Enhancing primary care psychological therapy for clients with comorbid physical health conditions: A Critical Discourse Analysis investigation into interprofessional identity

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to the University of Exeter as a thesis for the degree of Doctor of Clinical Research

September 2022

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I certify that all material in this thesis which is not my own work has been identified and that any material that has previously been submitted and approved for the award of a degree by this or any other University has been acknowledge.

Acknowledgements

My sincere thanks to my research supervisor, Dr. Martin Benwell, for his good humoured and grounded inspiration, expertise and an impressive array of metaphors to suit every supervisory dilemma. Also, thanks to Dr. Raluca Topciu, my second research supervisor for her support and encouragement.

To my husband, Matthew for his patience and spurring me on when I doubted myself. Love to my wonderful parents, Susan and John, for believing in me throughout and giving me much needed time out.

Gratitude too to my fellow DClinRes colleagues for your impressive knowledge and endless humour.

Finally, I'd like to extend my warmest thanks to all those who participated and gave generously of your time. I would like to acknowledge the support of my Talkworks friends and colleagues, and my field collaborator Isla Gale.

Abstract

Background / Aim: Improving Access to Psychological Therapies (IAPT) services are the largest provider in England of primary care psychological therapy for depression and anxiety disorders. Over recent years there has been increased recognition of the importance of therapists and their physical health colleagues (e.g. nurses, physiotherapists or other allied health professionals) integrating care for patients with comorbid long-term health conditions and common psychological disorders. Specialist teams have been creating differentiating Psychological Therapists as Core and Integrated. The aim is to investigate the implications of this shift for Therapists' professional identity.

Method: A Critical Discourse Analysis was conducted based on five focus groups with eighteen professionals from Core IAPT, Integrated IAPT and physical healthcare backgrounds.

Key Findings: Discourses related to expertise, responsibility and innovation / creativity emerged from the corpora. The research highlights the niche set of behaviours, skills, values and attitudes under construction by Integrated Therapists and the way in which their role shapes and is shaped by their interactions with their counterparts.

Implications: The research makes recommendations for Integrated Therapists' professional identity including to showcase niche skills and effective collaborative therapy. Future research recommendations are made regarding unheard voices and silenced discourses in professional identity reconstruction.

Key Terms: Professional Identity; Integrated Therapy; Cognitive Behaviour Therapy; Long-Term Conditions and Medically Unexplained Symptoms (LTC/MUS)

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Chapter 1 - Introduction

1.1 Introduction

The intention of this thesis is to contribute to the understanding of professional identity for clinicians who have any stake in the psychological wellbeing of clients whose difficulties are comorbid with a long-term health condition or medically unexplained symptoms (LTC/MUS). The thesis particularly has Psychological Therapists in mind, and specifically those working in Improving Access to Psychological Therapies (IAPT) services who aim to increase the availability of evidence-based therapy in primary care in England (Clark, 2018). The intention is to enhance the understanding of professional identity for this under-researched group of professionals who have recently undergone a significant policy shift through the creation of a new specialist pathway for clients with LTC/MUS, the impact of which thus far has been researched only through the lens of the client but overlooking the challenges to therapist identity and how those around them adjust to new ways of collaborating.

The relationship between long-term health conditions and depression or anxiety disorders is stark. Whilst many health conditions are resolved, treated or well-managed, an estimated 33% of visits to specialist medical centres are for unexplained somatic symptoms which can lead to challenging or unsatisfactory encounters for both clinicians and patient alongside the health economic impact from repeated attendance and medical costs (Kroenke, 2003). Not only are depression and anxiety disorders significantly more common for clients with long-term conditions (Department of Health, 2011a), they are associated with poorer outcomes for patients. Self-care and treatment adherence have been shown to be poorer for clients with depression or

anxiety alongside diabetes (Smith et al., 2015), cancer (Pitman et al., 2018), whilst fear-avoidance can be a maintaining factor in chronic musculoskeletal pain (Vlaeyen & Linton, 2000). Depression has also been found to be a risk factor for developing coronary heart disease (Sundquist et al., 2005) and can double the mortality risk (Barth et al., 2004)

Prior to the inception of IAPT many clients would not have received or accessed a NICE-recommended psychological therapy. Rather, clients without severe and enduring mental health problems, significant risk or complexity factors who would not meet the criteria for secondary care services were either not offered a service or treated with medication alone (Layard et al., 2014). Cochrane reviews of psychological therapies for chronic pain found insufficient evidence to recommend such treatments. Behavioural interventions, for example, were largely absent in clinical trials and only small positive effects were found for cognitive-behavioural interventions for low mood (Eccleston et al., 2009), however in a later review only two studies met the inclusion criteria and the interventions provided do not map onto NICE guidance (Eccleston et al., 2015). Pure self-help does not appear to fare much better in the relatively sparse literature on the topic. A systematic review and meta-analysis (Farrand & Woodford, 2015) found inclusive results for the efficacy of pure self-help for this population. IAPT offers easier access to evidence-based therapies and high-quality data collection affords better opportunities to evaluate outcomes.

The structure of the thesis will provide an overview of the IAPT programme before focusing on the ways in which primary care psychological therapy is adapting to meet the needs of clients with comorbid long-term health conditions. The way in which

Critical Discourse Analysis was utilised to better understand this phenomenon will be presented and the analysis will comment on three major discourses of expertise, clinical responsibility and the extent to which creativity and innovation is deployed therapeutically with this client group. The concluding chapter will then draw the central arguments together and a reflexive stance will be taken.

1.2 What is the IAPT programme?

The IAPT programme was first conceptualised following the publication of the Layard report (Layard et al., 2006; Clark et al., 2009). It is an ambitious mental health model of service delivery designed to treat common mental health disorders such as depression, anxiety disorders, and post-traumatic stress disorder (PTSD). It is distinct as a mental health programme for its dedication to evidence-based clinical interventions, most commonly Cognitive Behaviour Therapy (CBT), outcome monitoring and supervision (National Health Service; NHS, 2021). Treatment interventions are based on idiosyncratic formulation of clients' difficulties, their treatment goals and with consideration of the guidance from the National Institute for Clinical Excellence (NICE) based on the primarily presenting problem as referenced in the International Classification of Disease-11 (ICD-11; World Health Organisation, 2019) and the Diagnostic and Statistical Manual, 5th edition (DSM-5; American Psychiatric Association, 2013).

Interventions are tailored to the needs of clients through different levels of treatment. Psychological Wellbeing Practitioners (PWP) provide low intensity guided self-help from a CBT perspective over an average of six individual treatment sessions, group

interventions or online CBT (cCBT) for clients with mild-moderate severity. High intensity interventions are provided by Psychological Therapists (HIs) for up to twenty sessions of CBT for those with moderate-severe symptoms, those with an insufficient response to low intensity interventions, or for conditions such as PTSD for which a high intensity intervention has the strongest evidence-base (Ehlers & Clark, 2000). Furthermore, a high volume of people access the service yearly. In 2020-2021 IAPT services in England received 1.46 million referrals (NHS Digital, 2021). Of those, 1.02 million started a course of treatment, with 643,649 patients completing a full course. This represents a 4.7% increase on the previous year (NHS Digital, 2021). It is likely that this number will continue to grow. Indeed, IAPT services have increased their prevalence target nationally from 15% of the population with depression or anxiety disorders to 25% as of March 2021 (NHS Digital, 2020).

The IAPT programme identifies four key priorities as part of their future direction, laid out in the Five Year Forward View for Mental Health document: 1) to continue to increase access rates to 1.9 million clients yearly by 2024, 2) develop specialist pathways for clients with LTC/MUS, 3) enhance employment support pathways, and 4) ensure access for populations that may find it harder to enter therapy (NHS, 2019; NHS, 2021). This thesis is focused on the second of these priorities, the LTC/MUS pathway, which will be outlined further in the next section.

1.3 How is the IAPT programme adapting?

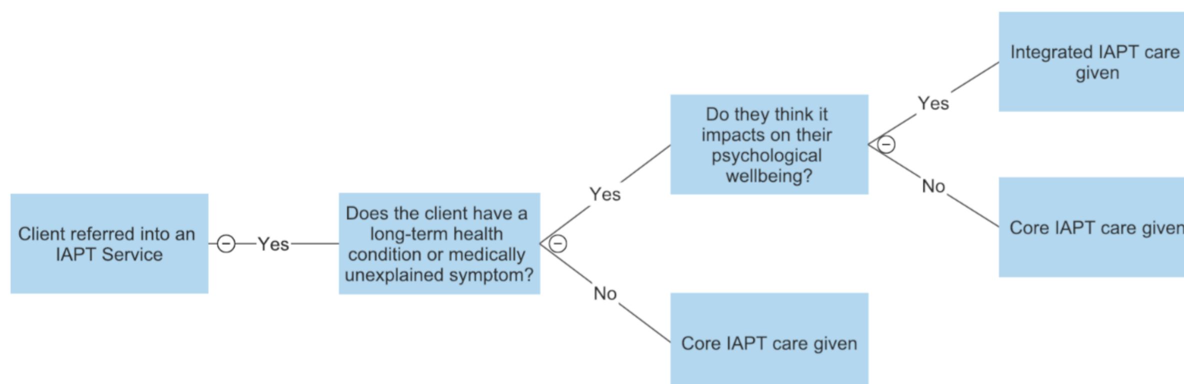
"No health without mental health"

- *HM Government (2011, pp.1) policy document*

In 2018, informed by the publication of the Five Year Forward View, IAPT services published their intention to develop specialist pathways for clients who had comorbid LTC/MUS (NHS England & NHS Improvement, 2018). It was thought that a significant proportion of clients with long-term health conditions may benefit from increased targeted access to psychological therapy leading to a trial of early implementer sites, following which the majority of IAPT services have adopted the model. The key changes to routine IAPT practice are that therapists are more commonly located within physical healthcare settings and receive the majority of their signposting / referrals from physical health professionals in contrast to the traditional GP or self-referral route. In terms of their clinical practice, therapists receive specialist training to learn about common long-term health conditions which initially focussed on obesity, Chronic Obstructive Pulmonary Disease (COPD) and diabetes before expanding to a wide range of LTC/MUS. Therapists were provided with a lengthy and thorough course of training regarding adaptations of CBT for clients with LTC/MUS (e.g. Furze et al., 2008; Naylor et al., 2012) alongside enhanced supervision with Health Psychologists (Wroe et al., 2015). Terminology has adapted to reflect the creation of the specialist pathways whereby therapists located in the new LTC/MUS treatment pathways are referred to as working in Integrated IAPT services to differentiate from Core IAPT (NHS Digital, 2018). The model below shows the framework from the first wave of implementation:

Figure 1

Core and Integrated IAPT Decision Tree, adapted from NHS Digital (2018)

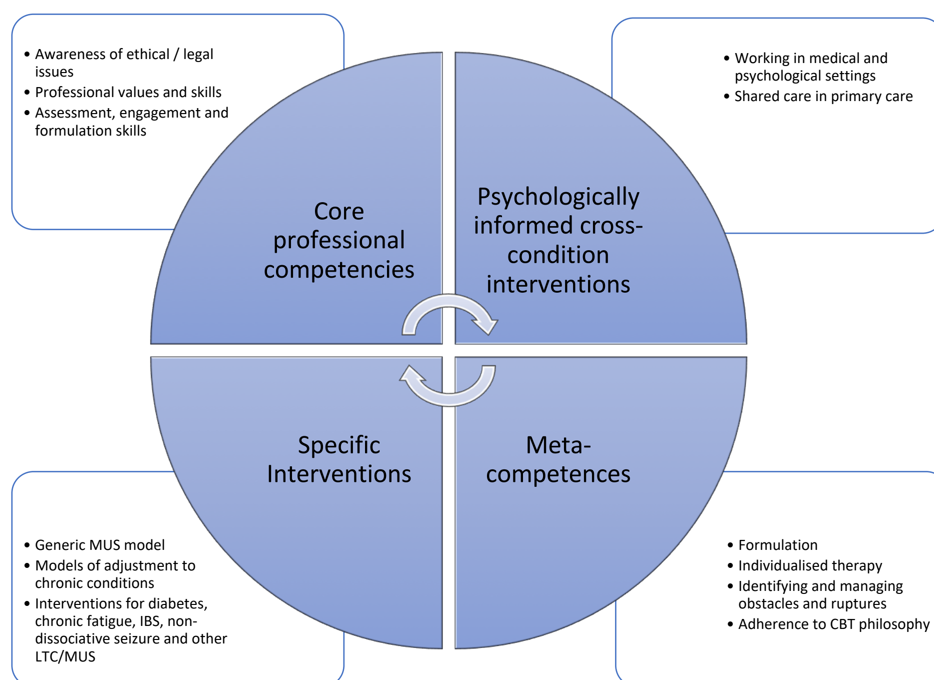


IAPT services attribute some of their success to their adherence to the evidence base. However, currently the evidence base for adapted practice for LTC/MUS is relatively sparse in comparison with guidelines for depression and anxiety, although it is promising thus far (Farrand & Woodford, 2015). Qualitative studies have shown the role of cognition in maintaining depressed mood and anxiety for example in the context of stroke (Gibson & Watkins, 2011), and cancer (Foster & Fenlon, 2011). Therapists are encouraged to think in a transdiagnostic manner which means applying core CBT principles and creative practice to the specific cognitive behavioural factors maintaining depression and anxiety for clients with LTC/MUS (Salkovskis et al., 2016). Competency frameworks have been used since the inception of the IAPT programme to train, assess, inform and supervise therapists when working with common mental health problems (Roth & Pilling, 2008). Updated positive practice guidelines were subsequently published by the Department of Health (DoH) for those working in psychological and physical health settings (DoH, 2008). Since this time, competency frameworks have been adapted for specific conditions such as chronic fatigue and irritable bowel syndrome to aid supervision and clinical decision making (Rimes et al.,

2014) and were formalised into a competency framework to reflect Integrated CBT (Roth & Pilling, 2015) which is now included in the IAPT pathway for LTC/MUS (National Collaborating Centre for Mental Health, 2019), as shown in Figure 2 below:

Figure 2

Updated competency framework for Integrated CBT in IAPT services, adapted from Roth and Pilling (2015)



Prior to the creation of the Integrated pathway, an analysis of a large group of patients in primary care with depression or anxiety disorders (n=28,498) found that those with LTC/MUS were more likely to require High Intensity CBT interventions, yet lead to lower recovery rates (Delgadillo et al., 2017). The early implementer sites such as those in the South West of England, however, found in a service evaluation study an

almost equitable recovery rate of 52% for the Integrated pathway compared to 54% in the Core pathway (Wilkins et al., 2018), both of which are above the national target of 50% (NHS Digital, 2020). It is recommended that Integrated Psychological Therapists adopt a collaborative care approach (NICE, 2016). The term *joint working* is used as an alternative term for such practice in the IAPT Integrated Pathway full implementation guide:

> *"Integrated care pathways: all therapists should be co-located with general health care teams and primary care. This requires participation in multidisciplinary team meeting, care planning, and, where required, joint working"* (National Collaborating Centre for Mental Health, 2018, pp. 18).

Integrated working has implications for both psychological and physical health professionals, as outlined by the IAPT positive practice guidelines and reviewed against the IAPT mission statement for early implementer sites (DoH, 2008). The guidelines advocate for Psychological Therapists to work closely with physical health, citing a finding from the Salford IAPT Pathfinder site in which early implementation of a joint endeavour between a diabetes clinic and the local IAPT service increased their access rate by 20%. This endeavour is bi-directional. Training was also provided for Diabetes Nurses in the identification of depression and anxiety disorders, and use of psychoeducational materials which can be sent to patients routinely if a possible mental health need is indicated. The IAPT Positive Practice Guidelines (DoH, 2008) suggest that collaborative working is most effective if strong relationships between clinicians in physical health and psychological therapy services are forged, citing the

cautionary tale of the Hereford pathfinder site who did not receive a referral for months after starting a joint endeavour with the COPD respiratory team until a more proactive approach was taken to developing and maintaining close links between Respiratory Nurses and the IAPT service.

Although CBT has been shown to be effectively adapted for many long-term conditions, the experience of therapists implementing Integrated pathways is varied. Rimes and colleagues' (2014) study reported therapists were largely optimistic about Integrated working, however this is not replicated across the board. Some studies have shown that therapists tended to lack confidence and relied more heavily on training to improve their self-efficacy (Hamilton-Westa et al., 2018). This phenomenon appears stronger in the less tangible area of medically unexplained symptoms (Salkovskis et al., 2016) which reduces the likelihood that therapists will use the full extent of their knowledge. However, this remains an under-researched area.

The effect of therapists lacking the confidence to adapt their practice to chronic conditions leads to incomplete idiosyncratic formulations (Salkovskis et al., 2016), errors and misinformation and failure to collaborate effectively, including duplication of services (Kebe et al., 2019). This suggests that there is a strong clinical need to address this phenomenon. To date however, much research in this area has tended to focus on effectiveness of Integrated pathways from the perspective of clients, whereas very little research has been published about the implications for therapists except perhaps for evaluations of the effectiveness of training programmes. As outlined by the Roth and Pilling's (2015) competency framework, the skill and confidence of therapists to deliver interventions is equally key to successful outcomes

and positive experiences for clients, as well as self-efficacy and wellbeing for therapists professionally. For clients to have hope for therapy, therapists also need to hold hope that treatment can be successful and have confidence in their abilities to develop a strong therapeutic relationship (Padesky, 1996) based on a cognitive behavioural conceptualisation (Beck et al., 1979), guided discovery (Beck, 1996; Beck 2011) and an ability to be attuned to their own assumptions (Butler et al., 2010). Thus, the thesis intends to address the important issue of therapists' confidence to provide evidence-based CBT interventions for clients with comorbidity.

In the opening section, the current priorities of IAPT services have been outlined and the specific considerations of Psychological Therapists working with a broader range of physical health colleagues have been introduced. It has been noted that therapists may lack confidence to implement effective treatments or use the full range of their existing skills as they adopt the new status of Integrated Therapist. This transition may pose a challenge to their professional identity as they consider what their new roles, responsibilities, and level of expertise are with regards to working with their clients, and how they step into physical health settings in which they are the face of Integrated Therapy to their physical health counterparts. In short, the creation of the Integrated Therapist comprises an identity transition point. The next section provides an overview of theoretical perspectives of professional identity and is followed by a systematic review of the literature.

1.4 Ontological Position: Professional Identity Theories

"…change is the only constant…"

- *Heraclitus*

Healthcare professionals in the NHS belong to one of the largest employers worldwide. Rolewicz and Palmer (2021) ranked the NHS as the fifth largest employer globally, a position consistent with findings from almost a decade previously by the British Broadcasting Corporation (BBC) (Alexander, 2012). So how do Psychological Therapists find a place amongst such a diverse group of professionals? The next session outlines what identity theories can offer to Integrated Therapists as their role develops further.

1.5 Social Identity Theory

The formation of professional identity is often written about in conjunction with the pedagogical journey and this is indeed not a bad place to begin. Training teaches students the expected practices of their profession, acquaints them with accrediting bodies and how their role is located within NHS professional structures. In essence training is the means "through which a learner transforms into a healthcare professional" (Gross-Hegen et al., 2019, pp. 70). Becoming a Psychological Therapists also requires acquainting oneself with NHS values (Department for Health & Social Care, 2021; Health Education England, 2022), the emulation of which allows therapists to develop a values-based notion of their profession which goes beyond the behaviours expected. In short, training begins to construct a core professional identity

as trainees reflect on what a therapist does, what is important to them and how they align with their colleagues.

Social Identity Theory (Hogg et al., 1995) argues that identity construction involves categorising oneself as a member of a certain group or groups, and that social identities are numerous. There are many groups to which Integrated Therapists belong, from *IAPT Therapist, CBT-orientated therapist, High/Low Intensity* or broadly *NHS worker* alongside other demographic categories such as gender, age, culture and so on. Defining oneself as a Psychological Therapist, a Nurse or Physiotherapist contains some information required to form a foundational sense of professional identity, however within this there are many nuances. Many professions develop specialities, such that the role of Nurse can be qualified with sets of clinical expertise such as (but certainly not exhaustively limited to) Diabetes Nurses, Mental Health Nurse and many others (NHS, 2021). Some of these distinctions are less formalised, such as champion roles which are driven on the micro level by the individual either through a specific requirement of the organisation, or due to individual innovation (Shane, 1995). The subdivision of the Psychological Therapist role into Core and Integrated Therapist provides a new identity dimension. These are good illustrations of transition points in professional identity within organisations in a process coined as *adaptive instability* (Gioia et al., 2000).

Whilst many of these social identities overlap and can be considered complementary (Gross-Hagen et al., 2019), Hogg and Terry's (2000) Self-Categorisation Theory posits that places in which the identity Venn diagram overlap provide scope for an individual to align their professional identity with their personality. This suggests that

some professional identity factors are fixed whilst others are chosen or some aspects emphasised. This was neatly illustrated in a study of staff working in a newly formed human resources call centre (Pritchard & Symon, 2011). In this study, individuals emphasised desirable aspects of their professional identity such as their professionalism, ways in which their role was skilled and unique and what they considered to be the main functions and values of their profession. In this way, individuals actively selected identity characteristics for which they wished to be perceived. Social identities, therefore, provide a means of augmentation of the similarities and differences between the behaviours, belief systems and attitudes of one's own group and other groups (Stets & Burke, 2000).

Professional fulfilment and distress are further argued to be influenced by psychosocial factors. (Petriglieri & Petriglieri, 2010) wrote about the social and career communities which operate independently from the core organisational structures. They argue that these *sentient communities* and *rites of passage* "sustain the psychological and social adjustments underpinning identity work" (pp. 50). A recent series of interviews with social workers in Canada found that professional identity, in particular ruptures in identity and professional wellbeing, is strongly influenced by the interaction between professional, organisational and personal factors (Negura & Lévesque, 2022). In particular, participants in the study highlighted how personal and professional life impact upon wellbeing, likewise external attitudes towards healthcare professions. Additionally, lack of recognition and resources to achieve organisational goals was foregrounded. Indeed, the notion of competing resources, perceived guilt and feeling professionally responsible for outcomes or feeling powerless to provide

care at a standard one would wish has been conceptualised as a psychosocial source of *moral injury* (Greenberg et al., 2020).

Social identity theory therefore provides a framework from which to understand the formation of professional identity and ways in which identity factors are interconnected. There are other transition points significant to identity development which will be discussed in the next subsection.

1.6 Transition Theory

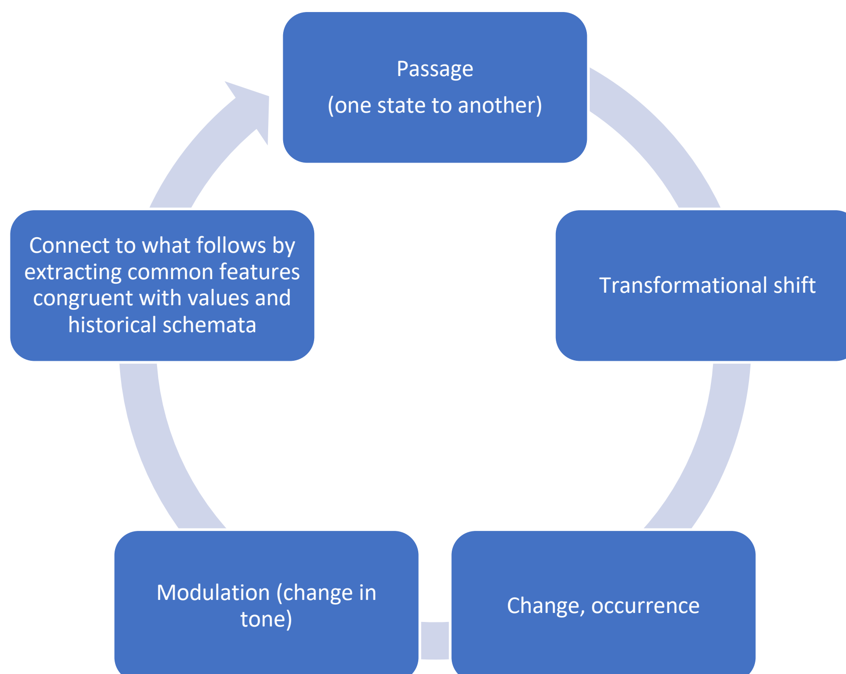
Professional identity transition is not as linear as first hypothesised, but rather involves cognitive shifts, adaptation and learning. According to Transition Theory, the changes that are most significant for identity used in the broadest sense include major life events and periods which require adaptation to “temporal and structural changes in daily life” (Manzi et al., 2010, pp. 970). In professional practice, these structural changes can be understood in terms of categories proposed by Suddaby and colleagues (2007): structural changes within an organisation, ideological shifts, and power. Ibarra (2004) believes identity can be consciously moulded during significant events. For Ibarra, individuals reconstruct identity during transition junctures by reflectively sifting through possible selves by asking oneself ‘who do I want to be?’, behaviourally experimenting and consolidation such that the new behaviour or concept replaces the old.

Adapting into the role of Integrated Therapist can therefore be considered as a series of transitions from one point to the next through interweaving the various complexities, interactions and crises in the external world alongside seeking to resolve conflict and

uncertainty in the internal world (Savickas, 2019). In contrast, Career Construction Theory argues that the construction of the *professional self* is considered always to be in a state of change whereby individuals reflect consciously on experiences which shape the narrative of the self-concept (Savickas, 2013). Kralik and colleagues' (2006) notable paper introduces the *shifting perspectives* model of adapting to significant changes. The authors suggest that transition is rarely a single momentous event, but rather a sequence of passages from one state to another:

Figure 3

Visual representation of the 'Shifting Perspectives' model adapted from Kralik et al. (2006)



Thus far, professional identity formation and transition has been considered as rather a personal phenomenon. During initial training, Psychological Therapists become socialised to the NHS, to IAPT and to the psychological therapies. Therapists then

develop a specialism, in this case they become *CBT-oriented* therapists which sets them apart from other therapeutic orientations and learn IAPT-specific language. Therapists learn, for example, of the importance of *evidence-based practice*, of the CBT concepts of *guided discovery* and *collaborative empiricism*. The Integrated Pathway created a transformational shift, modulating the *tone* of Integrated Therapists' identity towards LTC/MUS. As Therapists select consciously or unconsciously for identity factors that are desirable, over time this allows their identity to stabilise. However, as Brouard and colleagues (2017) write of their profession, accountancy, psychosocial factors are also important transition points. The authors note that power dynamics are relevant as professionals present a public-facing identity, serve their stakeholders and even vie for survival in a competitive environment. The way in which contextual factors shape professional identity for Integrated Therapists will be discussed in the next section.

1.7 Network Theory

"When individuals merge into a group, something new is created"

- *O'Leary & Wright (2005, pp. 258)*

According to Network Theory (Higgins & Kram, 2001) professional identity construction and modulation is a dynamic process. Transformational shifts are characterised by the professional networks in which the individual interacts. Professionals belong to multiple networks. For example Integrated Therapists belong to local and regional therapy networks, supervisory structures and friendship networks. In the context of professional identity, developmental networks relate to those whom

the therapist "names at a particular point in time as being important to his or her career development" (Higgins & Kram, 2001, pp. 268).

Developmental networks contribute to professional identity through knowledge acquisition and career development (Ibarra et al., 2005), alignment with values and ethics, and improve self-efficacy (Somers, 1994; Goltz & Smith, 2014). Collaboration is encouraged as a means to improve healthcare outcomes and to provide more efficient services (Long et al., 2014). Interprofessional networks enhance specialism (Sweitzer, 2009), reduces siloed working (Kreindler et al., 2012) and aid in negotiating complex problems (Julkunen & Willumsen, 2017). Dutton and colleagues (2010) suggest that individuals are driven by a wish to promote positive identity features to others such as caring, modesty, honesty and openness. Projecting positive characteristics is thought to increase social connectedness with colleagues and effective therapeutic work with clients. Yet, individuals may also be exposed to challenges to their professional identity. They are more likely to be faced with specialist language, ethical and procedural differences, and external views of their profession (de Medeiros-Anderson et al., 2021). Developmental networks are often assumed to be a proactive behavioural choice (Higgins & Kram, 2001), however this is not necessarily the case for Integrated Therapists who may be required by the organisation to promote the Integrated Pathway to a less receptive group of professionals. Thus, Integrated Therapists may be more greatly exposed to negative attitudes about their role. Further still, Casciaro and colleagues (2014) published a series of studies illustrating how networking can trigger feelings of professional moral impurity causing individuals to question their motivations and justify organisational choices in indifferent or even hostile environments. These challenges may create

identity drift whereby the organisation's "current identity becomes misaligned with its past" (Horton et al., pp. S13).

It appears, then, that changes to organisational networks can be both a challenge and an opportunity (Kim et al., 2019). There is a wealth of psychological literature to suggest that change creates uncertainty which most people find somewhat aversive, and in many cases can create a great deal of anxiety (Dugas & Koerner, 2005; Dugas & Robichaud, 2007). During periods of uncertainty, Dugas and Robichaud write, it is likely that individuals will employ an *avoidance or approach strategy* to either neutralise the source of uncertainty through procrastination or avoidance, or adopt an approach action which seeks to control the level of uncertainty. During periods of organisational transformation resources are often sparse or under threat, the uncertainty and emotional impact of which is mitigated through adapting features of the others' identity (avoidance) or assertively shifting power dynamics to gain influence (approach) (Srivastava, 2015).

Thus, Integrated Therapists are in the process of shifting their identity through a range of psychosocial factors. Their relationship with their Core IAPT colleagues has changed as in some respects they compete and in many others they are united by shared IAPT values and CBT-orientation. To what extent, then, does the taxonomical difference create competition, how do they complement one another and how are they different? As Integrated Therapists they must negotiate what identity factors they wish to project to stakeholders and colleagues, and it is likely that this effect will be reciprocal as their physical health colleagues and clients will expose them to new perspectives about LTC/MUS and perhaps require them to defend themselves against

role stereotypes they may not have encountered in their current structure. Their additional training and supervision expose them to new theoretical positions which may challenge assumptions of how CBT can be best practiced with a certain amount of uncertainty posed by the current state of the evidence-base.

1.8 Summary

The introductory chapter has outlined the historical development and current priorities of the IAPT programme as it strives to meet the needs of its clinical population and stakeholders. The scope of the thesis has been located within one of the major priorities for IAPT, the LTC/MUS pathway, and how this might affect the professional identity of Psychological Therapists. It has been demonstrated that the creation of the Integrated Pathway poses both an individual and a psychosocial transition point for Integrated Therapists, yet much of the research to date tends to focus on the effect of service transformation through patient experience and service outcomes. The aim of the thesis is to investigate the concept of professional identity transition with Integrated Therapists on both an individual and psychosocial level with the aim of producing recommendations which may benefit their successful adaptation to their role.

The following chapter systematically reviews the literature regarding collaborative psychological therapy and professional identity of Integrated Therapists.

Chapter 2 - Systematic Literature Review

The literature review explored therapists develop a sense of their professional identity and which transition points were significant for identity reconstruction. The review was interested in literature relevant for IAPT psychological therapists, in particular Integrated Therapy. Alongside the core theoretical frameworks noted, the review aimed to 1) develop the research question, 2) answer how Patient and Public Involvement (PPI) could best be utilised, and 3) inform the research methodology and analysis method. The chapter is structured according to the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) checklist (Shamseer et al., 2015).

There are varying methodological approaches to conducting a review of the literature. The approach utilised here takes a systematic approach whereby the problem and questions are identified beforehand, the literature is searched and studies are critiqued in terms of quality and relevance and then interpreted based on current psychological research (Aveyard et al., 2016; Cooper, 2017; Tight, 2019, Chapter 7). The objective is to identify gaps in literature, synthesise the current state of the evidence-base and inform methodological, theoretical and conceptual frameworks suitable for developing the thesis (Harden & Thomas, 2010).

2.1 Questions for Systematic Review

Systematic Review Question: How do professionals offering mental health care understand collaborative working with clients who have comorbid LTC/MUS in primary care?

It is intended that the systematic review findings will also answer the following second order questions:

1) How does professional identity develop for Psychological Therapists, and are there key transitional junctures?
2) How do multidisciplinary contextual factors affect therapists' professional identity?

2.2 Methodology

2.2.1 Eligibility Criteria

The systematic review included English language, peer reviewed publications between 2000-2021. This date range was selected to include significant mental health service transition points including the beginning of the IAPT programme and the Integrated Pathway. The PEO (Population, Exposure and Outcome) framework was utilised to guide the search (Cooke et al., 2012; Aveyard et al, 2016, pp. 71).

Table 1

PEO Criteria

	Inclusion Criteria	Exclusion Criteria
Population	Professionals offering mental health care to adults with LTC/MUS in primary care services such as IAPT Professionals who may signpost into primary care services or work alongside them, such as allied health professionals	In training without a clinical caseload Secondary and tertiary care Focused on bipolar disorder, personality disorder or schizoaffective disorder Education providers
Exposure	Patients with mental health and long-term physical health needs Multidisciplinary working environment Referring to a period of service transformation	Where multidisciplinary working refers to care co-ordination and social care
Outcome	Professional identity formation or transition Competencies involved in integrated therapy Patient experience of receiving an integrated service Studies which use formulation or scenarios	Studies in which the outcomes relate solely to the development of educational / training programmes

2.2.2 Information Sources

Databases consulted in the search were: Journal Storage (JSTOR), Psychological and Behavioural Sciences Collection, Web of Science, PsychINFO (Ovid) and PubMed.

2.2.3 Search Strategy

As recommended by Aveyard and colleagues (2016), the review began with a broad search in order to minimise the chance that relevant publications would be missed. The following search criteria were applied to all databases, with Boolean operators and truncation applied to account for orthographical variation and similar terminology:

1) (Professional Identity) AND (Psycholog*) OR (Healthcare)
2) (Collaborat*) OR (teamwork) OR (team work) OR (group work) OR (interdisciplin*) OR (communication)

An initial inspection of the search results found that a significant proportion of potentially suitable articles were published in the Journal of Interprofessional Care, therefore this journal was added to the search strategy. The search was then re-run with greater specificity using the following terms:

3) (Therapist) OR (PWP) OR (psychological wellbeing practitioner) OR (high intensity therapist) OR (HI) OR (psychological therap*) OR (clinician) OR (Improving access to psychological therap*) OR (IAPT)
4) (Long term condition) OR (Medically unexplained symptom) OR (LTC) OR (MUS) OR (chronic illness)
5) (Professional identity) OR (multidisciplinary) OR (Integrated) OR (Identity)

2.3 Analysis Methodology

Studies were evaluated using the Critical Appraisal Skills Programme (CASP) framework as recommended for data synthesis and literature reviews (Majid & Vanstone, 2018), although other options such as the PRECIS-2 (Loudon et al., 2015) were considered. It was noted from an early search of the literature that many studies of professional identity utilised qualitative methodologies. The CASP was therefore selected due to its flexibility for evaluating qualitative and quantitative research, whilst the PRECIS-2 is designed primarily for randomised controlled trials. CASP comprises evaluative questions to ask during the critique that yield a 'yes' 'no' or 'don't know' outcome. CASP provide different checklist tools depending on the orientation of the paper. Those utilised in this review were 1) CASP Qualitative Studies Checklist which yields a total out of eight, 2) CASP Case Control Study Checklist which is also scored out of eight, and 3) CASP Systematic Review Checklist which has eleven dimensions.

The Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidelines (PRISMA; Moher et al., 2015) was adopted as a means of synthesising the findings and structuring the systematic literature review.

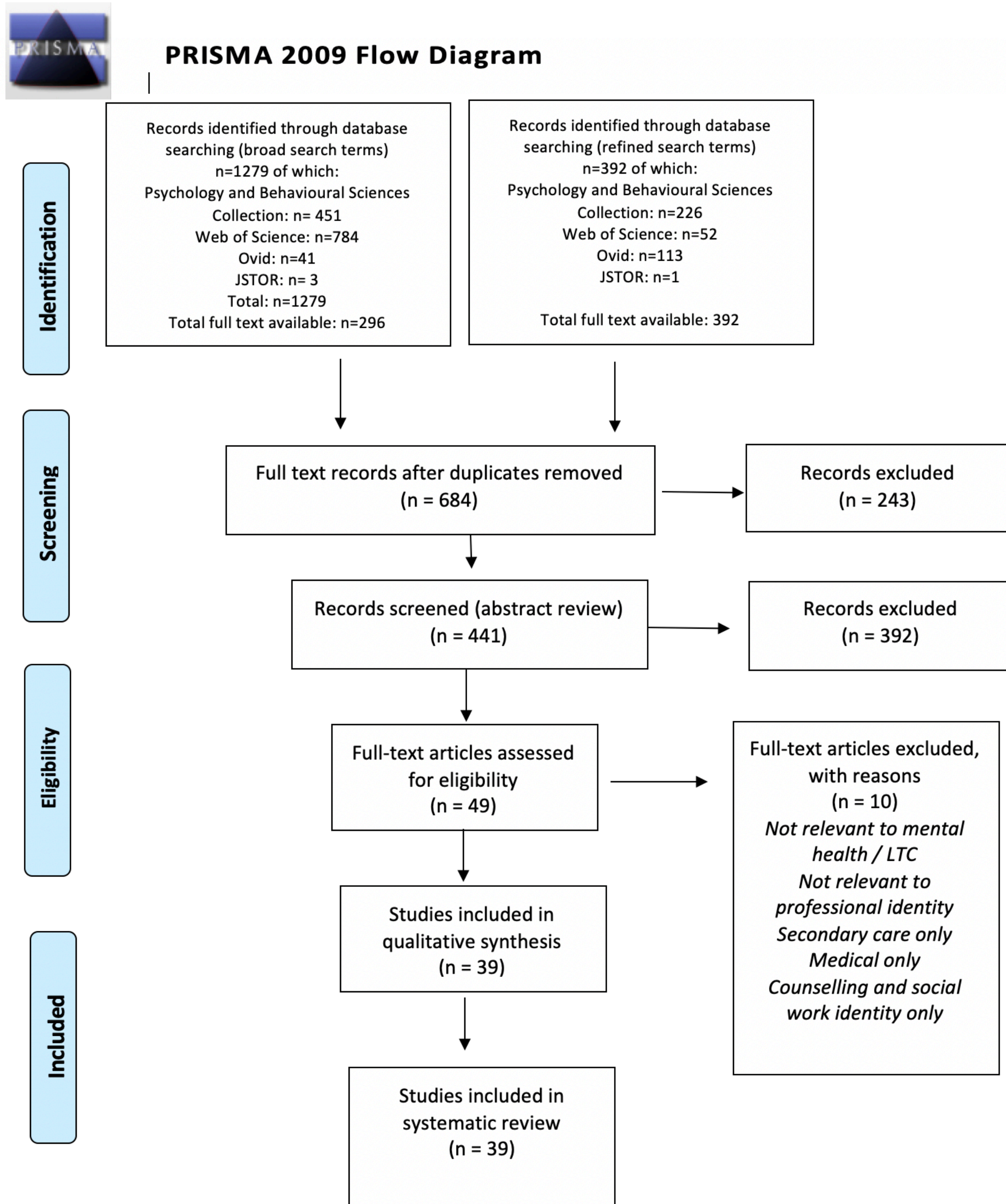
2.4 Synthesis

A total of 1,671 potentially suitable articles were identified. Duplicates and articles without full texts available were discounted and the abstracts of the remaining 441 titles were reviewed against the inclusion/exclusion criteria. The articles included a wider spectrum of professions and therapy orientations than originally envisaged. A decision was made to retain articles for full text analysis where it was likely the results

could be applicable to professional identity formation and challenges in interprofessional teams for primary care therapists working with comorbid LTC/MUS and common mental health diagnoses treated within IAPT services. Of the remaining 49 articles, 10 were excluded after full text review as they either recruited solely medical participants, had little to no reference to LTC/MUS, were substantially secondary care focused or focused on counselling/social work identities only which are not likely to be representative of IAPT services. Thus, a total of 39 articles were retained (Appendix 2). The synthesis is summarised below:

Figure 4

Data Synthesis



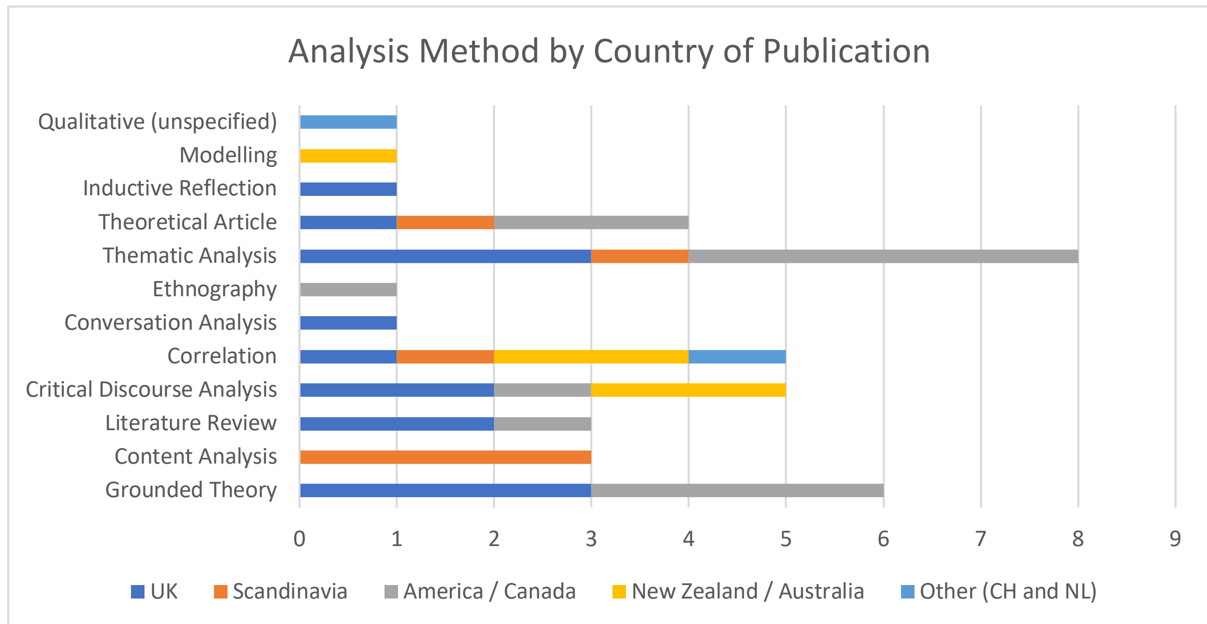
2.5 Results

Thirty-nine full text publications were retained in the systematic literature review, a summary of which can be found in Figure 5 below. The largest proportion of studies were published in the UK which is not a surprising finding as search terms containing IAPT were likely to preference UK studies as the only country adopting the IAPT programme. However, Mayden©, the company providing the technological infrastructure for IAPT in England, reported in their tenth year conference that other countries such as Australia were currently developing primary care services based on IAPT principles which presently represents the low intensity aspect of IAPT work (Mayden, 2019).

