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The Making of Psychological Therapists: Towards a Psychosocial
Understanding of IAPT Training, Culture and Practices

Volume 1

[Volume 2, via University Library only]

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Abstract

The UK government's IAPT programme has introduced new roles, therapeutic practices and interventions, within primary care mental health. An expanding workforce of Psychological Well-being Practitioners (PWP) and high intensity Cognitive Behavioural Therapists (HIT) has been recruited and trained since 2008, amidst controversy over policy aims, implementation and service delivery models. For this new workforce to be effective and sustainable, the psychosocial and organisational dynamics that surround the work and training system need to be better understood. Strong staff and public expectations, competing ideologies and professional claims all affect how practitioners deliver patient care. Similarly, a complex ecology of practices exists in each local setting, which makes demands of practitioners' organisational, interpersonal and clinical skills and resilience. This study explores how practitioners manage the transition into role during and after training, the dilemmas they face in practice, and their changing identifications over time. It takes a longitudinal and holistic perspective on both PWP and HIT journeys through the IAPT system, drawing on psychoanalytically-informed classroom-based observations, practitioner narratives and staff interviews and using a range of in-depth analytic methods. By focusing on contributions from governmentality theory, sociology of the professions, theories of practice, psychosocial studies and applied psychoanalysis, the thesis shows connections and tensions between the discourse of evidence-based policy, New Public Management and practitioner experience. This contrasts with the atheoretical and instrumental tendency seen in Health Services' Research. It shows unequivocally that the professional status of IAPT roles, is insecure. PWPs and HITs have an organisational, rather than occupational identity and share characteristics with historical semi-professions, in their strong collective beliefs and sense of having 'legitimate aspirations denied.' IAPT's distinctive culture of practice and the feelings evoked by high volume, low intensity work, have consequences for individuals' commitment and ability to stay in role, and for the services' future sustainability.

Keywords

IAPT, therapist training, role transition, psychosocial, organizational identity, professional identity, workforce development, sustainability, clinical practice, experience-near research, qualitative longitudinal research (QLR), emotional labour, ecologies of practice, career choice, mental health service, CBT, organizational culture, organizational anxiety, stepped care, ethnography, psychoanalytically-informed, evidence-based policy and practice (EBP).

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Abbreviations

ACT	Acceptance and commitment therapy
ANPs	Assistant Nurse Practitioners
BA	Behavioural activation
BACP	British Association for Counselling and Psychotherapy
BNIM	Biographic Narrative Interpretive Method
CAQDAS	Computer assisted qualitative data analysis software
CBP	Cognitive Behavioural Psychotherapy
CBT	Cognitive Behavioural Therapy
cCBT	Computerised Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CfD	Counselling for Depression (IAPT-specific)
CMHP	Common mental health problem
CPD	Continuing professional development
CPN	Community psychiatric nurse
CT	IAPT Training Course Teacher
CTS-R	Cognitive Therapy Scale - Revised
DNA	Did not attend (scheduled appointment)
DVD	Digital video disk
DWP	Department for Work and Pensions
EBP	Evidence-based policy (and/or practice)
EMDR	Eye movement desensitisation and reprocessing
ERP	Exposure and response prevention
ESA	Employment and Support Allowance
FANI	Free association narrative interviewing
GAD	Generalised anxiety disorder

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GP	General medical practitioner
HI	High intensity CBT (IAPT specific)
HIPI	High intensity psychological interventions (IAPT specific)
HIT	High intensity CBT therapist (IAPT Step 3 worker)
HCPC	Health and Care Professions' Council
HSR	Health Services Research
IAPT	Improving Access to Psychological Therapies
IPT	Interpersonal therapy
IT	Information Technology
LI	Low intensity (IAPT specific)
LIPI	Low intensity psychological interventions (IAPT specific)
LSE	London School of Economics and Political Science
MIS	Management Information System
MUS	Medically unexplained symptoms
NAPT	National Audit of Psychological Therapies
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NPM	New Public Management
NRES	National Research Ethics Service
OCD	Obsessive compulsive disorder
OED	Oxford English Dictionary
OHS	Occupational health service (employer provided)
OSCE	Objective Structured Clinical Examination
OT	Occupational therapy

PCMHW	Primary care graduate mental health worker (sometimes referred to as ‘graduate mental health workers’)
PD	IAPT Programme Director*
PSS	Psychosocial Studies
PT	Psychological therapy
PTSD	Post-traumatic stress disorder
PWP	Psychological Well-being Practitioner (IAPT Step 2 worker)
QLR	Qualitative longitudinal research
R&D	Research and development
RCT	Randomized control trial
REC	NHS Research Ethics Committee
SD	IAPT Service Director+
SDO	NIHR Service Delivery and Organisation research programme
Step 2	Step two (of IAPT stepped care service delivery model)
Step 3	Step three (of IAPT stepped care service delivery model)
SUP	IAPT service supervisors

* To protect confidentiality, references and quotations relating to this job role are generally combined with that of CT in the text.

+ To protect confidentiality, references and quotations relating to this job role are generally combined with that of SUP in the text.

Chapter 1 - Introduction to thesis

'Improving Access to Psychological Therapies' (IAPT) is a workforce development programme which since 2008, has sought to expand provision of 'evidence-based' psychological therapies, in the UK National Health Service (NHS). As a public mental health initiative, IAPT is directed primarily towards helping people with 'common mental health problems' (CMHPs), such as anxiety or depression, who might otherwise only have access to medication via their GP. IAPT has resulted in the recruitment and training of over 7000 new psychological therapists in two main roles, that of Psychological Well-being Practitioner (PWP) or high intensity cognitive behavioural therapist (HIT) (NHS England and Health Education England, 2016; Suss, 2017). This new group of workers are employed in local IAPT services which deliver a range of cognitive behavioural (CBT) treatments and interventions, for patients in primary care. This study looks closely at these new roles, the experience of those who take them up, their training and induction into clinical practice and what this might represent, in psychosocial, historical and cultural terms. Through an in-depth analysis of trainee and qualified practitioners' narratives, over time, it seeks to explore aspects of transition into role, how dilemmas of personal and professional identity are negotiated, and what an IAPT culture of practice looks like. These issues are explored with a view to questioning and reflecting on the sustainability of these kinds of roles within primary care mental health and the wider psychosocial context.

This introduction to the thesis sets out the research problem, aim and key questions, and my personal motivation for doing the research (1.1). It introduces the theoretical framework used in the research (1.2), some common terms and concepts (1.3), and the overall structure of the thesis (1.4).

1.1 The research problem

There is a national preoccupation in the UK with mental health, the prevalence of CMHPs such as anxiety and depression, across different population groups, their impact on well-being, social and economic prosperity and the stigma associated with them and with help-seeking. Social and news media regularly report celebrity-led campaigns on the validity of 'speaking out,' making it acceptable to seek help, and for it 'to be okay, to not be okay' (Ahmad, 2016; Fader, 2016; SAMH, 2018). For the last decade, initiatives such as

Chapter 1 – Introduction to thesis

IAPT have spoken to these concerns; the programme has been credited with raising the profile of mental health as an area of unmet need, and with providing an accessible, trustworthy and cost-effective solution, in the form of talking therapy, a real alternative to medication. Brief psychological therapies have now become more widely available than ever before in the NHS, for the primary care population.

However, since its inception, IAPT has also generated controversy, in relation to its aims, its evidence-base, the new roles it has introduced, its focus on CBT and a single model of care, and (lack of) patient choice. In relation to its aims, it has been seen as targeting people on out-of-work benefits, and being primarily a cost-saving measure (Pilgrim & McCranie, 2013). With the introduction of new roles, it has been viewed as displacing existing professionals' roles and experience in the field. The new routes into services IAPT has introduced have been both welcomed, and condemned; being seen to offer hope by some, and to distract attention from those with more severe mental health conditions by others. These controversies all point to the existence of strong competing individual, organisational and societal expectations regarding public mental health policy and provision.

IAPT is about 'improving access' to talking therapies in the NHS, yet all talking therapies have a long history of being contested. A 'plurality of practitioners' with widely differing world-views, have long coexisted under the 'psychotherapy' umbrella professional title (Marks, 2017: 6). This diversity, even where there is collaboration, 'acts as a gloss,' and the term psychotherapy 'effectively conceals the ontological incongruities and historical conflicts' that underlie it (Marks, 2017: 6). Individuals who take up roles in this sector have dispositions and practices which are shaped by this context, and by what their patients bring. How they inhabit their roles, their sense of personal and professional identity at work, in turn, directly affects patient experience and outcomes. When new roles are introduced, it is therefore important to look at the interpenetration of influences which may affect how they work in practice, to learn about how and whether to optimise and sustain them, for the sake of patient and societal well-being.

Individual biography and motivation are also significant contributors. How people come to train and work in different 'psy' professions needs to be understood alongside the external factors which shape and influence these roles. Variations in the way new services and job roles are implemented at a

local level, mean that individual practitioner biographies and experiences of work and training, need also to be studied within specific service and organisational contexts.

It is also important to recognise the way that occupational changes, of the kind introduced by successive initiatives such as IAPT, are often a signal of wider societal change (Saks, 2016; Muzio et al., 2013). The contemporary NHS, along with other public-sector services, reflects and reveals a history of 'top-down' interventions in workforce planning and design. At the same time, there is good evidence of the boundaries between different professional and semi-professional groups in these services, shifting and changing 'bottom up,' and from side to side, in relation to each other, over time (Nancarrow & Borthwick, 2005). Thus the government agenda, the socioeconomic context and inter-occupational dynamics all seem likely to affect what is achieved when a new workforce is created, and to impact upon its sustainability.

Within the disciplines of work psychology, sociology and anthropology, a number of in-depth and ethnographic studies of new therapeutic roles have been conducted. Besides early classics, such as Dingwall's 1977 study of health visitor training (Dingwall, 2014), more recent work has looked at paramedics (McCann et al., 2013), counsellors (Aldridge, 2010), nurse specialists (McMurray, 2011; McGibbon et al., 2010), and psychodynamic psychotherapists (Davies, 2009). However, no studies to date, have specifically addressed the history and psychosocial dynamics of the IAPT-specific psychological therapist roles.

1.1.1 The research aim

As with all research projects of significant duration (and this PhD has been conducted over a period of nearly 10 years), the research aim, as originally formulated, reflects the state of knowledge of the researcher, their disciplinary and institutional setting, when at an early stage in their investigations. The overall aim of the research when I started out was:

- to gain a greater understanding of the psychosocial dynamics of current initiatives to improve access to psychological therapies, and the implications of these for the sustainability of new occupational roles within primary care mental health.

This aim led, in 2010, after an initial literature review, to the following main research questions:

1. How do individual PWPs and HITs manage transitions in their role, during and after training?
2. What challenges to personal identity and professional competence do they face whilst working in these new occupational roles?
3. What are the implications for future service development, and the sustainability of new occupational roles within primary care mental health?

These questions shaped the research design and data collection instruments. They guided my investigation of the IAPT roles, highlighted the need to understand the experience of the work in personal, biographic and narrative terms, as well as in organisational and societal context. Inevitably, as relatively little had been published about IAPT when I started, and there is now a lot more known, I would not phrase the questions in the same way now (I return to this point in Chapter 2, section 2.6.1). A key concern throughout, however, has been to look at IAPT as a whole system, rather than pragmatically investigating particular parts, as in the majority of existing IAPT-related studies. I seek to add to the Health Services' Research (HSR) and improvement literatures, through 'thick description' (Geertz, 1973) and psychosocially informed interpretation, and to complement the body of narrative-informed research on patient experience of IAPT and mental healthcare (for example, Chambers et al., 2015; Baddeley, 2014; Campbell et al., 2007), with that of practitioners.

1.1.2 A starting point

Whilst I was working as a contract researcher on the first independent evaluation of the IAPT demonstration sites, funded by NIHR Service and Delivery Research Organisation (SDO) (from 2007-2010), I visited the call centre in a Northern city business park, where guided self-help for anxiety and depression was being delivered over the telephone, to members of the public. The service was co-located on one of the upper floors of a modern business centre, on the outskirts of town. The 'case managers' (as PWPs were then called) spent most of their time in a small room surrounded on all sides by ceiling-to-floor glass windows, looking both outwards (to the car park) and

inwards (to the corridor). They sat with headphones on and spoke to patients over the telephone for hours at a time, each day, recording their activities onto the computer screens in front of them. As I peered through the glass at what they were doing, I imagined what it would be like to be working there, and wondered whether it was a modern-day equivalent of Bentham's 'panopticon.' On a later occasion, I interviewed one of the case managers for the evaluation and noticed how she stumbled over her words and tended not to answer our questions directly. I had the impression that she was making an immense effort to be positive about the service, but was inadvertently suggesting the opposite in her weary demeanour and disjointed trains of thought (see Volume 2, section A10, for pilot work using this data). It made me think about how hard it could be to carry the public expectations of a new service, both from above and from below.

1.1.3 Personal motivation

I have always been interested in the politics and experience of psychotherapy. It is something which I have benefited from personally, and found to be important in my professional life. Although I have paid for private psychotherapy, I have always felt passionately the unfairness of my ability to do so. Knowing its potential for helping people to face loss, to grow and to change unhelpful patterns, I have long thought this kind of help should be available to everyone who feels a need for it. It has puzzled me therefore to understand why there should be any opposition to the idea of expanding provision of talking therapies in the public-sector health system, or to raising the profile of mental health as a public health concern, along with its associated stigmas and inequalities.

This PhD has enabled me to reflect deeply on these issues, in the context of what at the time of its inception, was a new and radical national policy initiative, that of the IAPT programme. At face value, IAPT appeared to offer a rare and significant opportunity to scale-up provision of publicly funded talking treatments in the NHS. I, like many others, felt inspired and relieved to see mental health receiving greater attention, not just as a source of negative perceptions, moral panics and crises (as in the examples of people's responses to the incredibly rare incidence of a person with severe and enduring mental illness attacking a stranger on the street), but as a 'common' problem of depression and anxiety, affecting most people, at some point in their lives.

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It was with considerable puzzlement therefore, when as a University contract researcher, I started to look into the practicalities of how an initiative like IAPT might be implemented and what it could do, that I found such heated opposition to both its content and delivery methods. As a former Government Social Researcher, I was well imbued with the philosophy of ‘evidence-based policy’ (EBP), and with the economic argument, that reducing incapacity due to mental ill health, was a positive thing not just for individuals but for society. I was prepared to believe that there was an answer to the question ‘what works, for whom, and in what circumstances?’ posed by realist evaluators, and that those who championed CBT as treatment of choice within IAPT, had a reasonable basis for doing so. This, despite my own preference for psychoanalytic individual and group psychotherapy. I really hoped, and wanted, the IAPT initiative to succeed and accepted that there was a historic under-provision of CBT that could usefully be redressed.

The PhD has taken me on a long journey through this field. Starting from the literature on ‘what works’ I have studied the pros and cons of different psychotherapeutic modalities, their inseparability from the dynamics of different service delivery mechanisms, implementation issues and professional cultures of practice. The journey has led me to question the role of psychotherapy in society - is it a force for good, or otherwise? - and to question the role of government in intervening in this field. My studies have highlighted the significance of professional competition and different cultures of practice in determining how a workforce develops and a new service takes shape. Most of all, through my continuing work as a professional researcher, alongside my PhD studies, I have become more curious about how the wider social, political and organisational context of initiatives like IAPT impact upon the people working to deliver care in the service and those the service seeks to help, the patients.

If, as heralded so publicly by IAPT’s chief instigators, the initiative has been an unparalleled success in terms of patient outcomes, reduced inequality of access, and increased choice, why have so many patients tried and walked away from the service, or not got any better? And why have new recruits to the workforce left so soon after completing their training? What might be going on, above and below the surface, that might help explain some of the diversity of reactions from patients, staff and members of the public alike? How does the external context interact with individual staff and patient motivations - and why does this matter?

1.2 Theoretical framework

This thesis reflects my location as a novice psychosocial researcher within an institutional setting that focusses on multi-disciplinary and applied approaches to HSR and Public Health. It draws on my own disciplinary background in anthropology, and my professional journey through the fields of government social and evaluation research, into the field of mental health and psychological services, led by Clinical Psychology colleagues.

The relatively new and evolving field of psychosocial studies (PSS) is often characterised as a 'trans-discipline' (Frosh, 2014; Stenner, 2014; Taylor, 2011), with eclectic methods and modes of understanding, drawing from sociology, psychoanalysis, anthropology, critical and social psychology. PSS is variously described as 'an attitude', a set of ideas, and as an innovative set of research practices. The PSS 'attitude' which I am drawn to is one that understands the human subject as having an inherent ambiguity, as 'both a centre of agency and action....and as the subject of (or subjected to) forces operating from elsewhere' (Frosh, 2003: 1549). The PSS subject 'is not a pre-given entity, or something to be found through searching; it is rather a site, in which there are criss-crossing lines of force, and out of which that precious feature of human existence, subjectivity, emerges' (Frosh, 2003: 1549). PSS, according to Frosh, asks 'what does it mean to theorize the subject as *always social*?' It recognises the interplay between internal and external worlds, the subjective and the societal, often represented through the metaphor of a Möebius strip (Frosh & Barrister, 2008: 354). It combines research with an affective dimension and reflexive research practice (Clarke & Hoggett, 2009).

PSS draws on 'a cluster of methodologies which point towards a distinct position, that of researching beneath the surface and beyond the purely discursive' in order to 'consider the unconscious communications, dynamics and defences that exist in the research environment' (Clarke & Hoggett, 2009: 2-3). PSS does not just focus on speech or communicative texts, but also on non-verbal communication, images, observations and dreams (Clarke & Hoggett, 2009). It is 'experience near,' and often experienced by participants as 'recognition-giving' (Clarke & Hoggett, 2009). This leads to a need to be alert to signs of the 'defended subject' and/or the 'defended researcher,' participants and co-producers in the research endeavour, who do not always say what they mean, or mean what they say, whether intentionally or not (Hollway & Jefferson, 2000, 2013). It seeks to uncover layers of meaning and experience, which surface phenomena may obscure and to which policy-makers rarely have

access (Hollway & Jefferson, 2000, 2013). Techniques such as ‘free association narrative interviewing’ (FANI) are informed by, but not the same as, the psychoanalytic clinical method; they allow respondents to structure the interview, to speak of how they feel, with minimal interruption, whilst reserving interpretation for a later date.

In addition, to this framework, which is described further in Chapter 4, I draw on a number of specific theories which are relevant to understanding the dynamic of IAPT roles. Firstly, the theory of governmentality, as presented by Foucault in his 1977-78 lectures at the Collège de France (Foucault, 2009) and developed by Rose (1999). This theory speaks of the ways in which a state exercises control over, or governs, the body of its populace and teaches them to govern themselves, by internalising the rationality of its central institutions, and acting in ways which fits this rationale (Huff, 2013). It describes the subtle way in which government exerts power, not simply by domination, but by influencing the ways in which the governed come to think of themselves as subjects (Dean, 2010a). This perspective is useful for understanding the links between language, practices and beliefs at different levels, from the individual to the wider polity. Secondly, I draw on the history and sociology of professions and professionalism, especially as represented by Nottingham (2007), Evetts (2009, 2011, 2013) and Saks (2016). These perspectives help to uncover the analogies between the historical characteristics of ‘semi-professions’ and more recently introduced ‘assistant’ and para-professional roles, with which IAPT roles have some things in common. Thirdly, I refer to contemporary theories of practice as applied to professional learning, which help to place the IAPT training experience in context; and fourthly, I make use of the long tradition of psychoanalytically informed studies of organisations and human services, which help to explain ‘how the outside gets on the inside,’ the ‘organisation/policy-in-the-mind’ and how individual and social ‘defences’ may operate, in different work settings. I attempt to bring these various perspectives together, with sociological research on frontline service delivery roles, and more recent psychosocial research on the dynamics of public sector organisations. Each of these theoretical viewpoints and their relevance to the research topic, are described further in Chapter 2.

