal and meaningful expressions of professional understandings can illuminate the manner in which individual practitioners subjectively deal with the complex professional demands made on them to derive understandings of how and what promotes individual change. This search for individual responses employed guided but open questioning of participants, using semi-structured interviews as described below. As individual practitioners arrive at their own understandings of change processes, a qualitative analysis is best suited to explore their individual interpretations and meanings of broader theories of change as they adapt general approaches to individual client presenting issues.

This qualitative research looks at a key element in this dynamic intervention process, the individual practitioner's conceptualisation of mechanisms of change – the change process. A deeper understanding of how some individual practitioners in the field conceptualise change processes might inform the practice of health and other psychologies and illustrate how some practitioners of just two different psychological traditions view how change is facilitated in the same population base, namely, clients with common chronic conditions. This investigation hopes to provide a small sample qualitative analysis of the beliefs held by independent practitioners about what they believe 'works' and how their internal models of the process of change may manifest themselves in their descriptive and reflective assessment of their interventions with chronically-ill people. The aim was to provide an opportunity for practitioner reflection in the interview process that would be compatible with their normal professional

reflexivity. It was anticipated that this would allow the practitioners' own understandings of how they work to emerge in a setting, possibly reminiscent of peer supervision, where space is provided to allow individuals to reflect on their practice (Akhurst and Kelly 2006, Andersen 1987). As the interviewer is also a trained psychological therapist and a health psychologist in training, it was intended that the interview would be conducted in a manner conducive to reflective thinking and open responses, as if part of a peer exchange.

In qualitative analysis it is important that the author acknowledges being part of their own research process (Smith 2008). The author has worked with clients with common chronic conditions as a clinical hypnotherapist since 2002 and has been challenged by the difficulty of comprehending the complexity of the links between the multiple factors relating to the clients' individual characters and contexts and the intervention for their health condition. The motivation to undertake this inquiry came from recognition of the researcher's own uncertainty over mechanisms of change when considering the many theories and models of behaviour change that might be appropriate to bring to one-to-one interventions. The author's training was a mixture of clinical and therapeutic relational intervention styles that is an eclectic synthesis of both counselling, psychotherapeutic and health psychological practice. The author recognised that somehow a poorly-understood placebo or relational component appeared to be a strong facilitator of change in his interventions with clients with physical and mental health conditions. The main motivation to this research was to explore how other practitioners dealt with these puzzling multiple issues when working with clients and to learn from their experiences. There was no agenda of seeking any specific outcome, rather an agenda of curiosity and inquiry to see how other health psychological practitioners conceptualised change processes, how they dealt with the competing theories and how they incorporated their understandings in an integrative or theoretically pure manner. The author was also aware of expressions of disfavour from a small number of health psychological colleagues concerning apparently 'competing' psychological professions of clinical or counselling in the field of health psychological interventions. There was some curiosity to see what at least one of these occasionally disparaged professions thought of health and other psychologists. Curiosity about the beliefs of practitioners and how they interpreted broad theories of change was the overwhelming driver for this research with the aim of learning from the results and building this knowledge into improving work with clients with health conditions.

Choosing thematic analysis to analyse the data

Thematic analysis, as systematised by Braun and Clarke (2006, 2010), was selected as it permits the method of coding and analysis to be reasonably transparent, requires clear defendability and, being a method only, is capable of being free from some philosophical limitations present in other qualitative methods as it permits a researcher to analyse their data in a manner both inductive and deductive, theoretical and data-driven and experiential and critical. The desire here is to seek a method that allows a wide interpretation of the data and to develop the analysis in an open manner to gain as much meaning from the data as possible. Thematic analysis is a qualitative analytical method for identifying and reporting such patterns, normally described as 'themes' within the data (Braun and Clarke 2006). Described as "sophisticated" and "probably the most systematic introduction to doing thematic analysis to date" by Howitt and Cramer (2008 p.341), Braun and Clarke's method of thematic analysis is a flexible and accessible means of systematically identifying and organising insightful patterns of meaning as themes across a data set.

Choosing thematic analysis to analyse the data (in a manner described below in Methods) reflects the contextual epistemological position adopted here. The research question seeks knowledge of the beliefs of practitioners concerning the processes of change and beliefs and these internal cognitive contexts to behaviour are expected to vary between individuals and to be accessible to verbal questioning. Practitioner beliefs are expected to have some internal group consistency relating to professional focus, purpose and similar training from accredited educational providers who conform to broad accreditation requirements. Nevertheless, while variability between individual professional beliefs is anticipated, patterns or commonalities of belief across unique professional groups are expected to be observed that characterise beliefs within such professions. Thematic analysis is appropriate to seek latent ideas and conceptualisations as well as essentialist/realist motives, experience and meaning that colours the ideas and conceptions that lie behind beliefs (Braun and Clarke 2006). It can be used to highlight similarities and differences across the data and allows for psychological interpretation. This method is said to be useful for producing analysis suited to informing the development of policy. This suits the research aim of illuminating practitioner concepts of change with an intent to inform training and intervention approaches.

Other qualitative methods can also generate patterns from the data such as IPA (interpretative phenomenological analysis), Grounded Theory, Thematic Discourse

Analysis and Personal Construct Analysis but are not thought appropriate to use here. IPA is more suited to explore 'lived experience' and experiential meaning, while here, beliefs and interpretations are sought (Smith 2008). Grounded Theory is more structured than thematic analysis and shares many of its assumptions. Nevertheless, it can be described as a 'purist' approach in that it can (in Glaser's version) preclude a prior literature search or discussion of the research area prior to coding to avoid biasing what might be found (Glaser 1998). This is inappropriate here as the research question seeks practitioners' beliefs concerning existing competing theories and this requires knowledge of the original theories and beliefs concerning them in a literature review. The author is also trained in psychological theories and does not suggest that his research interpretations are uninfluenced by knowledge of them. Thematic discourse analysis seeks to interpret texts while, here, participant statements are accepted as they are and thematically linked (Banister et al 1994). Thematic discourse analysis seeks themes from data that reveal how social and psychological life is constructed, possibly as social objects, while here, the psychological constructs of beliefs are sought and the assumptions underlying it, not any higher-level social construction.

It was thought appropriate to use semi-structured interviews to elicit data for this study. The choice of semi-structured interviews over other qualitative data collection styles was a desire for a simple, open and direct method of inquiry directly from the individual participants related to the research question. This is intended to derive data from an assumption of the participants having some self-awareness of beliefs derived from the reflexivity normal to their profession. Other data sources were rejected, such as focus groups for group consensus beliefs (individual beliefs were wanted), observational, ethnographic, naturalistic or participatory methods (potentially biasing and intrusive on client-practitioner confidentiality), or deriving beliefs from text data such as surveys, diaries, story completion tasks and vignettes (too interpretative rather than the ability to directly adapt enquiry in response to the face-to-face interview).

Methods

Aim

The research aimed to investigate independently employed health psychologists' and counsellors' beliefs concerning the processes and mechanisms of change in clients with chronic health conditions. It was intended that this would illuminate how and why different psychological practitioners incorporate a considerable volume of complex and

potentially competing knowledge and data into interventions and how they understand the extent to which these factors may improve the wellbeing of their clients.

Participants

Participants comprised 10 adult psychological practitioners, 8 women and 2 men, in private practice who operated independently outside the NHS. These were found through personal, academic and therapeutic networks, snowballing from early participants known to the researcher or suggested for inclusion by academic supervisors. All were White European adults who had completed at least one tertiary education training with adequate representation of both health psychologists and counsellors (co-incidentally equal numbers of each profession). All the health psychologists were women. Sufficient participants were sought from both professions to provide a useful range of individual cases to illustrate a range of different beliefs about the mechanisms of change. A sample size of approximately ten cases was thought to be a reasonably large number to achieve this. It was known that the numbers of independent health psychologists would be small while counsellors are plentiful. This proved to be the case and a search for independent health psychologists took the researcher across the UK. While counsellors were readily found locally in England's South-West where the researcher was based, health psychologists were drawn from both England (3 participants) and Scotland (2 participants).

Arguably homogeneous groups of each profession were required to explore cases that have a reasonable chance of illustrating some aspects that define beliefs central to groups of trained and accredited health psychologists and counsellors. It was thought that the beliefs found in each case study would be complex with a need for very detailed analysis to understand them and their context (Banister 1994, Smith 2008). This necessitated seeking a small sample size to provide the depth of response while not being so large as to provide logistical problems of swamping the research with too much data.

Participants' clients' range of common chronic health conditions

All participants, at time of interview, worked with clients with chronic health conditions. Table 2 below lists the chronic or long-term health conditions that the respondents reflected on in their interviews. Each respondent used one client's main health condition to illuminate their conceptualisations of change in that client. As part of the anonymising of participants and their clients, no breakdown is given of which

psychological practitioner relates to which condition, but does demonstrate some of the range of chronic health conditions where psychological interventions may prove beneficial.

Table 2: Health conditions of clients/patients reported by respondents

Practitioner	Condition	Associated issues
1 HP	dementia	decreasing cognitive function, care
2 C	chronic headache	whole body stiffness, stressed
3 HP	hypertension, infections	medication, bipolar, post-viral fatigue
4 C	back pain, stiffness	frozen/stiff vertebrae and upper body
5 HP	diabetes	diabetic wounds, quality of life, pain
6 HP	major surgery, palpitations	pain, trauma, adjustment to disability
7 C	ME, auto-immune	thyroid disorder, Epstein-Barr infection
8 C	whole body tremor	quality of life-limiting, social problems
9 C	morbid obesity	life-limiting, social discrimination
10 HP	cancer	lifespan-limiting, trauma

Table 2 – Participants labelled in order of transcript number and affiliation (HP = health psychologist, C = counsellor) and how they reported the principal aspects of the presenting and associated long-term or chronic conditions of their clients.

Participant training, experience and philosophical orientation

There was variation in the timespan of participants' experience and the nature of their training. All counsellor practitioners were fully accredited with the BACP, four of the health psychologists were chartered psychologists and one respondent was a health psychologist in the final year of training although self-employed as a health psychologist. At the time of interview (2009-2010), three of the health psychologists had completed registration with the HPC with two stating that they were close to finalising HPC registration and all were self-employed as health psychologists. The health psychologists all reported their belief in an evidence-based approach in interventions. Two of the health psychological participants reported undertaking health psychological training only while three of the five others reported taking additional (sometimes multiple) therapeutic training in counselling (2), cognitive behavioural therapy (2), coaching (1) and theology (1). The counsellors generally had a longer

practice experience (mean of 12 years) in face-to-face therapeutic/intervention work than the health psychologists (mean 6 years). Counsellors also expressed some variation of approach, having undergone training in diverse routes to achieve accreditation. The counsellors were all person-centred in their core affiliation but stated that they were 'eclectic' in selecting aspects of therapy from their experience to suit the individuality of their clients without necessarily declaring a specific allegiance beyond the 'approach' of person-centred counselling.

The theoretical and philosophical orientation of counselling has been said to appear to the outsider as being multiple and complex with an almost infinite variation, even within competing perspectives (Sanders 2003). Sanders has described competing philosophical approaches in counselling as 'tribes' who appear to 'war' with each other over which tribe holds to the most 'correct' approach to a theoretical position in counselling. Sanders (2003, Introduction p ix) describes the theoretical development of counselling and psychotherapy as being dynamic and contentious, "The history of psychotherapy is the history of big ideas, developments, disagreements and splits". If this is an accurate description in the UK, it would be difficult and presumptuous for a health psychologist to attempt to define just what a counsellor is and does. Nevertheless, some working definition is required to compare their approach to health psychology's and I have elected to opt out of fine definitions by referring to counsellors as being those accredited by the British Association of Counsellors and Psychotherapists (BACP) and the United Kingdom Council for Psychotherapy (UKCP). As suggested by the NHS, no differentiation is made between counselling and psychotherapy and all participants are referred to here as 'counsellors' (BACP 2010d).

To avoid some of the complexity of multiple approaches represented by the counselling participants, all participants professed adherence to the 'person-centred' approach, although within that approach, as indicated by Sanders, different 'tribes' are represented as shown in Table 3 below. All counsellor participants subscribed to the general principles of person-centred counselling as represented in the philosophy and practice of Carl Rogers integrated with additional influences from the approaches of psychosynthesis, mindfulness and focusing. Table 3 describes these approaches in addition to the person-centred approach although it should be noted that these brief descriptions omit substantial additional detail for the sake of brevity.

Table 3: Brief summary of Rogers' Person-Centred Approach and the additional approaches integrated with this by the participating counsellors

Model, type, main author	Main hypothesis of change	Limitations
<p>Person-centred approach (psychotherapeutic, Carl Rogers)</p> <p>Clients held to have a self-healing (self-actualising) mechanism promoted by a trusting and safe social interaction with a therapist who is empathic, understanding, caring, accepting (having unconditional positive regard) and genuineness (congruence).</p>	<p>The quality of the therapeutic relationship provided in partnership with the therapist is safe and caring enough for the client to become open to experience, be curious about the world, be creative and compassionate towards themselves and thereby heal older or current psychic wounds.</p>	<p>Emphasis on the quality of the therapeutic alliance between therapist and client more than in promoting an overt positive outcome.</p>
<p>Psychosynthesis (neo-Freudian, Assagioli)</p> <p>Clients are said to have weak connection to unconscious levels containing memories, emotional hurts, emotions, attitudes, skills, inspiration, spiritual influences and morality. Sub-personalities linked to these are integrated into a true self-knowledge.</p>	<p>Behaviour change prompted by employing a wide range of associative procedures employing imaginative work that seeks to connect with and integrate the unconscious functions with the known self. A strong emphasis on spiritual peace as an outcome.</p>	<p>Philosophical only with a strong influence of trans-personal beliefs in a human spirituality rather than a rigorous seeking of specific issues to be resolved.</p>
<p>Mindfulness (meditative practice, Kabat-Zinn)</p> <p>Based on Buddhist meditation, it is a stress-reduction procedure where clients are invited to pay an inward purposeful and non-judgemental attention to one's being in the present moment.</p>	<p>Repeated meditative practice creates an acceptance of self and body that trains in living in the moment rather than concerning one's self about the past or future. This acceptance reduces inner tension and stress.</p>	<p>Generally well-researched and positive with some negative impact where self-criticism and negativity is triggered when accompanied by poor therapeutic support.</p>
<p>Focusing (Experiential approach, Gendlin)</p> <p>A procedure where the therapist becomes aware of a 'feeling' or 'felt sense' within the therapist's body in response to a client. This gives an awareness or intuitive guide to a 'something' that relates to the therapeutic experience that can guide therapeutic exploration.</p>	<p>Focusing does not directly impact on client change but illuminates some form of non-verbal communication taking place between therapist and client. This produces a feeling located in the body that guides exploration of the exchange between client and therapist.</p>	<p>This is a procedure that guides therapy and by being experiential is not readily open to external validation.</p>

Table 3 Lists the principal philosophical and theoretical approaches displayed by the counselling participants. Three of the participants combined Psychosynthesis, Mindfulness or Focusing with the Person-Centred Approach common to all counsellors.

In summary, the health psychologist participants all appeared to be evidence-based in their intervention beliefs while the counsellors appeared to be philosophically founded in theirs.

Interview schedule

A semi-structured Interview Schedule was constructed to inquire into the therapeutic stages of interventions related to the conditions referred to in Table 2 above (see Appendix for schedule). A semi-structured interview was chosen to lead the respondents into the topic and to allow the participants to take a naturalistic control over the flow of question response with the schedule of core questions available to ensure that the topic was sufficiently explored for each respondent (Yardley 2008).

Piloting and finalising the schedule

The interview schedule is based on a range of areas intended to elicit intervention beliefs. The draft schedule inquired into a sequence of ideas that explored beliefs about the nature of the participant's client's condition, its origins and stability, through to its effects on their client, how any intervention could impact on these effects, how it might 'work', what they hoped would happen for their client in the future and the nature of outcome measures they believed valid. This sequence of inquiry was derived from informal discussions about the nature of case assessment, intervention formulation, practice and evaluation with non-participating health psychologists and counsellors personally known to the researcher and then iteratively piloted with further non-participant psychological practitioners. The original draft was found to be over-long and too time-consuming and was refined iteratively into the final schedule that was simpler, more open-ended and less detailed in form. The interview schedule aims to have a naturalistic conversational flow and appears successful in stimulating productive reflections on beliefs about client processes of change.

Following piloting of questions among a convenience sample of health psychologists and counsellors who took no part in the later research, the schedule was adjusted to its final form. The schedule was designed to explore a sequence of ideas that would move from exploring the nature of the participant's client's condition, its origins and stability, through to its effects on their client, how their intervention could impact on these effects, how it might 'work', what they hoped would happen for their client in the future and any other outcome measures. The schedule ended with a prompt to obtain information of the practitioner's comfort with their existing professional skills and their relevance to the task of facilitating change. The interview schedule was found to have a naturalistic conversational flow and appeared successful in stimulating reflections on client processes of change.

The schedule began with an inquiry into practitioner beliefs about the causes of the chronic condition presented by the client. This inquiry into what practitioners believed created and maintained the chronic nature of the condition and any biopsychosocial influences upon it, aimed to elicit beliefs about both the nature of the illness and any intervention style and efficacy beliefs. The inquiry into beliefs about how the condition impacts on the client, proposals for intervention and outcome goals, searched for beliefs about what might be the target of interventions and what the practitioners thought would be amenable to change. Elaboration of these beliefs and ideas concerning the nature of the process of change were to be derived from respondent speculation on how the intervention might work in a bio-psychological manner. Types of intervention goals were explored by asking about how or if success was measured. Beliefs about the validity of therapeutic approach were sought by asking how practitioners' approaches might give special advantage over hypothesised other approaches. These questions were thought sufficient to draw out beliefs about the mechanisms or processes involved in change in a semi-conversational manner, with prompts, if required, to elicit further explanation or clarification of points.

Interview procedure and materials

All respondents had been contacted prior to interview and had been given an information leaflet explaining the research (See Appendix for information leaflet texts). The leaflet contained a consent form which was signed by both participant and researcher and retained. The leaflet contained a brief set of the questions contained in the interview schedule. This was done to prompt reflection about the questions as they were considered to be too demanding of complex responses to be presented without prior notice. Analysis of the pilot suggested that the schedule questions were too challenging for practitioners to quickly respond in a manner that they felt was reasonably complete. In the moment of interview, however, the researcher still required to repeat questions or parts of questions to prompt answers. It is likely, therefore, that some of the responses to the questions were spontaneous as well as a result of careful reflection, despite the notice given of the question content in the explanatory leaflet.

Interviews took place in both England and Scotland from late 2009 to mid 2010. Interviews were conducted in private spaces with only the researcher and interviewer present, although interruptions occasionally occurred from respondent's pets in participants' self-employed home offices. One interview was conducted in a dedicated interview space in large community hall which, while noisy, provided privacy for the

interview. Interviews were conducted using a semi-structured schedule (see Appendix) and the interviews recorded using a digital recorder. During interviews, the question sequence was adapted to follow the natural flow of response with some questions being answered during the responses to other questions. All participants responded to all questions in addition to giving considerable unprompted data relating to the topic of process of change, mechanisms of changing client and patient health behaviours, spontaneous reflections about the nature of their work and their attitudes and beliefs about one-to one psychological practice.

Following the interview, respondents were given a debriefing leaflet containing the researcher's and supervisor's contacts, thanking them for their participation. Respondents were told that they would be contacted at a later stage of the research to comment on the provisional outcomes if they wished and that any comments would be included in the final analysis if they consented to this. This was done in late 2010 and the responses from the three counsellors and two health psychologists who replied to this communication are included in the discussion below and are listed in the Appendix.

Ethics

It has been suggested above, that NHS patients seeking psychological help for health conditions may be invited to consider independent practitioners as an alternative to limited NHS psychological care. This implies that clients of the psychological practitioners interviewed may at the same time be NHS patients. However, NHS care is ubiquitous in the UK and it is highly likely that all participants, clients and researchers will be NHS patients at some time. Here, psychological practitioners were selected who were not directly employed by the NHS and as it was the practitioners' beliefs that were the direct focus of the research, not that of patients, it was anticipated that NHS approval would not be required to proceed. However, to clarify this, the local NHS research committee was approached with details of the research design to ensure that the research fell outside their remit and this was confirmed (see Appendix). The Faculty of Health and Life Sciences Research Ethics Committee at the University of the West of England then gave ethical approval for the research to proceed.

Transcription and format

Interviews lasted from 35 to 65 minutes with a mean of 50 minutes. Interviews were recorded digitally using a digital sound editor to remove noise interference and to permit speech to be repetitively looped for accurate transcription (Acoustica Version

3.5 by Acorn Digital Media GmbH). An orthographic transcription was made of the recordings as this was considered to be sufficient for the purposes of thematic analysis (Braun and Clarke 2006, 2010). The transcriptions appear in the everyday disjointed fashion of reported speech. No attempt was made to modify the language or to tidy-up grammar, spelling or sentence form. Colloquial speech can be seen throughout the extracted codes and this was honoured rather than be artificially 'cleaned' to suit written conventions. English was not a first language for more than one participant and no attempts were made to correct speech to written English standards. Gaps and pauses are simply indicated by a short line of dots. Speech after a long pause was treated as if it was the start of a new sentence. Recordings of data and transcripts are held securely and anonymously in the researcher's home office.

To assist in identifying which profession provided which extract, each selected example is annotated with a simple code of 'HP' for a health psychologist's and 'C' for a counsellor's response. A number (e.g.1) indicates the transcript number in the appendix to assist matching quotes to participants. Thus '1 HP' represents a health psychologist quote from transcript 1, to permit the quotes to be seen in context if required.

Use of thematic analysis

The research data was analysed thematically using the systematic phases of analysis described by Braun and Clarke (2006, 2010). Thematic analysis was chosen as it has been systematised by Braun and Clarke (ibid) in a way that permits the method of coding and analysis to be reasonably transparent and defensible without it being restricted by procedures such as those found in Grounded Theory (although Braun and Clarke do say that thematic analysis uses methods that could be described as a 'light' version of Grounded Theory).

This analysis takes an inductive 'bottom-up' approach to the data, being guided by what is in the content of the respondents' words and phrases to derive initial codes of meaning, as opposed to the use of 'top-down' codes determined in advance. The thematic analysis aimed to be experiential and essentialist/realist, with the realities, experiences and meanings expressed by the participants determining the themes (Braun and Clarke 2006, 2010). While the researcher brings his own issues to the investigation, concerning his own uncertainties concerning complex and overlapping health psychological theories and models in applying psychological knowledge, the author wished the data to speak for itself whether it supports or undermines any author

expectations of uncertainty of approach from the respondents. Thus, the author used an inductive bottom-up method, anticipating that the themes would be derived purely from the data.

The themes and linking features in the data were arrived at by triangulation from different respondents discussing similar issues, with both practitioner sets contributing to all but one theme. This permits themes to be derived that represent meaningful aspects of the whole or distinct parts of the data set. The researcher analysed the data to generate codes as a sole investigator and this will have introduced unique interviewer bias into the output. As qualitative analysis necessitates personal influence, the quality and plausibility of the output is recognised to be a function of researcher's own assessments and judgements. The following general discussion hopes to make these assessments and judgements as transparent as possible to permit readers to understand how the final themes were derived. As this analysis was conducted by a researcher without a second reviewer/rater of themes, it is acknowledged that a second reviewer might have led to further reflection on the responses leading to modifications to the nature and labelling of derived themes and to the conclusions drawn by the author (Elliot, Fisher, & Rennie 1999, Yardley 2008). This analysis is, thus, acknowledged as the sole work of the author. It is also acknowledged that the emerging guidelines for assessing the quality of qualitative research is thought to be a 'politically fraught process' (Reicher 2000) and it is hoped that the transparency sought in the analysis here, clear use of Braun and Clarke's (2006) methodology, makes the analytical decisions clear and open for other researchers to see.

The codes were selected by seeking repetitive ideas, commonalities in cognition, patterns in the data and eliciting key features from the interviews. 'Disconfirming analysis', or looking for evidence to potentially refute any prior assumptions by the researcher, was used to 'welcome' the unexpected and to keep aware of the need to avoid homogenising the data and ensuring that the respondents beliefs are realistically reflected by the codes (Yardley 2008). Employing transparent bottom-up techniques gives a measure of protection against bias although it is acknowledged that the researcher's own perspectives will inevitably influence the analysis (Smith 2008).

Results and discussion

The participants strongly engaged with the interview schedule questions around the topic of comparative psychological professions' approaches to the process or

mechanisms of change. This provided reassurance that the interviews are likely to have provided an appropriate data set for this qualitative exploration of health psychologists' and counsellors' beliefs when working with a closely related client/patient base. It is appropriate at this point to state that many of the health psychologist participants appeared to find the interview useful to make some strong statements about their experience of work and training. The interviewer wondered if this had provided them with an opportunity to vent their frustrations and express their discomfort with aspects of their work, training and future. It is possible that the research may have given an opportunity for the health psychologists to air their opinions in the interviews that might not have been otherwise available. This possibility is returned to in the discussion and conclusions that follow. It is also useful to note that in addition to seeking themes that describe the data as a whole, this research also compares and contrasts the two participant groups in a qualitative manner. No general claims are made for this comparison as if the data was derived from a representative sample although suggestions are made that a more representative study might be usefully considered using outputs from this research.

Terminologies used by the two practitioner sets differ sometimes to describe their manner of working with clients. It is not always clear that even when the same word is used to describe a working practice or idea, that they both share the entire meaning of that term. Terms such as the word "pattern" appear to be used loosely by both practitioner groups to refer to regular aspects of cognition and behaviour ("where someone has a particular pattern of behaviour that works extremely well for them in very important aspects of their lives" (counsellor), "there's a pattern, you know, what person-centred theory says what anxiety is" (health psychologist). Examples of different terms used by the practitioners are descriptors used for their practice contexts, such as working in "interventions" or in "therapy". In several descriptions of an intervention process, health psychologists have referred to being in therapeutic work ("These people are not necessarily therapy-minded", "I mean there were, I think, several, anyway, aims to our therapy", "what we do is a mix of quick therapy"). While health psychologists may not normally see themselves as "therapists" (despite some clients describing them as therapists) they may use the term loosely as descriptors of parts of their way of working or about whole intervention procedures with a client or patient. In practice, both practitioner sets shared much of their terminology and the minor differences did not present any problems in interpreting the data.

The interviews were assessed to extract the important common and recurrent themes relating to the research question that lay latent in the data. These themes represented

underlying ideas, assumptions and conceptualisations of the process of change and how it may be facilitated. The 6-stage method recommended by Braun and Clarke (2006, 2010) was used to derive distinctive, cohesive and consistent themes that qualitatively characterise the participants' responses. Stage 1 required a full 'immersion' in the data, listening to the recordings, transcribing them and reading the transcripts until the researcher was fully familiar with the data. Initial codes were then derived that described key and meaningful aspects of the data (Stage 2). The coding represented features of the data that refer to the most basic elements of meaningful information that had some relevance to the research question. The codes were then combined into discrete meaningful elements of the data, where each element was considered to represent some distinctive feature of the data (Stage 3). The process of combining codes into discrete elements of meaning was iteratively replicated as each interview was systematically assessed. This dynamic process developed initial candidate themes that did not appear to overlap or contradict each other and logically linked the basic codes into a loose structure of preliminary themes.

The preliminary thematic analysis stage described above is a scoping task to attempt to form an initial overview of the themes derived from the whole data set. This was the start of a further process of repeated iterative reviews of the codes and themes that later provided a more cohesive and clear overview of the entirety of the data and produced potential themes that related directly to the main research question of conceptualisations of the process of change (stage 4). The scoping began with exploring if there was a potential for any internal cohesion in the themes or in the links between themes deriving from the data. During the early research proposal stage it was thought possible that the responses from different psychological perspectives might be so diverse that little generality would be found in the data. The piloting of the interview schedule suggested that generalities could be found and this forecast was born out when common themes were derived as shown in Figure 1 below. Figure 1 suggests possibilities of some overarching themes where a few of the themes might be developed into more comprehensively defined main themes (stage 5). The sixth stage of Braun and Clarke's suggested method is the production of a "convincing and clear story" that makes an argument that answers the research question. This is derived after exploring the initial candidate themes that were derived from the first set of iterations in Figure 1 shown below.

Figure 1: The initial themes as they appear to link across the data set

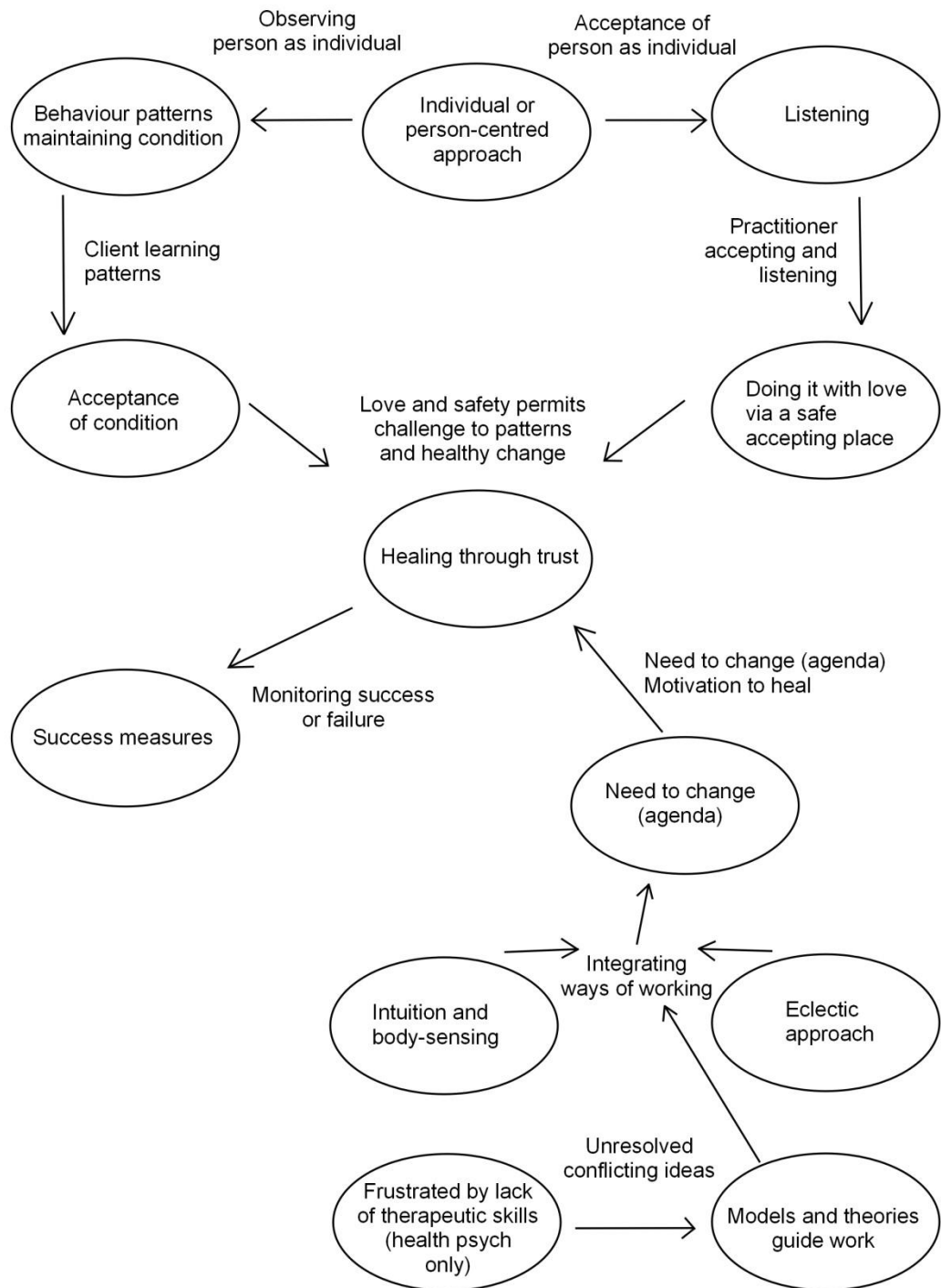


Figure 1 shows potentially meaningful clusters of themes. Named themes sit within ovals of equal size. A trend of one theme occurring meaningfully before the next is shown by an arrow with accompanying text descriptions.

Connected themes in the early thematic analysis

Figure 1 illustrates 12 themes derived from the preliminary analysis of the whole data set. This represents the first attempt to synthesise the themes into a meaningful pattern for the entire data set. This is the earliest stage in the process of repeated iterations to develop a broader understanding of the data and to give an overview of derived themes. The scoping exercise demonstrates that there is some potential for an overarching thematic pattern in the data set despite an initial weakly-structured appearance. Nevertheless, this initial attempt to derive thematic meanings across the data from the participants' responses illustrates the tentative nature the analysis at this stage.

The thematic map in Figure 1 shows some potentially meaningful clusters of themes. The named themes are shown within ovals of equal size to indicate that their relative importance is not yet defined. The links between themes are represented by arrows indicating a general trend of one theme tending to occur meaningfully before the next. Text descriptions represent the meanings behind the suggested links between the themes.

Potential thematic clusters linked to practitioners' ways of working

Figure 1 shows a cluster of psychological approach-related themes that characterise ways of working and possibly conflicting ideas. The themes, "Models and theories guide work", "Eclectic approach", "Frustrated by lack of therapeutic skills" cluster together, linked provisionally through an observation of, "Unresolved conflicting ideas". These early candidate themes and linking ideas will be reviewed later but are briefly explored below to test if they have internal coherence and 'make sense' with some cohesive meaning. While very conjectural at this point in the analysis, this linked but conflicting grouping of themes may parallel some of the complexity of multiple models and theories found in the health psychological literature cited earlier.

Eclectic Approach: All the psychological practitioners claimed to use an "Eclectic approach" in that they said they were prepared to use aspects of other approaches in their working with clients in interventions or therapy. Health psychologists and counsellors both tended to bring in different trainings if they thought it necessary and use what they thought appropriate to the client or intervention:

“Because, some of the problems, you know, are so chronic, problems go back, you know, existed even before the emergence of that physical crisis, so just barely, solely focusing on the physical side of things is not going to be helpful. So it helps, I think, to have a bigger counselling, clinical background as well. I’ve developed that as a health psychologist.” 6 HP

“The style that the agency I work with and very much my style is person-centred counselling. Ehm, woven into that, f., in my, in the way I practice is a degree of sort of, psychodynamic practice, so it’s an integrative approach.” 8 C

Unresolved conflicting ideas: Despite valuing eclecticism, conflicts seemed to exist as to how well different approaches of ways of working sat with the practitioners. An idea of “Unresolved conflicting ideas” came through in their reflections about lack of certainty about what skills should be used or be available in practice, or how to combine or come to terms with operating with unresolved ideas, possibly in different models, or simply being cautious in wondering how best to work with clients when ideas become conflicting or overlapping:

“But I think sometimes I think, yeah, I mean, you know, there’s a lot of people say but, oh, but, you know, have you been trained in CBT or trained in psychotherapy, you know, and those things. Ehm, you know, maybe, as a, it would be a useful tool to have that as part of your training, ehm, but then again, it is an additional tool you have as a psychologist, and not necessarily a tool you need to have to practice” 5 HP

“I would say to be honest, that I’m still in the process of integrating them, or deciding that I’m not going to be integrating them and I’ll be doing something different, and I haven’t really, you know .. the jury’s still out on that, to be honest. Ehm, but certainly I’ve always been, I.. I’ve never been a purist, I’ve taught it all in a teaching environment.” 6 HP

“I mean, you know, I was eh, I was I suppose.. you know I wanted to be a good, good therapist (laughs) and eh, but there was a certain degree of caution, and I think I was kind of compensating for that, and eh, of finding myself in this very heady place” 4 C

Models and theories guide work: The theme “Models and theories guide work” derived from both health psychologists’ and counsellors’ responses, albeit from different training perspectives. Counselling training and practice appears to be suffused with Carl Rogers’ concepts and writings about the ‘core conditions’ necessary and sufficient to promote therapeutic change, especially concerning the nature of the relationship between practitioner and client (Rogers 1957, 1959, Cooper 2008). Not surprisingly, this was frequently mentioned by counsellors describing their underlying approach:

“I think the most important part of therapy is the relationship aspect, and what happens in the room.” 7 C

“And she realises that she might not have got that same relationship, and it has been the relationship that has been key for her. You know, I mean, I am back to Roger’s core conditions with this woman. And that’s what the work’s about.” 9 C

“One is a focus, ehm, on the quality of the relationship, and that just resonates with me intuitively. Then if, if you have a really, if you develop a good quality loving relationship, it doesn’t have to be with a client, with anybody for that matter, ehm, then you’ve got the foundation stone for doing other stuff. But without that there’s really no safety for your client, ehm, and so many of the clients that I see have not had that experience, so it’s novel, ehm, it’s dangerous for them.” 8 C

For health psychologists, the models and theories learned in training were invariably mentioned as being a good foundation for understanding and explaining the process of change in clients and patients. The participants’ explained how they reflected about how best to link models and theories to the work with a client or patient:

“A lot of the time when I’m working as a coach, we use smart goals, ‘cos they’re very effective and I tend to use the business model, ehm, and we also talk about stages of change actually, the most useful theory out of all of the ones about behaviour change is actually Prochaska and DiClemente’s cycles of change, it is just, it’s, it really helps.” 3 HP

“I’ve seen me using health psychology theories and models, ehm, I sometimes, you know, ehm, what, CBT if it’s appropriate, so, kind of walking the patient

through process, ehm, letting them see themselves from one step to another, what's happening." 5 HP

"I think, the health psychology background, more academic background, gives you an understanding of the, what theories are out there that relates specifically, you know, to that condition or the management of that condition, ehm, and what treatment-related issues might come up specific to that condition. And I think that is a real strength of it." 10 HP

The theme of "models and theories guide work" reflects a commonality across the data, irrespective of psychological background.

Intuition and body-sensing: A theme of "Intuition and body-sensing" as a means of interpersonally relating to clients and patients sits as a separate but complementary theme to the other ways of working through eclectic and theoretical/model-driven approaches. Intuition is considered here as a form of inferential processing, or a means of arriving at an understanding of a situation without much conscious thought, while body-sensing (sometimes known as 'focusing') has been described as a means of responding to information from a client and this becoming noticed through awareness of one's own bodily reaction (Argyle 1967, Charles 2004, Gendlin 2002, Lane and Corrie 2006). The two processes may combine into an awareness of non-verbal communication leading to understandings of the client. Exploring the codes beneath these themes and links is briefly described below with both health psychologist and counsellor comments on the usefulness of "Intuition and body-sensing".

"I supervise a psychologist and, and, you know, she's often struggled with me when I've said, 'hang about', you know, I've just got this weird feeling going on here (indicating stomach) what's that about? And she'll say, well it might be this it might be .., and I.., mhmm. And, and what she's beginning to do is, is, thinking about things from a feeling, or approaching things from a more feeling point of view, as well as all this cognitive stuff." 7 C

"I suppose you do look at the general sort of posture of the patient, and general sort of, you know, would have they been paying attention to their clothing etc. You get a sense, when someone walks in, when you sort of, their shoulders slumped, and, or whether they walk in with a bit more energy into the room, ehm, and, so you look at those." 10 HP

Need to change (agenda): Practitioners from both perspectives expressed a strong wish to facilitate patient and client change, described as a “Need to change” for the client. This is linked to related ideas of an ‘agenda’ for the client that came through from the codes, describing the practitioner’s wish for the client to respond more healthily in a particular direction or to adopt or cease some specified behaviour or cognition. The “Need to change (agenda)” is a theme supplied by examples from both psychological professions:

“I think that’s when it becomes a bit difficult, I think, from the therapist’s point of view, or the practitioner’s point of view. You feel like you’re trying to convince them but you’re not. You know, just, I think, they haven’t quite internalised that there is a change that is happening.” 10 HP

“Oh I’d love to say I never have an, agendas for my clients, but (laughs). Yes of course I have agendas for my clients” 7 C

The “Need to change (agenda)” theme may reflect some strength of motivation in both practitioner sets to persuade clients to change or appreciate change in a directive sense rather than being permissive and accepting a client’s own timescale or wish to change.

Frustrations with lack of therapeutic skills: There was one theme that was not shared across the data and this single theme was only derived from health psychologist responses. The theme was originally labelled, “Feeling lack of practitioner approach”. After reflection and re-examination of the originating codes it was thought better expressed as “Frustrated by lack of therapeutic skills” and provides an example of the development of theme labels from repetitive analysis of the underlying codes.

Two health psychologists suggested that their training was remote from face-to-face working and that it was insufficient to prepare trainees for the challenges of face-to-face work:

“I think that most people are going to be in academia, they’re going to be in public health roles. You know, they don’t necessarily need that patient contact. But I think that sometimes, it’s useful to have it to realise how theory doesn’t relate to practice. You know, the two things don’t correlate (laughs).” 1 HP

“I was disappointed in some ways that by the time I had finished my Masters in Health Psychology I wasn’t really trained to do anything. You have to go on and do, a, another kind of training.” 3 HP

Asked about the utility of health psychological training, the same practitioner joked,

“Ehm, in terms of real practical use, about as much as a chocolate teapot. Ehm, my other training has been far more use to me as a practitioner.” 3 HP

In two quotes below, one practitioner complained about a lack of clinical, therapeutic or humanist values in the health psychological models and theories she trained in:

“I don’t think health psychology ‘cos it’s not clinically-oriented, when it started, and I don’t think many, many health psychologists think of it as a therapeutic tool, ehm, but rather as a behaviour change tool, ehm, and they don’t look for human values in it. But I think these are very important, especially with groups like, with the groups that I work with, you know.” 6 HP

“I’ve been thinking about, you know, proposing or putting together a sort of person-centred psychology, a person-centred health psychology, ehm, idea. Moving away from the typical classical models, moving into something different, ehm, which is, you know, applying person-centred values into applied psychology” 6 HP

Frustration about the difficulties that newly-qualified health psychologists experience in face-to-face interventions comes through:

“I don’t find it easy at all, I think. Like I said, maybe experienced therapists find it, I mean, I have great supervision, so that’s optimal, I mean it comes up in supervision about, sort of, my own kind of frustration, or my own anxiety. Whether I’m picking up patient’s anxiety, or whether I’m trying to do too much, you know, trying to do the work for the patient and therefore, when it’s not happening, it gets more frustrating. And sort of, how to, in a way, ehm, what’s the right word, how to scale back a bit and try to, you know, ‘cos, especially I think I’m young (laughs).” 10 HP

Despite complaints about feeling unprepared by health psychological training in one-to-one intervention work, appreciation of mainstream health psychological skills was voiced:

“The course at uni was absolutely fantastic and was really interesting. It really really helped me to clarify my thinking, to ask better questions, to be able to be collect information in a way that would answer those questions, it also told me there’re a lot of things about that we don’t understand about how people change their behaviour, how they make decisions about their treatment and so on. It raised a lot of issues and it was very interesting, but in terms of my actual practice, not really.” 3 HP

“I think health psychologists has got that additional I think, probably, background, knowing that that illness might have relation to other factors, that maybe a clinical psychologist or a, might not have, ‘cos they don’t even work with that particular physical illness. Yeah, I do find that is useful. Having said that, my own perspective is as a health psychologist, that also tries to do a bit of practice, it is rather important to have those counselling and clinical skills that, mm, need to be developed more intensely.” 10 HP

In summary, this single theme appears to clearly differentiate health psychologists from the counsellors that participated. Health psychologists generally reported that they felt unprepared for one-to-one intervention work when they qualified and wished that they had something akin to counselling skills training. At the same time, they valued their health psychological skills in their scientific approach to research, in recognising patterns in health behaviours and having proactive lobbying skills for clients and patients.

The theme of “Frustrations with lack of therapeutic skills” provides an example of the depth and richness of the qualitative data found in this analysis that would be difficult to imagine discovering as fully through quantitative methods. This gave a valuable insight into some early practitioner reflections about their health psychological training, their developing role in one-to-one health interventions and their professional awareness of the need for lifelong learning in practitioner skills.

Eclectic ways of working cluster: The themes derived above can be grouped into a loose 'eclectic ways of working' cluster. The cluster is very weakly connected into pragmatic ways of working to achieve an end using the skills available to practitioners. The practitioners who use these themes in their work seek to develop trust in the relationship between practitioner and client that may lead to some kind of change, but with an approach emphasising models, theories, eclecticism and sensing. In the case of health psychologists, frustration is apparent in a need for more appropriate skills. This loose cluster has potential to be further refined to see if an over-arching theme can be derived from its generality, possibly as a theme meaningfully grouped as skill-related directive intervention styles focused on symptoms or the client's condition. In itself, the theme of intuition and body-sensing, while exemplifying a skill, is probably insufficiently related to the idea of agendas or directive interventions and this theme should now be extracted in this first iteration and considered for placing elsewhere. The mechanisms of change do not emerge strongly in this cluster, apart from a mildly paternalistic suggestion that use of intervention skills plus a desire to 'fix' the client might facilitate change, reminiscent of the skilled paternalistic 'nudge' approach promoted by Thaler and Sunstein (2008).

This process of rough grouping of themes completes the initial scoping and moves onto further iterations to achieve greater cohesion and plausibility of analysis.

Exploring permissive dimensions of approaches to change

The remainder of the themes derived from the whole data base demonstrated much more cohesion and clustered strongly around permissive humanistic ideas relating to the process of facilitating change in clients. Figure 1 shows the theme of 'Individual or person-centred approach' linking through two process routes to the central theme of 'Healing through trust' via ideas of client behaviour patterns and acceptance of the condition and a process route of practitioner listening and care.

Individual or person-centred approach: Person-centeredness was derived from practitioners' seeing the client as an individual with full acceptance of their whole cognitive and physical aspects as unique characteristics that can be worked with to facilitate change. Both practitioner groups were represented in this theme and expressed a desire to know and understand the unique and individual characteristics of the client and to understand the client's world from the client's own unique and individual perspective:

“All those kinds of elements which are very very uncertain, ehm, unique, ehm, what I try to do is really understand what the patient tries to make. How the patient makes sense of that information and what kind of conclusion they draw for themselves. Ehm, and about the future about themselves. And the other part of it, I suppose, I try to understand what that illness suddenly kind of lashed upon them, what it means for their, in their kind of, life stories.” 10 HP

“I firmly believe this, irrespective of what we know, or what our job title is, it's who we are that determines what will happen when we are in somebody else's presence. And that as an environment for each other, we create that environment. For each other, and ehm .. So that, and also, the notion that it's important to try to start from where people are and not from where anybody'd like them to be.” 4 C

Behaviour patterns maintaining condition: The theme of 'Behaviour patterns maintaining condition' was derived from codes that closely linked to the theme of 'Individual or person-centred'. This theme reflected practitioners seeking to observe and understand patterns from the client's perspective through a hypothesised link described as "Observing person as individual". This might involve exploring clients' historic patterned cognitions, behaviours and responses, to accept that they are there for a purpose (possibly no longer relevant) and to explore how these patterns may be productive or counter-productive in maintaining aspects of the condition. Understanding 'Behaviour patterns maintaining condition' is a common feature from both health psychologists and counsellors in the transcripts:

“It's where someone has a particular pattern of behaviour that works extremely well for them in very important aspects of their lives. But it causes physical problems which suggests is due to stress. Often the therapist is left in a difficulty that the thing or the pattern that maintains her position also maintains her condition. And that's a real dilemma for many clients.” 2 C

“Ehm, so in terms of the origin of why they have it or why they continue to have the chronic illness, ehm, is, maintaining of, this behaviour that is unhealthy, in that respect, ehm, and not adhering to the treatments, ehm, that they are being prescribed, again, 'cos they are uncomfortable ..” 5 HP

Acceptance of condition: The theme of 'Behaviour patterns maintaining condition' links to the theme of 'Acceptance of condition' via a linking process of 'Client learning patterns'. This linking process represents a training function where clients are helped to accept and understand their patterns of cognition and behaviour as well as recognising the long-term characteristics of the chronic condition from which they suffer. The "Acceptance of condition" theme was strongly represented in both psychological practitioner responses:

"I think it's really important for the patient to understand. Accepting that probably it's never going to go away. 'Cos they come in there saying they never want to feel this way ever again. So, I also I suppose look at how, if there's a change in that, it is accepting, eh, that is part of the therapeutic establishment, part of the therapeutic goals as well really." 10 HP

"I say to her, I can't make your illness better, I can only help you how to be with your illness. And how to, and what things are aggravating it, so we can talk at that level, which is nice, 'cos it's like two adults, but inside there are very deep, ehm, structures that, I don't know, ah, how far any of this goes sometimes, I suppose, but we learn to live with ourselves I think, in a perspective change."

7 C

The acceptance theme links to the central theme of "Healing through trust" that is described below. The process of acceptance and moving on to a form of resolution of the issues was thought to be facilitated by the therapeutic relationship between the practitioner and the patient/client.

Listening: Figure 1 also shows a second alternative route to "Healing through trust" from "Individual or person-centred approach". This hypothesised route goes via a link of "Acceptance of person as individual" to the theme of "Listening". "Listening" links to the "individual or person centred approach" and describes the manner in which the psychological practitioner explores the individuality of the client. This manner is thought to offer a relational bond between the client and practitioner through which the practitioner offers what Rogers called "unconditional positive regard" (Rogers 1980). This involved an emotionally warm and empathic process of communication during the process of "Listening" that was more than just hearing and fed some communication of acknowledgement and warmth back to the client so that they felt heard:

“I’ve done quite a few different projects and I think the main thing overall is to listen to people’s stories.” 1 HP

“I’m listening, and mirroring where they are, in a way that they can then begin to receive themselves, so it’s a basic, you know, relational model at that point” 7 C

Doing it with love in a safe accepting place: From the theme of “Listening”, where the practitioner ‘listens and accepts’ with warmth, a link is made to the theme of “Doing it with love in a safe accepting place”. This link is where the practitioner’s listening to stories with acceptance and care about the client’s personal self, moves to the theme where a therapeutic relational bond is thought to become formed that creates an emotionally safe place for the client. This is where the strong theme of “Doing it with love in a safe accepting place” is derived that is represented in both practitioner types’ language as a pre-cursor to change. The term “love” is redolent with multiple meanings and used here in a non-religious form of “caritas” or “agape”, separate from “eros” (erotic love), and often translated as “altruistic love”, “care” or “unconditional positive regard” (Tjeltveit 2006, Rogers 1980, Wosket 1999):

“I believe that she re-experienced, stuff, which had a very negative outcome for her as a child. But she, she painfully re-experienced it, but this time with a much more positive outcome, ‘cos she was held, she was loved, she was cared for. Ehm, and that gave her, kind of the breathing-space to look at it all again. From, with the benefit of her life experience, but also, perhaps with a bit more objectivity, and realised that so much that she blamed, for example, that she blamed herself for, wasn’t her fault.” 8 C

“but what we’ve got in front of me just now is a very, you know, is something, is a person who is suffering physically, and you know, and I thought we could start from that, we work to create a sort of safe environment we go back and do the rest, hopefully.” 6 HP

Healing through trust: The route from the “Doing it with love in a safe accepting place” theme to the central theme of “Healing through trust”, the end-point of the permissive route, was apparently through ideas surrounding the linking process of “Love and safety permits challenge to patterns and healthy change”. The “Healing through trust” theme is also the end-point of both of the links from the “Individual or person-centred approach” theme. The “Healing through trust” theme held codes that

suggested that by providing a safe place, the sense of safety and trust felt by the client permits change to take place:

“And it, she journeyed through reliving a lot of very very challenging early history, ehm, and, but I like to think that she did it with, although still with the emotions of a child, it’s through the eyes of an adult. And in a place of safety, whereas before, she wasn’t. So there was some sort of reparative work that was going on at some level, it’s very difficult to describe, but at least she relived those experiences and came out of them safely, yeah, admittedly six decades further on. And I do ask myself whether all of that, I have a view, quite a strong view, that all of that has contributed to how she is now. I don’t know whether you’d subscribe to that. Ehm, and that the release that she got from really having the freedom to get know herself, took away a lot of this internal tension. It hasn’t removed it, but it’s diminished it. Ehm, which in turn might be a consequence of the anxiety and stress that has this physical manifestation.” 8 C

“Now how what I do works for them.. well, I don’t know. It might work but I don’t know it work, but it’s a case of constant vigilance, to sit with them, is it working, is there something else I need to do? But I think what I do is provide a safe space for them, and support that with some techniques if appropriate, when appropriate, when they want.” 6 HP

“Now in part, there is that sense of, you set someone up to believe something and if they trust you and believe you, then like kind of loads the dice a bit” 1 HP

Ways of Being cluster: This intervention theme cluster forms a conceptual whole where both practitioner sets practice in a permissive yet focused manner. It is much more cohesive and convincing than the looser theme cluster of ‘eclectic ways of working’. The apparent humanistic and permissive nature of the themes in this cluster contrasts with the implicit directiveness in the ‘eclectic ways of working’ cluster described earlier. This cluster of related themes is suffused with the Rogerian humanistic philosophy appearing to be adopted by most of the practitioners and its permissive character could be thought of as a ‘ways of being’ thematic cluster (Rogers 1980). This cluster sees the psychological practitioners working with clients in a way that tends to see clients as autonomous beings in a state of respect, affection and regard, linked to the central target theme of ‘Healing through trust’. The focus is more on the whole person than the person’s long-term condition.

Measuring success and output measures

Success measures: The final preliminary theme derived from the codes across the data concerned monitoring success (or otherwise) of interventions. “Success measures” codes were derived from all participants and these were linked to the central theme of “Healing through trust” by quite complex “monitoring success or failure” ideas. The linking ideas were different for counsellors and health psychologists in that counsellors were resistant to what they saw as crude measures of the kind they had seen used by clinical psychologists. One counsellor declared when asked how they measured success, “I’m not sure I do really (laughs)”. This was rapidly corrected in a discussion over the merits of measuring success in therapies other than counselling, but for counselling, success was measured by how they thought the client felt about themselves:

“I do, when I do EMDR, I use all the kind of nought to ten, one to seven, you know, and you do see levels of disturbance going down in people and you see that they’re able to function better in their life, so, I’m not anti-it at all. But in terms of, ehm, success, it’s, I sort of, ehm, I kind of leave it up to the client to how they measure the success, but of course I would measure the success really more in their relationship to themselves, than anything else.” 7 C

Another counsellor described recognising success in an intervention as a self-knowing of success in the quality of the relationship rather than a client measure:

“I suppose there’s a few strands, there’s not one thing I could put my finger on, ehm, one is actually the quality of the relationship. How I feel, rather than how, how she feels, ehm, when she comes into the room and sits down. Do I feel there’s a real deep connection here in a sense of understanding of each other. ‘Cos it’s not a one-way process. Ehm, and that’s not something I can describe very clearly, but I know it when I feel it. And when I feel it with clients, then I know that, something good is happening. Really really good, and it’s at a level I can’t understand. But it, it’s there.” 8 C

Health psychologists tended to measure success with more concrete examples such as when disasters *don’t* happen for their client:

“Oh, when they’ve not burned down the block of flats. That they’re not found dead in there after two weeks of nobody, noticing. But when you see them six months later in clinic. They’re still there. They’re still living their life. I think once things hit crisis point and they’ve hospitalised, actually, you’ve probably failed, because it should never reach that point.” 1 HP

Another health psychologist used similar tangible pragmatic measures when recognising that clients would not stay in an intervention if they did not feel it was useful to them:

“I think if it wasn’t, she’d have voted with her feet. She’s intelligent, she’s not going to hang around if it’s not .. she pays for it, you know, and she’s well aware she needs to get something out of it and I think if she wasn’t, she would have gone by now. Also there’s that sense of, every so often we check in with, is this getting you to where you want to go or do you need to move on and do something else?” 3 HP

Health psychologists also used formally standardised measures of effect to monitor success:

“Ehm, what I use, depending on the main, you know, the problem is, in the most of them they’re related to anxiety and depression related to their illnesses, I do use, sort of Beck depression inventory and or Beck. I tend to use those a lot, more Beckian, ehm, anxiety inventory. Ehm, so there is that kind of looking at scores and how also in different sections of the scale, the scores differed over time, what (laughs) over time.” 10 HP

Education and explanation also seemed to be a strong aspect of health psychological face-to-face work and when the client understands their condition better, then that is seen as a success.