The majority of papers favoured qualitative methodologies when researching professional identity. There were, however, some useful articles which had attempted to quantify key identity and personality factors (Mitchell et al., 2011; Molleman & Broekhuis, 2012; Scanlon, 2018; Porter & Wilton, 2019), the latter two of which selected the Professional Identity Questionnaire (PIQ) (Brown et al., 1986) in their studies. The PIQ is a validated measure initially treated with scepticism by field experts but which has fared well in more recent subsequent studies of its validity and reliability (Toben et al., 2021). A further quantitative study (Mitchell et al., 2011) utilised the PIQ and other validated measures of professional identity, including ruptures and conflicts that can occur when professional identity is threatened, yet highlighting the benefits to team identity with heterogenous members.

Figure 5

Summary of Studies Included in the Systematic Literature Review

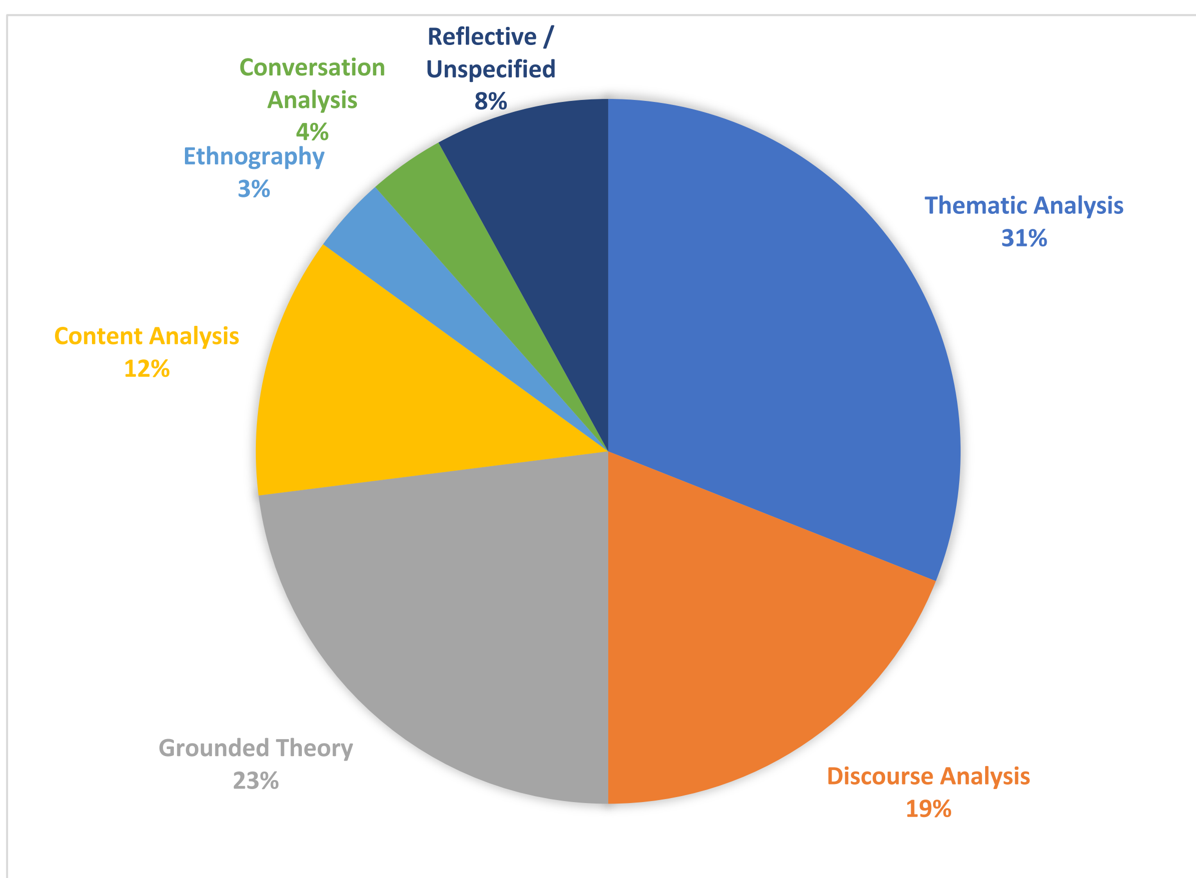


The range of qualitative methodologies was varied with a slight preference for Thematic Analysis, as shown in Figure 6 below. Some studies adopted qualitative reviews but did not overtly specify the analysis methodology (e.g. Choudhury et al., 2019). These studies were rated by the researcher as either theoretical articles or qualitative (unspecified) depending on the rigour of the methodology and paired with either the qualitative or systematic review CASP tools accordingly (Appendix 3). Mellin and colleagues' (2011) study, for example, was recorded as Thematic Analysis as the authors reported on themes such as values and role stereotypes, whilst another (Bochatay et al., 2019) is recorded as "qualitative unspecified" as the authors used semi-structured interviews throughout and therefore appears to be a research article rather than theoretical paper. The analysis method of Bochatay and colleagues' (2019) paper is reported through their Social Identity Theory epistemological position

throughout which underpins a range of qualitative methodologies. Another study reported two methodologies for their analysis, Grounded Theory strongly informed by Critical Discourse Analysis (Jongho-Park & Schallert, 2019). This study was thus recorded in the figure below as Grounded Theory to reflect the authors' primacy.

Figure 6

Composition of Qualitative Methodologies



2.6 Critique and Discussion

2.6.1 Systematic Review Question: How do professionals offering mental health care understand collaborative working with clients who have comorbid LTC/MUS in primary care?

Semantic Tangling

Integrated working was rarely explicitly and concisely defined, but rather described in terms of its function and its meaning often assumed. A clearer definition is provided by Ambrose-Miller and Ashcroft (2016) who considered that "interprofessional models bring various healthcare providers together…to provide team-based care…in the most appropriate an efficient manner (with the goal to) help improve health outcomes" (Ambrose-Miller & Ashcroft, 2016, pp. 101).

The concept of efficiency is echoed by Mitchell et al. (2011) who extend the definition to include that integrated working should contribute to clinical decision making through streamlined care pathways. The aim, they write, is to reduce duplication and subsequent costs in health economic terms. The authors add that integrated teams are assumed to "generate broad knowledge when compared with more homogenous teams" (Mitchell et al., 2011, pp. 1324). Mitchell and colleagues note that much is assumed about the positivity of integrated working but few studies were able to quantify or specify such factors which was a research gap they sought to address. The authors found a positive relationship between "openness" defined as willingness to learn from other professions, and team identity ($\beta=.64$, $t=7.00$, $p<0.00$) and an inverse relationship between openness and identity threat in tertiary healthcare teams. They

concluded that integrated working could yield mutually beneficial results for individuals and teams but only when team identity was strong.

A discourse analysis of data from online forums of students discussing inter-agency and interprofessional working and service users (Reynolds, 2007) also challenged the assumption that integrated working was entirely positive. They found that overly positive representations of increased collaboration leading to a seamless journey often led to a portrayal of roadblocks in care pathways for patients and power struggles between teams. Rose and Norwich (2014) agree that integrated working is often beset by challenges but they do not consider this problematic. Rather, they find that resolving dilemmas is part of negotiating how teams can complement one another's roles for the benefit of their clients. Focusing on organisational restructuring in children's services, the authors write that interprofessional conflict is part of navigating towards a common goal provided there is reciprocal respect.

The extent to which the findings above are able to provide a useful conceptualisation of integrated therapy suitable for IAPT remains under question however. It is problematic to compare IAPT with secondary and tertiary care where "care teams" as defined by Ambrose-Miller and Ashcroft (2016) and Mitchell et al. (2011) may be more akin to care co-ordination for those with severe and enduring psychological illness or highly complex physical health needs which would not map neatly onto IAPT patient cohorts. Two papers were identified as particularly relevant for IAPT therapists working with co-morbid physical health needs, and provide a useful comparison. Hammarberg et al. (2019) interviewed GPs in Scandinavia about their experience of working with "care managers" who were often specialist nurses trained to co-ordinate

psychological and physical healthcare needs for clients with LTC/MUS. Luca (2012) interviewed psychological therapists in the NHS about their experience of working with clients who have MUS.

Hammarberg et al. (2019) found that GPs were concerned about role definition / boundaries and the challenges of changing working practices. However, GPs felt that a care manager provided “structure and standardisation” (Hammarberg et al., 2019, pp. 278) such that depression could be more effectively managed alongside physical healthcare needs. Luca’s (2012) interviews sought to define what cognitive behavioural activities and interventions were most helpful to link physical and psychological factors to shed light on the nature of integrated working. They found that collaboration related first and foremost to the therapist and client reaching a mutual, formulated understanding of their difficulties. Collaborative therapy, they suggest, includes the therapist and client agreeing together when and how to bring in another professional’s skill. The role for *multi-disciplinary co-operation* was then sought to gain an alternative perspective by combining medical and psychological knowledge with the therapist adopting a care management role. This paper appears to be one of the first to write about integrated therapy as a set of targeted competencies selectively actioned through client/therapist collaboration as opposed to inter-department liaison.

One study (Balabanovic & Hayton, 2019) should be highlighted as the closest fit for the topic in question. This study was conducted with n=9 Integrated IAPT Therapists working with MUS in a London service who were predominantly Clinical / Counselling Psychologists, Mental Health Nurses or Social Workers. Six participants had additional training in Psychoanalytic Therapy, one in Systemic Therapy and the

remaining were unspecified. The authors noted that clients with comorbid MUS often had fractious relationships with their GP and may resist a psychological explanation for their difficulties. This made it difficult to accept a referral to an IAPT Integrated service. The study found that therapists considered Integrated Therapy to relate to three facets: to improve the means of access, to build a therapeutic connection with the client and then to engage in change processes which includes supporting the client to connect meaningfully with their condition and with all those involved in their care. This suggests that IAPT Therapists see integrated working as a means of therapeutic change, but also a means of empowering clients with agency so that they can gain the most from psychological and physical health care. Whilst the study scored highly on CASP (7/8) there are notable limitations. Firstly, although the participants were identified as Integrated Therapists the sample is not representative of IAPT services which are predominantly CBT oriented and therefore may formulate mental health needs differently. This suggests that the term *Integrated Therapist* is used ambiguously currently. Secondly, this study did not include discussion on how physical and psychological professions might augment one another's intervention during active treatment, which may perpetuate the dilemma of mind / body dualism.

The semantic tangling around integrated working may, however, be deliberate in some cases and shed light on aspects of professional identity. Kvarnström (2008) considers integrated practice as a continuum in which prefixes such as inter, trans or multi in relation to professional integration are related to the level of interaction and responsibility between professions. When responding to critical incidents in professional practice the authors found that respondents preferentially used some terms synonymously yet avoided others. For example, all participants conceptualised

their teams as "interprofessional" or "transprofessional" but did not identify as "multiprofessional." This was hypothesised to relate to perceptions of who held managerial responsibility. Terminology use however was considered not to affect team effectiveness as all participants "regarded their teams as having mainly patient treatment tasks" (Kvarnström, 2008, pp. 195). This could suggest that the way in which healthcare professionals conceptualise integrated working may influence team dynamics and that varying terminology may not be problematic in all cases.

To summarise this sub-section, the findings will be compared with the IAPT guidance on Integrated Therapy and the main issues related to defining integrated practice from the critique summarised. The current IAPT full implementation guidance (National Collaborating Centre for Mental Health, 2019) should be considered the source document against which the findings from the literature are assessed as this is the framework upon which the IAPT Integrated Pathway is based. The document defines integrated working as a means of:

> *"…Improving the availability and quality of mental health care…through a range of services including liaison mental health services, clinical and health psychology services and IAPT-LTC services"* (National Collaborating Centre for Mental Health, 2019, pp. 15).

Integrated therapy in this regard means enhancing *"the whole team's capability to provide more comprehensive, accessible and holistic services…identifying the person's needs more quickly and accurately…"* to include *"…a single jointly developed*

care plan [which] can lead to improved relationships within teams and services" (pp.16). In terms of collaborative working, the implementation guidance includes the following principles: clearly defined local pathways and referral facilitation between psychological and physical health services, proving a timely service, working proactively between teams and *"taking a collaborative approach to care planning"* which means developing a care plan that is developed and shared with the patient and all those in their care with a named person responsible (National Collaborating Centre for Mental Health, 2019, pp. 28).

The review of literature related to this research question has found that there is ambiguity in defining integrated therapy. In some cases, the definition of integrated therapy appears to be more applicable to whole teams learning to work together or seeking advice between departments (Ambrose-Miller & Ashcroft, 2016; Mitchell et al., 2011; Reynolds, 2007). In cases where integrated therapy referred to specific therapeutic competencies and behaviours terms such as "integrated," "multi-disciplinary," "collaborative" and "care manager" are used interchangeably yet seem to relate to different activities and practices (Kvarnström, 2008). The way in which terminology is used may therefore provide insight into values, behaviours, responsibility and power dynamics. These findings are consistent with a recent literature review of healthcare terminology (Flores-Sandoval et al., 2021) which found that ambiguity in healthcare terminology can lead to misunderstandings and difficulties in operationalising effective working practices. Together this suggests Integrated Therapy is poorly understood.

2.6.2 Second Order Question 1: How does professional identity develop for Psychological Therapists, and are there key transitional junctures?

Professional identity was defined as the way in which “one conceptualizes [sic] himself or herself in relation to their work” (Bentley et al., 2017, pp. 114), including task functions of “professional responsibility…self-confidence and drive, and [being] conscious of [one’s] own profession” (Jakobsen et al., 2011, pp. 443). Referring to Social Identity Theory, many articles held the view that the transition from training to qualified practice was a significant milestone in professional identity formation. Other articles in the review found that NICE guidelines, accrediting bodies, stakeholders and role-related tasks were important factors. These will be discussed in turn.

Education / Training

Training appears to be a key juncture in professional identity formation. In a study of academic professions, the journey from student to professor does not solely involve knowledge or skills acquisition to undertake the role, but individuals also recounted choosing a profession, and subsequent specialism, by *perceiving the fit* of the organisation alongside their own values (Sweitzer, 2009). This applied equally to healthcare profession cohorts (Gazzola et al., 2011). The extent to which individuals were able to feel proud to be part of an organisation sufficiently to consider themselves a member of a certain professional group was found to be of relevance to trainee psychiatrists (Bentley et al., 2017). This effect was particularly strong towards the end of a period of study when transitioning from student status to embodying the qualities of the occupation in question (Jongho-Park & Schallert, 2019; Holmsland et al., 2020).

The idea of *being professional* was deconstructed by Jongho-Park and Schallert (2019) whose participants subdivided professionalism into tasks such as problem-solving, reflexivity and collaboration skills. Educational and Counselling Psychologists according to this study valued learning discipline-specific language and discursive practices later in their training. Interestingly, a study comparing n=428 occupational therapy, physiotherapy and nursing trainees with a cohort of alumni (Jakobsen et al. 2011) found that identity factors shift in terms of importance throughout the educational process. Students rated clinical skill development (uniprofessionalism) as the most important factor, secondly the ability to collaborate (interprofessionalism), thirdly professional identity development and lastly honing technical competencies. However, the alumni cohort significantly increased the importance given to professional identity compared to the students ($\chi^2=20.53$, $p<0.001$), placing professional identity as the most important factor when transitioning from training to qualified practice. Comparing the professions individually, the nursing students and alumni were twice as likely as physiotherapists and occupational therapists to highlight professional identity factors, both of which were statistically significant. The authors suggested that declarative knowledge acquisition becomes less important, yet professional identity is strengthened through the interaction with other colleagues and contexts. In this way, they hypothesise a positive relationship between professional identity and collaboration.

Life events occurring during training were also considered to play a greater role in professional identity formation. Choudhury and colleagues (2019) broadly agree with Jakobsen and colleagues' (2011) assessment of professional identity transition, although they assume professional identity is more developed from the outset of

training. The article suggested that life events are more impactful before qualifying as "trainees begin with a diffuse sense of professional identity and can experience feelings of vulnerability, anxiety, and self-doubt…(with) only rudimentary ideas about what it means to be a psychotherapist" (Choudhury et al., 2019, pp. 108). These conclusions should be treated with caution however. The article draws upon personal experiences and vignettes "inspired by the actual experiences of early career trainees" (pp. 109) and therefore there is a greater likelihood of bias and reduced methodological rigour. The authors present a thoughtful and reflective account of their training journey and events in their own experience which they considered critical to developing greater empathy with their clients. The reflection however cannot evidence steps to reduce the impact of their own assumptions through clear research questions or stating an epistemological position which impacts on the ability to generalise the conclusions.

During training the effect of role models seems particularly important. Gazzola and colleagues (2011) interviewed ten Counselling Psychological doctoral students, finding that role models / mentors increase a sense of belonging to a profession and internalising organisational values which contributes to an "emerging sense of expertness." In this way, training was found to foster stronger resonance with the values which initially attracted the individual to the profession (Gazzola et al., 2011) and strengthened affiliation with the profession by internalising the factors which make it unique (Mellin et al., 2011). Mellin and colleagues found that a recurring theme for counsellors was that those who struggle with their professional identity tended to cite power dynamics as an influential factor. Power imbalance led to internalised negative perceptions of their profession and feeling undervalued. Counsellors in the study

noted that ambiguous definitions impede development of a cohesive identity. The term “counselling,” for example, is often used as a short-hand for any kind of psychological therapy which seems to negate role defining characteristics.

Counsellors in Mellin and colleagues’ study reported that when a profession is not as well established temporally it is challenging for individual professionals to view how their identity aligns alongside existing structures. This is all the more challenging, they suggest, when the organisational values are defined with only broad criteria such as “wellness” and “prevention.” These terms were considered difficult to operationalise, teach and evaluate and thus it was challenging for counsellors to internalise the core role functions. This effect is considerably stronger when counsellors specialise.

These findings are consistent with those from another qualitative study, Bentley and colleagues (2019), who interviewed twenty-two PhD candidates about their future career perceptions. The resulting model, Scaffolding Identity Construction, suggested that professional identity is composed of multiple interlinking component “selves” which comprise: direct observation (*doing model*), seeking advice from a trusted peer (*guidance model*) and crucially in the context of Integrated Therapy, a role model who embodies valued traits (*being model*). Access to multiple aspects of the professional self allows people to conceptualise themselves in contrast from their colleagues, and interestingly in the context of scaffolding these devices were also utilised to differentiate the current identity from previous incarnations. In this case, psychological practitioners with physical health backgrounds shaped their discourse around factors central to the new identity. These factors included how to use specialist terminology

and learning to talk, think, and relate to others as a representative of the chosen profession (Wade, 2016; Schubert et al., 2021).

It is possible, as Bentley and colleagues (2019) point out, that qualitative research with students or newly qualified professionals may be influenced by a desire to tell one's story in a way which is inspirational to other trainees, and the recency effect may increase the perceived importance of training to professional identity development. Yet studies which recruited professionals who had been in practice for much longer agreed that training was a significant formative experience for identity (Ambrose-Miller & Ashcroft, 2016; Luca, 2012). Studies which recruited qualified professionals however found other factors to be formative such as adherence to NICE guidelines (Court et al., 2017), accrediting bodies (Hemsley, 2013) and contextual factors. The next section considers the impact of such organisational infrastructure factors.

Systemic Factors and Accrediting Bodies

Psychological Therapists in IAPT must be affiliated with an accrediting body such as the British Association of Behavioural and Cognitive Psychotherapists (BABCP) and adhere to the NICE guidelines. No studies recruited IAPT CBT Therapists, however studies which recruited exclusively or mostly from Psychologists were considered to be closely linked to IAPT practice and would likely share a similar accreditation requirement. A quantitative study testing the measurement properties of the PIQ theorised a possible correlation between the strength of professional identity and adherence to the evidence base (Scanlan, 2018). Indeed, several authors foregrounded the competence to fulfil role expectation in the definition of professional

identity (Baker & Lattuca, 2010), however for many this is not considered sufficient (Hemsley, 2013; Court et al., 2017; Smart et al., 2018).

Court and colleagues (2017) interviewed Clinical Psychologists about their beliefs about, and use of, the NICE guidelines in their practice. For some, the guidelines were used informatively as a means of selecting the most appropriate treatment and making sense of complexity, however they may also “create an illusion of neatness” (Court et al., 2017, pp. 902). Some Clinical Psychologists noted that NICE guidelines were often at odds with their professional identity, feeling a “pressure to be NICE compliant” (pp. 904) which stifled creativity, flexibility and limited the ability to express individuality. Difficulty in explaining what a Clinical Psychologist does, participants thought, may impact on beliefs about the guidance. Particularly it was noted that a common assumption is that adherence to NICE guidelines comes from better knowledge of their contents. However, the study found that all participants were very aware of the guidance, and even thought that strict adherence derives from a lack of confidence in one’s knowledge.

Hemsley (2013) conducted a Thematic Analysis of interviews with trainee counselling psychologists regarding the interactions between professional identity and NICE guidelines. Participants considered NICE guidelines were validating for their profession by provided a framework through which to access expertise. The guidelines were described as “pluralistic” in the sense that such a framework provides a “collective identity” (Hemsley, 2013, pp. 99). These findings are consistent with studies in other areas of complex mental health where inter-agency therapy is often warranted. An editorial discussing NICE guidance for survivors of childhood abuse, for example,

illustrated how NICE guidance can conflict. In cases of high comorbidity or complex psychosocial factors, it can be challenging for practitioners to effectively utilise NICE guidance (Gray et al., 2018).

Important junctures relevant for Integrated Therapists' development post-training will be considered in the next section.

Significant Transition Points beyond Education

Identity transition is considered by some to be a linear progression from one state to another, *"I was…I am now…"* This has been usefully illustrated to be relevant to smaller transition points such as minor service change or completing professional development educational programmes, promotion or moving between professional domains (Bentley et al., 2019). In particular, the authors write that in times of change those who had developed a stronger sense of their professional selves were able to draw on their pre-transition and post-transition identities and integrated these along themes of similarity. For others, Social Identity Theory was a useful lens through which to illustrate how professionals negotiating identity factors were not only able to draw on other aspects of the self but shift to and fro depending on the context. For example, a Discourse Analysis of interprofessional teams working in the field of learning disabilities found that individuals accessed different aspects of their role when negotiating meeting agenda points by shifting "from manager in a meeting to clinician, [when] prioritising professional concerns" (Smart et al., 2018, pp. 695). Jongho-Park and Shallert (2019) echo this point, adding that professional interactions such as

conferences were important for students moving into qualified practices as it "allowed them to envision themselves in the field and develop a sense of belonging" (pp. 8).

Thus, interactions with other professional groups have the potential to shape Integrated Therapists' sense of their profession as Network Theory would suggest, and studies have shown that Social Identity Theory can be a useful lens to aid future research (Kreindler et al., 2012). Indeed, a theoretical article recommends that future researchers deviate from the tendency to see development in purely cognitive terms, but to interrogate what exactly is learnt and what is discarded during identity shift (Baker & Lattuca, 2010). Moreover, a literature review of a small number of papers (n=19) conclude that research consistently overlooks identity formulation and interprofessional interaction in primary care (Bélanger & Rodríguez, 2008). Although this study is small it scores highly on CASP for data transparency, and clearly demarcating differences between psychological and physical health professionals. It is also more likely to be meaningful to IAPT Therapists given its UK Primary Care focus. To address this gap in the literature, the authors recommend Discourse Analysis as a more sophisticated methodology for identity research. Whilst Discourse Analysis was not preferentially used as a clear majority, studies which used alternative qualitative methodologies such as Content Analysis (Holmesland et al., 2020) or Grounded Theory made similar recommendations that it would be more able to "elucidate the historical, political and linguistic forces" (Court et al., 2017, pp. 908) and that future research should include other psychological professions beyond Psychologists (Hudson et al., 2019).

To summarise this subsection, the findings from the literature suggest that education is a significant transition point in professional identity. Doubts that this effect is linked to recency bias can be partly allayed as it appears this effect is stable amongst longer qualified professionals. Accrediting bodies and NICE guidelines appear to provide some structure for accepted behaviours, attitudes and values which is important for developing a strong affiliation with the role. When such expectations were lacking or unclear, professionals reported greater discomforted and a weaker sense of their professional identity. Beyond training, other transition points appear to be those in which professional values are reinforced, such as conferences or continuing professional development events. These events were also considered to be transformational due to the ability to network with colleagues in other fields. This will be discussed in greater detail as the second order research questions are addressed.

2.6.3 Second Order Question 2: *How do multidisciplinary contextual factors affect therapists' professional identity?*

The literature responded to this question by researching the impact on professional identity through the lenses of clinicians' skill / confidence and how this subsequently impacts patient care. Negative effects were often researched through examination of inter-professional ruptures, organisational and political factors and uneven distribution of knowledge (e.g. Kvarnström, 2008). This section considers firstly the role of group dynamics and secondly micro/macro level factors of integrated therapy.

Homogenous and Heterogenous Teams

In studies researching team dynamics, individual professional identity was linked closely with team identity. It was recognised that most previous research approached professional identity by exploring static factors, and overlooking dynamic factors (Bentley et al., 2019) yet most clinical interactions around a patient are characterised by multiple professionals with a wide range of expertise (Gazzola et al., 2011).

Teams with a stronger sense of their own identity "were able to make use of their diversity to enhance team effectiveness" (Michell et al., 2011, pp. 1334). Mitchell and colleagues concluded that reflexivity and openness within a team increases resilience to transition. This is neatly described as "dynamically critical reflexive practice" (Hudson et al., 2019, e353) in a critical ethnographic study of Canadian interdisciplinary medical teams which found that trust between departments and individual managers was a moderating factor for using one's own expertise. Some participants in this study considered the term "collaborative care" to be jargonistic, even "wishful thinking." However, medics in the study noted that strong interprofessional relationships allowed them to test and develop the scope of their own role in the knowledge that their colleagues would support them if they felt out of their depth.

A study of intergroup conflict (Bochatay et al., 2019) concurred with this. Bochatay and colleagues interviewed a large heterogenous sample of medical professionals about their experiences of conflict. Steps were evidenced not to impose their own assumptions of the meaning of the term. The authors found that respondents often

perceived prejudice based on protected characteristics which impacted on their willingness to be professionally vulnerable or seek creative solutions to problems. Additionally, conflict between professions was associated with power dynamics between individuals, teams and hierarchical structures. This study, however has notable limitations. Within the methodology, the authors invited participants to recount a recent example in which conflict had occurred without operationalising the term in order not to prejudice the respondents. Subsequently, the authors accepted reference to "tension" and "disagreement" as markers of conflict. These terms, however, could signify an expression of effective problem-solving in the manner Gazzola et al. (2011) and Mitchell et al. (2011) suggested. Thus conflict may not be associated with the assumed negative connotations in all cases and may represent teams learning to work together and benefitting from one another's expertise.

In contrast, Porter and Wilton (2019) found a positive correlation between professional identity and time spent in the company of one's own professional group. This finding is rather puzzling considering the value placed on exposure to a wide range of professional connections. One hypothesis is that time shadowing one's own profession increases awareness of the potential scope of the profession and tacit skills beyond those learnt in the educational setting (von der Lancken & Gunn, 2019). In this study nurses were required to undertake significant interprofessional shadowing as part of their course and the study analysed a sample from critical reflective logs from course participants. Nurses reflected that shadowing other professional groups not only ameliorated their skill development, but also allowed them to view their own profession critically thereby gaining greater insight into their own professional identity.

Micro and Macro Factors

Theoretical papers (e.g. Hughes et al., 2020; Rose & Norwich, 2014; Wackerhausen 2009) explored role stereotypes and contextual factors affecting Integrated working. Wackerhausen's (2009) key theoretical exploration of professional identity development hypothesised that both macro and micro level factors were important and interlinked. Macro factors are the headline, the heuristic cognitive construct in the mind's eye, in short for Wackerhausen these are the *raisons d'être* of the organisation. Micro level factors are those on an individual level; the personal, ethical, professional or other motivating reasons that bring someone to their chosen area of work. Micro level factors contain the discipline-specific terminology which may be technical or jargonistic and relate to team / occupation cultural norms. This can be described as a sense of membership in a professional community, a differentiation between in-group and out-group in Tajfellian terms.

Large organisations such as the NHS have a strong macro level presence, by which is meant the public face of the organisation, the standards to which the organisation are held and the societal attitudes towards it. Alongside a significant public presence, there are multiple stakeholders who have sometimes competing interests in how organisations should operate which can bring a great deal of scrutiny from word of mouth and press. One needs only to read public commentary about high profile or notable negative cases reported in mainstream media to see negative generalisations about professions. A thematic analysis of interviews conducted with social workers (Legood et al., 2019) highlighted that professionals were not only aware of public

attitudes held about their profession but that this also increased the risk of internalising negative perceptions and burn-out.

A content analysis of focus groups with healthcare professionals which was rated highly on CASP (Holmesland et al., 2020) concurred that anticipation of role stereotypes seems to be an influential factor. Focus groups conducted with physical and mental health professionals around the topic of team-work and professional identity found that identity transition into new professional networks is greatly affected by role stereotypes and mutual reliance. The authors recommended that team culture and understanding other teams better can reduce group membership barriers. In short, professional identity was found to be significantly shaped through interprofessional collaboration about complex problems (Holmesland et al., 2020) and ameliorated by a strong affiliation to the values of one's profession, a spirit of curiosity, neutrality and reducing hierarchies.

The ability to separate historical discourses from practice is neatly conceptualised as *professional equipoise* (Smith et al., 2015). Smith and colleagues utilised this term to differentiate from clinical equipoise defined as "the suspension of judgement about the value of one treatment versus another because one has no good basis for a choice" (pp. 603). The study adopted a critical discursive methodology to analyse a large sample of historical records selected by field professionals as suitable materials for dominant discourses alongside focus groups. The authors found competing discourses were present influencing collaborative work. For example, psychologists were associated with a "conceptual" discourse, nurses with a "caring" discourse and medics with an "empirical' discourse. The authors noted that there were likely to be

many exceptions, but that “the dominant discourses and their associated stereotypes…are extremely powerful in interprofessional group dynamics” (pp. 606). It is possible that integrated therapists in IAPT may be affected by such contrasting discourses. Institutionally, IAPT aligns itself with evidence-based practice which seems similar to the empirical discourse, whilst the predominant CBT-orientation of IAPT Integrated Therapists may appeal to the “conceptual” discourse.

In contrast to macro factors, Molleman and Broekhuis (2011) explored how specialist medics’ individual personality traits impacted on integrated working for patients with LTC/MUS. A negative relationship was found between traits of extraversion and openness and professional identity in collaborative working. The authors hypothesise that integrated working appeals to extroverted professionals as “they communicate freely, [therefore] they do not easily feel their professional work is threatened if others participate in, or start, discussions on topics within the extravert’s domain” (pp. 61). Individuals who rated lower on emotional stability domains, they found, were significantly more likely to perceive interprofessional discussions as threatening and feel a greater loss of autonomy. No moderating effect was found between extraverted personality and task autonomy or accountability in interprofessional work. The authors hypothesised that extraverted professionals may feel restricted and dislike feeling accountable to others. The study provides empirical support for the role of personality and power in multiprofessional and specialist teams as they resolve complex health problems. The authors acknowledge that there remains unexplained variance which they hypothesised might relate to stakeholder demands, levels of transparency and leadership style of immediate managers.

To summarise this subsection, power dynamics seem to act upon professional identity in numerous ways and can be observed when collaboration is needed. Negotiating complex clinical decisions is a cornerstone of Integrated Therapy and has been researched either through direct observation of the discourses of negotiation (Smart et al., 2018) or through the use of clinical dilemmas (Holmesland et al., 2020). Indeed, replicating a regular team activity through dilemma has been shown to be an effective means of investigating identity during service transformation (Kvarnstöm, 2008) which the authors recommended for future research.

2.7 Conclusion

The aim of the literature review was to explore how integrated working is defined, how professional identity develops and whether there were certain junctures most notable for identity transition, and how the concepts of integrated working and professional identity relate to one another. The review found 39 studies which met the inclusion criteria of which 67% utilised qualitative methodologies, 18% were theoretical articles or literature reviews, and 15% were quantitative composed of 5 correlation studies and one modelling study. Of the qualitative studies 31% used Thematic Analysis, 23% Grounded Theory, 19% Discourse Analysis, 12% Content Analysis, 8% were reflective or unspecified, 3.5% Conversation Analysis and 3.5% used Ethnography.

The review found that professional identity and integrated therapy appear to be linked and a current important topic relevant for IAPT therapists. IAPT Therapists were, however, notably absent and underrepresented in the sampled literature. Methodologically, a common challenge for qualitative research is reducing interpretation or bias (Willig & Stainton-Rogers, 2017), therefore studies which scored

well on CASP evidenced steps taken to improve trustworthiness and data transparency. Although a higher proportion of studies used Thematic Analysis and Grounded Theory many authors reflected that the methodology was not sufficiently sensitive to explore power dynamics and made recommendations to include this in future research (Bélanger & Rodríguez, 2008; Bentley et al., 2017; Court et al., 2017; Hemsley, 2013; Holmesland et al., 2020; Jongho-Park & Schallert, 2019; Kreindler et al., 2012). Another study which used Grounded Theory (Steinauer et al., 2018) did not recommend this directly, however they highlighted the relevance of language use in case conceptualisation and power dynamics in clinical decision making in terms of permission or "authority" to use one's expertise.

Studies which used Discourse Analysis were able to address some of these issues, however those that scored lower on CASP conducted fewer direct interviews and sampling methods were not sufficiently robust to be applicable to IAPT (Reynolds, 2007; Smith et al., 2015). Discourse Analysis studies scoring higher on CASP were able to report on shifts in professional identity in psychological trainees and recommended future research consider how questions were used to navigate power dynamics (Wade, 2016). The review found that key transition points occur also after training, yet qualified therapists were underrepresented in such studies. Quantitative studies most frequently used the PIQ and had capacity for larger samples, however a recurring recommendation was to extend the findings with use of interviews or focus groups (Jakobsen et al., 2011). Vignettes or dilemmas were either used or recommended by a significant minority for questions of conflict, power dynamics and identity (van der Merwe & Wetherell, 2020; Kvarnström, 2008) citing the "benefits of using naturally occurring scenarios" (Smart et al., 2018, pp. 695).

Together this suggested a qualitative methodology, Discourse Analysis in particular, would be suitable to extend the current evidence base sampling IAPT qualified and trainee therapists. Kreindler and colleagues (2012) review found that 33% of sourced reports approached professional identity questions through the lens of social identity theory, concluding that this is a suitable framework. They added that group processes are often overlooked in research in favour of exploring professional identity at the individual level such as moderating factors of effective teamwork or structures within the organisation which facilitate transitions. There are features unique to each profession, they suggest, and that future research should be vigilant to the specific challenges faced by healthcare staff who work in complex systems and to explore how identity is socially constructed within complexity. These findings in sum were used as the basis for Patient and Public Involvement (PPI) to further develop the current research question(s).

2.8 Strengths and Limitations

The literature review utilised identification, extraction and data synthesis methods widely used in qualitative research. Using an inductive heterogenous search strategy allowed for a wide range of literature to be sourced and meant that the search could be refined based on the content being sourced. As with any literature review, there are limitations. The search terms were initially generated by the researcher. The terms were reviewed and extended based on feedback from PPI involvement from the field of psychological therapy in order to broaden the search terms without compromising relevance, however it remains possible that greater sensitivity of search terms may yield other relevant papers. Secondly, studies were excluded if they had a clear

secondary care perspective. It is possible that such studies may be able to offer insight into factors also suitable for Integrated workers as they are likely to have some shared characteristics such as experience of service transformation, and likelihood of working with clients with comorbidities, likewise patients with severe mental illness are likely to find similar challenges when accessing Integrated care (Melamed et al., 2019). Indeed, a recent literature review highlighted complexities within IAPT clinical populations suggesting that boundaries between primary and secondary care are not always mutually exclusive, and that there is a need to increase the interface more greatly between primary and secondary care mental health services (Martin et al., 2022).

Chapter 3 Methodology

This chapter describes the methodology and design of the research. It outlines how PPI was utilised to inform the research questions, the epistemological stance taken and the methodologies involved in the research and data analysis. Finally, the methodology for reflexivity is detailed. The research was developed significantly from the findings from the systematic literature review, and also from PPI involvement. The opening section of the chapter will report the PPI in order to contextualise the research, and then the research questions will be outlined.

3.1 Patient and Public Involvement (PPI)

The research question and design were shaped in consultation with service providers, patients, people with lived experience and clinicians as recommended for the effective use of PPI in research (Boivin et al., 2014). Indeed, a recent study of a clinical population with Tourette's Syndrome found that 71% of patients had a strong preference for being involved in research improvement (Anderson, 2022). PPI is not only a useful approach for researchers to adopt, but it is also considered an ethical imperative for stakeholders affected by research to be involved in shaping its design (Gove et al., 2018). Gove and colleagues (2018) strongly advocate for the patient voice not to be lost or tokenistic in their field of Alzheimer's Disease. They suggest that creative ways should be used to ensure that as many people as possible are provided unrestricted access to contribute should they wish. This recommendation was also made from wider healthcare research in Clinical Research Networks with the addition that PPI should be used at all stages of development from shaping research questions, design and dissemination (Ashcroft et al., 2016).

Some authors in the field of medical education argue that a formalised framework for PPI is lacking and needed (Regan de Bere & Nunn, 2016), however others suggest that simply engaging those who will be affected by findings increases the likelihood that research goals will be achieved (Anderson, 2016). Whilst the participant cohort of professional staff in this thesis is different from patient populations the same principles are applicable and the findings are likely to have an impact on patient and professional stakeholders. Moreover, a recent study found a significant relationship between PPI involving young people with comorbid LTC/MUS in setting up relevant projects and the self-perceived importance (Schelven et al., 2021) suggesting that PPI is also a factor in shaping attitudes and practices. It was therefore important that the PPI methodology was sufficiently diverse, including use of different media such as anonymous surveys and direct consultation as this has been shown to be a more inclusive means of fully representing priorities (Renedo & Marston, 2011). The phases of PPI are summarised in Table 2 below:

Table 2

Summary of Patient and Public Involvement (PPI) Phases

Phase 1	Phase 2	Phase 3	Phase 4
Assessment of key research priorities from organisations with strong patient involvement e.g. Diabetes UK	Consultation with service manager and co-Clinical Team Lead (co-CTL) of an Integrated IAPT team	Survey of patients, public and professionals	Vignettes written by people with lived experience highlighting issues pertinent to them

Firstly, in Phase 1 the priorities of the National Collaborating Centre for Mental Health (NCCMH) were searched for their research priorities. This organisation was selected as the starting point as they had been referred to frequently in the literature review by cited studies, and are a reputable, UK-based collaboration between the Royal College of Psychiatrists and University College London who review guidance, standards and competence whose work will be relevant to IAPT. Their published IAPT LTC/MUS full implementation guidelines (NCCMH, 2018) identifies the LTC/MUS IAPT pathway to be a current research and practice priority. The James Lind Alliance, a priority setting partnership invested in PPI steering of research, also rate research into psychological therapies for depression and anxiety for clients with LTC/MUS highly in conjunction with common long-term health conditions such as COPD, Diabetes Types I and II, and asthma (James Lind Alliance, 2022). These findings were echoed by other national patient condition-specific organisations such as Diabetes UK whose Top 10 research priorities provide two high priorities relevant to mental health: to find out how people with diabetes can best manage their condition and how care should be delivered, and how psychological support should be delivered for individual need. Thus, there is agreement across many credible sources that research into Integrated Therapy in IAPT is a current need.

In Phase 2, a Clinical and Service Manager of an IAPT service and a Clinical Team Lead of an Integrated IAPT service were interviewed about their research priorities with regards to the Integrated Pathway. The findings were that services were interested in 1) ease of access to psychological therapy for clients with LTC/MUS, 2) health economics, 3) facilitating referrals and strengthening relationships with physical health colleagues, 4) finding out how open patients were to thinking psychologically

about their LTC/MUS, and 5) how willing therapists and physical health professionals were to work in collaboration and how this could be optimised.

In the third phase, the findings were collated and distributed as a survey to patients, clinicians and the public via email and social media, and clinicians were invited to complete the survey in team meetings. Respondents were asked to consider an open question about their own research priorities and then were invited to rank the findings from Phase 2 in terms of importance. As one would expect from a broad cross-section of stakeholders, there were areas in which priorities were divergent. Health economics for example was rated of the lowest importance to patient, clinician and public groups, despite being of value to service leads. However, areas in which stakeholders intersected related to the nature and quality of links between physical and psychological professionals. Survey respondents were also presented with suggested research questions based on findings from Phases 1 and 2, from which they rated consistently with earlier survey sections. In the final phase, a person with lived experience and experience of working in IAPT in a non-clinical role was recruited to design research materials which will be outlined in the research methodology subsection related to materials.

3.2 Aims and Objectives

The findings from the systematic literature review and PPI were collated to inform the thesis aims, objectives and research questions. An overview will be provided below, following which the epistemological stance informing the research questions will be detailed:

Aim:

- To investigate the concept of professional identity for psychological therapists offering Integrated Therapy

Objectives:

1) To explore the concept of professional identity in the context of Integrated Therapy with a diverse group of psychological and physical health professionals
2) To explore the meaning of Integrated Therapy including barriers and facilitators
3) To offer guidance to primary care therapists working with clients with LTC/MUS regarding the development of a stable professional identity, and to services commissioning Integrated pathways.

The three objectives above were operationalised into the following research questions:

Research Questions:

1) How has the professional identity of Integrated Therapists developed and changed over time, and how do collaborative working relationships affect their self- conceptualisation?
2) What discourses are available or prohibited to therapists and physical health professionals regarding collaboration in the context of comorbidity?
3) How do professionals use discursive and rhetorical devices to construct their professional identity?

3.3 Research Design

A Critical Discourse Analysis (CDA) design informed by Gee was selected, adopting a social constructionist epistemological stance. Discourse analysis is a qualitative methodology concerned particularly with meaning construction (Gee, 2014a), power dynamics and conflict (van Dijk, 1997; Foucault, 1994). Research involving the study of language and discourse is highly varied. Historically, the post-positivist tradition moved away from the positivist search for certainty by taking an observer stance. Post-positivists aim to make context-informed predictions about the future, testing theory and minimising bias through an objective research approach (Levitt, 2020).

Although often seen as incompatible with one-another (Dunn & Neumann, 2016), Post-positivism and Critical Discourse Analysis share some similarities in their ontological and epistemological stance in the sense that both paradigms “hold to social constructivist, relativistic, and indeterminate notions of knowledge” (Cooper, 1997, pp. 558) and were developed from Foucault’s influential work on power dynamics (Dunn & Neumann, 2016). The critical paradigm, however, sought to explore the historical development of particular discourses (e.g. Fairclough, 1992a; 2008) arguing that discourses are not solely an observable feature of what is currently happening, but are also ways of ascribing meaning, evaluating and shaping ideas and practices, and reconstructing selves (van Leeuwen, 1993; Fairclough 1992a).