1.3 Some concepts, and common terms, used in the research

Psychotherapy: is defined as ‘the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their

behaviours, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable' (Campbell et al., 2013, based on APA, 2012). Psychotherapy may be given and received on a one-to-one, group or family basis. Much has been written about the overlap, similarities and differences between psychotherapy and counselling, and the boundaries are not distinct. In this thesis, I use the terms psychotherapy, **talking therapy** and therapy interchangeably. I generally refer to **counselling** in the specific sense of 'counselling for depression' (CfD), one of the treatment offers within IAPT (alongside low- and high-intensity CBT). The term '**psychological therapy**' has developed from Clinical Psychology, and usually describes a wider range of psychological interventions, including the use of self-help materials and psycho-educational groupwork, which might not otherwise be recognised as psychotherapy (Vybiral, 2014).

Professional: a simple definition is that a professional is a person who engages in a specified activity as a paid occupation, rather than as an amateur, who is not paid (OED, 2004). Professionals are often characterised as working in knowledge-based service occupations, requiring tertiary education, formal credentials, and an agreed standard of ethical behaviour (Scanlon, 2011a, after Evetts, 2006). Typically, they are understood to have considerable work autonomy, and to provide a service to the rest of society, such as health or education (Callaghan, 2014). Professional standards are maintained through widely recognised professional associations and being a 'professional' (or member of the professional classes) is usually associated with a high social status (Callaghan, 2014). The term is not however a fixed or generic one; it has changing historical significance, with differences between English and continental models, and needs to be understood in context (Scanlon, 2011a).

Professionalisation: refers to 'the process through which a particular occupational category obtains the status of "profession" (rather than "job" or "occupation"). It occurs when an occupation acquires the characteristics of a profession - an ethical code, a set of established educational practices, a defined set of specialist skills, a professional body (or bodies), and a process of self-regulation' (Callaghan, 2014: 1510, based on Friedson, 1970). Most importantly, professionalisation cannot be self-defined but depends upon being *recognised* as a profession by the public (Callaghan, 2014; Friedson, 1986).

Semi-profession: is an occupation that requires advanced knowledge and skills but is not widely regarded as a true profession (Hodson & Sullivan, 2008).

Traditional examples include social work, journalism, librarianship, teaching and nursing (Hodson & Sullivan, 2008). Such fields often have less clear-cut barriers to entry than traditional professions and their practitioners often lack the degree of control over their own work that has been associated with professionals such as doctors and lawyers. In addition, semi-professions tend to have been historically identified as ‘women's work,’ which has exacerbated prejudices against them as ‘true’ professions, despite the amount of skill involved. In most semi-professional fields efforts at professionalisation are ongoing. The terms ‘**para-professional**’ (or ‘**assistant**’) are job titles given to persons in semi-professional occupations, such as education, healthcare, engineering, and law, who are trained to assist professionals but who do not themselves have professional licensure (Harper, 2017).

Practitioner: is a person actively engaged in an art, discipline, or profession, especially medicine (as in ‘medical practitioners’) (Oxford Dictionaries, 2017). A practitioner may specialise in a particular occupational area, profession or religion, and may be referred to as a specialist or advanced practitioner. The term is commonly used as a job title in medical and social care professions to distinguish the level of qualifications, competency, and training a person has for their role. In the IAPT context, the PWP role is distinguished from that of cognitive behavioural therapist (HIT) by the national workforce development team. In this thesis, I use the lower-case term ‘practitioner’ inclusively, to refer to anyone working clinically with patients (for example, in the IAPT setting, this includes HITs, counsellors, GPs etc.), and upper case ‘Practitioners’ to refer specifically to PWPs.

Role: derives from the world of theatre and acting (Ashforth, 2001). Depending on your disciplinary perspective, it has different meanings; a ‘structural functionalist’ view of role, sees it as ‘a set of behavioural expectations associated with given positions in the social structure’ that are functional for the social system within which they are embedded; a ‘symbolic interactionist’ view of role is about ‘emergent and negotiated understandings between individuals’ (Ashforth, 2001: 4). Roles may be the product of ‘institutionalisation’ (the structural view) or ‘negotiation’ (the symbolic interactionist view) (Ashforth, 2001: 4); the tension between these contrasting perspectives may best be reconciled by looking at how an individual enacts a role within structural constraints (Ashforth, 2001: 4). Closely linked with the idea of role, is the idea of ‘**role boundary**,’ the lines of demarcation imposed or socially constructed around roles (Ashforth, 2001: 5). ‘**Role transitions**’ can be between roles, or within role, marking a major change, for example in

organisational or job context, or a smaller movement between simultaneously held roles, for example, between home and work (Ashforth, 2001: 7). They involve crossing role boundaries, and in so doing, 'doffing one persona and donning another' (Ashforth, 2001: 21). In the psychoanalytic literature, the term 'role' has a more intrapersonal meaning; for example,

To take a role implies being able to formulate or discover, however intuitively, a regulating principle inside oneself which enables one, as a person, to manage what one does in relation to the requirements of the situation one is in, as a member of this organisation or group. (Palmer, 2002: 161, after Reed & Armstrong, 1988).

I use the term 'role' in the hybrid sense described by Ashforth (2001), but also in the psychoanalytic sense, of discovering and managing oneself in relation to what one does, within specific settings.

Practices: have three main distinguishing features; they are organised constellations of activity, involve multiple people and rest on something that cannot be put into words (Schatzki, 2012: 13-14). Practices are social phenomena, and have an embodied non-propositional aspect that is both social and psychological (Schatzki, 2012). In relation to professional work and learning, practice may be summarised as, 'knowledgeable action, [involving] embodied and materially mediated doings and sayings, [that are] relational, evolved in historical and social contexts and power relations, and emergent' (Hager et al., 2012a: 8).

Stepped care: refers to a set of principles for service design, which are used in IAPT. The principles are that treatment should always commence with the least restrictive, in terms of burden on the patient and cost (i.e., typically, low intensity CBT); further, that treatment should be 'self-correcting,' in that allowance is made for scheduled review and detection of non-improvement, followed by 'stepping up' to more intensive treatment where needed (such as, high intensity CBT), or 'stepping down' when alternative or no treatment is appropriate (CSIP and NIMHE, 2008; Turpin et al., 2008). Stepped care is thought to improve efficiency of services by introducing standardised systems and procedures, reducing waiting times and increasing the numbers of people seen (Bower & Gilbody, 2005).

Discourse: refers to the use of language, as a form of practice which is social, involving speakers and hearers, common meanings and a set of shared conventions and expectations (Taylor, 2014). It also refers to a body of aggregate meanings and conventions which may govern how a particular topic is talked about, for example, illness (Taylor, 2014). It is about more than ‘just words;’ it includes embodied and non-linguistic features of how knowledge is communicated (Taylor, 2014). In discursive psychology, ‘discourse’ may be thought of as about talk, action, performance, positioning, agency (resulting in a major focus on transcripts and the fine grain patterning of these); and how identity is performed (you are not ‘a woman’, you ‘do woman’), and constantly changes. In discourse theory, it is about practices, including talk and how the subject is constituted by and through discourses (of class, gender, ethnicity etc.) (Hoggett, 2009a: 37). In PSS, discourse focusses attention on the social half of the psychosocial dyad; that is, on meaning-making activity (Hoggett, 2009a; Frosh & Baraitser, 2008). PSS suggests that what individuals do with discourse is what is interesting; for example, whether they accept it, are constituted by it, resist it, subvert it, or pass it by. In my work, I focus on the sense made by practitioners of the IAPT training discourse and how it influences their practices.

Social suffering: this concept draws on Bourdieu’s (1999) work on social inequality and multiple deprivation, and draws attention to the pain associated with life in late capitalist societies. It refers to the ‘lived experience of domination and repression, including feelings of humiliation, anger, despair, resentment, that may accompany, for example poverty, race and class’ (Frost & Hoggett, 2008: 439). ‘Suffering’ denotes ‘intermeshed components of thinking, feeling, responding, acting’ and may be reflexive (‘able to be thought about critically and creatively’), or non-reflexive (‘embodied, enacted or projected, precisely because it cannot be thought about’) (Frost & Hoggett, 2008: 439). ‘Double suffering’ refers to experiences of oppression which challenge individuals’ capacity to digest experience, and to respond resiliently; these experiences cause suffering to both self and others (Frost & Hoggett, 449).

Containment: drawing on Bion’s work, this concept originally referred to the mother’s capacity to think and give meaning to an infant’s cries, thereby giving the infant the experience of being understood (Auchincloss & Samberg, 2012). In clinical practice, it can be seen as, ‘the process whereby a potentially overwhelming feeling can be held, understood, and put into perspective through a dialogic relationship between self and other’ (Hoggett, 2013: 72).

1.4 Thesis structure

Chapter 2 positions this research within the socio-cultural context of 20th and 21st century Britain, with what has come to be known as its 'therapy culture', its governmental philosophy of neoliberalism, and its changing attitudes towards healthcare professions, organisations and practices. Chapter 3 describes the immediate origins of the IAPT programme, the controversies surrounding its aims and implementation, and the new roles and practices it has introduced. It assesses what is already known in the psychotherapy-related literature on role transition, motivation to train, identity development and effective practice. Chapter 4 presents the research design and methodology for the empirical work, and introduces the main research participants. It describes the setting for the research, the main procedures used, and how I positioned myself in the process.

Chapters 5 to 10 present the empirical findings on IAPT practitioner experiences, in roughly chronological sequence, from the point of joining the service through the first year of training and afterwards, into the second year and beyond of clinical practice. Chapter 5 specifically looks at themes from the participants' life histories, their motivations to train and entry routes into IAPT. It also introduces participants in terms of 'voice.' Chapter 6 tracks the ups and downs of the one-year taught course through which both PWPs and HITs are initially trained. Chapter 7 also relates to this entry year, but looks at participants' experiences beyond the classroom as they encounter clinical practice and supervision in the primary care setting for the first time. Chapters 8 and 9 take us into the first year following completion of training, and look at how both groups adjust to full-time clinical and case-management activities, their working relationships with others in different settings. These chapters look further at some of the dilemmas practitioners encounter, their hopes and beliefs at this stage and their positioning within the wider IAPT system. In Chapter 10, the experience of PWPs and HITs who stay on into a second full-time year after training is explored; their on-going learning and professional development is considered, along with their strategies for self-care, views about IAPT and responses to working in a high volume, performance-managed, service over a sustained period.

The final chapter of the thesis (chapter 11) reviews what has been learned in relation to the research aim and questions; including, the management of role transitions, the challenges and dilemmas of practice, the professional status

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and identity of IAPT practitioners, and the implications for sustainability of these new workforce roles.

Volume 2 contains the methodological appendices, including examples of interim and completed analyses of participant data.

Chapter 2 - Setting the Scene: therapeutic work and professions in UK context

2.1 Introduction

This chapter seeks to position my research as informed by wider historical, sociological and psychosocial debates on the politics and role of psychological therapies, professionals and practices. The focus is on how these wider perspectives help us to understand the context for and origins of the IAPT initiative, the new roles and practices associated with it and the factors that might shape how they develop and are experienced by those who adopt them.

I start by giving a brief overview of the different therapeutic modalities as they have developed in the UK and the controversies that have surrounded them (Section 2.2). I discuss the medical model, therapy culture and the idea of therapy as a technology of the self (2.2.2-4). I move on to look at the links that have been made between neoliberalism, new public management (NPM) and current approaches to psychological therapy as managed care (2.2.5-6). I also discuss a number of different theoretical perspectives that are relevant for understanding the dynamics of IAPT, and its new workforce roles; these are drawn from the sociology of the professions (2.3), some theories of practice (2.4), and the psychoanalytical and psychosocial study of organisations and society (2.5).

I argue that it is important to bear in mind this history and theoretical context in order to appreciate what happens to individuals over time in the IAPT workforce (Section 2.6). Without this context in mind, it is tempting to view IAPT as a one-off historically unique policy initiative, which operates autonomously with its own purpose-designed set of principles and practices. I will suggest that the majority of research that has considered the detailed operation of the programme to date, its training, job roles and practices has under-valued this wider context and complexity.

2.2 A brief history of therapeutic models and controversies

Vybiral (2014) suggests there are currently around 250 different psychotherapies which are recognized by the scientific community. Amongst the many variants, no comprehensive classification has yet been developed to describe them all. Differences tend to be drawn between main ‘modalities’ of therapy and the professional disciplines of practitioners. For example, therapeutic methods and treatments may be associated with humanistic, cognitive behavioural, psychoanalytic, systemic, group or individual modalities; and, they may have a focus on symptomatic relief or personality change. Each reflects a different conception of how the mind works, has different ethics (ideas about how to live) and practices. Practitioners may have background disciplines in medicine, psychology, mental health nursing, social work or a ‘lay’ subject. In the UK, the range of public sector (NHS) provision is more limited than in the private or voluntary sectors (although individuals may work across both).

2.2.1 The rise and fall of different modalities in the UK

Since their inception, the different psychotherapeutic modalities have waxed and waned in popularity and had a differential impact on NHS provision and on cultural attitudes and beliefs. Some trace their origins back to the philosophical traditions of Ancient Greece, most to the nineteenth century (Marks, 2017). I draw the majority of this brief summary from Hutten and Parry (2011). For the first part of the twentieth century, psychoanalysis based on the work of Freud was in the ascendancy. In the 1940s and 50s, the international influence and importance of the British Psychoanalytical Society was at its greatest. The British school was the most established and creative in Europe in this period, as the nascent profession in other countries had been wiped out by the war. The ‘controversial discussions’ between Anna Freud and Melanie Klein took place under the auspices of the British Society in 1943-4 and marked a turning point in the emergence of the British Object Relations School (Hutten & Parry, 2011).

Also during the 1940s, behaviourism began to emerge as a theoretical force. This had a profound influence on psychological treatments, as during the 1950s and 60s, theories of learning derived from animal experimentation were applied to humans, bringing experimental methods to human psychological processes. Early work by Skinner and Wolpe, amongst others was influential,

for example, at the Maudsley Hospital in London, whose medical school was renamed the Institute of Psychiatry (IoP) in 1948. By the 1960s, behavioural treatments were available in many mental health services throughout Britain. These developments also led to changes in the role of clinical psychology from a measurement discipline ancillary to psychiatry, to a therapeutic profession in its own right (Hutten & Parry, 2011).

The 'cognitive revolution' in academic psychology during the 1960s was followed by new emphasis on the importance of paying attention to cognitive processes in therapy. Beck and Ellis in the US redefined the therapist's primary role as being to explore how clients' belief systems came to be as they were, how they could be pulled apart and alternative more positive ways of thinking introduced (Marks, 2012). Adult psychotherapy based on psychoanalytic principles continued to develop in the 1950s and 60s, at the same time as the influx of white, mainly Jewish, refugees from apartheid South Africa, based at the Institute of Psychiatry (IOP) in London, led to the opening up and popularising of new training programmes in cognitive and behavioural psychotherapy (also known as CBT) (Hutten & Parry, 2011). Marks in particular was responsible for the development of nurse training in the new integrated CBT approach (Marks, 2012).

During the early 1970s, the gulf between the monolithic schools of psychoanalysis and behaviourism was filled with an explosion of 'new' therapies, based variously on 'humanistic', 'experiential', 'constructivist' and 'existential' approaches. These were largely developed outside the NHS, in the so called 'human potential movement', although they have had an important influence within NHS services (Hutten & Parry, 2011).

As CBT became more widely practised during the 1970s and 1980s, briefer, focal psychodynamic treatments started to become available within the NHS, pioneered by such clinicians as Malan in the UK and Mann and Sifneos in the US. Psychoanalytic groups, therapeutic communities and systemic family therapies were also developed within the NHS, and have had a major influence on clinical practice (Hutten & Parry, 2011).

An ever-greater number of therapies were applied to a wider range of problems during the 1980s, although many NHS professionals, mainly psychiatrists and psychologists, used a range of clinical techniques quite

pragmatically, rather than training within a particular school. Since then, interest in pan-theoretical and integrationist therapies has burgeoned (Marks, 2017). Overall, there has been a massive expansion in both numbers of practitioners and types of therapy and counselling available, with a sharp dividing line between those that are available via publicly funded provision in the NHS and those which can only be accessed privately or through the voluntary sector (Hutten & Parry, 2011). Amongst these, CBT has become the most dominant form of therapy in the 21st century, closely linked with the rise of evidence-based medicine (EBM). Its reach has extended beyond health services, into community settings, the criminal justice system, education and social services (Marks, 2012).

2.2.2 The medical model

Therapies, like CBT, which are based in ‘a medical model’ (focussed primarily on improvements in functioning) differ from those which are relationally- or meaning-oriented (focussed on personality change), such as psychodynamic therapy. There is also no neat overlay between these and the sectoral location of provision. The origins of the medical model, it has been argued, date back to eighteenth century ‘library medicine’ (based on the classical learning of the physician) and proceed through bedside and hospital models (based on practical management of the patient), to twentieth century ‘surveillance’ or population-based medicine (Armstrong, 1995). This latter form of medicine focuses on defining, measuring and researching ‘normal’ development and deviations from the norm and is accompanied by a whole machinery of observation, which gradually subsumes everyone as a patient, and renders death ‘abnormal’ (Armstrong, 1995). Under surveillance medicine, in Armstrong’s thesis, we see a shift towards population-focussed sets of interventions, rather than ones directed solely at the human body in hospital.

A characteristic of surveillance medicine, from this viewpoint, is that it involves widespread screening and activities of health promotion (for example, teaching hygiene rules), but its ultimate success comes from being internalised by the general population, via tactics of pathologisation and vigilance (Armstrong, 1995: 399). Surveillance medicine, it is suggested, requires constant scrutiny of health status, where ‘everything must be normal or it is precariously abnormal’ (Armstrong, 1995: 400). ‘Risk factors’ replace symptoms and signs as part of a continuum of endless health monitoring, in which illness and treatment play only a small part; ‘the problem is less illness *per se* but the semi-pathological pre-illness at-risk state’ (Armstrong, 1995: 401). In the psychological sphere, there appears also to be a shift from a binary view of

insanity/ sanity (in the case of particular individuals) to a more generalised concern with neuroses (which affect everyone) (Armstrong, 1995: 401).

The twentieth century also saw the notion of ‘common mental health problems’ (CMHPs) - defined as anxiety and/or depression - coming to the fore, following the shell shock studies of the first world war (Pilgrim & McCranie, 2013). It has been suggested that the CMHP term denotes a particular orientation to the person and the problem and carries different meanings of recovery in different contexts (Pilgrim & McCranie, 2013). There has also been an exponential increase in diagnostic categories, reflecting different professional disciplines, orientations and treatments. I argue that IAPT, with its focus on CMHPs, fits within this context of population focussed mental health initiatives. IAPT has a surveillance aspect, in that it aims to prevent the worsening of conditions that might threaten life chances if left unchecked (Layard, 2005b; Centre for Economic Performance, 2006). One of its main principles is also the systematic measurement, monitoring and review of individual mental health states (Clark et al., 2009).