“Well that explains the business, that explains the tickly fingers and tingling and all that, and that can explain obviously the light-headedness and the palpitations and talk about it, ehm, it seem to, everything seems to click and he seems to be more relaxed and so far so good.” 6 HP

Thus while health psychologists tended to use formal or pragmatic measures, counsellors tended to use intuitive and emotional understandings in measuring success

in interventions. Counsellors also used some pragmatic measures of success in addition to concentrating on the success in ways of working, the most obvious success measure being that of being told of success:

“In this particular client we’ve been talking about throughout, I knew that it’s worked because she’s told me.” 8 C

Failures were openly acknowledged as being a normal part of interventions and the necessity of accepting that things do not always work out. A common difficulty for practitioners was finding a balance between the responsibilities of the practitioner and the client towards successful outcomes:

“I do work in quite a ..I do take responsibility for what I do and sometimes it misses and I have a very angry client, well that’s life, I can cope with that, but sometimes that what it needs to be .. ” 2 C

“I think, used to, to a degree, probably I do still have that kind of sense of, well if something’s not working it’s ‘cos I’m not doing it right. And that was particularly again, I think for me, strong when I was training. But, you know, ehm, I must not be doing the technique well, you know, etc and. And then I would try the next one and the next one and that wouldn’t work, and then that would work for a while, but wouldn’t work all the time, and all these things and I’d get really frustrated with myself. And I think that part of the journey, in a way with being a practitioner, is to be sort of, accept it’s the patient’s responsibility as much as the therapist’s responsibility to, to do whatever they want to do with the techniques or the tool or whatever it is that you’re doing, so.” 10 HP

In the theme of measuring success, both practitioners acknowledged an acceptance of the idea of failure and learning from failure as well as from success. It seemed that the more experienced the practitioner, the more accustomed to failure they became, until it was seen as normal a part of interventions as success.

Summary of initial scoping of data and early candidate themes

In this discussion of the scoping of data to derive early candidate themes, a general pattern begins to emerge that is further refined below into a more cohesive and essential characterisation of the data. This scoping or first iteration found the general thematic pattern to be two-fold, one of “eclectic ways of working” with ideas, models,

frustrations, approaches and knowledge of techniques sitting alongside a second thematic pattern of “ways of being” in permissive acceptance of individual difference and personal characteristics that permits challenges to be made to long-established cognitive and behaviour patterns in the context of a safe and loving place. The central thematic aim of healthy change links to measurable outcomes of success or failure, albeit often measured in an intuitive or pragmatic manner of just knowing of success as well as in a standardised measurable and potentially evidential fashion.

Further thematic iteration and refining of themes

The initial scoping phase of identifying themes described above has produced an early, complex, but potentially meaningful thematic map derived from codes across the entire data set. Further iterations of reviewing the codes and candidate themes was undertaken to look for more refined and coherent patterns in the data. The clusters of candidate themes were revisited to attempt to combine closely-related themes, reduce overlaps and similarities and collapse some themes that displayed significant unifying features into larger-scale over-arching themes (phase 3 of Braun and Clarke’s method 2006, 2010). This review and reconsideration of overlaps and similarities resulted in the reduction of the original twelve themes into three over-arching themes that combined most of the generality shown in the thematic map in Figure 1. This more refined and higher-level thematic analysis is represented diagrammatically in Figure 2. Figure 2 shows how the codes have been reworked into themes relating to facilitating change derived from both the directive and permissive ways of working of both health psychologist and counsellor participants.

The two general thematic clusters of “eclectic ways of working” and “ways of being” provided ideas to allow all the codes from the earlier candidate themes to be used to create two over-arching themes focused on a central theme of “facilitating change in the client”. The two over-arching themes took their labels from details within the codes that were thought best illustrated the overall nature of each theme as they were derived from the synthesis.

Figure 2: Overarching superordinate themes of approach to client behaviour change across the entire data set

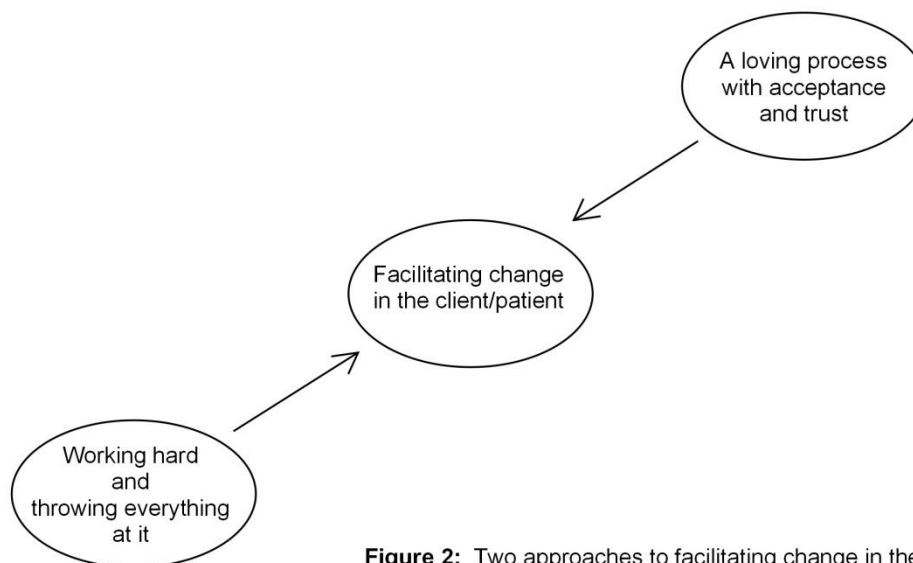


Figure 2: Two approaches to facilitating change in the client, one with faith that the client will change when given acceptance and trust, the other using as many skills and techniques as they can think of to make the change happen.

Working hard and throwing everything at it: There is now a candidate directive theme labelled “Working hard and throwing everything at it” that incorporates the codes from the earlier cluster of themes comprising the application of evidence from multiple and competing models and theories that focus on the condition more than the client, an ‘change’ agenda for the client and the use of intuition and body-sensing as parts of practitioner-centric eclectic ways of working. The theme represents many codes that place the practitioner as an ‘expert’ who will ‘fix’ things for the client in some way. The title for this over-arching theme is chosen to reflect some of the frustration that was evident from the health psychologist practitioners who contributed codes to this theme. There are elements of striving to understand and direct change in the client including the use of different kinds of intervention to prompt change. This reminded the author of a code from a health psychologist relating trying hard to ‘fix’ a client’s problem with many different therapies:

“I do still have that kind of sense of, well if something’s not working it’s ‘cos I’m not doing it right. And that was particularly again, I think for me, strong when I

was training. But, you know, ehm, I must not be doing the technique well, you know, etc and. And then I would try the next one and the next one and that wouldn't work, and then that would work for a while, but wouldn't work all the time, and all these things and I'd get really frustrated with myself." 10 HP

This led to the candidate over-arching theme being given the title, "Working hard and throwing everything at it". This remains a candidate title for a candidate theme at this stage as aims to "tell a story" that gives a "vivid compelling" picture of the theme's content (Braun and Clarke 2010).

A loving process with acceptance and trust: The candidate over-arching permissive theme is "A loving process with acceptance and trust" that incorporates the earlier theme cluster containing ideas of working in a manner of care and acceptance, seeing the individual as a person with unique characteristics and patterns that may be challenged in an unthreatening way in a therapeutically safe place. This second superordinate theme is derived from the codes that made up much of the earlier "ways of being" cluster and combine the person-centred humanistic "being" with the client with the search for past and present patterns of behaviour and cognition plus aiming for an acceptance of what cannot be changed. This represents much of what is common in the counselling participants' approach of person-centredness allied to aspects of mindfulness and traditional therapeutic exploration of past patterns that affect the present. The codes that present these ideas are shared by all participants, although more dominant in counsellors, and the following extract illustrates this common position. It aims for an honest acceptance, knowledge of inner psychological structures and accommodation or adaptation to the demands of the chronic condition with a sense of acceptance:

"Well, again, it's the mind-body link, I think, ehm, we have very very deep belief systems that derive out of our experience that maintains the, ehm, our reactions the body/mind in the same structure and that's what can keep, I mean, I don't know with this person, and we can talk about it, you know, I say to her, I can't make your illness better, I can only help you how to be with your illness. And how to, and what things are aggravating it, so we can talk at that level, which is nice, 'cos it's like two adults, but inside there are very deep, ehm, structures that, I don't know, ah, how far any of this goes sometimes, I suppose, but we learn to live with ourselves I think, in a perspective change. We are, you are, OK, I can tell you're no longer at war with yourself in the same way, because in a way, in order to grow up and survive and achieve, you may have to cut off from your

wounding at a very profound level because, you can, you just leave it there, somewhere.” 7 C

Facilitating change in the patient/client: The two contrasting superordinate themes of “Working hard and throwing everything at it” and “A loving process with acceptance and trust” link directly to the central candidate theme of “Facilitating change in the patient/client”. This central theme is revised from the earlier “Healing through trust” central focus. The “Healing through trust” theme has its “healing” and “trust” codes removed and incorporated into the two contrasting ways of working, leaving the basic end-state, the aim of facilitating client change. The two superordinate themes are apt descriptors of much of the intervention style described by and used by the participants with the end-state of change in the client remaining as the central goal. Further iteration followed this stage and it was decided to drop the central theme of “Healing through trust” and incorporate its goal elements into the two styles of approach in their respective themes. This is to ensure that the final themes directly relate to the research question and leaving the goal as a theme in its own right would have removed this key concept from the approaches that strive towards it. The final themes should directly relate to the research question of how psychological practitioners from different trainings conceptualise the mechanisms of process of change.

Final overarching thematic analysis

Through a final iteration of analysis of the data, and by exploring the complex concepts that underlie the themes, the ways of working described by the participants can now be more plausibly described in Figure 3. The themes illuminate much of the assumptions about how such ways of working hope to be successful and by deduction, revealing the underlying conceptualisations of change employed by the psychological practitioners.

The final overarching themes that derive from the ways of working provide the logical underpinnings of the overt focus of the health psychologists and counsellors who participated. These are the two major themes of beliefs that practitioners have expressed that are thought to facilitate healthy change in the patient/client, namely, the theme of “Change can be prompted by expert procedures” and the theme “Providing love and safety lets change happen”. These two major beliefs about how healthy change can be facilitated pervaded the whole data set and incorporate most of the underlying concepts and codes of how change happens in them. Both practitioner groups provided codes indicating that both main themes appear in their descriptions and explanations of interventions with clients with common chronic conditions.

Figure 3: Overarching superordinate themes of conceptualisation of the process of change in clients across the entire data set

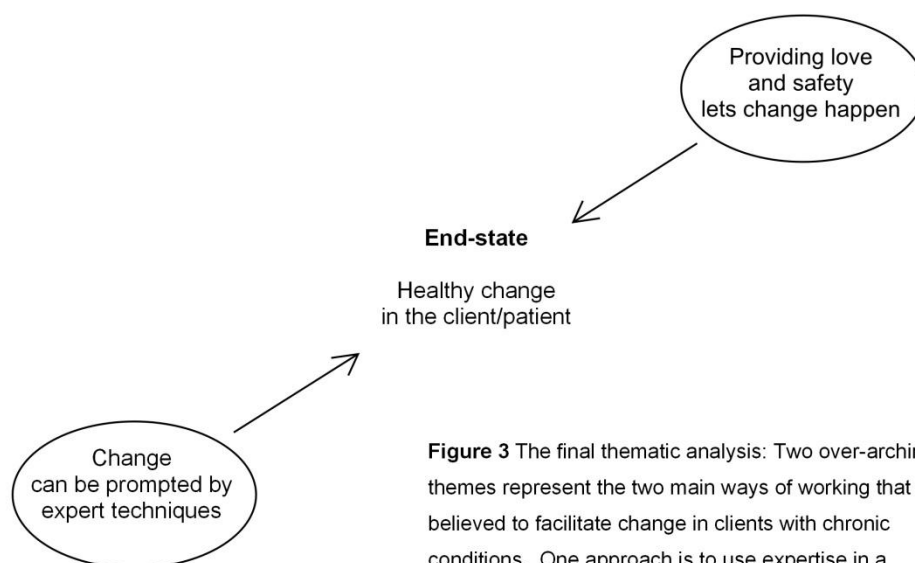


Figure 3 The final thematic analysis: Two over-arching themes represent the two main ways of working that are believed to facilitate change in clients with chronic conditions. One approach is to use expertise in a directive manner targeted at healthy change and the other approach is to provide a caring and loving therapeutic relationship that supports the client while they change.

Change can be prompted by expert procedures: The theme of “Change can be prompted by expert procedures” indicates a belief in expert intervention techniques using a variety of evidenced and trained procedures. Although this over-arching theme subsumes the codes and early themes that produced a weakly-structured theme set, it has an internal consistency that has a convincing foundation as expressed by the participants. This is exemplified by many closely-related statements by participants from both psychological traditions. Health psychologists indicated that their expert approach employed models and evidenced knowledge, elicited additional client information and controlled practitioner-client relationships in an expert-patient manner:

“There are other models we could be usefully looking at if we took other areas into account, you know. When I, when I work with clients, I do a holistic assessment, which is more like a 360 appraisal, than anything else. ‘Cos actually you need to see them as a whole person, not just the one ... It’s very interesting, they’ll come and tell you one particular thing they want to work with and when I do my holistic assessment I discover that actually, there’s a few other things that if I hadn’t asked them about, and it would have a profound effect on how we’re

going to work on this particular issue. So for me it's always about information-gathering and mixing and matching." 3 HP

"I've seen me using health psychology theories and models, ehm, I sometimes, you know, ehm, what, CBT if it's appropriate, so, kind of walking the patient through process, ehm, letting them see themselves from one step to another, what's happening." 5 HP

Counsellors too have expressed beliefs in certain procedures of working, such as in the use of special ways of behaving by the practitioner that, if performed well, prepare the ground for change to take place:

"I am back to Roger's core conditions with this woman. And that's what the work's about. And it, in terms of all my clients it's been a really slow painstaking piece of work, you know, there's been no quick fixes in this at all. But it's been that offering, that consistency of offering the core conditions that's made the difference." 9 C

"Ehm, there are certain things about it that work, that's well put, work well for me. One is a focus, ehm, on the quality of the relationship, and that just resonates with me intuitively. Then if, if you have a really, if you develop a good quality loving relationship, it doesn't have to be with a client, with anybody for that matter, ehm, then you've got the foundation stone for doing other stuff." 8 C

While counsellors may believe in a particular way of working, or a way of being with a client, such as the 'core conditions' or 'quality of the relationship', they also use overt procedures to notice psychological tension or to explore particular bodily sensations with the aim of evoking insight that might inspire possibilities for change:

"You know I am convinced that where there are tools, as you know, that are very simple, that can be used to engage people to control ... stress and all sorts of things, but for me there is also is something about helping people to recognise it before it gets bad." 2 C

"I'll mirror that part's kind of tightening up a little bit, and would it be right for you to kind of take a moment to notice it, and see if you can really notice, well, what's going on in there? And then kind of work slowly with, allowing the relationship between, if you like, them, inside them really to what's going on. And then

maybe, sometimes, I'll say does this feel like there's an image or a memory that goes with that?" 7 C

Exactly how interventions actually induce or encourage change is less clearly expressed but can be inferred by responses. Some responses from health psychologists appear to see change resulting from cognitive restructuring of internalised schemas or ways of conceptualising control over one's life and the chronic condition one has. Others see it is something they do that facilitates change, even if it is very unclear at times exactly what this might be:

"I haven't used it in a while, but I've also con, looked at therapeutic alliance type of scales. And I haven't used them in a while, actually, I should do that, 'cos I find quite, when I used that during my training, I found them quite useful, in highlighting what seems to be, what did they really think whatever it was going on is (laughs) helping them, or are they just sort of nodding along, and these sort of things can be highlighted during that, I think measurement which is quite often very very useful. And what it is that they are finding it useful really, or is it just sort of generally coming and chatting with me (laughs), you know, once a week or whatever it is, seems to help something, but you don't know what." 10 HP

"I think I, I, I am able to mediate, 'cos sometimes you, we're always stay set in our own ways, you know, whether or not you have, you are a patient with a chronic, eh, condition or whether as, you and me, ehm, sometime it's difficult to see if what you're doing, ehm, that you can do things differently, or add things to what you do or take away certain things. ehm, so in that way I can mediate, ehm, transition from worse to better." 5 HP

Counsellors also can see schemas or related forms of internal psychological structures as being sub-optimal and requiring to be modified or changed to improve a situation. This process of psychological re-structuring can be seen as a learning process, where the client becomes aware of what they do as a pattern (a "light-bulb moment") and then has an opportunity to alter it and change:

"I agree, if you don't change the structure, the internal structuring, then it doesn't matter how much healing or how much medical intervention you have, it will always come back as something else, so." 7 C

“Oh, an openness to learning if not, if not an immediate learning, ehm, because she will come back and sometimes say, ‘do you remember you said..’ and that will be, may be weeks, months down the line. Other times she’ll go.., ‘this is what I do’, you know, they are those light-bulb moments, ehm, but I think that, that exploring this bit out here, I think it will begin her process of being able to look at herself slightly differently.” 9 C

Other codes indicate a lack of knowledge about change processes and the participants frankly admit that the process of change and how it is facilitated is a mystery, except that the practitioner somehow provides what seems appropriate and change happens. Both practitioner sets had respondents who admitted that the change process or mechanism was not really understood:

“Now how what I do works for them.. well, I don’t know. It might work but I don’t know it work, but it’s a case of constant vigilance, to sit with them, is it working, is there something else I need to do? But I think what I do is provide a safe space for them, and support that with some techniques if appropriate, when appropriate, when they want.” 10 HP

“I felt something very satisfactory happened. I don’t quite know what it was, but it was something satisfactory, and that, you know, I had a different experience of him. And I think he had a slightly different experience, ehm, you know, and I think it was ... I like to think it helped him to get oriented, ehm, and to perhaps feel ehm, OK about what he had been doing quite naturally.” 4 C

These kinds of responses from both health psychologists and counsellors are interesting in that there is not always a clear practitioner understanding of “what works” or “how it works”. Implicit in the responses, however are constructs and beliefs that give good links to existing theories and models of change in both health psychology and counselling and these provide potential solutions to the research question.

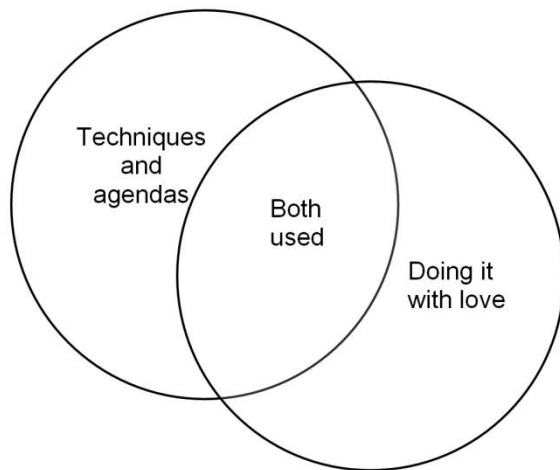
Providing love and safety lets change happen: The theme of “Providing love and safety lets change happen” encapsulates the earlier theme of “A loving process with acceptance and trust” with the ideas expressed about change happening in such a context. This combines the earlier central theme of “Facilitating change in the client/patient” with the “loving process” into a wider theme including both process and facilitation of outcome.

End State: Healthy change in the patient/client: This is now an end-state or outcome that is not a theme but an objective or agenda that is implicit in the participants' aims for the client.

Ways of working by both practitioner sets

The codes and extracts above suggest that there was a different emphasis on how eclectic approaches were used by the respondents. This was thought best described graphically as shown in Figure 4 below. Figure 4 shows how the themes might link to the ways of working by both practitioner sets and is designed to be illustrative and not a statistical reflection of real proportions of techniques and procedures used with a caring context to facilitate change in a client. Exploring the interviews of practitioners from both psychological trainings indicated that both professionals would vary in their approach to different clients as to what they believed would be best for them and this cannot be characterised by such a simplistic two-dimensional representation as shown here. Health psychologists and counsellors both discussed clients where techniques, such as education about a condition or bibliotherapy (reading about the condition and how to deal with it) was mainly used while at another time, possibly with the same client, a subtle and changing application of therapeutic techniques and skills might characterise the client session where Rogerian 'Core Conditions', such as listening with obvious acceptance and respect, would be the dominant procedure. However, this research focused on beliefs about the mechanisms of change across two psychological approaches and while this data relates to specific clients with chronic health conditions as a prompt for beliefs about process, it was not a comparison of practitioner beliefs against what was actually in the intervention. This represents a possible further exploration and is discussed below.

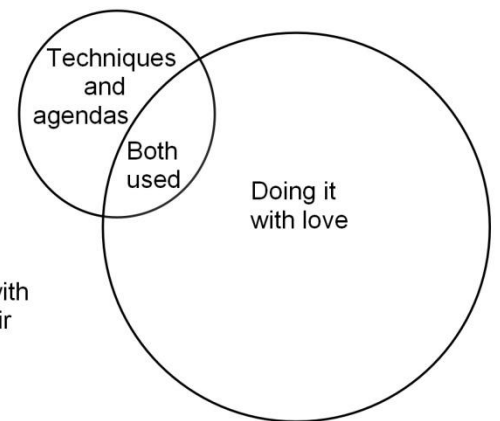
Figure 4: Potential ways of showing how themes link to ways of working for health psychologists and counsellors



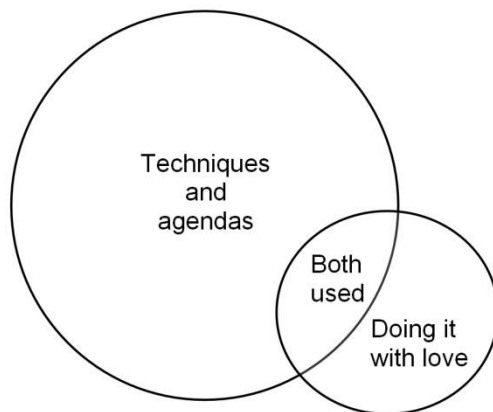
Equal use of techniques and relational care

The themes found in this study are discrete, coherent and represent understandings of different aspects of psychological interventions. Nevertheless, it suggested that it might be possible to characterise each professional group's approach based on their beliefs about 'what works', by seeing how much the two professions overlap these themes in practice when dealing with a client or patient.

It was thought that counsellors might see their approach as being mostly characterised by the Rogerian 'Core Conditions' of 'doing it with love' with some use of techniques and agendas their for their clients.



Strong bias towards relational care



Strong bias towards techniques

Similarly, it was thought that health psychologists might see their approach as being dominated by the applications of psychological understandings, models and theories with much less emphasis on simply 'being with' their client in a Rogerian manner.

Figure 4: Converting themes to ways of working gives an illustration of working styles

Feedback from participants

The respondents were then sent a brief abstract of the findings including the Figures above and asked if it fairly reflected what they had contributed. The respondents were invited to point out any aspect that might have been missed, over-stated or in some way misrepresented and that the researcher would modify the output accordingly (see Appendix for this communication). Four respondents (3 counsellors, 1 health psychologist) replied and were reassuringly complimentary about the clarity of the way in which the findings were presented:

“What a lot of work. You have made it look simple, that is the difficult bit!” 2 C

“Thank you for sending me the draft of the results from your research study with practitioners. You have some very interesting findings which you have described very clearly.” 3 HP

“This is fascinating, I love the clarity with which you have demonstrated your findings.” 7 C

One respondent responded that her contribution was fairly represented with a hint of criticality on the detail that may not have been fully expressed:

“I have enjoyed reading the summary of your dissertation. I broadly feel my views are represented.” 9 C

Two of the respondents (2 counsellors, 1 health psychologist) went beyond kindly appreciation and added their own reflections from reading the brief summary. The counsellor, who supervises a psychologist in a person-centred (PC) manner, suggested that this fitted her understanding of the difference between relational and expert focused work with clients:

“I realised on reading it that it fits so clearly with the occupational psychologist who I supervise 4 years of PC supervision have made a huge difference to how she works (her words recently) she sees a person less a set of symptoms to be fixed than she did before.” 7 C

This suggests that the supervisee now appears to work with a client rather than the client's symptoms and this evidently pleased the (counselling) supervisor. It is also

reassuring to note that for this respondent, the thematic maps fitted her observations well. This counsellor wished to emphasise the value of being on the receiving end of face-to-face work in psychological training, for its ability to improve empathic understanding of the client:

“I forgot to say at the time that I feel Health Psychologists would benefit from being in therapy themselves. I feel it was the most important part of my training as a therapist. If you don't know how it feels to be on the other side it will make the empathy side more difficult.” 7 C

This respondent suggests that health psychologists (and possibly other psychologists) should be ‘in therapy’ and it is assumed here that this means more than simply doing role-play as a patient or client but to undergo some much deeper therapeutic self-exploration to be equipped to work with clients. It also implies that delivering interventions in health psychology may involve more than just adhering conscientiously to a protocol but may require relational factors that can be brought out by therapeutic reflection. This comment, if correctly understood here, is discussed below when reflecting on the use of relational approaches in tandem with expert protocols.

The health psychologist (3) replied: “I particularly like the contrast of “throwing everything at it” versus “love & acceptance.” This suggests that the final thematic descriptors might have been better left at the previous iteration and its labels were evidently evocative for the respondent. Again it is reassuring that the thematic analysis was appropriate for this respondent's view of the two ways of working that was derived from the data. The respondent also gave an additional reflection on the findings that echoes some of the contents of the discussion that follows:

“Having read your results I think my reflection on it would be that health psychology is good at research and evaluation of interventions, but when it was set up as a discipline, no-one really thought through the practical training that would be needed for those health psychologists who might want to work therapeutically with clients in group or 1:1 settings. This is compounded by health psychology being taught by academic researchers who on the whole have no experience at working therapeutically as health psychologists with clients. It also doesn't help that the NHS itself doesn't really recognise health psychologists, further confounded by the fact that some clinical psychologists have taken to calling themselves clinical health psychologists. I worry that sometimes that health psychology is “sold” to students in a way that encourages them to believe

that they will be able to find work at the end of their MSc training, when in fact that is highly unlikely to be the case. Hmmm.

A really interesting research project. I'm very glad I took part." 3 HP

This respondent's reflection highlights several points that were raised in the other interviews and are shown in the extracted codes above. She comments on the academic and research excellence in health psychology not being matched by intervention skills training. She suggests that she had no indication that her health psychological trainers had experience of therapeutic 1:1 or group intervention work and that this had an implication of biasing the training to academic and research psychology. Worrying competition for jobs features strongly here in a fear of lack of NHS recognition and clinical psychologists relabeling themselves as clinical health psychologists in competition with health psychologists. This thought connects to her feelings of being misled by her experience of suggestions of the employment value of the MSc health psychology courses. These comments support some of the extracts above (unsurprisingly as hers were one-fifth of the health psychologist responses). This respondent's comments are dealt with in the general discussion below but add to the reassurance that the respondents who took the time to reply to the brief summary of the research found that its analysis did not clash with their own understandings.

General discussion

The responses from 10 independent health psychologists and counsellors working with common chronic health conditions provide valuable and interesting assumptions about how their interventions work. Usefully, the practitioners have been able to express their views and opinions about what underlies their practice in a manner uninhibited by any attachment to formal health agency intervention preferences. It was mentioned in the description of participants above that many of the health psychologist participants might have been given an opportunity to vent their frustrations and express their discomfort with aspects of their work, training and future. If the interview gave an opportunity for expressing feelings that might not be otherwise possible, then this could have coloured the responses in a way not echoed by counselling respondents. There was considerable negativity expressed by the health psychologist participants and this point will be dealt with in the conclusions.

A thematic map has been derived from the analysis of practitioner intervention assumptions and approaches. This map, together with illustrative codes and extracts

from the interviews, brings to life the substantial complexity of the processes underlying their psychological interventions.

It was anticipated that there would be substantial differences found between health psychologist and counselling participant beliefs and that these would illuminate their different conceptualisations about “what works” and how it “works” in health interventions. Although different perspectives are found in the belief-sets of the two practitioner groups, it was interesting to discover considerable overlaps and similarities in their approach to health interventions. Nevertheless, distinctive elements remain differently emphasised in the two approaches and these provided a very good guide to the assumptions surrounding their ways of working towards successful change in their patients’ and clients’ behaviours and cognitions.

The major differences between the practitioner groups may lie in the sampling choice of different professions and that different styles of training consequently produce a different focus on how to work with clients (Ogden 2007, Cooper 2008). Put simply, the differences may be a product of that health psychology appears to expect the incorporation of a variety of potentially competing or overlapping evidence-based models and ideas (Hagger 2009) while the counsellor participants here are strongly influenced by the major theoretical influence of Carl Rogers (1957) and the philosophy of person-centredness as it has subsequently developed (Cooper 2008). Health psychology appears concerned with reducing the psychological impacts of illness and is characterised by working to modify patterns of behaviour and cognition to improve the health of the client or patient (DHP 2010). Counselling focuses on a therapist-client dyadic relationship that aims to permit change to be explored safely in a caring relationship (Rogers *ibid*) with the counsellor focusing on the quality of the therapeutic relationship more than any benefits that may be gained by the client. It may be that main difference between the professions exemplified here is that the health psychologists principally focused on a successful outcome while the counsellors focused on the success of the therapeutic relationship.

The final over-arching themes described above in Figure 3, where “Change can be prompted by techniques” or “Providing love and safety lets change happen” illustrates these different practitioner foci in the two professions. The two major intervention approach themes cut across the data and mirror these practitioner differences. The themes describe expert directive and permissive relational intervention styles that aim to achieve change in a client. In the interviews, however, both practitioner groups said they used both methods in sessions although, as Figure 4 above suggested, the health

psychologists may be mostly associated with directive change while counselling is more representative of the permissive approach. The two final main themes exemplify aspects of working that typify the differences in the approaches, one being expert and technique-driven, the other being closely relational and empathic.

Considering the counselling approach typified by the theme, "Providing love and safety lets change happen", Roth and Fonagy (1996 p 255) describe counsellors in primary care as "psychotherapeutically trained practitioners who apply their techniques in a primary care setting", while Cooper (2008) explains that although techniques and procedures might be intentionally applied in the counselling therapeutic relationship, it is the way that they are provided that makes the difference. Cooper (ibid p 127) has suggested, the use of the term "intentionally applied procedures", rather than the term "techniques", as the best way of describing how counsellors work to create their therapeutic alliance with the client. The minimum conditions that Rogers (1957) believed were "core" to a successful therapeutic relationship, where change was most likely to be facilitated, is hypothesised to allow change to happen. With an accepting, non-judgemental, valuing, congruent (self-aware) and empathic practitioner, the client can receive the practitioner's empathy in the safe environment of the therapeutic relationship and by guided reflection and comparison with the counsellor's responses become aware of incongruities in their own thinking and behaviour.

Cooper also described additional counselling procedures of inquiry, assessing and psychological working such as Gestalt process-experiential-emotional techniques (Nevis 2000) or Gendlin-inspired focusing (Gendlin 2002). To use these procedures, the person-centred counsellors may undertake additional training in an analogous fashion to the health psychologists who seek additional training to gain therapeutic or counselling skills. Such intimate and intense social experiential approaches used mostly by counsellors in face-to-face therapy contrast with the more socially-distant evidential, behavioural and cognitive intervention styles used mostly by health psychological participants.

Health psychological models depend upon their internal logic, evidence and persuasiveness to be used as facilitators for change in interventions. For example, the theory of reasoned action and planned behaviour contains core ideas of conditioned behaviour interacting with intentions, attitudes, beliefs, values, social expectations and self-motivation (Ajzen and Fishbein 1980, Ajzen 1985). These factors are perceived as providing explanations for health behaviours and also providing ideas that can be operationalised in health interventions by a health psychologist who may attempt to

influence their client to become aware of these factors and through this awareness alter their future health behaviour. While empathy and warmth may be given by the health psychologist who implements such an approach, the quality of the relationship is not seen as a necessary requirement of the intervention as it would in counselling. Again, the social cognitive models used by health psychologists might contain ideas such as social learning, social awareness, social expectations of outcomes along with more individual factors such as psychological resilience or self-efficacy (Bandura 1977). Nevertheless, a health psychologist using Bandura's approach would not necessarily be required to add any social relational factors to a social cognitive intervention. The health belief model is again more psychological and socially distant, comprising ideas of susceptibility to illness and knowledge of its severity, awareness of costs and benefits of health behaviour change, including the impact of barriers to change (Becker 1974). Rogers' protection motivation theory (1975) is also essentially individualistic, where people assess odds of threats and consequences of health behaviour and evaluate alternatives for efficacy. The Precaution Adoption Process model requires personal cognitions such as awareness of a problem, whether there is an inclination to do anything about it, then deciding to act and maintain the new behaviour (Weinstein and Sandman 2001). These five examples of common health psychological models mostly apply to the person as an individual and do not normally depend upon a social intervention from a client-practitioner relationship for their routes to behaviour change. It might be assumed that a pleasant or kindly collaborative practitioner might improve the chances of a client's adherence to a protocol, but the mechanisms of change are thought to lie in the protocol and less in the client-practitioner relationship.

While the above models do not necessarily require a relational content, it does emphasise the wide range and diversity of theoretical and evidential sources that require to be understood and operationalised by the health psychologist participants when working with clients. In counselling, the same potential burden of evidential and theoretical diversity appears to exist. Cooper's (2008) review and discussion of counselling and psychotherapeutic research suggests that counsellors tend to adopt an unconscious assumption of cause and effect, in that they tend to assume that it is something they do that assists change in the client, whereas he points out that counselling research suggests that it is the client who has the dominant responsibility for change in interventions. Cooper reports that attempts to quantify the relative impacts of techniques or the context created by the therapist on therapeutic outcomes are varied and uncertain. He cites 'Lambert's Pie', as one estimate of what proportions of a client's improvement are as a result of therapeutic or other factors, derived from

'years of experience' (p 56). This qualitative estimate arrived at percentage improvement contributions of 15% for techniques and models, 15% for expectancy and placebo, 30% for the therapeutic relationship and 40%, the largest part, for client variables and extras-therapeutic events (Asay and Lambert 1999). Such qualitative guesses are far from conclusive and only acknowledge that the interplay between practitioner, theory, techniques, placebo/expectancy and client factors is complex, varied and unpredictable.

In health psychology, the model closest to the counselling therapeutic approach is the Transtheoretical Model (TTM) developed by Prochaska and DiClemente (1982). This model attempts to distil the essential elements of 24 counselling and psychotherapeutic models into a complex synthesis as an integrative approach (hence trans-theoretical) to facilitate the processes of change. Described by Armitage (2009) as the dominant health psychological model in use in the UK, it includes a comprehensive set of 10 clusters of processes that are purported to be used by people as they migrate through hypothesised "stages of change" proposed by the model. The processes in the model that are held to facilitate change provide a rich source of strategies useful in facilitating change, such as raising consciousness of a problem, an emotional response awareness that raises the issue in a dramatic relief to the background, a re-assessment of the social and personal impact of the problem, re-appraisal of values that permits the problem to be maintained, an idea of a freer more liberated self when the issues are resolved, finding alternatives that satisfy what is 'feeding' the problem, finding a relationship that supports through the change, rehearsal of 'if-then' scenarios to prevent backsliding, and motivational factors to maintain the change in place. This set of complex processes looks very familiar when compared to the counsellors' responses here and one health psychological practitioner spoke highly of this model, especially of the simplicity of the spiralling "stages of change" scenarios that seemed to provide a helpful metaphor to clients to gauge their progress when undergoing change.

"the most useful theory out of all of the ones about behaviour change is actually Prochaska and DiClemente's cycles of change, it is just, it's, it really helps."

3 HP

Returning to the research question concerning the conceptualisations of the process of change it is intriguing to consider that the two professions of health psychology and counselling may well use very similar intervention techniques and processes, except that health psychologists might think they are using a wholly psychological model if using the TTM, while counsellors may use very similar approaches and believe they

use nothing like a health psychological approach. However, the TTM has been criticised as being ineffective and weakly predictive when used in its common form as a “stages of change” model, somewhat stripped of its underlying psychotherapeutic processes (Armitage 2009, West 2005). However, when testing its complex “processes of change” derived from its psychotherapeutic roots (Prochaska et al 1993), good predictive power is achieved. Armitage (ibid) reports that these and similar later studies are confounded by the nature of the tailored interventions used in these studies that might, among other possible confounds, be “increasing the attention” to participants by its tailoring method. Prochaska et al’s (1993) approach used “standardised, individualised, interactive and personalised self-help programs” that Armitage suggests may deliver so much personal attention that it cannot be readily said that “attention” is not itself the facilitator of change.

It is somewhat ironic to consider that this model, developed from many aspects of psychotherapy, may become confounded by the main item that appears to be missing from its approach, namely, close personal attention or a therapeutic relationship from a therapist. Abraham and Michie (2008) come close to this position, albeit from a different direction of criticising the imprecision within reporting interventions, when they suggest that some health psychological intervention effects provide difficulties in differentiating their context from their content. It is precisely the approach of counselling to focus on context, the nature of the therapeutic alliance. Cooper (2009) suggests that in counselling, it is not the procedures alone that facilitate change, but that it is the relationship in which they are used that is central to good outcomes. Cooper appears to say that it is not what you do in therapy but the way that you do it.

It is not known if health psychologists working elsewhere would be happy to adopt the relational aspects of counselling as most of the health psychologists here did, but for these respondents to do so, suggests that they find it assists their confidence when working face-to-face with clients and, although not studied here, they might find it beneficial to outcomes.

The two psychological practitioner groups have very different professional training (Grafanaki 2010, Taylor 1990) and career-length experience and it became clear that some early career health psychological practitioners felt discomfort from insufficient training in working one-to-one with people with health conditions. While appreciative of the valuable research and evidenced health intervention skills they had learned, most of the health psychologist respondents complained that they were obliged to seek their face-to-face practitioner skills training outside their health psychological education.

Counsellors appeared to be more fortunate in that respect, generally displaying confidence in their training for working one-to-one, supported by a unitary explanation of the nature of change and a commonality in employing relational skills to achieve it. Although most of the health psychological participants complained of a lack of therapeutic skills in their training, changes have recently been made to the training syllabus for new health psychologists to introduce more emphasis on intervention skills (BPS 2009). Nevertheless, even the revised level of intervention skills required of trainee health psychologists is minimal if compared to that normally required of counsellors (BPS-DHP 2009, Grafanaki 2010). Counsellors outside of counselling psychology can normally, however, be expected to lack the training in scientific rigor, psychological understanding and evidence that health psychology offers. Cooper (2008) has advocated that counsellors should do much more to study the effectiveness of their own therapies as he sees counselling as being threatened by its tendency to reject scientific methods in assessment while still seeking to work in the evidence-based contexts of primary care settings.

The health psychologists who had taken additional therapeutic training pointed out how much they valued their additional counselling or therapeutic skills in addition to their health psychological education. As most of the health psychologists who participated had undertaken therapeutic training and worked as non-NHS employed health psychologists, they may represent an important and distinctive minority grouping within health psychology and be a useful group to study when monitoring the new DHP focus on training practitioner intervention skills.

Returning to Abraham and Michie's (2008) work on devising a coherent taxonomy of health interventions and other's attempts to rationalise, systematise and potentially further integrate theoretical understandings in health psychology, these combined endeavours appear to be moving towards an agenda of synthesis of thought that seeks a "parsimony of explanation" of those elements in health psychology "that do most of the work" (Hagger 2009). As an alternative to this suggestion, Elliott (2010) and Hagger suggest that a methodological pluralism provides more intervention options than might a synthesised integrated approach. Michie (2008), nevertheless, wonders if the considerably varied literature on health psychology that produces mixed results and little explanatory power might disguise a reality of the procedures being less important than the quality of the therapeutic context and the skills with which it is delivered.

Michie's comment appears to echo Cooper's question concerning the value of multiple interventions with little discriminatory difference, "is it what you do or the way that you

do it?" (2008 p 127). This reflects the debate over whether content or context works best in interventions. If, after all, it is the quality of the context or the therapeutic relationship "that gets results" in both counselling and health psychology, then relational skills may need to become a much more comprehensive outcome health psychological training than that required of the revised Stage 2 training. Of course, no assessment of the outcome of this debate is made here as the description of 'context' is as vague, if not more so, than some of the intervention descriptors that Abraham and Michie describe (2008) and this would include the contextual phrase, 'the way that you do it' (Cooper 2008).

The research here looks only at the reflections of a small group of independent health psychologists and counsellors. It is thought to be important, however, that most of the health psychologists responding here chose to add the personally demanding and time-consuming nature of an advanced therapeutic skills training to their already demanding and lengthy health psychology training. The health psychologists appear not to have made this commitment lightly and it suggests that their wish to add to their skills has some basis in intervention utility and that this issue should be examined to find if it has general rather than specific value for these participants in health interventions.

While counsellors did not express a need for training in expert health psychological interventions, being comfortable with their approach, there is a debate in counselling that points towards a more 'pluralistic approach' in counselling and psychotherapy for it to introduce more integrative, flexible and non-dogmatic ways of working (Cooper and McLeod 2010). Cooper and McLeod suggest that there is no incompatibility between counselling approaches being person-centred and applying appropriate psychological procedures. They especially suggest that counsellors should be more focused on outcomes, asking what clients want from the therapy and how they might best be assisted to achieve these goals. Again, Cooper (2008) points to considerable research that suggests that client factors form the largest part of therapeutic effect and that counsellors should adopt a research approach to evidence beyond the imputed powers of the relationship. Here, while the focus has been on the potential for intervention outcome benefits of therapeutic training for health psychologists, there is a balancing suggestion that counsellors might be too complacent in their trust in the relationship as a major influence on outcomes. Research has indicated that clients' own expectations of therapy, their predilection for cognitive as opposed to medical therapies, their own beliefs about the causes of their problems, their aptitude for behavioural as opposed to cognitive interventions and even their belief that the therapist is a similar kind of person

to themselves can impact on the effectiveness of counselling outcomes (Cooper *ibid*). Several counsellors in this study had already incorporated additional approaches to their basic counselling relational approach, suggesting that their open-ness to client characteristics beyond the relationship itself have a place in interventions. Further exploration of counselling benefitting from expert psychological techniques, models and knowledge lies outside this study but indicates that it is not just health psychology that requires opening up its philosophical and methodological outlook to other approaches to client change.

In the field of interventions with people with common chronic conditions, the thematic analysis provided a rich and evocative context of the work of the independently employed health psychologists and counsellors who were interviewed. It showed that there was considerable overlap in how both psychological professions worked with people with common chronic health conditions. Both practitioner groups brought eclectic, model-derived and intuitive tools into their work with clients in an agenda to facilitate client change by these methods and procedures. Both practitioner groups also brought to their interventions a context of an individual relational or person-centred approach to their client work, seeking patterns, encouraging resilience through acceptance of the reality of the difficulties chronic conditions impose and working with their clients in a very caring, attentive, listening and accepting manner. Both groups believed that by providing a safe and caring context in their interventions, some change (healing) is facilitated in the client through the trust engendered by the relationship. This context may well include many of the contextual factors alluded to by Abraham and Michie (2008) that might mediate outcomes, the 'attention' factors described by Armitage (2009) that can be seen as confounds in intervention research and which may be seen far more positively as 'relational' factors by counsellors and some health psychologists. This very imperfectly defined relational context may well be the 'way that you do it' that adds facilitative power to expert interventions. The eclectic use of a tailored mix of expert and relational approaches may provide a synthesis of approach based on what might be considered to be the best of both traditions. Belief in this pragmatic synthesis seems to lie at the heart of the participants' beliefs about 'what works' for clients.

The practice context described in the initial stages of the thematic analysis (Figure 1), has a resemblance to a form of the methodological pluralism or multiple paradigm approach advocated by Hagger (2009) and Elliott (2010) above. It has parallels with the multiple procedures model within the TTM with the addition of the therapeutic relationship model. The final thematic analysis produced a comprehensive two-theme

model that describes such a synthesis, where both practitioners used techniques (procedures) in an expert knowledgeable fashion and also used the philosophical approach of creating a therapeutic collaboration and alliance with the client. The two themes of “change can be prompted by expert techniques” and “providing love and safety lets change happen” both face the central idea of an end-state of healthy change in the client. The responses to the circulation of outline results from this study to the participants were scanty, albeit supportive of the general approach taken here and this gives a measure of assurance that the research outcomes are close to those of the participants.

The analysis found that both practitioner groups appear to believe that a mix of expertise and knowledge in a therapeutic relationship of care and safety is an approach likely to facilitate healthy change and that this synthesis seems to be the principle mechanism of the process of change in clients and provides much of the answer to the research question.

Conclusion

This thematic analysis explored intervention beliefs of 10 independent psychological practitioners from health psychology and counselling working with clients with common chronic conditions. The derived themes show that the participants believe that expert procedures delivered in a relational therapeutic context may facilitate a beneficial change in the client. In this context, the health psychologists appeared to believe that a wide range of overtly psychological tools were important in interventions, while the counsellors overwhelmingly believed in a context of relational quality to meet client needs. Health psychologists appeared focused on an end-state of client/patient improvement while the counsellors focused much more on the quality of the therapeutic relationship than outcomes. The more experienced counsellor participants also expressed more confidence in their therapeutic practice than the early career health psychologists, possibly reflecting early career uncertainties among the less experienced health psychologists as compared to the longer experienced counsellors.

Although the counsellor participants might seek health psychological and other expertise that they did not possess, they reported being comfortable looking for this from health psychologists or other specialist practitioners. When the health psychologists believed they needed deeper relational skills guidance they showed that they were comfortable in turning to counsellors and other therapists for supervision and training. There seemed to be a mutual respect for each other’s professional abilities

and an appreciation of their differences. Nevertheless, some counsellors considered that psychologists tended to see the client as a repository of problematic health conditions requiring to be resolved rather than a person with problems who needed attention. Among the participants, the counsellors did not appear to wish to enter much into the world of health psychology, apart from occasionally tapping into their expert knowledge, while the health psychologists appeared to have an apparently much greater wish for counselling skills for them to perform their individual practice more confidently. Although health psychologists are described as having skills appropriate for “direct psychological work with patients, families and carers (for example helping them to adjust to illness and treatment)” (DHP 2010), it was very clear that most of the health psychologists interviewed here believed that they needed more intensive therapeutic training to feel comfortable in direct face-to-face interventions.

It was apparent that the participating early career health psychologists expressed much more negativity about their training than the more experienced counsellors. It is possible that this interview process provided an opportunity to vent feelings or to ‘sound off’ in a manner that might be normally unavailable to them, an issue that hints at a possible need for some kind of regular debriefing or personal supervision of the kind compulsory for counsellors in private (and all) practice.

Implications of the research and further research possibilities

It appears that most participant health psychologists felt uncomfortable and somewhat unprepared for one-to-one practice and sought the relational skills training they later undertook. It is known that there is a risk factor for burnout and consequent chronic ill-health in professional practice (Lee and Ashworth 1996) and it would be unfortunate if health psychologists working on a one-to-one basis with clients with long-term or chronic health conditions were to suffer an uncomfortable stress load as an unintended consequence of believing they have insufficient relational or therapeutic training. It may be that for counsellors, their relational training and compulsory personal and professional supervision permits them to express and off-load their personal feelings in a way not necessarily open to independent health psychologists. This area was not a main focus of this study but the theme of frustration expressed by the participant health psychologists does suggest that research into the role of personal supervision for independent health psychologists might be worth considering, especially if there is a potential benefit to supervision in promoting professional reflexivity and personal support.

In this study, the health psychologist participants' descriptions of their professional beliefs have implications for intervention research, suggesting that a combination of caring context and psychological skills may have utility in face-to-face health interventions. Their generally seeking additional face-to-face training implies that an expertise in health psychological skills and procedures can sit well with a relational model of therapeutic change in health interventions. A comparison study of the effectiveness of health psychological interventions with and without an emphasis on a relational input would be a potentially useful follow-on research project. This subsequent research could examine if the beliefs of both practitioner sets actually reflects changes in client/patient outcomes. Longitudinal comparative studies would be necessary to explore whether relational-augmented health psychological interventions have real utility over traditional model-driven approaches and in what areas might this be preferable. Such research might cast some light on Abraham and Michie's (2008) finding that much health psychological research does not very well disentangle interventions from contexts.

This study noted the debate in health psychology over whether some integration in methodologies could provide an alternative to the current multiplicity of intervention models and techniques. The Transtheoretical Model in health psychology might be considered as an appropriate candidate for one means of integrating approaches, especially with its broad list of 'processes of change' based on relational psychotherapeutic theories. While criticised in its "stages of change" oversimplification, it may be that the processes of change within the TTM's psychotherapeutic roots could provide the basis of training in relational practice for those seeking this in face-to-face work with those with health conditions. Exploring the multiple domain techniques in the TTM and combining them with relational work may mirror much of the intervention styles already adopted by the small group of independent health psychological participants in this study. The changes made to the Stage 2 Qualification in Health Psychology (BPS-DHP 2009) were introduced after the participants had completed their Portfolio training. This recently increased emphasis on intervention skills for health psychologists-in-training adds weight to the suggestion made here for a more overt training in face-to-face relational context skills.

While the health psychologists in this study mostly appeared to wish to learn from counselling and related approaches, there is also potential for counsellors to learn from health psychological techniques and procedures. The counselling participants appeared much more confident in their practice beliefs than the health psychologists and yet seemed to wish to integrate specific psychological interventions into their work,

without, perhaps, the depth of understanding that comes from the much longer health psychological training. While it was not the remit of this study to explore effectiveness of practice, rather than beliefs about effectiveness that drive practice, there appears to be potential for counsellors to find benefits for their practice in health psychological procedures. Perhaps promoting health psychological concepts and models among counsellors might be a fruitful avenue to explore and to study if this benefits their working with clients with common health conditions.

In conclusion, if health psychologists wish to move more into primary care or related independent practice, this small study suggests that it may be worth considering if therapeutic relational training might support their health interventions. It may be advantageous for health psychology training to have therapeutic practitioner skills introduced at a much earlier stage than at present, perhaps at the MSc or undergraduate level, as it takes some time to become knowledgeable about and proficient in relational contexts. Relational skills might be logically introduced in the communication element of MSc health psychology training, focusing on social communication in one-to-one settings in the wider context of 'expert' advice and the manner in which it is perceived and received by clients. Research examining the role of relational approaches, when added to existing evidenced methods in health psychological interventions, may add to understandings of both predictive and beneficial effects of interventions in health, especially in exploring how a client may be supported in making healthy changes. Trainers in health psychology might be encouraged to explore the 'processes of change' underlying the TTM and how it might fit into a relational form of training new health psychologists. Independent health psychologists might consider the benefits of clinical and personal supervision, especially if working outside employer support mechanisms.

This qualitative analysis of independent psychological practitioners has found that relational training appears to be highly valued by most of the health psychological practitioners who participated here, despite the considerable additional effort required to undertake this training on top of their already lengthy health psychology training. Both practitioner groups appeared to share ideas that skills and context are mutually supportive in promoting healthy behaviour change. This suggests that there may be benefits in further research and theory-construction to explore if a relational form of health psychology would more beneficially operationalise health behaviour change models in the additional context of a relational model.

Limitations of the study

This study is a sole researcher small sample qualitative study and is necessarily influenced by the researcher's subjective assessments without the moderating contribution of a second reviewer. To compensate for this, the analytical processes contained within it are hoped to be as transparent as possible to assist readers to assess the logic and quality of the analytical decisions made.

The participants were selected opportunistically and are not presumed to be a representative sample of the professions from which they were drawn. The sampling process also tended to find early career health psychologists while the counsellors sampled had longer practice experience. The responses of the participants may well reflect aspects of this experiential difference. A qualitative study can make no generalisations concerning the wider psychological and counselling professions, other than to derive suggestions for practice, theory or training which are necessarily tentative and intended only for raising ideas and possibilities for consideration in later research. It is also important to emphasise that the effectiveness of participants' interventions are not assessed here and that this was a study of practitioner beliefs only.

Following Elliott et al's suggested guidelines (1999), it is hoped that the author's own perspective has been made clear earlier as being unaffiliated to any one perspective but with an admiration for the therapeutic underpinnings of the TTM. The sample has been situated in the practitioners' life in independent practice, the examples are grounded in the data with an open analysis that leads to the overarching thematic analysis, the credibility of the analysis is given through feedback from participants themselves, the analysis appears coherent and consistent and participant feedback confirmed this, the analysis resonated with both participants and when outline results were presented to non-participants, and the limitations of generalising to the wider population of practitioners is made clear – with the analysis recommending areas to study for confirmation of results or to guide future training.

No claim is made as to whether the comments expressed by participants are fair, reasonable or appropriate, but are to be heard, instead, as real voices of the practitioners who responded at the time of the interviews in 2009-2010.

Reflections on training to be a health psychologist

Introduction to reflections

Here I reflect on how my training and experience has permitted me to achieve the competencies to become a health psychologist and how I hope to continue my professional development. I introduce the chapter with a short narrative of how I came to choose health psychology as a career, how this route has affected my choice of demonstrating competencies, and concludes with a plan for my future professional development. These reflections cover the time period from changing my career as a local authority town planner to that of a self-employed health psychologist, combining a health interventions practice and short-contracts in psychological applications. Following the Introduction, I reflect on what has changed in my understanding of health behaviour and cognitions during specific parts of the training, what I have learned from this, what I might have done differently during this process and the directions of my future professional development.

In the 1990s, I managed an economic development department in a Scottish local authority, working closely with local business people, assisting in their interactions with local government. I became concerned how socially isolated some of the business people seemed to be as they worked almost constantly with few breaks and with little time to relax with their families. Over time I realised that I was being more useful to them as one of the few people they could talk to about how they were becoming unwell through the stresses of their work than I was as a business development advisor. My interest in workplace stress (and its impact on the economic health of businesses) grew and this sparked a desire to become more proficient at helping reduce the stress of the business people I had met and I decided to train in psychology. Thus started what became a much more lengthy process than I could have imagined at the time, enrolling with the Open University in 1996, training as a clinical hypnotherapist and completing the doctorate in health psychology fifteen years later.

After initial training, I left local government and worked in a GP-supervised clinical placement in the East End of Glasgow from 2002 – 2005. This gave me valuable experience in interventions relating to the psychological components of health conditions (pain, insomnia, health anxieties, weight control, self-efficacy and helplessness), the physiological co-morbidities of mental health disorders (pain, headaches, nausea, breathlessness) and commonly-occurring mild to moderate mental health issues such as phobias, depression, anxiety and some medically unexplained

conditions such as IBS and bodily pains. A health psychologist patient I worked with suggested that my interest in the mechanisms of behaviour and cognitive change might be best satisfied by training in that discipline and this suggestion proved to be very valuable in guiding my research into 'what works and why' in the psychology of health. I have not yet found a full answer to that question but the search has proved to be a powerful personal motivation in my studies.

At the end of my training, and facing the future as a practitioner psychologist, I will continue pursuing my private practice with a much better understanding of the psychology behind health behaviour change, better trained in professional skills and with a much wider set of psychological tools than when I started practice. I intend to continue to seek short-term consultancy and teaching alongside my practice as I find this a pleasing application of the skills I have learned as a trainee health psychologist and I enjoy the variety of work that this provides. I combine my town planning experience with health psychology on consultancy projects concerning how our wellbeing inter-relates with the quality of the urban environments in which most people live. I intend to become active in the Division of Health Psychology to promote its field and practice and for the pleasure of working with like-minded professionals. I will continue to review my practice in a reflective manner, in collaboration with other colleagues wherever possible and continue to refresh my professional skills with appropriate CPD.