In order for therapy to be focused and effective, Cognitive Behavioural Therapists endeavour to formulate a conceptualisation of the longitudinal and/or maintenance factors underpinning the client’s disorder. This information is drawn from a variety of sources. The therapist, for example, may receive a written referral, they may have

access to historical notes and a thorough assessment with the client is conducted. The therapist may then discuss the case with their clinical supervisor to further make sense of the client's presenting problems (Tarrier, 2006; Beck, 2011). Thus, a range of discursive information is available. Consider a hypothetical conceptualisation that might be drawn from the above sources: "the client's panic disorder was triggered by a frightening hypoglycaemic episode and maintained by catastrophically misinterpreting somatic sensations and trying to control their diabetes too strictly." This conclusion represents a specialist knowledge as it conveys a clinical opinion in which those involved in the discourse make certain aspects significant in order to provide a clinically useful and evidence-based treatment plan. Gee (2014b) argues that discourse analysts interested in *descriptive* factors seek to understand how language is used, whilst the *critical* paradigm seeks to "speak to and, perhaps, intervene in, institutional, social, or political issues, problems, and controversies in the world" (pp. 9).

CDA was therefore considered a suitable means for addressing the research objectives as it is concerned not only with an examination of the social world and phenomenology but is useful to explore how the existence of institutions such as IAPT, and practices such as the LTC/MUS pathway and Integrated working more broadly make possible certain ways of speaking, thinking and behaving (Hodges et al., 2008).

3.4 Epistemological Position

It is important to locate the present study more accurately within the CDA paradigm because, as Blommaert and Bulcaen (2000) point out, there are branches which have developed from the core work of Fairclough (1989) who is considered the founder of

the CDA school of thought. Discourse Analysis is a broad field containing rather divergent epistemological positions with Foucauldian Discourse Analysis at one end of the continuum and Discursive Psychology on the other (Locke & Budds, 2020). There are varying definitions of "discourse" over which Dunn and Neumann (2016) provide a clear overview. Discourse is considered a social practice in which speakers draw on psychosocial factors to make sense of their identity and important concepts (Willig, 2000). Post-positivist and critical discourse analytic traditions converge around the definition of a discourse as "a system of meaning production that fixes meaning, however temporarily, and enables actors to make sense of the world and act within it" (Dunn & Neumann, 2016, pp. 18).

A closely related concept is that of *interpretative repertoires*, a term which is often used interchangeably with *discourse*. Wetherell and colleagues (2003) observe that whilst these terms seem to overlap there should be a differentiation. They argue that the difference is perhaps conceptual rather than semantic, i.e. "discourse" is used by those "centrally concerned with the operation of power" whilst "interpretative repertoires" is used by those "who want to place more emphasis on human agency within the flexible deployment of language" (Wetherell et al., 2003, pp. 202). Thus, both terms will be used throughout the analysis with respect of these definitions.

The social groups with which one identifies exert power over the availability of discourses to the individual (Gee, 1996) which influences how people conceptualise their identity (Willig, 2000). In this case the social groups relate to professional affiliation such as Psychological Professional subdivided into Core and Integrated Therapist, and Physical Health Professional, whilst the identity factors in question are

the traits, attitudes and beliefs associated with belonging to the profession i.e. their *professional identity*. Professional identities according to Gee (2014b) are derived from taxonomy and are heuristic blueprints to understand certain “kinds of people.” In this sense, Integrated Psychological Therapists for example have a central taxonomical definition through their job description but this is not sufficient to describe everything a therapist *is* and *does*. For Gee (2014b), therapists in this example are recognised for certain characteristics but also that there are aspects of their professional identity which are chosen and some imposed. Alongside their core role functions, therapists are influenced by their personal and professional history, the history of their organisation and by their own role development such as taking on specialisms or champion roles alongside their practice. Professional identities therefore are “negotiated, contested, and change over time” (Gee, 2014b, pp. 23).

Discourse analysists are interested in the way in which individuals describe their role personally, and how they use verbal and non-verbal means to present their role to others. Linguistic relativity theory, also known as the Whorfian Hypothesis of cognitive linguistics, argues that language influences thought (Hunt & Agnoli, 1991) and indeed language constructs have been shown in many psychological studies to influence perception (e.g. Winawer et al., 2007; Sidnel & Enfield, 2012). Language however, is considered not to be a statement of factual experience, but rather it is a means with which professionals construct their professional world around them. Gee (2014a) argues that discourse is an active process, a means of constructing one’s own reality. When a therapist discusses their role, Gee would argue, they use their language to foreground or minimise certain aspects of their identity which they consider important or relevant. The way in which historical or contextual events are recalled and shared

is considered to be ideologically meaningful, and the way in which a therapist talks to an audience is a means of constructing a public image of their professional identity. Discourse is thus linked to power dynamics, in the sense that one's portrayal of the "self" is influenced by subjectivity (Foucault, 2000; Willig, 2000), and as a means of ascribing meaning to experience. For Foucault, human beings live in a society which preferences portraying "truth" about oneself (veridiction), yet psychosocial and historical-contextual factors affect what is acceptable as a truth by recipients and what "truth" is available to the speaker (Foucault, 2020). In this way, language is considered to be a means by which social actors construct their reality (Burr, 2015) and a means by which one conveys beliefs and attitudes to others (Baxter, 2004). Communication therefore consists of "situated meaning" in which what is considered relevant, desirable or not permitted is contained within the discourse (Gee & Green, 1998).

In professional practice, most professionals do not work in isolation but engage with a wide range of professional, clinical and public populations. Solly (2016) suggests that professional identity by this means is externally projected and shaped as "speech communities" are formed which he defines as "distinct groups of people who share the same way of using language and can be varied" (Solly, 2016, pp. 22). For Solly, speech communities can be created based upon personal characteristics, shared experiences, or for the purposes of a single activity (e.g. LTC/MUS Champion or IAPT representative) whereby members may not have anything in common other than this single purpose. Thus, linguistic devices and communities exert power over the professional identity development. For Integrated Psychological Therapists there has been a major ideological shift in classifying oneself as Integrated or Core rather than more broadly a Psychological Therapist or simply referring to oneself as "working in

IAPT." They have entered into a new speech community by being physically collocated with physical health teams and single-activity speech communities when they involve other professionals in discussion around individual clinical cases. Others within their speech communities, such as physical health professionals, are also likely to be affected by this change. CDA is also therefore concerned with the extent to which aspects of this shift are accepted ideologically. Thus, as teams inevitably develop and evolve it becomes overly simplistic to define an individual by their title (Mortensen, 2014), rather the practices, boundaries, beliefs and status/power factors are shaped by the extent to which they are accepted as belonging to an emerging professional identity (Clay-Warner, 2001).

When one thinks of power dynamics, it is likely that the picture that comes to mind is of a powerful agent imposing their will over another. Lupton (1995) however, argues that in CDA it is possible to "see power as sometimes repressive, but at other times productive" (Lupton, 1995, pp. 303). Gee (2014a; 2014b) suggests that a key concept linked to this is *positioning.* For Gee (2014a; 2014b), speakers influence their recipients by either actively positioning their listener (or the culture in question) to *be* or *do* what they expect or hope they should (active positioning). Communication is influenced by context such that the register or vernacular used differs depending on the audience, recipient or intent of the speaker (recipient design), or otherwise communication conveys assumptions (passive positioning), and invitations to "take on a new or different identity that may lead to a new or different beliefs or actions" (Gee, 2014b, pp. 21). The critical paradigm is therefore concerned with the way in which language operates on an ideological basis. Rather than being a fixed entity, discourse

is in a constant state of flux as it is modified and shaped by the social actors involved (Price, 1999).

Hodges and colleagues (2008) differentiate between different approaches to Discourse Analysis (Formal Linguistic, Empirical Discourse Analysis or Conversation Analysis, and Critical Discourse Analysis), the choice of which is influenced by the research question(s). Whilst Linguistic Discourse Analysis is concerned with the general use of language, syntax and grammatical structures, Critical Discourse Analysis questions are well suited to explore "the nature of roles and relationships, how they came about, and how they have shifted or changed over time" (Hodges et al., 2008, pp. 572). There are thus theoretical and methodological variations within Critical Discourse Analysis. A review of current discourse analysis literature noted both the robust theoretical underpinnings of Gee's approach to CDA alongside its structured analysis framework is well placed for "detecting the sub-stories, themes, and identities as well as paraverbial features" (Wodak, 2006, pp. 601).

3.5 Research Design

Participants were invited to attend one of five focus groups to discuss their views on Integrated Therapy and to discuss a vignette which replicated a team activity. Methodologically, the CDA strategy is equally diverse with some key theorists such as Fairclough preferring an inductive approach, while others opt for a highly structured framework (Blommaert & Buclaen, 2000). The methodology utilised in this thesis draws on three tenets synthesised by Locke and Budds (2020). Firstly, the notion that when one communicates one adopts a *subject position*, that is that the speakers not only adopt a stance as an audience but further still, through language, speakers "try

to *position* others to be and do what we want them to be and do" (Gee, 2014b, pp. 21). Secondly, it is argued that historical factors and context influence the type of discourses that are foregrounded. Rhetorical and linguistic devices are used with *situated discourse* to augment or elevate aspects of identity (or action) and by omission or assumption invite the listener to place less emphasis on other factors. Lastly, the third of Locks and Budds' (2020) tenets is that of *action orientation*, the ability of an individual (or group) to affect change; including their sense of agency, where they locate accountability and where boundaries are drawn or pushed. The subsequent sections outline the sampling method, ethical considerations, and the focus group schedules, coding and analysis strategy.

3.6 Recruitment and Sample

The study recruited healthcare professionals working with the NHS in England with three broad characteristics. They were either: working in an IAPT service or with clients who may be seen in Primary Care for a common mental health problem as part of 1) A Core team, defined as having a wide remit for treating any clients with depression or anxiety disorders in primary care, or 2) an Integrated team, defined as having a specific remit for providing primary care Cognitive Behaviour Therapy or Counselling for Depression (CfD) for clients who also have an LTC/MUS. The third category were physical health professionals whose clients may have primary care mental health needs in addition to their condition.

Table 3

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Psychological Therapists working in IAPT.	Those in a senior management role
Allied Health Professionals as defined by NHS England (https://www.england.nhs.uk/ahp/role/), Nurses including those with a speciality, General Practitioners Recent, relevant primary care experience	Those working predominantly with people experiencing complex, severe and enduring psychological conditions. This includes: Community Mental Health Teams, Crisis and Home Treatment Teams and specialist / inpatient teams
Physical health professional with a recognised UK ethical code who are likely to work with clients with common mental health problems	No recent primary care experience
Trainee or Qualified status	Non-clinical staff

Participants were recruited as a volunteer sample through professional networks and the researcher worked closely with a Field Collaborator who worked in an Integrated IAPT service. The Field Collaborator's role was to disseminate the study information and act as a gatekeeper for interested potential participants. The intention was to reduce the chances that potential participants would feel coerced into committing to the study if the invitation came from a third party. The Field Collaborator was also chosen as a person with links to a broad range of services meeting the research inclusion criteria thereby increasing the opportunity for suitable participants to inquire. In order to provide a wide range of professionals the opportunity to participate and ensure that many views were represented in the sample, the study information was posted in a range of fora including: Trust intranet, social media including closed groups

related to research, therapy and LTC/MUS communities, and posters in clinics with close links to Integrated IAPT such as Diabetes, pain clinics, stroke and cardiology.

There were a number of dilemmas and considerations during the recruitment process. Firstly, it was notable that the IAPT criteria were taxonomically a less complex population, and although CfD counsellors were able to participate, none did. One possible explanation for this is that there are significantly fewer CfD counsellors than CBT-orientated therapists. The data from an annual IAPT workforce report showed that in 2021 there were 8,734 PWPs and HIs compared with 1,060 counsellors (Health Education England, 2022). The data do not currently show the ratio of staff across Core and Integrated Teams, therefore it is possible that counsellors may have relevant experiences of Integrated Therapy which were not represented in the study.

Secondly, the researcher had been aware that the third category of physical health professionals was broad and varied and thus attention was paid in the planning stage to ensure the inclusion criteria would relate to Integrated IAPT practice. However, it was unexpected that many physical health professionals occupy dual roles and others were under-represented. A decision was taken to include an Occupational Therapist and Older Adults Mental Health Nurse through a screening discussion with them to ensure that their work was sufficiently primary care focused and that physical health was a sufficiently large proportion of their role for them to be classified in this category. Further still, a Consultant Psychiatrist was included in the sample after careful consideration. Whilst they could have been excluded due to a greater secondary care focus, through supervision and discussion with the participant it was considered that they had experience of General Practice which was an important perspective for

Integrated IAPT as GPs either referrer or signpost into IAPT frequently and currently act as care managers for those navigating physical and psychological health services.

A summary of the participants per focus group is presented in Table 4 below:

Table 4

Composition of Focus Groups

Focus Group and Duration	Total Number of participants in Group	Profession
1 **52:54**	3	Integrated PWP (female) Senior Core PWP (female) Midwife and LTC Champion (female)
2 **56:45**	4	Core PWP (female) Integrated PWP (female) Integrated HI (male) Occupational Therapist (female)
3 **43:41**	3	Core PWP (female) Integrated HI (female) IBS and Gastroenterology Dietician (female)
4 **53:35**	4	Integrated PWP (female) Core Trainee HI (female) Physiotherapist (male) Older Adults Mental Health Nurse (male)
5 **55:30**	4	Core HI (female) Integrated HI (female) Physiotherapist (female) Consultant Psychiatrist and former GP (male)

3.7 Ethical Considerations

The study required ethical approval from the chair of the Psychology Research Ethics Committee (PREC) and NHS ethical review was granted following the submission for ethical review through the Integrated Research Application System (IRAS), see Appendix 1.

3.7.1 Informed Consent

Participants were provided with full information about the study (see the Participant Information Sheet, Appendix 4). Participants were invited to ask any questions after reading the documentation and invited to complete the Consent Form (Appendix 5) once they were content that all questions had been addressed satisfactorily.

3.7.2 Confidentiality

Participants were informed that their contributions would be as confidential as possible. They were informed that complete confidentiality cannot be guaranteed due to the presence of other participants in the focus group. With this in mind, participants were informed about this issue from the outset and encouraged to respect the confidentiality of their colleagues in the agreed focus group guidelines. During transcription participants were anonymised by replacing their names with the role, and potentially identifying information such as names or locations of work were redacted.

3.7.3 Participant Wellbeing

A further consideration was that of intragroup conflict. It is likely in focus groups, Tindale and colleagues (2005) point out, that participants would disagree or that conflicts would arise between group members. The authors differentiate between interpersonal conflict associated with minority presence, and conflict arising from task orientation such as formulating the case vignette in which participants may disagree on the best way forwards. Indeed, it is likely that intragroup conflict would be exhibited based on the theoretical concepts outlined in the epistemological stance of power and discourses.

Tindale et al. (2005) suggest intragroup conflict need not be feared. It can lead not only to rich data for analysis, but the act of repair can enable group members to understand one another better and thereby become more cohesive provided trust is developed. Studies of qualitative research where intragroup trust is likely to be low, such as refugee populations and those who have experienced trauma have found that a flexible approach is useful with careful mediation by the facilitator (Ahmed et al., 2022). Fern (2001) mapped factors associated with successful focus group processes. Establishing a safe context through ground rules, a carefully considered location and an ice-breaker / warm-up can create a suitable environment for focus group members to “learn the extent of their differences” (differentiation; Fern, 2001, pp. 100). According to this framework, focus group members negotiate how to interact with one another around the group task (social integration) and discover commonality between one another (mirror reaction). Thus, attention was paid to collaborative construction of the ground rules, facilitation and researcher flexibility in taking the temperature of the conflict before deciding whether to intervene.

3.7.4 Data Collection and Handling

Focus groups were conducted via video conferencing using the Microsoft Teams© programme. This is the preferred secure platform by the Information Governance team of the local NHS Trust from which the majority of participants were recruited. A video recording was made of the focus groups with a back-up audio recording using an encrypted dictaphone which met information governance standards. Data were transcribed as soon as possible and deleted at the earliest opportunity. The audio file was deleted after transcription once it was clear that the data were audible enough for a full transcription. The video file was kept during the analysis phase as the CDA methodology requires a researcher to regularly return to the data throughout the analysis, and non-verbal cues were included in this analysis.

3.8 Transcription

There are a wide range of transcription templates one may use with qualitative data. Skukauskaite (2014) writes that many researchers record only that their data were transcribed, yet they often omit the underpinning theory and method. By doing so, Skukauskaite argues, one overlooks something vital about the process such as the purpose and theoretical perspectives which can be troublesome for transparency and trustworthiness. The level of annotation detail within the transcription varies dependent on the research question(s) and the theoretical underpinnings, for example linguistically focused social research studies are likely to require greatly detailed notation for changes in pitch, delivery, enthusiasm and animation (Hepburn & Bolden, 2017). According to the CDA paradigm, meaning construction occurs on more fronts

than the content of utterances. Gee (2014a) argues that language serves an influential function and thus attention to aborted utterances and intonation is relevant to the study of meaning in context. Studies in linguistics have found for example a measurable and reliable change in pitch when an utterance is framed as an interrogative which can be predictive of a social action (Sicoli et al., 2015) and thus such features are likely to be insightful. The transcription method chosen was informed by Wetherell and colleagues (2003) as this most closely aligned with the theoretical stance of the researcher and enables extra-lexical features to be recorded.

Researchers also need to decide whether to transcribe data themselves or to instruct a professional transcription service, the pros and cons of which are well considered by Walker (2017) when facing such a conundrum in her professional doctorate thesis. In this case, the choice made was to transcribe personally. By transcribing personally, the researcher begins to familiarise themselves with their data and make transcription decisions about recording particularly of non-verbal data. Entirely accurate and complete transcriptions are not possible given the subjectivity of interpreting human communication (Tilley & Powick, 2002), thus influencing decisions include how one records inaudible or partly audible utterances, whether to record utterances and hesitations, and which non-verbal cues to record (Paulus et al., 2014, chapter 6). Furthermore, Tilley and Powick (2002) found that transcribers working with others' tapes found it hard to decipher meaning if they were not familiar with the discourse field which impacts somewhat on accuracy of transcription.

3.9.1 Focus Groups

Focus groups were chosen as the data collection method. In total, five focus groups were conducted with n=18 participants, with groups comprising 3-4 members ensuring that each contained at least one Integrated Therapist, one Core Therapist and one primarily physical health professional. The background literature review found that semi-structured interviews and focus groups were suitable for addressing similar research themes. Barnour (2018) noted that both options are viable for qualitative research, but that researchers should align the method with their research question as individual interviews and focus groups elicit different kinds of data although they share many epistemological roots. Ethnography was considered as alternative method as it has been illustrated as a useful means of exploring clinical decision making in nursing staff and can be useful for researching power dynamics (Hodges et al., 2008). Although a case has been made to approach discourse analysis from an ethnological perspective (Gee & Green, 1998), ethnography may however have lacked the sensitivity to uncover the nuances around identity co-construction (Imafuku et al., 2014).

It is possible, Barnour (2018) suggests, that interviews may facilitate detailed, less inhibited accounts. The research questions and CDA more broadly, however, are concerned with the notion of the contextual construction of meaning. It was therefore particularly important to select a research methodology in which the social actors in question were engaged together in creating and shaping the discourse. It has been argued that identities are negotiated and organised when individuals interact, and therefore focus groups allow the researcher to examine how roles, responsibilities and characteristics are worked out, reorganised and updated (Myers & MacNaghten, 1999). During the planning stage of the thesis the covid-19 public health situation

ensued. Most primary care workers moved to remote delivery wherever possible and some were redeployed to work in tertiary settings. The initial plan for the focus groups was to conduct these in person, however given the clear public health risks the researcher considered how to proceed in consultation with the Research Supervisor and Field Collaborator. The option of video focus groups was considered and ultimately chosen as the means of delivery, which creates both an advantage and possible limitation.

The background literature was searched to see what considerations researchers who have used video formats encountered. Video conferencing is more cost effective, time-efficient and enables a wider range of participants to attend (Dendle et al., 2021). Several methodological papers which referred to online focus groups tended to refer to orthographic data in researcher-facilitated “chat” (e.g. Abrams & Gaiser, 2017; Stewart & Williams, 2012). Of those that referred to live video calls, many were initially sceptical both in research and clinical fields, fearing that video-conferencing would impair discursive expression (Peart et al., 2022). However recent studies (Lobe & Morgan, 2020; Lobe et al., 2020) found that focus groups can be equally effective including in social distancing conditions, particularly in small groups of an average of four participants. Groups of this size are in line with those used in studies cited in the systematic literature review. Of the five studies which used focus groups, three recruited 3-6 participants to each focus group (Hammarberg et al., 2019 Holmesland et al., 2010; Wade, 2016). The remaining two recruited 6-11 (Ambrose-Miller & Ashcroft, 2016; Bentley et al., 2017). Potential participants, even those who were subsequently unable to participate, reported that they were more accustomed to video-conferencing now as they had been using it more regularly in their daily work

and could see benefits for their clients from being in a neutral, comfortable space and less affected by social or performance anxieties.

3.9.2 Focus Group Schedule

Each group was scheduled for a maximum of one hour. The schedule (see Appendix 6) consisted of setting ground rules such as confidentiality and purpose, followed by an ice-breaker in which participants introduced themselves, and spoke a little about their background. This is recommended as a means of welcoming participants and aids to "build rapport and a sense of group cohesion" (Liamputtong, 2011, pp. 73). Stewart and colleagues (2007) compare the extent to which focus group schedules might impact on the data collected. They argue that less structured schedules can be useful for thematic analysis methodologies, or research questions intended to investigate what topics are important, relevant or of interest to participants. However, they note that important topics may not be discussed without guidance from the facilitator. Thus, it is important that prompts are as standardised as possible and might introduce topics without prioritising themes important to the researcher over those of the participants. More will be discussed about this in the reflexivity section in the concluding chapter.

In social identity research, the background literature has highlighted that individuals can access many variations on their personal "self" which can differ from the professional "self" and thus are quite different constructs. Thus, by limiting demographic information collection solely to roles and verbalising this with other members present the aim was to increase the likelihood that the professional "self" would be primed and therefore more accessible (Hogg, 2005). Participants were

asked in the first half about their current thoughts on physical and psychological services working together for clients with LTC/MUS, following which they were presented with a vignette which is discussed below and asked to reflect on how they might formulate the client's difficulties, for example what role they saw for Integrated working and whether there were important issues they wanted to raise around this. Lastly, participants were asked if there were any particularly relevant points they wished to highlight.

A reflexive stance is required from the researcher with regards to the methodological decisions made. There are relatively few papers written about focus groups, and the majority tend to focus on the practicalities and methodological implications of conducting them, however focus groups "have a life of their own" reflecting power dynamics, and social influence (Albrecht et al., 1993, pp. 51). The researcher sets the agenda and contributes as little as possible save to introduce topics, gently steer or introduce important aspects (Crabtree et al., 1993) such as the vignette in this case. Stewart and colleagues (2007, chapter 5) argue that the researcher is nominally in a position of power as the organiser and host of the focus group. Researchers inevitably self-disclose a certain amount of information which could affect power dynamics when conducting the focus groups. For example, participant knowledge of the researcher's role, either through prior collegial interaction or email signatures, may suggest an affiliation with certain assumptions of discourses thereby creating the potential for bias. There were a number of considerations made to mitigate against this fist. Firstly, the introductory wording of the focus group schedule was designed to include an ice-breaker in which all participants stated their roles. The researcher contributed by stating their position as a facilitator interested in hearing participants' perspectives with

no expectation that there are right or wrong responses. Secondly, conducting the focus groups on a remote platform provided a neutral venue.

3.10 Vignettes

Discussion aids can be a useful tool to researchers in focus groups to standardise the format and, enrich the discussion (Stewart et al., 2007). A vignette was designed through PPI by a non-clinical member of staff in an IAPT team with a special interest and lived experience of LTC/MUS. The brief provided by the researcher was that the vignette should present a client with a joint physical and psychological need that would meet the inclusion criteria to be seen by Integrated IAPT. Vignettes such as this replicate a regular team activity, i.e. formulating a client's needs and hypothesising suitable interventions. One must be cautious to fully consider using such discussion aids in Discourse Analysis research as vignettes are a discourse in their own right. Vignettes however can be useful for reducing participant inhibition thereby encouraging less forthcoming participants to contribute, and tapping into creativity (Wolf & Frey, 2005). Asking speakers to discuss a topic in different ways by using devices or questioning is considered good practice by Carter and Bolden (2012). Using different mechanisms during a focus group, the authors argue, creates a *narrative shift* in the sense that speakers can "change the voice from which they speak" (pp. 263) such that key discourses become apparent or available. Replicating regular team activities involving problem-solving and creativity has been shown to be effective for research involving the study of meaning construction whereby "different professional fields are expected to engage in group discussion to identify and solve problems regarding a patient…as described in case scenarios" (Imafuku et al., 2020, pp. 224),

and can aid researcher reflexivity and aid in elaboration of sensitive or ethical topics (Romani & Szkudlarek, 2014).

3.11 Coding and Analysis

“Speakers…are making history as they enact and recognise… different ways of being certain kinds of people”

- *Gee (2014a, pp. 195)*

Data coding and the structure of the analysis was significantly informed by the work of Fairclough (1992a; 1992b; 1993) and Gee (2014a; 2014b). Qualitative datasets are rich and vast, thus it is arguably impossible to derive an exhaustive analysis from such data (Given, 2008). Researchers must make choices regarding the significance and dominance of linguistic features and discourses which has often been a criticism not only of discourse analysis, but of many qualitative methodologies. Furthermore, discourse analysts have been cautioned that in pursuit of sociolinguistic change researchers may stray too far into the abstract (Krzyżanowski, 2016). Given (2008) writes that even within the CDA field researchers vary considerably in terms of the scope of their analysis. They differ in the extent to which they adopt a macrostructural approach compared with the finer linguistic detail. Adopting a critical realist perspective sheds light on extra-textual discourses through the fluidity of linguistic expression (Wetherell et al., 2003). Herzog (2016) further warns against replicating hegemonic norms, encouraging the analyst to adopt an approach suitable to elucidate the “social sense that is implicit and unnoticed by social actors” (Herzog, 2016, pp. 280).

Fairclough's (1992b) three-dimensional Discourse Analysis framework places the textual analysis in the centre, surrounded by examination of the discursive practices and lastly the social practices including the historical and interpersonal context. The guiding principle throughout the analysis was to construct a contextual map of emerging discourses through continual re-reading (Henry & Tator, 2007) of the corpora with theoretical principles at hand and interpreting the findings through this lens alongside the research questions (Wodak, 2004) including asking oneself how the interaction between implicit and explicit discourses function ideologically (Fairclough, 1992b). The starting point recommended by Dunn and Neumann (2016) is to revisit the transcribed data several times for familiarity and identification of macrostructural factors, coding key topics raised by the speakers in the margins. As Fairclough (1992b) argues, some theorists suggest separating form from texture, however in practice if one is to understand the content it is necessary to examine the form.

For Fairclough, the textual analysis involves two interlinked processes: linguistic analysis and intertextual / interdiscursive analysis. The linguistic analysis firstly comprises the register and vernacular adopted by speakers, which can often be indicative of power imbalance and contextual conventions, turn-taking, the dominance or silence of certain speakers and grammatical and lexical choices. Fairclough writes extensively of the centrality of *intertextuality* whereby speakers' linguistic choices are influenced by their historical context which includes citing of phrases and direct quotations, thus repetitions, slogans, citations and possible quotations were noted and compared across the dataset. Deviations and creativity (interdiscursivity) are

considered to be signs of novelty and evolution in discourse (Jørgensen & Phillips, 2002).

Echoing Krzyżanowski's (2016) cautionary tale of the hazards of abstraction, Gee notes that discourses and identities can suffer from semantic overlap. Gee suggests that discourses are activated, or "made available" though context and thus the corpora alludes to expressions of 'socially situated identity' (Gee, 2014b, pp. 58). The influence of culture and context shape the availability of discourses, preferencing some whilst others are not permitted. Thus, as Carter and Bolden (2012) write, according to the constructivist view of cultures, speakers adopt a "subject position from which an individual can speak, act, and interact" (Carter & Bolden, 2012, pp. 259). In order to elucidate the emerging discourses from the corpora, Gee outlines seven *building tasks* to ask of the data during the analysis informed by questions and twenty-eight *tools*. These questions to ask of the data enable the researcher to construct a detailed map of the emerging discourses to account for the key concepts of 1) situated identities, 2) characteristic ways of being and acting, and 3) how these characteristics are influenced, accepted and shaped by interaction. The terms "building" and "tools," Gee writes, were deliberately chosen from the construction semantic field to illustrate that speakers and writers are in the process of constructing worlds, identities, power dynamics and social connectedness throughout the interaction and the analysis should be astute to this. These building tools are outlined in Table 5 below:

Table 5

Analysis Framework (Gee, 2014a)

Critical Discourse Analysis Building Task	Question
1. Significance	How is this piece of language being used to make certain things significant or not and in what ways?
2. Practices / Activities	What practice is this piece of language being used to enact or get others to recognise as going on?
3. Identities	What identity is this piece of language being used to enact, and how does this help the speaker to enact their own identity?
4. Relationships	What sort of relationship(s) is this piece of language seeking to enact with others?
5. Politics	What is taken as 'good, proper, right, correct, the way things are, ought to be, like me or not like me?'
6. Connections	How does this piece of language connect or disconnect things; how does it make one thing relevant or irrelevant to another?
7. Sign Systems and Knowledge	What types of language are privileged?

As the corpora were reviewed, codes were assigned in the margins utilising Gee's building tools. These tools are designed not to be prescriptive, but rather "tools of enquiry" (Gee, 2014a, pp. 12). The researcher therefore returned to the dataset multiple times throughout the transcription and analysis and thus the structure is non-linear. Gee argues that an idealised 'full' discourse analysis could contain detailed answers to all the tools of tools on enquiry, however the theoretical stance of the thesis and research questions influence the extent to which certain tools feature in the analysis and some are less relevant. Wetherell and colleagues' (2003) Critical

Discourse Analysis Framework is also drawn upon to elucidate instances of dilemma construction and resolution. This Framework aligns epistemologically with Gee (2014a; 2014b) and Fairclough's (1992b) notion of power dynamics but provides additional tools to interrogate how participants present problems and hypothesise / negotiate their resolution with the members of the focus group. This model sheds greater light on power dynamics and complements Gee's (2014a) concept of *figures worlds* as by posing solutions (or lack thereof) participants involve other agents, are bounded by the confines of the figured future and provide insight into where the action orientation to resolve the dilemma is derived. A map was constructed for each focus group individually as shown in the example in Figure 7, following which the maps were synthesised for overlapping themes. The minority voice may be overlooked when searching the dominant discourses, however minorities can be influential figures for change. Thus the synthesis was further reviewed for codes which did not fit with the major themes and considered to what extent this was accepted in the discourse.

Figure 7

Example of Implicit / Explicit Discourse Map

There are also other ways in which lexical and semiotic cues can provide insight into the relationship between individual texts, text fragments and utterances. Georgakopoulou and Goutsos (2004) point the analyst towards “discourse markers” such as conjunctions which function to make connections which ‘essentially make explicit implicit relations between clauses’ (Geogakopoulou & Goutsos, 2004, pp. 91). Subjunctive moods and verbal tenses also aid in meaning construction, for example a past tense construction may refer back a former important factor in professional

identity which is no longer present in the new construction, in this way language use is part of the "long conversation" as Fairclough (1992b) considers the historical and contextual factors influencing the availability of discourses. Many Discourse Analysts argue that linguistic analysis is insufficient, advocating for applying any linguistic analysis to continually return to the subject positions and identities being constructed and the influence this has on world view (Henry & Tator, 2007; Cazden et al., 1996). In their book "why do you ask" Freed & Ehrlich (2010) discuss the role of interrogatives as a mediating factor in discourse development. The authors argue that questions have many functions beyond the simple seeking of information. Rather, interrogatives can be *direct* (e.g. 'what does an Integrated Therapist do?') in which the speaker takes the position of possessing no knowledge of the subject and seeks a factual response, or *indirect* whereby the question is informed by power dynamics such that the answer is already known or clarification is required. In short, the texture surrounding interrogatives ascribes meaning to the grammatical and lexical choices. Furthermore, Freed and Ehrlich (2010) provide two other means in which questions can shed light on emerging discourse. Inflection and tag questions can represent features of interest to a Discourse Analyst. Through upward inflection, or short interrogatives seeking agreement such as "isn't it?" / "don't you think?" speakers are able to test out the acceptability of novel discourses.

A final consideration is that non-verbal communication is also considered to be part of the discourse (von Leeuwen & Kress, 1995). Kress and von Leeuwen (1996) write, for example, of the importance of imagery in meaning construction, and Gee (2014a) acknowledges that how speakers dress, present themselves, and use non-verbal cues contributes to the discourse, and thus rather than indicating the *availability* of a

discourse, non-verbal communication adds information about *acceptability*. Many of the participants attended during working hours, thereby restricting their choice of appearance, although from the same principles adopted in the ice-breaker exercise of introducing oneself by role it is possible that by attending in role-specific clothing professional discourses are more accessible. The main focus for analysis of the non-verbal communication, therefore, was to note the ways in which certain discourses were permitted or supressed. Gee's "doing, not saying" tool suggests that nodding, facial expressions, silence and over-talking for example can be clues to the acceptability of certain discourses.

3.12 Reflexivity

An inescapable factor is that the researcher is part of the discourse. The ability to reflect on one's own practice is central to many helping and research professional groups and in qualitative research reflexivity is considered a cornerstone. Reflexivity has been defined variously as an understanding that the researcher is influenced by the research as much as that they themselves are influencing agents upon the research (Probst, 2015). For some, reflexivity relates to research ethics and integrity (Pope et al., 2020), for others it is the reflection and, crucially, action of identifying how multiple identity factors interweave amongst one another including points in which they intersect or complete (Galliher et al., 2017). In CDA the meaning is more specific and relates to the ontological and epistemological framework in which researchers are urged to reflect upon their "positionality…in a variety of sometimes overlapping contexts" (Lynch, 2008, pp. 710). Researchers' reactions and observations are grist to the mill and treated with the same scrutiny as the dataset in a spirit of dynamic self-awareness (Kondrat, 1999).

Jacobson and Mustafa's (2019) positionality / social identity map was used as a starting point in which the researcher's primary (Tier 1) social characteristics were explored. The second stage asks of the positionality map how the social identities affect one's actions, values and behaviours (Tier 2) and finally to observe the emotions connected with social identity facets (Tier 3). In CDA research, it is primarily the researcher who constructs the boundaries between what is considered discursive and non-discursive (Jørgensen & Phillips, 2002, chapter 3; Starks & Brown-Trinidad, 2007) and it was likely that the professional characteristics including training, IAPT membership and CBT orientation of the researcher were relevant, and indeed Jacobson and Mustafa (2019) suggest that additional Tier 1 factors can be incorporated to increase the depth of reflexivity with the positionality map. Similar approaches have been used in leadership and educational settings, for example Blanchard (2007) encourages professionals to consider their 'point of view.' Jacobson and Mustafa (2019) stress that the positionality map is certainly not a comprehensive understanding of a concept as complex as identity, but rather serves as a starting point. During data analysis, the authors highlight the potential for bias by drawing conclusions based on one's own positionality and thus the advantages of reflexivity make this more explicit.

When stepping into the role of researcher it would be tempting to think that one has compartmentalised other identity factors such that one can be a neutral facilitator. However, as Galliher and colleagues (2017) point out, identity is comprised of many facets some of which conflict and most of which overlap. The authors argue that it is misguided to only focus on role intersectionality without paying attention to dimensions

of power and privilege. The positionality map can therefore be a useful means of anticipating power and privilege dynamics which impact the researcher as well as the researcher impacting on the study (Starks & Brown-Trinidad, 2007). By stepping into the dual role of researcher alongside the existing psychological therapist role in a Core IAPT team affiliation is afforded between IAPT-orientated participants with whom there is a shared cultural and historical narrative (McLean & Syed, 2015). Herzog (2016) writes of the conflict posed to those embarking on Discourse Analysis from a Critical standpoint. That is, by attending to methodological rigour through adopting a neutral observer stance it is possible that by "pretending to have no normative stance only mean[s] failing to recognise one's own (implicit) normative viewpoint" (Herzog, 2016, pp. 280). Herzog (2016) provides two angles from which to reflexively assess the power dynamics in CDA, those of external critique in terms of Tier 1 social identities, and those of internal critique (Tiers 2 and 3) based on one's implicit preconceptions, expected norms and beliefs. As an IAPT Therapist it is likely that cultural norms and values will have influenced both the choice of research and there is likely to be a reciprocal effect. The assumption based on clinical work with clients with LTC/MUS was that greater attention could be brought to this issue and an implicit advocacy role was adopted. By making explicit the choices made throughout the planning and implementation phases of this research it is likely that these will have been influenced by "master narratives" (Gallaher et al., 2017, pp. 2014), a useful concept defined as the interaction between cultural and personal goals which can marginalise or privilege beliefs and actions.

3.13 Chapter Summary

This chapter outlined the way in which the background literature search and PPI shaped the research questions and subsequent methodology. The choice of CDA which was considered during the systematic literature review was presented with the author's epistemological position described. The methodological procedures and ethical considerations were reported and lastly the model of reflexivity was selected.

The subsequent chapters reports the results of the analysis. Stylistically for ease of reading and interpretation of the findings the following three chapters are combined results and discussion. A broad, but briefer general discussion is presented in the Chapter 7. The following three chapters discuss in turn the dominant discourses of Expertise, Responsibility, and Creativity / Innovation.

Chapter 4 – Analysis and Discussion

Each chapter of the results and discussion will focus upon a ‘Big D’ discourse (Gee, 2014a), beginning with the discourse of expertise. Subsequent chapters will follow in which Responsibility and Creativity / Innovation discourses will be discussed.

4.1 Expertise

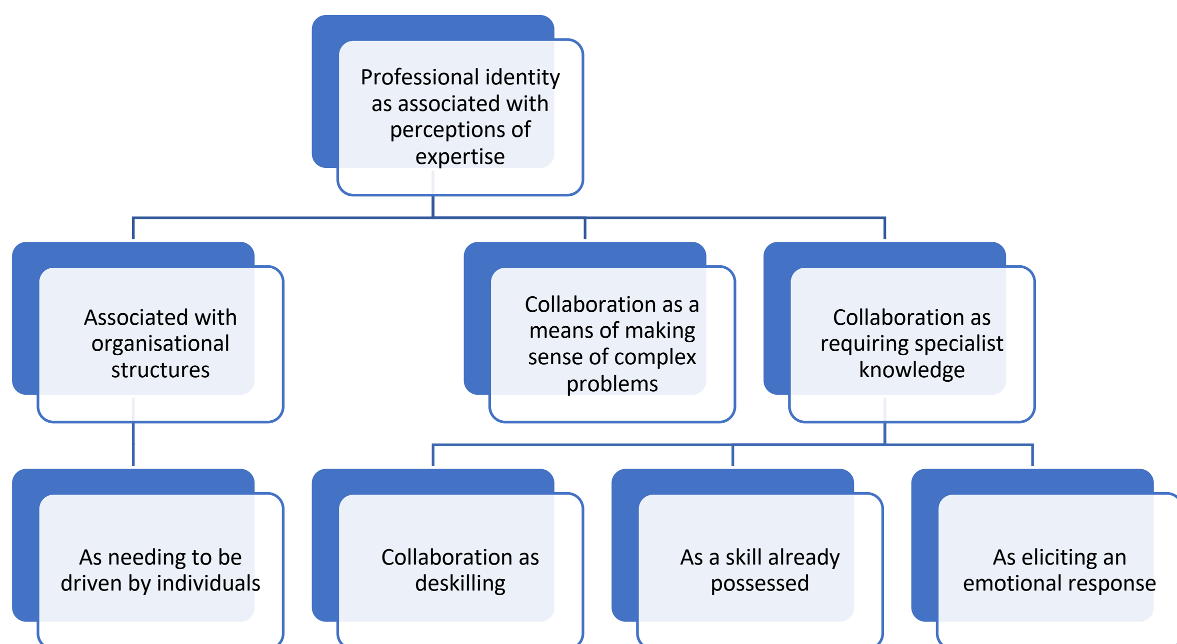
This chapter considers the Big D discourse “associated with expertise” as outlined in Figure 8 through Gee’s (2014a; 2014b) analytic framework, and Wetherell et al.’s (2003) Critical Discourse Analysis framework for the case of dilemma resolution. The chapter will be structured by professional group on the level of the individual followed by interprofessional factors in the following structure:

- 4.1 Expertise as perceived by speakers from clients
- 4.2 Perceptions of own expertise, divided into:
    - 4.2.1 Integrated Teams
    - 4.2.2 Core Teams
    - 4.2.3 Physical health professionals
- 4.3 Expertise as perceived by speakers from other professional groups
    - 4.3.1 Repertoire: Uncertainty (identities)
    - 4.3.2 Repertoire: Risk and Collaboration (relationships)
    - 4.3.3 Repertoire: Organisational Factors (politics)
- 4.4 How speakers negotiate the emerging discourse alongside their professional identity

Speakers often referred to epistemic factors to talk about collaboration and roles. The discourse was coded as 'associated with expertise' and subdivided into repertoires contained within the discourse as shown in Figure 8 below:

Figure 8

Discourse Map for the Code "Associated with Expertise"



4.1.1 Client discourses

Beginning with the client, the data were searched for the way in which the expertise discourse affected therapist-client interactions. In particular, Gee's (2014a) 'relationship building' question was asked of the data throughout with regards to what sort of relationships therapists and clients seek to enact with one another. Extracts will be provided to illustrate the results. The discussion will include attention to how language is used to construct the relationship between therapist and client

(relationships), what assumptions are being made about the role of therapist and client in terms of expertise (identities), what factors are considered relevant (connections) or important (significance) and what is considered the proper way to use expertise (politics). The results of the analysis found two distinct discourses constructing the relationship. In the first, clients were positioned as passive, sometimes reluctant or fearful agents seeking expert knowledge from their therapist. The second client discourse positions the client as a consumer with expectations of their therapist. These two client discourses will be considered in the following sub-sections.