2.2.3 Therapy culture and the pursuit of national happiness

Some commentators characterise the modern era as a ‘therapy culture’ (Füredi, 2003; Polsky, 1993; Moloney, 2013); one in which we over-rely on talking treatments to cure the ills of modern living. According to Füredi (2004), the dramatic growth in numbers of psychotherapy and counselling professionals since the 1980s is the result of the equivalent to a ‘pyramid selling scheme’, a self-generating industry creating work and income for some people, but on the basis of false promises (Füredi, 2004: 9). He describes an ‘emotional turn’ in modern cultural life, wherein we have all become obsessed with our own emotional well-being and are no longer able to cope with the everyday risks of being hurt, having disappointments and setbacks. Instead, he argues, we embrace the new emotionality as a reason for medical or psychological intervention, adopting a plethora of new diagnostic labels for our malaise. He argues this represents a ‘therapeutic imperative,’ which renders us vulnerable and powerless, and too quick to conform with government agendas, ‘in an age of uncertainty’ (Füredi, 2004: 22). James (2007) too, decries the pandemic of anxiety and misery that appears to have gripped modern society and which he labels ‘influenza’ (James, 2007).

For Rose, the ‘therapeutic imperative,’ is evidenced throughout publishing and the media, which ‘celebrates the emancipatory potential of the application

of psychological discoveries to the troubles of human existence' (Rose, 1999: 218-219). The increasing turn to therapy can be viewed as a form of 'narcissistic withdrawal', a response to the psychic damage wrought by capitalism (Rose, 1999: 219). In his view, new therapeutic movements and the hopes of happiness they hold out, have become fetishized elements of our consumer culture, thriving on disappointment and unfulfillable promises (Rose, 1999: 219). The psychotherapeutic is also linked with our obsession with personal identity (Rose, 1999). With the growth of bureaucracy, the regulative technology of expertise has invaded the competence of the individual and family, and produced dependence upon the state, the corporation, and the bureaucracy (Rose, 1999). In this context, the psychological therapies are based on a premise of positive commitment to the healthy individual, as good citizen and their real aim is the restoration of the individual to communal values (Rose, 1999). Furthermore, Rose argues, they are a method of learning to endure the loneliness of a culture without faith (Rose, 1999).

What Rose is getting at is our changing cultural beliefs about ourselves. These have accompanied the rise of individualism from the mid-nineteenth century onwards and are embodied in institutional and technical practices (Rose, 1999, 2016). These determine how individuality is specified and governed (Rose, 1999). Examples of this self-regulation in practice are: the growing use of writing practices such as confessional diaries, the Taylorisation of industrial work, and even of school-based education. Rose (1999, 2016) argues there is a tightening linkage between the tasks of government and our own personal capacities, with the language of social responsibility being invoked to generate commitment to values and ways of life that are supported by government (Rose, 1999, 2016).

Binkley (2011) suggests we are all now engaged in personal happiness projects of our own, drawing on the techniques and expert discourse of positive psychology. We use therapy to maximize our happy emotions through direct manipulation of our own thoughts, rather than via social engagement (Binkley, 2011). Happiness has become validated as a task of medical intervention and as a personal hobby, he says. Happiness is a plastic medium, to be stretched, manipulated, counted and measured. The discourse of happiness is a dramatic new presence in the therapeutic culture of our time (Binkley, 2011). Furthermore, Binkley argues, happiness is now a task - a regimen - a daily undertaking 'in which the individual produces positive emotional states just as a fitness guru might shape a desired muscle group. To govern oneself through the maximization of one's potential for happiness is to govern oneself as a

subject of neoliberal enterprise: agency, autonomy, freedom from dependence and external constraint, and the cognitive wherewithal necessary for the pursuit of self-interest....' (Binkley, 2011: 391). This argument has strong resonances with Foucault's classic theory of governmentality and the role of 'technologies of the self'.

2.2.4 Governmentality and technologies of the self

The theory of governmentality (see 1.2) is widely associated with the work of Michel Foucault in the 1970s, and as developed and adapted since (Lemke, 2002; Dean, 2010b; Madsen, 2014). Foucault defined governmentality as 'the conduct of conduct' or 'the art of government' (Foucault, 2009; Madsen, 2014). Government in turn refers to a wide range of control techniques which make subjects governable (Madsen, 2014). In other words, government involves attempts to apply rationality to the calculation of how to govern, via engagement with the way the 'governed' and 'governors' regulate themselves (Madsen, 2014). This may involve different ways of thinking, making calculations, defining purposes and employing knowledge and be represented through a range of practices, both of government and 'practices of the self' (Dean, 2010a: 20). Different mentalities of government, from this perspective, are best seen in practices, often in the language and technical instruments of practice, but also in the imagery, mythology and 'symbolics of power' or the 'taken for granted' (Dean, 2010a: 25).

Rose (1999, 2016) builds upon Foucault's hypotheses regarding 'governmentality' by examining the role of discourse (Rose, 1999: xxii). He describes, with some unease, what he sees as contemporary 'regimes of the self,' these are seen where there is a relentless focus on identity, choice, autonomy and self-realization in political and policy discourse, and a parallel denial of dependency, mutuality, fraternity, self-sacrifice and commitment to others (Rose, 1999: xxiv). In his analysis, talking therapists have become 'engineers of the human soul' (Rose, 1999: 3), because of the way they use technologies of subjectivity, symbiotically bound up with techniques of the self, 'to act upon our bodies, souls, thoughts, and conduct in order to achieve happiness, wisdom, health, and fulfilment' (Rose, 1999: 11). In other words, he suggests talking therapies have become part of the plethora of different ways in which we monitor and evaluate ourselves 'according to criteria provided for us by others' (Rose, 1999: 11). Every choice we make, Rose argues, is an emblem of our identity; and therapy is a means of instilling the imperative of choice by restoring those who deviate from this norm back to the status of a choosing individual (Rose, 1999: 11). The psychotherapies provide technologies of

individuality for the production and regulation of the individual who is ‘free to choose’ (Rose, 1999: 232). As we shall see, the concept of choice is an important trope in contemporary healthcare, and IAPT in particular.

There may be something specific about behaviour therapies, which mark them out as a technology of the self, argues Rose (1999): for example, practitioners tend to stress their potential for enhancing skills of ‘self-management’, and they use techniques of the laboratory rather than the bedside (Rose, 1999: 238). People with conditions such as alcoholism, anorexia, bulimia, phobias, obsessive compulsions and anxiety now have their behaviour ‘managed back to normality’ through expertly designed programmes, employing the systematic use of sanctions and rewards (Rose, 1999: 239). Behaviour therapy, in Rose’s analysis, in fact ‘symbolises the vocation of psychology as an administrative discipline, allowing the powerful to manipulate the powerless in the interests of social control, building the domination of subjectivity into its theoretical fabric and its technical approach’ (Rose, 1999: 240). Behaviour modification has become ‘consonant with the liberating technologies of self-assertion’ – easily transformed into a technique of self-analysis and self-help - a therapy of normality to enable us all to cope with stress, anxiety or demanding social situations’ (Rose, 1999: 241). An ‘educational’ or ‘skills’ model of human problems has taken over from a ‘disease’ and ‘treatment’ model (Rose, 1999: 242). Behaviourist technologies have democratic aspirations, but are fundamentally double edged in this analysis (Rose, 1999: 242).

Following in Foucault’s footsteps, Rose argues, there is no way of living as an ethical subject except through certain modes of subjectification, involving the monitoring, testing and improving of the self (Rose, 1999, 2016). Our new philosophy, he says, is one that prescribes that ‘the autonomous self will discover itself in the passage through the therapeutic’ (Rose, 1999: 247). Practitioners of psychotherapy have succeeded in colonizing the professions with their own vocabularies, images, evaluations, and techniques (Rose, 1999: 247). Each therapeutic system and each therapeutic context has its own particularity. The voice becomes a means of investigation and diagnosis; the training room a space filled with the murmurings of voices from case histories and the powerful ambit of tradition. The texts of psychotherapy have become instructional manuals in techniques of the self (Rose, 1999, 2016). The codes and vocabularies of psychotherapeutics bring into alignment the techniques for regulation of subjectivity and technologies of government elaborated within contemporary political rationales. The self that is liberated is obliged to live its

life tied to the project of its own identity (Rose, 1999: 258). As we shall see in the next chapter (Section 3.3), a number of the critiques of IAPT come from this perspective, disputing both the discourse, the method and the experience of those who work or are 'treated' through it.

2.2.5 The links with neoliberalism and New Public Management

Drawing on the governmentality perspective, links have also been made between the economic philosophy of neoliberalism, the reform of organisations and services under 'New Public Management' (NPM) and individual and workforce identity struggles (Dean, 2014; Ward, 2011; Evetts, 2009). Neoliberalism, according to Steger and Roy (2010) refers to an economic model or 'paradigm' that has dominated in the UK since the 1980s. It is an ideology, a mode of governance and a set of policies. Its ideas stem from classical liberal economics, with its idealising of the self-regulating free market. It is a mode of governance based on 'entrepreneurial values such as competitiveness, self-interest, and decentralisation. It celebrates individual empowerment and the devolution of state power to smaller localised units' (Steger & Roy, 2010: 12). Rather than pursuing the public good, neoliberals seek to adopt the tools of business and commerce, in the form of strategic 'risk management' plans, cost-benefit efficiency calculations, quantitative targets and outcomes, individualised performance plans and 'rational choice' models of behaviour (Steger & Roy, 2010: 12). The role of public servants under neoliberalism is to contribute to the success of the free market, by ensuring the smooth running of slimmed down state 'enterprises' (Steger & Roy, 2010: 12).

Neoliberalism is closely associated with NPM and the redefinition of citizens as 'customers' and consumers, whose entrepreneurial spirit must be cultivated. NPM repositions the role of government as setting the direction for services rather than delivering them, enabling individuals and communities to do for themselves, rather than meeting their needs directly, focussing on results, earning rather than spending, prevention rather than cure, and leveraging change through the mechanisms of the market (Steger & Roy, 2010). Another hallmark of neoliberalism is the proliferation of public policies aimed at de-regulating the economy, liberalising trade and privatising state enterprises (Steger & Roy, 2010). These are accompanied by policy measures to cut taxes, reduce social services and welfare programmes, replace welfare with 'workfare', reduce the size of government, enable tax havens for domestic and foreign corporations, and the combatting of trade unions in the name of 'labour flexibility,' amongst others (Steger & Roy, 2010).

NPM was first identified and defined by Hood (1991) as a set of doctrinal values involving: professionalized management, explicit standards and measures of performance, emphasis on output controls, disaggregation of public services and institutions, shift to competition in the public sector, private sector styles of management practice and greater discipline and parsimony in resource use (Hood, 1991: 4-5). It has generated what many commentators have termed an ‘audit society’ (Power, 1997).

As NPM has been implemented across the NHS the culture has changed drastically (Simpson, 2016). There is now a deepening and widening of the longstanding disparity between the aims of managers, administrators and clinicians; with, it is argued, tasks organised in such a way as to distance clinicians from each other and from personal contact with patients (Simpson, 2016: 56). The human, relational aspects of care appear to be devalued (Simpson, 2016: 56). Staff are increasingly put into situations which leave them feeling impotent and traumatised in the face of patient needs. The pressure to reduce financial costs triumphs over ethical, professional and clinical judgement (Simpson, 2016: 57). These concerns extend into the psychotherapeutic field, where it is argued the philosophy of ‘managed care’ is taking over, and the role and practices of the psychotherapist are being increasingly reshaped, to meet managerialist concerns (Rizq, 2014a; Lees, 2016; Simpson, 2016). This raises the question of how professional roles, identities and practices emerge and develop over time, how they are regulated and the meanings that may be attached to values, such as ‘professionalism.’ These questions are explored in the next section.

2.3 Some theories of the professions

The sociology of the professions has a lot to offer in relation to understanding workforce dynamics, the emergence of new roles, and decline of others, their characteristics and practices. Theories of the professions tend to differentiate different aspects of professional, semi-professional and other occupations, whilst also considering how these inter-relate and change (see 1.3 for definitions). They aid understanding of how professionals learn and how roles may be sustained over time. For this reason, they are relevant to understanding how people grow into the IAPT roles, how the low- and high-intensity roles inter-relate, and how both roles shape and get shaped by the wider organisational context. Finally, they point towards some questions and methodologies that merit investigation.

2.3.1 The dynamics of professions and occupations

One way in which professions have been understood historically is in terms of the jurisdictional claims they make (Abbott, 1988). For example, professional groups may vie with each other over certain key tasks such as classification, diagnosis, inference and treatment of problem conditions (Abbott, 1988). Through interdependence and competition in the workplace, some groups become subordinate to others, with advantages and disadvantages for each. Client characteristics, the measurability of results, and academic knowledge all play a part in determining the level of internal competition and where boundaries are drawn between professional groups (Abbott, 1988). External events (such as changes in technology, organisational context or client differentiation) play a part in unsettling the system (Abbott, 1988). From this perspective, professions have been characterised as exerting dominance, by directing and evaluating the work of others in the same field (Friedson, 1970, 2001). They have been linked with institutions that accredit their training standards and qualifications, and that license individuals to practice (Harrison & McDonald, 2008). These institutions enable self-regulation, by acting as disciplinary bodies (Harrison & McDonald, 2008). The clearest example of a dominant profession in the field of healthcare is medicine (Harrison & McDonald, 2008).

More particularly, professions have also been associated with the workings of the capitalist economy; they act as a vehicle for the exercise of power by social elites and ensure their own durability by protecting their interests as a group (Harrison & McDonald, 2008; Saks, 2016). They act as 'reality definers' on important social issues, through their role in providing certificates of sickness, disability or mental capacity which legitimate absences from work or school or severe punishment for crime (Harrison & McDonald, 2008: 33). Finally, collegiality is also an important characteristic in professions like medicine; this is the process by which members of a profession become socialised into 'an attitude of loyalty' to colleagues, which presents members' competence and trustworthiness well to the outside world (Harrison & McDonald, 2008). Practitioner associations help to maintain a professional culture, contribute to the 'mystification of specialist knowledge' and preserve an asymmetry between producers and consumers of professional work (Harrison & McDonald, 2008: 31, referring to Johnson, 1972).

When looking at the contemporary healthcare workforce, the boundaries between professional groups and dynamics of occupational change often reflect

changes in practice (Nancarrow & Borthwick, 2005). There are different and interconnected directions of change, including: diversification, specialisation, vertical and horizontal substitution (Nancarrow & Borthwick, 2005). Diversification is where new approaches to practice are incorporated into the activities of a particular disciplinary group, resulting in expansion of roles. Specialisation refers to the division of labour within disciplines that result in adoption of an increasing level of expertise and the use of a specific job titles. Despecialisation also occurs, where there is an oversupply of particular practitioners, and where generalists are required in higher proportions. Vertical substitution involves the delegation of specific tasks across disciplinary boundaries and between occupational groups with non-equivalent levels of training and expertise; as seen in the practice of nurse prescribing, the use of occupational therapy assistants and support workers (Nancarrow & Borthwick, 2005). Horizontal substitution 'arises when providers with a similar level of training and expertise, but from different disciplinary backgrounds, undertake roles that are normally the domain of another discipline' (Nancarrow & Borthwick, 2005: 911). The growth of interprofessional practice and training contributes to this overlap in worker roles. The potential for substitution increases when tasks are less well defined, are not protected through regulation and do not involve access to restricted technology (Nancarrow & Borthwick, 2005). The roles also need to be flexible enough that others can adopt them (Nancarrow & Borthwick, 2005).

2.3.2 Professionalisation and de-professionalisation

Professionalisation refers to the process by which a particular occupational group obtains the status of 'profession' (Callaghan, 2014: 1510). A key element is the regulation of access via lengthy training and close monitoring of training procedures (Callaghan, 2014). Professions monopolise sectors of the labour market through practices of occupational closure (Callaghan, 2014). The search for closure has sometimes been understood as driven by self-interest, a means to enhance salary, status and power, as well as to achieve monopoly protection over a particular occupational jurisdiction (Evetts, 2011: 6). This definition, prominent in the 1970s and 80s but less so now, is still important for the analysis of gender issues and of newly emerging occupations (Evetts, 2011: 6).

Professionalisation sometimes occurs 'from within,' as in law and medicine, at other times, 'from above,' as in engineering and social work (Evetts, 2011: 11). In the public sector, professionalism is most commonly constructed and imposed 'from above' (Evetts, 2011: 11). Professionalisation may be explored through a lens of governmentality, as a technology of the self (see 2.2),

comprising ideological practices as well as processes of 'professionalism' (Callaghan, 2014: 1512). These practices tend to polarise 'the personal' and 'the professional', with the 'professional' being portrayed as a neutral figure, a reified, depoliticised individual, and professional identity as separate from the personal/ political (Callaghan, 2014: 1512). The process of professionalisation thus implies a tension between professional and nonprofessional which has to be continuously negotiated, with personal and political affiliations relegated to the realm of nonprofessional (Callaghan, 2014: 1512). Professionals also act as institutional agents, vying for control over organisational resources, and exhibiting varying degrees of reflexivity and agency (Muzio et al., 2013).

In several areas of healthcare, successful and not so successful 'professionalisation projects' have been undertaken (McCann et al., 2013; Green et al., 2011; Sullivan, 2012). One example is Assistant Nurse Practitioners (ANPs) in primary care (McMurray, 2011). This group have the right to diagnose and to prescribe, following specialist training, but when working in a primary care setting, have been found to struggle to throw off doctors' view of them as 'handmaidens' (McMurray, 2011: 810). GPs have resisted the idea that ANPs can diagnose and make referrals effectively, framing these tasks as something far more complex (McMurray, 2011). As a result, in McMurray's study, a small group of ANPs broke away from their original GP practice and set up on their own, as entrepreneurial co-owners in a new area (McMurray, 2011). To achieve this 'ordinal switching' of the occupational hierarchy, they had to actively persuade patients and the public about their role (McMurray, 2011: 812-814). They claimed their right to question doctor's decisions and practices and were no longer willing to play 'Greek chorus to doctors' (McMurray, 2011: 815). This was, in effect, a minor revolution in occupational relations, which showed the ANPs' desire to extend their learning, develop their practice and raise their status (McMurray, 2011). In a wider context of growing entrepreneurialism and managerialism, these ANPs successfully engaged with opportunities at the margins and created a new marketplace for their expertise (McMurray, 2011).

Numerous challenges exist to the project of professionalisation however. Clients and/ or consumers may shift the balance of power within relationships between professionals and those they serve (Callaghan, 2014: 1514); for example, as seen in movements to 'democratise' professionalism, through 'shared decision-making' (Dzur, 2008). Similarly, inter-professional and partnership working in multi-agency teams contributes toward hierarchical re-structuring of relationships between professions, and enables some boundary crossing to take place (Callaghan, 2014: 1514, after Hudson, 2002). Other significant forces

that affect professional mobility, are those of globalisation and managerialisation; these determine, in effect, an international hierarchy of labour (Scanlon, 2011a). Furthermore, multiculturalism affects how professions are mediated through local cultural and political practices (Scanlon, 2011a: 6).

Deprofessionalisation refers to 'the loss by professional occupations of their unique qualities, in particular their monopoly over knowledge, public trust, autonomy and authority over their client base' (Scanlon, 2011a: 6, after Haug, 1973). Deprofessionalisation occurs when professional services start to be provided by non-professionals; when there is a loss or distillation of skills or when a professional's core values are attacked (Scanlon, 2011a). Deprofessionalisation is closely linked with changes in the workplace, under the discourse of new managerialism, where all workers are constructed as 'replaceable' (Scanlon, 2011a: 7, after Davies, 2003). The segmentation of professional work under NPM may also be viewed as a form of 'proletarianisation', wherein public professionals are assimilated into the same precarious status as other groups of workers in the globalised market (Ward, 2011). 'Post-professionalisation' refers to the loss of exclusivity over knowledge that is experienced by professionals because of the growth of technology and improved information accessibility, reducing the need for specialisation in the way knowledge is applied (Nancarrow & Borthwick, 2005, after Kritzer, 1999). Finally, hybridisation refers to the creation of roles which span more than one occupational group, especially the combining of professional and managerial roles (Croft et al., 2015). Medical hybrids, for example, mediate a critical boundary between general managers and their professional peers (Croft et al., 2015). The link with wider institutional processes means professionalisation and deprofessionalisation are best viewed as fights for survival in an ecology of institutional forms (Saks, 2016).