Teaching and Training

The Teaching and Training competence and reflections were assessed and passed in 2008. Since then, I have enjoyed designing and presenting in collaborative workshops in health psychology at PsyPAG at Manchester and Cardiff in (2008, 2009), presenting a poster (Health Psychology Annual Conference at Aston in 2009), a paper on health impact assessments (British Psychological Society (BPS) Annual Conference, Stratford-on-Avon, 2010), a workshop for public health practitioners (South West Public Health Conference, Dartington 2010) and departmental seminars with the University of the West of England (UWE) WHO Collaborating Centre for Healthy Urban Environments (UWE-WHO Centre) colleagues. This varied practical experience has been augmented by assisting and delivering over 250 hours of workshops and labs on Psychological Research Analysis and Design for second year undergraduates at UWE in 2009/2010.

The presentation to the BPS Conference was the least satisfactory because of it being the first session in the morning with me being the first presenter and the audience was embarrassingly small for the effort put into the presentation – consisting of only the Chair and the other presenters for that session! I adapted the presentation to the slow trickle of attendees as they came into the hall, adding very short summaries of the talk as I went along, and the tiny audience appeared to enjoy it, asking me questions afterwards and apologising for coming in late. The other three presenters had a similar fate and we all agreed that, however disappointing the numbers in the audience, we agreed that we had all provided a good themed symposium and satisfied ourselves that we had done the best we could do in such poor circumstances. I do not know how I could have avoided this experience but it did at least provide an opportunity to discuss the topic in a seminar-like atmosphere that might not have been possible with a larger audience. This was very disappointing for me, considering how much work had gone into preparing the paper, and I may restrict future presentations to Division of Health Psychology (DHP) events which I notice have tended to be more conscientiously attended.

Marking undergraduate student papers provided useful awareness of what had often dogged my own success in achieving success, namely, being too general in my examination responses and insufficiently precise. These failings tended to reflect the main difference between the good and merely average papers I marked – a salutary lesson for me and hopefully none too late. Positive feedback from the lecturing staff on my consistency of marking and close correlation to marking means from other staff left me feeling confident that I can follow assessment guidelines satisfactorily.

Unlike the position when I began training, I now feel capable and competent to work with both large and small audiences. I was recently complemented on how I ‘held’ a room of academics in a public health professions workshop and this was through application of the engagement skills learned from teaching and training workshops in my health psychology training. I have also learned from my mistakes, where I mis-judged an audience’s level of psychological knowledge or tried to pack too much learning into too short a session. Analysing my own and participants’ reactions and comments, has provided very useful lessons to research my audience carefully, prepare well in advance, rehearse teaching sessions and prepare suitable hand-outs and teaching materials to help audiences through the process of learning. I thoroughly enjoy the experience of teaching and working with students of all ages and backgrounds, am comfortable in adapting my teaching approach as I gauge audience

reception and will continue to incorporate these lessons into future workshops, presentations and training.

I will seek out further teaching and training opportunities to retain my skills and continue to learn from those with more experience in this field of work.

Learning from Consultancies

Two consultancies were completed for the Stage 2 training, involving different health psychological contexts. The first was the development of a rapid Health Impact Assessment (HIA) to measure the impact of the potential loss of community allotments on the physical and emotional well-being of its former users. The HIA contract became substantially extended beyond the basic remit of the Case Study and progressed to a lengthy involvement that was, nevertheless, very valuable for my training and experience. The second consultancy was originally intended to be an Optional Intervention competency submission but as it was still in process at the time I collated the Portfolio in June 2010, it has been re-allocated to the Consultancy section for the purposes of assessment. This work involved assessing a stress analysis of the working environment of the Emergency Department (ED) of the Royal United Hospital, Bath (RUH) and conducting a qualitative assessment of its impact for the client, a partnership between the hospital's Employee Assistance Programme (EAP) and the ED.

Both contracts were negotiated in a manner familiar to me when negotiating consultancies previously in local government. I used Socratic questioning to discover a full 'wish-list' from the clients, and negotiated them down to what I believed could realistically be achieved with my own and clients' resources, our joint professional knowledge and within the timescale available. My client negotiations were open, direct and effective in arriving very quickly at a set of targets that could be realistically achieved in the timescales required for both consultancies. As the hospital consultancy has become very slow to implement, reminders of targets have been required to refresh key players' memories of what they had agreed to do to prompt progress. This slowness has required more persistence from me than I had anticipated but I was told by hospital staff that this is normal for this work environment because of pressures of work and something I would have to accept. This slow progress was all too familiar to me from my previous local authority negotiations with consultants from the client side and I was able to bring other work forward to free up time for the consultancy later. This became an exercise in time management more than an

annoyance and I simply adapted to the situation as best I could. I suspect that there is little I could have done differently to speed up the process, being dependent upon others' goodwill, so I was glad that I could swap time reasonably well and dip in and out of the hospital work as required. This experience honed my time management skills and reminded me that professional health psychologists are as much subject to the exigencies of circumstances as much as anyone else and I must retain a sense of purpose and patience when I work in NHS settings to cope with the slowness of the process.

I believe that as the consultancies progressed that I refreshed and developed my knowledge and understanding of the research process and grew more into the role that a health psychologist should play in the field of applied practice. Again this points to potential for me to continue to work as an independent consultant and I will explore this more after completing my training. I enjoyed presenting my HIA case study as a poster on Health Impact Assessments (DHP Aston 2009) and as an oral presentation (BPS Stratford-upon-Avon 2010) which helped me to realise how much I enjoyed preparing and presenting material to psychologists and others, enjoying the debates and having my knowledge and understanding tested. I can envisage doing more of this kind of active health psychological knowledge dissemination, both as CPD and knowledge exchange in future years.

An unexpected outcome from the HIA consultancy was being offered a temporary post as a researcher in the UWE-WHO Centre based in the Planning and Architecture department of UWE. This organisation specialises in HIA consultancies and research into the interface between spatial planning and health. I am a co-author of two papers based on active travel (cycling and walking) in neighbourhood areas and these are currently under peer review in planning journals. I found this work both stimulating and exhausting, especially where several co-authors have to be cajoled into contributing and with each contribution changing the shape of the paper, finding it hard to keep the paper's focus clear. I have developed my final editing skills, tying several different thoughts together into a more coherent whole and this is pleasing to note. I can see that this authoring process will become faster with experience and hopefully continue into the future. I have been contracted for more 'health and planning' authoring projects with the UWE-WHO Centre and anticipate future opportunities to develop this training and disseminating aspect of health psychology and its links to urban environmental influences.

Reflections on the Optional Competencies

The HIA Case Study and subsequent **Expert Witness** experience at a formal public inquiry chaired by the Planning Inspectorate, required rapid thinking and retaining focus on key points of evidence to respond appropriately. This meant appreciating that apparently innocuous matters, such as late presentation of unseen evidence by the appellant, would not be introduced unless the appellant saw an advantage to it. Thus it was important for me to be able to respond rapidly to such new events to discern any potential implications for the case concerning my client. An unexpected sabotaging of my client's case in the public hearing by a clumsy supporter of the community case was an example of having to be sufficiently in command of the evidence to be able to refute such unwelcome intrusions at very short notice. This required full understanding of the issues key to the case to decide if comment should be made or not in order to protect my client. It also required me to have an ability to disregard minor points or asides made by the appellant's counsel that could confuse my presentation of key evidence. The appellant's representatives were quite aggressive and sneering and I was glad of my previous planning experience of this tactic (often used in such adversarial situations) and was able to ignore attempts to distract me or to raise my emotions to confuse or prompt unprofessional behaviour. I was glad that I was able to resist the temptation to respond in an equally adversarial manner and to retain a factual approach to indicate professional calmness and strict adherence to the evidence I had to give. I hope that my approach demonstrated a confident delivery which may have added weight to the manner with which the evidence was heard by the Inspector. The report made by the professional observer of my performance kindly suggested that I maintained at least an external semblance of a calm and reasoned approach during the Hearing.

I find these circumstances very challenging but also very stimulating and I enjoyed the opportunity to present my case and its defence as well as I could. I thoroughly enjoyed the cross-examination opportunities and after the session the opposition representative kindly congratulated me on a performance good enough for him to recommend working for him. As he had been particularly rude and aggressive, I'm not too sure that this was wholly a compliment but I took it that way. This suggests that I should consider approaching the BPS to train further as an expert witness. I am not fully aware of the circumstances in which a health psychologist might be useful as an expert witness, apart from the circumstances I have already described, but I will explore this possibility once fully qualified.

The **Case Study on weight loss** was enjoyable as it reminded me of the practice area that brought me into psychology after leaving local government. I was gratified by how much the client had become more confident and apparently much healthier in her approach to food and seemed to be more in control of her weight-related psychological issues. It was also good to see that my role complemented the support she had from her practice nurse. This intervention, somewhat like the provision of expert evidence, required me to react appropriately to a dynamic synthesis of cognitive and health psychological theory, research, and practice which incorporated knowledge of health behaviour, practitioner experience and the client's own self-understanding and self-efficacy. I enjoyed the closeness of the therapeutic relationship and hoped to use its intimacy to provide a safe place for the client to come to terms with her own conflicting ideas and behaviour that had contributed to her issues and to support her with the guidance and confidence to change her cognitions and behaviour. I believe that I was successful in doing this but am aware that I had always to be sensitive to the dynamic of the relationship and to avoid as much as possible a mental retreat into models and theories to the detriment of staying empathically close to the client, hopefully with sufficient warmth to encourage her to take the risk to use my support to change her patterns of behaviour.

I strongly relate to Fishbein et al's (2001, in Thesis Bibliography) belief that when delivering psychological health interventions, therapists' knowledge of mechanisms of therapeutic action is thought to be essential for their effective delivery. I have had many experiences of therapeutic change in clients where I have not fully known why or when change began to be effective until the client became aware of changes happening and discussed this with me. When working as a therapist, I am aware that I use interventions in an experimental and collaborative manner with clients, openly explaining this approach with clients, regularly checking on progress and fine-tuning the intervention to adapt to feedback from the individual experiences and cognitions of the client. This collaborative experimental approach seems to work quite well for most clients and it is in this manner that I interpret and attempt to adhere to Fishbein et al's belief. I interpret Fishbein's belief concerning knowledge of the mechanisms of change being essential to effective interventions by having multiple means of prompting change, borrowing general themes from several models and applying a wide range of psychological tools from my hypnotherapeutic, CBT and counselling skills training to the individual requirements of each client. I employ a client-centred methodology with a collaborative experimental philosophy which is led by the client's responses and willingness to adopt an experimental approach. In this way, both I and the client jointly explore what different behaviour and cognitions are wanted, what is realistic, what

might be tried in terms of techniques, selecting procedures to adopt and regularly feeding-back to each other how things are going. The emotional components are addressed as they occur, often unexpectedly, through listening and collaboratively interpreting their meanings with the client. Through this open relational process, with background attention to solutions and outcomes, the therapeutic journey is undertaken, with regular re-visiting of goals, to conclusion.

The wide range of techniques within Prochaska and DiClemente's Trans-Theoretical Model's Processes of Change provides a useful armoury for tackling individual issues in my work although I substitute the Stages of Change aspect of the model with a 'Journey' metaphor for my clients. I am well aware that belief in the process is very important to my clients in maintaining the therapeutic relationship and promoting maintenance of the behaviours and cognitions learned from the therapeutic work. I will continue to explore the process of change and will disseminate the outcomes of my doctoral research to health psychologists and look forward to listening and learning from their responses.

In choosing a health intervention Case Study for one 'Options' module, I was also aware of the change in the regulations for Stage 2 that replaced the 'Options' modules for an 'Interventions' one plus a reflection on that intervention. I am aware that my Portfolio has been presented to meet the BPS Stage 2 Regulations in place when I began Stage 2 in 2007, but I aimed to acknowledge, as appropriately as possible, the spirit of the revised 2009 Regulations against which the Professional Doctorate will be assessed in future years. With this approach, I wanted to provide a bridge that reflected the move from the older to the newer BPS Regulations in my submission for the qualification in health psychology.

Reflections on the Research competence

My original research idea had been to develop my interest in the mechanisms of change in clinical hypnosis by focusing on the effectiveness of hypnotic interventions for patients with common chronic conditions of the kind often encountered in health psychological practice. I was also very keen to improve my understanding of how I worked as a hypnotherapist and to better facilitate behaviour change in my clients. The rigor of Systematic Review methodology was difficult to value at first then became fascinating to me as I grew to appreciate the evidential usefulness that derives from the

rigor of the procedure. Feedback from the assessment of my first attempt at a systematic review (attached to this submission), although a pass, pointed to weaknesses in my searches, missed opportunities within the process and generally pointed to how I could improve the analysis of the search outputs. This encouraged me to look more closely at the search results and as I began to formulate the research project to be based on the systematic review I realised that the concluding recommendations I had made in the review effectively precluded me from continuing with the research.

My review recommendation was to stop repeating small studies that related poorly to each other and to do a large-scale study with much better controls and a better focus on the underlying mechanisms of change that lay at the heart of the intervention. To do this would have required me to be a part of an organisation that had access to substantial patient throughput and which used clinical hypnosis as a significant part of its practice. With my small private practice client list I had access to neither of the research requirements suggested in my review and I realised that I did not have the resources to conduct the research I had recommended. I considered doing yet another small study that would have been within my resources, but as this had been counter to my recommendations, I felt it ethically unsound to improve my systematic review along the lines recommended by its assessors and then effectively disregard my own recommendations to permit me to proceed with one of the small studies that would have been within my control.

It was profoundly disappointing not to be able to progress from my review in a straightforward manner. I felt very lost at this point and wondered what I could do to recover the situation and continue with the training. I lost quite a bit of time searching around for some solution to this dilemma before deciding to make the best of my review by taking an aspect of my finding that was not central to the conclusions and find another way to follow my interest in the mechanisms of change that facilitate client behaviour change.

My review of RCTs in hypnosis had found that there was only weak evidence of its effectiveness, due to the use of small sample sizes, use of inconsistent research methodologies, insufficient published detail in analysis of outcomes and the use of large-scale studies with weak or no controls. Where these studies were useful to the new research topic, however, was in that they listed sets of assumptions about the mechanisms of change that were thought to underlie the effectiveness of the interventions used. These included ideas of change being facilitated by better

treatment adherence, reduction of anxiety leading to greater sense of control and confidence, autosomal effects that reduced neuro-endocrine functions that exacerbated symptoms, reductions of negative inner focus permitting greater acceptance of limitations, improvements in personal attention to life-enhancing activities, positive changes in cognition over meanings of symptoms that lessened distress, reduction of pain through attention redirection, reduction of general stress reactions through unspecified means and improvements of mood through relaxation. This substantial and varied list of hypothesised therapeutic actions in hypnosis provided the background idea that led to my research into health and other psychological practitioner beliefs about the mechanisms underlying health behaviour change. I was pleased that there was at least one thematic link between my systematic review material and the research topic of comparing health psychologists and counselling beliefs about the mechanisms of change.

This research topic allowed me to compare my position as a health psychological practitioner with others conducting psychological interventions. I was sorry to learn that the health psychologists I interviewed felt less well trained to work in face-to-face contact with clients than the counsellors who were much more comfortable in their professional work. As the health psychologists would have been trained under the older regulations which contained little therapeutic training this is not too surprising. I felt sad that they believed that they had somehow been failed in their expectations of health psychology and I hope that newer health psychology students do not feel so troubled if they elect to become face-to-face practitioners. It did remind me that I feel very comfortable working one-to-one with clients and demonstrates the value of training specifically for this form of practitioner-client relationship.

I hope to use my practitioner research to lobby for a more relational approach to health psychological training in face-to-face work on health behaviour change. I hope also to encourage the consideration of the psychotherapeutic underpinnings of the Trans-Theoretical Model (TTM) as a basis for training health psychologists in one-to-one health behaviour change. As the TTM is already widely accepted as a useful health behaviour change model that incorporates a wide range of therapeutic techniques, I believe that it should sit well within a health psychological context and provide a ready-made set of procedures for trainees to adopt and adapt in a relational context. I believe that as I further explore and train in the TTM's Processes of Change, my professional practice ability will continue to develop and improve. This further training will be pursued as I have previously done with CBT and to undertake additional training with appropriate experts in such fields and to incorporate this learning into my practice.

Reflective Conclusions

Since undertaking the professional doctorate, I have found my previous experience of consultancy work very usefully improved but I have no doubt that my teaching and training skills have been substantially improved from the basic workplace trainer role in which I had been previously trained. My hypnotherapeutic (and latterly CBT) training has been substantially strengthened by my research into theories and models of behaviour change. I now feel much more competent and see commonalities in models and techniques that previously were unclear to me. I would, however, have appreciated more training in specific therapeutic techniques of the kind that lie in the Processes of Change in the TTM and will continue to train in these through self-education and through the training opportunities frequently advertised through Division, BPS and other psychological networks. I intend to publish from my doctoral research and to continue to contribute to debates in health psychological journals as I have in the past. Looking back at my progress through the professional doctorate, I suspect that I would not have done much differently during the Stage 2 from the route I chose to take as it fairly represents my interests and ways of working. I do, however, regret not finding Health Psychology much earlier in life when I began to feel stale and a little stuck in a rut as a town planner. Perhaps prompted by this regret, I intend to make the most of this opportunity now that I have found it.

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Appendix – Interview Schedule

1. “What do you know about the origins of this health condition and what might maintain its long-term state?”
2. What issues might this condition create for your client and the world he or she inhabits?
3. What ways do you think that psychological therapy can help the client and impact on this condition?
4. What do you think lies at the heart of the therapy inside the client – what is happening in their bodies, thoughts, feelings, behaviours and how these are affected by their social worlds?
5. What might you be trying to achieve for this client and how would you know if it was successful?
6. Are there special features of your approach that you think might give you an advantage over some others in the field of physical health?
7. Your answers to these questions may help to cast more light on the thinking of professionals who deal with issues facing clients or patients with common chronic physiological health conditions.”

Appendix - Information Leaflet and Consent Form (side 1)

**Conceptualisations of
psychological
interventions
for
common physical
health conditions**

**Are you a counsellor or
health psychologist
with an interest in clients
with physical health
conditions?**

**Would you be prepared to volunteer one
hour of your time to be interviewed?**

**You would be providing very useful
information for a research study into
professional's thoughts about
psychological therapy for those
suffering from chronic physical health
conditions.**

**If you are interested in helping this
study to succeed, please contact:**

Paul Millar
at
paul2.millar@live.uwe.ac.uk

**A research study approved
for the Doctorate in Health
Psychology by the
University of the West of England**

This study has been approved by the University of
the West of England for the purposes of the
Doctorate in Health Psychology.

Department of Psychology
Faculty of Health and Life Sciences
University of the West of England
Frenchay Campus,
Bristol,
BS16 1QY
Tel: 0117 3282192

Research Questions:

This research invites you to think of a client or patient who came to you with a problem relating to their chronic physical health condition, such as cancer, IBS, obesity, diabetes or other long-term health condition. When working with such clients you might wonder:

What do you know about the origins of this health condition and what might maintain its long-term state?

What issues might this condition create for your client and the world he or she inhabits?

What ways do you think that psychological therapy can help the client and impact on this condition?

What do you think lies at the heart of the therapy inside the client – what is happening in their bodies, thoughts, feelings, behaviours and how these are affected by their social worlds?

What might you be trying to achieve for this client and how would you know if it was successful?

Are there special features of your approach that you think might give you an advantage over some others in the field of physical health?

Your answers to these questions may help to cast more light on the thinking of professionals who deal with issues facing clients or patients with common chronic physiological health conditions.

Appendix - Information Leaflet and Consent Form (side 2)

Thank you for your interest in this Health Psychology study

The aim of this study is to improve understandings of how psychological therapies can help people who have long-term physical illnesses or who have physical health conditions that limit their quality of life. The NHS recommends psychological therapies for patients who seek to make changes in their everyday life. The kinds of health conditions where psychological interventions have been recommended have included cancer, cardiovascular conditions, IBS, asthma, diabetes and obesity. The BACP states, "counselling is ultimately used to help effect improvements in patients' health, well being, and capacity to work" (BACP *Shaping effective counselling services in health care*, 2005) and the BPS Division of Health Psychology states, "Health Psychologists are trained to help people deal with the challenges they might face as a result of ill health" (DHP *What is health psychology* 2008).

This research hopes to further understand some general themes in the underlying beliefs and ideas that counsellors and health psychologists hold about their work and the results will be written up with the aim of being published in a peer-reviewed journal.

You will be asked to take part in a single interview, asking you questions about your therapy, about the processes involved in your therapy and how well you think it helps people whose issues involve their health. The interview can take place at your own place of work or, if it is suitable to you, at the office of the interviewer, Paul Millar. The interview will require approximately 50 minutes to one hour to complete.

This interview will be recorded, transcribed and analysed to seek out major themes that characterise the therapeutic process for people with significant health conditions. No material will be transcribed that could identify the person interviewed. No information that could identify a client will be included in any research outputs. Any quotes will be anonymised and used only to illustrate significant themes that emerge from the analysis.

It is important for you to know that you have a right to withdraw from the study at any time without explanation. Similarly, you can ask for any material that relates to your interview to be destroyed at any time and this will be done without question. This study depends upon your freely volunteering information and any change of mind on your part will be accepted unreservedly. At all times, the research will respect your confidentiality and the confidentiality of any material freely given by you.

This study is part of doctoral research in health psychology and it is supervised at the University of the West of England, Bristol. If at any time you have any concern about the nature of the research or of the manner in which you are interviewed or about any matter concerning the research please do not hesitate to contact the researcher or if you wish, you can also approach the researcher's supervisor using the contact details below.

Researcher - Paul Millar
email: paul2.millar@uwe.ac.uk

Supervisor - Dr Diana Harcourt
email: Diana2.Harcourt@uwe.ac.uk

Department of Psychology, Faculty of Health and Life Sciences
University of the West of England, Frenchay Campus, Bristol, BS16 1QY

Tel: 0117 3252192

Consent Form for participation in conceptualisations of therapeutic action study

I have read and understood this Information Leaflet that describes the research proposal and I have been given the opportunity to ask questions about the project.

I understand that -

I may withdraw from this research at any time without being required to give any explanation and that all data that relates to my participation will be destroyed.

my personal details such as phone number and address will not be revealed to any person outside the project

anonymised and edited extracts from my words may be quoted in publications, reports, web pages, and other research outputs but any information about my name or any other identifying personal material, or any material that might identify a client will remain undisclosed.

research supervisors will have access to this data only if they agree to preserve the confidentiality of that data and if they agree to the terms I have specified in this form.

other researchers may use my words in publications, reports, web pages, and other research outputs according to the terms I have specified in this form.

I agree to assign the copyright I hold in any materials related to this project to the researcher, Paul Millar

I agree to take part in the project, being interviewed and audio recorded.

Participant Name.....

Signed.....

Researcher - Paul Millar

Signed.....

Date2009/2010

**Conceptualisations of
psychological
interventions
for
common physical
health conditions**

**Thank you for
taking part**

This study has been approved by the
University of the West of England for the
purposes of the Doctorate in Health
Psychology.

Department of Psychology
Faculty of Health and Life Sciences
University of the West of England
Frenchay Campus,
Bristol,
BS16 1QY
Tel: 0117 3282192

Thank you for taking part

Thank you for taking part in this Health Psychological study into the ideas behind therapy for people who suffer from the impact of common chronic health conditions. This research aims to improve our understanding of how well psychological therapies help people who have long-term illnesses and conditions that can limit their quality of life.

Your interview will be transcribed and searched for themes that may be in common with themes arising from other participants. It is anticipated that generalised themes should be derived that describe the underlying beliefs and ideas that therapists hold about their work and the results will be written up with an aim to be published in a suitable peer-reviewed journal.

It is important to remind you that all personally identifiable material from the research will be excluded from any published output.

It is hoped that this study will guide further research into the links between what is thought to happen in psychological therapies and the effectiveness of psychological therapies in treatments offered to people with chronic health conditions.

If at any time following this interview you have any further thoughts or concerns that arise from the research please feel free to contact the researcher, Paul Millar or his academic supervisor using the contact details below. If you have any professional concerns as to how this research might impact on your own professional practice, you may find it useful to raise these issues in supervision or even directly with your own professional body.

Once the research has been completed, a short outline of the outcomes will be forwarded to you for information and I would like to thank you very much again for taking part in this study.

Your contribution has been very gratefully received.

Researcher - Paul Millar
email: paul2.millar@live.uwe.ac.uk
Department of Psychology
Faculty of Health and Life Sciences
University of the West of England
Frenchay Campus, Bristol, BS16 1QY

Supervisor - Dr Diana Harcourt
email: Diana2.Harcourt@uwe.ac.uk

Tel: 0117 3282192

Research Questions:

This research invites you to think of a client or patient who came to you with a problem relating to their chronic physical health condition, such as cancer, IBS, obesity, diabetes or other long-term health condition. When working with such clients you might wonder:

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What issues might this condition create for your client and the world he or she inhabits?

What ways do you think that psychological therapy can help the client and impact on this condition?

What do you think lies at the heart of the therapy inside the client – what is happening in their bodies, thoughts, feelings, behaviours and how these are affected by their social worlds?

What might you be trying to achieve for this client and how would you know if it was successful?

Are there special features of your approach that you think might give you an advantage over some others in the field of physical health?

Your answers to these questions may help to cast more light on the thinking of professionals who deal with issues facing clients or patients with common chronic physiological health conditions.

Appendix – Confirmation that research falls outside remit of NHS ethics



Bath Research Ethics Committee

Room 11, John Apley Building

Research Ethics Office

Royal United Hospital

Combe Park

Bath

BA1 3NG Tel/Fax: 01225 825725

vanessa.bishop@ruh-bath.swest.nhs.uk

9 July 2009

Paul Millar
Health Psychology PhD Student
University of the West of England
Bristol

Dear Paul

Full title of project: A qualitative study of psychological practitioners' conceptualisations of therapeutic action in their clients who have chronic health conditions

REC reference: N/A

Thank you for seeking the Committee's advice about the above project.

You provided the following documents for consideration:

E-mail from Paul Millar dated 23 June 2009

This document has been considered by Acting Vice-Chair Mr Paul Shipley, who has noted that the study falls outside the remit of Research Ethics Committees.

Therefore the project is not one that is required to be ethically reviewed under the terms of the Governance Arrangements for Research Ethics Committees in the UK.

Although review by a Research Ethics Committee is not required, you should check with your Clinical Audit Department whether management approval is required before the project starts.

Yours sincerely

Vanessa Bishop
Committee Coordinator
vanessa.bishop@ruh-bath.swest.nhs.uk

Copy to: Clinical Audit Department, University of the West of England, Bristol

Appendix - Feedback to respondents and invitation to comment

Dear ,

I promised to send you a brief outline of the outcome of the study you kindly contributed to last year. It is hard to believe that it has been a year since I started this study into psychological practitioners' conceptualisations of the process of change in clients with chronic health conditions. It took much longer than I anticipated finding enough practitioner health psychologists working one-to-one with clients and I did not finish interviewing until September 2010. Both health psychologists and counsellors were very generous with their time and I hope that this analysis of their interviews fairly reflects your and their contributions. Despite having to work hard to catch up time, in this first draft I think I have reasonably well reflected the underlying themes found from the interviews of both psychological professions. I hope that you will find this very brief outline of the findings interesting. What surprised me was that every health psychologist I interviewed had felt it necessary to undertake, or had already undertaken, additional counselling skills training to equip them as health psychologists working one-to-one. What especially pleased me was the mutual respect both professions have for each other.

In the analysis of themes derived from interviews, the themes proved to be more coherent than I anticipated which was a relief. It had been suggested that I might find nothing more than a confused mixture of humanist ideas among practitioners and this, fortunately, was not the outcome. Following the brief summary of the study below, I attach the thematic diagrams that described the complexity of the general themes found and how I thought it best to analyse them.

I first made an overall 'scoping' diagram (Figure 1) to see how much I could show of all the main themes I found. These were then grouped into two over-arching themes in the final thematic analysis diagram (Figure 2) that described the beliefs as to how therapeutic interventions facilitate client change. This was modified to focus purely on the themes that are presumed to facilitate change (Figure 3). I have added a further diagram (Figure 4) to show that these two themes can represent ways of working in addition to how things are believed to 'work'.

I hope that this gives you a flavour of the study in which your contribution was so important and I would be very pleased to hear if you think I fairly reflected what was said. If you have any further points you think I might have missed, over-stated or if I have in some way mis-represented your contribution, please let me know and I will be delighted to modify the output accordingly.

I want to thank you very much again for your kind gift of time and thought. This has been a very pleasurable and interesting study for me and meeting and hearing from you and your thinking about the field was a privilege.

Very best wishes,

Paul Millar

Psychological practitioners' conceptualisations of the process of change in clients with chronic health conditions: a qualitative study

Summary

An exploration was made into conceptualisations of the process of change held by 10 independently employed psychological practitioners who worked with clients with common chronic health conditions. 5 health psychologists and 5 counsellors were selected from the private sector, who reflected on their working with clients. A thematic analysis of their responses found that they had a considerable overlap in their general approach to interventions, sharing 2 overarching themes of conceptualisations of change processes, namely “Change can be prompted by expert techniques” and “Providing love and safety lets change happen”. These themes were believed to facilitate an end-state of healthy change in the patient/client. Health psychologists were more strongly represented in the former theme and counsellors in the latter, although both practitioners were substantially represented in both themes. Despite this general similarity, one sub-theme of “Frustrated by lack of therapeutic skills” was only evident in health psychologists. This reflected the frustration they felt about their lack of training in relational skills which they believed inhibited the quality of their one-to-one work and increased its difficulty. To work as comfortably as counsellors claimed to do in one-to-one health interventions, health psychologists felt obliged to take substantial additional therapeutic training. Most health psychological theories, models and training lack much of this relational focus although it is central to client-centred counselling. In health psychology, the transtheoretical model (TTM) does provide a strong basis in psychotherapeutic method despite its surface “stages of change” aspects providing weak predictive power. Accordingly, it was suggested that the deep psychotherapeutic roots and expert procedures of the TTM could be usefully incorporated into future health psychological training. This could assist health psychologists to gain useful relational skills in working at relational depth in one-to-one health interventions and also focus new research into any improved practice effectiveness resulting from this training.

Figure 1: Scoping - initial themes as they appear to link across the data set

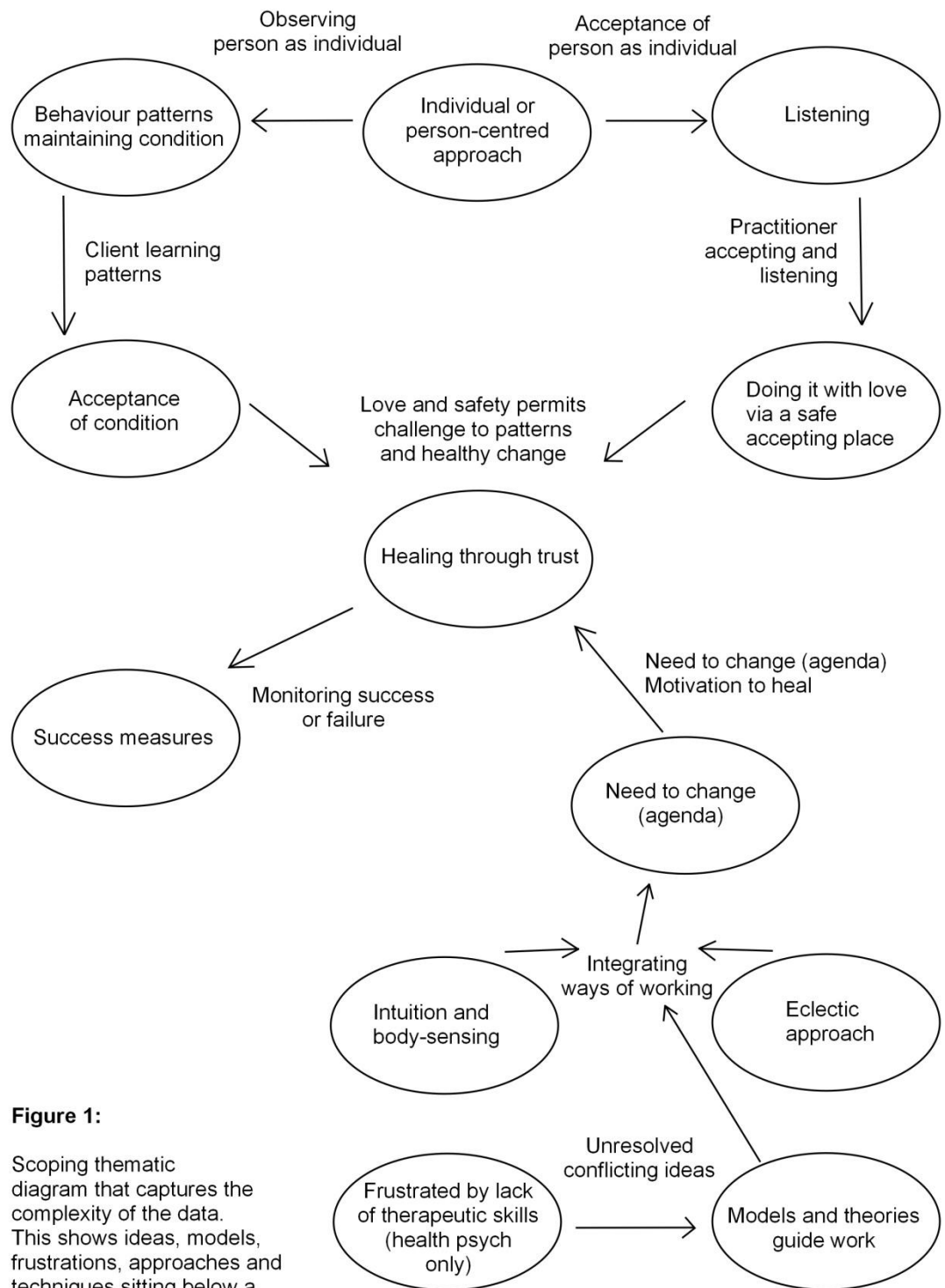


Figure 1:

Scoping thematic diagram that captures the complexity of the data. This shows ideas, models, frustrations, approaches and techniques sitting below a pattern of permissive acceptance of individual and personal difference.

Figure 2: Overarching superordinate themes of approach to client behaviour change across the entire data set

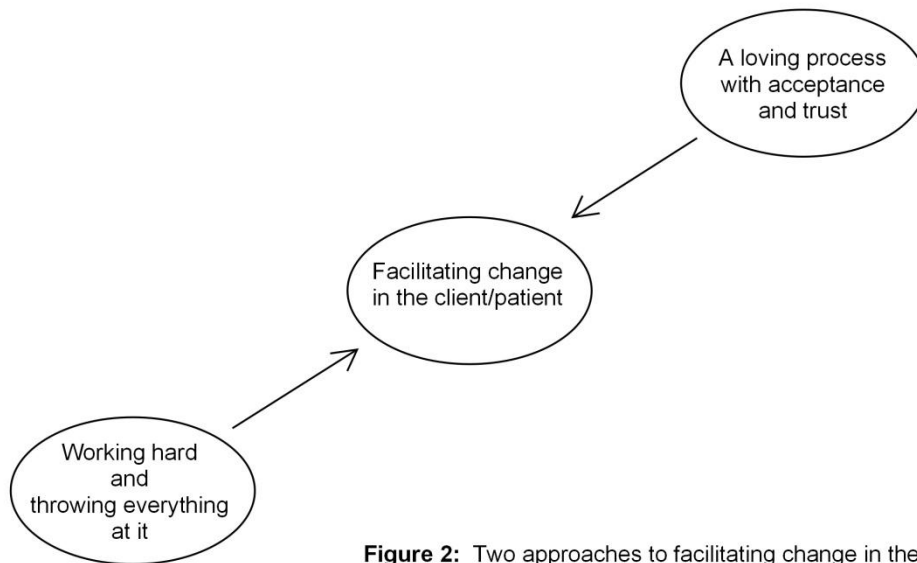


Figure 2: Two approaches to facilitating change in the client, one with faith that the client will change when given acceptance and trust, the other using as many skills and techniques as they can think of to make the change happen.

Figure 3: Overarching superordinate themes of conceptualisation of the process of change in clients across the entire data set

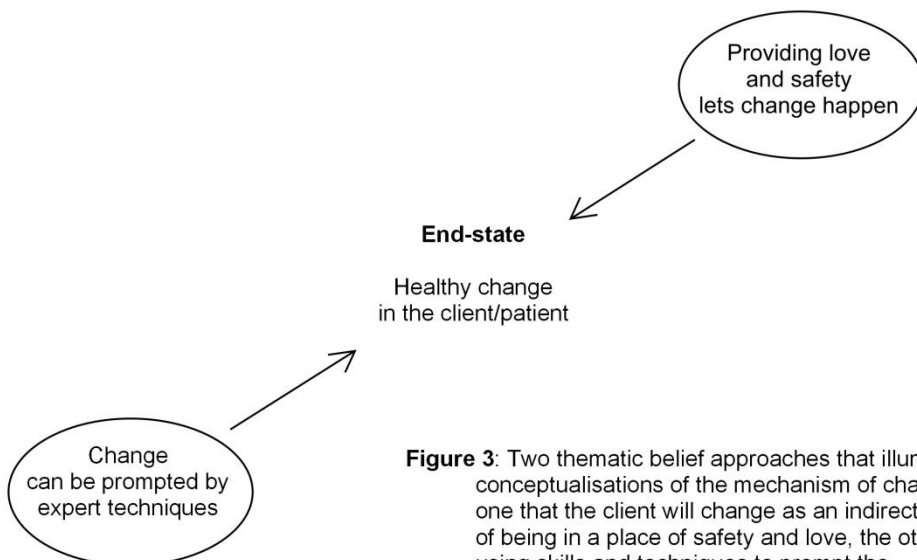


Figure 3: Two thematic belief approaches that illuminate conceptualisations of the mechanism of change one that the client will change as an indirect effect of being in a place of safety and love, the other using skills and techniques to prompt the changes directly. Both themes derived from both psychological professions and providing both was a common aim.

Figure 4: Potential ways of showing how themes link to ways of working for health psychologists and counsellors

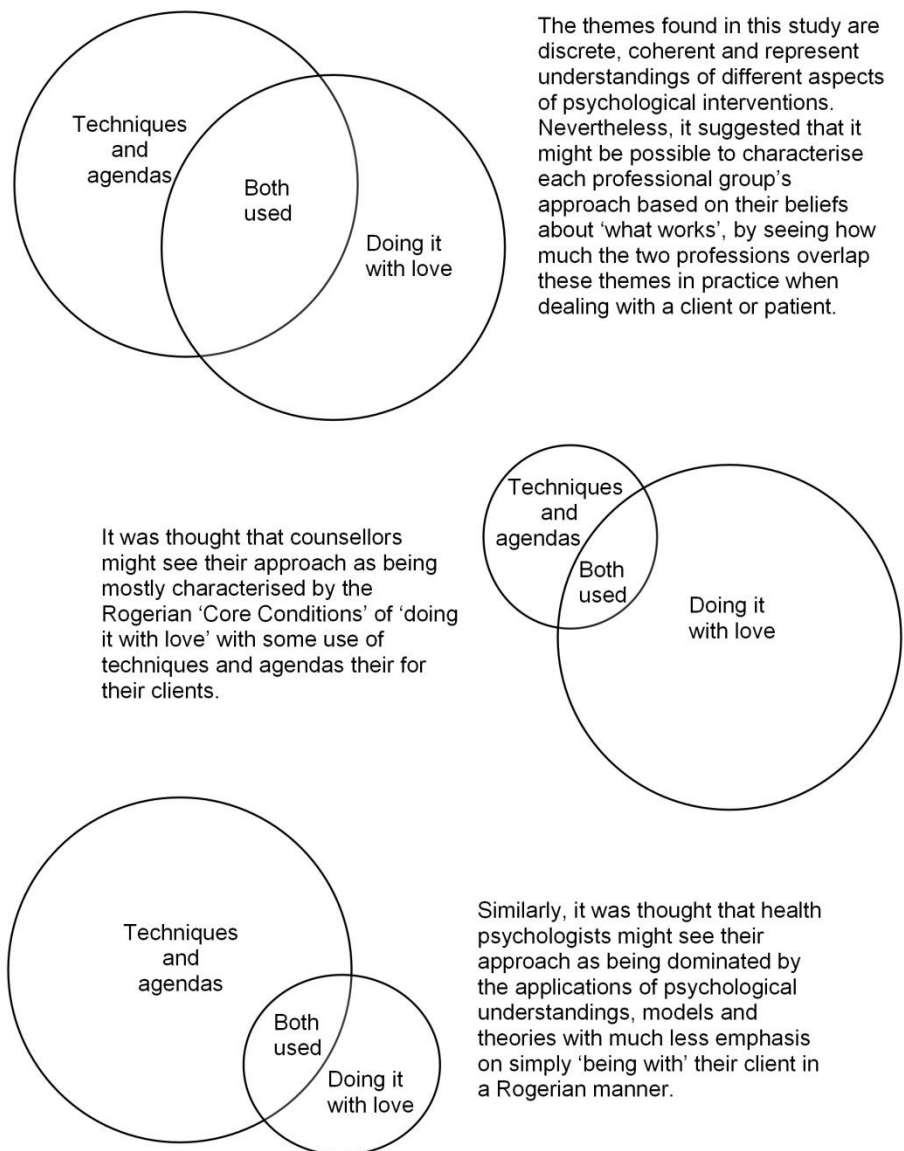


Figure 4: Exploring the interviews of practitioners from both psychological trainings, however, indicated that both professionals would vary in their approach to different clients as to what they believed would be best for them and this could not be characterised by such a simplistic two-dimensional representation as shown here. Health psychologists and counsellors both discussed clients where techniques, such as education about a condition or bibliotherapy was mainly used while at another time, possibly with the same client, a subtle and changing application of therapeutic techniques and skills might characterise the client session where Rogerian 'Core Conditions', such as listening with obvious acceptance and respect, would be the dominant procedure. Accordingly, while it may be tempting to attempt to characterise the responses to the interviews as reflecting dominant professional approaches of being mainly psychological technique driven or dominantly Rogerian, there was insufficient data to support this.

Appendix - Response to feedback request from participants

- 1 "What a lot of work. You have made it look simple, that is the difficult bit!" 2 C
- 2 "This is fascinating, I love the clarity with which you have demonstrated your findings. I realised on reading it that it fits so clearly with the occupational psychologist who I supervise 4 years of PC supervision have made a huge difference to how she works (her words recently) she sees a person less a set of symptoms to be fixed than she did before." 7 C
- 3 "Thank you for sending me the draft of the results from your research study with practitioners. You have some very interesting findings which you have described very clearly. I particularly like the contrast of "throwing everything at it" versus "love & acceptance.

Having read your results I think my reflection on it would be that health psychology is good at research and evaluation of interventions, but when it was set up as a discipline, no-one really thought through the practical training that would be needed for those health psychologists who might want to work therapeutically with clients in group or 1:1 settings. This is compounded by health psychology being taught by academic researchers who on the whole have no experience at working therapeutically as health psychologists with clients. It also doesn't help that the NHS itself doesn't really recognise health psychologists, further confounded by the fact that some clinical psychologists have taken to calling themselves clinical health psychologists. I worry that sometimes that health psychology is "sold" to students in a way that encourages them to believe that they will be able to find work at the end of their MSc training, when in fact that is highly unlikely to be the case. Hmmm.
- 4 A really interesting research project. I'm very glad I took part." 3 HP
- 5 "I have enjoyed reading the summary of your dissertation. I broadly feel my my views are represented. I forgot to say at the time that I feel Health Psychologists would benefit from being in therapy themselves. I feel it was the most important part of my training as a therapist. If you don't know how it feels to be on the other side it will make the empathy side more difficult." 9 C

(NB Identifiers link transcript number to profession to assist with matching, as in the main text)

Appendix – Transcripts of interviews

Transcripts are orthographic transcriptions of the interview as suggested by personal correspondence with Victoria Clarke (of Braun and Clarke 2008) in 2010. In the texts that follow, 'I' stands for the interviewer and 'R' stands for the respondent. The transcript begins after the setting-up of the recorder and it being switched on. Most acknowledgement sounds (bubbles) from the Interviewer and Respondent were omitted, unless they were thought to rise above background acknowledgement to foreground major acknowledgement or represented significant verbalisations that might be useful for analysis. Commas represent short pauses and a line of dots represents longer pauses within paragraphs or truncated speech when the sentence is uncompleted. Repeated words with no pause are left without a comma. No correction of speech is made to give a more grammatical record of language or dialect used and spelling is the responsibility of the author. Brackets indicate something happening that is not directly verbalised or led to some verbalisation that might not otherwise be understood from the transcript, such as (cat entered room) or (indicates a descriptive movement). Bubbles, coughs and laughs are also given in brackets (laughs) where they are thought to be sufficiently intrusive or expressive. Names of individuals have been substituted for confidentiality or deleted where it does not alter the sense.

Beginning of transcript Participant 1 HP

- I The main thing is ... if you can think of a client or some clients you have met who ..ehh.. amongst all their different issues, obviously have a physiological condition of a long-term nature ... that has been the principal reason you have been to see them ... and ... really, more than anything else, I'm interested in what condition of a long-term nature that's been the principle reason you've been to see them. And ,ehm, really more than anything else is I'm interested in what .. your best understanding of the origins of that particular condition, in that how you envisage it and where it might have come from
- R Actually, with dementia it is quite interesting
- I Yes exactly
- R Because, some people are absolutely convinced they've done something bad in their childhood. That is why they've got dementia. For other people there just like, well It's my fault you know I've smoked all my life, I haven't exercised, I've eaten chips every day, so I've got it. And other people it is just like, well it's just one of them things, which actually it is, I mean there's stuff out there that says there is a genetic link, there's stuff out there that says it's lifestyle, but I've known perfectly fit patients that have done everything all their lives and yet they've still ended up with the disease. And I think the dementia patients are out there rationalising the disease for themselves. But it's also realising that life's not over,
- I No absolutely not ...
- R you've got a condition but you're not dead.

I Mhmm Yup

R So it's learning to adapt and to live with that disease.

I Uhuh, Do you have your own ideas what it's about, or ...

R Ehm .. No I think it is just one of those things ...

I Yeah

R I. I think if you spend your whole life being absolutely obsessed by everything you're going to do you're not going to enjoy life

I Yeah

R If you're a fitness freak and that's what you enjoy doing, great, but it doesn't mean that you're not going to get some disease (laughs)

I Ummm

R And maybe for people that are actually, overly-healthy, it's harder for them to rationalise when they get a disease, but for those people who have just sailed along in life, enjoyed it, and got the disease, actually adapting to it might be a bit easier.

I And is that what you've been finding?

R Yeah, I think is actually.

I Umhmm

R Yeah, I do. I, I think people who are more educated are actually finding it harder to adapt. A lot of the research says, use it or lose it,

I Yes

R So they've used it all their lives. And actually they're going to lose it.

I Yes

R Where all the people that've, you know, just worked hard all their lives, they can rationalise that fine.

I So, they just live with the changes ..? So, What I'm really interested is, (coughs) .. em Have you any idea ... 'Cos one of the things about a lot of these long-term physiological conditions is that some things tend to maintain it in a ... continuous state or don't hold it back, do you have any feelings as to what works particularly well ...

R Sighs

I .. in your area or where you work in most?

R I think that's a bit of a lottery, because there are four cognitive enhancers out there.

I Mhmm

R They don't work for everybody and I think that's part of the problem. People come in and get the diagnosis; they think it's going to be a magic pill that'll cure it.

I Yeah ..

R Actually, it's not. It is always going to get worse. And for some people that magic pill will hold them.

I Hmm

R For a year, or two or three years, for others it's gonna make no difference. And it depends what stage they will go on that medicine, so if actually they've got the insight to realise that. And I'm a big believer in actually just enjoying life.

I Yeah, yeah ..

R What are the things you've always enjoyed doing and carry on doing them until the day you can't.

I Hhmm

R And it's not necessarily about medical treatment.

I Yes, mhm. I'm interested in your ... what you're ... what you're seeming to be saying is that obviously that people have such an individual way of dealing with the condition

R Yeah, very much so ..

I And how much they're conscious of ... or how they conceptualise what they've got.

R Yes

I Do find any particular variations around that? Is there anything you could generalise? Or is it too individual?

R (Sighs) .. I think it is very individual. And I think that's the thing with dementia. It's the one disease where you are treating everybody as the individual. And you've very much got to listen to their story.

I Yeah

R I think for other conditions, (sighs), there is a sort of path they take.

I Mhmm

R I just don't think that's the case with dementia.

I Right, so there's no one way you could say is general or ...

R (Sigh) No I don't think there is. For some people the diagnosis to death is a year and for others diagnosis to death is twenty years.

I Yeah, hmm

R It's, em, death is always going to be what happens...

I Mhhmm

R Some people don't want to talk about that.

I Yeah

R That's fine.

I Mhmm

R That's fine, they don't need to talk about it.

I Mhm

R It's different from things like diabetes, where you gonna live with that. The whole of your life and you've got to learn to adapt to it.

I Yes

R Diabetes isn't necessarily going to get worse.

I No

R You can manage it.

I mhm

R Dementia is going to get worse and it's going to be horrible (laughs).

I Yes. Mhmm

- R Yeah, And I think people are quite realistic to that .. just they don't want to think about it on diagnosis which is (shrugs)
- I Mhmm, Absolutely..... Do you think there is any particular way that..... for any particular client you have in mind ... although obviously you say that you don't have any typical client as such, but any client you worked with recently, how, where life has changed for them, with the diagnosis?
- R (Laughs) Well... I can think of a whole ...
- I Yes I know it's a silly question at one level, ... but nevertheless, it does ...
- R Yeah, it changes, life will change with a diagnosis of dementia. At some point you will have to stop driving.
- I Yeah
- R Which means your independence is gone, your freedom has gone.
- I Hmm,
- R A lot of people lose just simple things that we take for granted, such as reading a book. It goes.
- I Mhm
- R Because they can't follow that story any more.
- I mhmm
- R I recommend to a lot of people actually going for audio books. You know, they can still get the enjoyment of the story but it doesn't actually mean they've got to remember what happened last time.
- I Yes, OK
- R The story can start again. And I think that's the big thing with dementia, it's not just minor changes you've got to make to your life, big things are gonna change, especially for people living on their own.
- I Yes
- R Yes, it's really difficult. They're not always going to have that freedom living on their own. I can think of a couple of patients that've spend days locked in their porch. You know, it's not until a neighbour's come back from a holiday and they've seen them there, and the crisis happens and that's it, before they know it their freedom's gone and they're in a home.
- I Hmm

R It's quite awful.

I Yes, I appreciate that.

R Yeah,

I Yeah, yes it's really ... particularly difficult (breaks off to rescue recorder from an interested cat and R puts on a light as it has become dark as evening deepens and difficulty in seeing notes)

I What, .. I see how it is for the client... What ... I'm interested in what you feel that your, ... input is, particularly as a health psychologist, what do you feel that your training and experience brings to ...

R I think it's very much about reflecting as to where they are now and where they want to be. But it's also making them realise that it's never going to be the same again, and actually they've got to change and they've got to adapt. I think that's the big thing, and it's listening ...

I Mhmm

R I think that too many people don't listen. To the patient. And, if they want to go off on a tangent, let them go off on a tangent. You know, don't interfere with it (laughs).

I Yeah, Hmm

R You're there as a professional, to listen, to hopefully bounce ideas. And they might not want to do that. They might actually just want to talk at that point. That's fine. You don't have to talk about strategies for change (laughs).

I Yeah.

R That will come at some point, it has to come, but not necessarily in the first couple of times you meet someone.

I Yeah. So, do you think that this is really the point where you simply get to know them?

R Yes

I Where you really listen at this critical point to find out who they really are?

R Definitely, Yeah, let them tell their story. Sometimes you need to chip in to clarify. Sometimes you need to go behind their back and to talk to a carer to clarify. Because actually their story may not be the right one (laughs).

I Laughs, yes.

- R "Yes dear I cook every day" (laughs). She hasn't cooked for three years. She has meals on wheels, but I call it the magic fridge – everything appears (laughs).
- I Yup, Yup, So, there's the difficulty I would imagine particularly, in that there are several physiological conditions that you've said impact on people quite severely, and I can't think of anything quite so dramatic, obviously, as dementia, so in terms of how you're actually meeting your client and working with them, I wonder about strategies for change, how do you envisage what your suggestions might be that will work for them particularly if they have to make sense of what you are suggesting?
- R Sometimes, suggestions are not what they want to hear.
- I OK
- R You know, they like driving. You know, they have to stop driving. You have to sort of say to people at some point you will not be able to carry on driving. And they're quite harsh things that you've got to suggest for change. But they're changes that are gonna happen. You know, they can't stop those changes happening.
- I Hmmm
- R You know you're talking about moving to care homes. That's quite a sensitive area for the family and patient. But it's about quality of life. And they can actually have a better quality of life moving to a care home where the meals do appear every day. You know, the washing gets done. You know, they're safe.
- I mhmm
- R But there are some awful homes out there. And there's no point lying to people. You've got to be careful. Go in, visit that place. Does it smell? Can you understand the staff? And things like that.
- I Hmm. So do you've .. do you then work with certain guidelines? Or with some projects you were working with? I'm interested in, .. the thing you were piloting. What was it you were piloting?
- R It was an MRC funded study, looking at Aricept work. How it was used for behaviour problems. Because in care homes there is a massive issue with behaviour problems, with dementia. But it's not necessarily the person, it's just as you get into the advanced stages of dementia, that's where the behavioural problems, .. start ... and a lot of care homes just think if you shout at people then actually they'll understand you. Well, that doesn't happen with dementia. Cognitively they can't understand you any more. So it's about keeping people busy.

- I Mhmm
- R So, um, the study ran for two years and there was some positive findings but it was more about implementation behavioural programmes for people rather than the drug having any effect.
- I Right, uhuh
- R So I think there were twelve sites across the UK. It was quite a big study. A lot of money went into it.
- I Yep, yep. So what sort of findings made sense to you? From your own work.
- R (Phew) I've done quite a few different projects and I think the main thing overall is to listen to people's stories. Make any plan you're going to do very individual. Don't generalise people.
- I Right, Mhmm.
- R Hmm. That's the main thing. (Sighs).
- I It would make a lot of sense..... I'm just wondering, particularly with the difficulty with the inevitable cognitive breakdown, presumably it would be very individual with some things. Particularly with a mixture of psychological and motor..., is, um, is there any particular way ... which you feel that a health psychologist can offer is particularly useful, as for clients work through ...
- R Well, as for health psychology, because it's very much about change, um, and I think it can work quite well for dementia, because, for one thing, as the disease gets worse, people do tend to wander,
- I Yes,
- R Because there is, there's a need for them to be doing something to be going somewhere, but they don't know where they're going, and I think it's helping care staff in particular realise that you can't just put someone in a chair and they sit there from the minute they get up to the minute they go to bed again
- I Yes,
- R That actually wandering is a part of not only the disease but a part of life.
- I Hmm, yes
- R You know , not many people do sit down all day. And I think health psychology is particularly good for that because it can help the patient but it can help staff dealing with that patient.