4.1.2 Client as reluctant, fearful and passive

"Will you walk into my parlour?' said the Spider to the Fly"

- *Mary Hewitt (1828)*

The first client discourse portrayed the client as passively engaging in their treatment, or being led reluctantly into treatment or referred elsewhere through the guidance of their therapist or practitioner. The clients' level of agency (practices/activities) limits their choices to engaging or not in the treatment recommended by their therapist, thus it is implicit that they are not actively encouraged to shape their treatment journey but rather defer to the expertise of their professional as shown in the following extract from the data:

> *"It's been quite a big learning curve for us as clinicians to learn about how to explain this to patients and how to explain the whole mind/body link and for us I think that's been the real benefit of collaborative working. It's just starting to get a grip on that to*

understand it (.) so that we can talk to patients about it who may not have considered it at all." - IBS / Gastroenterology Dietician [FG3]

CBT is based upon the concept of collaborative empiricism (Beck et al., 1979) in which the client and therapist are both considered experts working together in equal partnership to find out how the world really works, whether there are more helpful interpretations of the self or circumstance, and whether more adaptive behaviours could be beneficial. Likewise, collaborative therapy assumes that therapists are embedded in clinical communities around a metaphorical Arthurian round table. However, by searching the data firstly for inter-therapist relationships and then for the way in which client-therapist interactions are discussed, it was found that relationships are commonly referred to hierarchically. In the following extract, a Core PWP and Integrated HI discussed power dynamics in their relationship with other professionals and their patients:

"I think cos sometimes when you reach out to like a physical health team? the first person you'll be in contact with is like a <u>consultant</u> or someone and I'm like "oh this is a bit scary!" - Core PWP [FG3]

The Integrated HI agreed that feeling *"intimidated"* by others' perceived expertise is *"a really important barrier."* The Integrated HI expressed that when they experience power imbalance they believe that their clinical opinion will be negated:

"If I'm being at all intimidated by the uh somebody's physical health knowledge, I'm a bit like 'ohh are they going to want to listen to me

> *or have this conversation around this patient?' Whereas if you're .hh embedded in a team there's no such barriers, you know, I'm very happy talking to our Senior OTs and Senior Physios about what-not um and our Psychiatrists and Clinical Psy- ClinPsychs and that's <u>fine</u> um but again you know if I've got a patient who um is seeing a Neurologist for example .hh I would have similar concerns about going "oh, not sure how best to approach this." - Integrated HI [FG3]*

The utterance concluded with reference to the patient, with the use of *"filters down"* suggesting that power dynamics are also present in patient-therapist interactions:

> *"...and of course if that's a barrier then that obviously filters down to the patients." - Integrated HI [FG3]*

In FG3 the group discussed challenges of working with incomplete information, particularly when using different record systems. Integrated Therapists positioned themselves as actively engaged in making sense of clients' healthcare journeys whilst patients and referrers were positioned as passive, and sometimes as inaccurate reporters regarding their treatment:

> *"I completely echo as well that patients don't always um don't always necessarily report um what we've got on the system…so there's- so patients don't fully understand where they've been half the time [laughs], professionals don't know where they've*

> *been [laughs] um because it's really confusing. It's a complex (.) healthcare system to navigate" - Integrated HI [FG3]*

The conceptualisation of the client as a reluctant and unwilling participant appeared in the following extract:

> *"[For some referrals, clients] have to tick that box and say "I've had psychological support'…and they need it but for other people they don't but they just come to us because they've been told to tick a box and I don't feel like that's the best joined up care either because it's just forcing them to a service they don't want to be in which then makes our job more tricky (.) because you're trying to get them to engage in something they don't need but then the physical health won't give them what they <u>do</u> need without engaging with us first." - Integrated PWP [FG1]*

Linguistically, the *connections building tool* asks of data how lexical choice connects concepts and what sort of relationships and identities are being enacted (Gee, 2014a). Revisiting the above extract for linguistic features there are a number of points which underscore the developing discourse. Recurring choice of verbs such as *"told to"* and *"get them to"* places the agency on the therapist's expertise whilst maintaining the client's passivity as they are restricted to either *'wanting'* or not to engage with what the therapist believes they *"need."* Adjectives were used infrequently to describe the client's experience, almost to the point of absence. The adjective *"poor"* however is

frequently adopted in FG5 to qualify *"patient"* and evokes a relationship between therapist and client as being hierarchically unbalanced:

> *"…We've got the same sort of unpleasant technical [Physio *yeah*] trundle through pathways of interferences as I call it. And you've got this poor disorientated person thinking [puts hands up in a gesture of confusion]" – Consultant [FG5]*

The extract below contains this adjective choice. In this extract, the speaker referred to three agents who are afforded the task of conceptualising the client's problem: the client's GP, hospital and the speaker (identities) which limits the client's agency to use their own knowledge of their condition to influence their care journey (politics):

> *"I am the patient's <u>absolute</u> worst nightmare. And the story would be: GP couldn't quite crack it. Complex pain syndrome, often. So they were referred to a general hospital which couldn't quite crack it so the poor patient is then said 'well you're obviously very difficult and we must send you to a regional centre' so they would meet me at [name redacted]…and I feel the poor patient trying to make a decision 'do I step out of that door or into the Psychiatrist's lair?" - Consultant [FG5]*

The use of the metaphor of a "*lair"* positions the client as fearful and unwilling to enter a hostile environment, although it could perhaps be a reference to a stigmatised view unique to the profession of Psychiatry (Möller-Leimküher et al., 2016). The authors

suggest that professions may attract, unjustly, such a stigma through lack of public understanding, interprofessional assumptions and self-conceptualisation. Further still, patients were conceptualised as passive in terms of their knowledge of their own conditions or services with which they are in contact. A Physiotherapist in FG4 ascribed this position to clients in terms of their perceived knowledge of their difficulties and engagement:

> *"…for the patient there's <u>not</u> a distinction [between psychological and physical health] but within services there <u>are</u>."* - *Physiotherapist [FG4]*

As Gee (2014a) argues, assumptions are often more visible when speakers imagine an alternative Figured World of what 'ought to be.' A Midwife with a special interest in LTC/MUS in FG1 painted an idealised future where clients are *"allow[ed]…to be able to have more control over their care."* In figuring the world in this manner, the speaker portrays a current state in which unequal power dynamics restrict patients' ability to influence their treatment, requiring them to repeat distressing information without benefit. The burden of repetition was foregrounded, paired with the assumption that if this is not mitigated against the patient will disengage from help-seeking:

> *"…replaying his story every single time with every single service. For some people that is too much and for some people that is a barrier." – Midwife [FG1]*

Through this discourse, "expertise" has so far been discussed with regards to client-therapist interactions. It was found that power imbalance contributes to Integrated Therapists doubting their capability when they believe they are solely responsible for finding effective solutions to complex clinical problems. Therapists adopt behaviours to co-ordinate care based on incomplete or inaccurate information on the assumption that clients expect them to have sufficient skill and knowledge to make sense of the problem, navigate the system and reduce re-telling of their story. These findings align with those from a previous study of therapists' feelings of competence in which therapists who assumed greater responsibility for change in the client reported greater competency doubts (Thériault & Gazzola, 2006). The next session considers clients' expectation further.

4.1.3 Client as consumer

The second client discourse positioned the client as a consumer with high expectations of the professional they are seeing. In some instances, the client is positioned as assuming *"the health professional knew everything" [Core Trainee HI, FG4]* which was paired with eliciting an emotion of fear on the part of the client. The client is portrayed as being fearful that they *"might get told off, so they hide. They feel less likely to share"* their problems with the therapist. In this way, the assumption of therapist expertise is seen as a barrier to developing a trusting therapeutic relationship.

The therapist resolves the potential rupture in therapeutic alliance formation through Socratic dialogue which the speaker hypothesises would be beneficial for the client by forming a view of the therapist as *"more approachable"* and *"there to help me."* There is an alternative view, however, that core therapist competencies may reduce

confidence in the therapist's expertise from the client. In FG5 a Consultant introduces the idea that by collaborating and offering patient choice there is a risk to their professional identity:

> *"You have to bear in mind that I'm a Glaswegian, so if you offered a Glaswegian choice they thought you were incompetent." – Consultant [FG5]*

It is important, then, for therapists to retain some of their perceived expert status but for clients too to be able to contribute their own expertise. In this discourse, the clients' stance is constructed through their expectation of their therapist, although sometimes disempowered in Integrated CBT. These findings align with research into those who raise complaints elsewhere in healthcare, yet shed a slightly different light on the notion. A discourse analysis of complaints raised in learning disability services (Jingree & Finlay, 2013) found that individuals were often reluctant to express dissatisfaction for fear of repercussions by invoking a 'controlling staff' discourse. The present analysis has shown that deferring expertise to the therapist can be equally non-conducive to effective collaborative care.

The following sub-sections explore the perceptions each profession has of their *own* expertise. This topic is divided into three headings: 1) Core Therapists, 2) Integrated Therapists, 3) Physical Health Professionals. As these sections focus on individual factors rather than interactional, Gee's (2014a) identity building tool was considered firstly to ask how each profession defined themselves. The discussion will then explore what practices were perceived as currently happening or idealised (practices /

activities), what are the most important identity features (significance), and how each group differentiates their identity from their counterparts (politics). In short, professional identity construction will be discussed in terms of "who we *are,"* "what we *do"* and "how are we unique."

4.2 Perceptions of own expertise: What kinds of people

4.2.1 Core Therapists

Core Therapists adopted a stance in which their expertise is considered insufficient for meeting the needs of clients with LTC/MUS which influenced the extent to which they related to the notion of collaboration. Clients' difficulties were conceptualised as requiring more specialist knowledge than Core Therapists felt they possessed. Two particular risks were foregrounded (significance): 1) they will be ineffective or that harm will come to the client (practices / activities), and 2) it will be detrimental to the organisation's reputation (politics) and recovery rates (sign systems and knowledge). These risks are often combined to evoke an action orientation towards deferring to their Integrated colleagues to provide enhanced expertise, training or referring onwards. The latter will be discussed further in Chapter 5 regarding responsibility, however this chapter will address the co-construction of Core Therapists' identity alongside their counterparts.

Firstly, Core Therapists made significant their perceived lack of sufficient expertise to the focus group fearing that their offer to clients would be ineffectual, or possibly harmful. They expressed fears of only being able to work at a *'superficial'* level and thereby miss something vital to sustaining recovery. Regarding the idea of efficacy, a

Core Senior PWP describes feeling disconnected from opportunities to collaborate. This sowed doubt that her intervention would be sufficient:

> *"On a personal level it can feel quite scary…I'd always be questioning "is this a superficial level of recovery? Maybe we haven't addressed some areas" - Core Senior PWP [FG1]*

The speaker connected their intervention with risk by recounting a story of mistaking a serious medical problem requiring intervention for a safety-seeking behaviour commonly associated with anxiety disorders. By emphasising that they were taking a personal stance, it is implicit that the speaker's opinion differs from the organisation or from their colleagues. This would be unnecessary to differentiate in this way unless there was a perceived divergence, something that could not acceptably belong to the Core Therapist identity. Further still, interventions are framed as not only being ineffective through lack of expertise, but even possibly detrimental or harmful to patients:

> *"Especially from a psychological therapies point of view, you don't want to put somebody in a dangerous situation…I say 'dangerous,' you know some of the things that we might be doing [laughs] with our <u>therapy</u>, you know, getting them out more or whatever…[I would ask my supervisor] "is this a safety behaviour or actually does this patient really <u>need</u> it?' Do I tell them to take that stick away at periods of time and actually they have a <u>fall</u> and because*

> *of their physical health that risk can be really uncomfortable." - Core PWP [FG1]*

Secondly, Core Therapists linked their identity with systemic factors. Prior to the inception of the Integrated Pathway, all clients for whom primary care psychological therapy could be helpful were treated by IAPT regardless of health status. Through the emerging discourse, therapists evoke the "client as impossibly complex" in which the Core Pathway is framed as not permitting the treatment of LTC/MUS. In FG5, a Core HI expresses a view that Core Teams *"have no specific LTC remit"* and therefore when she encounters clients with comorbid conditions she feels *"really underskilled."* This elicits a linguistic shift from clinical terminology to emotive language. As the speaker elaborated, she recounted a story of working with a client who had comorbid health conditions. The client in the narrative doubted the therapist's expertise when the therapist did not recognise another service with whom the client was involved. She adopted the evocative adjective "*just horrific Health Anxiety"* to describe the client's psychological difficulties concluding that consequently she had *"literally no idea about where to refer them."*

The qualifiers *"just horrific"* to Health Anxiety and *"literally"* to *"no idea"* are arguably informationally redundant. Indeed, in spontaneous speech it is common for speakers to make lexical choices that add nothing to comprehension (Kravtchenko & Demberg, 2022) and use adjectives as intensifiers in a stylistic manner which is dependent upon the individual's idiolect (Athanasiadou, 2017). However, intensifiers which are exceptional for the speaker or the context are likely to elicit a quantifiable cognitive shift in listeners (Bennett & Goodman, 2018). High frequency words such as *"quite"*

are often ornamental are therefore not greatly influential (Wright et al., 1995), likewise adjectives which are too vague to meaningful (Kennedy, 2007). By using a colloquial register in contrast to the preceding contextual vernacular and deviating from the accepted clinical terms of severity such as “mild,” “moderate” or “severe” to describe the client’s Health Anxiety the speaker is more likely to elicit a belief shift in other group members thereby connecting the “impossibly complex” discourse with LTC/MUS in the Core Pathway.

The Core HI’s narrative suggested that her perceptions of self-efficacy in working with comorbidity were stronger when working in medical centres in which she felt *“embedded.”* The speaker portrayed a Figured World (Gee, 2014a) in which Core Teams are siloed from medical practices, and thereby lose the *“official remit”* to work with comorbidity. This role is figured to now belong to Integrated Teams. Pre-existing skills are reframed as “unofficial” or perceived to be politically undesired, thereby inhibiting access to competency beliefs. The extract below in which a PWP conceptualises their role is notable:

> “*[For] me personally, not officially, we’re not physically health orientated. I’m not trained in physical health in any way.” - Core PWP [FG3]*

The shift in this example between the first person singular, first person plural and more abstract *“official”* line suggests a professional identity in flux. A recent study of professional identity transformation (Schubert et al., 2021) discussed the discomfort of cognitive dissonance during time of identity transition which is remedied by *making*

strange (Gee 2014a) previously familiar work through *othering*. Othering affords space for divergence in identity such that new identity constructions become available to speakers, i.e. a space which is filled with a niche for Integrated Teams.

However, when they were presented with a vignette and interacting with their Integrated colleagues, Core Therapists were able to draw on a wealth of formulation skills, competence in adapting CBT for comorbidity and even portray this with confidence. In one example, a Core PWP formulates a suitable approach to the vignette with a caveat regarding their perceived knowledge:

> *"I don't really know lots about diabetes, but I suppose…" – Core PWP [FG2]*

Some therapists connected confidence and experience with utilising their skills to adapt practice:

> *"I feel that comes with experience as well? You know, what [Physio] has been saying is that the more people you see with those kind of long-term conditions you are more likely to <u>know</u> that balance, you are more likely to <u>give</u> that advice and know how to deal with such kind of conversations…then you are more <u>confident</u> to approach the client from different angles." - Core Trainee HI [FG4]*

However, for others they retained the doubtfulness in their discourse despite therapy successes. Whilst some were keen to impress upon their interlocutors that they had

no training, remit or sufficient skills to work with comorbidity there was not universal agreement with this view suggesting they are currently working in collaboration with their counterparts to reconstruct their professional identity. Many of the speakers reported undertaking additional training in long-term health conditions, particularly those who had been qualified for a longer period such as experienced PWPs, SPWPs and HIs. Training was discussed by the speakers as a way in which they were able to access competence beliefs which were not available to them when making direct comparisons between their team and the Integrated team or discussing long-term conditions in a more abstract way:

> *"We're taught to see things through a certain lens. So as a PWP or an HI we're probably taught to see things as in "this and this means <u>this</u>," and then we only got for instance our IBS extra training once we qualified, and then you're suddenly feeling like "okay, I <u>can</u> work with IBS, I've got the CBT techniques but actually do I feel <u>confident</u> because I've only had a day's training and this is somebody's big issue…and is it possible that we can do it really well?" - Core PWP [FG3]*

Training has been hypothesised as a means of *microdynamic change* (de Saint-Georges & Filliettaz, 2008, pp. 213). It was hypothesised to have two functions which relate to identity transition resolution: to apply existing skills in a core team function and to situate the activity in the historical context. Research has shown that therapists often doubt their competence, even despite years of practice (Thériault & Gazzola,

2005). The present findings concur with this, however these findings suggest that interprofessional dynamics also impact on individual competency beliefs.

Finally, although Core Therapists position their Integrated colleagues as better equipped to provide therapy for clients with comorbidity, they recognised that collaboration remained part of their role function. The last use of the concept of risk related to the perception that collaboration was prioritised by stakeholders for both Integrated and Core Therapists which was somewhat threatening, but could offer opportunities of connecting with the expertise of colleagues (relationships):

> *"Change brings around fear, and brings around a fear of doing more work …change does initially bring around more work because we're having to change, but actually the long-term- if it is good change, and positive change done in a good way then the long term reward is actually we're probably doing less work in a better way with better outcomes for our patient groups in both their physical and mental health, isn't it." - Core Senior PWP [FG1]*

The speaker in the above example tested out the idea of collaboration as both a mutually rewarding concept. There is already a large body of literature about the use of interrogative tag questions such as *"isn't it"* which suggests that they are associated with discursive change (Ehrlich & Freed, 2010). Tag interrogatives are suggested to be associated with expressions of preference and power dynamics as speakers favour

aspects of discourse and invite interlocutors to concur or accept an identity feature into the discourse under construction (Speer, 2010).

In summary, the Core Therapists' expertise discourse contains the assumptions that "if someone has a long-term condition they will be extremely challenging to treat" / "if I try to treat such a group then the treatment will be unsuccessful or harmful to them." This assumption evokes an action orientation to 'other' LTC/MUS work and position the treatment of this client group firmly within the Integrated Therapists' remit. Core Therapists foreground a lack of skill or knowledge for working with this client group, yet they are able to access competency beliefs when working with clinical problems. The next section considers how the Integrated Pathway has shaped the perception of expertise for Integrated Therapists.

4.2.2 Integrated Therapists

The discourse of Integrated Therapists contains the idea of therapists as skilled professionals with a niche set of skills for working with clients with long-term conditions. During this sub-section there are two key points the analysis of the data should point the reader towards. The first is that Integrated Therapists are beginning to blend their CBT lexicon with medical vocabulary, which is believed to show that therapists are creating a niche professional identity. The second point concerns how the Integrated Therapists conceptualise complexity. These two notions should be considered together as it appears that perceptions of complexity can influence Integrated Therapists in terms of their access to competency beliefs.

Firstly, it was notable that Integrated Therapists are beginning to use language in a novel way. They began to blend their CBT knowledge with knowledge of long-term health conditions. The data were searched for any occasions in which therapists either formulated clients' difficulties and the extent to which they used or avoided medical language. Use of blended medical language was most noticeable when Integrated Therapists discussed the vignette. In the group discussion before the vignette was introduced Integrated Therapists expressed greater uncertainty and minimised the competence to others. A particularly good example of an Integrated Therapist juxtaposing LTC/MUS knowledge with CBT concepts can be seen in the following extract:

> *"If we're thinking about it from a psychological perspective I'd be thinking, you know, we've got a longstanding condition since childhood, it's a condition which has been exacerbated recently and that's triggering off some rules for living which are "I must not let others down," potentially and some difficulties then with how he can manage his diabetes a bit later on. So I'd be thinking if he were to come with us we could do work with him alongs- with- on some of those ways of managing his diabetes and some of the cognitions that come up for him in order to feel better able to then cope and have that nice virtuous feedback loop really of being able to recognise what he's thinking in order to change what he's doing" - Integrated HI [FG3]*

Integrated Therapists interwove psychological conceptualisations of emotional states with their knowledge of LTC/MUS, such as in the following example:

> *"A lot of it was just listening. A lot of it was the listening and I think there's a huge amount of sh- you know, shame and you now when you say a lot of that stuff goes back to early trauma I think that people have to- it- there's a lot of shame in there isn't there"*
> *– Integrated Therapist [FG5]*

In Beck's (1979) Cognitive Therapy for Depression it is common for CBT Therapists to explore cognitive factors which contributed to, and maintain their clients' depression. Commonly clients with Major Depressive Disorder hold negative schemas about themselves such as "I am not good enough" or similar beliefs related to worthlessness or lovability. Cognitive Theory argues that the individual with depression utilises rules for living, sometimes referred to as dysfunctional assumptions, to protect themselves from exposing such core beliefs. Integrated HI Therapists tended to apply this perspective when formulating clients' difficulties, adding their knowledge of LTC/MUS conditions and their understanding of adjustment into ill health. In the following example, this effect is particularly notable in response to the vignette:

> *"[indistinct] quite rule-driven does it, as a typical kind of long-term condition patient. You know um he's saying (.) he's almost saying "my um (.) my blood sugar levels should be" you know "I should be" you can almost feel it there you know. But it it would be a very- a very straight forward [laughs] long-term conditions patient"*
> *– Integrated HI [FG2]*

The ability to interweave psychological and medical conceptualisations of clients' difficulties appears present even when not overtly stated. Integrated Therapists expressed a greater understanding of clients' difficulties through their experiencing and having *"had the training:"*

> *"That bit of knowledge to improve some of the things that you can do because you sort of understand what that means to that person, that illness, that long-term condition, so you can ask the right questions…that I wouldn't have had any idea about before joining the Long-Term Health Condition Team." - Integrated PWP [FG2]*

The data were subsequently searched for how Integrated Therapists convey their current understanding, and what they felt they now understood better. Alongside viewing clients' difficulties in a new light, Integrated Therapists also spoke of gaining skills to collaborate effectively:

> *"…you know um and understand what it [collaboration] really is and what it isn't I think because .hh um in- if you were looking at it in CBT terms we talk about collaboration as partnership. An equal partnership." – Integrated HI [FG2]*

Their ability to collaborate more effectively, it seems, came from a greater knowledge of other teams and how they could contribute something novel to enhance the client's care:

"I think. for me more understanding of what each other's roles are and what you do and what you can offer? I think most most of it in my mind is because- it's having the time and ability to have conversations to learn.about.the other systems…[it's] that being able to have the conversations and understand other people's roles a bit more↑ because I think outside of your own little (.) bubble [laughs]" – Integrated PWP [FG2]

Through the expertise discourse, Integrated Therapists appear to be using language in a novel way and are constructing an identity that differentiates themselves from their colleagues. An Integrated Therapist in FG5 stated that adapting CBT for LTC/MUS is *"quite skilled work."* Those who had previously worked in Core IAPT services also sought to differentiate their current identity from their previous incarnation. The corpora were then searched for the associated action orientation. In other words, what behaviours, actions or values do Integrated Therapists evoke through this discourse to differentiate themselves or mark themselves out as unique, and how they use discourse resources to delineate themselves from their colleagues. When comparing themselves to a nursing friend who had assumed a patient was not depressed because they did not visibly appear so, an Integrated PWP reflected:

""This is depression, this is what it looks like, this what you do for it" but they're not really taught how to have those conversations around it.' [recounts the story of nursing friend] 'because

> *obviously for us it's just natural, we're trained in it, that's what we do." - Integrated PWP [FG1]*

Integrated Therapists acknowledged their contribution to the client's treatment but even when recounting particularly successful outcomes for their patients an Integrated HI was reluctant to accept complete credit for the client's recovery, instead emphasising collaboration as an influential factor in good outcomes. In this way, the therapist appears to be aware that others are likely to view their outcomes in a favourable manner, yet their expertise derives from an ability to collaborate effectively. Thus collaboration and expertise are connected:

> *"I did an audit and we have some brilliant outcomes for CBT for our patients with CFS, really really good ones and seeing as I'm like the only therapist that does CFS I was like [brushes shoulders] 'Thank you' [laughs] um but actually that's not really a reflection on me and how effective- it's a reflection on if you've got good collaboration with your colleagues in the CFS team then they know what you can do and they know what patients are likely to be suitable." - Integrated HI [FG3]*

A direct comparison was made between Core and Integrated Therapists in terms of how they experience their clients and clinical work. In the following extract, the speaker draws upon the "greater understanding of LTC" code to differentiate their emotional reaction to challenging clinical cases:

> *"I don't mean to be directly opposing to what [Integrated PWP] was saying but when we were introduced to the long-term health conditions [team] it was due to the complexity of the patient group that we had more time generally because obviously they are very intense aren't they [laughs], quite an intense group of people, or <u>can</u> be. So these are the people that would have been on the Core Team that people would have gone 'uhh' [drops head] you know but <u>now</u> we're learning to work with them better." - Integrated HI [FG2]*

This leads to second point that should be make in this sub-section, which is that of complexity. In the extract above speaker used two adjectives, *"complex"* and *"intense"* to qualify their client group. The term *"intense"* conveys strong connotations of negative emotion and was used only once in the corpora. The term *"complex"* however recurred often from all speakers to describe clients' difficulties, the healthcare system and collaboration. *"Complex"* is a more neutral term borrowed intertextually from clinical parlance and could therefore be a more acceptable, euphemistic means of conveying the emotional connotations of *"intense."* In this section, of particular interest is how Integrated Therapists describe their reaction to clients' difficulties and their work in terms of how they connect complexity with competence:

> *"Expertise is making sense of complex problems" – Integrated PWP [FG1]*

Prior research has found that emotional suppression / expression in high performing teams can be linked with efficacy and decision making for example in the context of individual London City investment traders (Fenton-O'Creevy et al., 2011). Although Fenton-O'Creevy and colleagues recognise that investors tend to pride themselves on rational, goal-directed cognition, there is suggestion that emotional expression plays a central role in team identity and team performance (O'Boyle et al., 2011). Troth and colleagues (2012) key paper extended previous studies which had explored emotion and team members on the individual level by exploring the emotional skills of teams at the point of team formation / transformation. They found there to be a significant interaction between team-level emotion, but not such a strong link at the level of the individual.

The conflation of expertise with problem-solving is reminiscent of Tindall and colleagues' definition of "expertise of clinicians, those with lived experiences of services (both consumers and carers) and provocateurs (curious questioners) to understand a "problem" and develop innovative strategies to address it" (Tindall et al., 2021, pp. 1693). In the corpora, speakers viewed working with complex difficulties as an essential function of their professional identity which differentiated them from other psychological therapies:

> *"When we were introduced to the long-term health conditions [team], it was due to the complexity of the patient group" – Integrated HI [FG2]*

Integrated Therapists position their colleagues as aware of their expertise:

> *"In my experience it's slightly different because being in [the Integrated Team] we are potentially specialising in long-term health conditions…our managers/supervisors are really advised to definitely get in touch, definitely get into collaboration…and we also have quite a lot of physical health professionals who are very keen to help and come to help with our Clinical Skills practices we have….which also gives us more confidence to ask and that would promote that collaboration" - Integrated PWP responding to Core Trainee HI talking about therapists receiving mixed messages from colleagues [FG4]*

In the above extract the speaker positions Integrated Therapist as holding an esteemed position in the eyes of their colleagues and managers. The image of expertise is therefore a key socio-political factor in the team's identity, more will be discussed about this in the next chapter. The emphatic use of *"<u>really</u> advised…"* and *"<u>definitely</u> get in touch"* and verb choice to *"promote"* collaboration intensify the visibility of expertise to others which is perceived to be met with enthusiasm. The adverb choice that others *"keenly come"* to meetings and support staff development painted the Integrated Team as desirable to others external from their own culture. Qualifying the utterance with *"potentially specialising in long-term conditions"* however stops short of claiming expertise in absolute terms, but perhaps reflects the intended external image Integrated Therapists wish to portray to the audience who in this case are from Core Team and physical health colleagues. However conceptualising their work in this manner often led to expressions of doubt in their competence:

> *"Very often I will find myself listening to diagnoses which I'd never heard before. They're very complex, they're very unusual and I feel out of my depth" - Integrated PWP [FG4].*

In this way, the complexity repertoire is both a central aspect of professional identity but also a potential threat to competence beliefs. The data were reviewed for instances in which participants spoke of complexity or expressed negative emotions to explore how Integrated Therapists seek to resolve the cognitive dissonance. In the following extract an Integrated PWP resisted competency beliefs in LTC/MUS in response to the vignette. To provide some context for the utterance, Cognitive Theory of Panic Disorder (Clark, 1986; Clark, 1996) suggests that panic attacks are triggered when people catastrophically misinterpret somatic sensations as a sign of impending disaster such as fainting, insanity or even death. As part of Cognitive Behaviour Therapy, the client and therapist work together to test out a less threatening explanation for their experience and ultimately stop using safety-seeking behaviours (Clark & Salkovskis, 2009) such as avoidance or carrying items such as water which were designed to reduce distress:

> *"Maybe it would be a good idea to just have a conversation with the Diabetic Nurse because this is out of my knowledge, 'I'm not a physical health professional and I would like to make sure that you're safe." - Integrated PWP [FG4]*

In the extract above, the complexity repertoire appears to reduce the speaker's confidence to trust the psychological explanation for the client's experience and

therefore they perceive dropping safety-behaviours as more dangerous to the client. An alternative resolution to the challenge to identity was to minimise the level of complexity. The speaker in the following extract reframes complexity in a demystifying manner and utilises the pronoun *"we"* to include all IAPT therapists, further emphasised by naming a Core HI:

> *"…having that space and actually even the most complex people- that's what I was thinking! So I know it <u>seems</u> complex [Core HI] compared to, say, what we would ordinarily do in [a Core Team], you know, there's all these additional things, but actually if you listen to- listen to a lot of it people can resolve their own problems <u>too</u>. Just by giving them space and they say it out loud that you- you <u>do</u> find a way through it." - Integrated HI [FG5]*

Lastly in this section, the findings from the analysis will be discussed with consideration of current psycholinguistic research. The choice and fluctuation of pronouns is a useful place to begin as this illustrates an identity in transition. Pronoun selection is a lexical device denoting power dynamics. Their use can be considered as a means of a speaker positioning their identity construction either in solidarity with, or holding power over others (Brown & Gilman, 2012). Bucholtz and Hall (2005) argue that it is not necessary for speakers adopting a new social identity to be fully consistent with one speech community or another. Rather it is enough, Bucholtz and Hall suggest, to associate oneself with desirable attributes of the identity under construction (adequation) using narrative devices to illustrate ways in which they are similar and suppress signals of difference (distinction).

In order to earn the esteemed position Integrated Therapists have been afforded by their peers it is necessary to speak in a way conducive to that speech community (Gordon & Luke, 2015). Formulating a client's difficulties aloud as the participants engaged in around the vignette can be a useful means of Integrated Therapists testing out their acquired knowledge of LTC/MUS (Antaki et al., 2005). In the analysis Integrated Therapists were beginning to test out interweaving medical and psychological concepts into their formulations, however they often invoked the "too complex" and "not knowledgeable enough" discourses to minimise their expertise to others. There are a number of explanations for this, all of which point to identity transition. Complexity is used in a seemingly euphemistic way to portray either insufficient skill or knowledge, or when the therapist experiences a negative emotion when working with their client group. Using a socially acceptable term which most listeners in their shared field will recognise can be a 'less direct means of instantiating identities' (Bucholz & Hall, 2005, pp. 594).

Gordon and Luke (2015) argue that becoming an expert involves meaningfully connecting with new concepts which can often be challenging, thus speakers often downplay epistemic differences with others which can reduce power imbalance and the risk of exposing doubts. This concept is familiar from previous research in which lexical devices used to minimise expertise such as *"potentially specialising"* and discourse markers denoting uncertainty such as *"maybe"* seek to appear more ordinary such that 'the dilemma between authority and equality is encoded in the discourse of the expert' (Dyer & Keller-Cohen, 2000, pp. 298). The following extract includes several discursive devices to this effect. The speaker places emphasis on

uncertainty terms such as *"imagine"* and *"no idea."* They use upward inflection and laughter which can be interrogative (Freed & Ehrlich, 2010) and defer expertise to others by insinuating that their questions might *"feel silly:"*

> *"It just works so well being able to have those conversations and the physios being confident that what they were doing was the <u>right</u> way of helping the person to manage the anxiety and it it just- it was just a <u>lovely.piece.of work</u> (.) and things and um for everybody I think involved because we- you know we could ask each other questions and I could ask about sort of like the physical limitations and and abilities and I think just that- that to me is 'collaboration' and things when we can do something like that for the patient and everybody knows which bit they're doing um and things then I would <u>imagine</u> that that's a bit like an MDT team [laughs] where everyone knows what bit they're up to but they also have a bit of an understanding of what the other people are doing as well↑, and why and things so it's- sort of it's a joint- and yeah and it just.felt.so.good being able to do something like that for.somebody but that.only.can.occur if like the people we ring answer the phone and things like that because they're so busy and stuff and we me- we end up being able to have that conversation which doesn't always occur, and things like that and also I suppose feeling open- be able to ask be able to ask questions that feel silly↑. I've rung Respiratory before and said you know "this person's really struggling in the shower, you know*

> *is there anything sort of you know we can look at for Behavioural Activation-wise that's going to aid this person with their COPD?" and things and- because I'm not medical, I've got no idea with some of that stuff" – Integrated PWP [FG2]*

4.2.3 Physical Health Professionals

Physical health professionals drew on their ability to think psychologically about their clients' difficulties and to work in collaboration with IAPT therapists. As illustrated in the two subsequent extracts, the impetus to engage with psychological concepts derived from a desire on the individual level to better understand their patients holistically and to be more clinically effective:

> *"We've made quite a big effort, particularly gastro over the last couple of years to really try to embrace [integrated working] for the benefit of the patient but also for us in terms of how we explain things to patients." – IBS/Gastroenterology Dietician [FG3]*

> *"I think reassuring people that you're not going to know everything. You can't know everything. It's about having those conversations, honest open conversations and knowing where to refer to or signpost. So I think the education part of my role is: I'm trying to give them some knowledge but they don't need to know everything about what I'm telling them, they just need to know who to refer to." - Midwife [FG1]*

The transcripts were reviewed to explore how physical health professionals described their acquisition of skills to work with comorbid presentations. Most speakers felt this was personally driven, such as the speaker above who had made *"quite a big effort"* to upskill. A minority recounted formal pedagogical routes of skill development in a top-down structure:

> *"All our physical therapists like OTs, physios have done ACT courses or compassion, courses or CBT courses, you know, uni level study in psychological approaches but they're not Psychological Therapists but they're definitely psychologically informed" – Physiotherapist [FG4]*

As a result of engaging with their clients' psychological needs and integrating care in collaboration with therapists, physical health professionals position themselves as a useful partner to therapists and effective for their patients individually although they too invoked the "complexity" discourse describe the comorbid client group:

> *"We have generic skills, so that saves doubling up on someone else going out, but then we have unique skills." – IBS/Gastroenterology Dietician [FG3]*

Interestingly, however, despite their personal enthusiasm many health professionals did not think psychological skills were prioritised by their departments or sufficiently by individuals:

> *"From more a traditional route…probably psychological interventions probably haven't historically been given as much credit as they probably could be." – IBS/Gastroenterology Dietician [FG3]*

It was suggested that mental health can be a taboo topic in physical health, as implied by the hushed tone in which the connection between psychological and physical factors is recounted in the following extract:

> *"It has been quite a big learning curve for us as clinicians to learn how to explain this to patients and how to explain the whole mind/body link…Sometimes clinicians aren't well versed in things like the [lowers voice] *Mind/Body link* and things like that when they're not so workwell versed in it then patients can have that explained to them and they can <u>hear</u> that the clinician is saying "you're crazy and this is all in your head.'" - IBS/Gastroenterology Dietician [FG3]*

Thinking psychologically about clients' problems is thus portrayed as potentially beneficial to both the clinician and client, yet either not prioritised or not a core part of physical healthcare. An outlier was an Occupational Therapists who positions herself in the centre of the physical / psychological health continuum:

> *"Definitely. I think Occupational Therapists come as a- we're a little bit unique. So we're mental health and physical health trained↑ I don't know if there any other professions that are trained in both↑ um so I think we're coming from a different perspective cos I was quite shocked um for a couple of years we've done talks to physio- first year physio students at [names university] and yeah absolutely shocking that they don't really do a lot of mental health which you think "well surely you need to understand that before you: work with someone because you need to know why they aren't doing their exercising" you know "what else is going on in their life as to why they're not particularly um not doing what they're told or meant to do?" so that's sort of shocked me a little bit um yeah so I think we're coming from a different perspective (.) as well." – Occupational Therapist [FG2]*

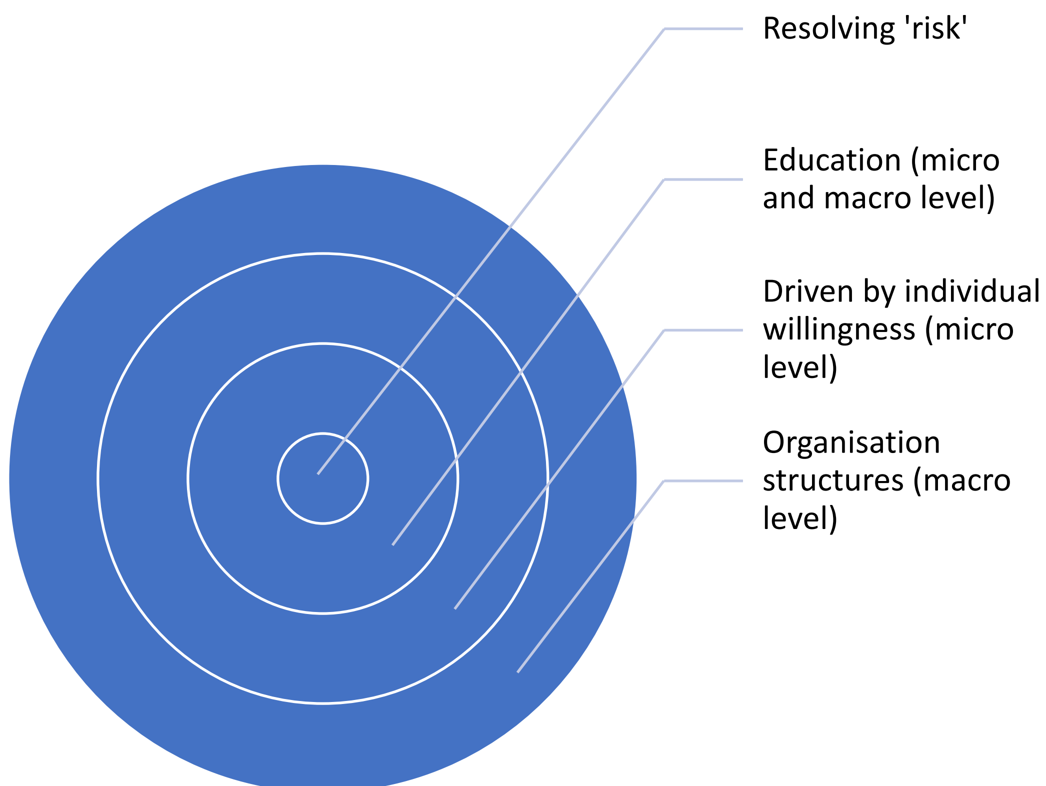
4.3 Expertise as perceived by other professional groups

Thus far, the expertise Big D discourse has been explored with regards to individual professional groups. The following sections will explore how expertise is related to professional identity through the lens of three discourses coded as: 1) Expertise as associated with uncertainty, 2) Collaboration as a risk, and 3) Associated with organisational and pedagogical factors. In short, these three discourses interact within the expertise Big D discourse as uncertainty appears to fuel therapist doubt to use their expertise meaning they perceive collaboration as posing a greater risk (see Figure 9). In some instances, speakers resolve this dilemma by requesting more training / education, although other speakers felt this would be either insufficient or,

interestingly, not desired. Lastly, the NHS system in which therapists operate was positioned as a less hospitable environment for effective use of expertise in collaboration. Conflicts can arise through the perceptions of others, neatly encapsulated in the title of an article regarding marginalisation felt by American young person counsellors: ‘if we don’t define our roles, someone else will’ (Havlik et al., 2019). These three discourses will be discussed in turn in the following subsections.

Figure 9

Overview of Professional Identity Repair Discourse and Code Shift Themes



4.3.1 Repertoire: Uncertainty (identities)

The repertoire of uncertainty emerged throughout the expertise Big D discourse. In this discourse, speakers drew attention to perceived gaps in knowledge, or instances in which they felt insufficiently resourced to treat mental health needs framed as complex:

> *"I think we mentioned you know sometimes you look at it and go "well they- they do need that safety behaviour to an extent" but my training tells me not to use safety behaviours so it's kind of having that understanding that if there is physical health there- the way.you.provide that mental health support is differ- a little bit different. The principles are the same but you apply it according to them um and also be open with them that you might be the mental health expert but they're going to be the expert in their own physical health and know how they (.) feel? um sort of being open to having that discussion "I'm really sorry, I've never heard of that physical health condition before. Can you tell me more about (.) that and how it affects you please?" I think they appreciate a little bit rather than if you just toddle into the room being like "and yes so based on what you've said we're going to do- we've got no understanding of what's wrong with you but I'm sure this will work anyway." Just making sure they feel listened to (3)" – Integrated PWP [FG1]*

In the above extract the Integrated Therapists adopts a *"mental health expert"* stance, yet this is inhibited when the client's problem is viewed as complex or insufficiently understood. In such cases the Integrated Therapist minimises their expertise by choosing verbs such as *"toddle"* which contain connotations of almost childlike lack of experience. The data were searched for how people spoke about clinical uncertainties they had resolved and what they propose they need in the future in order to feel more confident to use their skills. Education was introduced as a means of mitigating clinical risks or doubts and this was dominant throughout each focus group. The most frequent use of this discourse was to frame education as the solution to perceived gaps in knowledge, thereby increasing confidence and reducing the risk of adverse treatment events through therapist fault or oversight:

> *"I definitely think there are barriers. Um (.) I- I I (.) don't think we get enough education about it in the training and I think that's probably across the board across lots of different people that are clinicians hh in terms of how the- how the two (.) approaches could be um better joined up. It's not- like I certainly know that in my training as a Dietician it really wasn't something that got talked about enough we talked- we kind of touched on psychological a little bit in terms of the approach to CBT and what it is but what we didn't touch on so much is how your mental health and your physical health can be so deeply connected?" – IBS / Gastroenterology Dietician [FG3]*

In an instance of conflict in FG2 an Occupational Therapist defends her expertise introducing into the discourse the idea that training enhances interpersonal networks and respect:

> *"So I think we need to think about respecting each other's roles and not thinking "oh I can do that" you know "I've read a book on it I can do it" people are <u>trained</u> aren't they to do this so I think that's.when.it.falls.down- collaboration falls down when people don't respect other people" – Occupational Therapist [FG2]*

Interestingly, however, there is a significant minority voice which appeared in two focus groups in which education is conceptualised as neither sufficient nor always desirable. Although an overt discussion in this way was not typical, it is considered important to note possible outlying voices or those who speak most directly. For example, an OPMH Nurse describes that training in unfamiliar long-term conditions or psychological disorders is:

> *"Not an area of knowledge that I'd want to grab hold of. I very much only try and get that knowledge or access that knowledge when it is <u>particularly relevant</u> to the here-and-now problem I'm trying to* resolve…*If I was offered a training update on physical health care or, you know, choose any aspect of physical health care, I would probably turn it down." - OPMH Nurse [FG4]*

Confidence in this discourse can be tested by exploring grammatical structures and lexical choice, including how the conversation around the discourse is received by others. The discourse receives verbal and non-verbal agreement, and appears in FG3 where the IBS/Gastroenterological Dietician described:

> "*You get sucked into a particular line of work unless you get given specific opportunities to open your mind a little bit to what else could be going on with your patient and I think it could be quite hard to be pushed to learn a little more about it." - IBS/Gastroenterological Dietician [FG3]*

The way in which the findings relate to psycholinguistic theory will now be considered in light of the emerging discourse. Salkovskis and colleagues (2016) write of the uncertainties which therapists may experience when working with long-term conditions and medically unexplained symptoms. The term 'medically unexplained symptoms' itself places importance on the unknowns which may fuel therapist doubt including worry that they will miss something vitally important or neglect to treat or refer a client in the most appropriate manner. The authors suggest the cognitive model of anxiety and depression can be applied alongside assessment-based formulation within the Transdiagnostic Model for MUS. This approach, they conclude, allows therapists to maximise treatment gains without unnecessary focus on education as a solution. Rather, they locate the resolution to risk within the therapeutic relationship and collaborative empiricism. The rule of thumb, they suggest, is to ask oneself "if this was a non-anxious twin, what would I do?" and consider the psychological and physical aspects of the client's presentation holistically.