2.3.3 The meanings of professionalism

Professionalism, as already suggested, implies a set of normative values and workplace practices, linked with wider culture (Evetts, 2011; Malin, 2000). The term is often used in recruitment and marketing campaigns, to appeal to practitioners, employees and managers alike. It conveys a sense of having a work identity, a career and sense of self, along with exclusive ownership of an area of expertise and knowledge (Evetts, 2011). It suggests having the power to define the nature of problems in a given area, and control over access to potential solutions (Evetts, 2011). Professionalism also includes the idea of collegiality and the promise of supportive working relationships (Evetts, 2011). It offers autonomy in decision-making and discretion in work practices, serving

the public interest, and even self-regulation (Evetts, 2011: 30). For all of these reasons, the discourse of professionalism needs studying for the way it signals change in occupational and social control (Evetts, 2011).

Two 'ideal types' of professionalism may be defined: organisational and occupational (Evetts, 2009, 2013). The organisational form is closely linked with NPM (see 2.2.5), and is manifested by a discourse of control. It incorporates rational-legal forms of authority, hierarchical structures of responsibility and decision-making, standardised work procedures and practices, and managerialist controls (Evetts, 2009: 247-8). It relies on external regulation, accountability measures, target setting and performance reviews (Evetts, 2009: 247-8). Under this form, professional competences are defined by the work organisation; there is a focus on governance and structures rather than relationships (Evetts, 2009: 247-8). Under NPM, individual performance and competition is linked to the success and/ or failure of the organisation (Evetts, 2009). The occupational form of professionalism, by contrast, is the form associated with a discourse of collegial authority, and relations of trust between practitioners (Evetts, 2009). It is the form in which professionals are allowed authority, autonomy, discretionary judgement, and assessment powers (Evetts, 2009). Controls are operationalised via codes of professional ethics, monitored by professional institutes and associations (rather than by organisational managers) (Evetts, 2009: 248). This form of professionalism has been associated with gendered careers and specialities; and, it emphasizes relationships rather than structures (Evetts, 2009: 248).

It is also important to look at the formation of sub-groups, within professions, as a form of *intra*-professionalism. For example, this is seen in the status hierarchies of medical specialities (Numerato et al., 2012), or in specialisation within the GP role (Martin et al., 2009). These signal how professional jurisdictions are negotiated at micro-level. The study of *inter*-professionalism, on the other hand, points to the existence of hierarchies and power imbalances between professional groups, which lead to conflict and rivalry (Hudson, 2002). Tensions may arise when groups with similar interests in a client group (for example, doctors, social workers and nurses) attempt to demarcate clearly the boundary lines between their activities (Dingwall, 2008). Each time a boundary line is established, 'atrocious stories' tend to be generated as a way of challenging and preventing the controlling group's activity becoming exclusive (Dingwall, 2008: 35).

2.3.4 Professional identity and change

Another dimension of the professionalisation process, is the role played by learning and professional identity. These are key components of professionalism which affect job commitment, and organisational outcomes. As I will show in Chapter 3 (3.5-3.6) how psychotherapists train and 'become' professionally recognised has been studied, from a number of different perspectives, but has not always been linked with the wider literature on professional identity and change. This section briefly reviews two papers which are helpful in this regard.

In relation to professional learning, Anteby and colleagues (2016) suggest three main 'lenses' have been advanced in the literature (Anteby et al., 2016); that of 'becoming,' 'doing,' and 'relating'. The first 'becoming lens' refers to 'the process by which an occupational community socialises its members into a particular set of shared cultural values, norms, and worldviews' (Anteby et al, 2016: 189-190). It focuses on initiation and the problem of 'entry' into an occupation. By becoming socialised, new members of a profession enter a specialised 'habitus' (after Bourdieu, 2000), become 'cognitively entrenched' within their occupation, and surrender part of their autonomy to the collective (Anteby et al., 2016: 194). The second 'doing' lens looks at the nature of tasks and task domains, and how occupational members perform these activities or practices. It seeks to understand how people engage in certain activities and compete with other occupational groups for exclusive claim to perform those activities (Anteby et al, 2016: 200). The third lens is that of 'relating'. This seeks to explain the generative nature of relations within and between occupational groups, their dynamic and how they unfold. It looks at an occupation's entire field of relations, the way occupations engage in 'relating as collaborating', 'relating as coproducing' and/ or 'relating as brokering' (Anteby et al, 2016: 213). Each of these lenses has strengths and weaknesses. For example, 'becoming' studies are useful for understanding individual motivation, but not necessarily for the way socialisation processes influence organisational dynamics, or the impact of the broader external environment. They tend to focus on the entry period into an occupation, and ignore the experience of those who have been in role for a longer time. This PhD study, adopts a predominantly 'becoming' lens, but attempts to address the weaknesses described, by including people who have been in an IAPT role for a while, as well as new entrants, and to examine the impact of the wider context and occupational dynamics on practitioners, whilst also bearing in mind the 'doing' and 'relating' aspects of their work.

In relation to professional identity, there is little that is fixed about what this is, and/ or when it has been achieved. Stronach et al (2002) provide a persuasive argument that the very idea of professional identity is framed by contradictions and dilemmas, and is permanently in flux, caught between an 'economy of performance' and 'ecologies of practice' (Stronach et al., 2002: 109). It is suggested that professional identity requires 'self-work', that professionals are over-invested in acting for good in society, and are in fact an emblematic construct, forever 'at risk' of deprofessionalisation (Stronach et al., 2002: 110-111). The professional is often constructed as a 'collective individual', when the identity is better viewed as plural or split (Stronach et al., 2002: 112). Boundary issues reveal more about professional identity than the study of roles themselves, as they point to areas of ambiguity and uncertainty. This can be seen in the field of nursing, where historically, there have been repeated crises of 'non-identity', and in teaching, where identity has become 'hollowed out' over time (Stronach et al, 2002: 115-118). It is also important to examine claims to collaborative professionalism, as it is common for professionals to have a plurality of roles, making allocations of priority difficult (Stronach et al, 2002: 115-118). Professional selfhood, in this analysis, is about resolving tensions and splits, and managing ambivalence in particular ways (Stronach et al, 2002). As we shall see, this perspective provides insights that are relevant for understanding the identity and practices of those who work in IAPT low- and high-intensity roles. The boundary between 'professional' and 'semi-professional' in particular appears to be fruitful for further investigation in the IAPT context, as the two roles introduced by IAPT share characteristics of each, but are positioned differently; the PWP role appears to be closer to that of 'semi-professional' and the HIT to 'professional.' Indeed, one of the main bones of contention regarding IAPT has been the perceived 'threat' it poses for the professional status of psychotherapy training and practice in general (see also, 2.2.5 above).

2.3.5 Semi-professions

The 'semi-professions' have long been prevalent alongside more established professional roles (Etzioni, 1969), and it could be argued that the IAPT roles are more representative of these, than full professional roles. As indicated in Chapter 1 (1.3), these are occupations that require advanced knowledge and skills but are not widely regarded as a true profession (Hodson & Sullivan, 2008). The terms 'semi-profession' or 'insecure professional' are conceptual ones, which, as we shall see in Chapter 3, are relevant to the understanding of contemporary 'assistant roles' as well as IAPT roles. The terms 'assistant' or 'para-professional' tend to be actual job titles, applied to a wide range of roles in education, law, health and social care and often linked with specific government initiatives (see 3.5.4).

The key features of semi-professions, in Nottingham's (2007) historical analysis are that they struggle to professionalize, have a 'perpetual sense of legitimate aspiration denied' and are particularly susceptible to 'the ideology of promise' (Nottingham, 2007: 446). They tend to be taken up by young men and women with a progressive outlook, who have high ambitions but limited means, whose hopes are initially excited by the financial and other rewards of the work, but then slowly disappointed (Nottingham, 2007). They tend to involve a relationship with clients that is 'imposed' rather than chosen, and to operate in alliance with the state, often highly regulated by comparison with full professionals, whose clients are 'free to choose', and the professionals themselves expected to act with altruism and autonomy (Nottingham, 2007). Unlike professionals who have power, authority and expertise within an established domain, semi-professionals lack sustained authority and need the state to act as 'guarantor of basics' in relation to their client work; they also require 'Olympian supervision' (Nottingham, 2007: 460-461). Their roles are typically diffuse and promotional, rather than defensive and precise in the way that professions with secure jurisdictions can afford to be (Nottingham, 2007). They have discretion, but this is subject to periodic adjustment by the state (Nottingham, 2007). Their work is typically driven by a strong social philosophy and an internalised personal morality (Nottingham, 2007). This makes the individuals concerned vulnerable to suffering, as they deal with society's more uncomfortable transactions and zero-sum games, and work at the frontline of major social conflicts (Nottingham, 2007). Bourdieu et al (1999) demonstrated this in his study of social workers, and Polsky (1993) saw them as key functionaries in the 'therapeutic state' (Nottingham, 2007). Another common term that has been applied to these kinds of worker is that of Lipsky's (1983) 'street level bureaucrat' (see 2.5.4).

2.3.6 Regulation

The role of regulation is another area where professional boundaries tend to be disputed, where the competing forces of professionalisation, de-professionalisation and post-professionalisation may be observed. Arguments for and against regulation have been strongly articulated in relation to all health professions, and psychotherapy and counselling in particular, in recent decades (Allsop & Saks, 2003; McGivern et al., 2009; Aldridge & Mulvey, 2013). Modernisation of the regulatory framework of the health professions became a hallmark of the Blair government in the noughties, and gave rise to the establishment of the Health and Care Professions Council (HCPC). This body has extensive powers of scrutiny and review and direct accountability to the Secretary of State (Allsop & Saks, 2003: 11). It bestows protected title on some

professional groups (such as Art Therapists and Practitioner Psychologists) in return for adherence to HCPC standards of conduct, performance and ethics, proficiency, continuing professional development (CPD), character, health, education and training. For psychotherapists and counsellors not recognised by HCPC, a system of accredited voluntary registers, linked with relevant professional bodies (such as British Psychoanalytic Council (BPC)), is overseen by the Professional Standards Authority for Health and Social Care (Aldridge & Mulvey, 2013).

The debate on regulation has however been fraught (Waller & Guthrie, 2013). Regulation has been seen to confer or constrain professional status at different points in time (Waller & Guthrie, 2013: 5). For some occupations and sub-groups, it is an important milestone in a process of striving for status, respectability, and jurisdiction (after Abbott, 1988), a means to travel towards 'mature' professional status (Waller & Guthrie, 2013: 6). Amongst psychotherapists and counsellors however there have been fears that regulation would impose a medical model of practice, particularly with the advent of IAPT, and the development of the National Occupational Standards (NOS) for some psychological therapies by Skills for Health. These frameworks have been seen to be too rigidly defined, and to call into question the role of the unconscious, the value of therapist professionalism, knowledge and supervision (Morgan-Ayrs, 2016). There have been objections in principle to the interference of the state into the privacy of the consulting room; claims that it will adversely affect the therapeutic relationship and undermine the autonomy of practitioners (Waller & Guthrie, 2013: 8). Assured voluntary registration and the ruling out of regulation for some professions has thus been a valid compromise. The voluntary system seeks to protect diversity of practice whilst ensuring consumer protection. It refocuses attention on public protection, in Waller and Guthrie's view, and removes the incentive for individual professional groups to push for regulation solely for its benefits, in terms of protection of professional title, enhanced status and increased recognition.

2.4 Some theories of practice

As well as being novel in their own right, the IAPT roles have introduced new organisational and therapeutic practices and interventions. To understand the nature of these practices, how they are learned, negotiated and understood, I turn now to literature on theories of practice. I suggest that some theories of practice are useful for understanding role transitions (see also 3.6.3), and for

linking what happens in specific local work contexts with the wider organisational and societal processes. In other words, I contend that there is potential in the view that some theories of practice, when linked with a governmentality perspective, help to make visible ‘the interrelatedness of practices, patterns of power, and forms of governing,’ the connections between local sites and national programmes and with particular forms of political reason (Reich & Girdwood, 2012: 160). They also have implications for professional learning and can be researched in a number of ways.

2.4.1 Different characterisations

There have been many different characterisations of practice, but three main things that all practices have in common: first, they are organised constellations of different activities; second, they involve multiple people, rather than abstract structures; and third, they rest on something that cannot be put into words, they have a bodily non-propositional aspect that is both social and psychological (Schatzki, 2012: 13-14). They have been variously defined as being about ‘an open-ended, spatially-temporally dispersed nexus of doings and sayings’ (Schatzki, 2012: 14), and as involving characteristic relationships of ‘orchestration’ between people and between people and objects’ (Kemmis et al., 2012: 35).

Practices involve know-how (often tacit and taken for granted), rules about how to do things, intentionality and general understanding (Hager, 2012). More inclusive accounts of practice ‘view them as ranging from simple, discrete human behaviours or actions through to more complex activities and rule-governed routines’ (Hager, 2012: 27). They draw attention to the ‘interconnectedness’ of component parts of practice, and when drawing on a Foucauldian governmentality perspective show the close connections between power and knowledge (Hager, 2012: 20-21). More exclusive accounts, ‘view practices as complex holistic activities, ones that integrate diverse items such as goods and virtues, activity, experience, context and judgement, and often with a temporal dimension’ (Hager, 2012: 27). In other words, they incorporate the idea of practitioners adapting and interpreting rules to fit different circumstances, the use of reflexivity and particular forms of reasoning (Hager, 2012, after Kemmis, 2008). In more exclusive accounts of practice, learning is more complex because practice is about more than invariant rule following. Practice involves suspense and uncertainty, and asymmetrical time and action. From this perspective, practitioners engage in continual interpretation and reinterpretation of their work, and must participate in ongoing learning to be effective (Hager, 2012: 29).

Distinctions have also been drawn between what may be described as the 'internal goods' of practice, and 'external goods' (Hager, 2012: 23, after MacIntyre, 1981). The 'internal goods' of practice are the knacks, feels and know-how unique to the experience of a particular practice; they include things like the desire to excel, the avoided and/ or nurturing aspects of practice, which belong to a whole community of practitioners (Hager, 2012: 23). 'External goods' of practice, by contrast, can be acquired in other ways than by direct participation, belong to the individual rather than the community, and include for example, prestige, status and money (Hager, 2012: 23).

Focussing on practices shifts attention away from actors' consciousness, towards the unconscious or automatic activities embedded in taken-for-granted routines (Swidler, 2001: 84). Practice theory moves attention 'down' from conscious ideas and values to the physical and habitual (Swidler, 2001). This move is complemented by a move 'up' from ideas located in individual consciousness to the impersonal arena of 'discourse' (Swidler, 2001: 84). Practices are said to interact with 'discourse' to produce culture, in different settings (Swidler, 2001). Some practices may also be more enduring or influential than others, and enact constitutive rules; some may be at the centre of antagonistic social relationships, or be visibly and publicly enacted so 'everyone can see' and understand that things have changed (Swidler, 2001: 95-96). These kinds of practices may be termed 'anchoring practices', in that they anchor, control or organise others (Swidler, 2001: 88).

2.4.2 Ecologies of practice

Practices may also be viewed as living things (Hager et al., 2012). They share characteristics with living systems, in that they exist in interconnected networks, have different levels nested within one another, are interdependent on one another and with wider social processes, and they are diverse and have overlapping ecological functions, at times partially replacing one another (Hager et al., 2012). The sayings, doings and relatings of practice go in cycles, are energised at times and dissipate energy at others. Practices typically develop through stages, and exist in a dynamic balance; that is, they regulate themselves through processes of self-organisation up to a breaking point, in order to maintain continuity in relation to internal and outside pressures (Hager et al., 2012). Webs of inter-related practices coexist with one another, are embedded within time and space. Learning how to practice, involves learning how to orchestrate relationships between practices, language and actions which enable specific social arrangements to carry on (Kemmis et al., 2012). The process of

learning, when practices are viewed in terms of their ecology, is not so much a psychological one, as a ‘state of coming to know how to go on in language-games, activities or practices’ (Kemmis et al., 2012: 47).

This is somewhat different from, but not incompatible with, the Foucauldian view of ‘regimes of practices’ as forms of problematisation, modes of reasoning, which carry an ethos and set of techniques, and shape identities. Regimes of practices, in this sense, are understood to be an essential part of the way in which we are governed and govern ourselves (Reich & Girdwood, 2012: 153, after Dean, 2010b). Foucault’s concept of governmentality highlights how regimes of practices may become ‘part of workers’ identities and subjectivities, their ways of governing themselves and others’ (Reich & Girdwood, 2012: 153). It shows how rationality, or ways of thinking, becomes ‘governmental’, when it seeks to become technical and to insert itself into practice (Reich & Girdwood, 2012: 153, after Rose, 1993).

2.4.3 Learning to practice

When applied to the work of professionals, theories of practice draw attention to the role of learning as more than simply the application of theoretical knowledge; they show that it is also a process of ‘knowing-in-practice’, something that is collective and situated (Hager, 2014). Learning to practice involves investing in the purpose of practice; it has an affective dimension which itself generates meanings (Hager, 2014). As practice is embodied and relational, learning is always co-produced by a range of actors across space and time. Learning evolves within historical and social context, and takes shape ‘at the intersection of complex social forces, including the operations of power’ (Hager et al., 2012: 4). ‘Governmentalities’ shape the ways of thinking and acting across local sites and circumstances, augmenting and supplementing theoretical accounts. Practices destabilise traditional analytic categories of ‘macro-micro’, or ‘structure-agency’ in that they are emergent, changing and not fully specifiable in advance. They are best conceptualised, as suggested above (2.4.2) as ‘ecologies, dynamics, or choreographies’ (Hager et al., 2012: 5).

When examined from a governmentality perspective, some learning practices have been shown to give rise to a ‘worker-learner’ identity (Reich & Girdwood, 2012). For example, it can be argued that where a shift towards learning as ‘self-managed’ responsibility entwined with everyday work practices has taken place, and technologies of learning are used, these practices

collectively 'make up' people as worker-learners (Reich & Girdwood, 2012: 152, after Du Gay, 1996). Learning practices may therefore be viewed as regimes of practices, governed in particular place and time by techniques and technologies linked to political rationalities which make up worker identities (Reich & Girdwood, 2012). They may be said to represent 'a shift in form and configuration of power relations from disciplinary power to governmentality, with the worker-learner being governed at a distance, governing themselves and being responsible for their own learning' (Reich & Girdwood, 2012: 161). To understand how shifts in learning practices may give rise to a worker-learner identity, requires a close tracing of 'the relations of power and linkages between mundane and routine activities and actions, in local sites and programmes, and centres of power and calculation' (Reich & Girdwood, 2012: 162-3). In other words, if a governmentality perspective is accepted, 'the shaping of identities and subjectivities by these technologies and techniques.... implies that practices, including learning practices, can be usefully understood as inseparable from these new identities' (Reich & Girdwood, 2012: 163).

2.5 The psychoanalytic and psychosocial study of organisations and society

The application of psychoanalytic ideas within psychosocial studies is not straightforward, as I discuss in Chapter 4. However, there is a long history of applying psychoanalysis 'outside' the clinic (Frosh, 2010a) and one of the more successful applications has been in the field of organisational consulting and development. There is also a strong sociological tradition of examining the micro-practices and discourses of working life, that reveal wider societal processes at work. Drawing on these literatures would seem to be a useful way to develop an approach to exploring how the 'outside' gets on the 'inside' in programmes, such as IAPT, and vice versa, to help explore what the subjective experience of working in an IAPT service might reveal about the wider context.