- I Right, uhuh, Do you see your role as very much as working in the social environment for your patients as much for the patients themselves and helping the care staff understand, or ..
- R It depends where you are, when it's in a clinic setting it's very much about the patient and the family. When you're out in the community it's about staff issues as well the patient. And to a certain extent, the family. Because, they might not necessarily want their relative doing what the care staff have planned for them. You know, (laughs).. Any, (laughs) that's happened.
- I I can imagine it would, really, absolutely, they'd have their own memories and wishes for the person.
- R And I think, oh, but especially care staff ... take vegetarians, for instance, well they think they can't remember any more – it doesn't matter. Well, actually, it does! You know, just because they can't remember, it's very crucial.
- I Hmm, absolutely. Well, I'm wondering, so who's the customer then in some respects in terms of the services you offer? Is it as much to the ..?
- R Depends who I'm with, it can be the NHS staff, it can be nursing home staff, can be patients, it might just be the carer.
- I So your role is as much as a facilitator, or, um, an advocate for the patient, I still can't quite get my head around what it is you might be doing.
- R Depends which job I'm doing.
- I Exactly, yes, (laughs) , so in your current job?
- R Ehmm, which one? (laughs). That's the big problem. I've got so many different jobs, that it could be, you know, therapeutic for the patient, it could be training for staff, it could just be a matter of working on a clinical trial, so you've got to collect the data for that trial, it's very split...
- I So if it was for patient – perhaps with a recent patient you have in mind – are there any particular sort of models – or, some of the classical teaching in health psychology that might apply particularly, that you can think of ..?
- R (Sigh) No. Health psychology doesn't really fit with dementia.
- I That's what you've been saying. Yes.
- R You've really got to take it, what you've learned and adapt it for that patient. You can't really fit a model. That's where clinical psychologists fall down because they are obsessed with using the models they've learned to put onto the patients using set tools that don't really work with dementia. I think once you've got your head around that bit, you can use everything you've learned, about being a good listener, about being able to plan for the future..

- I Yeah, mhm
- R But, yeah, you can't really take a model as such and use that (laughs).
- I That's really pretty much what I was hearing,
- R Yeah
- I So, really, in terms of the range of skills that a health psychologist has got then using a good, .. I'm hearing that maybe perhaps a good psychological knowledge is probably as important.
- R Yeah. And not being judgemental. And, yes, some things like goal-setting will work if people are in that early stages. Especially people with MCI, who, they may never convert. That works really well.
- I Yeah, yeah
- R But actually, you're not going to be able to goal-set with a person that's got advanced dementia. Then it's more about making sure that the environment's safe for them.
- I Yeah, it's obvious sense, yeah absolutely ..
- R Really, it's a real difficult one. So I thought if you do this interview, I'll give you some different data (laughs)!
- I Well, it's, what I'm getting is ... pretty unique, whoever I speak to. Which is what I expected in particular. Honestly, I came into this without much ... preconception. Bizarrely, I genuinely didn't know (both laugh). So,.. in terms of thinking about a client, perhaps, in the earlier stages where they're aware of their condition and it hasn't progressed to the point where they're no longer ... too reachable, perhaps, what sort of thing might you feel that in terms of classical health psychology might be most appropriate?
- R I think that's where goal-setting is really important.
- I Yes, it is goal-setting, I remember.
- R Because they, they can plan what they want, over the next year, for example. You know, what they'd still like to maintain doing. I can think of people that their big thing is they still want to be able to walk to the social group they attend every week and walk home. They don't want their partner to take them there and back in case they get lost. You know, it's very much about saying, well what would make you safe, if you maybe bought a mobile phone? And when they go AHGHGH (laughs). What you're saying is well maybe just put your name and phone number in your pocket, if you get lost, then someone can find your home

for you. It's very practical things about their goals for the future and goals for the present.

I Yes. It also sounds as if it's guidelines for living..

R Yeah.

I As much as goals themselves, would that be fair to say?

R Yeah. Because I think now the big thing is about living well with dementia. Not dying from dementia, which actually that's what you're doing. And people know that.

I Hmm

R But it's about saying, Hi baby (greeted cat), It's about saying, well, you know, what're you gonna do. If you want to give up, well, that's your choice, if you want to say no, I don't have the confidence any more, I'm just going to stay in and do everything in company, well that is your choice, and, well, you know, you're never going to stop people doing that.

I Uhuh, yeah (break to rescue recorder from cat)

R He wants to be recorded (laughs)

I I see your cat's got you well trained as all cats do. (laughs) So in terms of the classical, eh.. CBT type ..

R Hate it!

I Yes, I appreciate that. So you feel it's not appropriate at all in your area?

R I think possibly MCI people, but I don't think dementia's right for it. I really don't agree with it, with dementia. Because I think it's getting people to think in the way they can't any more..

I yes, yes

R I actually think it's wrong. I wouldn't use it in dementia. Absolutely no way! No.

I Do you think in some ways it would be, in terms of your own, .. the other aspects of how you assess your clients and patients, em.. what I'm hearing you saying is that it is so individual you seem to have a completely open mind or do you have any pointers you look for?

R Yeah, I look for different areas. So you know, I look at the social, I look at the functional, what can they still do, what's now becoming difficult? And you know, there's is some cognitive element, are they actually understanding the explanations for things, if they're not, well ... you can't phrase things in that way,

you've just got to look at practical issues, em .. yeah. It's a difficult old disease (laughs).

I Yes, it's particularly, and obviously because it's so, as you say, so unique and still the same (unintelligible due to cat interference). In terms of a lot of the general views of dealing with health conditions, is dealing with checking out how people see the world and how they .. what are their assumptions about their own stories about how they go about, and how they deal with health?

R I don't... You just don't really touch upon that intention. Because there are so many practical changes that need to happen. Their own health, per se, isn't an issue. And although you do say to people, you know, you're probably not drinking enough during the day, just try a bit more. If they live on their own, they're never going to remember that. They'll right it down in clinic, they'll have their plan that they go away with, but actually it's not going to happen realistically.

I Mhm

R So I think health changes, you know (laughs) it's very much about practical changes.

I Mhm. How would you define or check up on practical changes?

R Em, basically, when the CPNs would go round to do a home visit make you sure that actually, the gas cooker is now disconnected and they still haven't got that gas cooker with the piles of newspapers sat next to it..

I Yes

R So things like that. Em..

I So that really is your ... the changes you really controlling to some extent are .. is it the environment of the patient?

R The environment.

I But under the control of the visitors rather than the patient themselves, would that be fair to say?

R Yeah, well you have to sometimes take it out of the control of the patient. So many people don't have smoke alarms for instance, and they do need that. Because, I know we all forget and leave things burning on the side .. when you've got a memory problem,.. well it happens every day.

I Yeah

R Not just once a week when you've picked up the phone to someone. You know people go out, they leave the pan on. A lot of people are living in ehm,

..communal, sort of self-contained flats. So it's not only an issue for them, it's an issue for their neighbours.

I Yeah

R I think that's the awful thing. You are taking that control of their life away from them in some respect.

I Hmm. To what extent are they aware of that, do you have any ideas?

R It depends where they're at.

I Exactly, Sorry, It's asking for generalities to the point where it doesn't make a lot of sense

R No, it does depend whether .. At the early stage people can actually say, I haven't got a smoke alarm, that would really be a good idea. But the people ..

I Mhmm (laughter as cat attacks recorder again)

R But for the people, but it's crucial that they have it .. They probably fight it because they have no insight, but that's what's happening and they need it.

I Absolutely so it sounds as if it is very much the .. what you're looking for is .. who is the customer of your services. And it's the bundle of people really. It's as much the social environment around your patients that's.. that you're controlling.

R Yeah, although, yeah, I wouldn't say it was controlling ..

I Sorry, that was the wrong word

R Making it safe, making it safe.

I Mhmm

R I suppose it is controlling 'cos you are saying well this has got to happen sometimes.

I Or, or, seeking ... seeking to make safe, is probably a better way of describing your controlling.

R Yeah, So that people can still live. But safely. (laughs)

I Sorry, I'm being attacked by your cat. That's really very useful .., so I presume ... the cast iron test is how do you know you're being successful? What helps you to find that?

R Oh, when they've not burned down the block of flats. That they're not found dead in there after two weeks of nobody .. noticing ... But when you see them six

months later in clinic. They're still there. They're still living their life. I think once things hit crisis point and they've hospitalised, actually, you've probably failed, because it should never reach that point.

I Um, do you think at some point you can, through your training, you can keep that going as long as possible or do you just think that's a failure when you finally see it?

R Phew..... I think that when people are resistant to services, because there is awful thing about, oh it's the patient's choice, so actually sometimes you can't do things that need to be done

I Yeah.

R And it's actually a failure of the system, not particularly you, because you've spotted that really needs to be done and it hasn't happened because of patient choice and that's hit crisis point. So, yeah, it's a service failure rather than a personal failure.

I Mhm

R Ah, you know, sometimes, maybe, you haven't asked the right questions when you've done that initial assessment ... you know and actually... have they given you the right answer or is it they didn't comprehend what you were saying because of their cognition?

I Yeah, exactly, mhm. Because you won't know until you actually see a result, I presume.

R Yeah. It's always interesting when you see someone in six month's time, whether they've got any recollection of you from six months previous ... you don't expect them to remember your name or anything. But if you sort of say something like, how was your holiday and they go ... "How do you know that?" And you think, OK, they're a bit worse than what I maybe thought they were, or actually that's confirmed that they are worse than I thought they were.

I Yes, mhmm

R But then I've had the opposite when a patients said, "Oh great to see you again Love", Like we've met?? (both laugh) So it happens both ways. (laughs).

I Happens both ways, yes. Quite again, the tricky thing with all of these is that frequently, .. em.. patients or clients will pass through quite quickly, there may be a form with some details on it, just how do you personally know what happens...

R Em, especially with many of them you don't necessarily see someone again, so it might be decided once you've done that initial assessment, they're high risk and they go straight off to a community team, so you'll just be the data gatherer.

Other times you will see them again, you will see them every six months for monitoring of their meds... So, yeah, it's a bit hit and miss.

I So in terms of,.. if you can imagine a patient where it is responding, (coughs) as well as they can do, they still remember who you are, in the early stages, ehm.. is it just as much as you describe, that just simply being there, listening, being attentive, being aware what's happening, would be the whole of your role or would there be more to it than that?

R Yeah, I think that is my .. the main bit of the role is just listening to what they're saying each time and letting them reflect on any changes that might happen, for people in the early stages ... I think that's quite interesting sometimes, because you can sometimes say, "Well when we met last time we said that this is becoming a bit more of an issue", and they might say, "Actually I've done this, this and this and it's not so bad now".

I Yeah, yeah

R And I think that a lot of people in the early stages now are actually computer literate and I think that's a big change. Because when they start, say, "Well it was OK but now I'm finding it a bit more difficult to get on the internet and find my way around", whereas maybe they've relied on that. Because that's how Terry Pratchett first noticed his problems was just working around the keyboard. And I do wonder with that new generation whether that will be one of the big things, because sometimes with subtle changes, you know, just because you've burned a couple of pans in the past month doesn't necessarily mean you've got memory problems.

I Mhmm. Because you remember burning pans in the past?

R Exactly!

I Uhuh, and, uh, yes, it is a tricky one.

R But it is reflecting on what's happened over the past six months.

I So it's very much observational then?

R Yeah, and listening to people. They might have said the tiniest thing, that actually ten minutes ago they said the opposite. And then you go, ooh, hang on a minute, (laughs) which one is it? And if they start to tie themselves up in knots, then you think, right OK they're not too sure either.

I So it's really being aware of discrepancies then, which would have a meaning for you.

R Especially if you talk to someone on the phone, I mean, you get the most classic conversations. And at that point sometimes you have to go, right, is there a relative here that I can phone. Because I'm a bit worried about this situation.

And that's part of experiencing things. When people first start to work with people with dementia I think they take everything they say is gospel.

I Right

R (laughs) Well you've got to say well, it might be, but listen to what they saying. Are they saying the same thing for the whole half an hour or are they changing their tune.

I Mhmm. So you're looking from a range from the normal inconsistencies we've all got into a more extreme position?

R Definitely. And especially when they say, "Well dear well I think it's probably 1945" and you say, yep, OK. And you say, well when were you born and they're like, "Oah, 1939"... you're like .. something's gone wrong here (laughs).

I So is that the kind of test you would do to check for dates and times when they're not ...

R Yeah, the Mini Mental's pretty standard.

I It is pretty much that, right, OK

R So you you would do that pretty much with everybody. Sometimes you wouldn't do it as the Mini Mental, and you would just chuck things in, like I might say to someone, "Could you just sign and date that for me?" As a random sort of thing. And see how they go. Um, the only thing I do regular with people is say, "Here's some coins. If you walk down the shop and went and bought a newspaper for seventy-five pence, what coins would you pick out?" Because a lot of people would say, yep I'm managing my finances absolutely no problem, and then a, a quick test like that you will soon know whether they do recognise money and they can use their money.

I So what range of tests would you use to assess them?

R Oh, blimey! CIBIC's a one I use for a lot of clinical trials. Mini Mental's quite standard, uh .. for clinic assessments, BNT trials A and B, ehm.. clock drawing, ray figure, Hopkins, digits, story, .. I think that's it. Yes.

I Quite a battery of tests...

R Quite a battery of tests. Which takes somewhere between half an hour for MCI and up to an hour for most of them. But obviously you wouldn't necessarily do all of it. If people are struggling, then you'd stop. For trials, well, ... I tend to be CIBIC rated, so it's CIBIC. If I'm doing the neurocyte rating then it tends to be MTB or with Mini Mental sometimes ADAS. And then there's a whole range of ADL scales that you'd use. Some are dementia-specific and some are more general, some are quality of life one, EQ5b is used a lot these days. Good scale..

- I Mhmm, Yeah. Well that's certainly quite a battery of things. I think, really, in terms of the final major thing in terms of your training as a health psychologist, is there any particular thing that makes health psychology of particular advantage to you?
- R I haven't trained in any other way, so I wouldn't know, to be honest!
- I Uhuh, it's a guess I have to say it's whether you feel there is a particular thing that health psychology can do?
- R Well, considering I hate clinical psychologists ...
- I Well that's what I've been thinking, hearing that clinical psychology is?
- R I think that health psychology doesn't shove people in boxes. I think it very much trains you to listen. And I think it's very much about building rapport and listening to people.
- I Mhmmm
- R And taking it from there. While I think clinical psychology is about well, right, lets do every test under the sun and shove them in a box. And I think that's the difference, health psychology isn't particularly about testing, it's about interviewing people and listening to people and developing strategies from that.
- I Mhmm
- R Well, that's my view of it.
- I Yeah, I appreciate that..
- R But, it doesn't, it doesn't work with all conditions. With dementia I've had to completely re-think what I've learned (laughs).
- I In terms of the other ... ehm, yeah, the other therapies therapies that are around, .. em, counselling, for example, or the other practitioners, have you ever noticed how you might be different from, say.. a counselling .. trained person? Or, what sort of other trained specialisms have you come across in your normal work?
- R Eh, we're quite multi-disciplinary really. I think health psychology's quite aligned with the OTs really. I think it's very much about planning for the future and living well. Yeah, I think it's more of a practical application of psychology. Whereas I don't think some of the others ... yeah ... we haven't got any counsellors on the team at all ... I wonder where we'd refer to for that ... And I think for ... Oh actually, saying that, we have got bereavement counselling. And that's always an interesting one, because the bereavement could actually be happening while the person's still alive. Which is different to other diseases, well while saying that

I suppose cancers in the end stages people might be in it for quite a while as the bereavement's again happening while they're still alive.

I A lot of chronic conditions have significant changes as they progress. Which people are aware of and they have to adapt themselves to. I've got no doubt that dementia has the extra unfortunate dimension that the .. patient is going to become less and less aware to some extent as to what is happening although completely aware of other aspects.

R But I think the other thing is that sometimes you've suddenly got the person back for an hour and the patient's ... the carer phones you up and say, "They're back, they're back" and you're sort of like, they are back now, but they'll go again. And they phone you back two days later, "They're back to normal" (laughs). And it's awful, 'cos they're constantly losing their loved one.

I Yes, yes,

R And I suppose Health Psychology gives you that chance to reflect with people what they're talking about.

I Yes. So you do as much with the carers and family as with the direct patient themselves?

R Yes, I think you do in the initial assessment. And definitely when I'm working with trials I do as much with the carers as I do with the patients. And in some trials I don't see the patient at all, I'm only working with carers, which is kind of different (laughs).

I And the final thing really is, is there any way in which ... as health psychology is obviously a general training in many ways. Are any things, perhaps you could think of that health psychology could have ... perhaps prepared you better for this particular type of work?

R Yeah. Well I do think that health eh .. well it depends. Most health psychologists become academics. Not many go to work with patients.

I Yes

R But I do think that there needs to be an element in that training of patient contact, because I think the professional module... is just .. It's not enough about patient contact. You've got your role-plays but that's not the same as thinking on your feet when you've got a patient in front of you. But that, but I, you know, I think that's... just health psychology. It's only clinical really that's got that .. hands-on training.

I Mhmm

R But it depends whether health psychology's going to stay as mainly academic.

- I Mhmm. What you might have noticed or maybe not, as its only just come in, they've changed the ... they're changing the Regs.
- R Right
- I And so, It's exactly the kind of area you're talking about. I think there's been an appreciation of, in terms in the general field of implementations for health psychologists aren't ... well enough trained at the basic level, although acknowledging that a huge amount of training has to go on forever. That's an interesting one.
- R Yeah. 'Cos I don't know with the D Health whether you get patient contact.
- I Only if that's the route you choose to go down. Which is the route that I'm going down.
- R Yeah, which is, yeah. And I think that's fine, cos I think that most people are going to be in academia, they're going to be in public health roles. You know, they don't necessarily need that patient contact. But I think that sometimes, it's useful to have it to realise how theory doesn't relate to practice. You know, the two things don't correlate (laughs)
- I No, I appreciate that ..
- R You've got to adapt it. Yeah. It'll be interesting to see what happens really.
- I Do you really think that the individual ... person skills, using the term loosely, or properly, will become more important or do you think that is trainable ... aspect of your work, the patient contact?
- R (sigh) I'm not sure it's trainable. I think it's experience.
- I Yeah
- R I think you can train people to.. know how to listen and do the role play and get people to shut up so they listen, but I don't think until you're out there that you realise how difficult it is (laughs).
- I Yeah, absolutely concentrated.
- R Yeah,
- I Well, thank so very much that's been really very kind of you it's been very useful indeed.
- R If there's anything that doesn't make sense, then just email me.
- I Yes, it really makes an awful lot of sense, I very much appreciate that, it's a particularly... fascinating and difficult area you're working in.

R Yeah ... yeah, there's no one way ..

I No ..

End of transcript 1

Beginning of transcript Participant 2 C

I But to repeat, remind you what this is all about this is a piece of research to study therapists' perceptions of how they think therapeutic work helps clients particularly with quite common chronic conditions such as asthma and heart conditions or whatever, and while obviously, sadly while we age, we all begin to develop certain levels of chronic conditions they're not necessarily central to us but when they do really affect people's lives in one way and another or they have to accommodate themselves or change their lifestyles then that's the kind of work where mostly therapy can be useful. So, em, you said you have a client in mind.

R Yes

I ..without obviously giving me details about the, that could be too personal for the client, em, what was the condition that .. would you be able to tell me the nature of the condition the client had ..

R Well..

I or at least give me a hint about it ...

R The client originally came to see me with eh, bereavement issues

I OK

R But it became apparent that there was actually a long-standing physical condition as well, and I started to address that. And that was quite interesting because the long-standing physical condition meant that she had extremely bad headaches

I mhmm, yes

R and such pain in the jaw that at times her dentist refused to treat her.

I Ow, yeah

R And on one, and on one occasion when she came in she said her head was so bad that she was, you know she has a whole raft of prescription painkillers

I Mhmm, Ok, yeah.

.. that she used in varied orders and whatever. And I knew she'd done yoga and I asked her to find some space in her body that wasn't tense. So she found ... I

mean looked at me as if I was bit yaya ... but never mind, looked, she said "yeah", and I said now just very quietly, think about that area of space, and I don't want to know how you do it, it doesn't matter how you do it, but think just that space into the seat of your headache.

I Mhmm

R And a few minutes later, she looked at me and said it's gone.

I Hmm

R And since then, during severe headaches, she has been using that technique and she has lowered her intake of painkillers.

I Marvellous, that's good

R What I would like to see is for her to look at her stress levels earlier, which is what, something we're working on now along with the bereavement issues that are ongoing. It's really interesting looking at the stress level of bereavement that's to do with anniversaries and so on. She hadn't realised that anniversaries triggered the grief as well .. and there were good anniversaries as well as bad anniversaries. And that has helped her as well, because she has now learned to plan her life to give her some space just prior to an anniversary, so she can think that it's coming and ..

I Right

R I mean she's fortunate in as much she's, is to an extent in charge of her diary.

I OK, that's good

R So she's learned to ..

I Hmm

R .. cope slightly better with stress.

I Hmm, quite astonishing

R Hmm, I think so, uh, but, uh, I know, as I said, I had one client in mind, and it irritates me no end when you get clients who you know you can help in a similar way, but, eh, haven't got the skill set, because they haven't got some yoga or anything and you can't start at the beginning. After all you know a lot of my clients have short, six, eight, ten weeks clients, you can't do that sort of change where you're talking of finding some space in your body or moment of relaxation. I mean I have worked for two years with somebody who has a long long term post traumatic stress, she's coming up to retirement age, this is childhood, and she will not ... you know she will not engage.

- I Yes
- R There are certain things she has done and then, “Oh yes it helps. Oh it doesn’t help any more” but then she won’t keep doing it, so..em.. And then, she slipped down the slope again, I haven’t seen her for some time.
- I Yes, that’s very sad when you see that.
- R Yes. You know I am convinced that where there are tools, as you know, that are very simple, that can be used to engage people to control ... stress and all sorts of things, but for me there is also is something about helping people to recognise it before it gets bad.
- I Hmm. So it’s very much the early warning as part of the training as much as anything else.
- R Yes. And also what, what is their own pattern about stressing themselves.
- I Yes
- R Because this person’s stressed, that I’m just telling you about, she could actually .. When I told her or suggested to her that it was stress, and I told her about how to track it back. She said “you’re absolutely right, so I’m, I’m in control” of, of tracking, tracking the stress. And said “I’m creating it”, and it’s like .. But some people are addicted to the stress as well.
- I Yeah, mhmm (noise of door opening and dog entering. Laughs) It’s alright
- R (R removes dog from room) Yeah, so ..
- I Hmm. That’s good. So what with this first client you mentioned, uhm, (dog returns to room, followed by cat, causing R to be distracted) Uh, (laughs) As if the animals are definitely coming in two by two now. When, yet again without going into details that are too personal to the client, what, what do you think was the origin of her condition in terms of its physiology as much as ..
- R Oh, I’m, I’m sure that her’s go, also’s going back to childhood
- I Right, OK
- R Um, There is a history of .. uh .. alcoholism .. uh .. violence .. um .. financial deprivation ..
- I Right, uhuh
- R Em .. And of her siblings .. She’s is the only one who’s radically changed her financial status. Her financials and I would have said probably her emotional status completely.

- I So she has been, made very strong moves in the way that perhaps her other family hasn't ...
- R Very proactive. Yes, and I mean.. yes and I mean, she's has striven. Really striven. Since she's ... In fact is that quite the right word? Past .. past of striving? She's really striven, to a huge extent, to change the way she is.
- I Yeah
- R And, it's quite interesting, because I think, well I know she's on the addiction spectrum. And she knows she's on the addiction spectrum. And it's like looking at the addiction striving as well.
- I Ok, mmmm, yeah
- R Which is very stressful (laughs)
- I Oh, absolutely, yes, absolutely. So I noticed when you were doing it (makes shaking tight arm movement) you were giving a .. quite a ..(demonstrates tight arm movement by R) was that hers ..em tension you were indicating or was that just indicating the nature of the... describing what you were talking about?
- R No it's mine, em, showing hers. But she usually sits extremely still.
- I I just wondered whether you were describing that
- R No, no. It's how I experienced it. And I'm a great one for using my hands and my body.
- I Yes, yeah, absolutely, yeah
- R Actually most clients aren't.
- I OK?
- R I, I don't know. I don't know whether it's 'cos I do so much they (laughs) they sit very still (laughs)
- I It seems very natural, so I, I can imagine that one, yeah. (Laughs as dog re-enters room.) Oh, someone definitely wants some attention here. (Speaking of the dog. Sound of door closing). You were talking about, the striving perhaps, or you were hinting that at least the pattern or maybe some addictive sense of the striving kept her in that position.
- R Yes.
- I Would you say this ...
- R The, Because of it's the holding she has in her jaw.

- I Right, OK
- R The, I can actually see the flexing in, in the muscles behind her jaw. Um, and I don't know how you can explain ... (shrugs) seeing the tension in the, in the the (indicates jaw behind ears with hands) ... I should know them all, the ...
- I The muscles, the various muscles..?
- R In the jaw. And um, the, the actual centre of her pain is .. you know, the nerve input. (indicates part of the head) At ..
- I Very much at the back of the skull
- R Back of the skull..uhuh. And that I find that really interesting. But, (sighs) I think having given her the key ... of being able to physically unlock the worst of the tension .. the last time I saw her, ..you ... I don't check every time on the degree of headache or jaw ache, because as (sighs) I like her to tell me a bit where she is before I just quietly slip the question in.
- I Yes, of course, you can't really probe too much..
- R Well, (sighs) Because ... I always have this issue about what are people come to see me for?
- I Exactly, hmm
- R I ...If, If ... If she had come to see me, quotes "to cope with stress", it would have been different. But it is a focus, now, of our work all the time
- I That's very interesting, yeah
- R Because, eh, I feel it is at the key of her life. Whether she ... wishes to continue to be highly stressed or whether there's more to life about the other things she has in her life. But because they are not "on the path to achievement" get cast aside. So we're looking at what get brought it about her, her .. her friendships, and her relationships with men and women and .. and .. and the other things that she's interested in as well as her work and her, uh, other business interests. And just trying to keep looking at how many ... how many plates do you want to spin and how fast do you want them to go.
- I Yes, yes, uhuh
- R Or, do you want them set out on the table, not spinning. And looking at how you can make a balanced meal of your life instead of spinning plates.
- I Mhmm, mhmm. So d'you think that you ..
- R And learning to say "No". To yourself, as much as to other people.

I Right. Do you think that what you're .. might be seeing here is basic character or do you think this is a series of skills that, you're client has learned over time to deal with, perhaps her past and her present difficulties?

R I think she's always done it like that.

I Yes, uhuh.

R And, uh, whether it, whether it's a character trait or attribute, it has brought her considerable success. Not, not to be laughed at, she said grinning. I mean her her actual achievements are immense.

I Exactly, and this is where .. what I'm interested in with a lot of physical conditions of .. is that physical conditions very rarely stand just on their own.

R Yeah.

I I'm sure they probably do somewhere but I've never come across it (laughs). It's where someone has a particular pattern of behaviour that works extremely well for them in very important aspects of their lives. But it causes physical problems which suggests is due to stress. Often the therapist is left in a difficulty that the thing or the pattern that maintains her position also maintains her condition. And that's a real dilemma for many clients.

R Well, I don't know that you know that I'm trained in cognitive analytic therapy, and that of course looks at somebody's pattern and how they can change it. So, even if I'm not using cognitive analytic therapy, it certainly doesn't ..it, it takes a lot of effort on behalf of the therapist, but I'm always looking at skills from it. And you see, you nearly always however one has learnt to do something from childhood you carry the pattern with you, until your life doesn't work any more and it's, you don't necessarily realise until somebody has a good go at you, that actually, it's your coping strategy that's causing you the problem and if you can look at the problem with adult eyes instead of childhood eyes, that difference matters. And so in a different way yes I do that with every client, even people who come and see me for very short times, and that's how I work. But it's my own personal interest in body work that make me notice how people carry their stress. And these things like headaches and all these things, I mean, I used to have them, and I don't have them any more, working with my body and through touching and things.

I Yeah, Mhmm. One of the things I'm interested in particularly with this piece of research, is the substantial overlap between counselling which is a huge field of many many different, multiply different ways of working, health psychology which is an emerging field which is still finding its way to some extent and not quite sure in which direction it will go, it's also coming from an academic bias into practitioner work more and more as time goes by, and it's simply using the best of what it seen around and hasn't developed a particular set of procedures that you could see were uniquely theirs, but what I notice very much from when you

were talking that the kind of work you were doing could as equally be done by a health psychologist as a counsellor .. from a cognitive analytical approach

R Well, yes, The, the work I do ... could be done ..I think anyone.. Ehm, I mean I spent a small fortune on my training .. but that also has been the key to myself, and addressing my own issues carried through since the year dot. What, I don't know where to go with this one because ... the work I do and the way I work, doesn't fit, 'counsellor' and it doesn't fit the word anything like that. I think the key is to understand how people .. and I'm talking about people as a series of individuals, not en masse, how we've all developed. The more people I see, the more I think, well actually you don't need to be trained to be a counsellor, you don't need to be trained to be anything, what people do need to be trained in is a degree of emotional intelligence, being able to listen. Because, I think the prime thing really, is to be able to be witnessed. And, if I get onto my political hobby-horse, I actually think if we brought more listening skills into schools, and amongst young men, I don't think we'd have so much violence in schools. I think a lot of these problems could be ironed out many many years before they become a problem. And I'm not necessarily sure we need school counsellors, but I think we need in-school listeners, where children can have some of the problems ironed out. We have so many of .. unitary families, where it's mum and child, where there's not enough room for the child to be held by anyone else other than mum. I don't know how a lot of these single parents do it, I couldn't do it. I couldn't have been a single parent. But to go back to what we were on, I do think it's a thing of listening skills, and for me, how I've had to access The solution to my problem has been through a form of body-work and learning how to control my stress, and because I've done so much work on that, then I can recognise it in other people, and say Oh, what about this, and, you know, being able to watch that particular client I'm talking about, and realising that .. It's very difficult to explain how there's a little subtle change in the chin texture... or, I'm not even sure that it's texture, the way she holds, underneath her chin..

I I think that what I'm guessing, in my way of understanding is that our ways of communicating with one other, are people who are really skilled in ways I would say good at listening in the much broader sense that just hearing words..

R It's body listening, body awareness,

I It's a whole body observation with understanding

R And watching for tension ..

I And you're noticing these muscle changes, or skin movements perhaps ..

R Yes, because, for about ten, twelve years now, I've been very interested in the work of Stanley Kellerman .. d'you know his work?

I Not intensely, but I certainly know a bit about it ..

- R Yeah, but ..twice a year I go to a day and a half workshop and lecture in Southampton, which is run by one of his .. closest associates, who comes over from Germany, and I've done this for .. (bubbles) 8 .. A very great simplification is the 'the How' exercise, so how .. how.. do you do any particular thing. How do you ask for something, well, I found that when I was asked how do I reach out to ask for something ... I don't! This is part of my wound that my reaching out is impeded. So the focus for many years has been how to reach out, so someone who uses her hands quite a lot as you may have noticed, what you won't have noticed, is that my hand movement.. as I'm sitting at the moment.. isn't extending beyond my knee, so that they're retained within my body space.. so how to reach out? You know, for me that's a big thing, to reach out beyond my body space, and so I watch people's movements quite acutely, but I find that when you're sitting one-to-one with a client, I'm quite restricted.
- I Exactly, and there's people's expectations of how to behave and how you expect people to expect and so on..
- R Yes, so only few minutes I have as somebody walks down ... the corridor in front of me, and how they walk down the steps when they leave, little things, but that's often an indication to me, to just where they're holding it.
- I Exactly, but what I'm hearing and what my little understanding of that kind of work is, what psychologists probably crudely describes as behaviour, because the how is how we go about things, how we move, how we present ourselves..
- R But that's why Stanley calls it formative psychology.. it is how you form your movements, it's actually .. it is, his work is how do you sit. You know, somebody who's depressed (mimics stooped posture)..
- I Mhmm, obviously..
- R Yeah, but you see, there's a huge difference between there and there, and actually, you can't expect anyone to go full throat from here.
- I Yes. A very sort of collapsed posture to an outward looking one ..
- R Yes, collapsed is one of his key words. So you get someone to put their fingers just here, just underneath the collar-bone, the clavicle, and what does it feel like if you just, straighten just a little bit .. and by straightening there, an infinitesimal, I mean really a tiny, the tiniest body movement, but it means that the head moves, and the neck moves and that actually alters the level of depression as well,
- I Yet again, it's one of the lovely ..beliefs that simple physical exercise, or movement, or wider or broader movements will do more perhaps than most medications ..
- R Yes, but you see again .. if it's done ..this is exercise ...God – isn't that boring (moves from collapsed position to a more comfortable one) .. if you can realise that you can be in charge of your own experience of your depression .. (mimics

movement) I'm totally depressed, I'm not quite so depressed, shoulders back a bit more, I began to raise my head a bit more .. and just by realising that by altering the curvature of the shoulders .. and as a result the straightening of the neck, and as a result, the changing of the eye level .. but it's not .. yes, I will .. ask clients if they will do an exercise to help them with boundary work, because also, sorry, I'll just skip backwards .. the client I said who recently dropped out, I worked with for two years .. I actually found an exercise for her related to her childhood, that completely changed her experience of where she was and enabled her to cope. But she would not do it .. regularly, because, I think the change was too frightening, because actually she doesn't want.. part of her doesn't want to change. Because it would involve all sorts of things, including facing up to the fact that she can't afford to live .. where she does live. She wants to move and doesn't want to move and all that ambivalence. And she would carefully destructure the exercise and became more ambivalent and less focused.

I Yes, OK Uhuh...

R Because too much, that that too much change was too frightening ..

I So she was into internal discomfort ..

R Yes, yes, and knowing that she would have to make a decision. And that's why she will go back to collapse .. because then people will come and rescue her. She doesn't have to do anything.

I So what I'm getting is a huge amount of .. the original client with headaches, to the one that is reluctant to .. using the term extremely crudely and probably unkindly, do the homework ..

R But then most clients don't want to do homework ..

I No and I can remember.. we can all relate to that one (laughs).

R Me most of all (laughs)

I But what's particularly interesting, I think, coming from a health psychological viewpoint, is how much of this is physical as much as emotional and mental ..

R Absolutely. And you see I also think that if you have ... that's also why I think it would be a good thing if you could engage with children, have a way, I mean, of .. at school children being able to access this kind of work so that they can become in charge of their own bodies at the same time.

I One of the things that I found fascinating coming from a therapeutic training into health psychology was that health psychology, unlike other psychologies, was very much interested in a holistic approach, however, being psychology, we have to use hideous language, 'biopsychosocial', but that's as holistic as one can be. Um, whereas, it's sometimes truly said of the other psychologies, they tend to be

more compartmentalised, in that they remain more in the mental field or purely the physical field ..

R Yeah, and you see .. But I also think that applies to medical science as well. You know, they look at the body and that's it. And if there's something wrong with 'the mind', you go to the mental health team. But the combina ... the whole .. the taking in of all aspects is unusual. I think that one medical model that's different is the treatment of cancer. Where they seem to bring in every therapy. My husband's recently had heart problems .. um, I went to most of the rehab classes with him .. and there was a fleeting visit from a psychologist .. a fleeting visit ..and it made .. when he said what he said, I suddenly thought, now if they brought in counselling and therapy of that kind early in the diagnosis of heart problems, an awful lot of people would view and cope with the treatment and post-operative traumas, very very differently.

I Yes, this was a health psychologist, wasn't it, if I remember?

R Well, Dave said he was a health psychologist, I don't think he is, I think he's, I think he's sorry, an ordinary clinical psychologist.

I Clinical and health can straddle both ..

R I did make some inquiries, and I think he actually .. he comes from the cancer department, the oncology department. But what interested me is that, with Pete and I are both therapists and in the class he would .. gravitate to us and I realised it was those people who had nothing wrong with them, who'd never smoked, never drunk, always exercised, who had a life-threatening heart condition, were the angriest. Because of course the one thing that everyone loses, forgets about, you cannot change your genetics. One bloke would have been dead had his GP not called him in and said we've got to give you your checks, look at your medical history. You have got to be checked. And woops, he found himself in hospital, major surgery, and I noticed the difference this time in Dave's major surgery procedure, nowadays it's called that (laughs), you nowadays you can undergo huge major invasive surgery.. But you're out in two days and you're back into your normal life, having been invaded – in huge ways and often you're awake, because you have to, can watch it on a screen, and you have to tell them how it's feeling, and if the talking side of the therapy was as skilfully employed as the medical side of the treatment, how different that would be for everybody. And I think that until there can be some..modification of the medical model, there is going to be, .. there are going to be people walking around who are severely traumatised.

I Right, uhuh. so it's really somewhat, .. just using the medical model merely in terms of the procedures they use ..

R Yes, the actual medical model .. Here you are, we shoved a tube up your leg, we've walked round your heart, we've left a small body in your heart, we've brought down the tube, you're fine now, just go and do your remedial classes and back to work! Ba-boom! That's the medical model.

- I They forget, perhaps, there's an imagination and a humanity attached to all this ..
- R The realisation, that without this ehm visit, possibly overnight, but often as day surgery, but certainly it's a day or two, I might be dead ... or I might be dead soon. And most people don't expect to being dead when this happens, and it's traumatising.
- I You're certainly describing a huge .. lack of appreciation .. from the medical side.
- R Mhmm. And you see .. Then, I had another client who had a vaginal hysterectomy,... and she was ... quite sort of ambivalent.. And when I said, well, when you think... I said about it ..put it in another way ..did you feel you'd been invaded, in a personal and private place. And she said, I've thought about it like that though... started talking about it as a form of medical rape, and then, how much consent did she give, and did she realise what was going to happen, I mean she hadn't thought about the emotional side of having a vaginal hysterectomy.
- I Well, medically, one can understand how clever, and non-invasive in a scalpel sense, in an emotional sense ..
- R Non-invasive, yes, and so talking about it with her in a .. a sort of ..I mean .. she is only in her early forties, and she's never had a surgical procedure of any kind, her children were naturally born, so she hasn't had, she hasn't been cut, in any way, she's of a generation away from if when having a hysterectomy, somebody cut you.
- I So no scars and stitches and so on ..
- R Yes, and apart from the muscle damage, you know you expect it to go like that, and when somebody says, oh if do it vaginally, then there's no damage, Oh lovely! How nice! But, nobody seems to talk to people in my experience of anyone I've seen, whether they're clients or friends or relatives, about what I would call the emotional damage and it's not even a consideration. Because all that matters is the body and the time it takes to you to 'get better'. But actually if you've had a hysterectomy and you're meant to feel better and you don't, because you actually feel as if you've been raped, but you don't realise what you're feeling, that's a conundrum for you, I don't feel as better as I should, and then there's all these judgements going on about why don't I feel better?
- R Any surgery that removes a part of the body has a potential for an element of loss at the very least .. (coughs)
- I And you see, this client, who I've been talking about with the headaches, is due to have .. My mind boggles when I think about it ..but I learn a lot from my clients, one of these procedures when they put a camera in through the throat and through the vaginal passage, and you know, so I did talk to her about how would it feel? And, you know, so we started, we started with a discomfort level,

but then also then I made it a bit more personal about the invasion. She said, well, I would never have thought about it. Well possibly she would never have thought about it, 'cos she's one of these people who just gets on with it, but I don't know... but .. but she did go in for her surgery or whatever they call it now, investigatory procedure, with preparation. I haven't seen her since, I'm not due to see her until, for a couple of weeks time, but I find it very interesting that having talked to her she can prepare herself, psychologically, for the invasion.

R There's a huge amount of work, as I'm sure you know, in preparation for surgery and preparation for any procedures ..

I Yes, but I'm not sure it's necessarily done now ..

R Yes it's not, it's done rarely now ..

I And I think that's a great loss, possibly that's where health psychology can come in ..you know ..

R What I was interested in, I had my list of questions and you've beautifully covered most of them, which is ideal, I'll just double-check I've not missed any critical points in this one .. Yes, I think one of the key points that did interest me was what was happening or what you imagined was happening in how the client's body's feelings and behaviour, and you described that beautifully. One of the tricky ones, I think during my own training, how do we know when we've been successful, how do you know when it's worked, the work that you do?

R In this particular client we've been talking about throughout, I knew that it's worked because she's told me.

I Exactly. And this is such an obvious beautiful measure of success.

R Ehm, and we've been actually been able to work with that and other things, and we even jokingly laugh that we have a mutual admiration society because I really admire her, how she's tackled her life and got it. ...she admires the way I help her in the things to do with the headache and this and that and name other things. I'm a very naming therapist, and

I What do you mean by that, for example, to make sure that I understand it correctly,

R Well, you know, because of the cognitive analytic therapy training, where you name roles, for instance, somebody... I'll do a very simple example, for somebody who is being bullied, they nearly always end up as being a bully themselves, so those .. those are what are called .. that's a reciprocal role ...you do it to someone else and someone does it to you .. and you usually end up doing it to yourself, particularly where it's perhaps, controlling to controlled. And so I will name people's roles to them. People who I work with slightly longer, we'll get a name going for a particular pattern of their behaviour ...

- I So for example with a headache, how might you ..I wondered if ..
- R With her it's not suitable, She's, no, that's completely bald, you don't need to name that, she has the headache, but she has the holding in the jaw, because that's the way she is, it would be entirely inappropriate.. you know, where there are inner child issues, it would mean big person, little person, and that sort of thing, ehm..Somewhere I've lost the plot of what I'm talking about ..
- I We were talking about the naming of .. processes or naming of behaviour patterns ..
- R Oh yes, yes, so how do I know it happens? I don't that's, I don't..
- I Although with this client who had the headache ..?
- R I know it was .. in her situation, now that's it's that's really unusual for me, ehmm .. I know if someone refers someone on then obviously, it works, what I did works.. ehm I think one of the greatest surprises was not this, just gone Christmas, the year before, I opened a Christmas card and there was a picture of a .. under a year old child, in a high chair, and I thought, I don't know .. I don't know anyone who's had a baby this year. I was completely mystified by, I don't know ... and it was from a couple I had worked with some time before where he had been adamant about not being a father. I had worked with them for quite some time, and the agreement we got down to 'oh all right, I won't do anything to prevent it' (laughter) if it happens it's good..
- I A form of consent ..
- R A grudging consent, one could call it. And, So when I got the card I just rang him and congratulated them after, so for the first time I'm going to overstep the client boundary and I'm going to ring them and congratulate them just to say thank you and how nice it was to get the card, and she said, well, you'll believe his comment, is 'why didn't we do this before' (laughs) I said, 'ooh'. I knew that worked, but often I don't know.
- I The reason I'm asking that one is that there's a huge amount of debate over client follow-up sheets, record forms, feedback forms ... And I know there's a lot of debate about this. Some people feel there's no debate because one simply should or one simply shouldn't ...so ehm ..
- R Well you see I think again, ... there's a difference between whether you see somebody privately or whether you see them in the NHS, and I think, I think if you see somebody within the NHS, there is a, a way you that could get feedback by saying, the GP could say, 'oh, Mr X or Mr Y .. but you see I think the real thing is that sometimes when you do something for, do some client work that is really successful, the most successful thing is when something's changed, ... and they think they did it! It's nothing to do with you. I mean the thing is to get them to think and take charge of it for themselves and give them the key to the door, this is how you do it, you've done it now, keep on doing it, here's the key, here's the

licence, just get on with it. I suppose I qualified in 2002, she says looking at this list! Anyway, well, I started taking clients in 2003. I'm not attached to outcome. I'm attached to change, I'm not attached to outcome. And I think whenever somebody makes a change in their ... life, the outcome is really how do they ..continue to change, continue to use the tools you helped them make.

I Yes, so maybe how they maintain the change ..

R Yes, or, or, not only maintaining, but change again and change their lives and realising they're in charge of change. I mean, the very first client I had, and I do mean the very first, as a training client, I still get the odd telephone call from her, and one, because I carry my client work in my brain, not in my filing cabinet, ehm, the one advantage of being profoundly dyslexic, is the way my memory works, ehm, don't take me amiss, Paul, if when you walk out of here I can't remember your name, I can tell you lots of things about you, but your name maybe not, and if I was seeing you as a client, you can walk into my room, and I've had it happen five, six, seven years later, I can remember the salient things about you. I may not remember your name, but the salient things, just I know, it's waste of time me going to look in the filing cabinet.

I So the human characteristics are fully retained, yes, lovely.

R Um you know, I've got two or three clients, ring me up, really lovely to hear from you, how's things? Oh well, obviously, as you're talking to me, things aren't that great, what's going on? And I'll say OK, so what's the pattern, what do you need to do about it? 'Oh of course I should know how to do that', and that's the end of the conversation. It's just remind them to pick the tool box, and open the tool box, get the key out and use it.

I So it's very much the pattern, and the key to change, really, yeah. And being aware of the pattern.

R And very often if people will get really tired or stressed, that's when they go back to their earlier pattern, their very early pattern.

I So that's what psychologists would label that, delightfully, automatic behaviour which is probably ...

R Exactly

I close enough to a good enough way of describing it ..

R Yes, and It's how do you recognise 'actually I'm on autopilot now' ... where's the key? Or how do I stop for for five minutes to look at what's really happening here, what I want.

I It's introducing a bit of mindfulness and self-observation, yeah ..

R Yes, and I do have .. I men, Oh yes, I've done a mindfulness course, ehm ..

- I I'm just thinking of ..
- R It's, yes, no, well, what I find .. it's suited me, because it took me back to some of the things I used to do that I'd forgotten how to do, but I've gone back to doing them and quit the mindfulness. Ehm ... The most, I think the most important thing is teaching people how to stop, and not necessarily step back, but take stock and engage not only brain but also emotion and a recognition of past behaviour patterns. Is this what I want to do? Again? Or do I want to do it differently. And if you have it differently, give yourself a little time to look at what options there are.
- I So again, it's bringing in awareness in of what is happening, what you know, what you perhaps has worked in the past to make things better. And which has made things worse! (laughs).
- R Yeah, and also, this is a slightly different situation, do I want to use any of the ones I've used in the past, do I want to use a new one? It's just fascinating and we're all different. I was talking to my brother, which, one of my brothers, never mind, I was one of the angriest teenagers in the world. To such an extent that this brother, who is slightly younger than me, complained that I'd, he couldn't do anger. I'd done it all for them. But, ehm, he was talking about .. the infamous, is it?, family temper, because but it's not nice to have a temper like that. Interesting to find out, as I'm not really in touch with the wider parts of the family, and he is, Mindless rage, turns up generation after generation. We have it tracked for four generations now.
- I So it must have some survival value! (laughs).
- R Getting your own way, perhaps, I don't know (laughs).
- I Thinking back to the very very beginning of our conversation of the client with the headaches, and by perhaps getting more into her body and understanding that there were quiet places in there, and then do some kind of imaginative moving of that to places that were unquiet, had an effect on the headache. Has she been able to keep this going over time?
- R Yes, yes.
- I That's been very successful then, I mean she does know, what it is. She now knows, but she only has to slow down for a minute, find a quiet place in her body, and she says there's always one somewhere, but she's very quick, she's very quick at being able to identify 'it'. And she knows now, that she only just has to stop, for the slightest bit, just long enough to find a quiet place, and she can lessen her headache. Ehm, and it will be interesting, when I next see her just to see how she is 'cos I'll see her in about six weeks.
- I One of the biggest difficulties, particularly in health psychology, for example, people with, say, diabetes, that they have a full understanding that this issue

requires constant vigilance, but the temptation of course is to keep up the old lifestyle that they enjoyed and found pleasurable, and the giving up of things is always a painful thing to do, rather than continue and take the risk, which is one of the constant very very human difficulties that we all face. Uhm, how do you think your client's been successful then in keeping this going. Is it just that the feedback has been so good for her, or, has it given her another tool that she enjoys using? Have you any idea how this has worked for her? Is that why she's been, or how she's managed to achieve the success for her?

- R Ehm, it's a period of immense change for her. And she's in two years into bereavement you know how her life and soul partner and business partner and so .. the at two years she's beginning to sort of come out of it. And so it's like .. There's so many things that are changing. The main focus for me has been to ask her to keep looking at how many things are changing at once and where does she want to keep certain things the same. And that for her is a new pattern, because her pattern is to .. Chuck everything out .. change, chuck everything out, change and she's done it secretly every ten years throughout her life, and this time it's different.
- I So she's good at change but this time it's monitoring as well.
- R And it's like identifying that there are certain things that she doesn't want to change. And the things that she's identified that she doesn't want to lose are things that before she came to see me she wouldn't even have thought to count. So ehm, whether that would have happened, with or without my interventions, I've no idea and she can't tell. And this is part of learning. I suppose it's learning to let go, ehm .. you can do what work you can do with every and each client and you never know whether it really really works or not.
- I Exactly, and it is experimental. Is there any particular things that .. I think you were saying you've spent a fortune on your training which I'm sure you have (laughs). Perhaps you would like to still feel that you're still lacking in some respects in terms of your toolbox you were talking about?
- R Well, There are lots of things 'I would like to do', but I know that I never will. Because one of the things is, I don't ever want to see more than about ten people a week. That has an economic answer, as you're well aware. Ehm, I'm profound .. my mind works in a very peculiar way, well I've now found out why, thanks to doing the Stanley Kellerman work, which is really good, so I have stopped beating myself up, which is really good .. ehm .. for my own purposes .. I'm really .. One of the favourite bit of my work is couples work. I'm really fascinated by attachments, and how it transfers into couples work. And I'm actually writing something and doing a programme for my own use not for anybody else's Ehm, but it's been seen by two supervisors because it's a framework I'm developing, for myself. They're quite interested in it,.. ehm .. so having waffled around ... I'm ... 63 ... And where I am now, there's lots of things that I'm interested in, there are certain things that I'd like to know more about but with the clients I get, we'd never change. Ehm... And it's a sort of vicious circle, because I don't want to work with more than about ten people. The way I work takes a lot out of me.

Ehm ..and so yes there's lots of things I think I'd like to do, but when it actually came to push and shove, and somebody says to me, here's £10,000 .. now you can go and train in X, I'd say well actually, you can keep your £10,000, ehm, but there .. there are .. I think it's unrealistic but I know I'm not going to change. I'm content with how things are. Ehm.. I think (laughs) I think ..and every now and again I think oh, ehm .. occasionally I'll get CPD things and think now that'll be really interesting and I go along, and I'll think Oh, I'd really like to do some more training in that, and then I think actually if you do more training, you need the clients to use that on, and if your not working at a high enough level, of numbers,.. I mean I think if I worked, if I'd ever worked in more off a team, it would be different, but I don't. You know ..

I It's more than adequate for the work you do or the work you choose to do.

R Absolutely, And I mean, as one of my supervisors said to me some years ago, there comes a time when you have to accept that you know what you know .. And I don't wish to be ... big-headed, and I know to cross-refer, I do know when to .. I can't work with somebody, I do know when there's somebody I don't want to work with. I always offer a free introduction. It's two-ways,

I It gives both people an opportunity to decide if this is the right person I want to work with and be with.

R Yes, and also, sometimes I'll think, OK, I could work with this person, but I don't think I'm the best person or it would be the best style, and therefore I'll say you know I think that so and so's approach might be different, because I know the way I work isn't conventional. (Cat enters room and interrupts seeking attention) And I get savaged quite regularly.

I I think one of the main things, that some of us said is that, eh, it's very important to know our boundaries but it's also important to take risks. And accept the responsibility for that.

R Yes, but then I always do take risks. Because I work so holistically, ehm .. I mean I have given a client a book to read, which is actually available from WH Smith's its not a best selling book, it's somebody's own story about about depression, because this client tells me she's severely depressed, and I think no mate, you can't be bothered to pick a step, you know .. pick your own feet up and walk your own walk.

I Oh I see, right, become a little frozen, perhaps, or afraid of life ..

R And so I lent her this book, It's not something I do, and I thought that's really interesting why I am thinking of doing it, and I think, actually I just want to, I just want to frighten her, into, getting out of her comfort zone.

I That's wonderful, that's the lovely exploratory work that find ...

- R Seriously, I'll find out when I next see her .. And I do, I do work in quite a ..I do take responsibility for what I do and sometimes it miss-fires and I have a very angry client, well that's life, I can cope with that, but sometimes that what it needs to be .. Ehm, yeah. No I'm still sort of thinking about.. what you said about, more training , different training ..
- I The reason I asked that is not so much .. the difficulty is we can slip into well we should be, we ought to, that wasn't the purpose of the question, it was more to, ehm, perhaps it's coming more from the health psychological viewpoint where they know their learning they know they still have find their way, there's so many ways to find, which would it be?
- R Yes but for me, that's like .. I suppose I'm always reading and looking and thinking and I think that's the difference now ehmaim the much wider range of CPD available so you can get introduced to all sorts of things, but I...I mean there are a lot of things that really interest me, and I think I'd like to but I know I won't. Do you know what I mean?
- I Yes, but the good thing is that you have a way, you've got many many ways..that may well be more than enough..
- R Well it's more than enough for what I do ..ehm ..
- I But obviously your curiosity's still going, you're still looking..
- R The curiosity's there, and I'm all .. what fascinates me is patterns. As a dyslectic, I see patterns. Now, for many years I worked as a book-keeper. Now for somebody who's dyslectic and can write numbers in the wrong order and read them in the wrong order, thank god for computers, because without computers I could never have kept my jobs, but .. shape. I can often tell where there's something added up right, not by adding it up, But I ..shape.. and I mean, Pete will look at me as if I'd seen so thrash it out but I haven't a clue, it's the wrong shape. So for me this transmits into body shape ..when I'm working with couples, it's relationship shape. There are two individuals who choose to make a container which holds both of them, a third shape ..and what they do when they're within that thing, too, hold their individuality or not. And if one of them chooses to, subvert their individuality, eventually, that will lead to rage or leaving or (inaudible).
- I So what was that last word there?
- R Doormat-itis,
- I I thought I heard doormat-itis, , I wasn't sure, What, Oh yes, becoming a door-mat, oh, totally subsuming yourself to the other, right yes.
- R (laughs) Becoming a door-mat! Yes, and so it's like, you know, watching and listening to what is a pattern of one becoming a doormat, and how they do it and why it's not satisfactory, and does the doormat want to go outside the door or

does it want to stand back up again, shake itself and (mimics shaking) and go back into fighting fit. So ..

I Mhmm, fascinating ..

R By using words like doormatitis, and I do that sort of thing with clients, you startle people out of their complacency, 'I'm not a door-mat!, What do you mean doormatitis?' You know, ..

I If the word's appropriate, if it's inappropriate, it stimulates thought ..

R Yes,

I At least you're realising well thank heavens I'm not, or at least it's coming, (laughs)

R If I've used it you're there, all the way! Ehm, and it's part of realising, if I've built enough trust up in the room, that they can hear words like that and challenge me, or if I've used it they trust me that there's an element of truth in it that needs looking at. And to me it's all about patterns. What did we think we were going to give, what shape were we looking for, what have we got and do we still want the original shape.

I Well, super, thank you so very much

R You're welcome Paul, I hope it's ..

I Beautifully along the lines of what I'd hoped to hear at this talk, thank you very much

R Oh, well (laughs)

End of transcript 2

Beginning of transcript Participant 3 HP

I Do you have any client, or do you have a client in mind who has a particular, eh, behaviour change activity that affects their chronic condition. That's really the area I'm most interested in in terms of, ehm, perhaps cardio-vascular conditions, asthma, I've got asthma, for example, ehm, that you can think of who you work with...

R I've one client who's bipolar, has recurrent viral infections and hypertension.

I So, that's a pretty potent mix. So what I'm interested in, with your best understanding as a health psychologist, and this predicated the answer to some extent, ehm, what would be your best understanding of what may lie behind his health aspect rather than his mental health aspects of his condition?

R She.

I She, sorry.

R Yeah, ehm, do you mean why do you think she has hypertension?

I Yes.

R That's an interesting question. I think some of it is related to the fact that because she was diagnosed with bipolar quite late, it was very dramatic, and she was hospitalised, there is that sense of ehm, working is very difficult for her and so there's that sense of giving to people in other ways, so her biggest problem is of low self-esteem and that need to please others, as there is that sense of her not being quite right in some way, she's different to other people, and she feels that need to please other people and put herself out for them so her boundaries are not clearly defined and a lot of her stress taking on board other people's problems, which for someone with bipolar is actually problematic. So I think that some of her hypertension in part is caused by the stress that she subjects herself to by taking on other people's problems. I suspect there may also be a dietary component as only up until recently, she couldn't cook. So I suspect that she was living on ready meals, living on ready meals, high salt content, I don't think that was really helping matters, and she also has a history of obesity. So at the moment while she's ... she's OK, she's on the high end of what she ought to weigh, I suspect there's probably .. It's quite complicated, I think that's also feeding in. She's also been through two bereavements, in very short order, she's about one year post anniversary of her Dad's death, it happened out of the blue, and I think some of it, some of the emotional stress of the bereavement's still working through, and I think that's also . 'Cos the hypertension is .. certainly an issue when she can't tolerate the medication, so we're having to look at other ways of her managing it. Plus managing the stress, plus managing the stress, and eating habits. And, so yes, it's a complex mix of many factors that's causing the hypertension. And the bipolar is, she's bipolar.