Enhancing skill by pedagogical means was evoked to resolve uncertainty in many focus groups. However, that does not appear to fit for all focus groups as the OPMH Nurse overtly stated that he would likely not accept training unless it was targeted for relevance to his current clinical work. The verb choice of being *'sucked'* and *'pushed'* into training convey a sense of reluctance, likewise the agentless passive construction is chosen *("you get given specific opportunities"*) suggesting that the individual may not proactively seek the opportunities and the provider of the opportunity is omitted (Dreyfus, 2017). Linguistic research into verb choice and causality has a general consensus from subject-object causality, but this is less clear when verbs are more abstract or passive constructions are adopted (Greene & McKoon, 1995). Green and McKoon (1995) compare the verbs *"to admire"* and *"to annoy*" in their study when they are used in subject-object interactions. They write "when one hears that John annoys Mary, one normally assumes that the cause of the annoyance is some property or action of John's...[but] when one learns that Bill admires Nancy, one normally assumes that the reason for admiration is to be found in some property of Nancy's" (pp. 262). In most cases of spontaneous speech, important aspects can be omitted or contracted without interfering with meaning which is most often employed when the meaning is assumed to be obvious and shared by all speakers (Karmiloff & Karmiloff-Smith, 2001, chapter 6). In this way, Tomasello (2003, chapter 6) argues that verb phrases can be "listener based, as the speaker takes into account the listener's knowledge, expectations, and perspectives in formulating the utterance" (pp. 197).

4.3.2 Repertoire: Risk and Collaboration (relationships)

A second repair repertoire resolves the risks of collaboration with a discursive construction which was coded as "collaboration as needing to be driven by individuals." This repertoire located responsibility to collaborate as being:

> *"Down to individuals within those teams being interested in it [rather] than the wider system" – Physiotherapist [FG4]*

Those who actively engage with collaboration are conceptualised, with emphasis, as:

> *"Very <u>committed</u> member[s] of staff [who] …actually got a good outcome out of it (collaboration) notwithstanding the fact that the team was not collaborating." - OPMH Nurse [FG4]*

The speaker continues by recounting a story of a well-established multi-disciplinary team which was less effective and occurred less frequently due to individual's not prioritising it: *"…nobody's kind of engaging in it and it keeps getting cancelled."* In the following interaction in FG4, the OPMH Nurse developed this repertoire by comparing two such teams, one perceived as effective and the other not:

> *OPMH Nurse: "…I don't really understand why [the problem with collaboration] is happening because one is [working well] and one isn't, and then in the third one it's happening and people are engaging…so it's kind of interesting to me that there's that big difference in what essentially is the same format for collaborative working, and in two of them includes quite a lot of the same people but it's still coming up with different outcomes.*

Integrated PWP: What do you think could be the reason for it? Would that be something from the service level or personal level?

OPMH Nurse: I think the one that's kind of almost not working is, to my mind, it seems to be something as simple as how frequently the meetings occurred. The frequency of it doesn't seem to me to be frequent enough that people are using another route to address the problem or get the client's needs met … the one that's working better, nearly all the pieces of work that the OPMH team is picking up from it are substantial genuine pieces of work that we can get on and do some benefit to the client with, with the other one we're picking up quite a few bits of work where we're making contact and then we're finding "oh actually no-one wants us to do anything here,' it's just kind of like a pass-the-parcel game."

The speaker locates willingness in whether outcomes and the process are considered professionally satisfying and of benefit to patient care. The discursive construction coded in the analysis as "collaboration as associated with caring" occurred briefly in most interactions. Considering that all participants were from helping professions it would make sense that they would place value on caring and for it to be socially acceptable in the context to be articulating the caring element to collaboration. The interaction above, however, illustrates that caring and satisfaction are considered to directly influence motivation and willingness to initiate and engage with collaboration.

In the literature, the link between motivation to engage in collaborative case conceptualisation and professional identity has received little scrutiny. It has been

argued that individual choice to engage in a teaching practice from the outset of a career influences the extent to which the new behaviour / schema is incorporated into the developing professional identity (Nolen et al., 2012). It is possible that this is also the case for other significant milestones in professional identity transition. For Nolen and colleagues, beginning a career in a profession (such as teaching in their study) professional identity is influenced by peers as “they are figuring imagined worlds that are populated by particular meanings and people and tools” (Nolen et al., 2012, pp. 269). A series of three studies conducted in the UK with private sector business and with police staff was one of the first to explore the relationship of optimism and hope when adapting to service transformation (Strauss et al., 2015). The study found consistently that optimism was not strongly related to adaptability, whilst the factor of hope was consistently related. The study recommends for organisations to develop hope during service transformation through mentoring and training. This is consistent with the value placed on pedagogical sources of development for speakers, but the role of peers may also be an important factor.

It was noted earlier that Integrated Therapists feel quite aware that they hold an esteemed position in the eyes of colleagues from other professional groups. Misunderstandings of others’ roles was a common conversation across each focus group and for each professional group, and tended to align with emotions of either annoyance or risk. The risks of being held in esteem were discussed by the Integrated Team using a narrative, in the following extract the Integrated PWP is talking about a patient who had *“quite complex needs physically”* (note the discussion earlier about the use of *“complex”* as a qualifying term), and who was open to multiple teams who were trying to locate the most suitable service to meet their needs, the referrers were:

"…convinced we had done more work than we had been, when all we'd done was an assessment but he said we were doing loads of great therapy – which we hadn't!" – Integrated PWP [FG1]

The suggestion appears to be that others defer to Integrated Therapists' perceived expertise which they somewhat reject. However, it is notable that the conversation took place in group context with people speakers did not know. Speer (2012) suggests that in such settings it is less conventional to praise one's own work or characteristic. She argues that self-praise can be construed as an unfavourable trait, and that there is a norm towards self-deprecation and modesty which is remedied through intertextual use and third-party complements which she suggests encourages listeners to be more willing to accept the praiseworthy characteristic.

Some misunderstandings are afforded less significance:

''The most glaring example to me is dementia diagnosis where GPs referring people who've maybe got lots of other things going on as well and the GP will say 'they've got dementia but I want you to give them a formal diagnosis.' It's one of my bug bears, sorry for mentioning it really" - OPMH Nurse [FG4].

The apology for bringing the topic into the discussion suggests the speaker disconnects this experience with the discourse on misunderstandings. However,

misunderstandings can create conflict, which was notable in the second focus group between an Integrated PWP and OT. When discussing the vignette, an Integrated PWP discusses the case and infers the patient's interaction with physical health professionals:

> *"I've had a lot that yeah that will go through- they'll be really good when they're: (.) really young and their parents are controlling it, then they'll go through a time where they just don't care and they'll ignore it and pretend it doesn't exist and (.) maybe about thirty they'll be thinking about the long-term difficulties they're going to get when they're Type I Diabetic [OT: yeah=] that= are really <u>nasty</u> and sometimes I think (.) I have heard that Diabetic Nurses have spelled that out quite harshly to some patients which has then impacted on their mental health and things= [OT: Mmm hmm=] yeah sometimes I think maybe- and again this is obviously individual rather than generic that (.) maybe that they can be quite harsh in medical side of things sometimes= [OT: Yeah=] um and not take into account that what they're saying- the impact on the mental health that that would have" - Integrated PWP [FG2]*

4.3.3 Repertoire: Organisational Factors (politics)

A third repair repertoire emerged related to organisational structural, procedural and policy factors. This repertoire conveyed the idea that even if individuals were willing to collaborate, organisational structures would either pose a hinderance through inflexibility or actively be inhospitable environments for effective collaboration.

Throughout the fifth focus group, the word ‘remit’ was used by most speakers, which had not been the case in previous groups. A search of how the word was used and by whom was used to develop a picture of the repertoire. A Core Therapist in FG5 felt that there is *“no specific LTC remit”* which she later repeats when recounting a story of a client who had expected her to know in great detail the functions of a wide range of different services, concluding that she felt under-skilled because when she:

> *“…used to work in GP surgeries at least I could have that stuff that I could create, but there’s no structure for it within our team because there’s no official remit.” – Core HI [FG5]*

The term “official” conveys ideas of permission being required from services to collaborate and benefit from skills and expertise of colleagues. Comparing this to Integrated Therapists’ sense of “remit,” an Integrated HI shifts from the Core Therapist’s problem-solving position, to a collaboration and team-working position:

> *“One of our remits is to try to work towards greater collaboration in physical health settings as part of the [the Integrated Team’s] brief.” - Integrated HI [FG5]*

Physical health professionals, such as the Physiotherapist in this interaction, were able to maintain their sense of personal efficacy and skill by framing their remit as only factors directly within the main function of their role:

> *"For me often what's really helpful is really having a sense of "so what skills is that person going away with at the end of your session" and "what are they using on a regular basis" and "how can I, within my remit, cue them to use that?" and to use the same language so that we don't have that ambiguity." – Physiotherapist [FG4]*

The chronic care model in primary care advocates for interprofessional working in order to improve the psychological wellbeing of people who are adapting to living with long-term conditions. The findings from the analysis are consistent with a Thematic Analysis of thirteen articles regarding the application of the chronic care model for clients with depression and long-term conditions between 2005-2011 which found that services and clients were generally in agreement that the chronic care model was desirable but organisational factors and the ability of organisations to implement the model were common barriers (Holm & Severinsson, 2012). The authors identified that there was less success when case managers and staff were unclear about their roles and responsibilities and cite leadership and team working as key factors in initiating the change. This is also consistent with the aforementioned Identity-Based Theory of Transition (Hannan et al., 2007) which cites organisational infrastructure as a key process in the development of professional identity.

This chapter adds the relevance of dilemma resolution, conflict resolution and negotiation to previous findings, including figured hypothetical resolutions to implicit power imbalance and conflict which is a notable feature of Critical Discourse Analysis which distinguished it from other qualitative methodologies (Wetherell et al., 2003).

There is a particular instance in which a midwife with a long-term conditions special interest and a Core Senior PWP debate this topic, whilst the Integrated Therapists remain notably absent from the section of the encounter. The Core SPWP figures an *'ideal world'* in which professionals are:

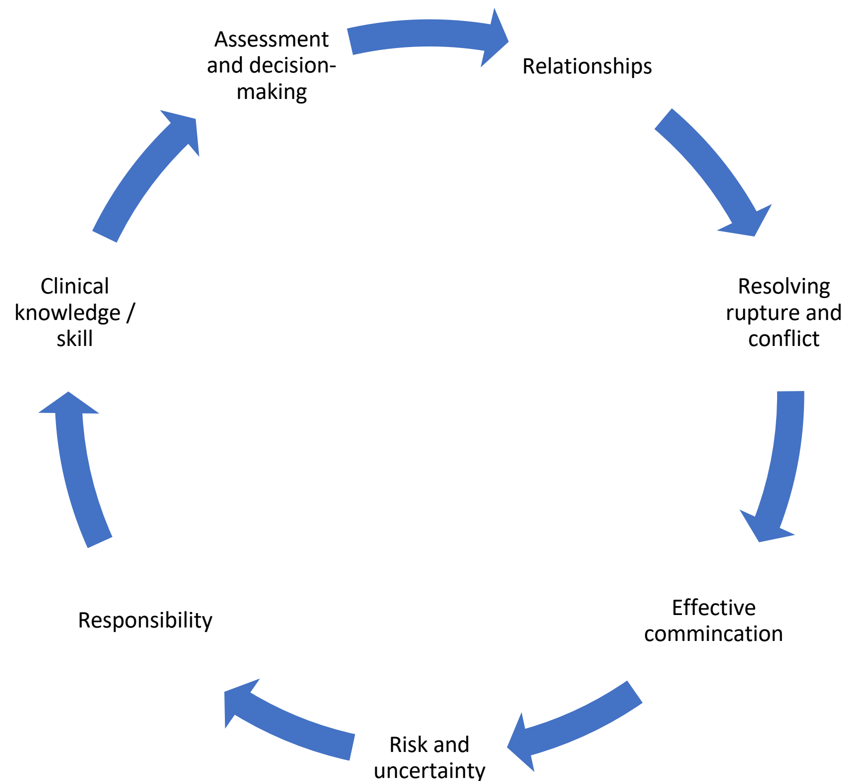
> *"…all able to sit in a room for somebody to only tell their story once I suppose, isn't it? [laughs]. I don't know." – Core SPWP [FG1]*

However, the implication is that speakers do not necessarily believe this to be a sufficient explanation for the barrier in question. Considering the epistemic stance of the interrogative, the speaker seeks tentative confirmation that their assessment is correct from the group (Freed & Ehrlich, 2010), conveying an assumption about a possible cause (Heritage, 2010) yet inviting interlocutors to amend and develop the discourse.

Professional identity transition not only includes gaining expertise to enhance knowledge and skills, but that this is a relationship phenomenon. As noted by Hood and colleagues (2017), expertise has traditionally been researched as a quality on the level of the individual, overlooking the expertise of a professional network to interact and collaborate. The analysis has shown that professional relationship rupture and repair can shape the expertise discourse as diverse professionals engage in shaping their respective identities. The figure below graphically represents both individual and network traits associated with the expertise discourse:

Figure 10

Theory of Interprofessional Expertise, adapted from Hood et al. (2017)



The theory highlights that sharing expertise across teams (and professions) can be divided into the domains of "competence" and "understanding." Effective interprofessional utility of expertise then involves concrete domains related to skills, role responsibilities (Hassan et al., 2021) and location of the professional within the healthcare system, but also metacompetencies such as relationship and conflict management, and effective communication. Education and training foregrounded by many speakers is one means in which a profession marks itself out as unique alongside other professional groups (Bucholtz & Hall, 2005; Garman et al., 2006). Indeed, this has been shown in a study of suicide prevention in veteran populations in the US (Wittink et al., 2020) in which clear role boundaries and responsibilities

maximised the utility of those skills. In their study nurses were attributed the action orientation towards identifying markers which may increase the risk of suicide and behavioural professionals linked their expertise with thorough risk assessments.

4.4 Chapter Summary

This chapter has explored the discourse coded as "professional identity as associated with perceptions of expertise." Interprofessional collaborative working is likely to increase the range of clinical skills of the collective workforce involved in a client's care, and is considered an intentional and fundamental aspect of healthcare design (Markon et al., 2017.) The expertise chapter illustrated how Integrated Therapists were testing the values, attitudes and behaviours they wish to embody and how they communicate this to related professional groups. In order to achieve this, it is important that Integrated Team members develop a strong sense of their own self-conceptualisation. There are many theories from the world of business and authentic leadership which can be drawn upon such as models designed to help professionals identify and develop their own beliefs and attitudes, and how these relate to those of the organisation in which they work (Blanchard et al., 2007; Norcross & Cooper, 2021 Gardner et al., 2005, Walumbwa et al., 2008). Creative dilemma resolution is also a notable resource for resolution of cognitive dissonance and professional identity construction (Bowen, 2018) which was noticeable from the corpora as speakers sought to resolve and make sense of the vignette presented to them.

The key findings from the analysis of the expertise discourse that should be highlighted are that Integrated Therapists appear to be developing a novel blend of psychological and LTC/MUS-oriented language into their lexicon. They test this out through active

case formulation and in relation to their colleagues' positive perceptions of their expertise. The complexity discourse seems to inhibit expressions of expertise by sowing doubt which some seek to resolve through education. However, there were contrasting views about education as a solution. Some felt that education could be either de-skilling or irrelevant unless it was targeted for particular relevance. Thus, in order to meet the needs of the client in psychological professional practice, it is important to be aware of one's own 'scope' which is defined as the differentiation between what one is competently able to provide, and what one is willing to provide. Integration is "not about being a jack-of-all-trades, nor is it about becoming a chameleon who changes colors [sic] to whatever a patient requests. Rather, it is about offering flexibility within defined parameters – and, where necessary, being willing to refer patients elsewhere" (Norcross & Cooper, 2021, pp. 64). The next chapter therefore discusses the discourse of responsibility.

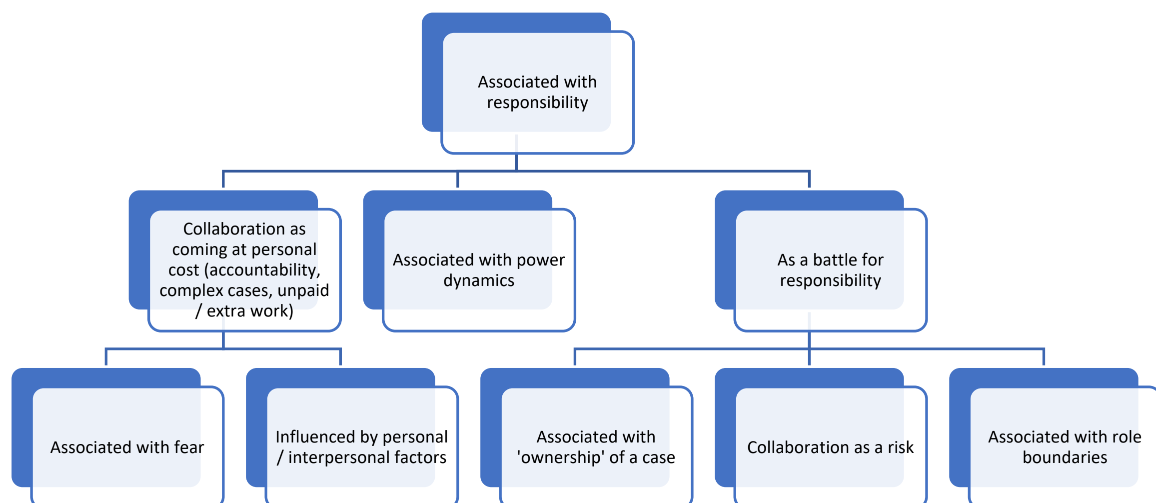
Chapter 5 – Responsibility: Battles or Orchestras?

Alongside expertise, a second Big D discourse made significant within the corpora was that of responsibility. This chapter will apply Gee's (2014b) CDA framework to examine what discursive, grammatical or lexical devices are utilised to highlight or minimise certain aspects of responsibility (significance), what practices are others encouraged to recognise (practices / activities) and how the speakers conceptualise themselves as professionals who embody certain characteristics or carries out certain kinds of responsibilities (identity). The chapter will also explore how speakers interact with one another around the concept of collaboration and responsibility (relationships and power dynamics), what is taken as the correct or acceptable way of integrating care (politics) and how links and concepts are interrelated by speakers (correlations). The focus will predominantly be placed on Integrated Therapists in line with the research question which includes how the discourse develops around them.

When integrating care for a patient with multiple healthcare needs, the concept of responsibility was considered integral to professional identity across all professions and all focus groups. Initially this was coded as *"associated with responsibility"* and was further subdivided into distinct discursive components as shown in the discourse map below:

Figure 11

Discourse Map for the Code "Associated with Responsibility"



This chapter will be subdivided utilising Gee's framework to explore the concept:

- 5.1 ownership of a case (significance)
- 5.2 -That's not my job (practices / activities)
- 5.3 Fear of getting it wrong (identities)
- 5.4 Relationships
- 5.4.1 – Personal issues in work (relationships)
- - 5.4.2 Respect (connections)
- - 5.4.3 "Advice" or "discussion" (sign systems and knowledge)

  5.5 What needs to be treated first (politics)
- 5.6 Chapter summary

5.1 – Significance: Ownership of a case

According to this discourse, speakers foregrounded the importance of ownership for an individual's care. Across all focus groups speakers placed responsibility for clinical management of a client's care, including sourcing suitable services and interventions, within the actions and tasks of the professional, whilst the client was positioned as a passive agent. This discourse co-occurred with code related to accountability and responsibility for decision-making such as treatment and suitable sign-posting. Three repertoires related to ownership emerged: 1) The professional / service with the greatest level of expertise should be most responsible, 2) Ownership of a case is governed by morality and ethics of the professional / service, and 3) Responsibility as associated with hierarchies.

When formulating the difficulties of those with LTC/MUS both Core IAPT Therapists and physical health professionals tended to defer to Integrated Therapists. Integrated Therapists often accepted overall clinical responsibility but attempted to resist this, and sought instead to collaborate with physical health colleagues whom they positioned in an advisory capacity. However, the hegemonic convention portrayed by many Integrated Therapists was that responsibility for a case was transferred to them not necessarily due to perceptions that they had greater expertise or even that it was the correct clinical pathway for the patient, but rather that the referring clinician was unsure how to proceed and was relieved to have found an onward route:

> *"It kind of feels like people with physical health just get passed to us and they're like "well we don't know what else to do, it's your turn now." Integrated PWP [FG1]*

As the discourse began to emerge, the data were searched for how the term "*refer**" was used, truncated to capture semantic variation. Most professions with the exception of the OT expressed the perception that the metaphorical buck stopped with their service when other services had exhausted their resources. An abbreviated extract from an earlier utterance illustrates this:

> *"The story would be: GP couldn't quite crack it. Complex pain syndrome, often. So they were referred to a general hospital which couldn't quite crack it so the poor patient is then said "well you're obviously very difficult and we must send you to a regional centre" so they would meet me" – Consultant [FG5]*

In both of the examples above the speakers utilised an agentless passive construction. The Integrated PWP foregrounds the action of responsibility *'getting passed'* but omitting by whom. By speaking in an abstract way about the doer of an action the Integrated Therapist as the recipient of the action is foregrounded (Dreyfus, 2017). This is similar for the Consultant who uses a passive construction in a similar manner (*"they were referred")* which suggests that the impact on the individual service or professional is seem as more important than the systemic implication. In other words, speakers positioned themselves as the end of the line and omitted any

discussion about to whom they might refer if they did not perceive their intervention as suitable for the client. This is shown in the following short interaction:

> *Integrated PWP: "…we had this MDT and then just realised that [a client] wasn't (.) suitable but we just kept trying to <u>go</u> because the case ↑wasn't joined up properly? so if that was a thing sooner or if it was clearer in referrals that had been made I think that would be helpful in joining everything (.) ↑<u>up</u> and getting that communication to improve?*
>
> *Core PWP: [nods] better communication (.) without.a doubt. I think. um easy communication pathways*
>
> *Midwife: that's what I was going to say. Yeah [Core SPWP laughs] very <u>clear</u> pathways" - [FG1]*

An OT in contrast does position themselves as a transitional part of the responsibility continuum. They positioned themselves as both the recipient of a referral with whom they applied their *"unique skills"* following which they referred onwards for further intervention:

> *"We can do (.) generic things so um we.don't want- if I go and see someone I mean and they need Inhaler Technique I don't want a nur- I don't want to say "oh I need to refer you to a nurse" because I can do the Inhaler Technique as well so we work- we*

> *have <u>generic</u> skills so that s-s-saves doubling up on someone else going out but then we have unique skills so um my team um we- we're brilliant because we know um (.) what each person's role is so we can refer correctly and we can always have that talk anyway. It's like "oh I've just gone- you know I've just come back from a lady I think she needs your input and X, Y and Z" and then you go "yeah that's fine, you know, send that referral it." – Occupational Therapist [FG2]*

A physiotherapist invokes the same discourse; however, they introduce the dichotomy between mental and physical health using the active voice in which the agent of the action is introduced. In the extract below *'mental health services'* (the agent) are positioned to pass clinical responsibility (action) *'to the Pain Service'* (recipient) leading to no action being taken (consequence):

> *"Mental health services will say "you're in too much pain, go to the Pain Service" and you just have this patient who's got pain and mental health stuck in the middle with us both being "the other person should be picking it up" and neither of us did…I thought then if we sat in a room together that we would be able to have more of a discussion about it, cos it's not black and white is it, there's a lot more subtlety to these things…if we all worked together on it I assumed that would just happen, it's interesting to hear that even when you are all in the room that might or may not happen." - Physiotherapist [FG4]*

When responding to the interview question about the interface between services engaging in collaborative care including barriers, speakers highlighted a number of procedural barriers, predominantly on the level of the organisation rather than the individual. In FG4 for example, a Physiotherapist and OPMH Nurse engaged in an extended discussion about barriers to effective integrated care. The Physiotherapist introduced gaps between services and teams which have overlapping remits as a possible barrier. They suggested that it can be difficult to identify which team carry clinical responsibility. The OPMH Nurse however introduced into the discourse the role of the individual, minimising organisational barriers. By deploying narrative examples from clinical practice an OPMH Nurse positions physical health colleagues as busy yet still capable of being collaborative because they see the benefit in the long-term of collaboration. If they perceive that collaboration will be effective they will be willing to tolerate uncertainties to work with clients or liaise with psychological colleagues:

> *"Some of the people who are managing to operate really well in these environments I know have got large work pressures but they are still able to respond, they're not just passing things along"*
>
> *- OPMH Nurse [FG4].*

An Integrated PWP then joined the discussion and posed an alternative explanation for this effect. They introduce the idea of *'accountability'* and *'consequence'* as relevant to this discourse:

> *"I guess it's about accountability? which comes into play. So whilst you are in the room and you keep passing the parcel despite the fact that potentially your team should have had to look into this and you keeping passing this, what- why- how- why is this happening? Is this person going to be accountable for this? What are the consequences of this? And also going further, what's the reason why they keep passing the parcel, because they're overwhelmed? Because they don't have time? Because their team are not providing them with something they need? [short laugh] which is quite- it could be possible with the NHS especially now with their massive case- massive kind of waiting list stuff, but I would just look a little bit deeper. What's happening there within their services and whether they have that protected time and space and, kind of, the management which can actually ensure that, because it could be on a personal level but it could also be on a service level that you are already overwhelmed and you know if you take something <u>additional</u> on you're going to end up doing overtime which nobody's going to pay you, you're already burnt out or very close to being burnt out, so just think about that, the accountability and also later on what could be wider reasons for this." - Integrated PWP [FG4]*

There are a number of interesting psycholinguistic points to raise about the evolution of this discourse from the extract above. The Integrated PWP names a number of risk

factors which they connect with the discourse. The problems, barriers and potential solutions speakers make significant can shed light on the interaction between professional identity and associated *networks of practices* (Wetherell et al., 2003). Rhetoric devices such as aborted sentences, laughter and upward inflection allow the speaker to test out a range of ideas within the speech community for acceptability (Freed & Ehrlich, 2010). Speakers initially referred to structural / procedural problems, and who holds clinical responsibility and the extent to which collaboration is prioritised by the NHS. However, the speaker foregrounded the concept of feeling 'overwhelmed' and *"burnout"* by minimising procedural factors (*"I would just look a little bit deeper"* and *"waiting list stuff"*) In this way, organisational factors are presented as hegemonic factors, axiomatically associated with responsibility which do not require further elaboration. It is assumed that all teams will have service-level challenges and that this is a historical contextual norm.

Burnout, defined as "the specific stressors with which we are currently battling are unparalleled regarding their energy-draining nature, intensity, and damaging long-term effects" (Schaffner, 2016, pp. 204) becomes conceptually linked with accountability in this discourse. This suggests that if the person does not have faith in collaborative working they utilise the "too busy / burnout" discourse.

5.2 That's not my job (practices / activities)

In order to explore why speakers felt responsibility was transferred in this manner the transcripts were reviewed through the lens of practices and activities. Gee's (2014b) activity building tool was utilised to analyse what practices were normalised and what

norms the listeners were invited to accept as being currently practiced. The analysis found the notion of role boundaries and distinction as a *leitmotif* throughout the corpora.

It was notable that when referring to practices and activities in collaboration with colleagues, speakers adopted first person quotations possibly to evoke a conceptualisation of the interaction within the listener, therefore for this section Gee's (2014b) Intertextuality Tool was further utilised to explore how quotations were utilised to say something about role boundary conventions and the nature of integration.

The findings were that Integrated Therapists pointed to siloed working as a physical barrier and psychological barrier to effective responsibility sharing. That is, if professionals were not proximate it was seen as more permissible to send a referral without shared decision-making, particularly if the receiving team is perceived as having a greater *"remit"* or skill.

Integrated Therapists drew attention to instances in which an external professional transfers a client to them seemingly without collaboration or great depth of thought because the relinquish their responsibility for this type of work particularly when there is uncertainty about how the client's physical and psychological health interact to maintain their difficulties. Integrated Therapists step into this role, positioning themselves as willing to accept responsibility despite ambiguity, complexity and uncertainty. Speaking of GPs who are traditionally high referrers into IAPT services, an Integrated PWP in FG1 says:

> *"Some of them are really really good and I think it depends on their training, but also on their personal view of mental health. Some of them are great and some you email and they sort of say "that's not my responsibility." If it's [about] risk they're like [shakes head] "no, that's definitely your job, you work in mental health."" - Integrated PWP [FG1]*

It is unlikely that this is a direct quotation from a remembered interaction, rather Gee (2014a) suggests that intertextuality is a device which can be used to construct identities, attitudes or practices from the perspective of the speaker. Evoking a third party to paraphrase the speaker not only ascribes it importance in a socially acceptable way, but also by "describing actions [one] invokes rights and duties for which people are explicitly accountable" (Enfield & Sidnell, 2017, pp. 515). This discourse is also invoked by Core Therapists:

> *"Our main link is a GP who aren't always very forthcoming and can be quite [laughs] separate around not understanding the link between physical and mental health. It's kind of like "I'm dealing with the physical side, you just deal with the mental side" and you're like "err, okay" and that can be a kind of a closed-door conversation which can be quite frustrating." - Core SPWP [FG1]*

The Integrated Therapists' can position their counterparts as looking only superficially at clinical information outside of their core professional background, considering this

to be not of their concern. The consequence is that they make a referral into the speaker's service without a clear rationale:

> *Core SPWP: "…I know a GP that won't ask about mental health. Won't even ask patients "how's your mental health" because they just don't want to open up Pandora's Box and their.mind.is "it doesn't matter." Their ment- you know it's just physical health .hh and maybe change- some better education maybe around that kind of (.) actually (.) there's no health without mental health and a lot of people with physical health condition as we know the research shows have also.been experiencing.mental health difficulties as well.*
>
> *Midwife: yeah I think you've both just hit the nail on the head really*
>
> *Integrated PWP: I would say that's definitely right. I think something we see- particularly if we referrals from [names an eating disorder service] sometimes if they want that bariatric surgery and stuff they have to tick that box [makes an air tick] and say "I've had psychological support" and for some people they- they do have binge eating conditions and they need it, but for other people they don't but they just come to us because they've been told to tick a box and I don't feel like that's the best joined up care" - [FG1]*

Integrated Therapists tended to pair this with frustration alongside their action orientation to advocate for their patient. In this way it is possible that the Integrated Therapists are beginning to introduce a niche set of values, behaviours and attitudes into their professional identity that they use to set themselves apart.

5.3 Fear of getting it wrong (identities)

The emotion of frustration was notable within the corpora alongside accounts of unsatisfying contacts with referrers or other professionals. The data were reviewed for use of emotional terms associated with responsibility, and very few examples were found directly although some were implicit by omission, context or non-verbal communication. The strongest use of emotive terminology was that of fear:

> *"I could say on a personal level working with somebody with a long-term condition can feel quite scary sometimes because of not having those connections with the physical side." - Core Senior PWP [FG1]*

The Core Senior PWP quoted above locates their speech as a personal view to differentiate from the view of the organisation perhaps because as a Senior PWP they are likely to have quite substantial supervision responsibilities including for new trainees. This suggests the emotion expressed by the Senior PWP was important enough to break from the role expectation and the choice of a first person perspective suggests that this emotion is not considered acceptable in the current discourse.

Rafaeli and Sutton (1987) argue that emoting as a rhetorical device influences listeners, in this case to accept the addition of the "fear" emotion into the Core Therapist discourse of working with clients who also have long-term conditions. The term "*risk"* was also used as perhaps a more socially acceptable euphemism to refer to this feeling. An Integrated PWP whose organisation would have enhanced links with physical health also invoked the fear discourse when they discussed holding responsibility for adverse events and accountability which they hegemonically simplified to *"risk:"*

> *"But when that's part of your risk protocol to inform the GP and ask for their support and that's their response it's not very reassuring. Like 'are you going to do anything? Are you going to help them? Do I need to do more on <u>my</u> side to make sure they're okay?' That's something that's quite concerning sometimes when they're just kind of "I'm a GP, I just have to have general knowledge about a small amount of things, I'm not doing it."' - Integrated PWP [FG1]*

Integrated Therapists began testing out novel aspects of their identity in relation to collaboration and role boundaries. An Integrated PWP and OT interact in following example to reconstruct how role boundaries and risk relate as identity shifts:

> *"I think [Integrated HI] perhaps meant that earlier and maybe I got that wrong, but sort of, we're all sticking to our own specialties but there's no harm in having basic knowledge of other stuff? [OT*

nods]. So things like you know all the- all the like you know having- we're having to learn about a bit about Diabetes and they're the common ones that I <u>see</u>. You know a bit about COPD, Parkinson's, MS, stuff like that. I think sort of having sort of like that basic knowledge of stuff helps the patient (.) feel like (.) you've got some idea of what they're taking about even though you're not- you know a medical professional. Um but I suppose the "being careful" bit is that you don't- it doesn't end up somebody trying to do something they're not skilled to ↑do [OT nods]. So I suppose it's that level and balance of- of not teaching people a few skills and then they do something that yeah could be damaging because it's [OT: Mmm] you know, they haven't had that <u>training.</u> Um but having that bit of knowledge to improve some of the things that <u>you</u> can do because you sort of <u>understand</u> you know what that <u>means</u> to the person, that illness, that- that long-term condition, so you can ask the right ↑questions" – Integrated PWP [FG2]

Social constructionist theory has long been cognisant of the role of emotion in identity construction, however it is only in recent years that the credibility of such exploration has been accepted within the analysis framework (Lindquist et al., 2015). Lindquist and colleagues' (2015) suggest that non-verbal expressions of emotion can be useful but are not always accessible to analysts and may be open to greater interpretation, therefore they suggest that verbal constructs of emotion within discourse are also of particular importance. Emotions, particularly fear have been shown to be very powerful

legitimisation devices in the context of political discourses in order to elicit a response from interlocutors (Reyes, 2011). Reyes suggests that this can connect feared consequences with the discourse to shape behaviours and actions. The implicit "if…then…" construction shapes behaviours and actions. The discourse that 'if one [treats LTC/MUS], then one will cause harm' legitimises the passing of responsibility.

In wider research, some emotions are more acceptably expressed within role expectation than others, for example contrast sales workers and funeral directors in terms of the range of emotions that are accepted in such roles (Rafaeli & Sutton, 1987). The authors suggest that role expectation limits through bounded rationality (Simon, 1997) the breadth of the repertoire for acceptable emotions to express alongside the role. Participants were interested in discussing clients and talking about emotion, yet there were relatively few instances in which they expressed emotions themselves. Clients are therefore positioned as permitted to emote but Integrated Therapists less so. For physical health professionals this effect was stronger still, including even fewer references to clients' emotions. It is possible that excluding asking about or displaying emotions permits responsibility to be located outside of physical health and therefore pass responsibility.

Rehearsal of the pairing between the emotion and this discourse links two independent concepts of "fear" and "integrated working" into a novel meaning within this discourse (Gerrig, 2015). The breadth of emotional expression is notable in clinical practice, for example in psychological therapeutic practice the ability to differentiate between emotions ('emotional granularity') has been shown to reduce the likelihood of negative emotional and psychological distress in clinical populations who have experienced

trauma (Kashdan et al., 2015) and the idea that "emotions and feelings [are considered] to be fundamental to the construction of the self….that human beings use to discern among competing priorities, orient to action, adapt to environments, and promote well-being" contributed to the development of Emotion-focused Therapy (EFT) as a treatment for depression (Salgade et al., 2019, pp. 293). It is quite a leap to suggest that this could also be true for less traumatic changes and with professional rather than clinical populations, however there are similarities to suggest that times of significant challenge to professional identity such as the creation of integrated IAPT teams may also pose challenges to professional identity and impact wellbeing as Schaffner (2016) describes in their chapter on professional burnout. This could be ameliorated through encouragement for professionals to explore their emotional reaction to integrated working. Indeed, this is already used to good effect in 'Schwarz Rounds' to help with clinicians' emotional reactions to issues within their practice.

Emotional language is notably absent in medical and professional discourses, however a Foucauldian Discourse Analysis of emotional use found three discursive themes relevant to medical and helping professions. These included: a universal experience of emotion on a personal level, emotion as a form of competence, and emotion as a commodity exchanged in social interaction (McNaughton, 2013). The most pertinent in this context is the idea of emotional expression and how it links with competence. Writing of educating medics, McNaughton (2013) suggests that emotional expression can be taught, provided it is modelled by senior professionals and reinforced within organisational values, and therefore can improve competence and confidence in complex decision making. The Integrated Therapists, and other speakers in the corpora who identified positive appraisals of integrated working in their

description of their job role, tended to resolve the challenge possible burnout poses to their finding their niche professional identity by the sharing of success stories. This was often conducted through narrative story-telling and third-party praise which are perhaps more contextually acceptable than direct self-praise (Speer, 2012), in this way novel pairings of positive emotions may be more likely to become more available to professionals when working with greater uncertainty and complexity.

5.4 Relationships

5.4.1 Personal issues in work (relationships)

The relationships between professionals seems then to be crucial to shifting from siloed practice to collaboration / integration. Throughout the corpora all professional groups placed importance on interpersonal dynamics and mutual understanding in terms of successful collaboration. Gee's "relationship building tool" was used to applied to the data to explore the relationship between collaboration and conflict as speakers move into novel speech communities. To conduct the analysis, Gee recommends that "for any communication ask how words and various grammatical devices are used to build and sustain or change relationships of various sorts among the speaker, other people, social groups, cultures, and/or institutions" (Gee, 2014b, pp. 121).

The relationship discourse explained problems with successful collaboration in terms of the agenda of different professions being at odds with one another:

> *"…I just wanted to come back to you on something you said there which is um even though a lot of people I see have been round*

> *lots of healthcare teams they haven't.felt.heard. And they haven't felt like they've had the space to (.) um (.) <u>speak</u> (.) or um explain what really matters to them and they've just had a lot of healthcare professionals talking <u>at</u> them. Or tell them what to do. And I think for me that's part of the .hh difficulties that we struggle with is that you know I'm- as one Pain Service we have a Pain Clinic which is a very <u>medical</u> approach and then we've got a Pain Rehab Team which is very much self-management, ACT approach and that a lot of- where <u>we're</u> bumping up against each other there's that <u>conflict</u> of pain-control versus (1) "what can I do for myself." And actually that's what makes collaboration difficult when we are looking through very different lenses." – Physiotherapist [FG5]*

In the following example, an OPMH Nurse is recounting a number of experiences of effective and ineffective collaboration for clients with comorbid conditions. They compare directly two cases, spotlighting the team dynamics.

> *"There's a bit of a cynic in me I'm afraid, I'm too old not to be cynical, and one of the first things I was thinking about as I was listening to you folks was a couple of examples, fairly recent examples where collaboration just hasn't happened. I started thinking about the reasons why it doesn't happen and one instance where various mental health teams and a physical health team were involved with a particular client and*

> *there began to be a battle – and it did become a battle really, between the mental health teams as to which team had responsibility for dealing with the particular client. [Physio] I think you mentioned about the individuals involved and in one instance that I thought of initially, that particular client there was a bit of opposition between a couple of individuals which then- their kind of personal issues to an extent <u>played out</u> in the wider team's response to the client and it was like people were playing out their- um fall out between two people rather than, you know, a Psychology versus Physio or whatever kind of issue, and that dynamic <u>completely</u> got in the way of collaboration" - OPMH Nurse [FG4]*

Lexical choice evokes imagery through metaphor from the semantic field of battlegrounds such as 'battle,' 'opposition,' 'played out' and 'versus' which elicit an emotional response from the listener. The inclusion of another professional within the discussion suggests that this assumption is perceived as a shared experience. Janier and Reed (2017) argue that meta-discourses, in which the discussion itself is referenced, are associated with power dynamics between interlocutors and are more commonly associated with spoken texts than written, and thus can be considered a means of social power adopted to influence discourse evolution and reproduction (van Dijk, 1993). Highlighting variations of the verb *"to say,"* Janier and Reed (2017) suggest that verb choice influences emerging identity discourses. *"To say"* is a high-frequency verb, whilst the speaker in the extract above opts to use the alternative *"to mention"* to make reference to earlier parts of the discussion. One function they suggest is that by

including another interlocutor within the discourse they invite them to agree with the development of the discourse. In the extract, the *"psychology versus physio"* utterance is separated from the problems in collaboration. By separating this factor in this way, the speaker assumes that listeners would have expected this to be the reason for the challenges.

Metaphors have been demonstrated to be a powerful semiotic resource. They evoke often vivid imagery and aid discourse transformation as new concepts coalesce into a developing discourse (Gerrig, 2015). Metaphors can be utilised to reconceptualise challenging concepts or novel situations creatively in a way that is both primed by historical contexts but has recently been shown to also aid in generating novelty (Leung et al., 2012). The media have been shown to use this device particularly effectively as news reports invite listeners to accept the pairing of concepts and construct as either true or related to one another (Grey & Shudak, 2018) or, as shown in a recent study of public health advice during the covid-19 pandemic, metaphors can be used a rhetorical device to ameliorate public understanding of a complex phenomenon (Boyd, 2020). Whilst imagery is not essential for comprehension, the images metaphors evoke have been found to enhance an emotional or cognitive effect (Carson, 2018).