2.5.1 The social defences against anxiety paradigm

Stemming from the work of Jaques and Menzies-Lyth at the Tavistock Institute in the 1950s, this paradigm is based in the application of psychoanalytic ideas to the study of organisations, and especially, organisations in trouble. It has been widely used in the fields of organisational consultancy, group relations and in psychosocial studies, where there have also been several well-founded critiques and revisions. It has been applied, for example, to the positioning of psychotherapy and counselling training programmes 'at the

margins' in higher education (Rizq, 2007). The original case study, by Menzies-Lyth (1959), on the difficulties of student nurse training and retention in a hospital nursing service has achieved 'classic' status. In her paper, Menzies-Lyth described the way the task allocation system for nursing staff in a large teaching hospital represented a 'social defence against anxiety' (Menzies-Lyth, 1959). She argued that proximity to death and illness, and the need for intimate bodily contact with patients evoked primitive anxieties which were protected against unconsciously, by the organisation mirroring the psychological needs of its members, and adopting a range of defensive techniques. These included frequently rotating staff, adopting strict discipline, overly hierarchical decision-making, and a rather rigid approach to standardisation of procedures. This led to a high turnover of student staff and poor training completion rates. Under-employment of student nurses and a deprivation of personal satisfaction from the work arose because the social defence system 'specifically minimize[d] the exercise of discretion and judgement in the student nurse's organisation of her tasks,' making it difficult for individual contributions to the work to be recognised (Menzies-Lyth, 1959: 68). New recruits to the profession were also faced with a painful process of adaptation to this system, which accounted for the high level of stress and anxiety reported (Menzies-Lyth, 1959: 77). I suggest that aspects of this account may still be relevant for understanding IAPT.

Menzies-Lyth and others in the Tavistock tradition, incorporated ideas from Kleinian psychoanalysis, regarding the individual and the mechanisms of defence, such as 'splitting, projection and projective identification, introjection, denial, and the interplay of the paranoid-schizoid and depressive positions' (Palmer, 2002: 160). They also drew on Bion's work on 'basic assumption' behaviour in groups (Bion, 1961), the concept of the 'container and the contained' (1970) and Winnicott's (1965, 1971) concepts of 'the holding or facilitating environment and of transitional spaces and objects' (Palmer, 2002: 160). Together these formed a formidable repertoire of concepts with which to explore the functioning of organisations, the definition of tasks, individual roles, and the challenge of facilitating change. The approach, also known as the Tavistock model, placed organisational development through consultancy, ahead of 'pure' research. It focussed on the role of emotions, the 'organisation-in-the-mind' (Armstrong, 2005) and understanding the 'workplace within' (Hirschhorn, 1988). Organisations were seen as 'projection screens' for unconscious defence mechanisms by employees (Andersen, 2012: section 3), with 'stress, performance anxiety, competition, insecurity, illness, passivity, indifference, grievances, and subversion' all being understood as different ways of subjectively processing a specific work situation (Andersen, 2012: section 3). Amongst the strengths of this approach was that it brought to light institutions' 'dark sides,' their 'anti-task' activities, and reinforced their capacity for self-

directed change (Andersen, 2012). The idea of social defences also helped to focus attention on how anxiety and other unacceptable feelings of ‘an ontological, sexual or moral nature’ are protected against, in socially organised ways, to enable those who work in organisations to cope with their roles and tasks, whilst, usually, at the same time being dysfunctional (Hoggett, 2010a: 202-203). Amongst the weaknesses, was the fact that the original approach didn’t pay enough attention to power relations, the regulatory context, or how these played out in the relationships between professionals, clients and members of the public, between management and employees, and between genders, races and classes (Andersen, 2012). As with all applied psychoanalytic work, there was also a danger of falling into a hermeneutic spiral, underplaying the agency of individuals (Andersen, 2012).

Allied to the idea of social defences, the identification of an organisation’s ‘primary task’ was also considered important in the Tavistock studies. This term described the activity an organisation had to carry out in order to survive (Roberts, 1994). Later on, distinctions were drawn between the ‘normative’ primary task (what members felt they ought to be doing), the ‘existential’ (what they believed they were doing) and the ‘phenomenal’ (what they were doing) (Armstrong & Rustin, 2015: 12, after Lawrence, 1985). Any misalignment between these could lead to a dysfunction in the organisational system (Armstrong & Rustin, 2015). These concepts proved useful for understanding belief, fantasy and reality in the behaviour of organisations and their members (Armstrong and Rustin, 2015: 13). The idea of the primary task has however been criticised for being too monolithic and assuming only one main purpose (Andersen, 2012), when most organisations, particularly in the public sector, are more complex, have multiple and contested purposes (Hoggett, 2006).

However, the Tavistock approach, and the social defences against anxiety paradigm in particular, has undergone a considerable transformation in recent years. It has been adopted and adapted both in the UK and internationally, as part of the wider cannon of work applying ideas from psychoanalysis to the study of organisations, work roles and change. For example, in a recent review, a number of further theoretical critiques, enhancements and applications to the social defences paradigm have been identified (Armstrong & Rustin, 2015). Halton (2015) has suggested that where there was ‘insufficient alignment between the nurses’ personal defences and the social defences of the hospital’ in Menzies-Lyth’s study, there was in fact a mechanism of obsessiveness at work (Halton, 2015: 29-31). This is what led to the ritualisation and excessive anxiety about trivial things (Halton, 2015: 29-31). In a contemporary context, it can be

argued that we now face ‘rituals of audit and surveillance’ controlling how work is done, and the relationship between practitioner and patient (Halton, 2015: 36). Far from making patients safe, these ‘obsessional-punitive systems, devoid of empathic relationships, increase the danger to patients of poor care, neglect, or abuse, when these systems are under strain or management is absent’ (Halton, 2015: 37). Even where feelings of care may be present, it is argued, ‘if the link between care actions and decision-making is absent, then mistrust and disempowerment of practitioners continues and contributes to a lower quality of care and greater risk to clients’ (Halton, 2015: 38). This raises questions about the links between care actions and decision-making in the IAPT context, where treatment protocols and routine monitoring of performance are used.

Hoggett (2015) and Long (2008) have also argued that Menzies-Lyth’s concept needs to be broadened out ‘to encompass defences against any feelings which threaten to overwhelm’ (Armstrong & Rustin, 2015: 6), including hope, shame, resentment and guilt, not just anxiety (Hoggett, 2015). Hoggett (2010a) points out that ‘depersonalization’ is after all a ‘defence against feeling’ and hyperactivity may be too; in public sector organisations, having a manic edge of busyness in front-line teams protects workers from thinking about what they are doing (Hoggett, 2010a: 203) (and see next sub-section). Stein (2000) showed that another gap in the paradigm was to omit ‘attacking’ modes of activity, feelings such as envy, hatred and greed which could be at work in groups, institutions and society (Stein, 2000: 202). Recognition and acceptance of these ‘negative emotions’ was, it was suggested, a necessity for effective leadership and ‘good enough’ containment (Walsh et al., 2016). Other factors, such as globalisation and industrialisation are also now understood to play a major part (Armstrong & Rustin, 2015: 16). The predominance of knowledge work, that is, jobs which require subjective judgement and problem-solving, has also been said to create particular kinds of vulnerability (Krantz, 2010). Knowledge work is very personal, and involves testing the ‘system-in-the-mind,’ whilst engaging with others (Krantz, 2010: 198). It is not clear how emotional containment works in this context (Krantz, 2010: 198); phantasies and anxieties tend to be expressed and defended against in networks and ‘virtual’ forums where conversations take place (Krantz, 2010: 198-9). Thus, in a ‘network society’ it can be argued that we have to look much further afield for the source of anxieties, including the external context, that shape individual psychological responses to distressing work (Armstrong & Rustin, 2015: 17).

2.5.2 Moving towards a psychosocial perspective

As we have seen, one of the critiques of the psychoanalytically informed study of organisations is that it pays insufficient attention to the impact of wider societal forces on the individual and organisational life. A psychosocial approach attempts to 'combine psychoanalytic with social scientific ways of thinking, without giving either one undue prominence' (Hoggett, 2015: 51). It is also interested in the emotions and what these represent, when shared by groups of people in organisations or more widely (Hoggett, 2009c). Concepts such as 'structures of feeling' have been introduced to describe how certain feelings have come to define 'the particular quality of social experience and relationship' in any given generation or period (Hoggett, 2015: 57, after Williams, 1977). For example, just as Bion showed that crowds could be gripped by specific feelings, when under the sway of basic assumptions - messianic hope, terror or resentment - so, Williams (1977) has shown that at the societal level, anxiety has become part of the 'enduring configurations of affect' that characterise modernity (Hoggett, 2015: 56-57). Anxiety at the societal level may be moral and socially constructed (as in the moral tone of debates on teenage pregnancy), or risk related (based on perceived physical dangers from scientific and technological advances) (Hoggett, 2013: 71). Survival anxieties, however relate to 'the self in a consumerist and 'me' oriented culture...where economic, social and political dangers threaten the survival of narcissistic investments both in oneself and one's loved ones' (Hoggett, 2013: 71). It is the task of government to contain these public anxieties, and where it fails to do so, these anxieties are projected, enacted or embodied (Hoggett, 2013: 72). Within public institutions, embodiment of powerful anxieties, it is argued, may be seen in the widespread adoption of rule-based systems, bureaucratic structures and procedures (Hoggett, 2013: 73). Real relationships between professional staff, clients and service users have, it is argued, been replaced by 'virtual' ones, a plethora of unreflexive practices, electronic recording and monitoring (Hoggett, 2013: 77). Public sector organisations act as a 'receptacle for social anxieties' because they deal with the 'impossible task' of protecting vulnerable people from abuse, a task in which 'failure is inevitable' (Hoggett, 2006; Cooper & Lousada, 2005). Enactment occurs when a government is faced with an intense pressure to be seen to be doing something in response to such a failure; it results in 'symbolic policy making' and quick fix legislation (Hoggett, 2015: 55). At times, it appears this is the only way governments and citizens can sustain their own sense of inner security (Hoggett, 2006). This is also the arena in which we see the propagation of unrealistic public expectations of policy (Walsh et al., 2016). This raises the question about the role that IAPT might be playing, at policy programme and service levels, as a receptacle for social anxieties of a moral, risk, or survivalist kind.

Indeed, the explosion of targets and indicators, that has followed on from NPM and its focus on performativity, has been described as ‘a perverse defence which fosters the development of an *as if* relationship between government and reality’ (Hoggett, 2010a: 202). New systems of regulation and audit, it is argued, encourage conformance and gaming rather than performance; they help create a virtual reality, or ‘auditable surface’ (Cummins, 2002) which then becomes confused with the reality it represents (Hoggett, 2010a: 206). Social defences become entrenched in policy, when the consequences of social and economic failure are too difficult to face (Walsh et al., 2016).

Under a culture of performativity, managers and policy-makers are separated from the experience of suffering by a ‘thick skin’ of performance indicators, which give the appearance of things being okay or getting better. This is not intentional cynicism, as government and the political elites really believe in the illusion they have created (Hoggett, 2010a: 210).

The use of standardised care packages and facilitated technologies of intervention is another aspect of the depersonalisation of professional work seen in many fields of health and social care (Hoggett, 2010b). These practices offer ‘a perverse form of containment,’ in that the client or patient is protected so long as they go along with the instrumental purpose (Hoggett, 2015: 53). There is ‘something perverse about the way in which the system operates, not only in terms of the collusion that it invites but in terms of the tendency to be contemptuous of the patient’s more loving, needy, and thoughtful aspects’ (Hoggett, 2015: 54). The institutional denial of reality is seen in the NHS, where patient choice and personalised service are promoted (Fotaki & Hyde, 2015). Patients are presented with choice as a ‘good’ in its own right, but value choice themselves less than policy makers want them to; they are not so much attracted by the idea of consumerist market choice, as wanting to have their relational needs met (Fotaki & Hyde, 2015: 451). In chapter 3, I discuss how these arguments have also informed some of the critiques of IAPT’s aims (see 3.3).

2.5.3 Dilemmas at the frontline

The relationship between service users and professionals is complicated by the fact that ‘policy culture’ also plays an active, and at times, contradictory part, ‘lived out in the minds of the actors in the system’ (Cooper & Lousada, 2005: 39). In public sector organisations, there is ‘a continuous contestation of purposes, values and policies’, which gets played out at the point of delivery and arises from the need to contain that which is disowned by society (Hoggett, 2006: 175).

Public officials are faced with the task of containing ‘the unresolved (and often partially suppressed) value conflicts and moral ambivalence of society’ (Hoggett, 2006: 175). There is also a gulf between policy and practice which persists because of a refusal of collective organisation and planning to face the ‘obstinate realities of limited resources,’ multiple and competing constraints on service delivery (Cooper & Lousada, 2005: 82). This is the arena in which we find challenges to the identity of those working in service roles; there is a constant tension between the good intentions and motivations of workers, striving hard to balance the wish to help and care for others with the modesty of what is actually achievable (Cooper & Lousada, 2005: 108). Such workers invest considerable hope in new policies, as a means of raising standards, securing resources and directing attention towards particularly vulnerable groups (Cooper & Lousada, 2005: 109). There is a desire for ‘newness’ to overcome existing difficulties, which at times generates an uncritical and zealous quality to the work, a lack of systematic evaluation of what has gone before, and an undervaluing of accumulated experience in the system (Cooper & Lousada, 2005: 109). This results in what Cooper and Lousada (2005) have described as a ‘borderline’ state of mind, embodied in welfare practices.

Drawing on the work of Honig (1996), Hoggett has described the experience of being ‘in a space where there is no longer any right thing to do’ as ‘dilemmatic space’ (Hoggett et al., 2006b: 761). Two ‘types’ of dilemma are common: a ‘type 1 dilemma’ is a value conflict (‘I ought to do A and I ought to do B but I cannot do A and B’); whilst ‘type 2’ is about ambivalence (‘I must do A, I must not do A’). Both have an ethical component. In type 1 dilemmas, there is no right thing to do and workers have to ‘act for the best’. In doing so, they inevitably take risks, and thus incur anxiety and/or guilt or loss about letting someone down or not pursuing the rejected alternative (Hoggett, 2006, 2009b; Miller et al., 2008). In type 2 dilemmas (‘heads you win, tails I lose’), whatever the individual does is going to be wrong; failure is an inherent part of the job; and anyone with a conscience caught in this dilemma is left to deal with feelings of resentment and ingratitude (Hoggett, 2006). Typically, type 2 dilemmas are associated with situations where all the parts do not add up or fit together, where there is no possibility of ‘closure’. Individuals are thus left with a period of continuing doubt and regret (‘the remainder’); a wish that things had turned out other than they did (Hoggett, 2006, 2009b; Miller et al., 2008).

2.5.4 Street level bureaucracy and Svejism

One way in which tensions from the wider social and organisational context get played out as dilemmas in decision-making at the frontline, is through the

phenomenon which has come to be known as, 'street level bureaucracy' (Lipsky, 1983). This refers to the detailed work practices found in public sector organisations, in particular, the moment of delivery between staff and members of the public. It is about the micro-politics of decision-making, discretion and control over resources, in daily work, which affects the interests of citizens and governments (Ellis, 2011). Typical 'street level bureaucrat' roles (a variation on the 'semi-professional' roles described in 2.3.5 above) are teachers, social workers, police officers, doctors, health visitors, social security officers and housing officers (Lipsky, 1983). These workers, it is argued, act as a buffer between government and its citizens, in situations where the services they deliver can only ever be supplied at a level insufficient to meet demand (Lipsky, 1983). High level expectations and demands on frontline workers relative to the limited resources at their disposal lead to the exercise of administrative discretion, sometimes in negative and punitive ways, at odds with professional codes of conduct (Ellis, 2011 after Lipsky, 1983). The concept of 'street level bureaucracy' is thus linked to the idea of covert rationing in situations where policy and operational ambiguity create a plethora of rules and tasks (Ellis, 2011). Although high levels of idealism and commitment are common amongst such frontline workers (Hudson, 1989), the intractability of street level bureaucracy means they tend to use their discretion in ways which are primarily functional to policy makers and managers, and which boost their own personal authority over clients (Ellis, 2011: 240). This makes accountability in welfare service organisations problematic (Lipsky 1983); as the more government or managers attempt to intensify pressure on individuals to be accessible, the more they will develop strategies for protecting themselves (Hudson, 1989).

There are different grounds for individual bureaucrats to exercise discretion, such as having a specialist skill. However, the overall purpose is to allow employing agencies to exercise indirect demand control and to delegate the difficult task of rationing to frontline workers (Hudson, 1989). In return, individual workers may modify their behaviour to make their daily routines more manageable; for example, by psychological withdrawal, by not escalating problematic issues, and by processing clients too quickly and indiscriminately, without sufficient follow up (Hudson, 1989). More recently, it has been argued that the role of discretion needs to be made sense of alongside the forces of managerialism, professionalism and user empowerment (Ellis, 2011). Due to the different ways these phenomena interpenetrate, the nature of discretion needs to be empirically investigated and assessed for impact in context (Ellis, 2011). It has been argued that there is now some convergence between the interests of managers and frontline staff, as workers search for a clear professional identity under NPM (Ellis, 2011). But typically, there is a tension between values-based and bureaucratic forms of discretion, as exercised in the interests of the service

user (Ellis, 2011: 234). In adult social care for example, separation of assessment from care management has opened up new discretionary spaces for informal rationing (Ellis, 2011), and the advent of personalisation has raised new questions about the scope for frontline discretion (Ellis, 2011: 240).

A different interpretation of the street level bureaucracy concept is that of the presence of 'passive resistance' in the workplace (Wastell et al., 2010). Described as 'Svejkism' (after the good soldier Svejik), this occurs where workers withhold their emotional commitment from work, in order to protect some autonomy for themselves, whilst appearing to conform to rules and expectations (Wastell et al., 2010). It is 'compliance without conviction' and occurs in situations where performance indicators inexorably drive practice and contribute to staff stress (Wastell et al., 2010: 313-15). Svejkism is thus a concept that specifically denotes 'manifestations of disengaged but obedient behaviour produced by obligatory conformance with the bureaucratic regime which reveal the absurdity of the imposed systems and processes' (Wastell et al., 2010: 317). As with street level bureaucracy, Svejkism leads to moral dilemmas for frontline workers, as resource rationing curtails what can actually be delivered. In the social work context, Svejkism reflects a very particular form of discretion seen in the frontline; that is, the way workers become increasingly disengaged from the goals of the organisation and the professional task (Wastell et al., 2010: 318). The question for IAPT, is whether the procedures and practices it has introduced have had any of the same effects.

2.6 Discussion and implications for my research

In this chapter I have shown that the talking therapies have deep roots in our national history and psyche. They are closely linked with wider developments in the fields of medicine, economics, politics and government and their role has always been a contested one. I suggest that there are good grounds for being critical of the expansion of talking therapy provision, such as that represented by IAPT, when viewed in the context of the professionalisation project, and wider institutionalisation processes, as described in the sociology of the professions literature (section 2.3). Competing claims have always characterised the proliferation of different modalities, with some practitioner groups and practices ending up marginalised, whilst others join the mainstream. At the same time, therapies and therapists that ally themselves to medicine, have benefitted from medicine's dominance within the professional hierarchy of healthcare; and, changes in the role of medicine over time, have contributed

towards a shift in focus from 'hospital' based treatments towards population level mental health.

I have summarised a diverse set of theoretical perspectives that may be brought to bear to understand the complex dynamics that are at work, in the relationship between and within the different therapeutic disciplines, practitioners and work settings. Each of these perspectives raises different questions about how professional identity and practice come about, the outcomes for organisations, individuals and the people whose health and well-being is being served.

From a historical perspective (section 2.2), it seems clear 'psychotherapy' is a form of cultural practice, which from time to time, *will* be resisted (politically, as well as in an emotional or cognitive sense) (Marks, 2017: 8 after Shamdasani, 2005). This is evidenced for example, in the movement towards 'coproduction' and 'user involvement' in mental health practice (Marks, 2017: 9).