I Yes, exactly, is it, does she have quite strong bipolar symptoms?

R She used to, but she takes her Lithium regularly, but she's now struggling to understand. One of the things was, when she was up, was making connections between things. And now she's, that sense of, you know, serendipity really freaks her out. Because for her it's that sense of 'am I becoming manic again'. Because she makes that connection between, if something's serendipitous, and the right person comes along at the right time, does that mean she's going mad again, in her words not mine.

I Yes, she's got a very strong memory and awareness of her high periods.

R And she can tell you about what she was hallucinating about, how real it was, and the different fantasies, and how she connected to stars, and ... yeah.

I She sounds like a very intelligent woman, to have got that, yeah.

R She is although she refuses to acknowledge that she is.

I Fascinating. So with the hypertension, how does that affect her life? If it does?

R Well, she can't take, she can't tolerate the medication. When she's on the medication that doctor has tried prescribing, she gets very very ill. She feels appalling. She can't do anything, she can't get out of bed. That has a huge impact on her life, obviously. The other issue around hypertension is because, obviously, relaxation is important, you need to do something to control the heart rate, reduce the stress on your body and so on. So there's then there's issues around how you manage your life, such that you have control and lower your blood pressure yourself, which you can do by sitting quietly doing breathing exercises etc and for her it's actually finding the time to do that. So, she'd like to live what she would call a normal life and she is finding that very very difficult. We've had a lot of peaks and troughs, and there seems to be a repeating cycle of peaks and troughs, and every time she gets to the point where she's just about ready to actually look for a job she gets sick, or something happens in her family, and we're straight back down to the bottom again and she can't do anything, she can't get out of bed, her doctor is very concerned about hypertension, would like her to take more medication and she just can't. So it's the issues around managing, managing that.

I OK, It sounds almost as if the medication is more of a problem than the hypertension. Is that exaggerating the situation?

R No, from her point of view, she would say that is the case. There are other things she thinks are more important. She's suffering from a lot of fatigue and I think that it's just post-viral fatigue, because she's had a lot of viral infections one after the other. Ehm, she's had flu quite badly last year.

I OK, that makes sense, yeah.

R So I think the fatigue comes from that and the bereavement obviously, she's not been sleeping well, that doesn't help. Ehm, but yeah, she would say that from her point of view, she has other concerns that she would rather the GP address, rather than fixating on hypertension. And she thinks that if he addresses the other issues then she'd be more relaxed anyway, and therefore might not need the hypertension drugs. So ...

I Do you think she's right in that or is it just a hope? (laughs)

R (laughs) I .. It's interesting isn't it, the mind is very powerful, if you really believe something, your mind can influence your body. And it could be that actually, if he co-operates with her and she relaxes, it might actually work out that way.

I I just wondered, yes. Even if it's somewhat paradoxical, it may be right for that person.

R Exactly, it's not always, you know, it's not always straightforward you must take this medication and all will be well. And equally, if she takes this medication and she's expecting it, and she tenses against it, that could actually cause a lot of the symptoms

she's waiting for them to happen and her brain goes 'Oh, so you're expecting to be ill? So I'll make you ill'. And there's that sense of it becomes a self-fulfilling prophesy so it might be co-incidence that she takes the hypertensive medication and then feels really really bad, and it might not have been the hypertensive drug that actually caused that, it could have been something else, but she made the association between taking these drugs and feeling that way. She asked the GP to, you know, withdraw from them, 'cos I told her she just couldn't just stop taking them, so .. And I encouraged her to go and talk to her GP and actually talk it out properly and ask for a double appointment and actually go through what she's experiencing and she wants to achieve through management of her condition, bipolar with the hypertension.

I Yes, yes. So is this the kind of advice you're giving her, is that the role you have, with her?

R (laughs) Giving her advice! (laughs). It's an interesting role. Some of it is she needs somewhere where she can, she needs somewhere where she can .. because she is still establishing her boundaries, she needs somewhere where she come and say, OK this is what I think my boundaries are, but is that actually right? Is that what other normal people do? Because she's bipolar, she has this sense she's not normal. So she comes to me and asks is this what normal people do? Is it normal to dot dot dot ..

I Yeah, so she's checking out? That makes sense.

R She wants to check. It's also partly around checking that she's not going down and she's not going up. So it's that sense of that she wants to check in with someone that she's stable.

I It sounds a very clever strategy in some respects, that she's actually monitoring .. what her boundaries are and how much they relate whatever normal is..

R Yeah, well. It's very interesting, her secondary care team discharged her because they weren't willing to fulfil that role for her and she really feels like she needs that long-term. And it's not around, I was concerned at first around learned helplessness, you know, that thing about fostering dependence. Are you ever going to flap your wings or are you going to be constantly sitting on my couch looking for me to validate you 'cos I'm not going to do that. But equally, the way it actually has played out, which is helping her understand her boundaries and other people who don't have bipolar make connections and it doesn't mean you're going manic. And it is OK when someone makes an unreasonable demand of you to actually say how am I feeling, can I actually respond to this, is it within me to do that, or are my needs such that at the moment I'll actually need to postpone what I'm being asked to do or ask them to give it to someone else 'cos I can't do it and that's entirely reasonable, other people would do that too. So it's about helping her and providing that place where she can come and say, OK these are my things, this is what's happened since I last saw you, this is how my boundaries are kind of playing out, what do you think in terms of, you know, this is a particular issue I'm concerned about, this is what I'm planning to do. I wish she would stop saying, is that what normal people do but that's what, that's her concern. She wants to be like other people.

I Mhmm. Well obviously, there appears to be a level of anxiety down there and a probably a very justifiable insecurity. Very understandable. So what exactly is your role in this one? How did you get involved?

R My role? (laughs) She came on one of my psychological educational workshops. I run workshops in South Glosc. They are group workshops, they help people who are suffering from stress, depression anxiety. They are very, very practical. It's a place where you can come as an adult, to get ideas about how to deal with stress, depression, anxiety, panic. If you've got self-esteem issues, I have a self-esteem workshop, doing anger, etc. And she came and did one of my workshops, she did one, I think she did one with me, and she did one with one of my colleagues as well. And she decided, the work, she really got a lot out of the workshops but she wanted to work one to one. And she wanted to work with either myself or my colleague, Midge. Midge works in Bath and my client didn't feel able to make the drive to Bath on a regular basis. Midge doesn't have a private practice here. So she said would you take her and so I did. So she came into my private practice because that's what she wanted. She was very clear she was looking for something that was long-term. Ehm, and it was a sort of life-coaching approach that she was really looking for, that sense of problem-solving issues, setting goals aims objectives, with a view to eventually, hopefully getting back to work at some point. But there's equally there's that sense of me helping her understand what normal is, and that's an element that's emerged is important for her.

I So you haven't told her the secret that we don't know what normal means either (laughs).

R Oh, yeah, I regularly tell her that normal is, a moveable feast, you know. There are some people who will say that washing your hands X number of times a day makes you OCD, and there are others who say, it doesn't, it just means you have good hygiene. Which one is normal which one is not. Who's actually the judge.

I Mhmm, and the context of course.

R Yeah, if you're a surgeon, you're supposed to wash your hands between every patient, is that OCD or is that just good hygiene in order to protect your patients, context is everything.

I Well, it's fascinating she's come to you for that. So how do you feel you're getting along with her, how do you feel she's doing in terms of her ... I appreciate her bipolar's going to colour so much of her experience and obviously ehm, whether she came with a, with a lack of confidence, or whether this triggered her lack of confidence, you'll know better than I will. ehm, but in terms of her condition, is this something that is proving more useful for her, do you think, over time?

R I think if it wasn't, she'd have voted with her feet. She's intelligent, she's not going to hang around if it's not .. she pays for it, you know, and she's well aware she needs to get something out of it and I think if she wasn't, she would have gone by now. Also there's that sense of, every so often we check in with, is this getting you to where

you want to go or do you need to move on and do something else? You know, do I need to signpost you onto something else, you know, there are other workshops that she could usefully do. But there's her decision to make, not mine, I just flag it up on a regular basis, so we review on a regular basis. 'Cos I don't want that sense of again, you know, that learned helplessness, I go to the therapist, she insists on calling me a therapist, ehm, on a regular basis, and it's that sense of, you know, what's appropriate for you. And sometimes you need to take a break, or you go and do something else and then you come back, and it's .. there should be that sense of what you do is OK. It's not for me to tell you, but it's for me to make sure we check on a regular basis that you're getting what you want. Now in truth, I've been seeing her for just over a year, and in terms of progress, she has actually made a lot of progress in that time. When I first saw her she had no boundaries at all. She might as well have had 'doormat' written on her forehead and 'kick here' written on her bottom. And she was being pushed around by her family. She's fairly upset by her father's death as you'd expect, a bit lost, and, and now she has boundaries, she's capable of saying 'no', she capable of identifying what she needs to do and how to go about doing that, ehm, so actually yeah, for someone who was in a real pickle, who's self-esteem was very low because of her bipolar, being admitted to a psychiatric unit more than once, she has made an amazing amount of progress and all credit her for kind of sticking with it, it's .. Yeah, she has, I'm, I'm really pleased for her.

I Sounds very good ..

R I think it's it's the energy issue, the peaks and troughs with her energy and these viral infections she keeps picking up. That is particularly problematic and I really feel for her. Because there isn't really a lot we can do about that. We just kind of .. She comes to see me and she says, 'I'm exhausted', It's like, yes, well you have a viral infection, post-viral fatigue, you're going to feel like everyone would feel would feel like that. it's just waiting .. and I keep trying to encourage this idea, she's very resistant, she's very.. she doesn't like waiting for things to be over. And I kind of encourage her, you know, there's that sense that if you accept something and stop fighting with it, it will actually pass quicker. The more you fight with it the longer you're gonna feel like it, 'cos what little energy you've got, you're throwing away in this tussle. You can conserve your energy by accepting that and it actually will come up quicker. 'Cos you're not spending it, you're actually reserving it. So I try to get her to think in terms of checking in with how she's doing, how she's feeling day by day. Doing what's appropriate each day, but having that patience with being able to stay with the fact that, that when you're post-viral, even when it's a well-known fact and even though GPs tend not to tell their patients, you will feel knackered. So it's just bearing with it's the same with everybody, whether you've got bipolar or not. When you've had a series of viral infections, that's what it's like. You know, one of my colleagues at university, same thing, series of viral infections feeling tired all the time, and she hasn't got bipolar but it's the same thing. And neither does my colleague got any patience with it, I have to say the same thing to her, you know, stop fighting it, you will get better quicker.

I What do you think is the ... I think it's what you're touching on that obviously, a theory behind, ehm, dealing with a post-viral condition. Or yet another viral condition, depending on your luck, ehm, what I'm particularly interested in is how, amongst all the many theories and understandings that happen in, ehm, I noticed that you resist the

term therapy, but in the light of .. are you OK with the Life Coaching as far as this particular client is concerned,

R ehm, ..

I ... even though she's looking for it? How would you describe your, ... I'm trying to tease how you would describe your role as a health psychologist .. (laughs) if you can!

R Ehm! How do you describe the difference! (laughs) I actually, I tend to just describe myself as a psychologist rather than any particular type, because I also do work around occupational, and, there's people who work get depressed and so on. So, it, it, my label varies depending upon what other people are comfortable with and some people prefer me not to use the term 'psychologist' at all. You know, they prefer the term mentor, or coach or trainer or whatever, so I kind of roll with it.

I Yeah, well one of the things that drew me to this research was, ehm, the slightly problematic, this is my words, obviously, what is saw as the slightly problematic nature of health psychological theories as to how ahm, how one alters and adapts at the very, very least, health behaviours, and the difficulty between the boundaries between health and clinical and health and counselling and all these things ...

R (laughs)

I And I confess I blundered into them all and got told off, but where, where do you think if any, at all, ah, is the health psychological background from your Masters, or theoretical background, how this applies to the work you might do with, say this client, with her, uhm, difficulties with medication and the side-effects. And you mentioned ideas of acceptance, so I wondered how this might fit in with ...

R Acceptance particularly, I don't use the psychological, there is a psychological version called radical acceptance, in actual fact it reappears in all kinds of different ways and it, depending on whether you're looking at psychology or religion, there's different varieties of acceptance. Ehm, the version I particularly draw on comes from mindfulness. That sense of if you sit with something, then you can accept it you use less energy in through doing that. That sense of being in the present moment, rather than causing yourself additional stress and de-stress by, you know, constantly either going forward or wishing things were back how they were, it's about saying, it's a journey, and it's about being able to accept the present moment 'cos the present moment is the only one you've actually got. The others haven't arrived yet and the rest has already gone. So when I'm talking about acceptance, it's in that sense of sitting with something, ready to accept. It comes very much from within that mindfulness approach, that eastern philosophy if you like.

I Is there any particular mindfulness, Kabat-Zinn, might be an obvious one is there any particular, bent of ..

R School of mindfulness?

I Mentor, school, if there's such a one, or such a thing,

R There, actual, well,

I Or your favourite author perhaps! (laughs)

R Favourite author! (laughs). I don't actually have a favourite author .. ehm, I've read various ones and what I tend to do is just kind of analyse it and then synergise it back together again and take what I need to make ..

I Make your own version of it, yes.

R I'm no great respecter of things like that. It's like CBT, I have my own particular way of doing CBT and it's radically different, but it works, so I don't I just take bits of things and adapt them. A lot of the time when I'm working as a coach, we use smart goals, 'cos their very effective and I tend to use the business model, ehm, and we also talk about stages of change actually, the most useful theory out of all of the ones about behaviour change is actually Prochaska and DiClemente's cycles of change, it is just, it's, it really helps. It does .. it's title is the transtheoretical model of change, we call it the cycle of change. I use it with a lot of people, and that sense of where am I going, where am I in this process, and helping them. And sometimes I mix that with action research, and actually kind of, rather than a circle, we have a spiral. And that really can help people as well. It's like saying, well Ok that really wasn't a complete waste of time, you're at this point in the action research thing, you go back to this stage in the cycle of change, we do this bit next and we'll just carry on rocking and rolling for ... I mix things up.

I Hmm. One of the fascinating areas, I don't know how much you can bear reading those health psychology papers after all that study, um, is that the trans-theoretical model, the theory it is meant to transcend, of course, is psychotherapeutic ones, um, they're not normally taught within health psychology although alluded to, and I wondered how much you felt that might have been easier or better or did you feel you were well enough served with the health psychology training you had? Or did you have to look elsewhere, or was it a good grounding for what you later learned, that .. in your journey?

R That's an interesting question, I was just discussing this over lunch with someone else. And actually what I draw on most, (laughs) this is completely off the wall, I have trained ... I have retrained multiple times, but the first lot of training I did was to work in the theatre as an actress. So my acting training is the thing I draw on most. Stanslavski, the model of the seeds, that whole kind of every human being has the capacity to do and be anything, actually is profoundly liberating. Ehm, and I use that a lot and I draw on that training more than I do anything else. The most useful set of skills I ever got. Ehm, I use a lot of business models, because I used to work in business when I was a business trainer, literature as well. Because I trained as a teacher, I have a teacher training qualification, I draw on the education models too, ehm, so in actual fact, I think health psychology, one of the things I find hugely frustrating about health psychology, was that it was very inward-looking. Whereas for me, I even studied a diploma in theology, and that, in terms of behaviour change, the

church, religion, is probably one of the best organisation theology, and that is one of the organisations that can get people to change their behaviour. You can radicalise people, now how is that for dynamic behaviour change? And that is one of those things I find fascinating. There are other areas, like the business world, schools and religion that can change people's behaviour than psychologists can. And I think there is a major lesson to be learned there and there needs to be some synergy between psychology and these other areas that have already demonstrated beyond any reasonable doubt, that they can change other people's behaviour, whether that's through 360 degree appraisals at work, where then you will be set goals and objectives where you're then set goals and objectives in which you are going to improve your behaviour or your practice over time and it's all very measured and evaluated or whether it's through religion and theology, where you spend time with like-minded others and you spend time studying things and they have support network and, have that sense of an in-group – that's a very powerful model for change.

I And simple rules for good behaviour?

R Yes. That you can very easily understand and apply and if you're not sure there's someone you can go and discuss it with and you have a handbook, it's called the Bible. (laughs) It's that or the Quran, or whatever your flavour of choice is. You know, in education, you've got that constant searching for knowledge and things, but you have, they offer more opportunity if you like and I guess from my point of view, 'cos I tend to be quite eclectic, this delimited number of models in psychology, and I find it very frustrating that actually they're not very good at predicting change.

I Do you mean in psychological models generally?

R Yeah, theory of planned behaviour, they're not very good at predicting change. Tested to within an inch of its life. There are other models we could be usefully looking at if we took other areas into account, you know. When I, when I work with clients, I do a holistic assessment, which is more like a 360 appraisal, than anything else. 'Cos actually you need to see them as a whole person, not just the one ... It's very interesting, they'll come and tell you one particular thing they want to work with and when I do my holistic assessment I discover that actually, there's a few other things that if I hadn't asked them about, and it would have a profound effect on how we're going to work on this particular issue. So for me it's always about information-gathering and mixing and matching. Some people are very spiritual and work well within that particular model. I have actually known, I worked with a Polish girl, there was an issue around acceptance and I have this theory which is all mine, that EMDR and prayer are not a million miles apart from each other, in that sense of sitting with something while your brain processes it. So I told her, 'cos she's Catholic, to go and pray with her priest, and it would have the same effect and she did and it did. Now in part, there is that sense of, you set someone up to believe something and if they trust you and believe you, then like kind of loads the dice a bit, but, there is that thing of is prayer really that different very different from EMDR, when you actually think of the processes involved in EMDR and how that effect plays out, for me I can't ... I'd love to do some research around it to check, but there is that sense of, I don't really think they're that different.

I Hmm, the funny thing is, of course, health psychology does not teach specific therapeutic approaches. Ehm, and of course it comes from a very strong academic and possibly medical sociological background, and of course it is a new area of psychology somewhat nervous of its boundaries and the like. Did you, did you find your training in health psychology was useful or was it merely a, perhaps a framework in which you could place some of these other trainings and learning that you had?

R Hmm, interesting question.

I Or is that the wrong question to ask? (laughs)

R No it's not the wrong question, it's an interesting question.

I I'm trying to get at the utility, perhaps, of the health psychological training you've had.

R Ehm, in terms of real practical use, about as much as a chocolate teapot. Ehm, my other training has been far more use to me as a practitioner. The course at UWE was absolutely fantastic and was really interesting. It really really helped me to clarify my thinking, to ask better questions, to be able to be collect information in a way that would answer those questions, it also told me there're a lot of things about that we don't understand about how people change their behaviour, how they make decisions about their treatment and so on. It raised a lot of issues and it was very interesting, but in terms of my actual practice, not really.

I That's quite fascinating. I'll check where I'm at. Yeah, I think you've pretty well covered most of my key points. What I'm interested in and where I've struggled I think as many health psychologists have struggled is, the role of health psychology and what is it there for. It has a very clear and obvious understanding in terms, particularly I would think it's close to the sociology of health, or the psycho-sociology of health it's got a very clear corpus of, ehm, understanding in that respect, but it's now, as you've probably noticed, or maybe you haven't, but it's changing it's training now, to be more implementation oriented ...

R Implementation as in..?

I As in how do you actually get the patient to keep taking the tablets (laughs)

R As in adherence ..

I So it's very much, well not specifically that, but it, it's becoming much more attached to implementations, whatever those implementations might be. And they're now changing the training to emphasise implementations, significantly more than they have in the past. And where I can see a drift, perhaps, slightly tentatively back towards the clinical world, it may not be intending to go there I'm not sure, ehm, would you feel that health psychology is, should be comfortable in that direction or do you feel that, if you were going to be doing your training again, you might, ehm, be more comfortable with a more implementation form of training or do you feel it did it well enough for you by providing all these questions?

R I, I was disappointed in some ways that by the time I had finished my Masters in Health Psychology I wasn't really trained to do anything. You have to go on and do, a, another kind of training. Now, I was in a much stronger position than anyone else anyway, simply because I've had access to all these other different ways of doing things. Lots and lots of different trainings and that really has helped. If I didn't have that, I, I lead a team of, there are fifteen people in my team, pretty much all health psychologists, ehm, and in respect of them, an awful lot of my time is spent broadening their knowledge and helping them apply health psychology, really practical working with clients kind of stuff. Ehm, because there is no clear and obvious role for health psychologists, and that is problematic. The training does need to change. Whether it needs to go down the route of just implementation, I would query that. I think health psychology has a lot to offer. The, the problem we have, like, well, the problem the discipline has, I think, is that clinical psychologists, who are the ones we are mostly in competition with, every time they see something that has health psychology in it, they say, I can do that, I can do that. And in actual fact, there are some things that health psychologists can do better than clinical psychologists can. I was recently having a conversation with a clinical psychologist and it was very clear that actually there was some things I could definitely do better than her.

I Mhm. What sort of things for example?

R Ehm, bless her, research is not her best thing. Eh, and I have, I chose to finish my Masters, my health psychology skills doing a PhD by research and so obviously my research skills are far in excess of hers. Ehm, but that was my choice, not everyone chooses to do that. Now what else was she wanting? Oh that was it, I, she was asking me what I thought her job should be. (laughs) And that was interesting! And I, I actually ended up saying to her I think your role is more about assessment and signposting people appropriately, because having the title 'clinical psychologist' carries even more connotations for the patient of, 'I am a nutter', than seeing someone who is a health psychologist where there is less of a connotation of 'I am a nutter', and I think that is one of the things my clients find reassuring is that, because I am a psychologist, I'm not actually telling them that they're a nutter, I'm just there to kind of help them with various issues they might be struggling with. I draw on a variety of approaches and I'm not labelling them, whereas a clinical psychologist has that sense of they can label them, Paul, and that's a really scary thing to do. ehm, ..

I I appreciate that even clinical psychologists can find that a bit scary as well! (laughs).

R Not all of them, they can be a bit precious about that! But there is that sense of, that there are more things we can do, and I think our, the position of health psychology would be better if we had better advocacy from higher up. We shouldn't be in the position where we have all these people coming out of university, with no posts for them to go to, and the clinical psychologists, you know, clinical health psychologist? What exactly is that about? Other than a land-grab by the clinicals. And there's that sense of actually, people should have been doing, higher ups in the BPS and the Department of Health, should have been doing the work which we've been training for, you know, it's the same with all new roles, I've worked on several in the NHS, and it's

that sense of you need to do the preparation with the managers, so that when these people come out, they know what to do with them. When I started in mental health, which was an entire accident, but when I started in mental health, the manager at the PCT thought he needed a clinical psychologist. The irony is that there isn't a single one in his entire team. Because you don't need a clinical psychologist. You need a health psychologist. Because actually, their training is better it's more relevant, we know about more things, we're not there to assess people, we're there, well we don't do assessments, we're there to actually help them with behaviour change. Yey! And health psychologists do that. And I'm not saying that clinicals can't do it, but, I just think health psychologists are better placed.

I That's not their forte. Yes, OK, And that's where I'm beginning to hear, that with all the frustrations, and perhaps the gaps, and in fact the very short period of time in which health psychologists are trained, we haven't done other things. That perhaps it sets up a world view or an understanding that behaviour change is possible, perhaps. And just about every improvement we can make, whatever our condition, involves a behaviour change in some respects. Very interesting. I'm trying not to put words in your mouth of course here, so please correct me, is that where I can see where a clinical psychologist's training, ah, is made more difficult for them, in that by looking for psychopathology, they may be looking for symptoms rather than, ah, behaviour that leads or accentuates or exaggerates the difficulties that these symptoms create, ..

R Mhmm, a good, good example would be when I work with my team, we encourage people, rather than saying that depression is pathological, what we actually say is we actually say to them is that we have emotions. And emotions are a source of information. And if you can get control of your symptoms, then actually you can learn to use your emotions for what they were meant for, which is in order to keep you safe. They, it's your fastest mechanism to help you respond appropriately in a situation 'cos thoughts take longer to form. So you're always going to have a feeling first. And it's just helping people to understand how their bodies work, and that actually depression is, OK, have a feeling first. OK it is problematic and no-one's saying it's not and it's very very difficult to deal with. But it's that sense of actually, you are normal, you're not going mad, and for whatever reason your body's activated this protection mechanism, and maybe investigating why that is is unhelpful. But you are where you are, and we can actually help you with some simple strategies to maybe alleviate some of these symptoms and when you come back up to help you actually manage it as a lifestyle thing, which is what I say to people on the anger management and the worry management too, actually manage it as a lifestyle thing, you know, be aware that you have triggers. Be aware that actually, there might be certain things that you need to do in order just, that your, you keep yourself stable. And other people have the same vulnerability and have to make the same choices and you are just one of many, that have to do that. I have to do that. And in fact the clients say to us, the sessions they get the most out of are the ones with the practitioners who have had the problem, whether it's the anger, depression or worry and the practitioners are very honest about it and say, yeah, I have to manage the same vulnerability. But that is what it is. It's not a pathology, it's vulnerability and you can learn to manage it, you can learn to control it. And yes, all right, it is behaviour change. There are certain things that you might have to do. It's not a sleep programme! You have to tell people they've to take responsibility for it. We cannot wave a magic wand and fix their sleep pro .., sleep. But

we can look at all the different things they need to do, and might need to address, stuff they're doing through the day, stuff they're doing when they go to bed at night, that the environment in which they sleep. But the, the whole thing is just behaviour change. And we actually have a session which talks to them about, this is the process that you're engaged in, this is the cycle of change, whatever, in order that they have some framework within which to understand what it is they're trying to do and it does make a difference. But I take a very practical, pragmatic, view.

I But it sounds as if what you're also taking, again, using another label, if you'll forgive me, is very client-centred. Would that be fair to say?

R Oh yes it is. It's always about what the client wants to achieve, not about what I want to achieve, and that's something I try and encourage my team as well. If you go into a session, wanting someone to do something, or wanting to have some particular outcome, that will get in the way. You actually just need to create some time and space to enable them to actually join the dots. And we give them information and we help them, in whatever way we need to help them, but it's actually about them and their outcomes. So you can want the best for them, but if you want them to go in a particular direction, your want and your needs actually can become a barrier to them being able to change. So it should always be about what does the client want, where is the client now, what is it they are needing to achieve, it's about their journey. And you're just a facilitator, you're an enabler, and you shouldn't be wanting .. And it's one of the, one of my practitioners, she's off the team at the moment, she's on tactical, doing some other work, thing, but she used to get really frustrated and she'd say to me, 'they should do their home work, it's really important'. It's like, they're adults. If you go into the session wanting them to have done it, all that emotion you bring with you will wind them up and then they won't pay attention to what it, the assistance you're trying to offer them. You have to just step back and let them do and be who they are. For all you know, not having done the homework in that way, they might have actually done something else, and it's had, you know, they're just suggestions, the homework is not set in stone. And I find it quite amazing, sometimes the clients on the anger management course will say to me, 'I've been really bad and I haven't done it, I've done nothing all week'. And I say all right, OK, and we're having a chat and then they'll say, 'Oh, I was thinking about so-and so', and I went, 'Oh, you're a rampant liar then, you told me you'd done nothing!' But people have this perception that home work is about writing it down. It's not, it's about thinking about it. It's about, you know, you were about to describe something one way and changing it and describing it a different way so it's not so emotionally loaded so you're not winding yourself up. That's doing your homework. So that's a practical way of doing your homework. So it's enabling people to understand, we give them ideas, but how they choose to actually do it, that's fine, that's no problem, and when you actually look at it that way, and people go, in that case I did my homework and suddenly there's this chorus of people round the room going actually yeah, I did do it! (laughs). So there is that sense of enabling, empowering and allowing people do be who they are and not overloading them with expectations about 'you've got to do it this way at this time', or .. They usually get along better when you just allow them to be who they are and take it at their pace.

I So it sounds again very much if as if it's a question of, eh, not doing a huge amount of interpreting of behaviour to allow them to assess their behaviour has, ehm,

at least been different from their former pattern, perhaps. Are you, are you into patterns of behaviour?

R Oh yeah. Yeah it is that sense of, quite often, I mean sometimes clients say to me this is just common-sense. I say yes it is, it's not rocket science. I like things that are very very simple that people can slip into their lives but that will have a big effect. And one of the guys, who, incidentally is another one of my clients, he has, he was talking about ways of controlling anxiety and one of the things you can do to help you control anxiety is actually to focus on something you really like, and he is a photographer, and he has this little gadget with all these really really nice pictures on it, he was showing it to me the other day, and if he's in the car and he's feeling anxious, he can pull over and he gets this little gadget out and he focuses on his pictures and just putting it together is very therapeutic, but he was saying the benefit of having this, and it's so simple. And he was saying it's really straightforward, it's very simple, but it's unbelievably effective. Those are the kinds of things I really like. And I say to people, you know, I don't like really complicated things, 'cos you won't be able to fit them into your life. Simple is good. So I don't mind if you laugh at it. But you know, we're looking, we can't, .. whole-life revolutions are not sustainable. We're looking for small changes that you can do regularly over time and will get you where you want to go. And all the work I do is based around that. Little, often, sustainable. Identifying what you need to change, making small changes, seeing how that pans out, making more change if you need to, but little and often.

I And obviously having a goal in mind and watching how, where you're going.

R Yup.

I Mhmm. That's beautiful. So what, I'm thinking, I think really, you've actually answered every single question beautifully without me having to ask too much ..

R (laughs)

I Which is lovely! Really really nice. Ehm, is there anything else you can think of perhaps, that you might want to, ehm, perhaps feed back into the research, in the sense that I'm looking for, how well psychological practitioners envisage the link between psychological therapies and improving people's physiological health. You've mentioned a whole bundle of ways in which this could be done. I wonder if there's a general theory or a philosophy that might underlie all of this for you?

R I'm not sure there is. I'm at that stage of thinking about what that might be. From my point of view, it's very much, I've got my psychology training, I've got my acting training, I've got my education, I've got my business world, I've got theology and the role of religion and spirituality, and for me there needs to be something that draws on all of those. I need something that is inclusive and eclectic and I think that's what my clients need too. And at the minute it doesn't exist. I nearly did a PhD which was around doing that. What would a model look like, what would a model of behaviour change look like if you drew on all the strengths of all those different changes. And how many different ways of working with clients would that give you in terms of determining interventions. In terms of awareness-raising about potential problems to

head help people off from certain dodgy behaviours. Ehm, one of my passions is about helping people understand their emotions, for example. And training around emotions finishes at junior school. Once you get into senior school, we tend not to support that particular bit of knowledge. There's a fascinating book by Margaret Donaldson where she's talking about does your head learning keep pace with your heart learning and the truth is no it doesn't. We value head learning far above anything else. And yet, emotional mastery, for me, personal mastery if you like, Peter Sange, working, right from the business world talks about the dance of change and, ehm, one of his ideas is personal mastery. That idea of being the best that you can possibly be. Being expert in being you. Having that self-knowledge and self-awareness, and being willing to invest in yourself, as someone who is worth investing in. And for me I guess that's my direction at the moment. Something that would enable people to draw on whatever they need to draw on all the different techniques that are available, but each different person's made to come at it, you know, .. I have clients who come from very professional backgrounds. It's useful that I share some of that background and I have that training. I can then work in ways drawing on things that I know work in parallel in psychology that's also in business literature so that I can work in ways they can understand. We something a bit bigger, we need some kind of .. psychology's needs to be less parochial, I guess that's where I'm coming from, and actually we need something that is bigger, I think if we draw on, it's that sense of if we draw on lots of different things, you end up with a whole that is bigger than the sum of its parts. And for me it feels like if we keep focusing on psychology, we're missing the point. There are other areas that do behaviour change better and we are missing a trick if we ignore them. And at the minute it feels like we are ignoring them. So for me it's looking at can we lose the parochialness, which for health psychology is going to be problematic as it needs to prove itself. And actually saying, well by the way, (laughs) we're different from clinical psychologies 'cos actually we have a foot in education and religion (laughs) more like .. what would that do to our credibility. And I think there is that sense of, that's a scary place to be, but teaching people how to think, and, you know, being the best that they can be and tapping all their potential. That is so important when you're working with someone's self-esteem empowering them that they can, you know, when you have low self-esteem, you never know find out who you truly are. And that means you never have a true understanding of what you're capable of and what you can deal with. And actually, that keeps people hampered, that keeps people stuck. If you want to free people, you need to help them have good boundaries, you need to help them have good self-esteem, and you need to help them to be curious about the world, to be able to think, to be able to find things out in a safe way, in an appropriate way and be able to build that into their lives. And they shouldn't need to keep coming back to psychologists for validation, and so on. They have the skills to be able to live their lives effectively. And have good mental health, physical health, good relationships, good education, good ability to work. And there are certain life skills that I think, you know, helping clients around that area of personal mastery and emotional education, all those things will make a huge difference. So I kind of have a proto-model, that I'm thinking about, but it's very eclectic.

I Yeah, absolutely, I was wondering also, the other group I'm comparing with is eh, I'm interested in, a very interesting comparison is a group of counsellors. And, of course, they come in all varieties as well.

R They do.

I Ehm, how much would you say your training would differ from, .. If you could generalise, you can't really generalise about counselling, but, in perhaps in some gross sense, how different would you, how different would you see your training was, as a .. wearing the health psychologist hat? Or a psychologist hat? Particularly when you're thinking in terms of, of behaviour change involving chronic conditions again, such as this hypertension client you were referring to?

R It's interesting, 'cos I work with counsellors and there's an interesting synergy that goes on between my approach and their approach and again it's one of those what we end up is better than what we actually originally started with. And we've started with a couple of new courses we've started which draw on both approaches because actually that's better for the clients. So I have this workshop that's called 'adjusting to change' and it's helping people who've had a bad thing happen, whether it's bereavement, job loss, having to deal with a chronic condition, either that they've been diagnosed with it or think they've being diagnosed with it, and what we do is a mix of quick therapy, which is drawing on that counselling model and education around, this is what grief looks like, this is the process of grief. Not only will you be going through this but other people in your family will be going through this and this is where some of the arguments come, you're at different stages at different times, neither of you is right and neither of you is wrong, it's just you're humans, you're having a hard time, so it's framed within that. Education plus the therapy, the support, the discussion and actually the clients say it's really really beneficial having that mixed model there. Yes my training is radically different if you like, but it's very interesting listening to the counsellors and how they talk about their clients, ehm, and their ways of working is very different and actually my team has learned a lot, we do a lot of joint training with the counsellors now, which we didn't used to do. Both sides get so much. The counsellors have found that their interactions with clients have improved from actually knowing that there are very simple practical things that they can either do with their clients or direct them on to, so you can get your client to a certain point and then you can get them to some skills training with us and then we send them back again, and actually that is really really good for clients. On anger management, it really helps if you've got a client who's seeing a counsellor and in the workshop at the same time, because then the issues arising in the workshop can be dealt with in a safe place and clients really value that. Both approaches offer something unique, so there's that sense of, yes, the training is different but it's appropriate that the training should be different. Do I feel that that I've missed out, no I don't. Occasionally I kind of think, it might be useful to go and do a certificate in counselling, just in order to have a better understanding of how counsellors work, but also to have that, when I'm around counsellors, there's that sense of, ehm, calm. But 'cos my personality's quite loud and vibrant, I sometimes struggle to be able to actually, sit quietly. You've probably noticed I have quite a sizeable personality and most of my clients come to me and know what they're getting, 'cos they've already met me, ehm, but there is that sense of actually there are some skills that counsellors have and that practice of, you know, engaging and closing them down appropriately, I don't think psychology training, some health psychologists don't necessary address that issue properly, you know, we're doing behaviour change with clients, we just merrily do what we're doing and then let them go, whereas with counsellors, there's that sense of, if we open things up, then we have

to close it down. When you do an assessment with someone, we open things up and then you close it down and I think it's that sense of ...

I Do you mean in terms of giving the beginnings and an ending?

R Mhmm, yeah. And I think it's that sense of how to disengage from a client and those practical issues, if you like, around working with someone and working with a group of people and managing their expectations and so on. That aspect of counselling training would be useful for health psychologists to have and I think it's a shame it's not in there.

I Yeah, well that's lovely.

R Does that answer your questions?

I Multiply!

R (laughs)

I Beautifully, thank you, I'll just switch this thing off now, Thank you so very very much.

R Your welcome.

End of transcript 3

Beginning of transcript Participant 4 C

I So again, just to remind you what, what these ...ehm.. this research is about is to try to find.. ehm ... psychological therapists which often come in lots of different types what are there impressions and feelings as to what happens in the client when they undergo therapy.. when the clients have .. ehm ... some kind of chronic common condition, such as the kind you were talking about. So, what was the .. are you able to tell me a bit more about the actual condition that the client you had in mind had that you remembered?

R yes, it was.. ehm.. he had a ..very ... rather immobile back

I OK, mhmm

R as a result of ...uhm ... a fusion of some of his vertebrae at the top of his back ... almost to the nape of his neck. And this had had caused him ..ehm.. quite a lot of discomfort ... It wasn't why he came to see me, but this was certainly,..ah .. from the outset, I was very aware of this condition .. and uhm ... he, he came to see me because .. ahm .. in his own terms he had questions to resolve around his relationship

I OK, yeah

- R ahm... and ... he ... was wanting in his term again a sounding-board, and that was the image he produced from the beginning and he produced it a number of times ... ahm... a sounding board ...ahm.. so his expressed need was really to, ahm .. as I understood it, to ask himself ..ahm ..questions to explore that with a sounding-board present to, to ..ehm .. facilitate him in doing that.
- I Yeah, OK, so it was a bit, I'm guessing this , it was a some sort of self-discovery but needing someone else to respond and maybe reflect back .. ahm.. what he was talking about. So what, yeah, so would this neck condition and the depth of the discomfort he might have had?
- R He ... when he referred to it really suggested that it was a ..um.. Because he'd been living with it so long, he experienced it as a chronic ache.
- I Yes, Ok, uhuh
- R eh.. he ..he'd ..you know.. he'd gotten used to it, you know, inverted commas, but it was ever-present.
- I So as far as you knew, he'd had it a long time? Or did you ..?
- R Oh yes, many years.
- I So many years, so.. back to childhood? Or..
- R Yes, I think early adulthood ... this was some ..um .. injury that had had arisen from some injury ..ehm .. that he sustained from on holiday somewhere.
- I Oh alright, OK that's very unlucky
- R Yeah, Yeah mhm.
- I So, what did you, so you were describing the .. stiffness. Did you ever get to the basis of what it was that was actually causing the problem?
- R Well, it, I ..ehm.. He had .. certainly been subject to a lot of investigations. Ahm .. and .. had had at least one operation on his upper back. The .. I don't know the detail, I must say, but what the upshot of this was that there was a certain fusion of the bone ... and .. that .. there was a limited amount apparently that could be done.. so.. so .. this, ehm, was what had already happened. So this .. ehm.. The effect of this was that he had ..ehm.. he, he was very stiff in his stance. He presented as somebody that had no visible neck. And.ehm..when he ...ehm.. In turning or in changing the direction of his gaze, he was more included to, to turn his whole upper body than, than .. ehm.. when he went to look to one side, so he didn't really have much in the way of flexibility.
- I Yeah, That's very unlucky, mhmm. Was there any other part of his body that reflected a similar condition, or ..

R Well, in, in a... energetically, I mean, my impression was that he, he was a squat man, very broad ehm, very squat, and ..ehm.. so, I experienced his, his energy as being on the one hand quite sort of grounded, but on the other there was a certain ..ehm.. a sort of a fixity about him that, that was my impression and, uh, although when I say that I'm looking, obviously, in retrospect now, and I think that that wasn't just born out of his physical, ehm, appearance, but I, I in getting to know him some more, I experienced him as somebody who was a ...ehm.. had a certain stuckness about him, yeah.

I OK, mhm. When you're saying stuckness, eh, would that be how I might think of it in terms of rigidity, or the kinds of words I'm thinking of are things like stiffness, which would, .. but stuckness I think would be a little different, I don't know ... it seems to suggest something different ...

R Yes, I, I think there was the circles crossed if you like, in terms of, I think psychically, and emotionally, there was a certain, ehm.. stuckness, and he expressed that in, in terms of ..ehm.. a number of inquiries he wanted to make ...ahmm.. which were really ..ahmm.. of, of a very emotional nature, potentially, as he was talking about relationships and frustrations in, in relationships and a sort of sense of thwartedness .. and ... ehm... it's difficult without ...sort of,... breaking confidence, ..eh.. I ..that.. I.. interestingly, his ..ehm.. work involved, ..ehm.. looking very carefully at things..

I OK, that's fine. But, it's really more.. 'cos I don't want the client too much, in, in the sense that ehm.. because obviously, not only is it intrusive here, you wouldn't be permitted to tell me, (laughs) so.. It's really that..very much to get get your impression, 'cos this is very much the kind of thing I'm interested in. 'Cos you're looking at this ..eh.. client clearly stiff around the neck from his condition. And you notice a stuckness ..um.. Is there any way that you could think that his that his particular, his physiological, or his physiology, was a significant issue ..in his .. coming to see you .. that might reflect .. this is your impression .. his physiology may be impacting upon his life and how he deals with his issues?

R I, I really had the impression that although .. his..ehm.. stiffness was ... was certainly ..ehm... at the very least or, well almost defined by the injury. There was something congruent for me about that, and how he ..ehm.. seemed to be in his, his outlook. That, that .. I, I couldn't help ..ehm.. perceiving .. on the one hand his, his .. ehm.. my impression of what must have been going on inside of him with eh.. and how it seemed strangely in keeping with his ... stance..

I 'Cos one of the things I'm interested in is how much, from a therapeutic viewpoint, .. ehm.. we are aware of people's physiology and how it impinges on the life, to some extent for many people it has very little impact. It's almost an incidental. For others it can be much more ..um.. or, or have a bigger repercussion in terms of the everyday way of being, and what I'm interested in .. what I'm getting .. a strong feeling from you that you feel at the very very least these two aspects of the gentleman's ..ehm.. upper body stiffness and his internal rigidity .. was at least congruent. Did you think that in any way there was actually a link or was, was this just co-incidental? This is just your gut feeling, of course.

R Gut, gut feeling? It, I, I ..ehm.. it was very ..it was very tempting, to, to ..ehm.. start making hypotheses about this resonance, that may be, that, that appeared to be there. ..ehm.. As we worked, ..ehm.. one thing .. I' I realised just how much I was drawn to one thing see him as an upper body, and particularly his head. He. he was ..ehm.. very, ..eh.. I would say it's fair to say an intellectual, and, and certainly, ..ehm.. clearly somebody who'd enjoyed .. applying logic, and, ehm.. was articulate .. ehm.. had a way of ..ehm.. as I experienced it, peering out, sort of peering at others..

I OK, I'm with you, yes.

R And, I think I, I really gained the impression that ..ehm.. to. to put it in the colloquial way, he was in his head. That's, that's what .. he certainly ..ehm.. referred a lot .. to.. thinking things through and I think he had a certain pride in being ..eh.. in his intellectual powers and, and ..eh.. so I had a sense that he was identified with his head, and .. eh.. and as the, as the work ..ehm.. as we moved on with it .. ehm.. and weeks and months went by .. ehm.. I really, uh, ended up orbiting that notion, that this was one of the tensions in his life. He, as we went a bit deeper and talked about his childhood, he, a number of times described the experience, ehm, of being inside, ehm, an egg or some such place. He didn't describe it as an egg, that's how I saw it, he described it as almost ehm, as a place where he could look out through a slit and peer at the world and that everything outside was befogged. and, ehm, that he was very curious to see through this fog, but it was a very dim place to experience and he reported being, ehm, despite himself, being a little bit disoriented and a little bit ehm, stuck, stuck and so... ehm. This image of peering out through a slit it did kind of resonate with the work, and, eh, so as time went on I really, ehm, yeah, I ended up orbiting the sense that here was somebody that in a number of different ways has a fixity about him, that he's not particularly happy with, and eh, what he was like I kind of hypothesised that what he was expressing was a need for a sounding-board and to inquire further into his reasons for his relationships not working. That he was .. that was his expressed need, that the need, ehm, diagnosis is the wrong word, but I picked up on that he was quite, rather disoriented and distressed, about not ehm, being the choice to move on in some way, to get beyond this place that he described a number of times, from which he could only look out and discern, like through a glass darkly kind of thing ...

I It seems a very unfortunate combination in the sense of being physically being held rigid with his feeling of, perhaps, I also get a sense of isolation here too , but I just wondered in terms of again, keeping the actual details of the therapeutic work that you did confidential, in what way did do you think in terms of how you continuously saw him very much as a head, that was in some respects rigid, that would have to turn into, ehm, perhaps into a limited vision here, I don't know if I'm putting words into your mouth here, do you think his physiological condition had an impact on this again, or was it an unfortunate coincidence or accident?

R I eh, the only honest answer I can give to that is that with a certain degree of ehm, I'm rather shame-faced by saying this, I couldn't help feeling that this

somehow was another expression of his, ehm, of his reality. It's almost like his phenomenology was given this expression, although I've got no logical basis for that and so it feels like magical thinking, but it did, ehm.. I think I, I, it became a sounding-board for me, as a notion, because, you know, as we explored a little more, ehm, the sort of what I've described as the stuckness and a kind of fixity, ehm, it was very easy to reach a conclusion that this had, this had set in, long, long before, he became injured. And, ehm, he, his circumstances were that eh, he had grown up in a family culture that was very very demarcated and ehm, that were definite rules and there were things that children did not see, or were not meant to see, they were not meant to be seen or heard that much and uhm, but clearly he was a very sensitive child as he was a sensitive man, and was, as time went on, was actually aware of conflicts and ehm, things going on in the family that officially he wouldn't have known, so there was a kind of ehm, a theme for me and eh, that I, I found, I found the notion, and I still do I found it useful when working with him, because it gave a system of, of making a sort of, uh, working towards some kind of hypothesis. I experienced it as I still experience it now, as a kind of healing fiction, as a way in, as an intuition, and I wouldn't want to claim it as anything more than a

I I think that's what's really useful is that, the way that, I guessing you work in a way that a lot of .. therapists work is to work very much with their own bodies and try to interpret the feelings they have that are triggered by the way they are dealing with their clients. And these feelings will tend to come, I suspect if they're reasonably appropriate, if not not necessarily wholly linked, and the kind of thing that I would imagine, that if, for example, your client had some disability in the same form, but in your work with them it became irrelevant to how they were, I suspect the link wouldn't be made as strongly, if at all.

R Yeah, that's interesting, yeah.

I This is me putting words in your mouth and I'd be very keen for you disagree with that or think, perhaps, that's really pushing it too far.

R I think one thing that it did do, was very, it, it squared a circle for me to, on reflection, I eh, I can use the example here that what he described to me, ehm, was I think he even used the term at one stage that it was as if he was in a bunker. And he also used the image of a suit of armour. And ehm, whereas what I was, my fantasy was that he was inside an egg, which has no logic to it at all. Because, you know, an egg certainly wouldn't have a slit, and wouldn't be as resilient too, so, I, it, it helped me to reach a position where he was communicating his predicament, ehm, very clearly with this image of being in this place, almost besieged, but at the same time unable to see clearly what was out there and ehm, but I was drawn to his head as if I was actually looking in through this slit. I really got a strong sense of that as it began to inform my perception of him, so I moved from really experiencing him as peering out at me to peering back .. (laughs)..

I Through this common slit of communication

- R Absolutely, we had this little slot that we kind of shared and ehm, so that it helped both of us to get oriented, that there was something going on in the room between us, and ehm, and then that developed into this sort of, not always explicit, but mutual acknowledgement of that, that's what we were, that's how it was between us. And eh, and that was, eh, I certainly experienced that as having a kind of ambivalence to it, because on the one hand there would be times where, you know, I would be, eh, very conscious of peering in and ehm, sort of, his eyes were peering out at me and other times I didn't feel that my gaze in was that welcome and that the energy would change and eh, you know, that tension of, eh, I would, if I could put words into his mouth, you know, I'd like to be seen and I'd like to really to be able to see more clearly and wouldn't it be good to meet you, properly, there was also the flip side of that which was I know what's going on, thank you very much, I don't necessarily As time went on and we did more work, you know, he did actually begin to articulate that, that he was experiencing this sort of eh ... at times, you know, the sense that, ehm, he mentioned a few times, well of course you know you're new this therapy, aren't you...you know.. (laughs) .. and, and there would be little indications, and I would feel it, I could, eh, I really became of my own effort, physically, and, and I would really, in my body become aware of becoming more and more, eh, into my head and, eh, which was helpful, because, eh, when I realised that I could use that as a resource, you know, in sort of saying well look this is how I am, I'm up here now, does that ... and we did open up the field somewhat, it became, you know, because, ehm, his initial reaction to that sort of feedback from me, was kind of puzzlement, complete puzzlement, you know, I'm not clear what this has got to do with dot-dot-dot ... you know. But, the reference to how I was in my body and how I was receiving him, did give us a shared currency..
- I So communication began to improve a little in some respects. So this is very interesting, coming, because this is again, coming from your perception of his ... whole being held in this very limited narrow communication, imaged by the slit Perhaps almost .. I get this impression of a medieval helmet perhaps,
- R Yeah, yeah, and eh, eh, very much so. Something very weighty, it certainly felt very weighty, and eh, which is peculiar because I also had eh, the more free-floating image of the egg .. and eh, a sense of him as very young, possibly even, you know, (laughs) pre-natal, that was going on too and eh, yeah, and as I think that as time went on .. ehm I didn't think that ever really ever surfaced in a way that .. I really felt that, you know, eh, it was, ehm, I put some tentative invitations out to go ... to look at that, but he didn't pick them up, ever, and, eh, but one thing that did become clear was that he, ehm, had, eh, he went from not seeing the relevance of this business about eh, .. you know, the eh, the weight that I put on this, to somehow, yeah, you know, I can't see a way forward if that what he means..
- I When you were talking about weight do you mean it was as if it was the physiological weight on his shoulders perhaps, was it bodily expressed, or,
- R Yeah, there was something around this. Although he wasn't stooped, far from it, you know, he was... He didn't have a visible neck, and, ehm, was a big man and

ehm, and, ehm, squat with it. So, there was a sort of weightiness to him. Yeah, I, I, I'm still aware of that now and that the word that would, went with that was 'holding', you know that if, eh, holding was, was .. seemed very appropriate.

I Yeah, does this mean that in terms of him holding, or you holding him, or what's holding him, him being withheld, is that ?

R Almost like holding the position. You know, looking out through the bunker.

I Right, Oh I see. Him being held in a fixed position.

R Yeah, Or holding it in the sense of at times he would be holding, 'this is where I am, and what's it got to do with what I'm here to (laughs) I'm here to get these questions out'. Eh, and ehm, I felt at times, that my attempt to interact with him was being rejected in favour of him saying, 'No, I'm here to reflect out loud'. And so it felt like the whole thing came with that set of rules, that it's about me. We then got into a set of, almost, talks about talks, eh, place, and, ehm, after a lot of supervision and a lot of (laughs) reflection, you know I began to reintroduce this idea, well this is how I'm feeling. This is how I'm experiencing this, and we soared. Late on, what became very interesting to me, and I think to him, where we met on that issue of where he was in himself and what was he wanting to achieve, it's difficult because again, it's, ritual did play a big part in his life, as a matter of choice, and ehm, and he revealed a real penchant for working with ritual.

I So the rigidity of the body was perhaps echoed for, was perhaps even preceded by a potential rigid behaviour pattern perhaps. That gave him some sense of security perhaps, I don't know how, do you think it gave him security or did you feel it imprisoned him? From his viewpoint ..

R I think it gave him .. I think in that sense it gave him, ehm, legitimacy and authority and also a place to be. Ehm, you know, that was where direction was clear and what to do was clear. Eh, and the other word that came up was dignity. It gave him a dignity. And, eh, one piece of work that we did do, which was.. I certainly found it very pleasing (laughs) was, ehm, he had had a very difficult relationship with his father, and at a very advanced stage of the work, we did a little ritual, which was about him making peace with his father, you know acknowledging his father and also saying what he needed to say, so he used a little ritual for that where it was very clear, you know, what it was about and, eh, what, exactly what he would do, so he was .. had the lead in designing it. Yeah and that, ... I experienced that as something that enabled him to leave the armour or the bunker and to travel (laughs), you know, and to look around and to, to ehm, ... yeah, he didn't say very much around it at all, because the agreement was that he, we would do the ritual and then we would .. and that would be the end of the session and after a little bit of time sitting, he would leave. And ehm, you know, so and the following week, ehm, he didn't say too much about it, ehm, and and I experienced him as.. I felt that the slit was, eh, somewhat bigger (laughs). That we were looking more at a more of a, more of a window really.

- I So the slit had really gone from a slit to a window, the way you were describing it in the area of the (face).
- R That's, yeah, that's, that's was my experience but ..
- I Yeah, this is, that's very much your intuitive reaction, which is exactly what I'm looking for..
- R Yeah, I really, I really felt that ehm, I mean intuitively there was a sort of sense of, ehm. Yeah, there were a number, there were a number of images that came up for me and at, ehm, over the time ... one was Darth Vader, and you know when Darth Vader takes off his helmet, there's a little guy underneath, and eh, the other one was the Wizard of Oz, and, you know, when they move the curtain back, instead of this sort of really .. horrendous, menacing creature, there was this little man with the .. and I really had that sense with him. We'd moved from me experiencing a sort of talking head to a much, ah, sort of having a sense that, that a much younger person was there, for whom, you know, there was some sadness. He reported, ehm, a dream in, in which a lot of feelings were expressed, and eh, it was a dream in which a radio features and he was listening to a well-known figure of a journalist, a hard-nosed journalist, talking about a woman who had done something ... being very generous, not financially, but generous in giving of herself, and the report had become very emotional (laughs). That was the sort of, the sort of the dream he had reported. That was, that was apparently, ehm, immediately after the ritual, so my fantasy was that that it wasn't unrelated, you know, and that somehow we had opened up this .. Yeah, I've said, eh, the reason I'm tentative is, is because my natural .. ehm, because, because it fascinates me, and, eh, because, eh, part of me wants to tell you all about it and I'm trying not to go too far with that..
- I I appreciate that, exactly .. But the difficulty with .. because you have, ah, this contract of confidentiality, means you have to speak very cautiously and carefully, and I really appreciate that, so, what I'm very much interested in very much your reactions to this, this is really the core of what I'm after, so you are in fact giving me the core of what, what I find so useful.
- R Well yeah, I mean, I really, I suppose, eh, Yeah I noticed a kind of enthusiasm that had .. so I experienced a sort of guardedness around him again, ehm, I wasn't sure who was in there, and I wasn't sure, ehm, I was very aware I was very new to the whole business, you know, my very first client, a few years older than I, ehm, and you know that, he had a sort of gravitas about him, you know, and I thought, well, hmm, ..
- I Slightly intimidating perhaps?
- R Yeah, yeah, I mean, you know, I was eh, I was I suppose.. you know I wanted to be a good, good therapist (laughs) and eh, but there was a certain degree of caution, and I think I was kind of compensating for that, and eh, of finding myself in this very heady place. And so, the head was figurative for me, in lots of ways, and armour (laughs), ehm, and so was the egg, so at the same time I had this

other .. thing going on around, feeling pretty vulnerable, and eh, you know very much a 'Capital J', Junior partner in the situation, so I can I can see my tractor beam of my projection on the situation was very, ehm, .. It was there but it also gave me some means of engaging with him, and, eh, giving myself permission to, to play with that and to ehm, to really work against the culture, that I would think would have certainly developed between us had we met in other circumstances, which would have been this sort of, eh, you know, don't pursue this if it's touchy-feely. You know, don't pursue this if it's ehm, not demonstrably logical and sensible and grown-up .. empirical (laughs). You know, we..ehm, And yet, I mean, my experience was that when, when I was able to, eh, be a little more fluid and free-er with my response to him, then, ehm, he was able to tell me, about some of his enthusiasms and eventually it gave us the currency to do a little bit of work. You know, that, eh, and with that , I certainly felt connected to him in a way that, that, eh, wouldn't happen. And I believe, that he felt the same way, or at least I felt a softening, I do feel that there was a sort of softening as I experienced him. Eh, and a kind of eh, a somewhat freer sense. We moved from a position where he would talk about relationship issues, and be muted but clearly angry, ehm, to one of ehm, asking questions about himself. So the enquiry wasn't in effect, why was this woman being so difficult and stupid and why am I putting up with this, to, 'Ah well', you know, eh, I've never really been clear about, blah, blah, blah.. (laughs) so that there was a certain ..