Whilst use of metaphor has been explored in discourse analysis, and indeed in qualitative research more broadly, for a relatively long time, the nuanced use of metaphors such as those from the semantic field of war has been explored in depth more recently (Schnepf & Christmann, 2021). The authors noted that wartime metaphors are used pervasively in public health messaging, disaster reporting and

when discussing personal challenges such as transitions into ill-health. The authors argue that this metaphor is particularly strong as it is commonly understood and evocative, therefore battle metaphors operate effectively in many contexts. The authors however weigh the applicability of this metaphor with the likelihood of undesired negative emotions such as guilt or difficulty with adjustment or acceptance if a “battle” is not “won,” when compared to the metaphor of a “journey.” The use of battle metaphors, and further whether these adopt passive or active clausal constructions is argued to be a linguistic device associated with power dynamics (Billig, 2008) as the metaphor invites the interlocutors to either accept or even empathise with the speaker’s position, and/or accept the “aggressor” role associated with the clausal subject. This has been shown in recent hot news topics such as the covid-19 pandemic in which news reporting uses war imagery to separate society into groups *fighting* the virus, people opposed to vaccines, or even their governments and health bodies (Skrynnikova & Astafurova, 2022). In disaster responses such as the missing Malaysian aircraft, a Critical Discourse Analysis study of international news reports found that metaphors and imagery were used to *other* and influence the perception of blame or where disapproval should lie (Arlini & Nasir, 2019).

Metaphors, however, are argued to be flexible. They can be *recontextualised* as Semino and colleagues (2013) describe over time and within interaction with others. There are equally widely understood metaphors utilised in the emerging discourse, most notably integrated working is also conceptualised as an *“orchestra,”* and, depending on the level of responsibility the speaker feels, they are positioned as either conductor or troupe:

> *"…so in the old days the idea was the GP would hold that who- when I did my General Practice training that was (.) really beaten into me that pe- you're going to hold the anxiety and you're going to conduct this orchestra of other people who will all be bit-players but for the patient.it's really important.that one: key individual, you, their GP, that's prime- that's the prime reason for your relationship with this person is to help them with this journey"*
> *– Consultant [FG5]*

This competing metaphor suggests that imagery associated with collaboration is in a state of transition and whilst emotive language is not greatly accessible in professional discourse, metaphor use is privileged by speakers to evoke an emotional reaction in the listener (sign systems and knowledge).

In this section, the analysis has found that relations between professionals integrating care for clients with long-term conditions are affected by professional responsibility factors which are entering the overt discourse. The role of metaphor and imagery has been adopted by speakers in order to elicit a response from listeners and pair constructs. However, within the discourse there were also personal factors such as role stereotypes and conflicts which impact on the integration discourse which will be considered in the next subsection.

5.4.2 Respect (connections)

Power dynamics become all the more important in interpersonal relationships as identity is reconstructed and social goods are at stake. This sub-section will focus in

greater depth on the interaction between speakers throughout FG2, particularly focusing on how conflict shaped professional identity. At the start of the focus group, the participants allowed one another to take turns to discuss how they conceptualise 'collaborative' therapy. In the following example, an experienced Integrated PWP minimised the differences between Core and Integrated Therapists:

> *"We're allocated a little bit more time to do it [collaborate] so we have slightly less patients that the Core Team so that if I've got to try and get hold of someone: respiratory, community matron or somebody I- I've got that little bit of extra time to actually do what we probably would like to be able to do in Core Teams as well but don't have time for. Hopefully that makes sense."* - *Integrated PWP [FG2]*

An Occupational Therapist responded to this with enthusiasm about collaborative working, describing it with tonal emphasis as *'tailored,'* and sharing clear personal opinions:

> *"Basically it's patient-centred, isn't it. It's providing the right service at the right time for that person and making sure that there- that it's tailored. But I think it's brilliant what you can bring into the mix. We always say in our team we work together but then we have unique skills? that we can bring? for that person? [section redacted for brevity] But I absolutely love working collaboratively (.) with other people um I used to work in a*

> *Memory Clinic and we had Social Workers in our team which was fantastic because you could do a joint visit and you could (.) tackle all number of things (.) and I think also knowledge as well, knowledge and skills so you upskill. You get all these skills you- it certainly rubs off on yourself and you gain that knowledge as well so I think you know exactly who .hh would be the right person for that (.) that job and I would absolutely love.to.have.more um working more in collaboration with people- you know with the IAPT service and mental wellbeing because it just makes it- the rest of the patient journey." Occupational Therapist [FG2]*

In response, an Integrated HI responded that when referring to collaborative therapy *"we've got to be careful of the buzzwordness."* They conceptualised their client group as *"quite an intense group of people"* and express scepticism:

> *"These are the people that would have been on the Core (.) um thing that people would have gone "uhh" [drops head] you know, but now we're learning to work with them better so this collaboration [makes air quotations] should it come um wh- when it comes I should say, that sounded very cynical! When it comes it will be fantastic. I hope." - Integrated HI [FG2]*

The above interaction maps nicely onto Yarbrough's (2010) concept of *triangulation.* Triangulation suggests that in groups in which there is a resistant minority, speakers actively shape their discourse around the object. In this case the enthusiastic register

of the Occupational Therapist as evidenced by absolute intensifiers with regular vocal emphasis is in stark contrast with the cautious modifiers used by the Integrated PWP such as *“a little bit”* and verbs such as *“try to.”* By using the future tense, the Integrated HI frames collaboration as desirable but not yet happening, and expresses doubt that their view of right and proper collaboration will be attainable. Yarbrough argues that such conflicts must be resolved as speakers “engage in a process of discursive revision that continues until the responses the interlocutors receive are the sort they expect” (pp. 5). In other words, the speakers are actively engaged in discourse construction.

A further conflict arose when participants discussed the vignette in which there is potential for rupture in the therapeutic relationship between the client and their Diabetes Nurse. When asked an open question about their views on collaborative care with the client in the vignette in mind. An Integrated PWP hypothesised that physical health professionals may have *“spelled out quite harshly”* information about the interaction between mental and physical health which they wondered may “*then [have] impacted on their mental health”* adding *“they can be quite harsh in the medical side of thing sometimes….and not take into account that what they’re saying impact[s] on mental health.”* The Occupation Therapist responded to this when the facilitator asked whether there is anything the focus group members felt was particularly important or unsaid. She highlighted that *“respect [for] reach other’s role”’* is important, arguing that role stereotypes impede effective integration as skills of other professionals may be overlooked without good interprofessional relationships. The Integrated PWP then modifies their position:

> *"I think it's (.) general [dental fricative] lack of understanding of each other's roles um a lot of the time, and wanting to understand and learn about them, and things, as well and like you say with the respect thing it's (.) yeah it's it's- and I've said sort of I'm being generalistic deliberately because it's it's those assumptions we all make [OT: yeah] and things and like a consultant you know aren't 'people (.) pe-persons' and things and I know loads of them that are [OT: yeah [laughs] yeah] and things so I think it's sort of being careful not to make those stereotypical assumptions um being aware that you've got them but but making sure that you don't use them and that you actually ask and find out" – Integrated PWP [FG2]*

Constructing identity through conflict can be a useful means of members of a speech community becoming more cognisant of one another's primary concerns as speakers manoeuvre between varying stances until agreement or understanding is reached (Uzelgun et al., 2015)

With the aid of a short extract in which conflict occurred, this analysis in this subsection has suggested how power dynamics may be a factor relevant to interprofessional identity reconstruction and that fostering good relationships may improve understanding of others' roles. This is consistent with previous findings that heterogenous professional groups often encounter conflict which strengthen professional identity provided the discourse comprises open-mindedness and respect (Mitchell & Boyle, 2015). The findings are consistent with previous research, for

example Hood and colleagues' (2017) model of expertise and professional identity also found that power dynamics are not solely relevant in times of conflict, but in reforming identity through negotiation thereby shaping identity in the eyes of another. This is discussed further in the next subsection through a psycholinguistic analysis.

5.4.3 "Advice" or "Discussion" (sign systems and knowledge)

Sharing of clinical decisions and interteam collaboration appears to be influenced by power dynamics which can affect the nature of integrated working. The corpora were examined for verb choice when speakers referred to liaising with their psychological or physical health counterparts. Two verbs were used extensively: "*to advise"* and *"to discuss."* The search terms were truncated to search the corpora for *"advi*"* and *"discuss*"* to account for variations from the stem according to verbal tense and conjugation, and orthographic differences when these are used as nouns. Variations on *'advice'* in relation to collaboration were used less frequently, and did not appear in two focus groups but there were no differences in their use by professional group. However, speakers tended to describe their professional interactions with counterparts as *"advice"* when they thought they were counterproductive or unhelpful interactions, and *"discussion"* was paired with collegial interactions with positive connotations. In contrast with the pairing of *"to discuss"* with *"conversation"* or variations thereof, a Core Trainee HI synonymises "advice" with "training:"

> *"If we were provided with that kind of external training or these kind of different aspects then you are more <u>confident</u> to approach the client from different angles in a way, so service funding whether- you know, are you g- are you able to offer*

that kind of advice, that kind of training…" - Core Trainee HI, [FG4]

Gee's (2014b) Figured World Tool was applied to the analysis to examine grammatical features such as lexical choice which can shed light on how speakers construct the world around them, and indeed their *position* within this world. When speakers utilise the conditional tense or the subjective mood they paint a hypothetical world which they figure does not currently exist but would change something about the present were it to happen. The verb *"to discuss"* is used to qualify *"collaboration"* in the following extract and is associated with clinical curiosity, whilst *'to advise'* is used in the corpora to suggest that collaboration is unsatisfactory or ineffective.

"It would make sense to have, like I don't know, I suppose for the people that do long-term conditions actually if it's quite severe, you know, a team- a place where you could sort of meet up, you know, with each other regularly or have regular points where reviewing patients and, you know, seeing "well actually," you know, "we're doing- within mental health we're doing this and this is working well, actually maybe you could work on the pain side of- some- you know, managing pain" or something like that. I think those two do cross over quite a lot from- 'cos I do also work with long-term conditions in the normal team as much- in the Core Team- but obviously not as much as [the Integrated Team] so I suppose, you know, collaborating that, you know within- kind of having a group or

> *something where you could actually discuss patients, I imagine that would really help I suppose patient care." - Core PWP [FG2]*

By including Integrated and Core Therapists into this utterance the speaker created a differentiation between the Core and Integrated identities (Bucholtz & Hall, 2005). It is possible from the construction and the action orientation of the speaker that they are figuring a world where pairing the more desirable *"collaboration"* and *"discussion"* is occurring in Integrated Teams (of which the speaker is not a part) compared with Core Teams. Note also the speaker uses colloquial vernacular when speaking about this phenomenon. Speakers would generally adopt a more formal register in professional settings when power is imbalanced, thus the colloquial register in the figured world suggests that relationships would be enhanced when power dynamics are balanced.

There is one notable example in which the verb is utilised from an alternative speaker perspective. In all uses above, speakers considered the advice or discussion as a resource they hoped to gain from an interlocutor. However, when a speaker positions themselves as a person receiving communication from another team they position themselves as willing to take on responsibility for some aspects of the intervention even without a direct referral made. In the example below, the speaker uses the verb *"to advise"* in the first person subject position to position themselves as having greater power to decide to what extent they wish to be involved and share their knowledge. Once this position is laid out, they are not only willing then to accept a referral without being directly asked, but also to bypass some of the formal referral processes:

> *"Since we've been collaborating in these environments and less referral-dependent, we've been more willing to have a conversation. Maybe give other professionals some advice and support on "have you thought about this, or have you tried doing that? Get back to us if it's still a problem." Or just saying "oh actually yes I can see that what is inside the parcel needs us to take that bit of work, don't worry about filling out a form, we'll take that parcel from you." - OPMH Nurse [FG4]*

Thus far, individual and interprofessional perspectives have been reviewed as relevant to the responsibility discourse. Lastly, organisational factors will be discussed, in particular how individuals position themselves as working within existing pathways and clinical guidance.

5.4.4 What needs to be treated first (politics)

There can never be guidance documents and pathways sufficient to meet the needs of every situation a practitioner may encounter and thus clinical judgement in the context of uncertainties is required. This is all the more important when working with comorbidity when interacting, and sometimes conflicting, guidance may exist or indeed there may be a lack of specific guidance for some interactions or conditions. Organisational structures and pathways in complex adaptive systems evolve as needs arise and commissioning requires, which also cannot account for the large number of professional communities contained within the network. This discourse emerged in the corpora with many speakers recounting challenges and uncertainties of navigating these systems. Integrated Therapists, such as the HI Therapist in the following extract,

introduce into the discourse the role of individual differences and clinical decision-making within the integrated working environment. The speaker also notes individual differences in clients' psychological and physiological experiences of their problem (pain and trauma in the corpus in which the extract takes place). They identified:

> *"That also has an impact on your working collaboratively with clinicians because they've got different perspectives on what's going to be useful and different priorities and they will say "no, you need to do your piece of work on trauma before we can do our piece of work on pain" so I've found that quite difficult to navigate because collaboration is very different whether it's with <u>this</u> team or <u>that</u> team." - Integrated HI [FG3]*

The discussions in response to the vignette were analysed in terms of how speakers formulated a hypothesised patient journey:

> *"It would depend on what Ashley was hh <u>hoping for</u> and things and what he wanted to get out of that and what support he needed um so obviously doing the mental health side first he lo- yeah looks like worry" – Integrated PWP [FG2]*

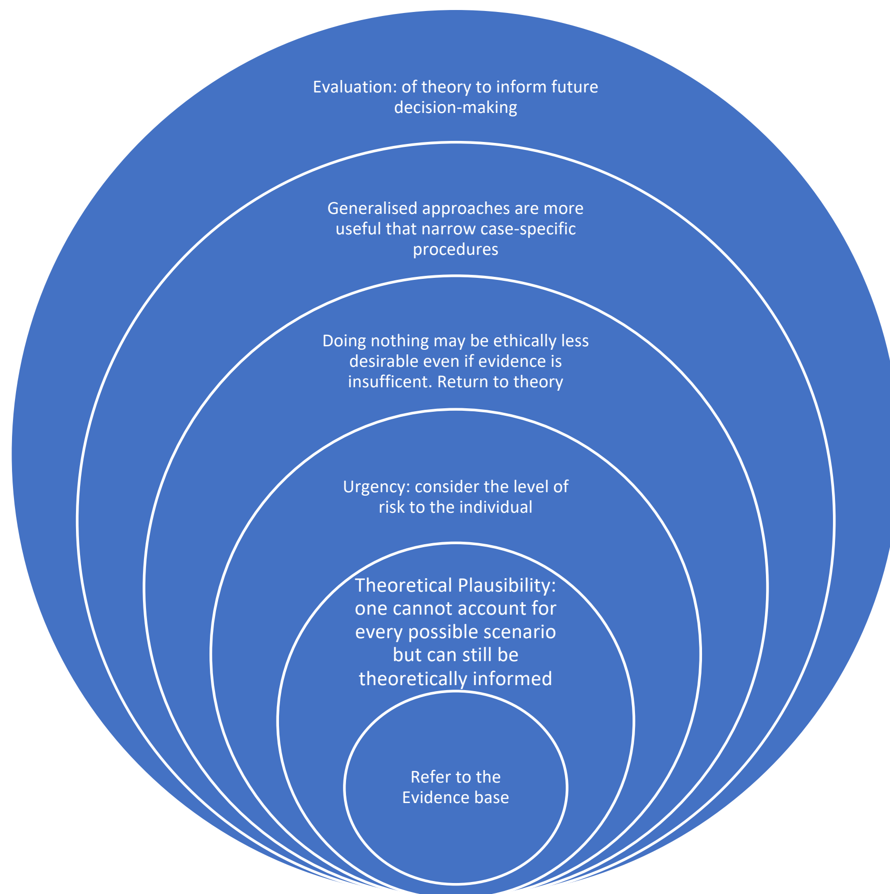
> *"If I was <u>very</u> honest and I- and I was seeing him I would be- my first thoughts would be "why aren't they being seen by the long-term.health.conditions.team? [laughs]" – Core SPWP [FG1]*

> *"I don't see why (.) there wouldn't be scope for collaborative working between the IAPT service and the Diabetes Nurse" – IBS/Gastroenterology Dietician [FG2]*

Clinical decision-making in the context of comorbidity often raises challenges for clinicians and service providers. Within evidence-based medicine clinicians routinely consult NICE guidelines to inform both the type of intervention to be provided and the order in which these should be delivered. NICE acknowledge, however, that this is a complex task and relies on stakeholders' expectations, availability of services and resources, and the theoretical frameworks available for the presenting problem(s) (NICE, 2014, updated in 2022). NICE are able to make clear "do not offer" recommendations and inform clinicians about the strength of research which supports or does not support interventions, although given the vastness of the comorbidity arena there are a wide range of interacting and sometimes conflicting factors. The individual level of responsibility in integration is considered by some influential reports to be key to successful integration. Informing the NICE guidelines, Tannahill (2008) advocates for ethical decision-making in the context of complex health needs:

Figure 12

Ethical Decision-Making Visual Representation adapted from Tannahill (2008)



Alongside the findings of the analysis and Tannahill's (2008) model, those transitioning into integrated working environments are recommended to maintain adherence to the existing guidance documents for evidence-based practice such as the NICE guidelines, service protocols including risk management, and consult the relevant ICD-11 and DSM-5 criteria. The additional recommendation informed by the analysis is that the importance of the learning from others through evaluation, reflection and sharing of good clinical practice is likely to ensure that effective clinical practices in complex decision-making are retained in the core identity of Integrated Therapists and

engaging with this amongst peer group settings is more likely than organisational structures to lead to safe and effective service cultures. Further still, considering the relationship building and politics aspects of the analysis, services would be recommended to invite speakers or participants from other services into such peer group settings. This would likely reduce the ability of inaccurate and unhelpful role stereotypes from entering further into the discourse and, alongside the considerations regarding expertise in the previous chapter, would increase the confidence of all involved to remain patient-focused and develop expertise in applying and broadening the current guidance for integrated working.

5.5 Chapter Summary

In summary, there are four key findings from this chapter: 1) Integrated Therapists are beginning to introduce a niche set of values which differentiates them from the Core colleagues by making a distinction between their roles and values, i.e. how are we similar, how do we differ?, 2) if therapists are not hopeful for the success of collaboration they tend to use the “burn-out / too busy” discourse, 3) conflicts / power dynamics are illustrative of identity being co-constructed in dilemma resolution. Finally, 4) through the competing metaphors of a push-and-pull “battle” for responsibility laden with hierarchy and power imbalance, and the harmonious “orchestra” metaphor, adaptive thinking and creativity is evident and suggests something novel about the current state of identity transition.

This chapter has explored the interaction of the responsibility discourse with professional identity and subsequently how effectively and authentically therapists apply the integrated working model in clinical practice. Professionals appear most

likely to tolerate uncertainties when positioned in an advocacy role, and when valuing the contribution of their colleagues from other professions with the patient central and foremost in the discussion. In such circumstances, professionals report that they utilise their colleagues' skills to enhance the application of evidence-based treatments and to fill gaps in their knowledge.

The question of when responsibility is transferred is equally relevant to the effective utility of the integrated working model yet more dependent on individual professional and interprofessional factors. In some cases, particularly those in which the clinician feels anxious about making incorrect decisions or perceiving that they are not able to provide a sufficient level of intervention for a client, power dynamics between teams and professions is more apparent. Clinicians in these instances seem to perceive that they are using the integrated care model, but rather defer decision-making and intervention to a team or individual considered more expert. Further, responsibility is likely to be passed to another team if the individual or team is positioned as overwhelmed and the narrative develops around structural problems such as caseload management, accountability and risk of burnout. Although a less frequent discourse, it is nonetheless important to acknowledge that personal issues being brought into work, including conflict between either individual team members or cultural inter-team conflicts, can influence responsibility. In an unexpected finding, it was notable that professionals may be more willing to hold greater responsibility for clinical oversight of a client's care if they perceive that other possible referral routes will lead to unsatisfactory outcomes or minimal treatment intervention. For example, if clinicians have had experience of referrals not being accepted or the external view is that a specialist service is running at high capacity or has greater treatment waiting time,

they will tend to be more reluctant to contact them for clinical advice or referral. Recommendations were made to foster good working relationships, ensure adherence to the evidence-base with the hypothesis that such an approach may contribute to extending the evidence-base in clinical practice.

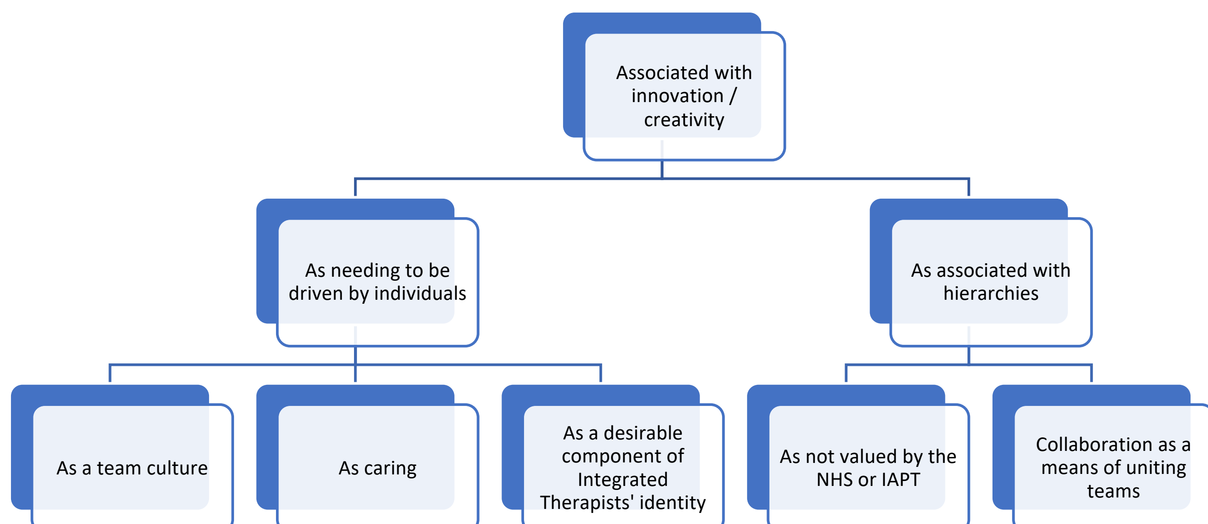
The competing metaphors noted in this chapter are cognisant of creative thinking about identity, the importance of which has been previously hypothesised in scientific fields (Sanchez-Ruiz et al., 2013). The next chapter will explore in more detail role of creativity as Integrated Therapists reconstruct their professional identity.

Chapter 6: Innovation and Creativity

A final distinct "innovation / creativity" Big D discourse also emerged from the corpora. This chapter applies Gee's (2014b) CDA framework to explore the contextual factors (relationships and power dynamics) and positionality of Integrated Therapists in terms of their creativity (practices / activities) and innovation (identity). The creativity / innovation discourse will be considered in terms of its significance to the Integrated Therapists' professional identity, barriers to the "actions" associated with innovation and how the discourse is legitimised.

Figure 13

Discourse Map for the Code "Associated with Innovation / Creativity"



This chapter will be subdivided using Gee's framework:

- Significance
- Legitimising Innovation
- Professional Faultlines
- Systemic Implications of Innovation and Creativity Professional Identity (actions and beliefs)

6.1 Significance

According to this discourse, the ability to be creative and innovate was foregrounded as important both for Integrated Therapists' professional identity and for successful interprofessional collaboration. Recounting an example of developing a programme whereby Integrated Therapists supported Physiotherapists to implement a Graded Exposure intervention for a client with a phobic anxiety disorder, an Integrated PWP concluded *"it was fantastic! That's how all care should look"' [FG2].* The terms *"creating"* and *"collaborating"* often co-occurred in utterances, a device often used by speakers to invite interlocutors to accept a link between the terms. By making this link, however, the repertoires coded as "collaboration as needing to be driven by individuals" and "collaboration as not currently prioritised" impeded the discourse. For example:

> *"I've got loads of hopes for my ideal work. So I'd <u>love</u> for it just to be really accepted and very <u>normal</u> and very "everyday practice" for both psychological medicine and physical health to be way more integrated and for it to be just normal in all specialities that*

everything is joined up…I think those are big barriers." - IBS and Gastroenterology Dietician [FG3]

"I think it's also the understanding that it will take a.long.time and lot of effort. I'm just having um an example of um my team trying to create a pathway with Gastro Team .hh it has taken three years [laughs] to have it kind of established and well-working so I guess it's also this understanding [laughs] I don't know if it's an understanding also having the patients that it will take time and what is needed there, it's definitely willingness of various professions of wanting the same um and not putting barriers because sometimes we will- (.) I guess there will be- but it's something new, and when there is something new implemented there's always many barriers within the teams which- you know they might be very <u>small</u> but you might for example say 'oh I don't have time to look at this email. I don't have time to- I have to- I have to pass this parcel, I have to do this' so there will always be some .hh (.) some some barriers you could come across, but it's about kind of kind of really wanting the same thing and accepting that it might a long some time as well to work." – Integrated PWP [FG4]

In the following quotation a physiotherapist presents collaborative work as something individuals choose to use should they feel it is beneficial to invest in, yet innovation

may not happen if it is either 1) considered too burdensome or 2) not prioritised by the NHS / IAPT:

> *"There's great work like [Integrated Therapist] says is being done in terms of communication and pathways and [siloed practices] are less distinct than they were, though they still are distinct. We try to be collaborative but it seems to me it's down to individual individuals within those teams being interested in it than the wider system working in that way to be necessarily collaborative." Physiotherapist [FG4]*

IAPT was framed as an inflexible structure which was not a hospitable environment for expressions of individual creativity on the whole, however participants were able to draw on personal contextual examples of innovation such as champion programmes. Speakers retained their "powerless to change" status by crediting the creation of these roles to top-down hierarchical features. This conceptualisation is familiar from Altson et al. (2015) who interviewed therapists who did not use CBT as their primary intervention in IAPT and were therefore in the minority. Their findings were that participants felt a pressure to conform to normative CBT language and perceived IAPT culture as less flexible to novel practices.

A larger extract from the corpora is provided in the Appendix 7. In this extract, participants were discussing the extent to which innovative practice was possible, whether it was rewarded or desirable. In the opening turns in this extract, the Integrated PWP named each interlocutor in the utterance thereby leading the direction

of the conversation. They introduced the idea of Integrated Therapists leading innovation as *"so valuable when it works"* yet they suggested they are swimming against the tide of organisational barriers thereby painting a less hopeful outlook. Linguistically, the speaker places emphasis on adjectives representing difficulty such as *"hard"* and *"effort."* Subsequently the OT and Integrated HI build on the genre of organisational barriers by adding macro factors into the discussion such as funding and minimising the role of the individual. The direction of the conversation changes when the Core PWP joins the conversation. They Core PWP adopted a problem-solving approach creatively using the structure *"I suppose…you could…"*, concluding that their skills are *"obviously not as much as the [Integrated Team]".* Following this interjection, the Integrated PWP took up the narrative, speaking enthusiastically about innovations members of their profession had made on the micro level which then gains non-verbal approval from other interlocutors.

McCarthey and Birr-Moje (2002) argue that the seeming dissonance in this exchange could be explained by the way in which identities are situated in relationships. The stories others tell, in this case the Core PWP creating a space for innovation in the Integrated Therapist identity, become "performed or enacted, rather than only told" (pp. 231) and serve to construct identity and belonging within a discourse community. The way in which this identity is enacted is argued to link with images individuals use to differentiate themselves from others (Johnstone & Mattson-Bean, 1997). In this extract, the Integrated PWP positioned themselves as the agent responsible for innovating *("I discussed with all of them…")* as others in the collaborative relationship follow *("and actually the physios and OTs were sort of carrying that out with the person")*.

The exchange ends by the Integrated PWP re-introducing macro-level inhibiting factors, in this case they expressed powerlessness to innovate when each profession works from different clinical record systems. Mitchell and Boyle (2015) argue that innovation is often associated with heterogenous teams, and indeed organisations rely on professionals in multidisciplinary teams to find creative solutions to complex problems. However, they write that innovation can be stifled or obstructed by withholding of information and interprofessional conflict. The authors found homogeneity alone was not sufficient to maximise innovative potential, rather this was contingent upon open-mindedness and professional identity salience. That is, “what members are aware of, and think of, other team members in terms of their profession” (pp. 886).

6.2 Legitimising Innovation

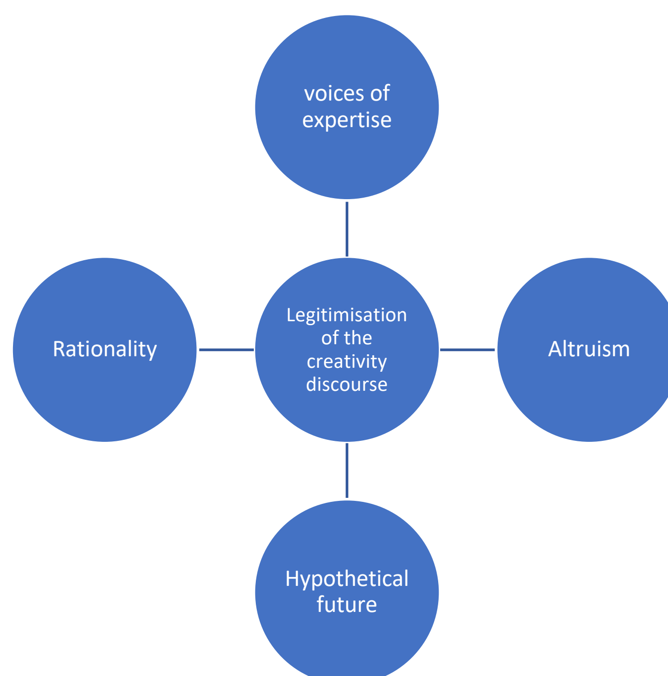
Whilst many authors use “innovation” and “creativity” interchangeably, Xu and colleagues (2019) argue that these are indeed distinct, whereby creativity relates to the cognitive process of idea generation and innovation to the behavioural action of implementation. This is an important distinction as some participants in the present study advocate for innovation but are more hesitant to act upon these when the risks of deviating from the dominant discourse are perceived as too high. Despite positioning themselves as a worker within an organisation conceptualised as not receptive or passive to innovation, speakers throughout the corpora used linguistic devices to legitimise the creativity discourse as part of the Integrated Therapist identity.

Writing particularly of legitimisation of power in political and public speaking discourses, Reyes (2011) identifies five rhetorical devices. These devices are effective,

Reyes (2011) argues, as “we share, as a society, certain values and visions of the world” (Reyes, 2011, pp. 787). The model shown in Figure 14 shows the legitimisation devices outlined by Reyes (2011) with the exception of ‘emotion’ which was not greatly utilised by speakers with regards to this discourse.

Figure 14

Legitimisation of the Creativity Discourse, informed by Reyes (2011)



Participants were able to resist their subjective powerlessness to innovate by making a logical case to create something novel (rationality), position this as good for patients (altruism) and mention others in the discourse often with intertextual reference to quotes of paraphrases which seem to show other professionals around the speaker also agreed it was the right thing to do (voices of expertise). Reyes (2011) discusses the idea of legitimisation through a hypothetical future in political discourses as a way in which public speakers create an imagined undesirable future which will come to pass *unless* listeners act, thereby inviting them to adopt attitudes and behaviours.

However, in this study speakers created an imagined positive future using the same implicit "if…then…" construction highlighted in bold in the following extract to invite listeners to adopt the innovation as part of the novel professional identity and to negate the position of innovate as deviant or undesirable:

> *"There's great work like [Integrated PWP] says is being done in terms of communication and pathways and they're less: distinct than they (.) were thought they still are (.) distinct and so the so so which we try to be collaborative but it seems to me it's down to individual individuals within those teams ha- being interested in it than a wider system working in that way to be necessarily collaborative? Do- I- um do you see what I mean? So* ***if*** *you've got a diabetic team or a pain team, I'm going to say that because I'm biased but I'm interested and um you've got maybe PWPs or an IAPT service or Older Persons Mental Health um inpatient whatever service that are looking- that* <u>*are*</u> *keen in collaborating* ***then*** *you can start to build those those (1) that that less distinct model I'm not articulating it very well (2)" – Physiotherapist [FG4]*

The opposing hypothesised future links with the previous chapters of expertise, responsibility and the two second and third order codes of "needing to be driven by individuals" yet "not currently prioritised." Thus, the undesirable hypothesised future is constructed as "if creativity is not prioritised by the NHS or individuals, then we will be ineffectual, not unique and burnout."

A further means of legitimising creativity and innovation within the Integrated Therapist professional identity discourse was to foreground this as beneficial to clients. In the extract below, an Integrated PWP narrated a story of integrating care with physical health colleagues for a client with anxiety, LTC/MUS and a learning difference which can be found in full in Appendix 7:

> *"I have got an example recently actually, and it worked <u>really well</u> which I was <u>so pleased</u> about, [describes the programme]. It was just a <u>lovely.piece.of.work…</u>we could ask each other questions and I could ask about sort of like the physical limitations and abilities and I think just that- that to me is "collaboration"…it just.felt.so.good being able to do something like that for somebody." - Integrated PWP [FG2]*

Positioning a desired identity trait as altruistic, Reyes (2011) argues, legitimises perceived non-conforming behaviours by framing the novel behaviour or attitude as beneficial to a certain group of people rather than the less desirable perception of self-motivation on the part of the speaker. Emphatic modulation and single syllable staccato pausing between *"lovely.piece.of.work"* and *"just.felt.so.good"* are common means of drawing attention to features a speaker wishes to transmit (McAteer, 1992; Soulaimani, 2018). This effect was notable in healthcare messaging during the pandemic to transmit easily memorable memes, in the original sense of the word as a transmittable unit of social information (Blackmore & Troscianko, 2018).

Furthermore, the speaker alternates between the first person singular and first person plural through this extract. Gent (2017) argues that by alternating they are "doing work on the self" (Gent, 2017, pp. 54) by testing out new ways of being and observing the acceptability to their interlocutors. Additionally, as an Integrated Therapist the speaker is creating a role for innovation within this professional identity when using the first person singular by positioning herself as the central driver of this change. A further function of altruism in this discourse can be seen in the way in which speakers position innovation / creativity as desirable for patients as well as for organisations, for example:

> *"Within my OHP role we're looking at those kinds of approaches to placements and models of training where it's not just profession-specific…and I wonder if that might be a way, you know, to give people a great- better experience" - Physiotherapist [FG4]*

Responding and elaborating on this utterance, an OMPH Nurse added that they consider it *"perhaps a reasonable model for sharing knowledge around."* These utterances together illustrate a number of interesting means in which innovation is entering the collaborative discourse. Firstly, the pairing of organisational lexicology *"placements"* and *"models"* with improved patient experience perhaps invites listeners to link patient-centred outcomes with systemic benefits. Secondly, in the response the OMPH Nurse adopts a *rationality* stance to further legitimise the altruism which may appeal more greatly to those in strategic roles in the NHS. The nuances of systemic and individual factors associated with this discourse will be discussed in more detail in the next sub-section.

6.3 Professional Faultlines

An emerging field of research in this area concerns the concept of *faultlines* first defined as categories which "divide a group's members on the basis of one or more attribute" (Lau & Murnighan, 1998). Whether professional faultlines are strong or weak is argued to relate to conflict, performance and the willingness to innovate (Mitchell et al., 2021). However, much research has focused on demographic faultlines rather than professional affiliation. The only study located that commented on identity when professional teams interact suggested that the professional relationships are influential in terms of willingness to be innovative (Li & Hambrick, 2005). The authors noted two distinct categories which increased the salience of factional groups: 1) if a professional is explicitly labelled as representing a certain kind of profession they will be more likely to embody the core characteristics and be viewed as such by others, and 2) if there is historical distrust between groups attention will be drawn to categorical difference.

Firstly, in the following example a midwife had identified to the focus group as having a special interest in integrated care:

> *"I'm not sure if this is very relevant to this but .hh just talking about hierarchy and within a <u>team</u> (.) it's quite difficult to work collaboratively if you haven't got everyone on board? [others nod] so if they're not buying what you're selling which is what I have come up against um is- they act as the gatekeepers sometimes? to the patients? and that can be quite tricky. And it's thinking*

> *about how we can (.) re-design I suppose the service to allow people to be able to (.) have more control over their care." – Midwife [FG1]*

A professional identity threat for members of the focus groups which impeded the acceptance of creativity behaviours into the discourse was the perception that innovation was not supported in organisational culture. This fits with recent research which has shown that individuals who may be skilled and willing would nonetheless be reticent to use behaviours if they were thought to be either undesirable (negative) or not prioritised (neutral) (Mitchell et al., 2022).

The midwife in the above extract positions herself as in a less powerful position to innovate by foregrounding *"hierarchy"* and utilising the metaphor of a salesperson who must persuade a reluctant and more powerful other that their offer is worthwhile. The creativity discourse was restricted for many by organisational and contextual factors, and through the "evidence-based practice" narrative which is central to the IAPT programme. Speakers recounted working within uncertainty as a discomforting factor, as there are gaps within the evidence-base for adapted practice. There is a particularly poignant example from a consultant who recounted his experience of longitudinal service transformation. He noticed that when he perceived innovation was an overt organisational priority he was more resilient to other work pressures. He described this as a

> *"…wonderful, extremely time-consuming but worthwhile thing" – Consultant [FG5]*.

Over time the consultant perceived innovation to be less prioritised leading to misalignment between his personal goals and those of his organisation. As a result, his desire to innovate reduced:

> *"I was a big Social Psychiatrist so I was <u>interested</u> in how all of that worked… and now that's all gone so frankly I take no pleasure in my medicine any longer [he recounts moving into a field more in line with his personal values] … As a clinician I need to see something from the work to feel okay about it. I see a lot of misery, but I also see successes…I think the whole culture of healthcare has shifted in a way that's not suited me too well over this last twenty years."* – Consultant [FG5]

However, the creativity discourse was liberating in terms of Integrated Therapists negotiating their identity as an active agent for change. Linguistically, rhetorical devices were used by speakers who were enthusiastic about the cognitive element of innovation (i.e. they felt it was desirable and somewhat possible) yet the set of behaviours required to *act* creatively were not permitted by contextual factors which was coded within the discourse as "collaboration as not currently prioritised." An example of this follows directly from the extract above. A Core HI shifts the direction to a more positive positionality of innovation by citing recent examples in practice which *"got [others] involved"* which *"made such a difference,"* however they felt this was not prioritised after initial training when they *"had the luxury of time"* which receives non-verbal agreement from an Integrated Therapist. Note that time is framed

as a commodity in short supply, therefore it is implicit that the organisation does not prioritise outcomes of value in order to be creative. Indeed, the Consultant positions leaders as *"paymasters"* who *"don't value time"* which *"is what makes our work successful."*

However, even in particularly challenging times in healthcare innovation has been evident (Langlois et al., 2020). Although covid-19 brought many additional uncertainties to the working world, arguably none more so than for the medical profession, Langlois and colleagues showed that medics were nonetheless able to combine their expertise with innovation to tolerate uncertainty. Those who were successful at doing this, the authors argued, were able to do so due to a core sense of their own identity, their proximate collegial relationships and an ability to creatively use the tools at their disposal. Interacting with peers was also found in the present corpora to influence the extent to which the innovation discourse was accessible. In the following extract an Integrated PWP, Integrated HI and OT discussed innovated practice. The enthusiastic lead in the conversation taken by the OT allowed the therapists to shift their position into accepting innovation.

> *Integrated PWP: "…[I'm] thinking "well actually this person's got great need" and things but actually there's nobody to collaborate with [laughs]. There's nothing (.) <u>there</u> that- that we can do [shakes head] cos the service is is isn't there at all. (.) Um so that's really hard isn't it [Integrated HI] sort of cos we're in these- well we're <u>all</u> in these fields I'm guessing because we <u>care</u> and want to- and we want to help*

Integrated HI: Yes I suppose we need somebody to be collaborative with [all laugh]

Integrated PWP: Exactly

OT: But I s- I think they're talking about sort of hubs and where a patient comes to a place where they have everything done? And I'm just thinking wouldn't it be great if [proposes a collaborative project about over-use of Ventolin]…if someone went in for their mental wellbeing you could cut that medication um bill couldn't you, you know if= [Integrated PWP: Yeah=] everybody- if we we collaborated and we looked at this patient and we think [reiterates the idea]…wouldn't that be amazing?

Integrated PWP: Yeah it might be that= [Core PWP: Yeah=] the anxiety's causing it and for everybody to be involved in that" – [FG2]

In the discussion above, the speakers began by emphasising caring. However, altruism alone was not sufficient to shift the action orientation into adopting the innovation discourse without interaction from a motivated peer. Xu and colleagues (2019) advocate for the development of innovative practice as a means of individuals and organisations succeeding in points of often rapid service transformation. They argue that contextual factors are important for creating an environment for creativity,

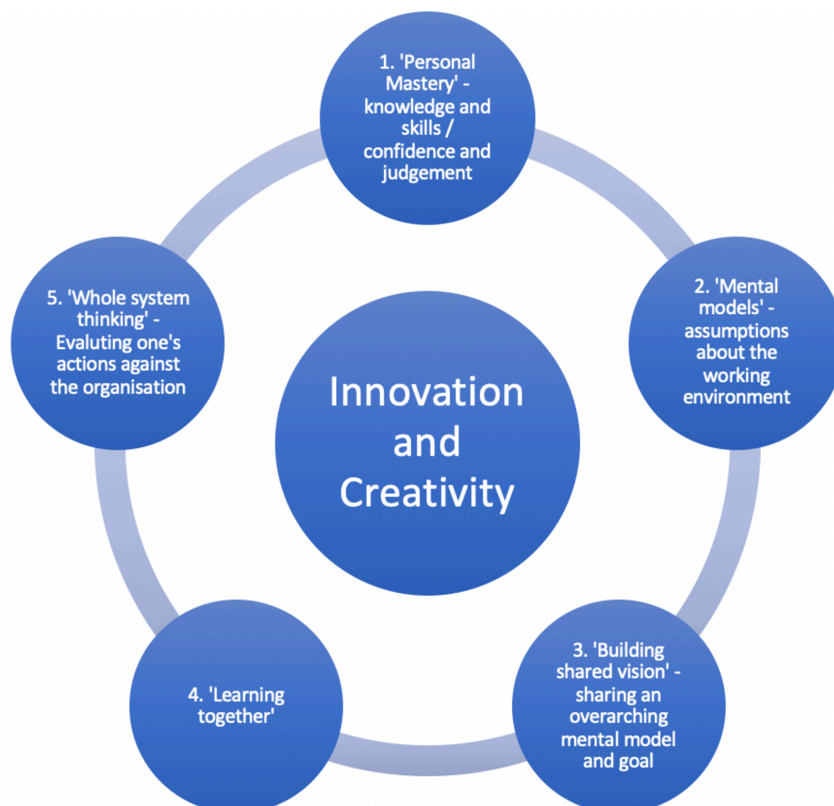
in particular for teams to be assured that their innovation is not only beneficial but well-received in the team culture. However, the authors add that the role of individual (professional) identity factors are often under-researched in terms of how contextual factors are formed and shaped. The present analysis is able to contribute to the understanding of this concept by demonstrating the way in which the "expertise" and "responsibility" discourses interact with the innovation discourse.