From the governmentality perspective, there appears to be an invisible thread of power that runs between the state, the national polity, the organisation and delivery of public services and the experience of individual subjectivity and conduct (see 2.2). There is a subtle intertwining of expertise, technology and self-regulation, in the everyday practices of contemporary culture, including talking therapies. It is, in my view, hard to refute the argument that the case for 'happiness' in policy discourse is socially constructed for instrumental reasons, or that governments do not benefit from the 'therapeutic imperative'. There is a relationship between government and our ways of knowing about ourselves, our ideas about citizenship and health, which may be reproduced in or resisted by the most intimate of practices, such as talking therapy.

From a theories of practice perspective, it will be useful to explore what, if anything, is distinctive about the IAPT culture of practice; how these practices are learned, the characteristic language terms and symbols used, the different ways of knowing that are inculcated through the training and in clinical practice. It will be important to look at the inter-relationship between the two new IAPT roles, how they operate together, and their interactions within the wider ecology of primary care occupations and practices.

From a psychoanalytic perspective, it seems likely that any programme to improve access to talking therapies which is delivered in the NHS will encounter high levels of projected anxiety from patients and staff, that need to be contained or defended against in reasonably organised ways. There may be other emotions too that have to be protected against in the way services and individuals work. It also seems likely that the new programme will be lived out in the minds of those who work in it, in particular ways which may be revealing of the wider ethos and/ or intent of the policy, and those that were involved in creating it.

From a psychosocial perspective, it will be important to question the links between the individual practices and ways of knowing promulgated within a programme such as IAPT, and public feelings about risk, aspects of performativity and choice in healthcare. It will be important too, to consider how the wider societal and organisational context for IAPT gets played out in dilemmas at the frontline of talking therapy delivery.

2.6.1 Developing the research questions

Inevitably, when I started out on this research, I understood far less about the implications of the different literatures I was looking at than when I came to revisit them, towards the end. Although still far from being a comprehensive analysis, I suggest now that a number of reframings and developments of my original research questions may be appropriate. For example, in light of my re-reading of the sociological literature on the professions, I would now want to question and critique the IAPT programme as a professionalisation and institutionalisation project, not just as a workforce development programme. Drawing on the governmentality and theories of practice literatures, I would want to ask how IAPT workers come to think of themselves as subjects, and what aspects of a worker-learner identity they have. From the history of the semi-professions, I would question where the IAPT roles fit in terms of the types of person they attract to work in them, the inter- and intra-occupational struggles they are engaged in, and what kinds of uncertainty and conflict they encounter during the work. With regard to their professional identity, a key question now seems to be whether and/ or how far 'psychological therapists' actually differ from 'traditional' psychotherapists in terms of who they are, and what they do. Drawing on the psychoanalytic and psychosocial literatures, I remain interested in the subjective experience of being an IAPT worker, the emotional dimensions of IAPT work, and what these may reveal about the social and organisational context, which is not necessarily self-evident. I am led to

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question what IAPT represents, as a policy programme, as a culture of practice and as a system of care, with more or less potential longevity.

Chapter 3 - IAPT and the new psychological therapy workforce

3.1 Introduction

This chapter provides details on the IAPT programme, its history and purpose (3.2). It outlines some of the critiques that have been made of its aims (3.3), the main strengths and weaknesses of its implementation (3.4). It looks in some detail at the new roles introduced by IAPT, their precursors in earlier government initiatives, and their similarities with and differences from a range of assistant roles used in other sectors (3.5). Finally, this chapter looks at the issues that are associated with the training of psychological therapists, drawing on literature on the motivation to train, 'stages' of professional development, role transition and the IAPT competence frameworks (3.6). The implications of these findings for the design and content of the research are discussed at the end (3.7).

3.2 The IAPT programme, history and purpose

3.2.1 Layard and Clark

The start of the IAPT programme is widely associated with the work of Richard Layard, a Labour peer and economist at the London School of Economics (LSE), together with David Clark at the Institute of Psychiatry (IOP). In 2005, Layard problematised the issue of 'happiness' (Layard, 2005a), or rather the lack of it, as a source of economic and social ill. He argued mental illness was a worse experience than that of poverty, that too many adults who were capable of working were falling out of work and claiming disability benefits for long periods (Layard, 2005b). In *The Depression Report*, he and colleagues set out a demanding agenda for policy change in relation to people experiencing CMHPs, described as anxiety and depression (Centre for Economic Performance, 2006). In addition, they argued that stigma was preventing people from coming forward for help and that many who did ask for help, preferred talking treatment to medication (Centre for Economic Performance, 2006).

Layard's 'case for action' was based on the government's failure to meet its own recommended treatment guidelines for depression and anxiety, as identified by NICE (Layard, 2006). These specified that evidence-based psychological treatments should be offered in conjunction with medication for optimum efficacy (NICE, 2004). At the time, waiting times for psychological therapy on the NHS were 6-9 months and in some parts of the country, no therapy was available at all due to a lack of suitably trained therapists (Layard, 2005b). Layard proposed that 10,000 extra psychological therapists should be recruited over a five-year period, approximately half to be clinical psychologists and half to be '[a] new [kind of] therapist' – trained specifically in CBT - to address this major gap in provision (Layard, 2006). The costs were to be recouped entirely via savings in government spending on out-of-work and disability benefits (Layard et al., 2007).

Having successfully made the case for investment (£33 million in 2008/9, £103 million in 2009/10 and £173 million in 2010/11) (DH, 2012: 37), and overseen the development and initial roll-out of IAPT during New Labour's terms in office, Layard and Clark (2014) continued to lobby for support (for example, £400 million was allocated as part of the 2010 Spending Review) with each subsequent change of government. The main benefits of the programme were stated as: helping half of all people treated to 'move towards recovery', putting IAPT in line with outcome rates achieved historically by mental health services (Layard & Clark, 2014); creating a whole new profession of psychological therapists using evidence-based therapy (Layard & Clark, 2014: 197); laying the groundwork for a continued steady expansion of the programme, co-ordinated from the centre (Layard & Clark, 2014: 197); and, providing a frontline 'assessment and treatment service' (Layard & Clark, 2014: 199), which although seeing many people only once, had achieved success even with those who had been ill for many years (Layard & Clark, 2014: 200). A cornerstone of their argument was a belief in the unique effectiveness of CBT based on the NICE (2004, and as updated in 2007) depression guideline development and evidence review methodology. In addition, they claimed that IAPT had the potential to deliver four percent of its patients into employment, earning back all the money spent on it (Layard & Clark, 2014: 188).

3.2.2 Purpose

IAPT is now in its tenth year as a national programme. At the time of its introduction in 2008, its purpose was 'to improve access to evidence-based talking therapies in the NHS through an expansion of the psychological

therapy workforce and services'. It was originally targeted at people of 'working age' only, but from 2010 was opened to adults of all ages. Currently, IAPT's purpose is stated as 'to provide evidence-based treatments for people with anxiety and depression (implementing NICE guidelines)' (NHS England, 2017a). According to NHS England, IAPT services are also characterised by three things:

1. Evidenced-based psychological therapies: with the therapy delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimize outcomes.

2. Routine outcome monitoring: so that the person having therapy and the clinician offering it have up-to-date information on an individual's progress. This supports the development of a positive and shared approach to the goals of therapy and as this data is anonymized and published this promotes transparency in service performance encouraging improvement.

3. Regular and outcomes focused supervision so practitioners are supported to continuously improve and deliver high quality care. (NHS England, 2017a)

At the beginning, policy responsibility was split between DH and DWP, to ensure an equal focus on employment and health, reflecting the original 'spend to save' rationale (Turpin et al., 2008). Currently, IAPT national policy continues to be jointly led (by the Work and Health Joint Unit).

3.2.3 Service delivery model and stepped care

Although there was considerable variation in practice, the original IAPT service delivery model, was defined as involving 'a team of therapists', taking referrals from GPs, and patients via self-referral, 'delivering NICE-compliant therapies at the level required in convenient settings in primary care or elsewhere in the community' and supported by employment advisors amongst others (DH, 2008: 6). Local service leaders were free to decide how best to implement the new services, whether through a 'hub-and-spoke' system (a central base, but the majority of therapists working out of local GP practices), a dedicated central service centre for the majority of staff, or co-locating the provision with other services, including secondary care. Either way, adherence to the principles of 'stepped care' was required (DH, 2008).

The two key principles of stepped care (least restrictive intervention first, and scheduled 'self-correction') were outlined in Chapter 1 (see 1.3). The stepped care framework was originally illustrated as a five-step pyramid model spanning the full gamut of mental health conditions and severities, where 'each step introduces additional interventions', and 'the higher steps assume interventions in the previous step' (NICE, 2004) (and see Figure 1). Recognition of depression was defined as the starting point, given that 'around half of all people with depression in the community do not present to their GP'; treatment was then to proceed through 'watchful waiting,' 'guided self-help' and other low intensity interventions (including exercise), through medication, social support, more intensive psychological interventions, and combined treatments, to in-patient stays (NICE, 2004). These principles could be applied either by the majority of patients starting with a low intensity intervention (step 2) first, and moving on to higher intensity intervention (step 3) if this didn't work; or, through allocation at the outset, to either step 2 or step 3, depending on the severity or type of problem experienced (Turpin et al., 2008). For some conditions, automatic referral to step 3 was recommended (see 3.2.4 below).

Figure 1: Original IAPT stepped care service delivery model

Step 3 High Intensity Service	Depression Mild, Moderate and Severe	CBT , IPT behavioural activation
	Depression Mild-Moderate	Counselling , couples therapy
	Panic Disorder	CBT
	Generalised anxiety disorder (GAD) mild- moderate	CBT
	Social Phobia	CBT ,
	Post Traumatic Stress Disorder (PTSD)	CBT , eye movement desensitisation and reprocessing (EMDR)
	Obsessive Compulsive Disorder (OCD)	CBT
Step 2 : Low Intensity Service	Depression Mild-Moderate	cCBT , guided self-help , behavioural activation , exercise
	Panic Disorder Mild -Moderate	cCBT , guided self-help , pure self help ,
	Generalised anxiety disorder (GAD) mild- moderate	cCBT , guided self-help , pure self help , psychoeducation groups
	OCD mild - moderate	Guided Self-Help
Step 1 : Primary Care/ IAPT Service	Recognition of Problem	Assessment / Watchful Waiting

(CSIP Choice and Access Team, 2008: 23)

Through a succession of updates to the Depression Guideline (NICE, 2007, 2009, 2011, 2017b), a broader range of therapies were gradually recommended and the stepped care approach became more differentiated. New forms of brief therapy were made available with a view to matching specific CMHP conditions to specialist interventions, largely within a CBT framework (NICE, 2011); for example, BA for depression and ERP for anxiety (see Figure 2). Each of these was manualised in the form of detailed and IAPT-specific treatment protocols, around which the training of practitioners was then based. Counselling was also recommended as an alternative to both step 2 and step 3 CBT, alongside various forms of groupwork and psycho-education.

Figure 2: Revised IAPT stepped-care model (based on *A Combined Summary For Common Mental Health Disorders*, NICE Clinical Guideline 123 (2011))

Focus of the intervention	Nature of the intervention
<p>Step 3: Persistent sub-threshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention; initial presentation of moderate or severe depression; GAD with marked functional impairment or that has not responded to a low-intensity intervention; moderate to severe panic disorder; OCD with moderate or severe functional impairment; PTSD.</p>	<p>Depression: CBT, IPT, behavioural activation, behavioural couples therapy, counselling*, short-term psychodynamic psychotherapy*, antidepressants, combined interventions, collaborative care**, self-help groups. GAD: CBT, applied relaxation, drug treatment, combined interventions, self-help groups. Panic disorder: CBT, antidepressants, self-help groups. OCD: CBT (including ERP), antidepressants, combined interventions and case management, self-help groups.</p> <p>PTSD: Trauma-focused CBT, EMDR, drug treatment. All disorders: Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions.</p>
<p>Step 2: Persistent sub-threshold depressive symptoms or mild to moderate depression; GAD; mild to moderate panic disorder; mild to moderate OCD; PTSD (including people with mild to moderate PTSD).</p>	<p>Depression: Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes**, nondirective counselling delivered at home†, antidepressants, self-help groups.</p> <p>GAD and panic disorder: Individual non-facilitated and facilitated self-help, psycho-educational groups, self-help groups. OCD: Individual or group CBT (including ERP), self-help</p>

Focus of the intervention	Nature of the intervention
	groups. PTSD: Trauma-focused CBT or EMDR. All disorders: Support groups, educational and employment support services; referral for further assessment and interventions.
Step 1: All disorders – known and suspected presentations of common mental health disorders.	All disorders: Identification, assessment, psycho-education, active monitoring; referral for further assessment and interventions.
<p>* Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.</p> <p>** For people with depression and a chronic physical health problem.</p> <p>† For women during pregnancy or the postnatal period.</p>	

(NICE, 2011: 14-16)

3.2.4 Treatments offered

The NICE 2004 depression guideline, on which the IAPT service delivery model is based, specified use of CBT in all severities of depression. Treatment duration was also specified. This was based on NICE's assessment of the best available evidence of treatment effectiveness. Other modalities (such as psychodynamic therapy) were justified only where complex 'co-morbidities' existed alongside, and where patient or clinician opinion favoured it (NICE, 2004). It became a requirement that practitioners of these alternative modalities inform patients that there was uncertainty in the evidence for these approaches (in the 2009 update), based on the NICE 'hierarchy of evidence' and cost-effectiveness criteria (Barkham et al., 2017) (see 3.3.4 for further discussion).

Chapter 3: IAPT and the new psychological therapy workforce

The two main forms of treatment were the backbone of what was offered through IAPT; low intensity interventions (LIPs) consisting of:

- computerized Cognitive Behavioural Therapy (cCBT), pure self-help (e.g. books on prescription), guided self-help (facilitated and based on CBT principles), behavioural activation, structured exercise, psycho-educational groups, and other therapies

and high intensity interventions (HIPs), which included:

- CBT, interpersonal therapy (IPT), counselling, couples therapy, other therapies (CSIP Choice & Access Team, 2008: 22)

The majority of people with mild-to-moderate depression were expected to begin with a LIP. A person who was more severely depressed was expected to require a HIP. Some anxiety conditions, like post-traumatic stress disorder (PTSD) or social phobia, were also considered to be valid reasons for immediate referral to step 3 (see 3.2.3 above). Having a persistent anxiety disorder, such as generalised anxiety disorder (GAD) or panic disorder, that did not respond to LIPs, would also lead to 'stepping up' from 2 to 3 (CSIP Choice & Access Team, 2008).

One of the advantages of CBT in this context was its amenability to delivery at different levels of intensity, and using different 'dosages' (Bennett-Levy et al., 2010). David Richards led the work to define and manualise LIPs for the IAPT demonstration sites, having already successfully advocated the widespread use of CBT for self-help (Richards et al., 2003; Richards, 2004; Richardson & Richards, 2005). One of the arguments in favour of LIPs was that delivering them did not require the kinds of lengthy professional training that was common to most other therapies (Richards, 2007; Bennett-Levy et al., 2010). LIPs, it was argued, made possible the scaling up of psychological help to meet population needs without massively expanding the numbers of elite (and costly) professionals (Richards, 2004). Through provision of high quality 'sign-posting' information and social support, it was suggested that more 'patient-centred and flexible approaches to mental health care' could be achieved (Richards, 2007: 19). A new cadre of workers 'recruited from the same culture, the same class and the same community as the people they serve' – in effect, a

‘new breed of hairdresser’ was promoted, as having unequivocal benefits (Richards, 2007: 19). LIPs were said to meet service users’ wishes for quick access to a talking therapy, to acknowledge and build on their existing capacities, strengths and coping resources, in convenient, accessible and culturally competent ways (Richards, 2007: 19). The model of care drew on the experience of Support Workers (and other types of assistant roles), described as ‘an unquestionable policy success’ across a range of sectors (Richards, 2007: 19, and see 3.5.3 - 3.5.4 below). It was argued that intensive therapy delivered by highly trained professionals was not necessary for the majority of people experiencing a CMHP; instead, case managers, ‘using a theoretically sound, CBT-based guided self-management recovery programme’ could provide a cost-effective route to improving the nation’s well-being (Richards, 2007: 20).

3.3 Critiques of IAPT’s aims

From the outset, IAPT has attracted strong support and criticism from a variety of quarters. It has been praised nationally and internationally, for the size of the investment it represents (Sudak, 2015; Priebe, 2006; Clark, 2011; Carey, 2017), for putting mental health and talking therapies firmly on the policy agenda, raising public awareness and reducing the stigma associated with seeking help. Other regions of the UK and other countries have introduced similar services. Yet the criticisms have been vocal and persistent, and these may be expected to have had an impact, in different ways, on those who work in or around IAPT, or make use of its services. As suggested from the debates in Chapter 2, there seems to be a division between those who view it as a force for good (therapeutic optimists); and those who see it as something more sinister (therapeutic pessimists) (Pilgrim & McCranie, 2013). Layard and his colleagues have been described as optimists for their uncritical acceptance of the medical model, their view of therapy as a form of entitlement and for advocating therapy as a technological fix, along with medication and social support, for the ‘problem’ of unhappiness (Pilgrim & McCranie, 2013: 8).

3.3.1 Tension between the health and employment agendas

Although presented at the outset as an example of ‘joined-up government’, the shared ownership between DH and DWP brought into conjunction two different agendas; one promoting health as a public good and the other the ‘rights and responsibilities’ agenda of employment and welfare conditionality. Those whom Pilgrim and McCranie (2013) term as ‘therapeutic optimists’ point to the fact that being in work has been associated with better mental health (and protection against depression) and that prevalence of CMHPs is higher amongst those who are unemployed (Harvey et al., 2009). However, critics of

this viewpoint argue that the causal links have been over-determined in Layard et al's analysis; that in the way the original 'spend-to-save' argument was couched, it was *as if* the only source of poor mental health was joblessness, and the only significant cost that of state expenditure on out-of-work benefits (Fraser, 2006; Pilgrim & McCranie, 2013). This viewpoint, it is argued, gives limited recognition to the contribution of socio-economic conditions to mental ill-health or well-being, and assumes that the prevalence of 'misery' is an independent variable, adversely affecting the prospects of economic recovery from recession (Pilgrim & McCranie, 2013; Pilgrim, 2008b; Walsh et al., 2016). The targeting of 'working age' adults was cited as an example of this reasoning, in that those who were not in this category, such as children, older people and the chronically sick or disabled, were thereby under-valued (Fraser, 2006). The positive messages associated with IAPT's vision of improving access and choice were also overshadowed, in the eyes of many, by the spectre of compulsory therapy, becoming part of the DWP's [then] condition management programme (Fraser, 2006), or more recently, the 'sanctions regime' for unemployed jobseekers (Friedli & Stearn, 2015). Whilst the evidence of coercion is unclear, the location of employment advisers in IAPT services, and IAPT practitioners in Jobcentre Plus offices has raised questions about whose interests are being served. Scanlon and Adlam (2010) for example, questioned whether IAPT's true preoccupation was with indigence – targeting the mentally unwell who claimed benefits, much in the same way as earlier welfare reformers differentiated between 'deserving' and 'undeserving' poor (Scanlon & Adlam, 2010; Scanlon, 2014). And Denman (2007) described Layard as having successfully recruited the state 'to be psychological treatment product champion because of its interest in turning its citizens from being benefit recipients into taxpayers' (Denman, 2007: 82). Critical psychologists and psychotherapists (such as Loewenthal, 2015b, 2015d, 2016, 2017; Lees, 2016; Friedli & Stearn, 2015; Watts, 2016) have observed that worklessness is too often equated with worthlessness under 'psy-welfare'; and that initiatives like IAPT have been used by politicians, as a means to blame the individual for the problems in society.