- I What I get is a feeling is someone who is so cerebral, eh, that their repertoire of communication was probably very limited, in some respects. But when, when your, your relationship began to grow, and clearly with this ritual complete, and am now able to communicate through a window rather than a slit, were you .. I'm also getting the impression, this is purely from the very way that you're relaxing more as you're thinking of him, did you notice him looking more relaxed or perhaps slightly more mobile in his upper torso and head, the head thinking, as you first saw him?
- R It certainly became less, figurative for me, and eh, I, I began to experience him as having legs and, you know, having a belly. Partly because we started to move round. We started to stand up and in a pre-arranged way, we used, eh, different corners of the room for different activities, and eh, and yeah, it, he really went from being somebody who was up here, looking out. I didn't experience a radical move, but I did experience him moving about as if on track-ways, you know, but there was a, ehm.. One thing that was, became figurative for me was that he had a very deep voice. and he spoke out, he spoke up, and, ehm, which was .. from being a kind of a murmur, albeit quite a deep murmur, to, to being almost a baritone. So there was a, you know, um, ..
- I So he became much more vocally expressive in his pattern of speech, perhaps?
- R Yes, absolutely, yes. And eh, yeah, uh, again the eh, .. he was, he was able to talk about, ehm, I suppose this is grief, he said at one stage, about his father and this was on, on the lead-up to having the ritual, we, I used some smudge, eh, ... And at a certain point, you know, ehm, pre-arranged, he allowed me to put some smudge on his head, and eh, well, not only there, but here as well (indicating

face) and eh, and this was, by agreement, ehm, to really, establish the link with his father, re-establish the link with his father and express what he wanted to say.

- I Is this in the context of perhaps in the context of things like sack-cloth and ashes just to make sure I understanding correctly ..
- R Yeah, that's fine, yeah, so, ehm, He, he.. my intuition was that he would be able to digest that. Ehm, but it needed an explanation and it needed dignity. And eh, so I , you know, ehm, I felt that, eh, and I mean I would say that, but I really felt that was borne out by what happened, that he ...ehm, I felt that he'd been doing this in a strange way, you know, ehm, for a long time.
- I Yeah. By this do you mean in his ritual behaviour, or ..?
- R Yeah, he, he's because his ritual behaviour was something that .. it wasn't ehm, sort of compulsive, secret sort of ritualised behaviour, it was, kind of social. And so he, ehm, .. He seemed to take to it like a duck to water, you know, ehm... And one thought that I did have is that it was about, what a genius we have for doing what we need to do. And he'd been doing it, ehm, and it also raised this thing about he needed witnessing. So what he described as a sounding-board, was, ehm, I experienced as a request to witness him and to give him some, ehm, acknowledgement, I suppose, you know, ah, which I wanted to do. I wanted to give him that, you know. I got a high on that, and I felt that it was something very positive, and uh... Hmmm.
- I You seemed to get such a strong reaction and a change in behaviour. It's fair to assume that there was a cause and effect here.
- R Yeah, I I think that certainly, the ehm, .. When I thought about, you know, who would I talk about with, it didn't, it didn't take too long for him to come up. Because it was, not only because he was my first client, but because there was something, I felt something very satisfactory happened. I don't quite know what it was, but it was something satisfactory, and that, you know, I had a different experience of him. And I think he had a slightly different experience, ehm, you know, and I think it was ... I like to think it helped him to get oriented, ehm, and to perhaps feel ehm, OK about what he had been doing quite naturally.
- I Yes, I understand, yes. What I'm feeling, what does intrigue me I think this is when I approached this piece of research, that I freely admit that I don't understand quite how psychological therapies affect people's physiology, and when .. which raised this issue of this client in your memory to some extent, and getting the image of a client who came to you very very rigidly with this physiological condition, that appeared to be more than co-incidental it seemed to suit the character to some extent. And yet at the end of the therapy after you had done a series of behaviours that suited his pattern and suited his pattern so well that he seemed to soften and become probably marginally less rigid, but that for him would be a huge change..am, am I getting close to the experience for you?

- R Yeah, I think it's it ehm, I think it was very important for him to retain a sense of his authority and his dignity and the recognition of that, you know he, he would spend quite a bit of the sessions talking about such things, you know. He was somebody with particular expertise, you know, he was ehm, certainly, I experienced him as you know, ehm, up there intellectually, and ehm, but I do feel that he reached a position, maybe not fully consciously, he reached a position where, other attitudes and other approaches were beginning to appeal. And if I put it in the context of his ritual behaviours, ahem, then I think that there was almost as if there was an extension of that happening, but it was rather more personal than anything that would be, you know, a, a formal way of being with others, it was a kind of a way of addressing something much more core to him.
- I Did you meant the actual ritual therapeutic work you did?
- R Yeah, yeah... yeah
- I Do you think that in any way that and this is the big puzzle, really the core of my research, do you have any idea or any explanation of how you feel the therapeutic work you did at a level of psychological understanding seemed to change his physiology, as he appeared to be much less 'heady', as you called him, at the end than he was at the beginning.
- R Yeah, I um, ... oh it's, em, there was a perfect figure in his dream. And eh, he, in the dream report on the radio, one of the things that was reported was a, ehm, a burning ... there was a phrase which was 'love in you burns' or 'love burns in you'. And ehm, it was ehm, it certainly corresponded with a time where I felt that this, you know, I did experience him at the end of the whole process as being, as being in here (indicating heart).
- I Much more in his chest than his heart... uhuh, OK.
- R More chest than anything, not, I, you know, I would say he was he was in this sort of strip (indicating chest) that was how I experienced him and eh, um, and the word that came up for me was this idea of 'barrel', barrel, but not ehm, but not sort of hollow barrel, but kind of barrel-like. So he went from being a Darth Vader helmet to being a barrel, and eh, which ... that was the kind of move, you know, the, sort of secretive images, fantasies ...
- I Absolutely, yes. You're getting image there of something still quite rigid about the torso, perhaps, but the vulnerable head exposed. Would that be fair and accurate?
- R Yeah, I think that's fair to say, yeah. Yeah there was eh, ...
- I So a freeing, a freeing-up of the head from the body to some extent...
- R Yes, yeah, there was

I Did this express itself physically in any way, did he actually look differently or did you think this was your, just that you're emotional perception of him?

R I, I remember, ehm, becoming aware of his, that his complexion had changed. He was very white and pasty-looking and ehm, I remember seeing him as being more pink, that was my impression, he was pink, you know, and eh, He was very round-faced, and uh, you know.... I did have the impression, and ehm, not even after the ritual, but on occasions, he could seem like a giant baby, to me kind of thing... yeah and I think, and quite a disoriented one at that, and ehm, it's so that .. And so, it's tricky, because that a lot of the things that are figurative for me now in his story, even as, even as I'm saying this, there is a sort of strange chicken and egg, because he did report an experience where as a child um, he, um, hid under some furniture and stayed there for a very long time and witnessed things from under there, you know, and ehm, a kind of bunker-like experience. And really when I reflect on that, ehm, the impressions that I had, within the first hour, that was all there, energetically. And in my phenomenology, you know, that became figurative for me, the whole idea of peering, and, you now, and I .. But then again, I'm looking back on it and so I've now got my story (laughs) I've got the story-line, but the.. I think there was something for me about being able to enter into that fantasy, and to see it as relevant and to utilise it, and ehm, and as I got more confidence in reporting my fantasies, I really felt that he was able to, eh, sit through what I was saying, and some of it he did pick up. And the thing that he really did pick up was the ritual. And I'm convinced about that. He seemed to take to that with enthusiasm, you know, and uh.. in quite a muted way. But in a very, in a way that I experienced as 'Ooh yes' a little bit of Sartori thought – I'll have a go at that. And eh, yeah, uhm.. And so I think that from being 'in slit' I experienced him as performing, as being a performer in this, and, you know, ehm... I experienced myself as being a performer as well, It gave us, I'm sure that sort of .. parallel processing .. Yeah ..

I I really see that there was a real communication between you at the end, as much as ..perhaps could be achieved ...

R Yeah, yeah ..

I As a final thing, do you think that there was anything from the training you had for this client that you feel might possibly have equipped you better for that experience?

R Well I feel that, ehm, I mean that ..ehm, I felt very grateful for the psycho-synthesis training, ehm, because, ehm, that's very much around beach-combing for, ehm, our own process and utilising it. Trusting the intuition and engaging on that level. I was very pleased about that. Ehm, I suppose, training ..?

I Perhaps, in a way which your approach could perhaps teach others as much as other approaches could teach you for an experience like this. 'Cos this is, seemed to be something that seems to have worked extremely well for you.

R Well, I , I think that one of the things that, ehm, my training has been informed by are years of working with troubled adolescents. And ehm, something that's, I've tried to take on board there, is that the belief, ehm, I firmly believe this, irrespective of what we know, or what our job title is, it's who we are that determines what will happen when we are in somebody else's presence. And that as an environment for each other, we create that environment. For each other, and ehm .. So that, and also, the notion that it's important to try to start from where people are and not from where anybody'd like them to be. Ehm, and paradoxically, 'cos there's no real way of knowing where they are, ehm, we can only grope towards where we are. And that somehow seems to work (laughs). So I think that there's an interesting sort of ..ehm.. I really feel that with that particular, ehm, you know, ehm, I've beach combed ehm, for what's going on inside of me and that kind of get, kitted me out to begin ehm, I'm .. I'm aware as I say that, of a kind of tentativeness in saying it, because it's almost, I suppose to answer your question, you know, ehm, although psycho-synthesis says, you know trust your intuition and work with it, it also says, you know, don't jump to conclusions too early, and I'm a little bit kind of, ehm, I think I tend to have to keep stopping myself, to, because,....ehm..

I In case you jump too far, perhaps? Yeah.

R Yeah, and, yeah.

I You'd rapidly take yourself beyond where you happen to be at this moment, ah, when your intellect takes over from your intuition perhaps. Would that be fair to say?

R I think so, and also, although I'm not of the school that, ehm, in, I don't use the deprivation models, psycho-synthesis doesn't do that, but at the same time, I talk too much, and eh, (laughs) yeah, that's, ehm, I've always found that a continuing story of the most difficult thing to do is just to simply, ... stop.

I Yeah, I appreciate that.

R (laughs)

I I'll just switch this off, that's fine, thanks very much ..

End of transcript 4

Beginning of transcript Participant 5 HP

I I wonder if you could describe to me what you know about the origins of that particular condition in any client that comes to mind. Where you think they got that illness from and how that illness makes sense to you.

R Ehm, I think a lot of the clients that I work with, ehm, some of them have got Type 2 diabetes, so, ehm, if we, I deal with clients with chronic wounds, so ehm, so,

kind of as a, having Type 2 diabetes means that you have a more sensitive skin. It's much easier to acquire a skin rupture and because of the diabetes it's slow healing. Ehm, again Type 2 diabetes you tend to develop in, ehm, the second stage of your life, eh, it's often behavioural and environmental, ehm, so your actions and your lifestyle's got a lot to say about that you're Type 2 diabetes. Ehm, so them again, the healing process, ehm, if you sit around a lot and you're not very mobile, then obviously the circulation and everything that you have in your feet, which is poorly anyway, in that those kind of things, ehm, so if I think about, take one client with Type 2 diabetes, ehm, foot ulcers, ehm, again, ehm, overweight, not very mobile, and again I guess that goes in a cycle, in a circle, ehm, because you have you get the ulcers, it gets really painful, you can't wear your normal shoes, they seep, they smell, they, you know, the person often doesn't go out very much. Ehm, so in terms of the origin of why they have it or why they continue to have the chronic illness, ehm, is, maintaining of, this behaviour that is unhealthy, in that respect, ehm, and not adhering to the treatments, ehm, that they are being prescribed, again, 'cos they are uncomfortable, and they, in terms of ehm, binding the wounds, and not letting, ehm, taking off bandages and things like that, and very often they, they clip little holes in them, and they take bandages off, 'cos it itches, and so forth, you know.

I So to some extent it's quite understandable,

R Oh, yeah, absolutely ..

I Albeit maybe not a good long-term solution for them.

R So what starts out as a very little wound very often turns into the whole leg, the whole of the foot.

I Quite dramatic then.

R Yeah.

I Yeah. Do you think, to some extent, what maintains this particular condition for your clients and patients you meet, eh, is there any particular thing about the treatment they're offered, or their understanding of the treatment that is particular consistent, you might think that gets in the way of their healing?

R No, I think certain aspects of it is, ehm, as long as they have the illness, ehm, they have a social outlet. Ehm, 'cos they like coming to clinic, they like seeing the nurses, they have a chat and a banter, ehm, and obviously, if they've been coming for six months, two, three years, it becomes a part of the daily routine. And it's getting out of the house which they don't normally, do, ehm. So I think, in certain aspects, at least with some of the clients, and say, thinking of this client I have in mind, it's very much one of the aspects of her condition. Eh, there isn't a great incentive, per se, ehm, to heal, as she's socially excluded.

I Right, really unlucky then, you know.

R And that's, that's with quite a lot of the patients. And I mean, one of the things that's ehm, is come back when I've done focus groups, about this, this ehm, type of client, is that, ehm, they're trying not to moan and they try not to talk about their condition and they try to be very normal, but, because they can't be normal in terms of the situation, they just don't go and don't do them, because they don't want to be the person who moans and that people don't want to be around, because their foot or their leg, or, and so forth.

I So do you think they're accidentally excluding themselves, or do you think there is a real exclusion going on?

R I think it's a, a bit of both. Ehm, well there are physical aspects I presume with that kind of chronic condition whereby it's there's a smell, their seepages, and you know, there's, sometimes it can look very unpleasant, ehm, and I think, although it's 2010, people are still kind of, 'whoa, very unpleasant'. And people are still kind of stepping back and thinking there's something contagious and something not, not right. And the patients are viewed as being not clean, ehm, and they're not looking after themselves which obviously is why they have these things, ehm. And sometimes, there is, they have problems taking a shower or a bath, because they can't physically do it, ehm. Other times it is the fact that, you know, you have, rotting flesh. It's going to smell, ehm. So I think it's just, there's quite a lot, ehm, stigmatism of, against the client group.

I Yeah. Really very very unlucky. Is there something perhaps, in their own view of, either the condition or how they got there, or both, that inhibits their healing behaviour, if you like, or their coping?

R I think it's very very individual and it's ehm, again it goes back to the, ehm, biopsychosocial role they have in the society on how they cope with pain, how they cope with their physical condition, being healthy versus not healthy, ehm, again, social network, ehm, their ideal of themselves, so their identity, so how their outlook on life is, plays a part in, .. I don't think that there's an, a stereotype of the type of the client I work with, and often that's the problem because the medical staff generalise quite a lot. So a lot of the time they don't, ehm, clients don't actually get maybe what they need.

I Mhmm. Is this b.., I'm intrigued 'cos this has been reported back by several people when they're dealing with several conditions, that there's an assumption of a standard patient, that comes into a, any particular disease category and I wondered what kind of way would that get in the way perhaps for some of your clients?

R Well I think ehm, in our field, obviously I work in a multi-disciplinary team, ehm, pain is the big thing. Dressing change in particular is, kind of what the medical staff thing is, ehm, very concerned about, ehm, 'cos again, there's a lot of evidence that says that if you can reduce the pain in dressing change, the outcome is better, ehm, ..

I What's in, do you mean, that the, the dressings, are the dressings are cleaner or what do you...

R Ehm, sometimes, the pain the dressing is, so it's literally taking the dressing off, having it debrided, having it cleansed, so, you know, the, the physical pain of having your wound cleaned and ehm, re-dressed. Ehm, and our assumption of what type of wounds and what type of ehm, medical backgrounds, say, a Type 2 diabetic foot ulcer is viewed as much less eh, painful than a venous leg ulcer. Whereas actually in fact, pain is so subjective, that although that you might say overall that a venous leg ulcers is much worse than a diabetic foot ulcer, you can't really compare them because it's to do with the individual him or herself and how they cope with it. So I think that that sometimes comes into the way, or comes in the way ehm, say where, say, medical staffing might be less considerate when it comes to a diabetic foot, ulcer, than when it comes to a venous leg ulcer.

I Oh, is, what, is this from their own research or is this a general position there where they simply don't take account of individuals, or is there some logic behind this thinking?

R Ehm, I think it's, ehm, there is a lot of research in terms of the, in terms of pain eh, and different kinds of wound types, but it's, a lot is anecdotal, ehm, experience as well, ehm, and a lot of time I think, the, although there's a lot of evidence for a lot of things, ehm, it doesn't actually reach the ground staff, so they go on what they have experienced for the last ten, twenty, thirty, years, ehm, and obviously do great work, but not necessarily what's most appropriate for the patient.

I Ok so perhaps not being as sensitive to the individual as much as the treatment .. So I'm wondering about what your role, then would be to, mediate this complex process between the individuals with their conditions and the medical staff, what do you feel as a health psychologist, can do or does do in this process?

R Well, I think, ehm, my role is two-fold. I do research, clinical research and I work with patients in, in the hospital setting, around the health care professionals. So I think for me, my role of health psychologist will, its, well I presume it's three-fold even, I'm there for the patients, ehm, to enable them, or to give them tools, help them to gain tools to cope with their conditions better, ehm, again chronic, it's not going to go away, how can you best cope with different scenarios, situations, and so forth, ehm, secondly, obviously the research I do, dissemination is very important, so my findings, ehm, I share that with the ground medical staff, ehm, internally and externally, I think that's as a health psychologist, that's something you can do. You can bring the gap between patients and health care professions, health care professionals, closer. And you can eliminate some of the anecdotal, ehm, evidence, so to speak. And then thirdly, to work with health care professionals ehm, to enable them to cope better with the processes that they're going through.

I Right OK. So that's, so if we going into slightly more detail into this one, if you're dealing with the patient directly, their experience of the system, how might you ameliorate that situation or how might you deal with that situation, if you're taking the patient's view?

R The patient's view, I think it's, my role is often to listen to them, and let them kind of speak their mind. And it's often, reassure them that the anxieties and the

questions, the unanswered questions that they have, ehm, it's got nothing to do with the great care that they always feel that they've been given. 'Cos they're very apprehensive of, to criticise or to say anything that is negatively loaded because of the great care that they're getting. But there's obviously lots of stuff that they're not getting, ehm, and literally have a chat about ehm, you know, depending on what comes up for that particular person. There might be certain aspects that is more important to him or her than for others. So again, it's just picking up on the different important issues for them. So if that means, ehm, how can I go on holiday, because I have fifty thousand bandages and I'm only allowed fifteen kilos of x, y, z, and also I'm going in the sun and how can I deal with that scenario. Ehm, or to say I'm, you know, I'm petrified of coming to have my dressing changed, because I, I know it's going to be so awful. So again, how can we change that attitude, ehm, into something more positive, ehm, kind of decrease the physiological response which again increases, ehm, feelings of pain.

I And, how, how would you do that as an example?

R As an example? Ehm, I've seen me using health psychology theories and models, ehm, I sometimes, you know, ehm, what, CBT if it's appropriate, so, kind of walking the patient through process, ehm, letting them see themselves from one step to another, what's happening.

I And how would this work with them? Examining the process of walking through the process, how would this, how would this happen?

R Well it would be, ehm, the patient won't necessarily, they won't have an appointment with me. Albeit when they come in, normally, for their dressing changes, I would often ask the nurses whether they feel, 'cos obviously they know the patients as well, whether they feel that there are any patients that could benefit, for having a chat. So there's no structured session as such, it's more, ehm, having a chat with me if they want to and also letting the patient know that I am there, ehm, would they want to have a chat. Ehm,...

I And how does the chat help them, do you think?

R I think just sometimes it alleviates anxiety, ehm, and also gives them an outlet. 'Cos I think I'm impartial, in the way that they can have banter with the nurses, but there are certain anxieties and fears and issues that they they don't particularly want to bring up where there's two other patients behind curtains, and, you know where they privacy isn't all that ... So I think it, its, sometimes it's just an outlet for things, sometimes its, ehm, building on the process so that when they come next time we can go back to, you know, how are they getting on, and building on things that are working rather than things that aren't working.

I So to, to some extent, I'm trying not to put words in your mouth, 'cos ehm, is this a form of re-framing do you think, where you invite patients to view their experiences differently?

R Yes, I presume so.

I Or is it being more sympathetic to their viewing of it without changing it necessarily?

R Yes, I think it's .. well I presume it's re-framing in the way that, ehm, we talk about things and you can maybe start mastering some ideas for them and then obviously let them go through the, their processes, ehm. 'Cos again it needs to, without knowing that much about their background, initially, it's difficult to go into depth to say what they should or shouldn't do in their daily lives.

I Yes. It's certainly quite a tricky one. Again the kind of experiences that other colleagues have had, ah, that seems to be, really, the way to look at the individual patient which is either to work on what I might short-handedly call acceptance of the situation and the other one is to reframe their views and that seems to be the general thing, but am I missing, would I be missing anything out on that?

R No, yeah, I think that's quite correct.

I Hmm, that's a tricky one. And when you dealing with the medical staff what's your feeling of their understanding of the client or their patient's experience?

R I think they, they're very sympathetic, ehm, they often say that they're really really busy on, on clinic days, seeing a lot of patients, and I know that the nurses feel that they are not able to give each individual patient, you know, all the support that they need, but also they're not trained for that. And they miss not having a more structured framework where the patient can kind of leap from, you know, from one health care professional to another in terms of to get all their physical and psychological needs better met and to address those things.

I Is this something you can intervene with or are you just aware that this is happening?

R No, ehm, a certain thing, you know, I am, one, I'm aware that it is happening and two, I am there, ehm, but there isn't a, I don't have as much as a formal role within that, although I think that there should be, and there is room, really, in the unit to have me and use me in that capacity, ehm, it's medically run, so I don't think that us health psychologists are utilised as well in the department as we could be.

I Is this, is this really because the medical staff you're dealing with feel they can't simply refer the patient back to you, for you to deal with, perhaps with the psychological issues ..

R I think, no I think it's the ..

I Or do you think you have to go through a different hierarchy and, or they don't know quite where you fit in?

R No, I think, yeah and what, not necessarily where I don't fit in, but I think, ehm, it's assessing whether there is a need to address the psychological issues, ehm, whereas eh, although the head of the department is very aware of the psychosocial

needs of the patients, ehm, she doesn't actually actively involve, ehm, kind of the staffing who's got the ehm, credentials and experience to deal with those issues and rather want to focus on publications and making sure that we have a high profile. So I presume that there is a give and take and there's certain things they don't wanna give.

I Fair enough. Yep, OK. So, do you think this is really almost an accident of the structure then? And that sounds very much as if you're not saying it is a deliberate policy to exclude. It didn't sound like that.

R No. I think it's just, ehm, I think it's literally just one of those things that is always been a certain way. And changing it seems maybe a bit too much.

I Perhaps. I can see to some extent, understanding the potential of health psychology more may be more useful. Yeah. So in that term again, with client again, ehm, in terms of your understanding of your client's behaviour, ahm, their thought and their feelings have you any understanding of how they may see your role, how they may see your helping them?

R I think, ehm, very often when I, first of all when I say what I do, they go 'Oh you're going to read my mind?' But then when I explain what I do and what I don't do, I think they see me as, ehm, someone who can give them a bit of a nudge and a bit of, eh, courage to maybe go in some directions they haven't been before.

I So along the lines of emotional support as well as advice, or a mixture of both?

R Yes, yeah. So I kind of, and I presume opening doors that they didn't think were there, ehm, as the, and they're very, I think what I have, what I have done in the past is, ehm, putting some patients together, just to have a .. I've been a mediator and literally, had them sit there and have a chat about ehm, their life. And the feedback is very often is that, ehm, they feel more uplifted and better able to handle their daily life, 'cos actually compared to other people it's not as bad, or there are others who's got the same thing, or, you know, creating a support network for patients, ehm. Again, it's funding, ehm, related. It can't happen on a regular basis, but it's kind of opening up the, ehm, the opportunity for patients to start their own support group. And it has happened, that there is a small number who tend to meet up, so, yup. So again, I think the role, the way they view me, is maybe just a, as a facilitator, ehm, someone who listens and maybe comes with a couple of ideas. And they, I think they realise that I'm not there to pull out everything in their heads. (laughs).

I Yes, yes, uhuh. So obviously you're getting feedback that they do appreciate you being there, where you can be effective, ehm. You mentioned they were uplifting, so, at the very least you seem to be describing, ehm, at the very least, a raising of mood, at the very very least as well as a facilitator.

R Yeah, yeah.

I And have you found in your research this links to their ability to adhere to their various treatment regimes they have to have, or improves their outcome in any way.

R Yeah, ehm, I mean, in the research that we have done that's, it does, adherence is correlated with ehm, better outcome. But there again, very often you have to think about the type of clients who often are willing to participate, participate in your research. So they are in the first place gonna be patients who's more keen to make changes than the ones that doesn't want to take part 'cos life is so awful. So I think that you do lose out on a, on maybe the most neediest client group and maybe the people who could benefit from your work the most, ehm, are being excluded or excludes themselves, but then there's nothing you could really do about that, so I presume doing the research or working with the client group that are willing to work with you at least you have ehm, you get some sense of a base of information what can help the other group. And they do have to come to clinic, which means that you can feedback to the nurses, make sure that they can incorporate that into their treatment.

I OK, yeah. 'Cos I can remember reading that one of the big splits between a belief about a success rate eh, is between the, those patients and clients who feel they can have a positive change on their environment and those who do not. And of course obviously in the field of many chronic conditions like diabetes that it's, ehm, a fatalist can also get in the way which is different again from, ah, feeling negative about things. Do you find that acceptance stands in the way that how some clients may deal with the treatment or is that a separate dimension altogether?

R Well, I think that depending how you define acceptance of your condition so if that is, well this is the way it is, I have a chronic condition, may get better, probably not, and even if that gets better I'm going to get another ulcer, so I might as well just do what I do. Ehm, that can get in the way, ehm, 'cos there's no incentive to change your behaviour, but I presume that if you have acceptance of your condition and you think about it and you think, OK this is how it is, some clients think that way. OK I have this blooming ulcer, ulcers on my feet and legs, I have to come to clinic, twice a week, that is gonna mean that I'm not gonna be able to go down to Southampton and see my family which I used to do once a week beforehand, ehm, however, I can speak on them on the phone instead and they can come and see me once a month, because going to clinic means that it will get better, and although I'm probably get another one, there might be a period of time where I can be well enough so I can go down to Southampton and see my family. So again, it's the effect of how they view their condition, ehm, and the acceptance of it and again that's very individual.

I So, so that's quite a difference then between acceptance and fatalism in that sense. I see.

R Yeah and, I mean, I had ehm, one client who'd had his first, he's had an ulcer for twenty-two years, 'cos on and off, I mean this is constant, ehm, and the first time I think he just hit his foot on a shopping trolley in Sainsbury's, and got a little sore and that was it. And for the past twenty-two years now, he's been in and out, and he was like well, obviously it's not going to change, ehm, so his outlook on things is, well it's a bummer, ehm, however, I can't stop living because of it. Ehm, whereas others would go, well, this is the end. I might as well sit here with my foot up and do nothing.

I So, there's a very obvious feedback for yourself in terms of the patients who you feel are successful. I was wondering if you feel to some extent you can actually

mediate this process or do you feel it has set in with the patient? Personality characteristics say?

R What do you mean in terms of mediate the process from the, negative to positive, or from..? Yeah I think I can mediate in the way that ehm, obviously, your personality, your outlook on life, you know, your background's gonna have a lot of say on how do you cope with things, but if you take that into account when you deal with an individual, ehm, I think I, I, I am able to mediate, 'cos sometimes you, we're always stay set in our own ways, you know, whether or not you have, you are a patient with a chronic, eh, condition or whether as, you and me, ehm, sometime it's difficult to see if what you're doing, ehm, that you can do things differently, or add things to what you do or take away certain things. ehm, so in that way I can mediate, ehm, transition from worse to better.

I Well that's very good to know, that's very interesting. So it is, it is a very much or it can be I presume for some of these clients, a very hands-on, deliberate significant change in their approach, attitudes or beliefs. Or feelings of positivism, perhaps. So that's an obvious sign of success then.

R Ehm, yeah, I presume so, yeah.

I So one of the obvious questions is how do you know you're being effective and that would be a very clear, clear measure.

R Yeah, yeah, a change in beliefs, and attitudes and various things.

I And in the unit you've been working in, is that has there, in the research in particular, has that actually come through in the, eh, basically how do you know you've been successful, measures.

R Ehm, yeah, the research, ehm, research has come through. I think in particular there's ehm, I've been a part of, a major study over two thousand patients, over fifteen countries in the world, looking at pain in chronic ehm, chronic wounds and, ehm, from the patient perspective, so ehm, although it's a semi-structured questionnaire, ehm, it was based on the deep focus groups in the first place, trying to get the patients' view on what should be included and excluded and so forth. And, there's also quite a lot of open-ended questions, ehm, I mean, in that study in itself has changed things very massively within the field of wound healing, in the UK as well as abroad, so ehm, so in terms of dissemination, knowing that for certain that certain practices within the NHS, ehm, NICE guidelines as well have changed as a result of the research that we done ..

I Once again, is this handling ehm, the single issue of pain, or is it a across the whole field of wound treatment?

R Yeah, eh, it's... Some of it is dealing with pain and dressing change, ehm, but also it's dealing with pain not necessarily, 'cos the conception of it or, 'cos of the preconception within, ehm, health care, within the health care sciences, that pain is the worst factor of living with a wound. Whereas what has come out of the study, is that actually it is one of the contributing factors to poor quality of life, but it's not *the* factor.

And although there are, we know this is the case in many other, ehm, areas of chronic illness, ehm, that hasn't actually been, ehm, the case within chronic wounds. Ehm, so again, there are other aspects of, ehm, living with chronic wounds that are actually more important to the patients, ehm, than the actual pain of dressing change. So this influenced how health care professionals ehm, and specialised nurses and doctors, how they actually deal with the process of seeing them in clinic.

I And would that be from what you saying earlier in terms of people's ability of having a quality of life that's more important. So it's the issues of mobility, their identity, all these things you mentioned earlier. Yeah, fascinating, it sounds a lovely piece of research.

R Yeah, there, it is. Very very interesting and very useful, yeah.

I Yes, so in terms of I know at the moment you're being obliged to take time out ..

R Yes, being a fatty! For another week or so!

I (laughs) So how, looking back, your training as a health psychology perhaps has given you an advantage over the other, if it has given you, I'm envisaging that, has given you a special way to look at this particular group of patients with chronic, ehm, wounds and difficulties. How do you feel that viewpoint has helped?

R Ehm, in terms of other ...

I In terms of the unit you've been in, what do you think has been your training and experience as a contribution to ..

R I think my training and experience has very much led me to emphasise on the psychosocial aspects of living with the conditions that they are, and to acknowledge that, ehm, there is very much a biomedical view, ehm, kind of dominance in the field I'm working in, and that's all well and good. Ehm, but also, I think, I see my training has taught me how to very gently nudge, ehm, and help other health care professionals, ehm, not to see it my way, because, kind of, enlightening, the path that there are other viewpoints as well, ehm, and not black and white, but that's... I presume what I do to be added to the view that they have and therefore enhance the whole experience that the patient is having.

I Is this, from what, getting from what we were saying earlier and if this isn't quite right please correct me, do you feel this, perhaps, seeing patients much more as individuals within their social context, or is it something in terms of the psychosocial, is there something beyond that?

R I think its ehm, it's taking the individual into account in the larger scenario. Ehm, and I think, yeah, my training has, I presume, taught me better how to handle and deal with that. In terms of, ehm, getting, getting my views, or health psychology views, put across to other health care professionals.

I Ah, yes, right, to some, so it's communication skills then?

R Yeah, I presume, yeah, yeah, I mean, yeah, communication skills, ehm, but I think also, ehm, yeah, my health psychology training has taught me to better approach, the, the scenarios and the problems that they're having, oh, I'm sorry ...

(phone rings, conversation deleted).

I I think we, well, what we were at before the phone rang, was ehm, we were talking about the possibility of being able to see things in a particular way from the training, and the communications skills allows you to, ehm, contribute particularly well within the unit. That was really it. And what I was interested in, really, as a final position, is, having been through the training you've been through, in the way that health psychology currently trains, are there any particular things that you could have felt, could have done with do you think, perhaps, or things that might have been more useful to you within the training that wasn't available?

R Ehm, I think, ehm, maybe some, it's weird, because it's not as if the hands-on training that's wrong, you're being taught in your work setting and obviously the, eh, additional competencies that you require you have to pick from here and there, ehm, and in a way, in many ways I think that's is a good way, because you have to be, resourceful, you need to go out there and kind of really put yourself forward, it means in many ways you're more motivated, and you want to get things done, but I think potentially, a, the opportunity to have a wider selection of clients, and, ehm, physical and psychological conditions, ehm, I think that could enhance in a way our portfolio, ehm, for later use. Ehm, I think other things in terms of the training, ehm, I think because we're doing so different.. All our students are working in so different scenarios and different settings, in many ways it's difficult to amalgamate these. And that's, you know, that is the same comparison as when we're dealing with patients, which depends on which patient group we're dealing with, saying that we're all individuals and therefore have different needs. Ehm, and I think within a small group, although we are, ehm, we all have different needs. And it's not going to be possible to meet all our needs, ehm, within the session that we have, ehm. Some of those sessions on our professional days have been not as useful to me, maybe as, as for others.

I Yes, mhmm, yes, that's fair to say, yeah. In terms of your selfish needs, what might you have liked to have had?

R Ehm, I think, potentially, more one-to-one, eh, within the different competencies. Ehm, so not supervision as in, as such, but, a more structured, eh, approach to say, the different competencies of teaching and training and consultancy and, ehm, and I think sometimes, ehm, when it's just a big slot saying pop in, or if you want to see me, but actually, they don't particularly have time today, ehm, so don't come in! (laughs) Ehm, yes, so I think in terms of the training there are, so some of the structure, I was in the first cohort, so ehm, we've had the swaps and changes and eh, what works and doesn't work, throughout the whole process, and a lot of it has been ironed out, for, for the years to be, beyond. So, ehm, so I think for me, literally, knowing that from when we started, we would be a bit of, you know, guinea-pigs, but I think I'm very lucky with my supervisor, and I kind of, in a way, just created, ehm, the needs I have. I've

created, basically, the type of a structure that I need to work within, ehm, and that, they've been very accommodating with that.

I Yeah, that sounds very good. So you feel you've been reasonably well been looked after then?

R Yeah, yeah. But I don't know, I'm just trying to think in terms of, ehm, ..

I I'm thinking in terms of, there's a wide range of psychological trainings we could get in theory, and health psychology focused on, a reasonable range of them. But if there was another, range within psychology perhaps that might have been useful ..

R But I think sometimes I think, yeah, I mean, you know, there's a lot of people say but, oh, but, you know, have you been trained in CBT or trained in psychotherapy, you know, and those things. Ehm, you know, maybe, as a, it would be a useful tool to have that as part of your training, ehm, but then again, it is an additional tool you have as a psychologist, and not necessarily a tool you need to have to practice, ehm, so, ehm, maybe, ehm, maybe just some, some, going back to, ehm, working models and, ehm, theories, 'cos although you know them and you work, you work with them and they become sort of unconscious in time, and ehm, assume that you remember what you've done for years and I think that maybe that, is something that, within health psychology, that we don't do enough of. We work within the frameworks, but we sometimes forget to refresh our knowledge very much.

I Yeah, so just, it's really, it's really you're talking about maintaining professional development of a sort and perhaps in a more formal way than has, has been possible so far.

R Yeah, yeah.

I Well thank you very much indeed. That's been really, very, very useful indeed, I'm very grateful.

R Thank you (laughs).

End of transcript 5

Beginning of transcript Participant 6 HP

I So, what I've been asking you to think of is, ehm, either a client of groups of clients or just even the thought of a client with a physical condition has been a significant part of your relationship with them, and ehm, thinking of that client, ehm, what's your best understanding of where this condition occurred in them and what kind of role does it play, might it play, or, in their, the difficulties they face.

R Well, yeah, sure well ehm, I'm working with a male client at the moment, actually today, ehm, I saw him for, ehm, a second appointment with me, although he had an assessment before that. Because that's in the place where I have a practice

room. We are getting them through an assessment when we look at their needs, all of their needs, holistically, and then we allocate them to different kind of services, where I get to do counselling, ehm, and so I, I sat in all the assessments where his physical issues came again and again. Well obviously he's a survivor of abuse and torture, and he's an amputee as well. And so, ehm, he's got at the moment chronic palpitations. Where, you know, their bothering him. He's talking about them. And he's got headaches, chronic headaches and, ehm, he's got chronic pain after the amputation. And it's not healing properly and they don't know what's going on with that, so that again bothers him a lot. Although he came as a survivor, ehm, that's what he wants to talk at the moment, or not talk rather, but just drink. And so, ehm, it's interesting for him, because, what he thinks and what I would think doesn't simply coincide, so several things .. you know, well, psychological trauma is your main issue, but he thinks well, the palpitations and the pain is my main issue.

I Yes, it makes a lot of sense, yes ..

R Yeah, for him. And so, ehm, that's interesting, ehm, and eh, and your other question was, how ..?

I Really what do you .. what was his background, how did he end up injured, or, or was this through the torture he faced, or was it coincidental with other parts of

R Yeah, Well it's a mystery, the headaches seemed to be traced back to some of the beatings, he.. the torture, and the beatings he suffered on the head, several times, ehm. The leg, the amputation of the leg and the pain, obviously. That can be traced back to when he was in detention, and we don't know the circumstances of that amputation .. and .. it seems like it's been an accident, but he won't talk about it yet, ehm. And the palpitations, again it not too clear, it seems like ehm, they've intensified since he came here as an asylum seeker. But it seems like they've been there for a while, quite a while ... for a longer time. And in fact, because he's gay, he's a gay man. In his country, of origin, where he used to live, that was a forbidden behaviour, by law. And that's why he's been captured and tortured. And, you know, and so he fled, ehm, and for a while there, it seems like he lived under enormous stress of being discovered. And also, ehm, under enormous rejection by the community and his own family who didn't .. most of them didn't approve. And he was a married man and his marriage collapsed, in circumstance that are not clear, but it seems to do .. have something to do with that, and obviously he lost trace and contact with his two children, so there's a very difficult story, like most of them who survive torture, there are layers and layers, like an onion its said, you peel a layer and there's more to peel until you find the place where they think they feel what they could feel, so lots of layers that I'm discovering, ehm, that we are trying to discover together, ehm, but I'm realising they are there, and ehm. But it seems like for him, physicality, is what worries him this much and although he won't talk about .. specifics, he's worried about palpitations, he's previous appointments we spent an hour talking about palpitations and trying to ehm, .. I use a mixture of approaches, it revolves on person-centred, I think tend to occur, with these particular clients, there's lots of issues, there's stress, there's a mix of factors, sometimes, I bring in other approaches as well as person-centred and so I use lots of similar themes, my therapy I call it, so a little bit of scheme therapy, a little bit of cognitive restructuring, and a little bit of .. a lot of psychological education seems to be

working for them quite well. Cognitive grounding and and some of the systemic ideas as well, so for the palpitations, we thought, well ... Let's talk about palpitations, it's been something that terrifies him, and it interferes a lot with, you know, his day-to-day quality of life. It feeds back into the fear that he feels..

I Oh I see, so it tapping into that as well .. hmm..

R You know, of, that he's going to die. And because he is an asylum seeker, not even an asylum seeker yet. He's, ehm, what we call destitute, so he lives in hotel and until, he goes under Section 4 so called well, he gets some housing and some pocket money. At the moment he relies on charity and he lives in a hotel .. Ehm .. and so ehm, this fear, you know, is very unsettling for someone who doesn't have anything to fall back to, ehm .. and he's got a particular fear of death as well which relates to a lot of things,

I Yes, I can really understand that ..

R And so I thought, let's work on the palpitations, we did together some psychological case work. I introduced him the idea as well that palpitations sometimes is a symptom of severe stress, what about that? So we talked about it. That's what happens in .. the circle of .. we talked about anxiety and stress and how we act physically .. how the body acts physically to you .. you know, how you hyper-ventilate, but we had to go through the .. it's the cultural issues as well. These people are not necessarily therapy-minded.

I So you have a large educational job to do ..

R Educational job to do. Ehm so to communicate and ehm and talk obviously about ehm trying to find out what he was experiencing, and putting it in some words he can understand, and find out what was going on really, ehm, because he's been through a lot of investigations ..

I Ok so he's been through all the medical ..

R He's been through all that, you know.. been through the medical .. and ehm, they couldn't find anything, and they said, OK, we'll look for more later (laughs), but what he was describing, he was not told that. He was hyper-ventilating and it was particularly around the fingers, and dizzy and light-headed, and nobody had picked that up, and I thought well, that's what I'm here for, so, do you ... you start the question, what happened to him, you get that, you get the others, you get that.. And so OK hyper-ventilation's there. Well that explains the business, that explains the tickly fingers and tingling and all that, and that can explain obviously the light-headedness and the palpitations and talk about it, ehm, it seem to, everything seems to click and he seems to be more relaxed and so far so good.

I OK So he's picking that one up quick, so thinking what would be ... your best, understanding of where he's at, is that this physical condition which is probably seems to be bothering him probably more than anything else at the moment ...

R At the moment .. yeah,..

I is being the dominant issue, .. is, is being maintained, likely as not by the anxiety, and presumably the memories and the trauma he's been through, so would that be fair to say?

R That would be really fair to say, because you, there's a pattern, you know, what person-centred theme says what anxiety is. You know, got this circumstance experiences in yourself, and they don't fit together. You cannot integrate it into what you've been told. Or you think, it's yourself, and so, you know, I suppose, it's all theorising really, but, as I told that, eh, I'm thinking, well he was a gay man, ehm, in a relationship, even though, ehm, so.. with a gay man,

I So he's lost that, that relationship as well, of course, ..

R Exactly, so it was forbidden, and that's the anxiety, which, could of course, you know, result in the palpitations, but also there's a lot of shame .. strong hard-wired shame in him ..

I Mhmm, so there's still a lot of shame with him as well ..

R Lots of shame. The fighting inside can be explained, from that too, but what we've got in front of me just now is a very, you know, is something, is a person who is suffering physically, and you know, and I thought we could start from that, we work to create a sort of safe environment we go back and do the rest, hopefully. So that's it really.

I So, so when you talking about describing a safe environment, you really, as much as anything else, you are building up the trust in the relationship you both have in that room.

R Trust in the relationship, Ehm, creating also some breathing-space, from the anxiety maybe, so we can work on the rest, you know... Like people person, just how are we.

I Absolutely, is it, what's the name of the organisation, is the place where you work?

R Well, it's the Medical Foundation for Victims of Terrorism and Torture, that's the long name, medical foundation, which is, you know, a human rights organisation. Stemming back from Amnesty International.

I I've seen there's a Scottish equivalent simply called Breathing Space, I'd wondered if .. as you'd used the expression, is it just a co-incidence?

R It's a co-incidence. I like the expression 'Breathing Space' (laughs).

I It is, yes, sounds a .. Again, I'm interested in the sense in which .. because you've done both trainings, of health psychology and the counselling training. Is there

a way in which they .. are they ... are they compatible at all for you in this sort of circumstance? Because I'm thinking in terms of, all those years ago, when you were describing the models in terms of things like self-efficacy and understanding the nature of people's views about, ehm, how's their body's working. Does this still apply or do you feel, this is really not your focus ...

R Well, ehm, I would say to be honest, that I'm still in the process of integrating them, or deciding that I'm not going to be integrating them and I'll be doing something different, and I haven't really, you know .. the jury's still out on that, to be honest. Ehm, but certainly I've always been, I.. I've never been a purist, I've taught it all in a teaching environment. When you teach it, you're happy, you know. You talk about it functionally, they're good tools, but, ehm, they are not the only tools. And I've always thought they want a context, because if you take this .. that's the problem with health psychology, it doesn't give you a wider context, of values, if you want .. that would be really useful for therapeutic relationship.

I What sort of thing is missing, the link, I'm not sure I fully understand.. what sort of missing values, or what wider view would help the health psychology you need?

R I suppose what would need to see, what I would like to see, is a wider set of values where all these techniques would be. It's like having lots of tools on the table but you don't even know what sort of thing to do, so a context would be like the friends I need, a community, psychological context. Or it could be the person-centred.. ehm .. values relating ehm with people, the core conditions ehm, you know, and all that. Ehm and these tools could make sense within certain environments for me, but I don't think they absolutely make sense. They're very good and .. useful for you to understand. It's wealth of knowledge to understand ehm the physical health and issues, to conceptualise them and capitalise them and help people, but I think, within a therapeutic environment there's much, many more things to do that, skills, and in the wider context of that, and I don't think health psychology 'cos it's not clinically-oriented, when it started, and I don't think many, many health psychologists think of it as a therapeutic tool, ehm, but rather as a behaviour change tool, ehm, and they don't look for human values in it. But I think these are very important, especially with groups like, with the groups that I work with, you know. And so I've been thinking, going back to your question about integrating, well I've been thinking about, you know, proposing or putting together a sort of person-centred psychology, a person-centred health psychology, ehm, idea. Moving away from the typical classical models, moving into something different, ehm, which is, you know, applying person-centred values into applied psychology and innocent of all that and seen from the wider context.

I Mhmm. I was thinking that .. as you probably know the regulations are .. I don't know how much you're up on this thing, but the regulations for membership of the Division are now changing..

R Oh, God, I've been through that! Big thing with that! I'm still wounded (laughs)

I Sorry about that! And so, obviously, the theme then was to consider far more about the idea of interventions and, the problem is that most people's understanding is that, OK, but how do we do it? Is this the kind of gap you're talking about, or

interventions are being considered but without having a philosophical context perhaps, or, is it something more than that?

R I think interventions are a good way, eh, to go, but I'm concerned about what interventions, eh, again, in the ..

I What kind of interventions? Yes, right, OK.

R What kind of interventions concern me, because, behaviour change, yeah, Because now in Scotland we have a secondment that appointed of the Government and what they are doing is to health psychology ..

(Interruption deleted)

R So, ehm, we've been doing, mapping all kinds of existing interventions in health psychology for behaviour change and all the skills needed for being in charge of them, and that's .. They think it's a big job and it is pretty difficult job. But again, ehm, if you're asking me to, speaking from my heart, it's good for the health of the nation, I still believe that without a strong value, I said strong.. a strong set of values, ehm, and the more moral and philosophical grounding of where we want as well to go, then all these sort of things are up in the air. And what dangers sometimes, .. you know, vulnerable to political influence of any kind which, yeah, can which political thing that could go any way, but it could go in a way that isn't necessarily humane or even fair way to be open to you ehm, lots of ways, influences .. So ehm ..

I Do you really feel that health psychology practically is almost amoral or, amoral if it doesn't have any, a guiding philosophy?

R I always say it's a spineless little creature! (laughter) Spineless, you know! It needs, you need a spine to do this. I think, I've always been, you know, an advocate, especially through years, the latest few years. I've been an advocate of, you know, health psychology, psychology in general being political in terms of .. you know .. human issues, social issues, important issues, I think, you know, I've always thought as a scientist, that we need to have, especially as a psychologist, we need a vision of where we want this world to go. Or at least a willingness to create and find a vision of that, otherwise what's the point? We need to have a bigger goal than just 'prove this intervention'.

I I'm beginning to hear a sort of, a form of, almost a ..a critical person-centred health psychologist from what you're talking about ..

R You do hear, yes, (laughs) you do hear that.

I OK, Yup, OK that's fine ...

R Eventually two of us!

I It's a very nice idea, I love the idea.. So when you think of this particular client, if you were thinking of this.., this is not very fair of me, 'cos I know you're still developing this, but ..

R No that's fine.

I Thinking in terms of a sort of critical, ehm, person-centred health psychology practice, with a client with a physical health condition, how do you think .. the therapy actually works in them. I mean I can understand the approach, how do you think the therapy actually works .. It sounds as if it's subtly different from things like, ehm, psychological ideas or improving self-efficacy, or ..is that's what you're doing?

R Well yeah, I mean the way that maybe clinical psychology colleagues or other colleagues in health psychology do that I know with this particular client. Well, eh, let's do.. let's get the problem or we do the safety work first, and then we do trauma therapies and then we'll see, then if need be, we'll do motivational interview (laughs). But, ehm, that's fine.. I envy, maybe, them sometimes, if they can do that, but I cannot do that, ehm.

I So you don't do the hot cross bun, and things like that ..

R Well, I'll, it's not like I'll sit with him and do that, but in my mind I will consider part of that, I might not do that from the start, maybe I'll do that later on, ehm, and so I don't really follow that protocol, that you know, they follow, ehm. Now how what I do works for them.. well, I don't know. It might work but I don't know it work, but it's a case of constant vigilance, to sit with them, is it working, is there something else I need to do? But I think what I do is provide a safe space for them, and support that with some techniques if appropriate, when appropriate, when they want. I have the luxury of time and it's laid on. I'm lucky for that. But I'm lucky, I work long-term for as long as required, which is good, but also I've got more challenges, in I work with interpreters, in the room, every single time. About human rights issues, about asylum-seeker process, the Home Office targets. They're going through a lot of adversity and I've got a cultural issue as well, not just language, but a whole different world. And human rights is a whole different world. A lot of trauma therapy and trauma theories. And behaviour change theories wouldn't apply at all in this situation.

I I'm thinking about this particular client who's also, to some extent, caught in this complex world of the position that he's found himself in. Simply being a gay man is difficult enough in most societies..

R Yeah, it is challenging enough, in any world..

I But now he's caught up in this complexity of civil rights in a foreign country.. Ehm, what do you think, in terms of where his own healing is concerned, where do you think he might be?

R Well, I think I got a glimpse today of where he might be, you know, if my perception's accurate, then , you know ... It seems like, you know, ehh, in his view. Yes, he knows he's been.. I think he knows, he says about it, he's been through a lot, he's found resources difficult. I think it's more comfortable for him to talk about the

physical, because its, I think that, it's helps, it's less stigmatising, 'I've got ehm, headaches', rather than say I'm feeling things.. and you know, it certainly happened to a client, where it was easier to say 'I've got asthma, and I can't breathe', rather than say, you know, 'my life is so suffocating, I'm feeling very sad, my life is so suffocating and I can't tell anybody!' (laughs).

I So you're well aware of the, of the holistic link between the body and the spirit as it were.. I wonder also, the way you're describing, it seems as if you're also coming up against another international feature that's beyond us.. that's he's a bloke, even though he's gay, and I wonder if, this was perhaps, one of your guesses, or do you feel that's, a feature at all, dealing with him in terms of masculine views of health and well-being?

R Absolutely. And, ehm, interestingly enough, all my clients at the moment, at the medical foundation are male. All of them, interesting, and ehm... Most of them are, they speak Arabic, and are muslim men, which again comes with specific aspects of masculinity. And this, ehm, client, ehm, yeah, he's a gay man, and he's a Muslim, and he's an African, ehm, and so, it's a complex, you know, that area. Probably I haven't started yet, I can't fault it. But it seems to me, if I'm honest, I haven't worked with gay men before, for some reason, it hasn't happened, ehm, for the last three years, four years, ehm, and although I've worked with males before, but not gay males, and so ehm, I think there's lots of issues. And it's so related back to the way he sees his problems, but also the facts of a relationship, you know, because I'm a white woman, ehm, a straight woman, from a different culture, a non-Muslim, and, and there are issues there. In fact another client today, he told me, 'well that's a pink way to see things'. Oh, Wow! A pink way of seeing things, because I, oh, yeah, because he thought, 'that's a girly way to see things'.

I A pink way! Oh I see, yes. Oh I see. Not, not, I thought you were talking about the .. or.. pink versus black, or black or black set of.. a girly way of thinking! Ahh.

R Can't be positive about it! No not black .. A girly way, a girly way of thinking things. And I thought, well, I thought that's under the belt.. and I said so. But, you know, it gives me an inkling of how it could be with this particular man. It could be different, or it could be grammatical. But certainly, yeah, it's not to be ignored, yeah. It's something to keep in mind.

I Yes, it sounds very complicated. Well I think, bizarrely, you've actually covered all questions completely..

R Have I? Oh well..

I You've said everything I need .. That's really delightful.. Are there any things that .. If. If for example, if I asked you the magic wand question. If you could change health psychology, what would the magic wand make it become. And what, how would you..

R Oh, that would be amazing if I could change it, you know. I've always said, I've even in a situation yesterday when I've been in discussions with my colleague, about ehm, well first of all I've been very concerned about my employability,

I About? Oh employability, yes, uhuh.

R Employability. And I think it's getting very serious. It's a serious step for psychology itself. But especially for health psychology. So that's why I meet the secretary of the society, ehm. It's this lack of identity. Health psychology. We define it all differently, and that, you know, it's not a best message for the outside, but also it doesn't give us a clear identity. We're out of the NHS, there's no health psychology jobs, ehm, and it's tough. So I've been thinking, my view is that, you know, health psychology should become much more applied than it is, but with the, the, we need, could include counselling skills in there, practical skills, ehm, in terms of counselling therapeutic skills. I think this should be paramount for health psychology in the future, ehm. That's not really the mainstream view but that's ..

I Because, what I've found.. If for example.. Would you, would you say there was a distinct .. would there be a difference between, say, counselling psychology and health psychology .. in this change..

R It's a good question, because then obviously, the obvious answer would be, well, although the reason it does include primary social health, health's invested in health psychology, and then the other one's got to be counselling psychology, but for me I think, I think we should be moving.. strong word, we shouldn't be worried about, I think the way to go is to create, uh, unified psychology, applied psychology, saying they're all applied psychologies, in parenthesis, focus on these opportunities. So we should unify the training. And I think that would solve a lot problems of identity, employability, unity for all, training, sustainability, I think that's the way to go. And I'm ready to do that.

I I think, interestingly, the Health Professions Council is almost obliging that..

R Yeah, but, still, you know, the Divisions and training's separate. But I think the curriculum should be unified. That's my feeling. That would make it stronger. And it would be better for everybody, less confusing, better for jobs, you know, it's better.

I How, how might it be for some of the more mainstream things that health psychologists tend to feel more comfortable doing, like smoking cessation, alcohol.. ehm..

R Well, they could still do that, but we have to remember but if it comes to smoking cessation, I know only one person, one post in Scotland ever created for that in health psychology. You know, let's face it, you know, when I talk to people when I talk to some people who really were friends, ehm, the fact of the matter is they are clinical psychologists, in training, they used to be in the NHS, they used to, they're still blocked because they're health psychologists, they still do that. And I talked to them, what can you do? And they said, get your clinical skills, they said, clinical psychology. Health psychologist's not clinical skilled, because NHS is the biggest employer. And

the biggest employer wants to cut down waiting lists and our waiting lists are not on smoking cessations only, they are, you know, on all those issues, and so .. you need to see people and you need to be able to do that. And at the moment that's the conditions, say you've got applied skills, but they don't have counselling skills, and so, very rarely, somebody will be referred to you for (inaudible). Most of them will be referred to you for that, for to do, maybe what I do, unpeel the layers, and, you can't do that when you don't get the qualifications. So my .. that's my view. I've always said before I was an advocate of health psychology courses to be accredited by COSCA, or either of these.. So that when the graduates come out, they have at least a counselling skills certificate which they can build up later on. But I really think, that's the way to go, but that's me!