6.4 Systemic Implications of Innovation and Creativity Professional Identity

Witzel argues that as Integrated Therapists interact in novel speech communities "their awareness changes, and they begin to view the world in new ways…[which] leads to deeper changes in attitudes and beliefs" (Witzel, 2017, pp. 310).

Figure 15

Visual Representation of "the Learning Organisation" adapted from Witzel (2017, pp. 310) in relation to the Innovation / Creativity Discourse



The innovation / creativity discourse relates to a rather different aspect of interprofessional identity in comparison with the expertise discourse. Expertise is concerned with the knowledge and skills possessed by professionals, including the extent to which this knowledge is used and expertise recognised (personal mastery). The analysis found that beliefs about working environments (mental models) impede innovation:

"The overall system doesn't lend itself naturally to it" – Integrated HI [FG5]

However, as shown by conflict resolution and formulation members of the speech community discover their shared values and work out which values and behaviours should be prioritised (building a shared vision). Creativity and innovation are associated more closely with *tacit knowledge*, defined as "knowledge that is possessed by individuals that is hidden and not expressed in written form nor easily expressed orally" (Fernandez et al., 2020, pp. 537). Through the discourse Integrated Therapists test the acceptability of creative and innovative beliefs with their peers (learning together).

A study of aerospace scientists explored professional identity in a way in which the present innovation discourse may be examined. In this study, Lifshitz-Assaf (2018) argues that working within knowledge boundaries protects professional identities, however the result is the rejection of innovative practice. Many professionals, the author argued, would view attempts of others to take greater responsibility on a project viewed as their own as a threat to their professional identity whilst those who are on the fringes of a profession may be more willing to adopt new practices. A new collaborative model focused on professional identity was trialled. Participants began to view their boundaries as restrictive and collaboration as a means of "boundary perforating work" such that knowledge and skills can be allowed to flow in and out without undermining identity.

6.5 Chapter Summary

This chapter has extended the analysis of the expertise and responsibility chapters by discussing the relevance of tacit knowledge and systems in the expression of innovation. Key findings were that Integrated Therapists considered the cognitive capacity for creativity as part of their professional identity but required the organisation to be a welcoming environment to enable/allow behavioural expressions of innovation to be present. Participants were most animated when sharing stories of innovation and were keen for others to recognise this as part of their professional identity which is considered to set them apart from the historical discourse of IAPT as a formal, process-driven programme. Innovation is seen by Core Therapists and physical healthcare professionals as needing considerable motivation from individuals to move it forwards and is presented as rewarding patients, services and therapists themselves in terms of job satisfaction. However, Integrated Therapists begin to set themselves apart from their colleagues by presenting innovation and creativity as a central skill unique to their profession rather than confining it to champion roles although they appear to be affected by the historical systemic discourses which can be an impeding factor. In the concluding chapter, the key findings will be reviewed and recommendations provided from the study.

Chapter 7 – Conclusions and Implications

The concluding chapter will consolidate the key findings from the analysis and situate the thesis in terms of implications, originality and contribution to the field. The chapter will be structured around the research objectives and how the findings respond to the three research questions posed. Recommendations will be made for clinical practice and for future research, and a reflexive stance will be taken. An analysis of strengths and limitations will be undertaken.

7.1 Conclusions

Integrated Therapists are in a crucial stage of professional identity development and the thesis has shown that professional identity is a dynamic concept in which identity is influenced by both individual and professional network factors. The inception of the Integrated Pathway has meant that psychological therapists have acquired a novel set of skills for adapting CBT for comorbid presentations and they are developing much closer relationships with their physical health colleagues. Integrated Therapists have learnt to adapt their Cognitive Behavioural Therapy skills effectively and are seen both by their proximate Core colleagues and by their physical health partners to be proficient and highly regarded. The transformational identity shift includes a modulation in tone as described by Kralik and colleagues (2006) as Integrated Therapists appear to prioritise thinking creatively about complex clinical problems as a central part of their professional identity. However, confidence and perceived permission to utilise creative skills can be impeded by siloed clinical arrangements and moderated by meaningful connections with colleagues. Interaction with Core and physical health colleagues appears to strengthen capability beliefs, in conjunction with

training and systemic factors augment internalisation of values. These findings are consistent with Bentley and colleagues' (2019) notion of Scaffolding Identity Construction according to which cohesive professional identity built on core values is more likely to increase motivation and a proactive professional stance.

The analysis provides insight into the discourses which are available and inhibited to those working for the mental and physical health of clients with long-term health conditions. The discourse analysis explored three 'Big D' emerging discourses of 1) expertise, 2) responsibility, and 3) innovation / creativity, analysed through the Critical Theory discourse paradigm.

7.2 Research Question 1 - *How has the professional identity of Integrated Therapists developed and changed over time, and how do collaborative working relationships affect their self-conceptualisation?*

Therapists were shown to be actively engaged in reconstructing their professional identity and co-constructing how their profession aligns with the objectives of their organisation and their colleagues. Integrated Therapists possess a unique set of skills which allows them to differentiate themselves from their Core colleagues. They draw on cognitive behavioural theory, training and models of adapting to long-term ill health in order to holistically conceptualise comorbid presentations and they value innovative ways to work with a broad range of colleagues.

Training was foregrounded as an important means for developing competency beliefs to work with comorbidity, and specialist training was one way in which Integrated

Therapists mark themselves out as unique amongst other professions. Conversely, formal training *contributed* somewhat to therapists feeling deskilled. Integrated Therapists perceived that they were expected by their colleagues, who hold them in esteem and clients who rely on their expertise, to have a great deal of knowledge about a wide range of medical complaints. It became more likely then, that therapists would conceptualise their clients as "complex."

Interestingly, Integrated Therapists appear to be constructing their professional identity in part around the notion of complexity. On the one hand they perceived the ability to work with multimorbidity to be influential as both the *raison d'être* of their profession politically and a desirable professional characteristic. As an Integrated PWP in FG1 described, *"obviously for us it's just natural, we're trained in it, that's what we do."* On the other complexity was associated with greater uncertainty which could not be satisfactorily resolved through pedagogical means alone.

Integrated Therapists' professional identity was also reconstructed through their interactions and context. Role stereotypes and uncertainty about boundaries between services and the extent of one's own profession were important in therapists' discourse. Collaborative working relationships allowed therapists to test the boundaries of their professional identity and how they were received by their colleagues. Integrated Therapists assumed greater responsibility for finding solutions to complex clinical problems and were able to demonstrate core skills and creative thinking through narratives and formulating a response to the vignette. Such "self-formation strategies" (Gent, 2017, pp. 53) allowed therapists to work within the boundaries of their

organisation and role but the subjectivity and positioning devices adopted allowed participants to test creativity as a feature of Integrated Therapy.

NICE guidelines and role definitions were a useful baseline for identity but the creativity discourse was helpful for participants to both adapt to structural changes within the organisation as a result of service transformation and also flourish within the gaps in the evidence-base. The Integrated Pathway is considered to be the way forward for all professions represented, which aligns with the direction of the NHS but a significant adjustment is required and siloed working remains an obstacle which participants are overcoming by developing a novel discourse to flourish in the new team dynamic. As Legood and colleagues (2019) suggested for social workers, the importance of increasing the visibility of good work undertaken is also a highly recommended for Integrated Therapists and their teams. This thesis adds that this is not only relevant for the public image of the profession, but also to bolster individual confidence in integrated therapy.

A further means of shaping professional identity was conflict resolution. The notion that systemic change can pose threats to professional identity is well documented, including between members of professional groups (Callan et al., 2017). Little had previously been written, however, about conflicts between collaborating individuals as they grapple with case formulation and negotiate role boundaries with the organisation's priorities (Martinez, 2000). This analysis has shown how role stereotypes can enhance or inhibit collaborative practice and can be a way for individuals to better understand one another. Indeed, conflicts are inevitable when interacting within different professional groups. Wherever possible, conflict resolution

can be an effective means of understanding one another better, negotiating role boundaries and thereby improving care quality as long as all parties are acting in the best interests of their client (Ham & Alderwick, 2015). Taking opportunities within interprofessional networks to promote integrated therapy accurately is a further key recommendation from this study,

7.3 Research Question 2 - *What discourses are available or prohibited to therapists and physical health professionals regarding collaboration in the context of comorbidity?*

The response to this research question will be subdivided into each of the three Big D discourses.

Expertise

Two client discourses emerged. Firstly, clients were positioned as passive or fearful agents in the healthcare system which activated responsibility beliefs whereby therapists would orient themselves to find solutions to the client's problems. The second discourse was the "client as a consumer with high expectations." According to this discourse, Integrated Therapists perceived their clients as expecting their therapist to have an in-depth knowledge of multiple health conditions and healthcare systems, the gaps in which activated the *"out of my depth"* discourse.

The dichotomy between Core and Integrated Therapists also was found to have a de-skilling effect upon Core Therapists, particularly when comparing themselves to Integrated Therapists. Some Core Therapists positioned themselves as having no

training, permission or skills to effectively treat psychological difficulties alongside comorbidities although this was not consistent across all speakers. The resulting action orientation was to engage in *othering* clients with comorbidity. However, competency beliefs were more accessible through discussion of clinical cases such as the vignette as Core Therapists were able to draw on their skills, training and clinical experience of working with LTC/MUS.

Responsibility

Collaboration, by definition, involves multiple professionals working around a client's needs. There is a shift within NHS Trusts lately from siloed services competing for tender from commissioning groups succeeding or sinking on their own merit, to emphasising how organisations will work together as a cohesive whole. In order for this to be effective, it was foregrounded in this discourse for expertise be realised and utilised, and to share resources without overlap or replication. Who takes ownership for a case, or a part of the client's recovery journey is an important question which this thesis sought to answer. Most participants indeed seemed concerned about how their involvement or not in a client's care would affect the client's experience as they move through the care pathway. They were concerned for clients to receive a streamlined service to avoid unnecessary repetition.

Systemically, an interesting paradox emerged from the analysis of the responsibility discourse. On one hand most professional groups tended to assume clinical responsibility stopped with them, whilst on the other the perceived changes in *"remit"* activated the *"that's not my job"* discourse in Core and physical health groups.

Responsibility was constructed to lie with either the profession perceived as possessing the greatest skill, or the greatest authority to treat LTC/MUS. Thus, even though Core Therapists felt they had something to offer clients with comorbid presentations, the action orientation often involved transferring responsibility to Integrated Therapists on the assumption that Core Therapists no longer had a remit to work with the client group.

The strength of the collaborative network impacted on the responsibility discourse. Good quality relationships were described as mutually beneficial in terms of sourcing suitable treatment(s) for clients, ease of referral routes, and each professional offering their *“unique skills.”* When Integrated Therapists do not have faith in collaboration they invoke the *“too busy / burnout”* discourse.

Creativity / Innovation

Lastly, Integrated Therapists tested out the acceptability and possibilities for being creative in their developing professional identity. The discourse suggested that the innovative thinking was a valued identity characteristic, and something unique to Integrated Therapists in terms of applying their specialist knowledge to resolving complex clinical dilemmas. Creativity was, however, inhibited by the discourses of *“the organisation as not hospitable to expressions of creativity”* and *“creativity as needing to be driven by individuals.”* When this discourse was utilised, speakers often figured a world (Gee, 2014a) in which innovation is paired with Integrated Therapy and collaborative working more broadly using the construction “wouldn’t it be wonderful if…?” Innovation was legitimised in the discourse by pairing creativity with positive

patient outcomes, upskilling (Reyes, 2011) and visibly presenting desired characteristics to others as a politically desirable trait (Legood et al., 2019).

Witzel compares the relative merits of "incremental" innovation over an extended period with "rapid / breakthrough" innovation emphasising that successful developments are often more sustainable through "continuous, incremental innovation" (Witzel, 2017, pp. 309). IAPT leaders and team culture play a role in permitting creativity in the emerging discourse if innovative behaviours are positively reinforced. Witzel (2017) further notes that organisations cannot rely too completely on their infrastructure but instead should consider relationships and individual creativity to be the driving force steering the Integrated Pathway.

The analysis of the Innovation / Creativity discourse found that Integrated Therapists are testing out new aspects to their identity as they find their place amongst their colleagues and their clients' expectations. They initially seem to place importance on training as a means of resolving this discomfort, however the analysis of the creativity / innovation discourse suggested that they are beginning to find a niche set of skills to draw upon which is likely to be meaningful in reconstructing their professional identity above and beyond traditional champion roles and differentiating themselves from their Core colleagues.

7.4 Research Question 3 - *How do professionals use discursive and rhetorical devices to construct their professional identity?*

In order to develop a cohesive profession identity it is important for Integrated Therapists to meaningfully engage with their patients and professionals with whom they hope to develop strong collaborative relationships (Gordon & Luke, 2015). As Gorden and Luke suggest, it can be challenging to adjust one's boundaries and therefore tentative language tends to appear in professional discourse. The analysis illustrated how therapists adopt metadiscursive devices in this manner to introduce and test out professional identity features amongst their peers (Martínez-Guillem, 2009), for example by interweaving psychological and physical health concepts into their case conceptualisation.

The analysis found that emoting overtly was rarely utilised, which is common in professional discourses. However, the analysis explored instances in which overt emotion was expressed or implied as implicit or explicit emotional expression is likely to prime a response in the listener as well as the speaker (Lindquist et al., 2015). The analysis of emotion included a detailed inspection of the use of metaphor in relation to the emerging discourses. Responsibility was an emotive topic which evoked metaphors of *“passing the parcel.”* When a clinician felt they had insufficient expertise, or when collaborative relationships were not strong metaphors drew on the semantic field of war. The analysis of this metaphor highlighted that role stereotypes were an important factor in power imbalance. Lastly, an alternative hopeful metaphor of collaboration as an *“orchestra”* was evoked to construct the notion of professionals working together harmoniously, each contributing towards a holistic outcome. The fluidity with which metaphors were adapted appears to show work being done to construct a cohesive professional identity.

7.5 Recommendations

The study has a number of recommendations to offer organisations and professionals working with clients with LTC/MUS. The recommendations will focus particularly on Integrated Therapists working in the IAPT LTC/MUS pathway, and the subsection structure is informed by the three key factors highlighted by Best and Williams' (2019) findings from a scoping review of the intersection between individual professional identity and interprofessional teams. In the scoping review Best and Williams (2019) argued that considerations should include 1) implications for individual professional identity development and evolution, 2) strategies for overcoming roadblocks which impede successful adaptations, and 3) considerations for organisations and leaders.

Firstly, training is recommended to be routinely offered from psychological and physical health disciplines. It was evident that participants would be less likely to accept the offer of training, or at the least give it only casual attention unless educational resources directly apply to current clinical caseloads, a principle described as the "target for relevance" approach (Elvira et al., 2017, pp. 194), and therefore training programmes could be planned with staff involvement. Peers were also an important factor in developing a strong professional identity, which also helps remain buoyant during service transformation, thus organisations could consider involving expert peers in less formal expertise sharing and case discussion.

Elvira and colleagues (2017) Integrative Pedagogy Model recommends that initial training should draw attention to concepts and complexities in order for those entering healthcare professions to develop their critical thinking, supported in the IAPT Competency Framework for LTC/MUS which notes that it can be particularly the case

for MUS that therapists fall into either-or thinking which can impact outcomes for this population (Roth & Pilling, 2015). Elvira and colleagues (2017) argue that clinical dilemma resolution can aid in this process, whilst anchoring therapists within the evidence-base which has been shown to reduce vicarious traumatisation and burnout in therapists working with complex trauma (Craig & Sprang, 2010). Initiatives such as Schwarz Rounds in which clinical dilemmas or personal reflection is shared by clinicians and leaders have been utilised in healthcare and business for just such a purpose. Such programmes enable participants to explore their profession beyond the functional level and engage more deeply with their own professional identity and understand their colleagues' identities in a more holistic way and have been shown to be received positively by clinical staff (Flanagan et al., 2020).

Programmes which focus on connection with identity factors has also been shown to be helpful for developing emotional resilience during service transformation and to prepare for future challenges in healthcare (Clancy et al., 2020; Legood et al., 2019) which is all the more important with greater degrees of complexity, multimorbidity and uncertainties in Integrated Therapy. In short, providing greater opportunities to transmit tacit knowledge is more likely to be achieved with proximal interaction, collaborative reflection to "lift it into the bearer's consciousness and make it available to be transmitted" (Fernandez et al., 2020, pp. 524)

Finally, the study recommends that organisations promote the specialist knowledge and innovation that their Integrated Therapists offer. The research has shown that individuals are better able to access competency beliefs when they have the opportunity to use them, when they are positively reinforced and when they have a

visible template from peers to support collaborative practice. The research has shown that tacit knowledge as a discourse is more transmissible when individuals drive professional priorities forwards and encourage others to adopt these concepts into their conceptualisation of what it means to provide integrated psychological therapy.

In siloed working environments Integrated Therapists are unlikely to recognise the esteem afforded them by their colleagues, and less likely to feel confident in using their expertise which would risk feeling deskilled and could lead to self-doubt or passing responsibility. Furthermore, in terms of intrateam power dynamics, status inequality has been demonstrated to be a moderating contextual factor which can impact on teams' utility of innovation and creative discourses (Park et al., 2018). Regular interprofessional contact is therefore encouraged to be part of team culture, however as Xu and colleagues (2019) point out, team culture is also dependent upon individual personality. Therefore, in order to foster creative thinking and innovative practices organisations should consider creating opportunities for staff to follow specialist interests (Park et al., 2018), reinforce common values in team especially in times of transformation and uncertainty (Hall, 2005; Smith et al., 2020), and include innovative members of staff in interprofessional projects (Xu et al., 2019).

7.6 Recommendations for Future Research

Lastly, a recommendation can be made for future research in this area. Foucault (1993) asserts that normative power struggles are ever present and should be somewhat anticipated whenever individuals interact. Power dynamics and individual personality differences are likely to create conditions for the "key informant" effect in focus groups whereby certain group members become dominant (Payne & Payne, 2004). This is

both a strength and a limitation. The power dynamics in such a setting can yield rich insight into which discourses are privileged, which are not permitted and what are the obstacles that prevent participants' aspirations from transpiring into reality. However, the "silenced discourses" (Herzog, 2016, pp. 285) are likely to be underrepresented. Herzog (2016) presents a sociologically focused discourses analysis to reconcile the silenced discourses upon the assertion that suffering is a universal norm and avoided wherever possible. This thesis does not seek to comment on sociological discourse analysis, and perhaps "suffering" is too strong a term in this context. Rather, there are clearly points of conflict, distrust / disrespect, and discomfort which can silence important discourses in the construction and evolution of professional identity in the world of IAPT and Integrated Therapy which may be more accessible to researchers in an individual interview setting or ethnographic research methodologies.

Furthermore, discourses can also be silenced by other means. In addition to the rhetorical devices discussed there are also professions which are not represented in the study. Whilst IAPT services have a larger cohort of CBT-oriented therapists many services also employ Employment Support Co-ordinators, Counsellors for Depression, Interpersonal Therapists and perhaps therapists from other therapeutic backgrounds. Given the smaller distribution in IAPT services (Health Education England, 2022) it may be unsurprising that these groups were not more greatly represented in the study, however their absence may be part of the silenced discourse preventing them from taking part in the debate. Indeed, therapists from minority orientations in IAPT terms have written about just such experience of being a counselling minority group working in a CBT-dominant profession, (Mason & Reeves, 2018; Proctor et al., 2019). These two studies emphasise the marginalisation of counsellors in IAPT and pressure to be

IAPT compliant (Owen-Pugh, 2010) and from a psychodynamic perspective (Gent, 2017). Many studies describing such a *culture clash,* as Proctor and colleagues (2019) title their study, write of first-hand experience which could indicate a difficulty in recruiting marginalised voices in IAPT to discuss their profession identity which is suggestive of a role for discourse analysis. Future research should therefore seek to recruit participants from a wider range of IAPT professions.

7.7 Strengths and Limitations

Gee (2014a) notes that Critical Discourse Analysis, and indeed many other qualitative methodologies, are often critiqued for their inability to contribute to the understanding of a concept in a reliable, credible and trustworthy manner. Discursive methodologies in qualitative research are particularly interested in the evolution of discourse and "tracking its emergence" including how discourses compete, interact and are shaped by speakers. The Critical Paradigm applied to Discourse Analysis focuses the researcher's attention on marginalised voices and silenced discourses (Levitt, 2020, pp. 27). Data are, however, shaped by the researcher's perspective and each qualitative tradition has tools at their disposal to evaluate the trustworthiness of findings based on their ontological and epistemological underpinnings (Starks & Brown-Trinidad, 2007). Gee (2014a) suggests that it is not accurate to dismiss Discourse Analysis as solely the opinion of the researcher or as subjective, but rather he proposes four criteria by which Critical Discourse Analysis can be evaluated in terms of trustworthiness based on a systematic and logical analysis using the range of discourse building tools in the analysis framework. These are: 1) *Convergence*, defined by Gee as the extent to which the responses to the building tools are confluent across the corpora, 2) *Agreement*, defined as the extent to which respondents are

consistent in their responses, 3) *Coverage* such that the historical context and the ability to infer future predictions from the findings are considered, and lastly 4) *Linguistic details* such that grammatical and lexical devises are sufficiently and rigorously interrogated in the analysis and interpreted alongside the discourse construction.

The *key informant* effect risks minority or less-dominant characters' views being under-represented and thereby missing important undercurrent views, reactions and attitudes. This effect was notable in many focus groups, for purposes of evaluation the example of Focus Group 5 will be considered in which one speaker, a Consultant Psychiatrist, emerged as dominant in terms of adopting an expert stance, story narration and air-time utilised by the speaker. Although the speaker deferred to others, and was respectful and attentive by allowing and inviting others space to contribute they would likely meet the two criteria of a "key informant" as outlined by Payne & Payne (2004) in the sense that they held a hierarchically elevated position and adopted an extroverted interpersonally communicative style.

This focus group was selected as one in which less dominant voices may be under-represented and therefore an invitation was extended via email to participants in this focus group to add a further contribution. The wording was considered carefully so as not to influence the direction of the response, that is that participants were invited to write a short response about their experience of taking part, including anything that they particularly wanted to highlight or anything they held back from saying. Seventy five percent of the group members responded to the invitation. The Consultant

Psychiatrist and Integrated HI highlighted topics contained within the discussion and reinforced concisely their stance on these.

A relatively recently qualified Core HI however commented on power dynamics, they felt that *“having come from the non LTC team and not having any formal experience in physical health care settings I think I may have found it intimidating.”* They added that the discussion topics felt relevant to them, thus suggesting that Gee’s agreement criterion was met, but that it *“highlighted my own personal gaps in knowledge.”* They positioned themselves as someone enthusiastic about integrated working which had informed their decision to participate in the study and valued *“the relationship building between the physical and mental health care worlds.”* This respondent commented on the impact of power dynamics and expertise in the discourse, themes identified in the main data analysis, which suggests that Gee’s (2014a) *convergence* test can also be viewed with more confidence.

A further limitation which became evident through the focus groups and the above invitation to comment separately, was that of sampling bias. Sampling bias is a critique often levelled at qualitative research in terms of selecting participants (Collier & Mahoney, 1996). The sample included a wide range of experience and a mix of trainee and qualified professionals. The focus group schedule provided prompts for participants to access their prior knowledge and hypothesise on the future outcomes suggesting that Gee’s (2014) *coverage* criterion is likely met. Efforts had been made to reduce sampling bias throughout in terms of the recruitment strategy and materials.

Collier and Mahoney (1996, pp. 57) point out however that this can “create as many problems as it solves” as it became apparent that many participants outside of Integrated Teams had a particular interest in integrated working and may have decided to participate because they had a special interest rather than representing a generalisable sample. For example, a midwife and physiotherapist in different focus groups both self-identified as having a special interest and/or champions role in long-term conditions and mental health. Even those who expressed less confidence in their expertise such as the Core HI quoted above expressed a particular interest in integrated working which may have influenced their decision to take part. With regards to Gee’s (2014a) “linguistic detail” criterion, the analysis was formalised with regards to credible psycholinguistic sources and steps were taken to increase researcher objectivity.

Thirdly, a procedural choice should be highlighted. The author of the vignette contributed the scenarios through PPI involvement with the study. They provided two vignettes which met the brief. The same vignette was used in the same format across each group which has advantages and disadvantages. This method was chosen to ensure consistency and increased confidence in the trustworthiness of the findings in accordance with Gee’s (2014a) agreement test. There is however, a contrasting argument that by varying the vignette (or using the other option provided in PPI), a broader model can be constructed regarding the emergence and evolution of discourses (Wooffitt, 2005, chapter 4). The topic of the vignette was designed to be sufficiently applicable to all participants even if they do not work directly with the conditions therein. However, in FG1 a midwife stated that they found it hard to relate

the topic to their own clinical work. They were able, however, to apply their experiences to clinical dilemmas which they encounter.

7.8 Reflexivity

"Culture is "alive" in individuals who are actively engaged with cultural practices"

- *Galliher et al. (2017)*

In the methodology chapter, the framework for reflexivity was discussed. In this subsection, attention is turned to the researcher journey with a reflexive eye on subjectivity, positionality and situated contextual influences upon design, methodological and analytical aspects of this thesis. In particular, the extent to which the research was shaped by the researcher, the duality of researcher/clinician roles and the ways in which the research and analysis were shaped by myself and the participants will be considered. The reflexive account will be written in the first person.

The service context in which I work, and my role as a Core HI Therapist is likely to have influenced the research process. The service was an early implementer site for the Integrated Pathway and therefore myself, and many of my IAPT-working participants, were exposed to the political and organisational desirability favouring the success of the Integrated Pathway. This too was reinforced through the research priority search. I therefore sought to reduce the likelihood that being privy to some of these contextual factors would preferentially bias the research question through the four-phase PPI approach which included a wide range of stakeholders beyond IAPT's doors and consideration of my "point of view" as Blanchard and colleagues (2007) describe.

As an IAPT therapist in addition to researcher, it is possible that I was positioned by participants as holding a political agenda to preference the pathway and therefore they may have withheld some critique or promoted perceived desirable characteristics of integrated therapy. Indeed, I noticed that I felt inclined to write in a favourable manner about the Integrated Pathway. Revisiting my research log, I reflected that physical health clinicians were often forthcoming with connections they had made and projects they were involved with. In FG1, a Midwife self-identified as a "Midwife and LTC Specialist" and reported that she felt *"quite lucky in my role that I have quite a lot of scope"* to utilise her skills. She positions herself as someone whose *"role is educating staff"* and in this group she is a more dominant voice than IAPT therapists. This raises two interesting reflections. Firstly, as she and other physical health clinicians position themselves as outliers in their field, it is possible that there are some discourses not present from clinicians less invested in integration. Secondly, by presenting oneself as someone sharing expertise this may exert power over discourse availability and the interactions with other group members. In my research log, I observed similar effects in other groups. In FG5 a Consultant Psychiatrist is a dominant voice throughout, evident from the larger quantity of speech and his use of narrating stories from previous points in his career or practice. This may have exerted power over the psychologist therapists' discourse, for example in this group I observed an Integrated HI was conscientious of their wording, often hesitating or self-correcting:

> *"…you know, and and CBT is very much about- well any kind of collaboration isn't it- or <u>any</u> kind of therapy- physiothera- so that that is um I think a big part when I think of the word "collaboration"*

> *as well that this agreement that we're in this together and we're going to- you know someone is not- the patient isn't a (.) or the* *<u>client</u>* *isn't a silent.partner.in.it" – [Integrated HI, FG5]*

During this group I felt that other participants had less power to contribute, or to introduce new topics and I was unsure whether to interject. As Stewart et al. (2007) argue, it is sometimes appropriate for the researcher to offer new topics into the discussion although this can risk confirmation bias or raising topics of interest to the researcher which may not be so for participants. I opted instead to send an email asking for broad feedback from each participant without suggesting a theme as I was curious whether less dominant voices had experienced inhibited power. The responses, which can be found in Appendix 8, were consistent with this as the more dominant voices of the Consultant Psychiatrist and an experienced Integrated HI reiterated discussion points, whilst a more recently qualified Core HI positioned herself as someone wanting to learn from others.

It was possible that by facilitating the focus groups as both Researcher and Core IAPT Therapist there was a potential for bias. I had sought to reduce the likelihood that being privy to some of the service-level contextual factors would preferentially bias the research question through the four-phase PPI approach which was implemented to include a wide range of stakeholders beyond IAPT's doors and a conscientious approach to wording and interpretation of findings was taken. However, although it was not directly expressed, participants may have perceived an agenda to promote Integrated Therapy.

From the outset I was encouraged by the welcoming response to recruitment. I received several enquiries to take part throughout the recruitment process, particularly from IAPT therapists. The range of physical health professionals was somewhat surprising however. The service in which I work as a Core HI Therapist was an early implementer site for the Integrated Pathway and I had been aware that the service had initially worked closely with diabetes, obesity and COPD organisations yet none of these physical health groups of professionals enquired. Notably I received a large number of expressions of interest, even after the study had finished recruiting, from professionals working with chronic pain, functional neurological disorders, and those working with people adapting to developing chronic conditions. Reflecting on who was most interested in participating influenced the audience I held in mind as the research developed and the recommendations section was written.

Generally speaking, participants appeared to present themselves as caring, pleasant and agreeable people which led me to wonder whether they were leaving important views unsaid for fear they would be too risky to express. I wondered therefore whether they regarded discussions of systemic barriers to collaboration as safer territory, or indeed whether participants were saying what they thought I wanted to hear. There was an interesting brief exchange in Focus Group 4 in which participants seemed to be excessively polite to one another in terms of turn-taking. There is a particularly stark example in which a Physiotherapist begins to elaborate on the idea of gaps between services which is often a source of conflict and was a hot topic at the time of interview in the region due to the creation of new Primary Care Networks which had shifted the geographical boundaries and remit of some teams which would have affected all professionals present. The speaker did not develop this discussion, stating *“we’re just*

detracting from [the Facilitator's] question" and responded later in the discussion to the invitation to highlight one aspect most important to them by saying *"what's the one question you've got for us [Facilitator] that you wish you'd asked that would help your research?"*

My status as an IAPT Therapist and Researcher may also have been influential upon Integrated Therapists. As a group of people, they appeared keen to emphasise the successes of their role which was the source of a rare expression of interprofessional conflict during the focus group which was discussed in the analysis. Furthermore, by sharing a professional affiliation with the Core IAPT participants my attention was drawn to opinions perceived as outliers from my contextual experience of IAPT. Revisiting my research log, I had reflected after a number of focus groups that Integrated Therapists did not appear to be hesitant in discussing the perceived pitfalls, frustrations or conflicts that they had observed. Using the Positionality Map, I reflected upon my preconceptions and utilised a structured approach to coding and analysis including methodological approaches to representing and reporting dominant and silenced discourses and was conscientious to represent the emerging and silenced discourses fully in the thesis.

7.9 Final word

To conclude, as the Integrated Therapist role becomes more established for clients with comorbidities developing a robust sense of professional identity is likely to be beneficial for effective collaborative care. This thesis has shown that whilst collaborative therapy is valued and recommended, it is often poorly operationalised. The inception of the Integrated Pathway has been demonstrated to be an important

identity transition milestone which has required Core and Integrated Therapists to reconstruct their identity and relationship with one another.

The research has illustrated that Integrated Therapists are adapting the way they conceptualise psychological difficulties for those with LTC/MUS and this means they feel upskilled and can employ creative ways of approaching complex clinical problems. Many therapists, however, doubt their confidence when their sense of professional identity is not cohesive and role stereotypes impede good working relationships. Services and individuals tend to rely on training to resolve complex clinical problems, however this does not appear to be sufficient based on these findings. There was compelling evidence to recommend that organisations and individuals invest in clinical activities which involve strengthening interprofessional networks and connecting with professional values. Provided the conditions are amenable, conflict should be anticipated and welcomed as a means of learning from one another. All therapists and healthcare professionals engaged in collaborative therapy are likely to enhance Cognitive Behaviour Therapy as clients adapt to, and live with their long-term conditions. Their rich and diverse knowledge base and tacit skills are key to providing clinically excellent patient-centred care. Care quality and therapist self-efficacy will likely be ameliorated by taking time to invest in professional identity, close professional networks, and by raising the profile of innovative work and good collaborative practices.

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Appendix 1 - Ethical Approval

Mr. Jamie Elston-Short
TALKWORKS
109 Boutport Street
Barnstaple, Devon
EX31 3FQ

Email: approvals@hra.nhs.uk

27 July 2021

Dear Mr. Elston-Short

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Enhancing primary care psychological therapy for clients with comorbid physical health conditions: A discourse analysis investigation into interprofessional identity**
IRAS project ID:	**296626**
Protocol number:	**2020-21-25**
REC reference:	**21/HRA/3331**
Sponsor	**University of Exeter**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **296626**. Please quote this on all correspondence.

Yours sincerely,
Deanna Herron

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms. Pam Baxter*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Contract/Study Agreement template [296626 Sponsor Letter to CI - DA of PIIT Study]	1	09 July 2021
Copies of materials calling attention of potential participants to the research [296626 Poster - DA of PIIT Study]	1	04 May 2021
Copies of materials calling attention of potential participants to the research [296626 Email and Social Media Text - DA of PIIT Study]	1	04 May 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [296626 Certificate of Employers' Liability Insurance - DA of PIIT Study]	1	01 April 2021
Interview schedules or topic guides for participants [296626 Focus Group Schedule - DA of PIIT Study]	1	04 May 2021
IRAS Application Form [IRAS_Form_26072021]		26 July 2021
Letter from sponsor [296626 Sponsorship Confirmation Letter - DA of PIIT Study]	1	09 July 2021
Organisation Information Document [296626 OID - DA of PIIT Study]	1	16 June 2021
Participant consent form [296626 Consent Form - DA of PIIT Study]	1	04 May 2021
Participant information sheet (PIS) [296626 Participant Information Sheet v1 - DA of PIIT Study]	1	04 May 2021
Referee's report or other scientific critique report [296626 Academic Assessment of Protocol - DA of PIIT Study]	1	04 May 2021
Research protocol or project proposal [296626 Protocol v1 - DA of PIIT Study]	1	04 May 2021
Schedule of Events or SoECAT [296626 SoE v1 - DA of PIIT Study]	1	04 May 2021
Summary CV for Chief Investigator (CI) [296626 CV CI - DA of PIIT Study]	1	04 May 2021
Summary CV for supervisor (student research) [296626 CV Supervisor - DA of PIIT Study]	1	25 May 2021
Summary CV for supervisor (student research) [296626 CV Field Collaborator - DA of PIIT Study]	1	02 June 2021
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [296626 Certificate of Public Liability Insurance - DA of PIIT Study]	1	31 March 2021

Appendix 2 – Systematic Review: Summary of Studies and Critical Analysis

Article	Author(s)	Design / Methodology	Analysis	Key Findings	Critical Evaluation	Future Recommendations	CASP Rating
1	**Ambrose-Miller & Ashcroft (2016)** *Canada*	Focus Group of social workers educators, practitioners and students, n=11	Thematic Content Analysis 'with elements of Grounded Theory	Professional identity is weakened by conflicting messages within the profession Power dynamics influence clinical decision making	**Strengths:** Relationship between findings and theoretical underpinnings explored in a detailed manner. Consideration of power dynamics **Limitations:** Demographic information not collected. Not audio recorded, rather a Research Assistant took notes risking transcription errors / missed verbal / non-verbal data	Organisations should attract individuals overtly with the expectation of collaboration Collaboration should be driven by dedicated individuals	Yes: 4 No: 4 Can't tell: 0 Total: 4/8
2	**Baker & Lattuca (2010)** *USA*	Theoretical Framework	Theoretical Article	Experience is a stronger factor than age for effective. Outcomes of training are epistemic and ontological. 'Competence' relates to multiple social identities	**Strengths:** Anchored in strong theoretical underpinnings **Limitations:** Located in higher education rather than professional psychology	Research: there is a tendency to define learning in cognitive terms, studies should seek to interrogate the definition of 'learning' in identity shift	Yes:5 No:1 Can't tell:2 Total:5/8

3	**Balabanovic & Hayton (2010)** *UK*	Qualitative Semi-structured interviews N=9 (2 Mental Health Nurses, 3 Clinical Psychologists, 3 Counselling Psychologists, 1 Social worker all working with MUS). NHS, Primary Care	Grounded Theory	multidisciplinary cooperation is ‘essential’ to overcome organisational barriers to working with MUS	**Strengths:** Variety of processes utilised for analytic rigour. NHS focused **Limitations:** Despite being based in the UK recruiting participants working with MUS, IAPT CBT therapists are not represented in the sample. Of the total number of participants, it seems only 3 participated. Primary modality was psychodynamic.	Clinical Practice: ‘critical’ for psychological and physical health services to collaborate closely for clients with MUS	Yes:7 No:1 Can’t tell:0 Total:7/8
4	**Bélanger & Rodríguez (2008)** *UK*	Qualitative Literature review Range: 2001-2008 n=19 studies of primary care	Literature Review	Research consistently overlooks (inter)professional identity formation and team interaction	**Strengths:** Data transparency and comprehensive search strategy and synthesis. Demarcates differences between psychological professionals and physical health practitioners **Limitations:** Methodology unsuitable to identify features of this differences	Research: Discourse Analysis as a more sophisticated methodology to address interprofessional identity	Yes: 6 No: 1 Can’t tell: 1 Total: 6/8
5	**Bentley et al. (2017)** *USA*	Focus group of trainee psychiatrists exploring how	Thematic Analysis	Professional identity evokes a strong sense of pride and	**Strengths:** Results applicable to any profession working in patient-centred care	Services – tailor training around professional identity	Yes: 6 No: 1 Can’t tell: 1

		they characterise their profession		commitment to systematic decision making processes in practice.	**Limitations:** No exploration of power dynamics Thematic analysis may not be sensitive enough to explore how PI presents	Research – power dynamics; the reciprocal impact of effectively used shared decision making on the affirmation of Professional Identity	Total: 6/8
6	**Bentley et al. (2019)** *UK*	Semi-structured interviews with n=22 PhD candidates considering their future selves	Thematic Analysis	People who have a clearer sense of their future professional identity report higher levels of motivation and proactive career behaviour 'Scaffolding Identity Construction'	**Strengths:** Participants from a broad range of disciplines **Limitations:** Sample is not representative Participants may have told their story in a way which inspires other students in their PhD	Services – role models. Embed new team members in diverse networks of professionals and peers and encourage them to build and maintain important relationships.	Yes: 7 No: 0 Can't tell: 1 Total: 7/8
7	**Bochatay et al. (2019)** *Switzerland*	Semi-structured interviews with n=82 randomly selected physicians and nurses. Of 82, n=42 shared 52 stories of conflicts involving group processes	Social identity theory epistemological framework (qualitative methodology unspecified)	Conflicts in group processes were linked to: 1) group membership 2) intergroup boundaries/power differentials. Conflict leads to doubting own abilities, disillusionment	**Strengths:** Identified role of conflict in intergroup processes. Reduction of bias through research agreement **Limitations:** Researchers did not define power/conflict, and also accepted 'tension' and 'disagreement' which may		Yes: 8 No: 0 Can't tell: 0 Total: 8/8

				with professional ideals and negative perceptions about other groups.	indicate productive problem-solving conducive with integrated working rather than power imbalance		
8	**Choudhury et al. (2019)** *USA*	Vignettes for discussion were presented to psychotherapy trainees with issues related to clinical practice.	No analysis method stated. Narrative assessment of four vignettes using psychodynamic and counselling theoretical concepts.	Professional identity is vulnerable to external life events and perceptions of 'failed' therapy.	**Strengths:** Explains mitigating factors and interaction of life events with professional identity. Vignettes may reduce inhibition **Limitations: V**ignettes may be biased to researcher hypotheses. Team dynamics overlooked. Psychodynamic themes - transference. This concept may not align well with CBT theory discussions.	Therapists should embrace vulnerability in supervision if the supervisory relationship is strong and be aware of one's own assumptions and reactions in clinical practice	Yes: 6 No: 1 Can't tell: 1 Total: 6/8
9	**Court et al. (2017)** *UK*	Qualitative Semi-structured interviews Participants: n=11 Psychologists NHS Primary care	Grounded Theory	Therapists perceive pressure to be NICE compliant NICE guidelines are associated with professional identity formation but not sufficient	**Strengths:** Transparent interview process. Sample excluded those who have written about NICE guidelines involved in their publication. Development of a theoretical model of professional identity in times of transition and ambiguity	Research: Discourse Analysis to 'elucidate the historical, political and linguistic forces…contributing' (pp. 908). Repeat with other psychological professionals	Yes: 8 No: 0 Can't tell: 0 Total: 8/8

				on their own to create a strong, stable professional identity	**Limitations:** Findings may not be generalisable to all psychological professions or client groups	Clinical Practice: Apply NICE guidance flexibly and patient-centred	
10	**Gazzola et al. (2011)** *Canada*	Semi-structured interviews with n=10 counselling psychology doctoral students asking what experience contribute towards professional identity, and what hinders it	Inductive approach influenced by grounded theory	Identity helping factors: Resonance between own and organisation's values, supervision, mentors and belonging to a professional community. Hindering factors: 1) exposure to negative views of the profession, 2) internal conflicts	**Strengths:** Explains milestones after education **Limitations:** Does not use a core qualitative method. 'Judges' are used to arrive at a consensus of data, their role and relationship to researcher or participants is not. Wide range of therapeutic orientations, only one CBT Limited transferability	Services – training should involve connection with core values and awareness of what makes a profession unique Using supervision to address emerging professional identity more directly	Yes: 4 No: 2 Can't tell: 2 Total: 4/8
11	**Hammarberg et al. (2019)** *Sweden*	Qualitative Five Focus Groups Participants: n=29 GPs Context: conducted within a randomised trial of depression and chronic illness	Content Analysis	Care managers integrating care are useful but GPs would rather have increased access to psychological therapists. GPs were concerned about role blurring in integrated working	**Strengths:** Identification of beliefs of physical health providers which may influence their use of / endorsement of integrated care **Limitations:** GPs in England do have increased access through the IAPT integrated pathway.	Research: Explore beliefs of physical health care providers likely to refer to psychological services and other physical health practitioners involved in integrated care for	Yes: 5 No: 1 Can't tell: 2 Total: 5/8