3.3.2 Competing paradigms of recovery

The arguments over the true agenda of IAPT and its links with welfare to work policy, reflect wider differences and competing paradigms in mental health. For example, concerns about over-diagnosis, and medicalisation of distress, have deep roots (as suggested in Chapter 2). Although ostensibly seeking to address the stigma of mental illness and help-seeking by making access to talking therapies more available, critics perceive that IAPT continues to abide by a medical model of illness and recovery, in its use of condition-specific treatment protocols, and manualised interventions for specific

'conditions' (Pilgrim, 2009, 2011, 2008a; Rustin, 2007; Lees, 2016; Loewenthal, 2017). Medicalisation it is argued, pathologises individuals and over-plays risk, placing the burden of responsibility for recovery on the individual, and paying insufficient attention to social and economic determinants (Pilgrim & Bentall, 1999; Middleton & Shaw, 2000; Shaw & Taplin, 2007). IAPT's emphasis on supported self-help and continuous monitoring of outcomes, suggests this is the dominant paradigm behind it.

The issue of 'recovery' in mental health has also long been disputed. Originally, the term appears to have been adopted from physical medicine, to describe the outcome of successful treatment from illness (Pilgrim, 2008a, 2009). This was the approach of biomedical psychiatry and required patients to comply with medical treatment (primarily medication) to get better. Over time, its meaning became modified to include the idea of 'rehabilitation' from impairment; this was the philosophy of social psychiatry, which led to a process of agreeing tailored packages of treatment, including social skills training, that would enable patients to stay out of services for as long as possible (Pilgrim, 2009: 114). Finally, a third dimension of recovery arose as a result of the service user movement in mental health, where 'recovery' was viewed as the outcome of successful survival from invalidation (Pilgrim, 2009: 114). In this latter perspective, service contact was seen as part of the problem rather than the solution. This too became modified, as critics of the earlier approaches including psychiatric survivors, urged a refocussing of the concept towards a 'capabilities approach' and away from that of individual 'deficits' (Pilgrim, 2009: 114). Capabilities, it has been argued, enable integration of social structural factors, the assessment of community and family resources as well as individual ones (Pilgrim, 2009; Morrow & Weisser, 2012; Andresen et al., 2010). Critics of IAPT argue that it is too much based in the second of these 'recovery' approaches (Pilgrim, 2008b; Scanlon & Adlam, 2010; Scanlon, 2014). A more valid account of recovery, it is suggested would focus on the existence of empowerment, purpose, and hope, as represented through engagement with meaningful activities, access to independent living, social support and improved personal relationships (Pilgrim, 2009; Pilgrim et al., 2009; Ellison et al., 2018). The language of 'recovery' has instead, it is argued, become a 'colonising' one, used to legitimate particular forms of mental health practice, such as 'person-centred care', which are not always what they purport to be (Scanlon & Adlam, 2010).

3.3.3 The link with NICE

As mentioned in sub-section 3.2.1 above, an important part of the economic rationale for funding IAPT was the fact that the government was failing to meet its own treatment guidelines for people with depression and anxiety, as recommended by NICE. This was in direct contradiction with the commitment to fund all such treatments recommended as cost-effective for people with physical health conditions. The existence of NICE's 2004 Depression Guideline was therefore pivotal to the argument made by Layard and Clark at the outset, and each updated version (NICE, 2009, 2011) has continued to be important in securing funding for IAPT services and determining what therapies and interventions are available.

The official role of NICE has been stated as 'to improve outcomes for people using the NHS and other public health and social care services' by 'producing evidence-based guidance...., developing quality standards and performance metrics...., and providing information... for commissioners, practitioners and managers' (NICE, 2017a). Unofficially, it also plays a determining role in how NHS rationing works in practice, by identifying new and existing treatments and services which are (and are not) cost-effective. Because of its importance in this regard, NICE's role has come under close scrutiny and substantial criticisms have been directed against it. These relate to its selective use of evidence and reliance on the biomedical model of 'evidence-based medicine' (EBM); the composition of its guideline development groups, its deliberative process and focus on cost-effectiveness (McPherson et al., 2009; Guy et al., 2012; Chapman, 2012; Moncrieff & Timimi, 2013; Loewenthal, 2015a, 2017).

In relation to the use of evidence regarding psychological therapies and services, NICE has relied heavily on findings from RCTs and meta-analyses, which are statistically under-powered, lack generalisability in routine practice, take insufficient account of researcher allegiances and are highly selective, in terms of the diagnostic categories used to define patient groups (Barkham et al., 2017). This has resulted in the effectiveness of CBT being rated more highly than other therapies as a treatment for depression, when in fact, it has been shown that there is little or no difference, and that all therapies have comparable moderate-to-large effects (Cuijpers et al., 2012; Cuijpers, 2017; Barkham et al., 2017). A further key criticism is that administrative and outcome data from routine practice has been vastly under-used (so called, 'practice-based evidence' after Margison et al., 2000), and qualitative methodologies which could capture the experience of both patients and

practitioners, largely ignored (Barkham et al., 2010, 2017). Indeed, even the former Chair of NICE, Sir Michael Rawlins has acknowledged that a wider evidence base needs to be considered (Rawlins, 2008), although the changes proposed for the 2018 Depression Guideline, are still largely shaped by RCT reviews (Barkham et al., 2017).

In terms of its approach to cost-effectiveness, NICE 'insiders' have acknowledged the value judgements inherent in its deliberative process (Rawlins & Culyer, 2004; Culyer, 2006). The use of cost effectiveness measures, such as cost per quality adjusted life year (QALY) ratios, have been said to assume a particular model of recovery (see previous sub-section) which is focused on functioning and disability, rather than on more subjective, patient-defined measures of well-being (Fraser, 2006; McPherson et al., 2009). Altogether, it is argued, 'while NICE recognises many of the issues raised concerning its methodology, it is acting as though they don't exist' (Loewenthal, 2016: 16). This underlines the importance of the representation of different stakeholder groups, and in particular the decisive role of 'experts' appointed to its guideline development groups (Guy et al., 2012; Moncrieff & Timimi, 2013). These tend to be dominated by members of the medical profession, those working in partnership with the Royal College of Psychiatrists and British Psychological Society on issues of outcome measurement, with only a small minority being exclusively psychological therapists (Guy et al., 2012: 30).

3.3.4 The Politics of Evidence

Beyond the use of evidence in NICE guidelines, the wider and equally problematic paradigm of 'evidence-based' policy (and practice) (EBP) has been invoked by successive governments and policy actors, in support of IAPT, its interventions and system of training (Layard & Clark, 2014; Clark, 2011; DH, 2011; CSIP & NIMHE, 2008; NIMHE, 2004; CSIP Choice and Access Team, 2007; IAPT Programme, 2011a, 2013). EBP is based in a positivist paradigm (stemming as it does from EBM, and the use of clinical trials, as discussed above); and, its critics argue, EBP is too often focussed on measurement concerns (Greenhalgh & Russell, 2009). Best practice guidelines risk ignoring vital sources of information, such as field-based observations ('what happens') (Petticrew, 2015), local knowledge and lived experience (Yanow, 2017). Like EBM, EBP tends to privilege certain kinds of evidence and to discount others (Greenhalgh et al., 2014). In the healthcare field, it is suggested, EBP needs to recognise the 'wicked' and intractable nature of the problems it is seeking to tackle, and to draw on a much wider base of evidence (Greenhalgh & Russell, 2009; Cooper &

Wren, 2012). There is also a case for reframing the notion of evidence to accommodate causal factors which may be interactive and not just additive' (Cooper & Wren, 2012: 202).

Adherence to EBP has however become a *doxa* across all fields of policy and practice. Part of its appeal lies in the way it appears to offer a rational way of translating research knowledge into practice (Head, 2010). This despite the numerous studies which have shown how far from being rational the policy process is; that more often than not, it is the evidence which is policy-driven, rather than the other way around (Head, 2010; Greenhalgh & Russell, 2009; Fotaki, 2010). Thus, it is suggested, the role of power and ideology in decision-making needs to be explored (Saltelli & Giampietro, 2017). In the field of psychological therapies, many now consider it to be a flawed concept, which says more about contemporary audit culture than it does about effective practice (for example, King & Moutsou, 2010; Loewenthal, 2015a, 2015d; Chapman, 2012). Indeed, IAPT has been cited as an exemplar of the way EBP has been used to prop up a new form of management ideology, 'Digital Taylorism', based on 'the codification and routinisation of what was previously considered to be subjective knowledge and practice' (Chapman, 2012: 33). In psychotherapy research however, the person of the therapist has been viewed as a crucial contributor to patient outcomes (Klein et al., 2011: 15) in part, because it is the clinicians (not the interventions) which remain sensitive to sociocultural differences in context (Klein et al., 2011: 16). These kinds of objection to the role and characteristics of EBP have carried through into the disagreements between professional bodies over IAPT's role, and into the inter-professional tensions and rivalries it has evoked (see below, and earlier discussion in Chapter 2).

3.3.5 The focus on CBT and a single model of care

A final major reason for controversy surrounding the IAPT initiative relates to its prioritisation of CBT over other therapeutic modalities, and its adoption of a single model of care. It has been argued, that by advocating a single clinical model, based on CBT, Layard's 2006 vision has made a panacea of CBT, and 'sustain[ed] the fantasy that society's ills can be contained within one limited model....[that] mental distress [is] a technical problem or medical illness, divorced from social culture and context (Simpson, 2016: 64). It has, it is argued, reduced the use of CBT to that of a drug, or technical fix belying the complexity of therapeutic processes and relationships, and reducing choice for patients and practitioners. Furthermore, it has transformed what was once a bespoke 'cottage industry' of psychotherapy into a factory-based production

line (Totton, 1999; Blackmore & Parry, 2010; Fay, 2013; Loewenthal, 2015c). This, it is argued, risks providing second class care for those who cannot afford private treatment (Sayles, 2011; Samuels, 2016; Pilgrim, 2011).

Some of the objections relate to the nature of CBT itself. For example, CBT has been stereotyped for paying insufficient attention to the therapeutic relationship, being too mechanistic, all about 'positive thinking', never going near the past, providing a 'sticking plaster' and not a core treatment, a short-term 'fix' and not real or enduring change, being about thoughts and behaviours and not feelings, and involving the therapist *telling* the client how to get better (Veale, 2008; Shankland & Kellett, 2009; House & Loewenthal, 2008; Neuhaus, 2011). These criticisms misunderstand the distinctiveness and depth of CBT, which at core, is problem-oriented and present-focused (Neuhaus, 2011). A more accurate characterisation might be that CBT 'emphasises an overt process of learning how to overcome psychological difficulties through the use of skills and education about one's problems, in addition to learning through lived experience' (Neuhaus, 2011: 216). It is in fact a heterogeneous treatment perspective with many sub-divisions and approaches, reflected in the way therapists are trained and analogous to the different schools of psychoanalysis (Neuhaus, 2011: 214-15). The key challenge in CBT is to use what is known about treating a particular diagnosis, to develop a case formulation, and use clinical judgement to design a treatment plan that matches the patient and his or her unique characteristics and life circumstances (Neuhaus, 2011: 217). Furthermore, there is no *one* view on the role of the therapeutic relationship in CBT; rather, there is a dialectic between the view that the relationship is 'necessary but not sufficient', and the view that it 'is part of the treatment' (Neuhaus, 2011: 220).

Another set of objections relate to the adoption of protocol-based treatments and manualised versions of CBT within IAPT. Manualised care, it is argued, attempts to provide a clear set of instructions for the therapist to apply in conducting time-limited forms of intervention, but 'implicit in this, is the notion that all therapists are equal and interchangeable, and the method of treatment, not the person of the therapist, or his or her relationship with the patient, is critical in producing change' (Klein et al., 2011: 10). There is an assumption in protocol-based approaches that a specific method of treatment can be predetermined in advance (Neuhaus, 2011). Protocols tend to be rigid, and based on treatments that have been tested in clinical trials, with all the problems of 'translation' into routine care that this implies (see 3.3.3- 3.3.4 above) (Neuhaus, 2011: 217). In practice, variation from protocol depends on

clinical judgement, and guidance is not provided for this within the protocol (Neuhaus, 2011: 217). This contrasts with 'principle-based' approaches which do prepare a clinician to make decisions according to the contingencies of a patient's presentation (Neuhaus, 2011: 218). Principle-based approaches, it is argued, are superior because they use principles to decide what protocol meets an individual patient's needs rather than trying to fit a patient to a protocol (Neuhaus, 2011: 218).

Concerns have also been raised about the limited choice of treatments offered in IAPT services (see next section, 3.4 on implementation). Some critics have described the proliferation of CBT delivery methods within IAPT as reducing choice to that between telephone CBT, computerised CBT or face-to-face CBT, with the occasional offering of group-CBT (McPherson, 2017). Others point out that prior to IAPT, patients in primary care had no choice other than medication as a treatment (Layard & Clark, 2014; Veale, 2008; Samuels & Veale, 2009). Those whose professional training centred on other modalities than CBT, such as counselling or the psychodynamic therapies, have expressed concerns about the implications for patients who are looking for an alternative, more exploratory and less symptom-focussed, approach, and for those who may have complex, chronic and 'treatment-resistant' conditions, which do not respond to CBT (Pilgrim, 2011; Samuels & Veale, 2009; Rizq, 2011). They have also challenged the displacement of their respective professions from mainstream NHS services (primary care, in particular), in favour of those accredited by the BABCP (Aldridge & Mulvey, 2013; BPC & UKCP, 2015; UKCP & BPC, 2016; Jenkins & Bell, 2017).

3.4 Implementation

3.4.1 Progress and outcomes

In March 2015, IAPT services fulfilled their 2011 commitment to reach 15% of the population with anxiety and depression (at least in terms of those making initial contact) (DH, 2011; HSCIC, 2015). However, the target of achieving a 50% 'recovery rate' for those completing treatment was not met at this time, with national performance averaging 45% (and considerable variation between local services). Recovery was defined in terms of change in the clinical outcome score achieved between the point of referral and the end of treatment, using pre-defined cut-off points for each measure, to establish 'caseness' (NHS Digital, 2017a). Between a quarter and one half of those being

referred also did not go on to enter treatment (Marshall et al., 2016; Richards & Borglin, 2011).

Since January 2017, the 50% recovery rate at national level has been achieved, with variation between providers ranging from 22% to 89% (NHS Digital, 2017b). Two additional measures of recovery have been introduced; 'reliable improvement' referring to significant change in clinical outcome scores between first and last contact (regardless of cut-off points) (66.6% in June 2017); and, 'reliable recovery' referring to people who 'have moved from being a clinical case at the start of treatment to not being a clinical case at the end of treatment, and there has also been a significant improvement in their condition' (around 48% in June 2017) (NHS Digital, 2017a). Attention has also focussed on waiting times, with targets set for the volume of referrals entering treatment within six weeks (88.8% in June 2017) (NHS Digital, 2017a).

The numbers of IAPT-qualified practitioners and therapists has grown steadily, with just over 3,600 working in IAPT services by the time of the 2015 Adult Workforce Census, and a further 780 in training (out of over 6000 trained since the start) (NHS England & Health Education England, 2016). In addition, there were around 500 non-IAPT qualified therapists working at Step 2, just over 500 accredited CBP therapists trained prior to IAPT, and 187 non-IAPT qualified therapists working at Step 3. The turnover rate in 2015 for PWP's was reported as 22% and for HITS 9% (NHS England & Health Education England, 2016). Recruitment and retention difficulties were identified as being high for the PWP group (with a 10% vacancy rate), compared with HITS (4% vacancy rate) (Health Education England, 2017).

Currently, over 900,000 people access IAPT services each year (NHS England, 2017b). The operation of stepped care has proved more complex than first anticipated, with large variations in patient pathways between services (Richards et al., 2012).

3.4.2 Strengths and weaknesses

Just as IAPT's aims have been disputed, so have its key achievements, strengths and weaknesses since national implementation. The main strengths have been cited as the numbers of people seen, the placing of mental health firmly on the national agenda, the use of session-by-session outcome measures, the supervision system, ease of access and being an autonomous service

(Layard & Clark, 2014). Outcome measurement for example, has been designed to facilitate monitoring of the use of IAPT services by different (especially minority) groups, to improve equity and fairness; it enables patients to review their own progress as part of the treatment process and engage in shared decision-making, including over movement between 'steps' in the stepped care system (National IAPT Programme Team, 2011). It supports practitioners and supervisors to monitor caseloads, judge progress against targets, identify risks and appropriate interventions, and ensure compliance with NICE guidelines (National IAPT Programme Team, 2011). The systematic approach to supervision within services has also ensured tighter 'quality control', it is argued, compared with different GP practices employing their own independent counsellors, prior to IAPT (Layard & Clark, 2014). Success has also stemmed from IAPT being built (and funded) as an autonomous service, with its own ethos and standards (Layard & Clark, 2014). It has been able to occupy a unique position, 'in-between' primary and secondary care and independent of each, whilst at the same time, being accessible to the public, via different routes, including self-referral (Layard & Clark, 2014: 204).

Some of the weaknesses (acknowledged even by IAPT's supporters) relate to the continuing inequalities of access and choice (see next sub-section for details), the impact of scaling up provision to an industrial scale, minimising individual differences, the use of performance targets, and time limits on treatment. The production line aspect of the IAPT service delivery model has, it is argued, resulted in the 'industrialisation' of the craft skill of psychotherapy (see 3.3.5 above), and risked losing sight of the individual patient, oversimplifying the human and emotional skills required to treat them (Parry, 2008; Blackmore & Parry, 2010; Loewenthal, 2015c). With the majority of treatment being delivered at Step 2, low-intensity, by PWP's and equivalent practitioners, questions have been asked about whether those working in these roles, can actually be described as part of the 'psychological therapy workforce' at all, other than for politically expedient purposes (Watts, 2016: 92). As described in 3.5.1 below, the role has now been repositioned, from 'low intensity worker' to PWP, and is described as akin to a 'fitness coach' for the mind (IAPT Programme, 2010). The use of targets (as might be predicted from the discussion in Chapter 2, see 2.2.5 in particular) has divided commentators, and those involved in and around IAPT services. At the outset, targets related to take-up (the number of referrals, relative to 'prevalence' of depression and anxiety in specific localities), the numbers waiting for assessment (from 'active referrals'), entering treatment (from assessment), completing treatment (having entered), and moving to recovery (having completed) (IAPT National Team, 2009). In addition, the numbers who completed treatment who did not meet the criteria of clinical 'caseness' at the outset were recorded, and the

numbers who moved off sick pay and benefits (having entered treatment) (IAPT National Team, 2009). There were also targets relating to the recruitment and training of the workforce (IAPT National Team, 2009). Over time, these targets have been maintained, with some modifications, and further, more 'stringent' measures of 'recovery' added (as described in 3.4.1 above). Attention has shifted towards targets for waiting times, between referral and assessment, and between assessment and entering treatment (NHS England, 2015), as signs of these creeping upwards have been reported in local and national news media. Questions about variation in performance within and between local commissioning group (CCG) areas, also continue to be raised (Marshall et al., 2016; Wickware, 2017; Vaillancourt et al., 2015).

The expected duration of treatment has also proved contentious, with all services setting limits to the number of sessions offered at low- and high-intensity (for example, at around 6-8 sessions for LIPs, and 16 sessions for HIPs). Commissioners have been blamed for imposing these limits and also for any reduction in spending on secondary mental health care, as a result of funding IAPT (Layard & Clark, 2014: 207).