I That's OK, so thanks very much. Any other thoughts you have on this sort of area of research that I might be missing ..

R Eh, research on, ehm, ..

I Particularly on the ... what I'm interested in how, how change occurs with.. inside the client. I know it's an extremely difficult question to answer.

R The process?

I The process itself., yes.

R I've been moving to Roberts, this kind of area, so I've been working with lots of psychologists, counselling, counselling, clinical, because when you've got some work on childhood sexual abuse again, ehm, you know, again you've got lots of physical problems, lots of, you know, psychological, emotional, and social work problems. So this has been good area for me, working with lots of other applied psychologies, and I've been looking at process, how it is for a person, you know, for an adult who's abused this child, and recovered in order, recovery process, how is it to go through therapy, what works, what doesn't, so, I'm really interested in this kind of process, research, eh, what are the main issues there or, you know, what makes the change, or what doesn't make the change?

I How does change happen? Yes.

R Exactly, and then what is in the therapy, the relationship, the therapy-client relationship, or indeed, with the therapist themselves that can contribute to that. Or why we do the works, the work that we do, why am I doing the work with trauma and ehm, how, you know, and how our own experiences can contribute to that or, ehm, how to protect ourselves, about protection. How do we experience supervision. How do we make supervision to be imagined. All these kind of processes. These are the kind of things I am moving towards, ehm to. And I think psychological trauma, complex trauma, is very interesting. Because it has all the physical aspects in it, body and mind aspects ehm, it's such a good area to inform, you know, these are various things, ehm, so, yeah, that's what I'm being directed, directing what I do towards these kind of areas for, ehm, and if, sometime, if you want do any collaboration, keep me in mind!

I Exactly, Absolutely, Yes, lovely! Well, I'll turn this off now if that's OK. Thank you so much, really really kind, because it's a ... I'm beginning to ..

R Thank you, I've found this interesting ..

End of transcript 6

Beginning of transcript Participant 7 C

I But what I would like you to think of is, a, a client, or some clients, without specifying any of their details, which would be confidential, ehm, because I don't need to know that, it is really, what I'm interested in is your beliefs as to how you feel that, that change happens. But particularly, because I'm coming from a health psychological background as to where, eh, it, that change happens where a health condition has been a significant part of their process. It could be associated with heart, it could be ageing, it could be cancer, a health condition has been a significant part of their process. In my case it could be asthma, which is what got me into this whole field, so it's some sort of common chronic condition where their physical body was a significant issue as to how they've come for help or guidance or whatever.

R Right, right, ehm, I will have to run through my client list in my mind. A present one, it mustn't be present, you see. I mean, I'm trying to think, I have someone, ehm, who came and, it's been a background, but a very present issue, if you like, an ongoing auto-immune condition, I would say, so ehm, they have a lot of joint problems, they have a thyroid problem, they have a multiply complex problem, ehm,. Maybe I've chosen, because they're maybe in the field of psychology themselves, so in a way they're quite informed, quite well informed. And I have other people, trying to think of anybody else who might be less informed,..

I But that's OK. It's, because it's not so much from the client's viewpoint,

R It's my viewpoint.

I Because it's yours.

R OK, yeah.

I And so that's ehm, that would be a good one if it's one that immediately came to mind, it's often the best one to go with.

R OK

I You can change your mind of course (laughs). So in your best understanding, having worked with the client, and one, from your viewpoint, what you best understand the origins of their condition as you would interpret it.

R OK, ehm, I think, it's a difficult thing to say the origins of any condition, and, eh, we now know that certainly, auto-immune probably are genetic, some of them are even

going into poor nutrition and previously I've watched a programme about this, so obviously, this person isn't from here, they've come from Northern Ireland, and it's not a wealthy background, so I don't know how much, it's a complex family structure, ehm, with a lot of, and also during the troubles in Northern Ireland, there's a lot of trauma, I would say, and there's also a developmental and attachment trauma, and, there's complex and there is some actual violence and, this, that emerged during the work and I would say all of that led to enormous stress on the system. And, therefore, I'm not an expert in physiology, but I would say, if I go into the neurophysiology, I would say that there was a lot of kind of adrenaline and cortisol and therefore an impact on, perhaps, the, what do you call it, the suprarenals, which effects all other levels, so I would say it was a complex chemical mix that's definitely involved physiologically in the cause of her illness. But body and mind are not separate, so are completely interactive, and, ehm, as I work as a trauma therapist, I see trauma as an very important part even if it can be developmental, extreme trauma's a very important part of what holds the physiology in a state of fight or flight or freeze. And I see that as having a very huge impact, but one of the things we now know is that early attachment wounds make you much more vulnerable to traumatic reactions. So I also see it in that way. So the causative factors are absolutely multiple and, you know, obviously, the external environment effects the personal sense of security and ability to self-soothe and to make good attachments and to feel nourished and all the things that give us a good flexible sense of self, being able to be permeable in some way, and if you don't have that, then there's a sense of rigidity in the system.

I When you say permeable, what would you mean by that?

R I mean that we can be open to giving and receiving.

I OK, I'm with you, yes uhuh, I understand you.

R We tend to get a bit rigid when we're frightened or if we're constantly ..., and we kind of shut ourselves down.

I So it's partly an isolating, eh,

R It's an isolating thing.

I .. defence perhaps, whatever, yes or a reaction whichever.

R Yes, so I think all of those, I see it, all of those, and as therapy's about relationship, mainly, I think the most important part of therapy is the relationship aspect, and what happens in the room. And so my relationship with myself has a powerful impact on people, so I have to be very honest about what's going on in me and keep working on what's going on in me, otherwise I'm making the patient an object. It's not. It's two subjects sitting in the room, relating.

I Well, actually, that's the most beautifully concise description of the whole process I have ever heard. (laughs) So what do you think, ehm, particularly with this client in mind, and processes you've talked about, what do you think might maintain the position, as in theory, as you know, the underlying factors might be left behind as we

move on, what do you think maintains the condition, perhaps for the client, the one you're thinking of.

R Maintains the illness, or the ...

I Maintains the illness, yes, really (coughs)

R Well, again, it's the mind-body link, I think, ehm, we have very very deep belief systems that derive out of our experience that maintains the, ehm, our reactions the body/mind in the same structure and that's what can keep, I mean, I don't know with this person, and we can talk about it, you know, I say to her, I can't make your illness better, I can only help you how to be with your illness. And how to, and what things are aggravating it, so we can talk at that level, which is nice, 'cos it's like two adults, but inside there are very deep, ehm, structures that, I don't know, ah, how far any of this goes sometimes, I suppose, but we learn to live with ourselves I think, in a perspective change. We are, you are, OK, I can tell you're no longer at war with yourself in the same way, because in a way, in order to grow up and survive and achieve, you may have to cut off from your wounding at a very profound level because, you can, you just leave it there, somewhere. And, this is where I may differ I believe it's a relationship between the conscious and unconscious, building a bridge and that becomes a relationship that's a part of healing. Sort of it's intra-cyclic and extra-relational. So for her, I think it is just that there are such deep wounds that they will maintain it and the structures aren't so easy, you know, she's in her fifty's and you know thyroid deficiency, once you've been on a drug like Paroxat, or one of even the natural ones, the body gives up its ability to maintain the homeostasis, and so, at that point you are going to be reliant on a drug, but that doesn't mean that your psyche at that point can't at that point become flexible, and still achieve, you know, ease and well-being, and all sorts of things, despite the illness.

I Mhmm, we're still totally dependent on food, we can't give that up. (laughs)

R No, we're dependent on food, yes, there're all sorts of things that are ..

I 'Yes, fine, when you said, ehm, it really appealed to me one thing you said which was, the nature of the auto-immune condition, parallel or related to being at war with oneself. Ehm, is it possible to expend a bit on that and how you feel those two are related?

R Well, it may be, it may be I'm just using it as a kind of symbolic .., in a symbolic way, I can't say whether that's actually real, but if auto-immune's is the body turning against itself in some way, then you could say that maybe there are deep, it's possible that it might be the deep structures that are at war, and it's interesting that it's in Northern Ireland where of course, it's a war situation going on too ..

I A nation at war with itself ..

R A nation at war with itself as well. It's a quite interesting parallel that's playing out there. But it's not true that everybody who's at war with themselves will develop an

auto-immunity. So this is where you can't go X=Y you can only say it's possible, it's only part of the picture.

I Mhmm, so it could perhaps be the way of assisting the client come to terms with or cope with ..

R Yes, this can, yes

I With that, amongst many other aspects of, ehm, what she's come to talk to you about.

R I think the isolation would be one of the biggest factors actually, when I think about the structures that have, have, even though she's very relational, there's some, probably some aspect of isolation that's a bit like the Northern Irish thing, but ehm, but it might be the deepest one that's, the most difficult to access.

I Do you feel she's actually, in some way, eh, I'm trying to generalise as much, as well apart from the specific client, a distancing of one's, ehm, being from one's body in some respects, is that where you were at, have I misunderstood that?

R I think so. Yes, I think that's, certainly people very much, ehm, do that. I have someone who has very, very high anxiety and who's coming to do mindfulness with me, on an individual basis, who is quite a high function, very high function, they're both very high functioning people, but, eh, the distance from her body is really high, and it's higher when the anxiety is high.

I When it's uncomfortable, you can understand the logic behind that to some extent.

R Yes, you do kind of disassociate when the anxiety is high.

I Not what, excuse me, I'll take a look at my notes here, ehm, so to some extent, I'm also interested in the way that, if for the particular client you're talking about or others, where their conditions are a significant part of their issues, ehm, how they relate to their world either damaged by the condition, or inhibited by the condition, or almost irrelevant to their condition, is that a, I was wondering with the ones you've dealt with, how significant their condition has been, to how they interact with the world.

R Right, OK. Ehm, it's interesting. I, It's been foisted upon this person I'd say. She has a very strong will and a very, she's got a very strong understanding, and in psychology herself, so she's been able to over-ride I would say, a lot of her background a lot. And then she had a crisis, which is what brought her into therapy. I think she was given some homeopathy which caused a huge reaction, where everything kind of went into a very difficult place, and that's when she came into therapy, so.. Ehm, and then she's forced to take note, I would say, of her condition and via that. But she chose to, she'd had some CBT and she chose to, she didn't feel that wasn't going deep enough because of all the physical aspects of her condition, so she came to me, I'm a body-oriented psychotherapist, and so she kind of knew that it was stuff held in her body, and that's the other stuff, 'cos I obviously work with, very specifically how

people're holding their bodies, what they are holding in their bodies, and how the character like with ripe, the structure, characterological structure.

I Ehm, so in what way would you think that the therapy that you do impacts on the condition, if it does?

R Ehm, well I would say, as they start to, well I'll make it general, as they start to make a, a deeper relationship with the, ehm, part that might have been left behind, if you like, the, the inside relationship, ehm, then there, sometimes, not always, there is an unravelling that enables the nervous system, (laughs), ehm, to start to not be running at such a rate of knots, and that in itself can have an impact, now that may not be initially positive, and may lead to another health crisis for people. 'Cos when you've been running in a certain way and you cease to run in that way, I mean like one person came, very high functioning, I don't know quite what happened there, but she now has very bad ME. And the way she sees it is that it was the system was ready to break down and she came into therapy in a way to break down at some level. And she's also got thyroid, Epstein-Barr, and then everything.

I So very severe ...

R Yeah, some of it auto-immune too in some ways, eh, and she's also, ki ..., a psychotherapist, but she sees this as a very deep unravelling that would eventually allow the system, with the support, medical support, it's like she sees it, and I agree, if you don't change the structure, the internal structuring, then it doesn't matter how much healing or how much medical intervention you have, it will always come back as something else, so. So I do think, you know, resolving that stuff is really important and you know, often, I've seen in ME, some very deep anger issues, coming up, and it's like locked inside, at some level, in the nervous system. So I do think it's possible, and certainly what changes it is also your relationship with yourself because I'm mindfulness-based, it's that struggle with yourself, being able to be open with yourself and be alongside so, working intra-cyclically, alongside your condition, whatever it is, with that kind of fight or flight or fear, beginning to be able to open in a slightly, possibly less conditional way.

I More accepting perhaps?

R With more acceptance. There's lots of research now, isn't there, that shows ..

I Huge amount, a huge amount ..

R .. how all that works now, that if you are good to yourself, the same as if someone else is good to you outside, that the whole body responds. So I think the unravelling happens in that better relationship to yourself and that affects the whole body definitely, I think.

I So this speaks more than just learning to cope with the condition ..

R Yes, I think it is. I think learning to cope with the condition is really really important, but I think that 'cope' is learning to live with the condition, 'coping' implies the

managing. So I would say that if you can get someone to actually be alive in themselves with the condition, and, and not forcing it to change, 'cos that in itself, .. but just working with the overall, it's possible that certain aspects will shift and change.

I So, it certainly sounds as if it is a stage well beyond. But co .. Mere coping isn't, isn't a fair way to look at it, 'cos coping's quite an achievement,

R Oh, it's wonderful, yeah, don't knock it!

I But it sounds as if you're talking about something genuinely beyond that, into a, into a deeper healing in some way.

R Yeah, which is still a bit of a mystery, I'm afraid.

I Yes, oh absolutely (laughs)

R (laughs) I don't think I could say how that happens, 'cos I don't know how the client's going to unravel, but their psyche has it's own innate wisdom, if we can start to, lock into that, and that's the difference between, I think, psychotherapy and CBT a little bit, I don't know enough about CBT, but lock ..., opening to the capacity ..

I I think it's, I think it's much less .. it started off as a very, well CBT started off as free-flowing. And open and became very rigid accidentally as it was wheeled out into practice.

R OK

I And it's now rapidly becoming much more free and open and almost indistinguishable in many ways from other forms of psychotherapy as I've seen it practiced now. But that's just my experience.

R OK, Interesting. Well that's really interesting how things flow and change.

I Mhmm. Yeah, it seems very much it went, eh, as an obvious gift to nursing and psychiatric nursing. And it was applied in the scientific format of a very formalised nature to give a standard product for, sadly, for non-standard patients (laughs) and not surprisingly, it gave very interesting even with it's limitations, it gave excellent results, but it's much better being free and more patient-focused rather than process-focused, which is how it was in the past. So I think most modern CBT realised that was good, but an error and it's moved well beyond that now, or at least it should have done. Well that's very interesting, so, ehm, actually you're rapidly filling all the questions beautifully, that was even your first response was just, you got most of it in a oner! But in terms of, ehm, going over again, how, from the client's viewpoint, what do you think is happening as far as their concerned, and I'm trying to get a good understanding of how you engender a, a posit .. a situation in which the client can be, allows themselves to change. I wonder how you facilitate that process? If that's what you do?

R Yes, well, first of all by relationships, if anything a relationship whereby there's a sense of some kind of trust in me and that means I'm listening, and mirroring where

they are, in a way that they can then begin to receive themselves, so it's a basic, you know, relational model at that point and, ehm, and then I tend to turn people towards their experience intra-cyclically, as well as inter-personally, and so I'm asking them to, kind of sense, try to help them to slow down a little bit and so to less be in a cognitive place and more in a mindful place and in that place to, just to literally to turn towards what the experience is in their body and how they're experiencing, ehm. So they may come in with a lot of tension and they're talking about something and they get very anxious in some part, and I'll say it looks like that's part's kind of, and I'll mirror that part's kind of tightening up a little bit, and would it be right for you to kind of take a moment to notice it, and see if you can really notice, well, what's going on in there? And then kind of work slowly with, allowing the relationship between, if you like, them, inside them really to what's going on. And then maybe, sometimes, I'll say does this feel like there's an image or a memory that goes with that? And they may go down a route like that or they may stay in the present moment, just with the sensation, but it's all about them turning towards themselves and beginning to make that relationship and opening, and beginning, and so when they kind of get into rejection models, then, rejecting themselves then we just kind of work with the rejector, so we notice the person particularly who's rejecting them, and how that works, so. Just like that.

I So it's a really powerful re-connecting. I think early on you talked about the simplest form of understanding which was fight or flight, and then really you seemed to be talking about a running away from one's own body or parts of one's body,

R Parts of one's experience.

I Yes . And by combining, by looking in a safe place, with a trusted person, to eh, make that extremely difficult and uncomfortable process tolerable, might be part of it.

R Yes, absolutely. Yes and some people can turn inwards and some people, the focus is on me and the relationship with me more, And that's fine so then we stay with that, are safe or unsafe in the room, what is it they notice, and can they turn inside again, so it's a, movement. And honestly, I work with myself, in the room, noticing my own adrenal reactions, or, whatever's going on, or what's going through my mind.

I So perhaps as, ehm, your client's anxiety rises, you might notice your own mirroring that.

R Absolutely, yeah and I will actually explain things, to them, I've talked about self-soothing to people, and how that's, eh, passed on very early on and if not, and I'll talk about, ehm, and if I'm doing specific trauma work I'll talk about trauma reaction and how that works in the system. And people, and I've had one person who came just for EMDR, who was sent by some legal firm, for whom I didn't do all that much (laughs), and he basically got the most from the first session when I just explained the trauma reaction, and it's common to feel shame because you're not in control and he was kind of a big bloke.

I A bit blokish, yeah,

R A bit blokish with sort of tattoos, so he was not going to, you know, for him it was very shaming that he couldn't control his reactions, and I just said it's totally normal. So the normalising was very important for him.

I That's delightful.

R That was very nice to see that happen. He couldn't go any deeper, I think.

I Well that's OK, it's part of a, that's how I started off! (laughs). Doing a tiny little bit, dipping in and then feeling more comfortable and reassured and then moving on.

R Yes, that's fine, I think so, yes, he got as far as he could go, he's fine.

I Yes, that's good, a first step at least, and a very important one. So what I'd like you to think is, ehm, whew, I'm, it's really a difficult question in that at one level it's terribly obvious, but in, certainly in psychology, they're very much into trying to get a good scientific angle on things and understand things, so they go into measures of change and understanding the nature of change, and eh, it's obviously done subtly differently in counselling. But how would you measure, how would you know you'd been successful if you even think in these terms?

R I'm not sure I do really (laughs).

I I know a lot of counsellors found that a bit, slightly offensive, even, to be asked how do I know..

R No, no, no. I do, when I do EMDR, I use all the kind of naught to ten, one to seven, you know, and you do see levels of disturbance going down in people and you see that they're able to function better in their life, so, I'm not anti-it at all. But in terms of, ehm, success, it's, I sort of, ehm, I kind of leave it up to the client to how they measure the success, but of course I would measure the success really more in their relationship to themselves, than anything else. And that they were able to live in a bigger world, that may be, contraction areas, which is what we do, and we contract into small dark rooms, a lot of us. That at least the door's open, or there's a window view now, that people get as far as, so the person's got as far as they feel they can in this moment, and that their relationship with themselves.. Sometimes it's more painful for people, there's some really difficult things that, ehm, And then it's difficult to measure this as a success because it doesn't look successful if someone, is actually feeling more pain now and it's a shame if they stop at that point because that's just part of the passage. And so you want them to be able to get to the place where they can go through the pain, and know that they can turn towards pain at other times, so I suppose. Living in a bigger world with a more adult sense of self, I suppose, ehm, having a sense of who they are and what they kind of, in their relational capacity, whatever they are, 'cos there's no one, one boot fits all, you know, kind of thing, so I suppose my success is that. A sense that this person is a bit more rounded, a bit more in their world, and their physical conditions may have eased to some degree. Certainly that's possible, and but mainly that, I think.

I Mhmm, that's a really a very powerful.., and very understandable, I'm hoping to understand what you mean by it's stuff that I do, (laughs) It's certainly poor psychologists are sometimes left in a clinical setting where it's a, they're left with which they understand themselves are very unsatisfactory measures of, eh, 'have things got better?' Although the very simple question of, 'do you feel better' is often a very good and profound answer, eh, so yes, they, because they are into active measuring, for them it is more, eh, they've given themselves a bit of a difficult task to follow. And it's an area for them that they're still struggling with to try and improve, so that was very interesting, very, very useful, eh, to feed back on that one. That's very kind and very instructive. Ehm, (sneezes) Sorry, slight hay fever, ehm, any particular areas gives you, particular with the body therapy or working with the body, do you feel that gives you advantages over other therapies in some ways? Is it, how you, I presume, you tend to arrive at a certain, using the word loosely, 'toolkit', through experience, really, of what works and what doesn't, and what advantage do you think working with the body gives you?

R Well I think, well you've said it, people live far away from their bodies, and I've kind of thought about that a bit, 'cos I, I have a lot of friends who are analysts, and they don't necessarily explicitly work with the body. My husband does now, but, 'cos he uses focusing a lot, as a tool, ehm, so I think that's the advantage is that I specifically am inviting people into that. 'Cos we feel our emotions in our body and of course it is a very specific embodiment, and so I think that is an advantage actually, especially as trauma is held in the body, ehm, I think that is really powerful. And I mean I think, I don't know, I can't really say, I talk to some of my analyst friends and I think it's is if their embodied, then of course it has an impact on the client in the room, so there is an embodied, ehm, it takes a lot of work, to become embodied, actually,

I Oh gosh, yes, I appreciate that, yes, uhuh.

R I think. My experience is.

I Yeah, I'm still struggling (laughs)

R Yeah, it's an ongoing thing, as our society is a very, ehm, mind-oriented society, isn't it.

I Mhmm. The nice thing is in health psychology is 'cost it comes very much from the head, ehm, and yet their whole approach was to use go into, a difficult term, but I understand that they use it, is 'biopsychosocial' which is to try and get to the idea that it's both the biology and the mind and the social environment helps interpret our feelings for us, so it's definitely in the right direction. Ehm, the labels are clumsy and rather horrid for some of us, but it ...

R But it's a very high cost to come into your body sometimes, and that's why I think people often avoid it. 'Cos to actually feel what's going on and to be present is ultimately your freedom, but on the way it can be jolly uncomfortable.

I absolutely, ehm, particularly as your body will react physically to ..

R To emotions ..

I To emotions and the discomforts and ...

R All that.

I Even untying tight positions is physically painful (laughs)

R Well, that's right and that's why you do it slowly. I mean, I would say, if you look at Chinese women with bound feet, it was not a pleasurable event to have those bindings, so that's so, that's why you had to be jolly careful, unbinding ...

I Yes, yes. A horrible, horrible image that, sorry (laughs, coughs). Ah, the feelings we can do to ourselves!

R Yeah, yeah.

I Thinking, is there any way, because we talked about how you arrived, is there any feeling as to what further training or any gaps in your training that you might have noticed that you might feel that you want to do additional, eh, learning?

R Mhmm. I'm always looking out for that. And it's, it's difficult, because I kind of, part of me wants to just do more mindfulness retreats, 'cos that deepens my sense of something, but in terms of my psychotherapy, I mean, I thought of doing more body-oriented work with trauma centred motor training. I did..

I So what's that, I'm nor familiar with that one?

R Sensory motor, well I studied it, Hakomi, which a mindfulness body-oriented psychotherapy, from the States, which, ehm, works very beautifully with the body, and one of the people who was part of that, someone who is called Pat Ogden, who then developed something called, 'sensory-motor' which, using Hakomi stuff, specifically for trauma. Ehm, so, I, I'm kind of baulking at the price and everything on about the training, but I'm thinking about it. 'Cos I've already done the training, it's just the specifics. But I've already read up about it a lot, because it uses, eh, very much that trauma is very much an action frozen in the body and if you can find it and help the client find the next movement, then, eh, you know, in a very skilful, slow way, and working a lot with resources, 'cos you have to do a lot about resource development, so that's one thing. I think the Mindfulness is very much, I'm very interested in it. I'm thinking about reading up some more recent stuff on developmental, you know, getting a bit more on specifics on very new stuff on developmental, you know, it's about psychology, so...

I Well the nice thing is that they're now doing mindfulness in scanners and seeing what lights up in the brain, so that's ..

R I know, there's a lot of very exciting.. I've got a book called the Buddhist brain,

I Oh yes? I haven't seen that one.. no, no..

R Which is kind of nice easy read, ehm, book on what happens during mindfulness, which is lovely. So yes, so I mean, I think mindfulness-body relationship's it's all kind of out there isn't it?

I Absolutely, yeah. as I've said, the interactions between different approaches is fascinating, far far more complex than perhaps some of our earlier training would have suggested.

R Yes, it's nice. 'Cos it's, you know, always a concern for me that things as we get into trying to formalise stuff, it often loses its creativity, doesn't it? Yeah, so all the emphasis on CBT trainings and all these kind of things, yeah. I hope it will lead to excellence, not constriction.

I I'm sure it will, no doubt it will, you can't .. New knowledge usually leads to an expansion rather than contraction of our understandings.

R Yes, I hope so, yeah.

I Which really all comes almost full circle to where I started off, that in where health psychology there's been a huge evaluation into who they are and where they're going. That's roughly why this research is quite nicely timed, quite accidentally, but nicely timed! Is there anything that you can think from .. you may not know very much about health psychology, I don't know how much information you've got from your colleagues who have been doing this.. Is anything in particular that you'd feel that counselling can offer health psychology? Ehm, or is it just too, an unknown area to make that kind of suggestion..?

R I don't really know enough about it to be able to. But I think it's that trusting of the psyche itself, which is, I think really powerful and we actually... Because, if we trust it we're encouraging the client to trust that there's something in them that holds the bigger picture which would take me back to my Jungian framework, really. But also the body itself sometimes knows, so I think it's that trusting, ehm, trusting the unconscious. Trusting the overall psyche. And if you really really listen and you really relate, and I think that most good therapists do that whatever their training, anyway. But I'm just, you know, I wouldn't want to imply that health psychologists don't, but, when I think that when you're in an NHS setting, you're much more defined by achievement-oriented, you know, stuff that you have to achieve, and time-oriented stuff and I think that's, ehm, quite difficult. But I think bringing-in the body, yeah, absolutely, really powerful to, really specific to bring in that relationship to the body..

I Well thank you, that's really good. Well that's really really kind of you, I really much appreciate that.

R OK, Well than you.

I I'll switch this off now ..

End of transcript 7

Beginning transcript Participant 8 C

R I don't believe in accidents or coincidence as far as human behaviour is concerned. And, ehm, I saw a client for, I would guess, about fifteen sessions. Who very precisely fits the category you've just described. Ehm, and when she ended, ehm, her counselling was time-limited because of funding. 'Cos it was supported work, ehm, but we did leave the door open, that if she felt it would be helpful to come back in three or four months, to call us and we would see if there was any additional funding available. And, very coincidentally, I've just seen her. And she came back, I've been on holiday as you know, and she contacted the organisation while I was away, and they fitted her in. So I've seen her for the first time for ten sessions, which I've now started.

I Oh all right, that's very very good. Well just to reassure you, what I'm not interested in are the specific issues with the client 'cos I appreciate that is confidential. What I'm very interested in are your own understandings of the nature of her condition, how it relates to her process. And that most difficult of questions, for which I know there isn't a good answer, your understanding of the nature of how clients change. So, it's the same thing for health psychology, but far more from a clinical background and understanding and what I'm doing is comparing is the two approaches from counselling and health psychology and seeing what the overlaps and similarities are, and quite a similar area. If you don't mind, I'll use my crib sheet here to remind myself, ehm, so, is it possible, without breaking any confidentiality, to describe the nature and perhaps, the origins of your client's health condition?

R Yes, ehm, she's an elderly lady, who for the past year and a half, has developed very significant body tremors. Ehm, and that evidences itself in quite violent shaking, ehm, and what she calls head nodding. And the first time she came to see me, ehm, she literally just shook in the chair. And the reason, the diagnosis that she has been given, and I can't begin to pronounce it, a medical thing, but is a disease of the muscles. Ehm, but it can be a transient disease, but nobody knows how to cure it, it has to burn itself out. It's what the doctors have said. Ehm, and they can't give her a timeframe. It could be twelve months, it could be several years, it could be never.

I Hmm, very unfortunate.

R And so, when she came to see me, her presenting issue was, the difficulty she was facing in her life, living her life with this affliction, and the fact that, ehm, she didn't feel there was anybody else who really understands how she felt. That she could share with.

I Quite powerful stuff then isn't it. So your best understanding, do you have even a rough idea what the condition is, out of curiosity? Or is it..

R I do. Yes, yes, because she's explained it to me. But I didn't beforehand. It is a disease and it affects the fibre of the muscles, ehm. This is what she's been told, ehm, I don't necessarily subscribe to it, but this is the medical version. Ehm, and this in

some way affects the nerves, and the nerves transmit messages which are confused, resulting in the shaking, and, ehm, pain in her joints as well.

I She's got pain as well?

R She has a lot of pain, yes.

I Did the doctors give her any idea, or do you have any understanding where the condition came from, or what it's about?

R There are no sources. The doctors don't know. Her, her GP is at a loss and has actually referred her to somewhere else. Ehm, and they're equally at a loss, because there is no established cure for this. There is, there is ehm, medication that can alleviate the symptoms, but that's all, and that has quite serious side-effects. So it's the devil and the deep blue sea again.

I OK, well that's really really unlucky. But I'm getting a hint from the way you're describing it, eh, that you don't fully ascribe to the diagnosis, perhaps, as it has been explained to her and I wonder if you could, ehm, I'm getting a hint that you may be feeling that there's some psychological issue perhaps, or, could you explain your feelings about that one.

R Yes, yes. Well my sort of opening statement is that I don't know.

I Of course, yeah.

R I mean, sort of.. Part of my profession is living with unknowing. But having said that, the first time she came, she shook violently, to the point I had difficulty, concentrating on the relationship between us. There was a massive distraction. As we came to know each other really well, the shaking diminished, to the point where it ehm, almost ceased, apart from some nodding of her head. She did tell me later on, that she'd had the nodding of her head for many years. It preceded this particular illness. At one level, there's no doubt in my mind that severity of the shaking was a consequence of stress, or nervousness, something else was going on. Ehm, and the evidence was in front of me. Ehm, I did question, had I become, ehm, kind of, had my threshold had increased so I was no longer aware of her shaking, as we can become sometimes, but that wasn't the case, definitely not.

I So what sort of evidence did you get that was suggesting that it was more sort of, or at least psychologically affected, if not ..

R Well, from what she would say to me, she would say to me that when she went to see her doctor, it returned with a vengeance, a bit of a white-coat syndrome, sort of stuff going on, ehm, 'cos I remarked to her, after three or four session, I see that you're not shaking like you used to. And she said, that's when I come here.

I Wonderful, really nice.

R Yes, ehm, but she said, when I go outside, as soon as I step into daylight, where I work doesn't have any windows, ehm, it's a basement, ehm, she said it all comes back. And, ehm, so I had the evidence of my own eyes, and I had the evidence she fed back to me of her own experience.

I That's pretty convincing.

R Well, it convinced me, yes. Ehm, yes, so that's, that's, that's about it really.

I That's really fascinating, so in what way do you think that eh, something about how she is or the circumstances in which she is, exacerbates or maintains this condition, do you .. I don't need to know any of the details or, in terms of the confidentiality, but it is, you hinted that it might be stressors. Is that your best understanding of it?

R Ehm, stress is such a catch-all, and it is tricky to give you a lot of information without crossing boundaries, ehm, but..

I Please don't, please don't do that, 'cos I don't ..

R My, my knowledge of her history, her early history, made it clear that a significant, ehm, anxiety that she had since when she was very young, was a fear of and an antipathy towards, eh, institutions, ehm, dominant organisations, dominant figures, authority possibly, with somebody shouting, ehm, so any situation linked with a sense of embedded guilt, ehm, any situation that capt .., resonated with that circumstance, would ehm, stimulate all these feelings. I don't know if this is right, it is just my surmise ..

I Well, it is your, it's your best guess at the moment, at this point, yes.

R And when she found herself in this state of anxiety, then the shaking become, became significant and exaggerated.

I Yeah. That would make a lot of sense.

R And she also found it difficult to, ehm, be as coherent as she is normally. She's a very intelligent woman. But in that state, she couldn't make the connections between arguments when she wanted to make a statement, for example. So there's a lot going on.

I I can see that, a huge amount, yes.

R Too much.

I And eh, not surprisingly, this must make a profound series of issues for her in her daily life. Ehm, I suppose there's some sort of tie-up, are they having any effects, again, without going into specifics in terms of her behaviour, her relationships with other people, that this condition affects. I'm only guessing, is she withdrawing from the

world, is she still happy to interact, but still have the condition with other people, ehm..
?

R She's a very brave woman. And I don't think her condition constrained her from going out and meeting people, engaging with people. And, if anything, it tended to trigger compassion. She would, she had a good reception and people would care for her, because she was obviously infirm. She looked more infirm than she probably is. Ehm, she's quite small, frail, so, you know, she was never a threat to anybody.

I Oh yeah, I'm very reassured that she was getting a positive response, that's nice, that's very very good.

R And she has a very loving partner who cares for her, ehm, physically, that sort of thing, so..

I Well, so quite a profound set of difficulties then. So, what, what, you talked about she seemed to, clearly seemed to be improving in your presence in some way. Ehm, are you able to say much about the kinds of therapies or the approach that you think might have been helpful for her?

R Yes I can, again, I think that's one thing where I feel I'm reasonably safe to say ..

I So this is very much coming from you, in your, your ..

R The style that the agency I work with and very much my style is person-centred counselling. Ehm, woven into that, f.., in my, in the way I practice is a degree of sort of, psychodynamic practice, so it's an integrative approach. Ehm, so I'm interested, if the client is interested, in going back into childhood experiences, and then living that experience in the present. Our concept of chronological time is irrelevant in the present tense, it's all present in one way or other. Ehm, and, I did a lot of work like that, which was immensely moving for both of us. Ehm, and very painful for both of us. And it, she journeyed through reliving a lot of very very challenging early history, ehm, and, but I like to think that she did it with, although still with the emotions of a child, it's through the eyes of an adult. And in a place of safety, whereas before, she wasn't. So there was some sort of reparative work that was going on at some level, it's very difficult to describe, but at least she relived those experiences and came out of them safely, yeah, admittedly six decades further on. And I do ask myself whether all of that, I have a view, quite a strong view, that all of that has contributed to how she is now. I don't know whether you'd subscribe to that. Ehm, and that the release that she got from really having the freedom to get know herself, took away a lot of this internal tension. It hasn't removed it, but it's diminished it. Ehm, which in turn might be a consequence of the anxiety and stress that has this physical manifestation.

I It sounds as if, I might be putting this rather clumsily, it sounds as if by allowing her to re-live incidents in her past, that I presume she volunteered clearly, 'cos you wouldn't know, eh, re-experienced to some extent as a child, but also seen as the adult, allowed them to be resolved in some way, to reduce tension that was somehow held from the past. Is that a fair summary?

R That's absolutely spot-on. It's, I think, I believe that she re-experienced, stuff, which had a very negative outcome for her as a child. But she, she painfully re-experienced it, but this time with a much more positive outcome, 'cos she was held, she was loved, she was cared for. Ehm, and that gave her, kind of the breathing-space to look at it all again. From, with the benefit of her life experience, but also, perhaps with a bit more objectivity, and realised that so much that she blamed, for example, that she blamed herself for, wasn't her fault. It doesn't mean it was anybody else's fault either!

I No (laughs) But that's the feeling she had, that she was in some way to blame for her bad experience, her, bad feelings or bad consequences or whatever.

R Yes, a lot of that sort of guilt, that she could let go at a feeling level and not just at a sort of worked-out intervention.

I But what you just described there, eh, is a way as you described in some detail, you talked about her being held, her being loved and being cared for. Is that, is that you describing your best understanding of the relationship you have with the client and the, I'm trying desperately not to put words in your mouth here, just repeat them as much, and the relationship perhaps, in the centre you work in, is it a combination you perhaps provide, or do you feel it's like more than just the relationship between yourself and the client?

R But that is the relationship though, isn't it.

I I presumed it would be.

R That is the foundation stone of the agency where I work, a person-centred and, well, unconditional positive regard, personal empathy all this sort of thing, but for me, I, I distil that into love. If you cannot find it within yourself to love your client, and I mean deeply love, I don't mean to serve it a passing cr..., a kind of affection.

I I mean in the sense of caritas or the loving-kindness approach, this kind of thing?

R Yes, yes. And if you haven't got that within you, ehm, I think it's really hard, ehm, to achieve any healing without working in that style, there are other styles of course.

I This is very much at the heart of what I'm trying to tease out of the two psychological therapies, It's eh, they're often described quite coldly, unintentionally, because they have to be in print. But the living experience of them is something else. And that's very much what I'm trying to, see how the two compare. So have you any idea what, this the hundred thousand dollar question to some extent, what actually happens in the client's body, or in their being or however you might describe it, that allows the healing to take place? Do you have an idea of that?

R I have a theory, Ehm, and it comes back to, I mentioned time earlier, for me, the construct we have of time, and in the counselling room, that construct is left at the door. Ehm, and I think that, well I believe that this affects all of us to some degree, but people who are suffering anxiety, significant, chronic anxiety, neurosis, some sort of mental imbalance, emotional imbalance, ehm, they're, ehm, stuff that happened in the past is existing in the present, but is unresolved, or defended against, all that sort of thing, so they can't actually be present in the moment, not completely. Ehm, in a sense, it's like they're like in a prison, and they need to be released from a prison, so that they can live outside. Ehm, and going through that process that I've described, ehm, of reliving the pain of the past, by literally reliving it in the present and, but in a safe repairing way, ehm, gives them the chance to come out of that prison and to be present in the moment, so that they can be themselves now. Not a fantasy of how they would like to be in the future, or, ehm, a memory of how terrible they were in the past, but literally to be present now. And it's living in that present moment., I know it's a bit of an overused phrase, but living in that present moment, is how I think healing happens actually. And that is, for me, an, an ideal outcome. It's very very rarely you find people to do it all the time, but just to actually savour every single second as it is, ehm, and not be rehearsing the past, or, you know, filming the future (laughs). And then you actually cease to live, well you do cease to live, yeah, because you're not in the moment. So if, if I have a role, I think it's to help my clients move towards that. To start that journey, you know, not to, not to accomplish it. A bit like opening the window and seeing. It's like being in a house with no windows, just open a window and say right, look at all that out there, yeah, that could be yours. And you are entitled to it. Ehm, so when they've finished ten sessions, maybe all they've done is opened a window. Some have actually opened the front door and ventured out.

I Beautiful, beautiful thought. What, what I'm again trying to think of how I can interpret it into psychological terms, understandable by the audience for whom I'll be writing. It sounds as if, and please correct me if I'm wrong, ehm, as if they carry around alternative presents, that actually reside in the past, with whom we're trying to negotiate our way in the present, and these are perhaps getting in the way,

R Hmm, very definitely,.

I .. colouring our thoughts and feelings and interpretations of the world.

R Yes, yes. And whatever our recollection of that past, it will be wrong, which makes it more complicated (laughs). So it's more our perception of that recollection.

I And again, please, if I'm saying something slightly out of understanding it, it sounds as if we, what you're suggesting is, the clients or, the ideal state is obviously a bit ambitious for us all. Eh, but because we relate to our surroundings, then relating to our surroundings is coloured by non-real events, i.e., our mem., our memories of them, that leads to confusion perhaps or false assumptions, and

R And massive anxiety ..

I .. reliving pain, perhaps ..

R If those memories are painful memories and they are unresolved, it's a bit like bereavement, you know, if, if, you get stuck in bereavement, that's, that's understandable, but if you get stuck in a phase of grief and you can't get out of it, then it's kind of the same sort of thing. Trauma, we're, I'm talking about trauma, really at some level. One of the characteristics of trauma, as you will know, is that people are stuck in that experience, and that they can't, they say they can't negotiate their way out of it in, in the extreme way. I don't think there's a massive difference, really, it's just a question of degree.

I Ehm, so in that sense, with this living in the moment, or living as much as we can in the moment, as the clients go, how does that affect the physiology of the body, do you think?

R Well I've never asked myself that question, ehm (laughs)..

I I'm not saying there is an answer, I'm just intrigued if you have a feeling for what that might be.

R Well, I suppose what was at the back of my mind when I was describing that to you, ehm, if my guess is right that, ehm, in the case of this particular client, eh, the physical manifestation is a consequence of all this anxiety. That if this anxiety can be diminished or eliminated, then the physical manifestation doesn't have a cause, doesn't have a root, so that's, that's the link for me. That the review, I couldn't describe it in any chemical way, but it carries an intuitive sense, and we've all experienced it, if you feel anxious, you know, you feel yourself, oh, the shakes, where did they come from? You know, stuff happens. I can remember, ehm, about thirty-five, forty years ago, near my house we had a tree, leaning over like that, very close to it (indicates steep slope of tree), so I thought that tree, if it falls, is going to fall on the house. So I got an extendable ladder, took it up the tree, strapped it to the top of the tree, got my chain-saw out, big old chain saw, and climbed up the tree, wedged myself with my knees at the top of the ladder, buzzing away with a chain saw, as I had to cut the top of the tree off first, ehm, first. What I hadn't realised was how heavy wood is. And the top of the tree was enormously heavy. And once it came off, the tree, was then released of its weight, and being like that..

I Swung back..

R And swung back and was trying to fling me out into the heavens, with a massive chain saw being lifted up.

I Holding on with your knees!

R Holding on with my knees (laughs). And to this day, I don't know how I stayed on, that's animal instinct. But what was very interesting to me was when I regained my balance, ehm, my mind was absolutely clear. And I said, I thought, I was saying to myself, well that was a lucky escape, you'd better stop what you're doing and get back down off the ladder. I couldn't move. I could not move. I was staring. My mind was working perfectly. Saying to my legs, come on legs, all you have to do is go down. I couldn't do it. And you've heard of people frozen with fright, and it must have been a

version of that. You know, something had happened in my nervous system that had frozen me to the spot. And it took me a couple of minutes before I was able to get down from out of.. My mind was crystal clear. So stuff happens, is what I was saying, and you know, beyond our control.

I Uhuh So clearly from that frankly terrifying experience (laughs), ehm, physiology to some extent, appears to have a mind of its own. Affected indirectly by our thinking, yeah.

R Yes, well I think it has unconscious stuff going on, well clearly it does. Ehm, and eh, I suppose that's the link that I'm thinking of. A lot of stuff's that goes on in this particular client I was talking about, at an unconscious level, which was affecting her, physiologically.

I Really very clear. So this may seem a very silly question at one level, because your client will have come for, ehm, specific reasons which you can't give me the detail of, although. one can guess one major one, but when you're dealing with clients in ehm, in this particular client I imagine, I have an imagination as to what you may recognise as being success, using the term loosely. How would you measure success with this particular client? How would you know you'd been successful in therapy?

R Ehm, I suppose there's a few strands, there's not one thing I could put my finger on, ehm, one is actually the quality of the relationship. How I feel, rather than how, how she feels, ehm, when she comes into the room and sits down. Do I feel there's a real deep connection here in a sense of understanding of each other. 'Cos it's not a one-way process. Ehm, and that's not something I can describe very clearly, but I know it when I feel it. And when I feel it with clients, then I know that, something good is happening. Really really good, and it's at a level I can't understand. But it, it's there. Ehm, It was never my purpose to diminish her shaking. Although that was her presenting issue. It was the, as I've said earlier, it was the, the emotional pain she was experiencing as a consequence of all of this. So I can't say my objective was to diminish her shaking, other than the by-product was that it did significantly reduce. Ehm, I suppose the other thing that other than how I feel in a relationship is how my client seems to be to me. Do I observe difference, you know, in their approach to life and their zest, that you .. A client may come to begin with to be quite withdrawn, quite self-blaming, ehm, doesn't express any ability to feel very much, and if at the end of the counselling, they are more emotionally demonstrative, can talk about their feelings, get angry with me, you know, eh, laugh, then that feels like progress to me, but I would hate to have to measure it! (laughs).

I Well, yes, this is where we, eh, it is a kind of, it's a crass question at one level, and I apologise for it.

R Well, you know, I don't think it is. I think it's a very good question to ask. I think a lot of counsellors should perhaps ask themselves that question, on a regular basis. Yes, ehm, is it working? And if it isn't, why not? And if it is? Hmm. What's happening is right.

I What's particularly interesting with the answer is to some extent it does highlight one of the major differences between the health psychology side and the counselling side. Because the health psychologist sometimes does use very very gross measures to see an improvement in the condition, ahm, it is a lot more subtle that that in reality, but sometimes these gross measures are what they use as a general indication they're going in the right direction.

R Yes, and I've seen these measures. and some counsellors use them every session, you know, which sounds a bit.., that makes me recoil, actually.

I Right, OK What sort of measures are you thinking of?

R Well, there is, there is a standard, I think it's got about ten questions. That's really test how depressed somebody's feeling, or anxious about something. Often you find this in, ehm, large agencies and organisations who are under some pressure to show performance and value for money. Ehm, and so, you know, the client scores you know, minus 20 on the first session, minus five on the next and so on. That's seen to be progress.

I So that's things like these Becks Inventories and things like that.

R Yes, you've probably used more sophisticated things..(laughs)

I Um, Well, I think most psychologists realise they pretty unsophisticated and squirm with them as well, 'cos they are very gross measures. But at least if there's a change in a gross measure, it's useful feedback for the client and possibly the agency that's employing them (laughs), but it has a place, but it's I think most therapists accept they're far from perfect. Ehm,..

R I can see they have a value if they're used as a basis for a, ehm, discussion, with the client.

I Yes, that's normally how they should be used, but they're not always used that way..

R I've never used them, so I but I can see how that could work very well because a client isn't necessarily honest when they fill these in, but even that's very interesting. So, it's like, you know, you most want to see are generally are often the ones who don't turn up.

I Well, this leads me beautifully to one of the last questions which is, because I talked briefly there about some of the obvious differences between different psychological approaches, ehm, what would you feel that your particular approach may give you an advantage over others or give you a particular advantage in how you work?

R Well I don't know whether it does or not, ehm,..

I Of course, absolutely. There may some things about it that particularly work well for you.

R Ehm, there are certain things about it that work, that's well put, work well for me. One is a focus, ehm, on the quality of the relationship, and that just resonates with me intuitively. Then if, if you have a really, if you develop a good quality loving relationship, it doesn't have to be with a client, with anybody for that matter, ehm, then you've got the foundation stone for doing other stuff. But without that there's really no safety for your client, ehm, and so many of the clients that I see have not had that experience, so it's novel, ehm, it's dangerous for them. 'Cos they might have started off being promised that experience but it transformed into something awful. And that works, that just works well for me. I think it's the only way I can describe it, having that real sense of, you know, connection, community, even though it's only two people, but, and it's more than, ehm, it's like a fifth dimension. You can't describe it because words aren't adequate to describe it, and I often talk about there being a presence in the room, you know, and I will discuss that with my clients as well at times. There is something else in the room now, what is it? Which you know, could have a hint of madness about it in any other context, but it's almost tangible and I can feel when that, ehm, when, eh, at a stage in a counselling hour it moves into that, it doesn't always, but when it does, then I can feel the changes in my body, the hairs in the back of my neck standing up, I can feel a stillness, in myself. And I feel, I feel a stillness in the room as well, that's probably my stuff, but it's very real. Ehm, and clients comment on it as well. So there's something else going on there which I can't describe to you, except in so far as I have, ehm, and that's very important to me.

I Right, OK, I understand that. I can imagine some of my cognitive psychological friends saying, 'aha, I recognise that', but they would recognise it within their own understandings. And it might be, I'm just intrigued to see how close this comes to, that, eh, within a relationship, that another party enters the room, which is in fact the social being that emerges from two individuals when they meet, that has a power and an ability to behave which is different from either of the two individuals, that might be how they would put it. Does that come anywhere close to the kind of experience, or is that too metaphysical perhaps?

R Ehm, no I'm happy with the metaphysical, sort of, eh, framework, ehm, eh, I'm just, I'm just very intrigued by that idea. It is, for me, ehm, obviously I can't explain it, but I can describe it a bit more, perhaps, but when it happens, ehm, things look a bit different as well for me, ehm, slightly distorted, ehm and there is a real, my mind becomes very still and very very open to what's going on. It's like my defences have been removed. Ehm and there is a much stronger flow of feeling and truth and honesty and stuff going on between me and my client, and it's almost like something or somebody magical has come into the room to make this possible. 'Cos I think I couldn't make that possible, and I don't think my client can, not on their own, so it is like a third, I described it like a third presence. And what was that phrase you used, it's a socie, eh,

I Eh, It's one of the theories that when we cease to be individuals, ehm, a third party emerges between two and more people,

R So it's like a fusing of the two, is it?

I Which is, well it's something slightly, again it's when the whole is greater than the sum of the parts, so a third party comes the room which is a sum of their meeting which is I would call the relationship, which can only be present when they open up to the other and then it takes on a life which is more than just the one or the other. And then that's as far as you can go with it, before you lose language to describe it!

R You see, that's making my hairs prickle now because that is so close, so close, that's that's incredible.

I Hmm that's an interesting one..

R Well thank you very much, that was good..

I Well, maybe we can talk about that later a little bit later when we switch this off as I'm desperately trying not to put words in your mouth (laughs). The final thing, again, it's just a small thing, in terms of the training you've had, and I know you went through the training quite recently, which is very much why Wendy thought it would be very useful if you were prepared for this to would talk, eh, because people's learning, eh, or semi-scholarly learning, eh, adapts as we go through, eh, the professional experience and, you're nice and fresh as it were! Is there any particular form of training that you may feel would help you more now, with the experience you've had? That you might look for? That perhaps might plug a gap or a feeling of something you need more of, in the work you've been doing so far?

R Ehm, not at this stage, because I feel that I've taken in as much as I can digest for the moment. But having said that, where my interest is really opened up, is what we've just been talking about, this kind of the trans-personal, spiritual aspects of what goes on in counselling. Ehm, and that's something which I do intend to explore further, academically, eh, and because I want to test now, whether other people have this experience, and to what extent and is it similar, and is it as really as helpful as I think it is, eh, or is it just my stuff that's still lying unresolved. And so that's where.. And some of it comes out in supervision of course, 'cos that's a form of training in a way. Ehm, but that, if, I was moving on immediately now into another formalised training arrangement, that's what would draw me. That's kind of the next stage.

I Well that's been extremely useful. I'm very very grateful indeed for this talk. It's very, very very helpful. I'll switch this off now.

End transcript 8

Beginning transcript Participant 9 C

I So what I'm really interested in is the overlap between health psychology and counselling. Ahm, there's quite a lot of effective overlap, depending on who health psychologists look after, and mostly they're based in academe at the moment. But they're now moving much more into interventions and practice. And because they

come from more a psychological theoretical background that's slightly different from clinical psychology, they're still finding their way and I was, I had no idea this was such a controversial area, (laughs) in my innocence. I should have guessed if I was dealing with boundaries between different divisions within a single profession it was bound to be extremely touchy, so I blundered in with both feet, and, ehm, and obviously having worked with counsellors and lived with one for a long time, I'm very comfortable with the idea of what counsellors do, but health psychologists do come from a different area, so I'm just exploring the differences. And it's not, while I will be asking you to think of a client I don't necessarily want much in the way of fine detail about the client, because obviously that's confidential. I'm very much interested in how you see your work with a client, so effectively I'm studying practitioner's views. Which makes it a lot safer. So I was wondering if, do you have a client or any clients in mind where some physical condition, some chronic condition perhaps that might have been a significant part of what they came to see you about? Or at least played some part in the background, and it could be things like cancer, or heart condition, simply age perhaps, asthma, a whole range of different things, diabetes, that affect people's behaviour. Do you have any client in mind, or ?

R I do, I have a young woman who is morbidly obese. It isn't what brought her, but it's certainly a significant part of the work.

I OK. Well that's exactly the kind of thing and that's where there often is a huge overlap, particularly in weight control, between health psychologists and counselling, as you can imagine.

R Absolutely

I Although this may seem an obvious question, what's your best understanding of where this client and people like her might have found themselves with this condition.

R Hmm, well this client has, she's been overweight since childhood, and she has compensated for that in all sorts of other ways. And it's this compensated for that in all sorts of other ways and it's that over-compensation, if you like, that's subsequently brought her into therapy. Is that the sort of thing you're meaning?

I Yeah, it's fine. It's to say, with something like obesity, it's I think it's subtly different in many ways from, eh, a more clearly labelled condition, such as, eh, cardiovascular, but it's certainly a, can be a life-affecting condition and the causes are probably unique to each individual. So there's some very very gross generalities. So any, well thinking particularly, of this client again without going into confidentiality, if it's not possible, then don't tell me. What might have been the issues perhaps that kept her in this position and perhaps sustained her overweight.

R Ehm, I think it was an interesting one because her mother was obese as well and so the mother normalised it. And so she didn't grow up believing that she should be any different. Ehm, and there were other physical things as a child. She didn't speak until she was about eight, she could make sounds but she couldn't articulate words. And so she was a fat child who didn't articulate and so bought friendship. And then through her teens, she bought friendship because she was overweight, and...

And that's part of the compensatory stuff that we've been working with, ehm, you know, over, she's been a long-term client, over three-and-half years, so, and that's taken her into quite severe depression, a real real suicidal stuff and it's, it's been that, you know, she's coming out of that now, but what she's looking at now is what part, she's just had weight-loss surgery, and what part has that played in how she has lived her life. Which is why I thought she might be really appropriate.

I It couldn't be more appropriate in the field of health psychology, probably, it's a large area. So if she's had eh, clearly some surgery, is this affecting, thinking of her physiologically at the moment, is that affecting how she's behaving in terms of her eating?

R Yes, she's had, she's had three-quarters of her stomach removed and her, the first part of her intestine, so it's absolutely radical and she can only eat this much at a time (indicating small amount) and, eh, the weight loss has been phenomenal. And, ehm. So it's really impacted on how she's lived her life, you know, I mean her husband goes on eating and eating and eating and eating and eating and she says 'I'll have a tablespoon-full of that curry' and that's enough. Ehm, so in those very practical terms, ehm, it's had an impact. But the other thing where it's really impacted, is that, .. She decided to go for it because she, ehm, was realising that she couldn't walk her dog properly. It hurt her knees. And she didn't have, but she.. She dieted pretty well, but, but she didn't, she just didn't lose enough. And it was, that was the motivating factor, that she said, 'I'm thirty-five, I want to be able to walk for the next sixty years', you know. Ehm, and so, it's that, it's the emotional bit of, of, 'why have I sustained this for so long?', as well as the physiological impact. And allowing herself to be really bullied in the relationship, and, eh, constantly demeaned. And so there's that real link between her physical size, how she's compensated for that, all the way through her life, one way or another. And staying in this bullying relationship, ehm, and the depression and now she comes out the other side, it's like, oh, who am I, what do I do?

I Yes, beginning to learn how to be the new person, perhaps.

R Yeah. So it's really really complex.

I That's very complicated, yeah. So I'm think how that, this really sort of leads nicely onto the next stage where, obesity's a tricky one because it's so much a part of how the person is, if it's been there a long time, and as some measure of social difficulty for many people it doesn't, it's got a, a kind of very individual thing. So I was thinking, for apart from her personal life, is there, have there been any other aspects of her condition that's caused her difficulties, perhaps? I'm thinking perhaps in terms of employment, or ..

R That's very interesting, because that's been a huge part of her work too, she's an architect, and she chose always, to do in the practice, the last, the penultimate practice she worked in, because she's been off sick for four years, ehm, she chose to do all the work with conversions for disabled, disability. And and, I, when I, 'why did you choose that?' she said, 'Well I think I have a better sense of what that life might be like for people.' and she was actually bullied in her job as well. And so she was bullied at home and bullied in her job, and so we've looked at her part in that. And it does come

back to buying people's friendship, and in terms of going back to work, this whole process has really knocked her self-confidence enormously. And she's beginning to talk about, 'I will go back, I will go back', rather than 'I can't ever see me going back'. So in terms of her actual work prospects, before she, (a wasp's just zipping round you).

I Exploring (laughs)

R Yes (laughs) Ehm, before, I mean, she actually took this company to tribunal..

I So it's been very severe for her.

R So it's been incredibly severe, and ehm, and we've often looked at, if you weren't this size, do you think this would have happened? And initially she said, no, no, no, no, no, and subsequently she thought, well maybe, you know. Maybe I have contributed to this in some way. Ehm, and ..