					Semantic tangling: ‘care manager’ may map more closely onto a UK ‘Care Co-ordinator’ role in secondary care	clients with LTC/MUS	
12	**Hemsley (2013)** *UK*	Qualitative Semi-structured interviews Participants: n=9 counselling psychologists Primary care	Thematic Analysis	Professional boundaries and core principles are highly influential Professional affiliation (BABCP, NICE) are containing and provide an anchor for negotiation in interdisciplinary identity formation	**Strengths: P**rimary care therapists in interdisciplinary working, therefore applicable to psychologists and CBT therapists. **Limitations:** terminology – refers to ‘Increased Access to Psychological Therapies’ rather than ‘Improving’ suggesting the authors may not be very familiar with IAPT. Methodology overlap: primary analysis method reported as TA, yet authors report on discourses	Research: explore the underlying discourses in the relationship between professional identities and NICE guidelines Clinical Practice: NICE guidelines provide a ‘valid voice’ in interprofessional identity formation and communication	Yes: 7 No: 1 Can’t tell: 0 Total: 7/8
13	**Holmesland et al. (2020)** *Norway*	Qualitative 3 Focus Groups with two groups. Participants: group 1 - health professionals and group 2 – education.	Content Analysis	Professional identity is strongly affected by role stereotypes. Transition anchors discipline-specific values.	**Strengths:** Variation of professions and agencies. Wide view over aspects of clinical practice i.e. supervision, clients and decision-making	Clinical Practice: Increase opportunities for teamworking so networks. Focus on team identity	Yes: 5 No: 1 Can’t tell: 2 Total: 5/8

		Age range: 14-25		Expertise is more likely revealed and utilised with a strong formation of professional identity.	**Limitations:** Norway has a different healthcare system to IAPT. Healthcare professionals unspecified therefore it is unclear how generalisable findings are to IAPT. Young age range unlikely representative of CBT workforce	Research: Explore cultural barriers (dominant discourses) in times of professional identity transition	
14	**Hudson et al. (2019)** *Canada*	Qualitative Semi-structured interviews, review of policy documents and informal discussion Participants: n=20 healthcare employees	Ethnography	Effective healthcare is based on networks between professionals, providers, patients	**Strengths:** Detailed, high external validity Credibility checked by external sources **Limitations:** Canada has a different system to IAPT Professionals represented in the sample were not specified suggesting reduced generalisability to IAPT and CBT therapists	Replication with a wider population, utilising differing qualitative methods to explore mechanisms of interprofessional relationships	Yes: 6 No: 1 Can't tell: 1 Total: 6/8
15	**Hughes et al. (2020)** *UK*	Qualitative Review of concepts and narratives in interprofessional care n=71 sources	Narrative review of literature	Professional identity is related to professional core values. (Inter)professional identity emerges and develops	**Strengths:** Multiple sources Narrative analysis provides insight professional identity construction	Research: Critical Discourse Analysis to explore how conflicts and tensions are managed in the formation of new interprofessional groups	Yes: 6 No: 1 Can't tell: 1 Total: 6/8

				through networks, contexts	**Limitations:** Search terms included related to 'hospitalisation/admission' suggesting some themes relate to secondary care		
16	**Jakobsen et al. (2011)** *Denmark*	Feasibility of new measure of identity. N=428 OT, physiotherapy and nursing students post-qualification investigating identity factors	Chi Square	Recently-qualified professionals rate professional identity as the most important factor which is a shift from the declarative nature during training	**Strengths:** Large sample Multiple professions **Limitations:** Use of a non-validated questionnaire	Use focus group or interviews to understand causes to changes in attitude	Yes: 6 No: 5 Can't tell: 0 Total: 6/11
17	**Jongho-Park & Schallert (2019)** *USA*	Longitudinal study of n=34 educational psychologist trainees and counselling psychology trainees on a doctoral programme	Grounded Theory (Informed strongly by discourse theory using the 'constant comparative method'	Discipline specific discourse attained through presenting research meetings, collaborating. Discourse identity = recognition from others and signs that one has been understood, Affinity Identity = identity from experiences and distinctive practices.	**Strengths:** Extended previous research with a longitudinal study Reflexive approach **Limitations:** participants recruited from USA from one disciplinary field All trainees Researcher bias acknowledged in interpretation of qualitative data	Services – normalising identity shifts. Encourage people undergoing shifts to engage in writing articles, presenting and take part in social Research – investigate how discourse practices are related professional identity.	Yes: 6 No: 0 Can't tell: 2 Total: 6/8

18	**Julkunen & Willumsen (2010)** *Scandinavia*	Case study of n=2 social workers	Thematic Analysis	The level of individual motivation affects how well they adapt to role transition. Professional identity enhanced by specialisation. Transferrable skills aid in identity repair.	**Strengths:** Detailed data **Limitations:** Small sample, case study methodology. No extracts provided. Analysis method is not clearly defined and largely reflexive. Researchers are supervisors of both cases, possible bias. Overlooks group dynamics and contextual factors	Services are recommended to set clear role boundaries and engage in inter-team reflection	Yes: 4 No: 1 Can't tell: 3 Total: 4/8
19	**Kreindler et al. (2012)** *Canada*	Systematic review of n=348 reports	Systematic Review	N=114 of studies supported Social Identity Theory as a framework for researching professional identity Group dynamics are frequently overlooked in professional identity research	**Strengths:** Large sample Good reliability between sources Clear inclusion/exclusion criteria and search strategy **Limitations:** Issues related to career development are not discussed Other studies sow that training is less important Canada do not implement IAPT	'Social Identity Theory offers a coherent framework' to research professional identity Researchers should be sensitive to factors which make professions unique and consider their context Consider group dynamics	Yes: 7 No: 0 Can't tell: 1 Total: 7/8
20	**Kvarnström (2008)**	Scenarios (Critical Incident Technique) to	Content Analysis	'Teams' are considered a transient group of	**Strengths:** Replicating a regular team activity. Developed a model of	Services – reflection should include all members of the	Yes: 8 No: 0

	Sweden	observe interteam working with n=18 healthcare workers from 9 professions with ≥1 year experience		members. Boundary conflicts evoke strong emotions. Transition increase silences, insecurity. When respondents demonstrate lack of interest they are easily silenced	dilemma resolution in transition periods **Limitations:** Professions unspecified, but likely to include psychological professions. Participants recruited for experience of interprofessional difficulties. Personality factors overlooked.	interprofessional team Research – use of dilemma to identify inter-team conflicts and resolution	Can't tell: 0 Total: 8/8
21	**Legood et al. (2019)** *UK*	Semi structured interviews with N=16 social workers asking about how they coped with negative public criticism	Thematic Analysis	Internalising negative perceptions of one's profession is linked with burnout. Rhetorical devices are used to reword, for example avoiding the term 'social worker.' Other professions' views may be unrealistic or inaccurate.	**Strengths:** Data transparency Demographic information Steps taken to reduce bias **Limitations:** Small sample Focus on external perceptions, unclear whether this would generalise between teams	Services - training should include emotional resilience. Capitalise on positive media reporting, raise the profile of good work achieved. Individuals – take an active role to correct misinformation. Improve self-promotion of the profession.	Yes: 7 No: 0 Can't tell: 1 Total: 7/8
22	**Luca (2012)** *UK*	Semi-structured interviews Participants: Psychotherapists:	Grounded Theory	Therapists working with MUS therapist should: avoid assumptions on	**Strengths:** Methodology suitable for theoretical development. Identifies issues for CBT therapists and psychodynamic	Move away from biological primacy. Increased integrated working between primary care health	Yes: 8 No: 0 Can't tell: 0

		Psychodynamic and CBT n=12 Primary care, Two NHS Trusts		causes of MUS, idiosyncratic multidisciplinary cooperation, flexible application of change methods	therapists do differ but share commonality and intersect **Limitations:** 2 NHS departments may not be representative of all NHS therapists. Not specified whether there is a specialised LTC/MUS pathway in the services	colleagues such as GPs and psychological therapists	Total: 8/8
23	**Mellin et al. (2011)** *USA*	Semi-structured interviews with counsellors about how they define their profession. N=238	Unspecified, aligns with Thematic Analysis	Professional identity is linked to values Professional identity is influence by role stereotypes which impede inter-team working	**Strengths:** Large sample Steps taken for inter-rater reliability **Limitations:** Unspecified data analysis strategy	Pay extra attention to aspects of the profession that relate strongly to core values	Yes: 6 No: 1 Can't tell: 1 Total: 6/8
24	**Mitchell et al. (2011)** *Australia*	Survey of n=47 interprofessional teams	Partial Least Squares structural equation modelling	A strong team identity enhances the effectiveness of collaborative working Motivation to collaborate on the individual level strengthens team identity	**Strengths:** Validated measures used to measure team identity Explains previous ambiguous research with mediation factors **Limitations:** Small sample size, some key relational factors may not be	Theory and service: Developing individual motivation to collaborate with different teams can strengthen team identity Methodological: Longitudinal methods	Yes: 9 No: 0 Can't tell: 2 Total: 9/11

					identified. Tertiary medical settings unlikely to apply to IAPT	recommended for team dynamics	
25	**Molleman & Broekhuis (2012)** *Netherlands*	Survey of n=2068 medical specialists in multi-professional teams	Correlation of three personality domains	Shed light on personality domains and accountability Resilience to negative emotions weakened problems with task autonomy	**Strengths:** Representative sample with robust analysis **Limitations:** Non-significant findings for main hypothesis Cross-sectional design impacts on inference of causal relationships Individual traits may be diverse from professional group traits which may link with resilience	Explore what makes a profession and individual unique	Yes: 9 No: 1 Can't tell: 1 Total: 9/11
26	**Porter & Wilton (2019)** *Australia*	Survey using the Professional Identity Questionnaire (PIQ) of ambulatory staff, physical health care professionals and AMHPs	Mann-Whitney Correlation	Professional identity is related to time spent with one's own profession	**Strengths:** Homogenous representation of the organisation **Limitations:** Low response rate Low proportion of psychological therapists Secondary care focus	In times of transition, reinforce key elements of one's own core professional identity and align positively with new elements	Yes: 6 No: 5 Can't tell: 0 Total: 6/11
27	**Randall-James & Head (2018)**	Semi-structured interviews with	Unspecified – facilitated	Professionals are more inclined to	**Strengths:** Unsolicited positive feedback provided	Provide overt permission to test out	Yes: 4 No: 3

	UK	trainee Clinical Psychologists in CAMHS during service transformation	reflection exercise, inductive qualitative analysis	take discursive / creative risks when permission is overt. This aids in creating new narratives. Modelling from established team members is empowering	from participants suggesting **Limitations:** Analysis method and theoretical underpinnings not clearly defined	new ideas related to roles and responsibilities, such as Schwarz Rounds	Can't tell: 1 Total: 4/8
28	**Reynolds (2007)** *UK*	Analysis of 1) forums about inter-professional working on undergraduate social work/nursing course, and 2) four service user engagement programmes	Critical Discourse Analysis	Colleagues from other professions are 'othered' and their contributions devalued. Pairings help locate own professional identity such as 'therapist/client' 'mother/child'	**Strengths:** Includes a wide range of professionals Participation was not for course credit Retrospective dataset reduced likelihood of researcher effects **Limitations:** Applicability to qualified psychological practice	Services – seek interprofessional collaboration at every opportunity to reduce 'othering' Research – where academic disciplines can contribute to a policy goal, they should do so	Yes: 8 No: 0 Can't tell: 0 Total: 8/8
29	**Rose & Norwich (2014)** *UK*	Theoretical Framework	Theoretical Article	Dilemmas occur when there is a mismatch or conflict between the level of expertise and type of task leading to	**Strengths:** Enhanced theoretical stance for the dilemma resolution in collaborative working Can inform recommendations to integrated teams for	Motivational processes feed into collaborative outcomes Focus on individual belonging in group identity which	Yes: 5 No: 0 Can't tell: 3 Total: 5/8

				not using expertise. Dilemma types: role, identity, control (power)	effective working and dilemma resolution **Limitations:** Theoretical article, needs to be tested in a clinical setting	involves collective commitment. Collaboration as a dilemma resolution strategy	
30	**Scanlan (2018)** *Australia*	Survey of n=118 OTs using the PIQ	Correlation	Poor professional identity is correlated with decreased adherence to the evidence-base	**Strengths:** The PIQ has good preliminary construct validity Demonstrates the link between professional identity and outcomes **Limitations:** Small OT sample may not generalise to CBT	Use the PIQ to measure professional identity Research to explore the link between professional identity and NICE compliance	Yes: 9 No: 0 Can't tell: 2 Total: 9/11
31	**Schubert et al. (2021)** *Australia*	Semi-structured interviews with n=9 psychologists and psychiatrists working with young people	Discourse Analysis	Psychiatrists position themselves rhetorically as distanced from medical models, not 'fixers,' both embraced professional identity. Discomfort with taking risks in risk-averse settings	**Strengths:** Rigorous data analysis strategy Clear theoretical position taken **Limitations:** Open Dialogue is not used in the UK, although shares commonality with IAPT values Secondary care professional focus may not generalise to primary care	Researchers to explore language use when researching construction of social identities of professional groups	Yes: 8 No: 0 Can't tell: 0 Total: 8/8

32	**Smart et al. (2018)** *UK*	Observation of inter-team meetings n=unspecified includes managers, OT, nursing, SLT and GPs in primary care	Conversation analysis 'viewed…from a critical discursive psychology perspective' (pp. 691)	Discursive features navigate interprofessional networks Alignment through laughter and use of humour Repertoires shift from 'manager' to 'clinician' to prioritise certain professional concerns	**Strengths:** Data transparency Small sample but rich data comprising 11 hours of interactions in primary care **Limitations:** Service managers may have different priorities to CBT therapists Dilemmas unspecified therefore there may be unobserved discursive features relevant to negotiating clinical formulation in LTC/MUS	'Benefits of using naturally occurring scenarios' (pp. 695) Reflexivity and feedback in clinical decision making	Yes: 7 No: 0 Can't tell: 1 Total: 7/8
33	**Smith et al. (2015)** *USA*	Literature review of 52 peer reviewed articles, 35 books and 20 American state licensure policy documents. Semi-structured interview with n=4 nursing and psychology professionals	Critical Discourse Analysis	Professions differ in their definition of 'competencies.' 'Professional equipoise' suspending judgement, seeking to stretch own skill, inquisitiveness	**Strengths:** Adapting the concept of 'clinical equipoise' familiar to CBT therapists to 'professional equipoise' relevant to professional identity in multidisciplinary teams **Limitations:** Few direct interviews. Convenience sampling method is not robust to generalise to CBT therapists / IAPT.	Spirit of curiosity and openness between professions in the interest of patients creates stronger professional identities / networks, addressing power imbalance through removing hierarchy-focus. Encourage discussions about difference	Yes: 2 No: 4 Can't tell: 2 Total: 2/8

					US has different healthcare systems than IAPT		
34	**Steinauer et al. (2018)** *USA*	Semi-structured interviews with n=26 fourth-year medical students who were invited to describe a negative emotion they have felt in their practice towards a patient	Grounded Theory (Social Constructionist orientation)	How clinicians interpret clients is affected by personal motivating factors. Reduced chances of being evaluated positively for outcomes led to feelings of frustration. This led to increased likelihood of conceptualising clients as 'difficult.' Resources and feeling that they have the 'authority' to affected the patient interaction.	**Strengths:** Bias reduced through multiple researchers checking codes IAPT services are affected by outcome measurement which could lead to similar attributions and therefore results are likely to be of benefit to therapists. **Limitations:** Students responded as a volunteer sample. It is possible that those most interested in the researcher were those with the strongest reactions to portray, therefore minority voices may be unheard	Routine reflection to raise awareness of attribution Facilitate challenging assumptions entering the discourse	Yes: 8 No: 0 Can't tell: 0 Total: 8/8
35	**Sweitzer (2009)** *UK*	Semi-structured Interviews with n=12 doctoral students, n=22 network partners and n=15 administrators	Theoretical framework	Immediate managers are not always the most important relationship in identity transformation	**Strengths:** Longitudinal follow-up Fits with previous theory (Transition Theory, Strange Attractor Theory)	Services to support newly qualified professionals to identify their influencing factors	Yes: 6 No: 5 Can't tell: 0 Total: 6/11

		Theoretical Position: Social Network Theory		Professionals do not always recognise their own strongest influencers	**Limitations:** Findings may not be generalisable to primary care psychological therapy services Focus on transition from doctoral training to qualified practice. Overlooks other significant transition points and impact of social networks	Consistent communication, particularly in times of service / role transition	
36	**Van der Merwe & Wetherell (2020)** *New Zealand*	Semi-structured interviews with n=10 Clinical Psychologists and n=1 Health Psychologist working in Primary Care	Discourse Analysis	Psychological professionals construct emotions in dilemmic ways Professional identity involves balancing evidence-based practice with emotional expression including knowing and expressing one's professional identity	**Strengths:** Data transparency Consideration of the effect of the researcher on the discourse Reflexive approach **Limitations:** New Zealand do not utilise the IAPT model currently Unspecified, but some participants appear to be working with Secondary Care clients	Research: Use of dilemmas to explore discursive features Clinical Practice: reflectivity, 'understanding the emotional life of psychologists as they practice requires a social analysis of emotion'	Yes: 8 No: 0 Can't tell: 0 Total: 8/8
37	**Von der Lancken & Gunn (2019)**	Reflection of n=50 students' experiences of shadowing when	Thematic Analysis	Shadowing helps people become aware of the full potential scope of	**Strengths:** Addresses professional identity at a key juncture	Provide opportunities for reflective practice when one is transitioning from	Yes: 3 No: 4 Can't tell: 1

	USA	entering nursing training in paediatric, adult nursing and maternity		their profession and aids understanding between professions. Learning from interprofessional networks is essential	Took steps to reduce bias **Limitations:** Focus on those newly entering a profession would not account for role diversification. Data analysis strategy is unclear. Identified as a case study but consistent with Thematic Analysis	training to qualified practice in healthcare. Shadowing helps relate to the range of values and practices associated with the profession which strengthens affiliation	Total: 3/8
38	**Wackerhausen (2009)** *Denmark + Norway*	Theoretical Article	Literature review and theoretical framework	Collaboration may be ineffective if macro and micro interprofessional factors are not considered. Language can be a barrier or a unifying factor to interprofessional collaboration.	**Strengths:** Through review of theoretical underpinnings of conflict in interprofessional teams. **Limitations:** Broad scope of review may reduce applicability to other professional groups	Use 'second order reflection' routinely to strengthen identity with own profession. Pedagogy relates to *becoming* 'one of our kind' and collaborative networks relate to *staying* 'one of our kind'	Yes: 5 No: 0 Can't tell: 3 Total: 5/8
39	**Wade (2016)** *UK*	Four focus groups (3-4 per group) with n=15 Trainee Educational Psychologists	Discourse Analysis	Training is key stage in professional identity as people test out new repertoires. Experimenting can be seen in the form	**Strengths:** Diligence to own assumptions through reflexivity **Limitations:** Without a co-researcher it was more challenging to observe non-verbal communication	Services to invest in opportunities to develop and recognise professional expertise.	Yes: 8 No: 0 Can't tell: 0 Total: 8/8

	of confusion, interest and curiosity.	Develop tacit knowledge through research and peer discussion

Appendix 3 – CASP Analysis

Author(s)	Are the results valid?	Is a qualitative methodology appropriate?	Was the design appropriate for the aims?	Was the recruitment strategy appropriate for the aims?	Was the data collected in a way which addresses the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into account?	Was the data analysis sufficiently rigorous?
Ambrose-Miller & Ashcroft (2016)	✓	✓	✓	x	x	x	✓	x
Balabanovic & Hayton (2010)	✓	✓	✓	x	✓	✓	✓	✓
Bélanger & Rodríguez (2008)	✓	✓	x	✓	✓	?	✓	✓
Bentley et al. (2017)	✓	✓	✓	✓	✓	x	✓	?
Bentley et al. (2019)	?	✓	✓	✓	✓	✓	✓	✓
Bochatay et al. (2019)	✓	✓	✓	✓	✓	✓	✓	✓
Choudhury et al. (2019)	✓	✓	✓	?	✓	✓	✓	x

Court et al. (2017)	✓	✓	✓	✓	✓	✓	✓	✓
Gazzola et al. (2011)	?	✓	✓	✓	✓	x	?	x
Hammarberg et al. (2019)	?	✓	✓	?	✓	✓	✓	x
Hemsley (2013)	✓	✓	✓	✓	✓	✓	✓	x
Holmesland et al. (2020)	?	✓	✓	✓	x	?	✓	✓
Hudson et al. (2019)	✓	✓	x	?	✓	✓	✓	✓
Hughes et al. (2020)	✓	✓	✓	x	?	✓	✓	✓
Jongho-Park & Schallert (2019)	✓	✓	✓	✓	✓	?	✓	?
Julkunen & Willumsen (2010)	?	✓	✓	✓	?	✓	?	x
Kvarnström (2008)	✓	✓	✓	✓	✓	✓	✓	✓
Legood et al. (2019)	✓	✓	✓	✓	✓	?	✓	✓
Luca (2012)	✓	✓	✓	✓	✓	✓	✓	✓
Mellin et al. (2011)	?	✓	✓	✓	✓	✓	✓	x
Randall-James & Head (2018)	x	✓	?	✓	x	✓	✓	x

Reynolds (2007)	✓	✓	✓	✓	✓	✓	✓	✓
Schubert et al. (2021)	✓	✓	✓	✓	✓	✓	✓	✓
Smart et al. (2018)	✓	✓	✓	✓	✓	?	✓	✓
Smith et al. (2015)	?	✓	x	x	x	?	✓	x
Steinauer et al. (2018)	✓	✓	✓	✓	✓	✓	✓	✓
Van der Merwe & Wetherell (2020)	✓	✓	✓	✓	✓	✓	✓	✓
Von der Lancken & Gunn (2019)	?	✓	x	x	✓	x	✓	x
Wade (2016)	✓	✓	✓	✓	✓	✓	✓	✓

Author	**Did the study address a clearly focused issue?**	**Was the cohort recruited in an acceptable way?**	**Was the exposure accurately measured to minimise bias?**	**Was the outcome accurately measured to minimise bias?**	**Have the author(s) identified all important confounding variables?**	**Have the author(s) taken account of confounding variables in the design and/or analysis?**	**Was the follow-up of participants complete enough?**	**Was the follow-up of participants long enough?**	**Do you believe the results?**	**Can the results be applied to the local population?**	**Do the results of the study fit with other available evidence?**

Jakobsen et al. (2011)	✓	✓	x	x	✓	x	x	✓	✓	x	✓
Mitchell et al. (2011)	✓	✓	✓	✓	✓	✓	?	?	✓	✓	✓
Molleman & Broekhuis (2012)	✓	✓	✓	✓	✓	✓	x	?	✓	✓	✓
Porter & Wilton (2019)	✓	✓	✓	✓	x	x	x	✓	✓	x	x
Scanlan (2018)	✓	✓	✓	✓	✓	✓	?	?	✓	✓	✓
Sweitzer (2009)	✓	✓	x	x	✓	x	✓	✓	x	x	✓

Author(s)	**Did the review address a clearly focused question?**	**Did the author look for the right type of papers?**	**Were all important, relevant studies included?**	**Did the review's authors do enough to assess quality of the included studies?**	**If results have been combined, was it reasonable to do so?**	**Can the results be applied to the local population?**	**Were all important outcomes considered?**	**Are the benefits worth the harms and costs?**
Baker & Lattuca (2010)	✓	✓	?	x	?	✓	✓	✓

Kreindler et al. (2012)	✓	✓	✓	✓	?	✓	✓	✓
Rose & Norwich (2014)	✓	✓	?	?	?	✓	✓	✓
Wackerhausen (2009)	✓	✓	?	?	?	✓	✓	✓

Appendix 4 – Participant Information Sheet

Participant Information Sheet

Title of Project: Enhancing primary care psychological therapy for clients with comorbid physical health conditions: A discourse analysis investigation into interprofessional identity

Researcher name: Jamie Elston-Short
Supervisor name: Dr. Martin Benwell

Invitation and brief summary:

Thank you for your interest in this research study. Please take time to consider the information carefully and discuss it with family or friends if you wish, or ask the researcher any questions you may have.

Purpose of the research study:

In this study we are interested in how medical professionals and psychological professionals find working together in primary care in support of clients who have depression or anxiety disorders, alongside a long-term physical health condition.

Psychological therapists and medical professionals are increasingly working together to share expertise and provide a tailored evidence-based treatment built around their patients. Many Improving Access to Psychological Therapies (IAPT) services have already set up closer links with their medical colleagues. This means that professionals are now working in different ways than they are used to. For example, therapists have new clinics in medical practices and hospitals, meetings have a wider group of professionals present and teams are sharing expertise.

The study aims to understand the experience of working together in order to support staff to work effectively together.

Why have I been approached?

You have been asked to participate because you are either a Psychological Wellbeing Practitioner (PWP), High Intensity CBT Therapist (HI) in an IAPT service which has an 'integrated' pathway for clients with long-term conditions, or you work in a physical healthcare setting in which you are likely to encounter clients who have depression or anxiety disorders alongside their condition for which you might refer clients to primary care psychological therapy. Your experiences of working with this client group and with other professionals is highly valued and your thoughts on the topic are very welcome to help us shape services for the future.

What would taking part involve?

The study involves five focus groups, of which you will be asked to participate in only one. You will be invited to attend a focus group of 3-6 participants with a mixture of psychological and physical health professionals in each. There will be dates available within working hours and evenings. Each focus group will last approximately 1 hour, and you will be invited to discuss your thoughts on collaborative working and then you will be given a number of hypothetical patient scenarios about which you will be invited to share your thoughts and conceptualisation.

Your safety and comfort

It is important that the groups are Covid secure and at a time suitable for your convenience and clinical commitments. All discussions will be held remotely using the Microsoft Teams© programme.

The discussions will be audio-recorded and transcribed. Other than your profession, length of professional experience and contact details, personal information will not be collected in this study. Your contribution to the discussion will be anonymised in the transcription and any contributions that identify you or you wish to be removed will be redacted by contacting the researcher. You will be allocated a participant reference number and the researchers' contact details to use should you wish to request any information to be removed. It is possible that some members may feel uncomfortable to speak in front of senior management, therefore clinical team leads are not participating in the study.

What are the possible benefits of taking part?

There are no intended benefits to you as a participant, however this might be a good opportunity to reflect on your own professional identity as you provide a service to clients with long term conditions. Working in these newly developed teams can involve a fair amount of lone working or communicating predominantly with your own professional colleagues, therefore this is intended to be a good opportunity to meet with colleagues from a range of professional backgrounds and locations from which it is hoped stronger links can be developed and a chance to reflect as a group on your shared experience.

What are the possible disadvantages and risks of taking part?

There are no significant risk factors for participation in this study. Risk of psychological harm is low as there are no sensitive or personal questions asked. It is possible that some may experience discomfort sharing opinions with their colleagues, it is important to note that team leads are not participating in the focus groups. You are invited to contribute to the discussion in whichever manner feels most comfortable, sharing as much or as little as you would like.

Guidelines for the focus group will be discussed at the start, with all members invited to contribute. A key guideline is to remind all participants to treat the opinions of their colleagues with the utmost respect and without judgement.

Should you experience any discomfort, please be aware of your own wellbeing and respond accordingly. You are welcome to discontinue, step out for a time and rejoin the discussion or voice your discomfort should you wish. You may also speak with the facilitator, your line manager and the CIC confidential staff support service is also available to all.

What will happen if I don't want to carry on with the study?

Taking part is entirely voluntary and there will be no detriment to those who do not wish to participate or continue. You may discontinue from the focus group at any point without giving a reason. Should you wish for your data to be removed from the study at the point of transcription, please contact the researcher with your unique participation number and your contributions can be deleted. Please be aware that your colleagues will have heard any contributions you may have made, so full confidentiality cannot be guaranteed. However, the group will be requested to treat all contributions with respect, without judgement and respect one another's confidentiality.

How will my information be kept confidential?

The University of Exeter processes personal data for the purposes of carrying out research in the public interest. The University will endeavour to be transparent about its processing of your personal data and this information sheet should provide a clear explanation of this. The focus group discussions will be recorded on Microsoft Teams and uploaded to the University's secure server and also on an encrypted audio recorder, which will then be stored in a locked cabinet and transcribed as soon as possible by a transcription organisation with whom a data sharing agreement will be in place to protect participants' information. After transcription, the audio recording will be deleted. The transcript will be saved electronically on a University of Exeter computer accessible only to the researcher with file encryption. Your contributions will be anonymised using a unique participant number. Any information that might identify you personally in the discussion will be redacted.

How will we use information about you?
We will need to use information you provide about your role and your contribution to the focus group discussion for this research project. People who do not need to know who you are will not be able to see your name or contact details. When the discussion is transcribed your name will be replaced with a pseudonym and things you say which might identify you will be redacted. We will keep your information safe and secure. Once we have finished the study, we will keep some of the data so that we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.
In 2018 regulatory changes in the way data is processed came into force, with the EU General Data Protection Regulation 2018 (GDPR) and the Data Protection Act 2018 (DPA, 2018). Since the UK left the EU, the key principles of EU GDPR have been adopted in the UK GDPR (a 'UK-only version') and the DPA 2018 still applies. The University of Exeter terms its lawful basis to process personal data for the purposes of carrying out research as being in the 'public interest.' The University continues to be transparent about its processing of your personal data and the Participant Information Sheet should provide a clear explanation of how your data will be collected, processed, stored and destroyed. If you have any queries about the University's processing of your personal data that cannot be resolved by the research team, further information can be obtained from the University of Exeter's Data Protection Officer via the link: https://www.exeter.ac.uk/aboutoursite/dataprotection/dpo/. If you have any concerns about how your data is controlled and managed for this study, then please contact the Sponsor Representative: Pam Baxter, Senior Research Governance Officer
All information collected in this study will be kept strictly confidential and stored either on an encrypted password protected computer, or in a locked cabinet in a secure office at the University of Exeter, which can only be accessed by the research team. You will be allocated a unique participant number, to ensure your information will be protected and cannot be identified outside of the research team. Any personally identifiable information will be stored separately and securely from information obtained from the research, it will only be kept for a limited time (until you have attended the focus group) and securely destroyed after your attendance at the focus group and transcription has taken place (3 months after attendance).
Your rights to access, to change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguarding your rights, we will use the minimum personally-identifiable information possible.
Where can you find out more about how your information is used?
You can find out more about how we use your information by asking one of the research team. If you do have any queries about the University's processing of your personal data that cannot be resolved by the research team, further information may be obtained from the University's Data Protection Officer by emailing dataprotection@exeter.ac.uk or at www.exeter.ac.uk/dataprotection.

What will happen to the results of this study?

The study contributes to a doctoral course at the University of Exeter and therefore findings will be submitted for academic evaluation. The findings are likely to be of benefit to IAPT services, and in acknowledgement of the support of Devon Partnership NHS Trust for this study the findings will be discussed with service managers through presentation at the Audit, Improvement and Research (AIR) committee and at the Psychological Professionals Network (PPN) https://www.ppn.nhs.uk/south-west. The key findings from the study will be publicly available on Open Research Exeter (ORE).

Who has reviewed this study?

This project has been reviewed by the Psychology Research Ethics Committee at the University of Exeter (Reference Number….) and reviewed for legal compliance in the NHS by the Health Research Authority (IRAS reference number: 296626).

Further information, concerns or complaints

Jamie Elston-Short is a Cognitive Behaviour Therapist and Trainee Clinical Researcher completing this research as part of his doctorate in Clinical Research with the University of Exeter.
Should you wish to make contact for further information or if you were unhappy with any aspect of the project and wish to complain you may contact any of the following:
Jamie Elston-Short: jdjs202@exeter.ac.uk

Dr. Martin Benwell, project supervisor: M.Benwell2@exeter.ac.uk
Pam Baxter, Senior Research Governance Officer, University of Exeter: p.r.baxter2@exeter.ac.uk

Should you have any questions at all in relation to your safety, comfort or the study more generally, do not hesitate to contact the researcher or study supervisor.

Further Support

Should you require any support at any time, all Devon Partnership NHS Trust staff including IAPT therapists can contact the Confidential Care service. They are available 24 hours a day, 7 days a week on 0800 085 1376, text relay: 18001 0800 085 1376, www.well-online.co.uk

Royal College of Nursing offer support on a wide range of topics including advice and mental health support to members: https://www.rcn.org.uk/get-help

Thank you for your interest in this study.

Sponsor Representative

Ms Pam Baxter – Senior Research Governance Officer
University of Exeter, Research Ethics and Governance Office, Lafrowda House, St. Germans Road
Exeter EX4 6TL / Tel: 01392 723 588 / Email: p.r.baxter2@exeter.ac.uk

Appendix 5 – Consent Form

CONSENT FORM

Study Title: Enhancing primary care psychological therapy for clients with comorbid physical health conditions: A discourse analysis investigation into interprofessional identity.

Name of Researcher: Jamie Elston-Short
Name of Supervisor: Dr. Martin Benwell

Participant ID:

1. I confirm that I have read the information sheet dated 04/05/2021 (version 1.0) for the above project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. ☐

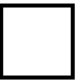
3. I understand that the data collected during the study may be looked at by members of the research team, individuals from the University of Exeter, Devon Partnership NHS Trust, or regulatory authorities where it is relevant to taking part in the Research. ☐

4. I understand that taking part involves Microsoft Teams© and Dictaphone recordings which will be transcribed and used only for purposes described in the information sheet. Transcriptions will remove all identifiable information. ☐
I understand that taking part involves audio and video recording which will be uploaded and stored to a secure server within the University of Exeter and deleted at the earliest opportunity following transcription.

5. I understand that taking part involves a discussion with a small group. Data will be anonymised in the transcription process but confidentiality cannot be fully guaranteed due to the presence of other participants. All participants will respect the confidentiality of one another. ☐

6. I understand that the anonymised data will be kept securely and used by researchers from the University of Exeter. Findings will submitted for publication in an academic journal and the resulting
thesis will be published on the Open Reserach Exeter repository ☐

7. I agree to take part in the above project.



Name of Participant	Date	Signature
Name of researcher taking consent	Date	Signature

When completed: 1 copy for participant; 1 copy for researcher/project file. Consent forms are saved onto a secure server. Consent forms can be completed with an electronic signature or by hand and scanned.

Appendix 6 – Focus Group Schedule

Enhancing primary care psychological therapy for clients with comorbid physical health conditions: A discourse analysis investigation into interprofessional identity

Focus Group Schedule: Approximately 1 hour

- Welcome and Group Guidelines
- Ice-breaker
- What are your current thoughts on physical health and psychological therapy services working together?
- This includes: pros and cons, thoughts of the future direction, how teams should work together in your opinion (duration: 30 mins)
- Vignettes. Task: choose one of the two scenarios below. Discuss as a group 1) your thoughts on the case including how you might formulate the client's difficulties, 2) which team should be responsible for which aspects of the client's care, 3) how might physical health and psychological health work together for to support this client, 4) what would need to be in place for this to happen?

VIGNETTE

Ashley is 30 years old and has had Type I Diabetes since the age of 10. He lives with his wife and 6 year old son and works part-time. He has a supportive family and group of friends, and generally leads an active life. He is supported by his GP and Diabetes Nurse and has recently been referred to his local IAPT service to help him with his mental wellbeing alongside his diabetes.

Ashley is really worried about his annual diabetic review as his levels have been running slightly higher recently and he is not really sure why. He thinks that he has let people down and fears that he will be told off by his Diabetes Nurse. He has been feeling very tired lately and has been thinking of reasons to give about why his reading his higher, 'if I just say I will keep working on it,' he thinks, 'maybe they will leave me on a 12 month review.' Everything feels really difficult to deal with at present and he constantly worries about his sugar levels and the more he worries, the higher they get.

Appendix 7 – Extract from Focus Group 2 lines 150-237

Integrated PWP: I think. for me more understanding of what each other's roles are and what you do and what you can offer? I think most most of it in my mind is because- it's having the time and abil-ability to have conversations to learn.about.the other systems↑ because the systems are different um so yeah for me it's sort of being able to have those conversations and and yeah it's it's- and what [Core PWP] was saying about being face-to-face I was next to Bladder and Bowel in [names region] for. eighteen months and sort of definitely learnt a lot more so there definitely is the- we've lost that during Covid is that being able to have the conversations and understand other people's roles a bit more↑ because I think outside of your own little (.) bubble [laughs] and things um a lot of the time- and they change so frequently as I- uh I think [OT] probably would um and and [Integrated HI] you know we've been working in this field a long time the three of us that that you just get to know something sometimes of how somebody- something functions and then it and then it changes again and you have to try and re-learn the new (.) new changes so I I yeah so I think it's (.) it's pro- (.) it's hard and things and it takes a lot of effort and things but it's it's so valuable when it works

OT: Mmm. I think you're right sort of following on from that it's- I don't know about you but you get new c- all-singing-all-dancing carer's services but they're only funded for three years so it's through Age UK and then you get another three years then they lose their funding and their contracts so something else starts again and yeah I think it's quite a sort of short-sighted (.) thing isn't it because you think "well I referred to them last week but I can't refer to them, I need to refer them to somebody else this week" and I think really tricky isn't it. I think the funding, because it's so limited (.) things do change from (.) you know every three years so like you say it's knowing who to refer to isn't it and what their role is.

Integrated HI: I think we need to be careful=

Integrated PWP: and those links= (.) sorry

Integrated HI: [laughs] I was just going to say I think we need to be careful of the uh (.) the crossover between physical and mental health because (.) um I think (.) most of us um especially if you've worked in the area of mental health psychological health would understand that. people's physical health is

massively massively affected by their psychological wellbeing however If you look at the disparity between funding for psychological mental- we're lucky in IAPT I know we can't grumble we've got- we get an okay funding, but generally=

Core PWP: Mmm=

Integrated HI: -it's quite poor, and (.) you see a lot of the people- I mean [coughs] I was talking to a supervisor yesterday who was saying that she gets- you know she's a Psychologist and um working in the crossover of physical and mental health and hh she was saying that every two years (.) they have to review these people that you know have to prove that they're (.) that they they should be getting their benefits [Integrated PWP emphatically nods]

Core PWP: Mmm

Integrated HI: -and it's she said it's a real waste of funding when that funding you know when that funding could go to developing a better bridge between [laughs] physical and mental health and you know that would be- you wouldn't need that conversation. because these pe- there's a lot better- you know people would be a lot- you know (.) a lot weller.

Core PWP: Yeah definitely

Integrated HI: did I mean a lot 'weller' a lot 'weller' [all laugh]

Core PWP: It would make sense to have li:ke um I don't know I suppose for the people that do long-term conditions actually if it's quite severe you know a team- a place where you could sort of meet up you know with each other regularly or have regular points where reviewing patients and you know seeing "well actually" you know "we're doing- within mental health we're doing this and this is working well, actually maybe you could work on like the pain side of- some- you know managing pain" or something like that, I think those two do cross over quite a lot um from- 'cos I do also work with long-term conditions in the normal team as much- in the Core Team- but obviously not as much as [the

Integrated Team] um so yeah I suppose that you know collaborating that would you know within- kind of having uh a group or something where you could actually discuss patients, I imagine that would really help with uh I suppose patient care.

Integrated PWP: I had a- got an example recently actually and it worked really well which I was so pleased about, with a person that had um had anxiety over falling and they'd had medical problems and an operation and things, and Occupational Health went in and the physio and they would sort of look at the physio side and I actually hh managed- I had time and they also had a learning disability this person, so we actually managed to sort of set up a programme where the physio were doing the Exposure that that I had discussed with all of them, so we'd talked about how to do the mental health side of the anxiety with Exposure and and actually the physios and OTs were sort of carrying that out with the person [OT nods] and it was fantastic! That was- you know that's how all care should look

OT: Mmm

Integrated PWP: but it's it's where- it just works so well being able to have those conversations and the physios being confident that what they were doing was the right way of helping the person to manage the anxiety and it it just- it was just a lovely.piece.of work (.) and things and um for everybody I think involved because we- you know we could ask each other questions and I could ask about sort of like the physical limitations and and abilities and I think just that- that to me is 'collaboration' and things when we can do something like that for the patient and everybody knows which bit they're doing um and things then I would imagine that that's a bit like an MDT team [laughs] where everyone knows what bit they're up to but they also have a bit of an understanding of what the other people are doing as well↑, and why and things so it's- sort of it's a joint- and yeah and it just.felt.so.good being able to do something like that for.somebody but that.only.can.occur if like the people we ring answer the phone and things like that because they're so busy and stuff and we me- we end up being able to have that conversation which doesn't always occur, and things like that and also I suppose feeling open- be able to ask be able to ask questions that feel silly↑. I've rung Respiratory before and said you know "this person's really struggling in the shower, you know is there anything sort of you know we can look at for Behavioural Activation-wise that's going to aid this person with their COPD?" and things and- because I'm not

medical, I've got no idea with some of that stuff so (.) it's it's sharing that knowledge I think and understanding so that you can put it in (.) your (.) bit of work or that understanding in that bit of work so that you're making sure that the work you're doing is sort of in line alongside the physical health and isn't going to make anything worse or things like that so I think from my point of view sort of being able to do that makes me feel like I'm doing a better job and I think it makes patients feel that everybody's on the same page and that you're all able to sort of communicate cos I think that they- a lot of them assume that you can read notes and things like that when we're all on different symptoms [OT laughs] which is such.a.basic.thing! but yet it's like "no, we can't actually read anything" um

OT: yeah (.) that would be good

Integrated PWP: yeah=

Core PWP: Mmm= (4)

Appendix 8 – Participant Feedback Emails following FG5

Integrated HI: *“I felt afterwards that there was still a kind of view about the patient as someone to be manged which I felt was still very much designed around a “one size fits all system” and the idea that a patient will be “looked after” by various people. I guess that highlighted the differences between primary care IAPTUS and Secondary Care longer term patients.”*

Consultant Psychiatrist: *“Take home for me is that we all would like to be able to work in an interdisciplinary way around the patient but our systems and professional sense of obligation get in the way. Time is valuable and it’s use poorly articulated. Language & tribal culture confuse the professional effort and the patient experience.”*

Core HI: *“Sorry I have not emailed you before now!*

It was very interesting to be a part of that discussion though having come from the non LTC team and not having any formal experience in physical health care settings I think I may have found it intimidating had I not known peter quite well and [Integrated HI] a bit.

The conversation was very interesting but to be honest mostly highlighted my own personal gaps in knowledge. Given that I was willing to engage in this study and I would say am generally someone who likes to develop my knowledge of lots of different things as much as possible, I did come away from it thinking how if I felt personally quite under aware (?) then what must it be like for those who were not willing to be a part or who are newer to working in the sector. It is good to acknowledge these gaps and to hear about the relationships building between the physical and mental health care worlds.

Thanks for providing this opportunity.”