I Do you mean by the very virtue of her size or people's reaction to her?

R Her compensating for it.

I OK, right, uhuh, so she has some kind of image in which it diminishes her in some respect? Eh, something to be added to make her acceptable perhaps?

R Well I think it's, it's like her, she described the other day about, ehm, her mother, asking her mother to buy her sweets to buy friends in the playground. And she said, she's identifying now that all the way through her work, she's been the one who's brought the cakes in, she's remembered everybody's birthdays and she says, would these people be friends of mine if I didn't do that? Why might they not be, well because, maybe because I'm fat. So although she doesn't, it, it, she doesn't, she didn't think, I shouldn't be this fat, but it's what she thought other people would think she shouldn't be. People would judge her, because of that. They'll look at me and say, 'why is that woman so fat, she doesn't take care of herself, she's a lazy fat slob, sort of thing. But that wasn't how she felt about herself. So there was that.

I So, ehm, also thinking in terms of the surgery she's now had and you were saying she has lost quite a significant amount of weight and this will obviously affect her appearance and her behaviour, is this genuinely better for her or is it still a question of becoming accustomed to this new aspect?

R Right it's definitely better for her. I mean she can, she can go and buy clothes in shops now for the first time since she was about eleven. Ehm, she can, when she comes to see me for counselling, we don't have to go and get a chair with no arms. And you know, the day that she came and she said I don't think I need that chair today and, and she sat in this sort of tub-shaped chair and, and you know, over these weeks, about six months since she had it, you know, she says things like, look, I can even get my hands down the side of the chairs now. And the other day she came in and said, how much do you weight, and I told her and she said, I have lost more than you. And so,

I So she's quite proud of it then?

R She's incredibly proud of what she's doing with it. And I saw her this morning, she just said today, you know, she said, if I could get that buzz I've got from losing this again, I'd have the operation again tomorrow!

I (laughs) Well, that's an incredible, ah, thought, that she's got so much from it, hmm, quite amazing. So I think in terms of and this is where we get to the nub of what we're looking at here, and it's, and I don't expect you'll have a very clever answer with some sort of.. (laughs) and I'm not insulting you in any way, is that looking at the very nature of how therapeutic activity creates change, so I was wondering in what way you could best describe how the therapy you have done has actually influenced her behaviour, or, how, I'm trying not to, desperately not to put words in your mouth here, how do you think the therapy with her actually worked?

R Right, the, the key thing, and, and we have talked about this relatively recently, ehm, the key thing for her, initially she had a relationship with me unlike a relationship she's had with anyone else before, and that was really key. And when we talked about that she said, 'Yes but I buy it'.

I Oh yes, I see. Yes, right. OK, She sees you that way. It can be seen that way.

R So 'I buy it, so just as I buy other friendship, I buy it'. And what she has subsequently begun to realise, that actually, she could have bought therapy from anybody else. And she realises that she might not have got that same relationship, and it has been the relationship that has been key for her. You know, I mean, I am back to Roger's core conditions with this woman. And that's what the work's about. And it, in terms of all my clients it's been a really slow painstaking piece of work, you know, there's been no quick fixes in this at all. But it's been that offering, that consistency of offering the core conditions that's made the difference. And she's said, you know, she's said, I've come in here, and I've come with a mess in my head and I just spill it out on the table and you help me sort it out and sometimes you say to me, that sounds a bit rubbish, you know, (laughs), and I go, oh well yeah, and other times, you know, I used, I used, you know, you can say, but you know that seems really painful, or whatever, so it is that, having a space where, whatever's in her head, she can put out there. And she said, she rarely comes with, this is what I wanna do today, she just comes with how she is, and puts it out on the table, and, and that for her is really key. And in fact, you know, in these years, she's left her husband, well she tried once and didn't, and then she did and left him for a year, and and she's gone back again at the moment and, he's ill, and, and she's now in place of acknowledging that actually, the only person she can say to, in fact she knows she needs to get out, but she can't go because he's ill, is with me. So it is having that safe accepting space that is, has been really challenging for her. Ehm, ..

I Is this for her to accept as well, or just to come to terms with?

R Oh, both, both. You know, today she came in and she was wearing a really brightly-coloured, outfit and I said, oh you look fab today, and she said, oh that's so difficult for me. And, and so it's about being able to receive what I offer her, and

realising that actually, even though she's paying me money, that's not what it's about. And that's been a real tricky thing for her. So I, I do, go back to the core conditions. Ehm, so it's not a smart answer, but it's (laughs).

I No it's, I, I, no there isn't a smart answer (laughs), or life would be a lot simpler!

R Wouldn't it!

I I was wondering if you feel, this is probably one of the .. At the heart of the therapy, what happens inside the client is what puzzles, certainly health psychology, and how do, ehm, and I don't know if this is anything you've even looked at, working at the university, the health psychological models, have you?

R No, no.

I 'Cos there's as many, almost as many models as there are practitioners because, they're trying to struggle to find their way, to try and find a nice psychologically safe way of describing how you go from A to B, and of course, if, and they admit themselves, most of the work occurs in the little arrow between A and B and what is this arrow about? And it's the same thing with the counselling research, where the main thing is to try and understand, well OK, you have the core conditions, you have the quality of the relationship, change takes place, eh, how would you describe how it actually happens within the client, if possible, perhaps with this particular client in mind. What was it in the relationship that allowed her to move?

R I think being, my, I think, my preparedness to take real risk on the edge of that relationship, in terms of challenge, and her trusting our relationship enough to hear that challenge, and not dismiss it. So I think that, I think that it's it's that joint bit, that if I had not been prepared to take that risk, because, she was very fragile and she was very, very vulnerable and it's a really dodgy thing to do, but, but I think without that, it was almost like, woah! You're not just sitting here being nice to me, which, what the buying stuff is about, you know, I will buy, I'll buy you, I will buy you to be nice to me, sort of thing, and I wasn't. I wasn't horrible, but I (laughs), but I really ..

I (Laughs) but you challenged.

R I really challenged, her, her view, of herself. And I think the first time I did that, I think we were both quite shocked. And as soon, I can remember really clearly saying to her, Ohh, I'm really not sure whether I ought to have said. It sort of was out of there before I, before I censored it. And she immediately said, as she would do, 'Oh no, no it was fine'. And I said, well no, let's have a look and see just how fine it was. And, in that particular session, we didn't get to how fine it was and it was several sessions down the line before we got to that. And then, it's only, and that would have been a couple of years ago, and it's only in these last few months, weeks, that she's been able to say, actually, it is, I'm not just buying something nice here. I'm buying something that helps me look at the world and myself differently.

I So really it's in, I'm thinking in terms of how psychologists might deal classically with the situation. They would look at a, eh, a listing, perhaps, of the client's emotions,

feelings, styles of thinking, looking at their behaviour and, ehm, check that was alright, was this accurate enough, and then start to suggest ways in which this is, eh, more destructive and constructive, and so it certainly would be done in a much more overt sense and what I'm hearing with yourself, that is, would it be wrong to say you're doing something similar but you're doing it in a much more intuitive fashion or are you, are you actually looking for, discongruences, if there's such a word, in the behaviour?

R Right, I, no it's on an intuitive level.

I I presumed it would be, I was double-checking that one.

R Yeah, ehm, yeah, no. I can't, I can't hold enough stuff in my head to do that, (laughs). Ehm, but I, I think that one of the things that often in me, cause, enables me to, to, or stimulates that 'eugh' reaction, is an incongruence, between, you know, my experience of the client and, and the, what they're actually saying. And that was what triggered this. It was like it was, 'woo', out there. Ehm, so certainly not a cognitive process for me. Ehm, no, on another level!

I I can imagine it wouldn't be. I was wondering if there was a similarity of sorts, but obviously the process seems to be very different.

R I think the similarity might lie in, ehm, that, rather than this bit (indicating the head), sort of doing the ticking off the list, this bit (indicating the stomach area) does the ticking off the list.

I Coming much more for a, your body reactions, yeah, yeah.

R Yeah, it's almost, it's almost a visceral thing, ehm, for me, it's certainly not, not a thinking thing.

I Yeah, yeah. 'Cos certainly, this has sometimes been described, nothing perhaps can describe it well enough, as a holistic response, to a client's story, or way of behaving. And that response and issue, it's something in yourself and you respond to that initiation of a reaction.

R And I think but that's where the risk comes in.

I Yes, that's right, in the nature of the response.

R Mhmm.

I And checking it out.

R Yeah, yeah. But it is, it is, you know, it's, it's fascinating. And I supervise a psychologist and, and, you know, she's often struggled with me when I've said, 'hang about', you know, I've just got this weird feeling going on here (indicating stomach) what's that about? And she'll say, well it might be this it might be .., and I.., mhmm. And, and what she's beginning to do is, is, thinking about things from a feeling, or

approaching things from a more feeling point of view, as well as all this cognitive stuff. So it is that interesting thing, sort of rubbing up against each other.

I It is, and they are subtly different and it's, the differences are quite fascinating. On the client's side again, and I'm being a bit naughty coming back here again, you can tell me no, you've gone as far as you can go here, what do you think happens inside the client when these, when this feedback happens, when they get, a, when you tell them of your lack of congruence of what they've just said and what they hope to do and how they are?

R Right. With this particular client, I can see her react physically, 'cos it, you know, I mean, I can, it's not particularly overt, but there's something physiological or physical that goes on and, and I will say to her, 'what happened to you there?' And, and then, I think what that does, and she might say, 'well what do you mean?'. And I'll say when I said this, something happened to you. And, and in the early stage of the relationship, she'll would just have said, 'no, dunno'. Whereas now, what she'll do is, she will check herself, and perhaps not in the way I might do which is sort of say to my body, you know, OK, what happened there? She will go, OK, what did you say, what was I thinking, and I will add so what did that feel like, and that is the sort of process she might go, go through. And then, she either will go, 'dunno',

I Simply doesn't know, uhuh.

R Or, she'll, she's great at doing an avoidance thing and she'll just change the subject, and, or she'll say, 'I don't know, but..' and that's when the real change might happen when she, when she can do the 'don't know, but..'.

I This is perhaps exploring, either alternatives, or different ways of looking at the same thing. And I suppose the challenge will be that you don't quite know what she means by that, but something is happening.

R I think Gendlin's 'Edge of Awareness' stuff, is your, it's quite crucial here, you know. Because I will say, I've got something that's just here, and, and she'll go, 'Oh yes, so have I', you know, or.. She does, you know, initially she'd wouldn't have made any sense of that, but now she'll go, 'Yeah, I do, I have something just there, and we'll we'll sit with that. And, and so again, it's not cognitive, it might be.

I Mhmm, I mean obviously it'll have an aspect of it, but it'll be something more complex than that. Particularly if you're being stuffily psychological as I have to be from time to time, if its cognitions, what's in the conscious? So what you're not conscious of, can't be classified (laughs).

R I'll go with that (laughs).

I But there again, I'm trying not to put words in .. So that's really helpful. And my presumption there, is that by reaching out and exploring what's lying just beyond easy reach in her understanding of how she is and how she behaves, a learning takes place. Would that be fair to say?

R Oh, an openness to learning if not, if not an immediate learning, ehm, because she will come back and sometimes say, 'do you remember you said..' and that will be, may be weeks, months down the line. Other times she'll go.., 'this is what I do', you know, they are those light-bulb moments, ehm, but I think that, that exploring this bit out here, I think it will begin her process of being able to look at herself slightly differently.

I OK, mhmm, yeah. So perhaps in looking at herself slightly differently, she begins to see, other aspects of herself and other opportunities that she can decide whether to take or not, and explore, what that may lead to in terms of behaviour change, I can see that, hmm.

R She's quite good at the , at the, saying 'right, I can see this is an option, but', and at the moments she's very much in the 'yes, but' place, and, you know, we've been there before and we'll be there again, ehm, but she knows she does that now. And is prepared from that 'yes, but' place, to explore it a bit more. Ehm, and, I know I think that's a really courageous thing for her to do.

I Oh, well absolutely, it's huge and my guess is, and this is where, from what you've said earlier, you're suggesting that by forming a relationship, that gives, and you've described it as being a safe place, or the creation of a safe place, where exploration can safely take place, and challenges be made without it becoming overwhelming perhaps, ehm, you've also said she's good at changing the subject and avoiding. Ehm, but, I'm guessing what the therapeutic relationship is to allow that to also happen.

R Absolutely, and eh, I think ..

I And it's also safe to make avoidance.

R Yup. And actually she's taught me that very clearly, perhaps more clearly than a lot of clients. Particularly because of the length of the piece of work. But that fact that actually, that avoidance thing is, doesn't mean, as I might have thought in the past, 'I'm not going to look at this ever'. What it means is I don't wanna go there right now. And, you know, if I'm going to be continually accepting and challenging, I have to be prepared to hold that too. And not have my own agenda for getting her, X, Y and Z.

I Yeah, and you've also suggested that her background, in fact probably much of her life has been one of being belittled in some respect in her choices, and whether they were positive or negative, eh, not being accepted in the relationship she had.

R Mhmm, yup. And, and that, you know, that I think has been a real challenge in terms of our relationship, how do I challenge her whilst not demeaning her. And, and I think that, you know, that's been another bit that's been quite key.

I So when you were saying earlier that you said that you might have gone too far, or spoken too much or too spontaneously, eh, that could be taken for a form of apology, if you didn't actually apologise (laughs) and I could imagine how that could

then allow her to see that you can challenge, but without intending to squash or hurt or manipulate in any way.

R Yup. And again, that is something that she and I have talked about and, you know, I am quite a spontaneous therapist and I have said to her, 'I've done it again, I'm sorry'. I did it this morning, I opened my mouth and (indicated clapping hand over mouth) like that. And she just looked at me and said, 'go on just finish it, you know you want to' and, but, (laughs) But it is for her, she knows that, or she is learning that it is OK for somebody to have an opinion that's different from hers and it doesn't mean that she's bad or wrong for it. And so it's all in that whole context of relationships.

I So, eh, I presume that is always the delightful thing about that kind of relationship is that, not only you're making a relationship with her, she's beginning to live with your imperfections and your own styles, as well. It was a full exchange really. (laughs)

R Absolutely (laughs) It was great when she took me off the pedestal, it really was. It was, that was fantastic. Ehm, and, and I think for somebody like her that has been an amazing step. And I'm still, you know, I mean, I have days when I think, and I will say to her, Sarah, am I back up there again? And she'll say, 'Sorry, eh' and it is, there's much more mutuality in this relationship now.

I Yep, mmmm, sounds delightful. Now, where am I at? I think, bizarrely, you've probably answered all the questions, I'm just checking to see if there's anything that's missing (laughs). Oh yes, this is the, one of the big difficulties between the psychological approaches, between the counselling and, ehm, certainly the health psychological, is that health psychology has its targets much more overt and open. And, ehm, a good one will negotiate them with the client and it will be very, eh, target-focused. How does this sit with you in terms of the kind of work you do, do you feel you have a target at all or an unspoken agenda with your clients.

R Oh I'd love to say I never have an, agendas for my clients, but (laughs). Yes of course I have agendas for my clients, ehm, she came originally because she was off work having been bullied and was depressed and the doctor had said to her you might want to have some counselling. And so she sought me out and came and so at that stage, you know, it was going to be a bit of work with somebody who was depressed, ehm. As the time has gone on and I understand more about her and her marriage, I do have an agenda for her to leave and leave for good. And, eh, I have to put that to the side there. And, and she knows that. She knows that I would support her staying, I supported her going back and I would support her if she leaves. But she said to me recently, she said, 'You'd really like it if I left again for good, wouldn't you.' And I said I'd be lying to you if I didn't say 'yes'. So I do have an agenda for her. And I work really hard for it not to be too present in the room, but it's there.

I What, the kind of agenda is, well that's a very specific one, I presume, the obvious one is for your client to get better, if you want to put the term loosely.

R Yeah, yup.

I Ehm, and ideally, much more, (laughs) this is very bad grammar, much more better that they could otherwise be than if they got a little bit of a fix and moving on. Now obviously psychologists might think in terms of fixes and techniques, 'cos that's the kind of language they use, um, and a lot more jargon-like as you know. I presume it, this is something you may have in your own mind, or is it, or is it really not really what you have, when you meet a client and begin to develop the relationship?

R Right, ehm, my agenda for any client for any client when they first walk in through the door is that they might be able to live their life in a more satisfying way, regardless of what brings them through the door, that's, that's my agenda. And I would say that to people on the phone, you know, I can't fix this for you, but, you know, my hope would be that we'll find a way for you might be able to live your life that it's better for you. Or something like that, so in that way, that's overt, ehm, but I think that's about it.

I I presume because you simply don't know how it's going to go, and what's going to come.

R No, I haven't a clue. And even in short-term work, ehm, you know, four sessions for an EAP, you know. I think that agenda is probably even more in my head then. Ah, right, I've got to find some way of making this person's life, so that they can live it more satisfyingly and in that four sessions. And it doesn't make a huge difference in how I am, but I think it makes a difference in what I might do.

I OK and in what way might that be?

R I think that I might work in a much more focused way, so, you know, if somebody comes in and says, you know, a client came 'cos she was really stressed at work. What appeared was that the work stress was the work stress was to do with the fact that her husband was going to have to have his leg amputated and the implications for that, and we had to decide, we had four sessions, what did she want to work with? And, if it was a long-term thing, then, you know, that would have played out. But in terms of offering her the core conditions and acceptance, you know, that would be, that would be underpinning, regardless. So I think it's that focus, that's different.

I 'Cos trying to unpick the difference between the more traditional psychological approach and, there's no such thing as a traditional counselling approach because there's so many different fields, although they overlap a lot. Eh, in a way it sounds similar in many respects as you do invite the client to give you their agenda, and in a very, in a , when you're working in very, very short timescales, you'll do your best to facilitate that is, I'm guessing from what I'm hearing

R Yes I would, but, if what they got into was something else, I would go with that and just flag up that, you know, I'm really happy to go with that. Just bear in mind, we've only got two more sessions. You know, the Uni's a great example of it, you know, we've got six sessions and OK they can, they can ask to come back later on, but, you know, they come in because they're stressed with their work and actually it's nothing to do with that at all, ehm, more often that not, then the other bit's addressed,

the work stress actually becomes less stressed. Not always, but, ehm, but it is about giving the client that choice and the power to do with that time what they want.

I Thinking again back to your client with the obesity issue, are there any areas, and you've hinted at, from what you've just said, where you feel that perhaps, you might seek further training, particularly having worked, perhaps, even with a psychologist as well, and seen the kind of different framework they sometimes work with or presume?

R Ehm, no my work with her hasn't triggered the thought that I might need further training because my work with her has reinforced the necessity and sufficiency of the core conditions, for me, ehm. And, and I was talking, in fact I was talking about her with my supervisor last week, and some friends of mine are trying to persuade me to do the CBT course up at Jordanhill, 'cos several of them are going to do it. And I think, well I, no, no I don't, I don't want to do, I don't want to go, it's not what I want to do, it's not how I want to work. And my supervisor was saying, you know, if you were, if you were oriented to CBT do you think that this work would have been, you know, would have been good for her, with a CBT therapist? And actually I don't think it was, because it was about a relationship first and foremost, being accepted for who she was, along the line. So no, this particular work hasn't. Ehm, I think when I have worked and I haven't done very much work, I haven't done any long-term work with, ehm, people with things like cancer, or, sort of, life-threatening, when I have done short-term bits of work with them, I have suddenly gone into, 'oh my goodness, am I equipped to do this?'. And actually, yes I am. Because what these people need, they're clients, (laughs) and they need relationships first and foremost. And there's always that, that thing for me about learning from my client and one of the interesting things I do think, and it was triggered by the article on 'kinky clients' in the latest journal, ehm, is that do I expect, is my expectation that I will learn, my client will teach me, is that ehm, OK? Ehm, and what was said in that article was that, by all means ask the client if you don't know, but to have an expectation that the client will teach you feels like a step to far. And I think that it's, it's that balancy thing. Ehm, so in terms of her, I'd never worked with anybody who'd had this sort of surgery before. I've worked with some pretty obese clients, long-term before, ehm, but I've always thought it's really interesting, having had a history of an eating disorder myself, I've ended up with this obese client. And, ehm, I think, it's like, there's something about that, that I am able to offer in that context.

I Mhmm, I really appreciate that. Speaking to a couple of the, both psychologists and counsellors, I think, probably, that one of the most dramatic things that one of the health psychologists explained to me who had taken a counselling training, that before, she thought the counselling skills would help her, but until she did it she had no idea of what the range of skills would be, and how much she needed them, and she couldn't have told anyone that until after the training. And that was a very interesting one and, eh, she's currently thinking quite where, ehm, her professional self now sits, because it's still very recent, and still in the process of training. And it's been very interesting having done both, effectively, although she's still very much learning counselling. That she's really appreciated the strengths she's brought with her in terms of her clinical understandings, eh, and what she was suggesting, and I don't know how this may strike you, is that she's still comfortable with recognising substantial differences

between clients, that might fit some of the DSM manual, for example, in terms of, pathological behaviour, which she still finds helpful. But the idea of what she says of working with love, has been a new experience for her,

R Oh, right, oh well ..

I Which is rather lovely.

R That's gorgeous!

I It is rather lovely. And so that's, probably for her, has been the ..., does that sound at all realistic for someone you might think, coming from a psychological perspective into counselling?

R Well, I'm, I'm thinking about my, my supervisee, and ehm, and she, she, I think intuitively has good skills. But when I've talked to her about skills, it's like, you know, if I say to her you know, well, you know, maybe you could have just paraphrased that, or, you know, reflected that, would that not have been sufficient for that client? It's like 'ooh' (indicating realisation), and it just wouldn't, it's obviously not in, in the training.

I It wouldn't be in the training, no.

R No.

I It's not part of the training, although to be fair, I think most practitioners of, seriously now, of psychology realise now that there's a huge gap in the training that's now trying to be filled, but it will take some time.

R And I'm also thinking from their point of view of having delivered quite a lot of counselling skills training, ehm, I'm thinking of two or three psychologists who have been on courses that I've trained in, they are, they have been almost without exception the hardest to get them to, actually appreciate the necessity of those skills. And the necessity to practice those skills. And my supervisee's not been resistant to it at all. Ehm, but, but you, yes it is interesting, I love that phrase, working with love, and I think that's what my supervisee does intuitively. Ehm, and she does have, you know, if I wanted to know something about, I don't know, a something, I, I could ring her up and say tell me about so-and-so. She has that knowledge that I don't. Ehm, yeah, so, it's, it's, I guess I have always viewed psychology as a more academic thing than counselling.

I Certainly more scientific, clearly, whatever that means. Is there anything that's missing, a silly question, is there anything you think I haven't asked you, that perhaps I should have done.

R Yeah, I think one of the, one of the things that is, ehm, that is important for me, to reflect on quite often, no not quite often but regularly, in terms of this long-term client with this very long-term entrenched condition, is actually, can I go on doing this for as long as it takes? Ehm, and there is sometimes when I think, I don't know that I can. And then something changes in me, in the relationship usually, when I have that

feeling, it shifts something in me which therefore it unsticks a bit of the relationship and it's fine, But, I think that in a long-term piece of work, that's a possibility anyway. But when it's underpinned by a long-term physical condition, then it somehow makes that even more, ehm, potent.

I Yup, mmmm, and in what, why would it be more? What's the potency?

R Right. As soon as I said the word 'potent' I thought 'he's going to have that'!

I You can withdraw that (laughs)

R (laughs) No, no, because it's right, yeah, no, because it does, it does feel like that, ehm, you know, I've worked with .. Actually that's really interesting, because the client that came into my head, was another young woman, with the same sort of age who was also significantly over-weight. She wasn't, she wasn't as large as this client but she was really significantly over-weight. And, and, I'd finished working with her when I moved down south. And I'd been working with her for three, four years. And, ehm, ending that relationship was really difficult, because I mean she'd, she'd made huge strides in terms of her self-esteem and all the sorts of things that she, brought her through the door in the first place. Nothing had changed with the weight thing, and now that's not the case with this client, 'cos she's taken this very drastic, ehm,

I Yes, very brave step,

R Very brave step. But I think it's that bit. It's like however hard I work, ehm, will this, will this change? Ehm, and you know, cognitive, in my head I know it'll only change when the client's ready and it doesn't matter whether it's physical or whatever and maybe obesity thing's not a brilliant example in that, you know, anybody's who's obese, if they starved themselves, they would eventually lose weight. If you have a dodgy heart, it, there's nothing that you can do. OK you can exercise gently and, but, so it is it's sort of different.

I So I was wondering, I think that what I'm getting at, guessing from what you've said, so to some extent it's almost, the life-challenging nature of the condition, is that what you mean?

R I think so, yes.

I Not in a direct manner, but a question of life and death. Is that the potency or am I over-stating it?

R No, I think, I think, it's almost the reverse of that, the fact that, that indirectly it could be a matter of life and death, rather than the heart attack is directly, whereas, this, she could starve herself and lose weight and therefore, you know, OK she might die of malnutrition, but, ehm. But indirectly this carrying around the extra twelve stone or whatever it is she's carrying around, ehm, more than that, fourteen stone, she was overweight fourteen stone. And that, I think it's that. That could kill her.

I Yes, yes. So it's something that really amplifies your concern?

R Mhmm. And even having lost, you know, well it's nearly ten stone now. She's still huge. And, you know, if, if you walked into a room and saw her, you would think, wow, you know, that's a big woman still. So there's still that life-threatening bit, even though she has lost all that. And I think it's that bit that makes it, makes it more potent. Does that make any sense?

I It does, it makes you human, and I'm guessing it just reflects, reflects your concern, your care. And probably although it's very difficult not to do so, a sense of responsibility perhaps. Would that be wrong?

R Responsibility?

I From the little part you might play?

R Uhm, that's quite interesting. I think if you'd asked me that question two years ago I'd have agreed with you. I think now, and that takes me back to the level of trust in the relationship and my trust in her. I, my responsibility is to be as professional, as professional and as human as I can be. That's, that, I don't feel, I don't feel that, that responsibility, *for*. But I would have done early on in the piece. It's like, OK, you know, if, if this doesn't work, and I think, well if this doesn't work, whatever that means, I trust this woman enough to know that she will do, whatever she needs to do.

I So the responsibility clearly lies with her.

R Yup.

I You're facilitating.

R Yep, yeah.

I Well thank you, I'll switch this off, and thank you very much.

R All right.

I Well that was really fabulous.

End transcript 9

Beginning transcript Participant 10 HP

I And I wonder if you could tell me briefly, what you know of the origins of the condition.

R In my sort of practice mostly I see cancer patients. In fact those, ehm, people who have been treated for cancer, and they're actually now, it's the after-treatment period. 'Cos that directly corresponds to my research area, so I've been fortunate enough that my local health board has been, you know, letting me see those patients

more directly, ehm, associated with my research. Ehm, so I guess, the patient that jumps to my mind is, would be a patient, you know who, ehm, mid-thirties who would have completed treatment would be actually finding it quite, ehm, sort of difficult to, ehm, quite difficult to deal with the uncertainty that the future involves. And your question asked me to think what, about what I would know about the origins of that problem?

I Yes, yes what do you feel, it may be incredibly obvious, but it's just to fully understand what you think her particular, eh, physical condition comes from in addition to her psychological position.

R Uhm, I mean, in the particular, ehm, in that particular case, I think my thoughts were about how she would have dealt with uncertainty in her life in general beforehand, and what that, actually uncertainty would have, mean for her, in her circumstances. She was a young lady with, with, ehm, children and who, who was also kind of, you know, really upset about not having kids in the future. And so, I would, I think, my sort of line of thinking was come, really look at the family component of it as well what, ehm, with cancer actually how it sort of really impinged on that family unit, because, and also how that person would now find ways of dealing with that uncertainty. Ehm, so it was, it was, I think from my point of view is both, you know, how the relationship between the sort of the patient and her husband, ehm, with regard to that patient, sort of cancer experience, and what they, what it actually means for them as a couple in the future. So that was one part of it. There was a bigger picture there as well, but I'm not sure if that ..

I Well it's very good that, it means that it's very much you're talking about the meanings of the condition are, yeah of course,

R Sure, yeah, absolutely.

I Ehm, and obviously the implications from those meanings and understandings.

R Exactly, yeah.

I Which, I'm, I'm jumping to conclusions here and assumptions that by perhaps working with those, eh, how would you proceed? What was, what were the, what were the aims of the work you were doing with the client, did you have in mind for her?

R I think, one of the aims is that the patient has, really has come in a state of confusion. And was quite puzzled and upset about her own emotions around, ehm, how upset she was, about the future, and, you know, the, you know, the, prospect of not having any more children, despite the fact that probably she might not have wanted any more children but now that choice was taken out of her hands. And also she had given up work since she had children. And now, she was really struggling with, just going back to a normal life. So, part of it was really examining what was happening beforehand, and how this, any cancer experience has always, almost always happens, was a very sudden experience for this patient. How it suddenly changed or did not change things, and sort of kind of really trying to disentangle some of these confused emotions and put them in places really what it means for the patient, for the family, and

how. And another component that I did not mention was the patient was experiencing of, memory-related problems after chemotherapy, so she was really finding it very difficult to function on a day-to-day, day-to-day basis, so part of it was also trying to come up with some simple strategies that would help her around the memory problems and, get it even investigated for her. Ehm, so, I don't know, it was really trying to understand, you know, trying, giving her the opportunity to discuss these emotions, these very complex emotions that she's had, ehm, sort of really untangle them. And also help her specifically around sort of more practical side of things around memory, more sort of cognitive, neuro-cognitive type of stuff.

I So a very complex situation, really, as you're describing it.

R Yeah, it was.

I Multi-layered, obviously.

R Yeah, absolutely, absolutely, I mean, ehm, I don't know if she was a good example to pick, but she was the first one that came to my mind.

I Well, that's, that's often the best one to go with. Because it's, it's the one that, ehm, seems to fit the question pretty well. But in terms of the actual origins of the condition, does, do you think as a health psychologist, that has relevance, or is it the meanings of that condition to the client. That feature in your understanding of what is happening in the client.

R Sure, in this particular case, the only thing that made me really think in terms of her, her own history, was how she used to really deal with her own anxieties, and, and the uncertainties and how she also dealt with, one of the things that she often came up with was how difficult it was to talk to other people about the cancer experience. Especially as she kept on forgetting things and which meant that she had to justify herself every time, which meant that the cancer had to come into the picture every time. Which she found, found very difficult as she did not want to talk about it all the time. Ehm, so it's relate to how she actually talked her own problems too. People that she considers close, these family and close friends and, ehm, and how she dealt with anxiety in general. And, ehm, but other than that, it wasn't, I can think of another case which was really, you know, the, ehm, with the past history, what a complex personality of the patient has been very prominent. But it, I wouldn't necessarily think of this case, this case was clearly crisis, in the form of cancer coming into the patient's life. And had changed things unexpectedly. Which interacted with her way of dealing with anxiety, her way of dealing with people around her, how she related to them when it came to her own problems. Ehm, so it was a moment for her to take a step back and to think about things and she, it was getting very confusing for her.

I I can understand that, yeah. Very difficult thing to happen for anyone. So, the way you're describing it then, the cancer as you're describing it, is having a, kind of being a sudden occurrence. That has almost, I'm almost getting an image of sort of a pebble thrown into a pond, with enormous ramifications for her. Ehm, in what other ways did it affect her, do you understand, did you understand how it affected her life? You've mentioned, obviously, her understandings of the condition, it's implications.

How does, where does, where do you come from as a health psychologist to deal with these issues?

R I mean, I think from my point of view, I was trying to really understand what actually, what, what beliefs there were around cancer in general for that patient. In most people, most people do have certain beliefs about particularly when it comes to cancer. Ehm, and how that might be affecting in a positive or not so positive way in the way she was dealing with it, and the way she was thinking about the future. Ehm, and what it was actually really. As I psychologist I also try to find out as much as I can. What they've being told from the health care profession point of view. And that seems to be a very important component to really help the patient make sense of that information, about particularly the future. And sometimes we have access to some material from, which has been given, referred by health care professionals themselves, ehm, that gives some of idea about how much uncertainty we're talking about, whether the prognosis was good or, you know. All those kinds of elements which are very very uncertain, ehm, unique, ehm, what I try to do is really understand what the patient tries to make. How the patient makes sense of that information and what kind of conclusion they draw for themselves. Ehm, and about the future about themselves. And the other part of it, I suppose, I try to understand what that illness suddenly kind of lashed upon them, what it means for their, in their kind of, life stories. It becomes a sudden rupture in their sort of story of. Some people experience it, I think as, ehm, as an unwanted change. There is a desire to go back old self, but old self is no longer there. And they find it very difficult. Whereas other people, they just sort of, they just sort of, are able to brush it aside and continue more easily. So I try to, kind of, understand why it has been such a rupture for them. What kind of prevents them from, sort of, ehm, picking up the pieces and continue. What are the barriers along the way for them. Whether it opens up questions about relationships, opens up questions about what they want to do, and whether it's dealing with the uncertainty about the future, the threat of cancer looming over them all the time. Ehm, so really trying to understand where it is the problem that they're finding it especially difficult with. And from the psychologist's point of view is, part of it is just to, you know, trying to, is there any inaccurate beliefs that might exist. Trying to identify them and try to sort of, you know, bring them in line with more with not to say the medical model but with, with more real, with more realistic terms, what that actually might mean. And give some tools to deal with and, I'm trained in cognitive behavioural psychotherapy, so try to sort of really give them, equip them with some tools. Especially when it comes to dealing with uncertainty. Ehm, yeah, so yeah, I'm not sure..

I No, yes, that's fine. Because, what you, what you, if I'm understanding you correctly, what you seem to be describing is, you've got a, an amazing task of how to almost walk in their shoes to understand what it is to be them, with their life history and their experience, eh, what it is like also to be them to have the shock and the huge turmoil and the physical interventions in their whole physiology, that is affecting the memory. That, plus their understandings of the informations they are getting from the doctors and how this links their whole.

R That's right.

I It's a huge complex,

R It is, and what I try to also draw

I Task that you're taking on.

R Exactly. I also try to draw out, like I said within the, within the, ehm, how do I put it, I mean, but, I really try to understand what their beliefs about what that illness that cancer is and that often relates to some other life experience that they've had. Most people do know someone who have had cancer. And most people, you have had them in the family. And that can relate to that family experience which, you know, often very traumatic, and very upsetting, eh, when they were younger maybe. Um, so try to really, you know, also understand what it's meant for them to have that experience as a younger person. How it shaped their beliefs about cancer. Now, you know, especially if they were a similar age. You know, how it shaped their own kind of expectancies about their own future, if that, particular that person ended up, you know, dying with cancer. So all these things, you know, you try to sort of, I try to develop a picture of that cancer experience for that person's, not only for that person's illness, but with the general sort of, experience of illness in that person's life, really. In sort of, a broader sense.

I You've also described the disentangling of the confusions, ehm, with this particular client in mind, particularly with the memory deficit, or whatever is the cause of that, whether it's anxiety or the treatment or a mixture of both, or whatever, ehm, it means you must have also an understanding of forgetfulness, what it means to people. So, in, how do you think this therapy is received by the client, in the sense of how do you, what I'm interested in is your belief in how the process of change takes place. I know there's no full answer to this question, but how, how you feel psychology facilitates change, for this particular client?

R Ehm, very good question. I mean, the thing about this case was that I've seen her about maybe six times and then she completely dropped out (laughs), so I, we haven't had, sort of, a formal ending for it. Ehm, she, I knew she was moving away and, and then, you know, we made an appointment and she never turned up, and I didn't have her new address, or I could have sent an appointment. So it was, it was a sudden end, which, ehm. One of the things that, I mean there were, I think, several, anyway, aims to our therapy. One of them was dealing with the anxiety. But dealing with anxiety, particularly when talking about it to other people, especially like I said, it came up often, with regard to her memory problems. And she found it very upsetting, having to justify herself, and what with other things, what would other people think about her, she was a needy person, and, she had to be the centre of attention kind of thing, by bringing up the cancer all the time. And, ehm, and she had this image of herself before the cancer as very able, you know, very efficient, young woman, you know, a housewife. She had also had a working life prior to having kids, and suddenly that was, you know, she, everything was kind of, in a way disintegrating around her. She was just not able to cope and, she felt that she was a lot more short with kids and.. So in a way, one of them was trying, one of the aims was really, trying to get her, thing back. What was really so wrong with talking about this and trying to mention it? There was a real problem here, and. What was she really afraid of from other's perspective, you know, others reactions to her. Ehm, was she, in a way, reading their minds,

coming from a CBT perspective. Does she really know they were thinking badly of her? And kind of trying to look at it in a bit more detail. And how much was it her own fears and her own assumptions and how much of it was reality, really. And also part of it was also, kind of, helping her communicate a bit better with her husband. And part of it was really, in a way, assertiveness. Training her really, because she was in some way she was trying to get on with her life as she would before, but she was really not managing it. You know, she would easily agree to look after other people's, other neighbours, kids, but she, she was just overwhelmed. And how do you, sort of, but she didn't want to say no, because of the cancer. I mean she didn't want use that as an excuse, and. Ehm, so part of it was how to communicate with others without sort of, overwhelming ourselves and really taking on too much. And, with her husband as well. So part of that was communication, assertiveness training, ehm, and creating situations where that can happen without, sort of, ehm, disrupting one's integrity, and ehm,

I Would this involve role play with imaginatory scenes, or how ?

R Sometimes, not with that patient. I, I mean I've done that with patients, but not with that patient. But, ehm, that would involve really giving also, I can't really remember whether I gave her material, but, I would have given some material about assertiveness. Ehm, there are materials that actually go over several situations and they're often even going through that assessment, I, you know, I find that patients find it quite useful, to, sort of, suddenly draw their attention to the kind of difficulties they're experiencing. Ehm, and the other, like, I said, there was a part of that sort of being comfortable with their own needs and expressing them and finding them. They do deserve to be looked at more carefully, they're justifiable needs within her context. And the other part was really her memory problems. Ehm, she had tried a lot of practical things, and they were not really working. I mean, nerves and things, all those kind of things that, ehm, ehm, were not really working for her. And at that point I was really trying to get a referral to see a, ehm, sort of, ehm get a neurocognitive assessment.

I To see if there was something real there.

R Exactly. Because her own assumption was, it was chemotherapy. She had sort of chemotherapy-related side-effects. Ehm, but I was trying to get it, at it better, to understand what was really going on there. Was it, was that related to her anxiety, or whether was it really neurocognitive problems there?

I So really trying to disentangle the, eh, the illness, the directly illness-related conditions from what may be her interpretations of who she is in her life.

R Exactly, yeah.

I Sounds like a very complex mixture of, of putting it, but without the positive aspects of it.

R Yeah, yeah

I Sounds a really unfortunate mix there. So, well delightfully, you've answering all my questions before I've asked them, that's wonderful, I think this is quite, very

useful that, because you're also in the academic world, you are likely to have thought this through very carefully.

R Oh (laughs)

I I don't think anything unkindly to the other practitioners who are out there. They're often sometimes seemed to be somewhat overwhelmed by the specifics of the clients they're dealing with. So that, in terms for this, or perhaps other clients in terms of knowing their, that you've been successful. How do, how do you measure success, if you even do such a thing?

R Ehm, what I use, depending on the main, you know, the problem is, in the most of them they're related to anxiety and depression related to their illnesses, I do use, sort of Beck depression inventory and or Beck. I tend to use those a lot, more Beckian, ehm, anxiety inventory. Ehm, so there is that kind of looking at scores and how also in different sections of the scale, the scores differed over time, what (laughs) over time. Ehm, part of it was also kind of, ehm, you know, I ask them to keep diaries of how often they are bothered by a sort of thought, and looking at how, I mean, if it's around, particularly around fears of recurrence, the aim is really not to completely get rid of them. They, you can't. I mean, at least, that is not the aim. Because they serve a function, fears do serve a function. But looking at how, how much hope we've less their bothered by those thoughts, and how much,...

I This is almost a mindfulness form of training, or would you call that something different?

R No, no, no, not at all. I mean, I'm very interested in. I don't necessarily formally introduce mindfulness in my practice. Ehm but parts of it is really relevant to that. It's almost being aware of those thoughts and fears, ehm, but not being as overwhelmed by them as they would have been and, and, and not ruminating at them much as they would. Ehm so that might take a form of a scale, but also to be sort of, if, you know, why did their therapeutic experience is successful in some way, they do report feeling a lot less bothered by it. And, you know, maybe having not thought about it for a week, or when something triggers their, their fears, they're able to deal with it a lot better. And they also would sort of look at, if I have done some relaxation training with them, how often they do it and how they feel. It's helping them. Most of the time it does, if they do it, somewhat regularly, (laughs) and how often they report using it. So, ehm, I think in terms of actual measures, I rely mostly on anxiety and depression inventories of some sort. Ehm, I haven't used it in a while, but I've also con, looked at therapeutic alliance type of scales. And I haven't used them in a while, actually, I should do that, 'cos I find quite, when I used that during my training, I found them quite useful, in highlighting what seems to be, what did they really think whatever it was going on is (laughs) helping them, or are they just sort of nodding along, and these sort of things can be highlighted during that, I think measurement which is quite often very very useful. And what it is that they are finding it useful really, or is it just sort of generally coming and chatting with me (laughs), you know, once a week or whatever it is, seems to help something, but you don't know what. Ehm, so yeah, I guess those are the..

I So I guess this is quite a complex, I think what you're saying is, in the crudest possible sense, before and after, in terms of the measures. How about your feelings about the clients in their, in your inner understandings of how things are going, how would you know your, do you have yourself, do you have a form of internal measure or awareness of how you're doing, beyond the external measures.

R Yeah. Ehm, that, that is hard, more, I think harder to operationalise, really, but, ehm. I suppose you do look at the general sort of posture of the patient, and general sort of, you know, would have they been paying attention to their clothing etc. You get a sense, when someone walks in, when you sort of, their shoulders slumped, and, or whether they walk in with a bit more energy into the room, ehm, and, so you look at those. I mean, I tend to look at those things and, and also kind of comment on it if I really feel there's a change, and, ehm, ehm. I think some of the time, the difficulty is, you know, that if you do see a change and there is a change, that sometimes the patient is quite reluctant to accept that change. And I think that's when it becomes a bit difficult, I think, from the therapist's point of view, or the practitioner's point of view. You feel like you're trying to convince them but you're not. You know, just, I think, they haven't quite internalised that there is a change that is happening. It's quite difficult for some people to see that, that things are changing. Ehm, so yeah, I think I pay attention to the externals, and, ehm. And I think part of it's really also to bring in to the discussion, you know, if they say something along the lines of, you know, calling someone that they haven't called for a long while, for a chat, whereas they would quite isolating themselves. That is not something that's easily measurable, by a scale or something. Those also give you indications in other ways, that they are maybe, getting back into life, (laughs) but it's more ...

I Mhmm, yeah. Are, are you thinking more of getting away from sort of an inner focus to a more general outer social focus, that kind of thing, yeah. How, how about inside you, how does that, are you, do you do that kind of monitoring in any way, on a formal basis or?

R Yeah, I do that thing, ehm, I do that thing with patients I find particularly difficult to progress. Ehm, like, they'll be a few of those. Ehm, I'm not, I mean I'm only been doing sort of the practice side of psychology very recently, since actually 2008, ehm, 7 to 8, ehm, and to me it is, it is, you know, when you, I think those changes I feel in myself, I'm obviously being, you know, pleased and glad when something's working, taking note of that, um, and sharing that with the patient, but, ehm, but it's when I don't, when those cases that give me more difficulty I think in myself, are those when I see a change, and this is very hard for a patient to acknowledge that, and there is, then I feel a conflict in myself, in terms of, OK, there is actually you are moving forward, but I don't want to convince you of that. So there is that, the times that I feel conflict, and, you know, the times when things are working out fine, that's great, and. In the beginning I think I would get a bit anxious about, sort of, discharge, ehm, you know. When they feel confident, that's fine. But they, if they feel a bit sort of uncertainty, despite positive change towards the therapeutic aims, and it's been a source of a number of, sessions I would get very anxious about, sort of, discharging. Because I'm pick up, in a way, on their anxiety a lot more. And my own anxieties, am I doing the right thing (laughs) when it's time to discharging. But I think over time that got a lot better from my point of view. A lot more I think. But, like I say, the times it does, when I monitor my own

feelings, those are the times that doesn't sit well. Or, when I feel frustrated, that, you know, I've tried so many things. What is it that it's not working? Those are, those are, happen to everyone, I think it's a very hard work.

I Oh, absolutely, yes, absolutely. I was very, I was very interested to hear what your experience had been in that particular thing, 'cos it's bound to happen.

R Yeah, I don't find it easy at all, I think. Like I said, maybe experienced therapists find it, I mean, I have great supervision, so that's optimal, I mean it comes up in supervision about, sort of, my own kind of frustration, or my own anxiety. Whether I'm picking up patient's anxiety, or whether I'm trying to do too much, you know, trying to do the work for the patient and therefore, when it's not happening, it gets more frustrating. And sort of, how to, in a way, ehm, what's the right word, how to scale back a bit and try to, you know, 'cos, especially I think I'm young (laughs).

I Be aware of it, but keep some self-protection or distance perhaps, is that?

R Yeah, yeah, it is, it is.

I I'm trying not to put words in your mouth here (laughs)

R No, no. I think it is partly self-protection, it is. I think, used to, to a degree, probably I do still have that kind of sense of, well if something's not working it's 'cos I'm not doing it right. And that was particularly again, I think for me, strong when I was training. But, you know, ehm, I must not be doing the technique well, you know, etc and. And then I would try the next one and the next one and that wouldn't work, and then that would work for a while, but wouldn't work all the time, and all these things and I'd get really frustrated with myself. And I think that part of the journey, in a way with being a practitioner, is to be sort of, accept it's the patient's responsibility as much as the therapist's responsibility to, to do whatever they want to do with the techniques or the tool or whatever it is that you're doing, so. Those are the ones that don't sit well with me, because it's still sort of the thing, I think more 'cos of my lack of experience or expertise in this particular area. And sometimes you overdo it because of that, because. Chucking everything (laughs) which don't always work.

I It's living with the failures. When you, it is when we,.. 'cos I do it myself, ehm, we have our failures. They never feel good (laughs), they shouldn't.

R Of course, no of course. And does this answer you questions?

I Very well indeed, because what I'm trying to do, very well, now, this is why I'm.. You're actually the last person I'm interviewing in the .. which is delightful at one level, because, it's very fortunate, because, I think in a way because you're also teaching and working in the area, you're thinking, I think you're obliged to think about it more than the average practitioner who's working outside does do. So, you're much more eloquent about it, which is fantastic.

R Oh, really, oh god, I don't feel like that, but thank you, thank you.

I It's really really good. Ehm, but what do you think, in terms of the, ehm, nature of the health psych, again, I'm thinking very much of the health psychology background, ehm, I'm not saying put aside the other CBT practitioner or the other therapeutic work you've been doing, eh, do you think, what, would you think that might give you an advantage, perhaps, over other psychological therapists? With your understanding of, perhaps all of the, particularly from the health psychology viewpoint and the training and the models?

R I think it does, and I think, the health psychology background, more academic background, gives you an understanding of the, what theories are out there that relates specifically, you know, to that condition or the management of that condition, ehm, and what treatment-related issues might come up specific to that condition. And I think that is a real strength of it. And I think part of it is also, I think, you know, if someone with a physical illness that is struggling with whatever they are struggling with in relation to that area goes straight to someone who has no background in health, I think that practitioner might be, I mean I'm not, I don't know, I mean, I might be wrong in that, ehm, that person might be more likely to find something that maybe relates to, in the past, and rather than focusing on the present and what that illness actually brings up as issues for that person, ehm, and I think that health psychology has an advantage because they focus on the present rather than the past. And rather than sort of, in a way pathologising that, whatever is going on, tends to be also more I think solution-focused. Trying to work with that, with that individual within their own setting, trying to get the help that they need. Whether from a psychologist or from anybody else, or from occupational therapist or somebody like that. Sometimes actually, something very practical makes a whole lot of difference. Ehm, so I think health psychologists has got that additional I think, probably, background, knowing that that illness might have relation to other factors, that maybe a clinical psychologist or a, might not have, 'cos they don't even work with that particular physical illness. Yeah, I do find that is useful. Having said that, my own perspective is as a health psychologist, that also tries to do a bit of practice, it is rather important to have those counselling and clinical skills that, mm, need to be developed more intensely. I mean I find myself very very lucky to have done that CBT course, which was very intense, but looking back, ehm, you know I had been chartered at the time that would have allowed me to see patients, if I hadn't, even if I hadn't done the CBT course, I guess, I don't think I'd been doing it in the same way at all. So it does give you a huge amount of background, that clinical psychology, counselling psychology have huge advantages over us, in really understanding and bringing out those past experiences or experiences that relate to personality of that person, in a way that a health psychologist, without that training, would be able to bring it out that easily or that quickly. And, and deal with, in a way, also their own kind of emotions in comes within that setting. Because, some of the problems, you know, are so chronic, problems go back, you know, existed even before the emergence of that physical crisis, so just barely, solely focusing on the physical side of things is not going to be helpful. So it helps, I think, to have a bigger counselling, clinical background as well. I've developed that as a health psychologist. I've find a huge benefit to it. A huge benefit.

I I completely understand that. So in terms of, where you might go next, I think any further. Is there any sort of further training that you feel you might need to answer some of the questions or the way you're practicing?

R Say it again, I didn't understand the question, sorry.

I 'Cos we've looked at is, ehm, what we've achieved, incidentally, is what health psychology brings to the understanding of the incredible complexity that you've just described, and you've mentioned that, ehm, health psychologists obviously aren't foolish people, but they could probably manage. But, this sort of training has been invaluable to you in dealing with the complexity and your own, eh, reactions to what you're hearing. Is there any further sort of training that might attract you to fill further gaps, or take you further, that you might like to go? If you continue to do therapeutic work?

R Yeah, yeah, absolutely. I think, one of the things I found most difficult to deal with in my practice is how to deal with potential personality disorders. And I found that those cases where that might have been the case, without really having done any, you know, psychiatric assessment of it, or I'm not trained to do that, but, you know this through observation, etc, and with discussion with supervisors, that comes up as a real possibility. And for me that was the real difficulty, not really knowing how full well how to set it aside, or not, or how to deal with that and how to deal with your own emotions when that other person's personality issues, pushing you. In that sense I think, I find, I would find it very useful to think of, those really difficult to treat cases where there might be a sort of personality disorder component. Ehm, because it's easy to, and some of them, like I said also very chronic, and they tend to have really chronic, chronic problems. Ehm, and just, sometimes, CBT is very limited in those cases. Ehm, so I think, that may mean more clinical training. But if, if when it, when you come across those cases all the time, then you feel, well in some cases CBT works like a dream. But in some cases you just sort of need those additional skills and understanding of the bigger picture that's better. And I think, personality I would say, is one of them. And another one I think that I've mentioned is that mindfulness I'm interested in. And those, I think, especially when to the uncertainty management of any illnesses, mindfulness I find quite useful, might be useful to take. So I think, I imagine it's personality and mindfulness are two things I want to pursue. Mindfulness, there's a lot of trainings out there.

I Oh, yes, and it comes in all shapes and sizes of course, and through acceptances and so on.

R Absolutely, but I find, sort of the training around personality a lot more difficult within health psychology. Just, I think, shoved aside.

I It's not part of the training at all, normally.

R Not at all, not at all. I mean, there are obviously a lot of research, particularly around cardio-vascular health and Type A, Type B, all these different, ehm, personality types I suppose, but. But I don't think it is really well, ehm, hashed out within the practice context.

I Nothing to prospectively look at the personality disorders, and the range or, and the very controversial nature of them as well, their descriptions.

R Exactly, exactly. What, that is what I find is that. Once a patient presents with a physical ailment that gets referred to health psychology services, whereas actually it might be needing more clinical, mental health input, it becomes very very difficult to negotiate that within the health care system, where that patient is best suited to get help. So those are the ones I found most difficult to deal with as a practitioner, really.

I I can imagine, yeah. Are there any, well, I'm just so, you've covered it all beautifully. Bear with me, I've hardly had to ask anything, 'cos they all flowed very very nicely. Is there anything, do you think, that I should have asked you? Is there anything that you feel that you should tell me that I haven't asked? About your belief about the nature of change, or where health psychology's going, or not!

R In terms of nature of change, in the therapeutic context, I've, this is my own sort of background, my own interests. I tend to look at the behavioural outcomes a lot more. And I quite also like sort of behavioural activation aspects of psychotherapy, ehm, but I'm also aware that it doesn't always go, always work with many patients (laughs). But that is usually a good indicator, in that the patient is able to overcome the low region, overcome and become more active. And it's just, you know, in, I think all the time that I've come to realise that it is not only, you know, the mention of the frequency of whatever that was bothering them, the thought or whatever, but how much they're bothered by it, the sort of severity of it and I, I've think I've become more attuned to that rather than just looking at the frequency. In terms of the change.

I OK, yes. The strength of the reaction, rather than how much of it.

R The qualitative rather than just the quantitative. And if they're doing something more. You know, they might be doing something more, which is a good positive change, but how they're feeling when they're doing it. So, I think, the hope is that they're feeling more and more comfortable doing something, rather than just feeling absolutely terrified but doing it three times a week, whatever it's going to be. But they're also feeling slightly less anxious etc etc. Validating the experience and validate that, but that anxiety's always going to be there. It's just part of it, I think, I think it's a huge component of just saying, no it's never going to go away, we're trying to just make it a lot less impactful on your life. And I think that's really important for the patient to understand, is that it's sort of the ..

I It's a form of normalising the that fact that anxiety's, universal.

R Normalising, exactly. And just sort of, I think it's really important for the patient to understand. Accepting that probably it's never going to go away. 'Cos they come in there saying they never want to feel this way ever again. So, I also I suppose look at how, if there's a change in that, it is accepting, eh, that is part of the therapeutic establishment, part of the therapeutic goals as well really. There's a huge discrepancy (laughs) between where I would coming from and where the patient's comes from, it's a big problem. Part of it is also, sort of, you know, bringing us to the same page. There's not a magic wand that is going to take all that pain away, so, ehm. And, I mean, I, in terms of whether you've covered everything, I think you have. And I think, just to sort of, really make sure that it's clear I'm a very new practitioner.

I Oh yes, I will. What I'll doing is looking at comparisons, and it's very clear I saw very little of it when I started, and I'm really beginning to see where counselling and health psychology approach things differently. Ehm, but there's a massive overlap and that's the fascinating area. What we can learn from each other. Ehm, and health psychology seems to be a bit defensive of other psychologies in some ways.

R Health psychology is? OK!

I Because it is still a little new and making sure that it is distinct.

R That's right. Yeah, and I think I completely agree with you. I find that. But partly, it is because of my own background. I see a lot of overlap in what I might seem sort of distinct disciplines. My background is also social psychology. Ehm,

I That gives you a huge advantage, I would imagine.

R I think, I feel so. And that kind of relates to what I was trying to say earlier on about, not pathologising something necessarily. And because we're all kind of drawn to those kind of biases and etc. And having knowledge of that helps me to put that in perspective and not jump to conclusions about something about, maybe, possible personality disorder or something like that. Ehm, moreover, I'm not trained as a clinical psychologist so I can't do that anyway. But, ehm, I think health psychology has an advantage, because they are kind of sitting in a way, you know, psychology did come out of a sort of social psychological background, so it's kind of sitting a bit, on top of, sort of, social psychology and clinical psychology gets fed with both of them. Ehm, in that sense there is a unique position, but in terms of specific techniques that they can use in, during practice, I think, that really is mostly fed by clinical psychology and counselling, obviously. I mean that in that sense, I think there needs to be training if people, health psychologists really want to practice, I would find it, I found it in my own, myself, that it's hugely important to me, hugely useful, ehm, having had that CBT training, hugely. So. ehm, yeah. I think you covered pretty much everything, so! (laughs).

I Thank you so very much, it's been, I'll just stop the recorder, thank you very much indeed.

R You're welcome.

End transcript 10