3.4.3 Access and choice

The concept of 'access' in IAPT (and other services), has been interpreted in different ways. Simple availability does not equate with service use and considerations of equity, relevance and timeliness, quality and effectiveness are also important (Gulliford & Morgan, 2003; Gulliford et al., 2002). Differences exist between service users' perceptions of 'access' (the 'demand side'), and service provider definitions ('supply side') (Culyer, 2001). Increasingly, IAPT services are seeing patients whom they have already had contact with on one or more previous occasions, who either did not complete treatment, did not achieve 'recovery,' or relapsed since being seen (Cairns, 2014; Griffiths & Griffiths, 2015). It seems that in IAPT, as in other services, a more 'dynamic' view of access is needed; one that recognises access not as a one-off 'door-opening' or 'door closing' event, nor even necessarily linear or progressive (Dixon-Woods et al., 2005).

Equally, there have been difficulties implementing even the limited choice of therapies approved by NICE. For example, even though specific 'doses' of CBT, counselling, IPT, couples therapy and psychodynamic psychotherapy have all been recommended as interventions by NICE at different points, for the treatment of depression in adults, only a tiny proportion of IAPT services

actually offer all five therapies (one in 114 IAPT services, according to a recent analysis (Perfect et al., 2016: 17). It has therefore been concluded that ‘the IAPT programme has so far failed in its intention to provide a choice of the full range of evidence-based therapies for clients with depression across England’ (Perfect et al., 2016: 19).

3.5 New roles, new practices

The two new IAPT roles, as already mentioned, have been designated as ‘practitioner’ and/ or ‘therapist’ roles at different times. In the third year of the programme, the label ‘low intensity worker’ was dropped and that of PWP introduced. From this point on, the term ‘therapist’ was said to apply only to HITs.

3.5.1 PWP Role Description

PWPs train at NHS Band 4, and become Band 5 practitioners on qualifying. Their role has been described as building on the previous role of PCMHW (see 3.5.3 below) but ‘more focussed on guided self-help, supporting patients with managing common medications, particularly antidepressants, case- managing referrals and signposting to other agencies such as social care and condition management organisations’ (IAPT Programme, 2010: 5). The PWP’s professional relationship with patients has been likened to that of a personal ‘fitness coach’ (see also 3.4.2 above). Their role is to be ‘educator and supporter, helping motivate the patient to use evidence-based LIPs but always acknowledging that the work is being undertaken by the patient, who is seen as the expert in their own recovery journey’ (IAPT Programme, 2010: 5). They are expected to rely on published and manualised interventions, rather than clinical discretion (IAPT Programme, 2010: 7). Since 2010, Senior PWP roles (at NHS Band 6) have also been introduced, in some services, to take on additional responsibility for supervision, management and special projects (IAPT Programme, 2010). The PWP role is now predominantly a graduate one, with training delivered at first year postgraduate level.

3.5.2 HIT Role Description

HITs train at NHS Band 6, and become Band 7 cognitive behavioural therapists on qualifying, with scope for progression to Band 8 supervision, management and leadership roles. Their role has been described as providing CBT to a standard at which they are eligible to be accredited by the BABCP, for

people with moderate to severe depression and anxiety disorders (IAPT Programme, 2016). They are expected to be able to work with people from different cultural backgrounds and ages, using interpreters when necessary, with a commitment to equal opportunities (IAPT Programme, 2016). In terms of background, HITs are expected to have a 'core' profession, as clinical psychologists, counsellors, nurses, occupational therapists, experienced PCMHWs or psychotherapists, prior to training. The main change that has occurred has been to formalise the requirement for experienced PWP's wishing to apply for a HIT training post to have at least two years post-qualification experience in the PWP role before becoming eligible (IAPT National Team & BABCP, 2011).

3.5.3 Precursors to these roles

The PWP role appears to have had its origins in the primary care mental health workers' (PCMHWs) initiative in the early 2000s. Graduates were trained in brief evidence-based interventions and self-help materials for people of all ages with CMHPs (DH, 2000; NIMHE, 2003) and based in GP practices. The roles were designed to operate at three levels: individual work with patients, team work within GP practices and wider networking within the local community (NIMHE, 2003: 12).

Evaluation quickly showed up a number of tensions and ambiguities in the PCMHW role. First of all, there was considerable variation in the way job descriptions and responsibilities were defined by different PCTs, and there was pressure on PCMHWs to take on additional work such as health promotion, education of team members, and to plug perceived gaps in service provision (Bower et al., 2004). It proved difficult to strike a balance between the clinical and care co-ordination aspects of the role and to ensure a collaborative approach between PCMHWs, GPs and specialists (Bower, 2002). Certain disorders requiring specialist input had to be excluded as inappropriate for the primary care setting (Bower, 2002). Where GPs retained primary responsibility for patient care (rather than handing them over completely), PCMHWs appeared to be more effective (Bower, 2002). However, it was a major challenge to ensure integration of the roles both horizontally - within primary care, and vertically - between primary and secondary care (Bower, 2002). Individuals also appeared to be very susceptible to the expectations and judgements of their co-workers and inter-professional boundary disputes were not uncommon (Bower et al., 2004). PCMHWs struggled from a lack of power and authority, due to their relatively junior positions in the therapeutic pecking order (Bower et al., 2004). These tensions, together with a perceived lack of 'ownership' of the role,

could lead to significant personal difficulties for the workers concerned (Bower et al., 2004). The quality and amount of supervision and support available was found to be critical, given the relatively limited training and experience of the workers themselves (Bower, 2002). Finally, in relation to the training programme for PCMHWs, it was found that the courses were faced with the challenge of ensuring relatively inexperienced recruits were equipped to work safely and effectively across the care pathway, and yet also able to retain an openness and lack of preconceptions about expected ways of working (Lucock & Frost, 2004). High-quality supervision tailored to the variety of roles undertaken, in addition to close co-ordination at strategic level between the training and service providers, was found to be essential (Lucock & Frost, 2004).

3.5.4 Comparison with other assistant roles

As suggested in Chapter 2, there may be parallels between the IAPT roles (and PWP role in particular), and that of 'semi-professionals' historically. In the last two decades, there has also been a growth of assistant roles across the public sector, and notably in social work, teaching, health and social care. Looking at these provides some instructive comparisons (and contrasts) with the new IAPT roles. Healthcare assistants (HCAs) and Rehabilitation Assistants (RAs), for example, have been positioned at the boundary with nursing to support the direct care needs of patients and aid inter-professional communication (Bach et al., 2008; Stanmore & Waterman, 2007).

These roles share a number of characteristics, whilst also exhibiting great diversity dependent on the sector and workplace concerned (Kessler et al., 2006, 2013). It has been argued that the growth in their numbers is closely connected with the standards agenda, by which government imposes ever more stringent requirements on providers to meet demonstrable performance criteria (Kessler et al., 2013). They have also been linked with the drive towards cost-effective and consumer-centred services, where they are said to enable greater flexibility in workplace practices and to break down traditional professional demarcations (Kessler et al., 2013). The roles have been mainly filled by women, and by employees with relatively modest, if any, formal qualifications (Bach et al., 2006, 2007). For these reasons, there is a debate in the literature as to whether these roles represent a form of degradation or of empowerment for those who hold them, and if they are a form of enrichment or devaluation of the work traditionally carried out by professionals (Bach et al., 2007). For example, assistant roles have been found to provide an alternative route to increased discretion, job enrichment and career

opportunities for some, and alternatively, to be a route to work that is low-paid and dominated by mundane tasks for others (Bach et al., 2007). In practice, many different combinations of degradation and empowerment have been found, as different control strategies, employee and manager responses affect how work activities are organised, the degree of discretion and variety in job design involved (Bach et al., 2007). Assistants are seldom passive recipients of their tasks (as other frontline workers, see 2.5.4).

There is also a great variety of tasks undertaken by those in assistant roles and Kessler et al (2013) have categorised these into four main kinds: 'co-producers,' in this classification, provide complementary skills to that of the professional; 'relief' workers remove burdens from professionals by taking on non-core tasks; 'substitutes' take the place of professionals by performing their core tasks; and, 'apprentices' are those who are in the preparation stage for a move into the associated profession (Kessler et al., 2013: 1650). The definition of core and non-core tasks is not however unproblematic and post holder backgrounds are significant in determining what is and is not included. Similarly, boundary issues between assistant and adjacent roles are common; as are expectations that the assistant role can be a 'stepping stone' to the professional role (Kessler et al., 2013: 1652). Another common characteristic of assistant roles is the frequency with which they are engaged in 'hidden' work, or emotional labour (Bach et al., 2008, 2012).

One important aspect of these roles is how they interact with adjacent professionals, and the impact they have on their co-workers. This appears to be related in part to how the new occupational group has been inserted into the workforce (as discussed by Nancarrow & Borthwick, 2005; see section 2.3.1). Discourse may be used to discredit competitor professions on the basis of their approach to clinical care, skills or competence (King et al., 2015). Horizontal substitution in particular has been found to be more likely to invoke disputes that can't be solved by negotiation (King et al., 2015). Looking at the HCA role, Bach et al (2012) found that hospital nurses tended to seek to emphasise their distinctive contribution in relation to medical staff and also within nursing specialities (Bach et al., 2012). They saw HCAs as playing a subordinate role, lacking independence and possessing generic rather than specialist skills (Bach et al., 2012). They saw themselves as better qualified and providing higher standards of patient care (Bach et al., 2012). HCAs however saw themselves as working autonomously, and used the metaphor of teamwork to suggest that all staff on the ward had similar roles and made an equal contribution (Bach et al., 2012). They saw nurses as having a specific role only in relation to drug

administration (Bach et al., 2012). Furthermore, they resented differences in pay and status because of the similarity of their role to that of nurses (Bach et al., 2012). HCAs thus tended to be more dissatisfied with the allocation of work and felt 'invisible' to the hospital hierarchy (Bach et al., 2012: 217). HCAs tended to highlight process issues in terms of the number of tasks they had performed, whilst nurses highlighted complexity and links to the whole patient journey (Bach et al., 2012: 219). The distinctiveness and difference between the two IAPT roles merits examination from this perspective; to see how they are affected by the behaviour and characteristics of those in adjacent roles in primary care, how they relate to one another and to patients, as 'practitioners' and/ or 'therapists.'

3.6 The training of psychological therapists

The IAPT programme, as stated in 3.2 above, is as much about workforce development and training, as it is about introducing a new model of service delivery for NHS talking therapies. To understand how new practitioners and therapists are 'made,' and to complement the theoretical review in Chapter 2, this section reviews some of the common themes from the empirical and occupation-specific literature relating to therapist motivation and training, role transitions and competence. This will help set the framework for the empirical investigation of my research questions (see 1.1.1 and 2.6.1) which follows in Chapters 5 to 10.

3.6.1 Motivation to train

There is a considerable literature relating to people's reasons for choosing psychotherapy as a career. Most of this pre-dates IAPT, and relates to traditional psychotherapy or counselling training, rather than the new forms of psychological therapy role (for example, in 2005, Farber and Norcross edited a Special Issue of the journal, *Clinical Psychology*, with eight individual accounts from clinicians working in different modalities on 'why I (really) became a psychotherapist' and one review article) (Norcross & Farber, 2005; Farber et al., 2005). There have been questionnaire-based studies (and meta-analyses) on motivation conducted amongst graduate trainees and more experienced therapists alongside these primarily personal and individual accounts (for example, Orlinsky & Rønnestad, 2005; Richardson, 2009); and, a recent review based on a database of responses from over 10,000 therapists internationally (Heinonen & Orlinsky, 2013). A common theme has been to explore the personal characteristics that may be attributed to those who work as therapists,

and the validity (or otherwise) of the 'wounded healer' hypothesis (Farber et al., 2005; Orlinsky & Rønnestad, 2005; Gilbert & Stickley, 2012). For example, amongst the most recurrent associations with choosing psychotherapy as a career, found by Farber et al. (2005) were: the experience of cultural or social marginalisation when growing up, painful childhood experiences, a high degree of psychological mindedness, serving as a confidante to others, acquiring a mentor, engaging in personal therapy, needing to help others, needing to understand others, to have autonomy, safe intimacy, intellectual stimulation, self-growth and healing (Farber et al., 2005: 1024). The most essential of all these factors was 'psychological mindedness, amplified by experiences of cultural, familial or individual distress as well as by personal therapy' (Farber et al., 2005: 1029). It has been suggested too that there may be some 'generational' differences in motivation between therapists, with younger, contemporary trainees in Clinical Psychology for example, placing more importance on research orientation and strong cognitive skills, than on other aspects (Farber et al., 2005: 1016-7).

The 'wounded healer' hypothesis refers to the idea that 'most psychotherapists have had their own burdensome experiences, possibly leading to an unconscious need to help oneself and others' (Safi et al., 2016: 187). The therapist is, after all, 'a person with his own life history, traumas, wounds and difficulties, sometimes no less than those of the client' (Wheeler, 2007: 247). These wounds can helpfully contribute to the therapeutic endeavour, when linked with an openness to self-examination and supervision, alongside therapeutic practice (Wheeler, 2007: 245-6). Strong unconscious motivations may be at work, and can lead some individuals to feel compelled to put the needs of others first in order to feel secure themselves (Barnett, 2007: 267-8). Extrinsic forms of motivation have also been found, with job qualities and tangible rewards being at least equal to the desire, or unconscious need, to help amongst nurses (Dill et al., 2016). Anticipation of future occupational possibilities, an interest in personal development, the influence of candidates' social environment and the framework and conditions of training have also been important, alongside altruism for psychotherapists (Safi et al., 2017). The existence of role models among family and social environment, and previous personal experiences with therapy are also relevant (Safi et al., 2017: 193).

The decision to train in a particular modality has also been associated with personality and epistemological traits (styles of thinking and theories of knowledge) (Arthur, 2001; Plchová et al., 2016; Safi et al., 2017). Differences have been found between CBT and psychodynamic psychotherapists (Arthur,

2001; Safi et al., 2017); with CBT therapists being described as less interested in the inner world, making use of their physical senses to gather information and develop hypotheses, using data that is concrete, objective, observable and measurable (Arthur, 2001: 54). Psychodynamic psychotherapists, by contrast, are more concerned with the inner world, adopt a thinking style that is intuitive, draws on imagination, theorising and experimentation (Arthur, 2001: 56). They process their knowledge through the use of feeling in introspective analysis, insight and empathy (Arthur, 2001). Although there appears to be an element of chance in the choice of training route, linked to the availability of opportunities and the right timing (Norcross & Farber, 2005), differences have been found relating to the degree of official recognition of the therapeutic method, the scientific evidence for the method's efficacy, the method's therapeutic attitude, the status attached to the method at trainees' former universities and their views and critiques of respective other orientations (Safi et al., 2017: 191). CBT candidates have been found 'to start their psychotherapy training earlier...to be influenced and supported by family and their close environment...to strive for socioeconomic security and to rely on the method's scientific foundation and manual-guided processes' (Safi et al., 2017: 197). Psychodynamic psychotherapy candidates, on the other hand, have been found to 'regard biographical aspects to be more meaningful for their choice of training,' (Safi et al., 2017: 186). They tend to be older on starting training, to place more importance on the role of personal experience and life history, to pursue personal development above socioeconomic security, to be creative and have more conflict-based and self-reflecting ways of perceiving (Safi et al., 2017: 197). Overall, however, the literature does not confirm any 'ideal' motivation for training (Richardson, 2009). Theoretical orientation and modality 'fit' can also take a while to develop, and may change over time (Arthur, 2001).

3.6.2 'Stages' of training and professional development

Research on therapist training and development has identified some common 'stages', skills and experiences, across a range of modalities, and looked at the learning processes involved. Sections 2.3.4 and 2.4.3 in the previous chapter reviewed theories of professional learning and identity, based on the work of Anteby and colleagues (2016), Stronach et al (2002) and various practice theorists. This sub-section looks at the 'stages' literature, with a view to anticipating the steps and transitions IAPT trainees might be expected to make.

A 'stages model' of therapist development, it has been argued, helps to identify the discontinuities that occur within a process of change (Rønnestad &

Skovholt, 2013). Different schemas have been put forward; for example, Skovholt and Rønnestad (1992) identified an eight-stage model wherein individuals may be seen to move from the stage of novice 'conventional helper' to the stage of 'integrity' as an experienced professional over a career life span. At each stage of professional development, it is suggested, a growth in individuation occurs; and, during training, external and rigid adherence to the role, practices and conceptual scheme of the therapy are strongest, but these become increasingly internalised and more flexible as the professional matures (Skovholt & Rønnestad, 1992). Reflection gradually becomes the central developmental process enabling practitioners to move from a reliance on external expertise and senior practitioners to having confidence in their own internal expertise (Skovholt & Rønnestad, 1992); the therapists' conceptual system and working style becomes increasingly congruent with their personalities over time; and, increasingly, they construct knowledge rather than receive it (Skovholt & Rønnestad 1992). Using a similar model, Orlinsky and Rønnestad (2005), classified nearly 5000 therapists surveyed mainly in the US, Germany and Norway (with 100 from the UK) into 'statistically viable cohorts' of novices, apprentices, graduates, established, seasoned, or senior groups (according to length of time in practice). They also defined three main dimensions of therapeutic work experience: healing involvement, stressful involvement, and controlling involvement; and, four categories of work practice: effective practice, challenging practice, distressing practice and disengaged practice (Orlinsky & Rønnestad, 2005: 84). They found that for novice therapists, formal supervision was more salient to positive growth than for more seasoned therapists, for whom direct clinical experience was the most important (Orlinsky & Rønnestad, 2005: 156). For young practitioners, large doses of support in their work setting and through supervision, training, or personal therapy were also required to maximise healing involvement and reduce stressful involvement with patients (Orlinsky & Rønnestad, 2005: 178-185).

More recently, it has been argued that 'the movement therapists undergo in strengthening, expanding and solidifying their professional self is in major part a result of negotiating the misalignment of the internal and external dimensions of both the personal and professional self' (Rønnestad & Skovholt, 2013: 15). Thus, far from being a linear progression, there appears to be a fluctuating movement from a fragile and incomplete practitioner-self to a solid and complete practitioner-self over several decades (Rønnestad & Skovholt, 2013: 15). At the novice phase (start of graduate training), it has been found that anxiety is the norm, and students are particularly prone to experience stressful involvement with their patients (Rønnestad & Skovholt, 2013: 56). Whilst anxiety is contained by most after relatively little therapy practice, the training

experience itself can be threatening for students, with risks of information overload and vulnerability to negative feedback and evaluation by supervisors (Rønnestad & Skovholt, 2013: 60). Peer support is however likely to be highly valued, and imitation one of the main learning methods preferred (Rønnestad & Skovholt, 2013: 60). As students progress (through clinical placements), they are likely to struggle with dependency and independency in relation to supervision, to have high aspirations and some misplaced expectations regarding their responsibilities and ability to help (Rønnestad & Skovholt, 2013: 75-80). In the 'novice professional' phase (two to five years after graduation), confirmation of qualified status generally enhances former students' confidence and commitment to their training approach, whilst also risking periods of disillusionment when patients do not improve, drop out or are very challenging (Rønnestad & Skovholt, 2013: 85). In this phase, positive coping with adversity is important, in order to create a work role that is congruent with their own self (Rønnestad & Skovholt, 2013: 89); that is, novice professionals need to develop an individualised, and self-directed approach to both personal and theoretical issues (Rønnestad & Skovholt, 2013: 90). It is not clear how far IAPT trainees will conform or diverge from these 'stages' models, given the shorter duration (one year) of their formal training (compared with traditional training routes of on average, four years' plus). The novice student, advanced student and novice professional stages may occur more rapidly, or they may overlap.

Overall, it has been said that, 'three central lifelong challenges must be repeatedly faced by all psychotherapists: i) how to remain sufficiently open to permit new learning/ growth as a person and as a professional; ii) how to most effectively use oneself in the treatment process; and iii) how to maintain resilience, arrive at a viable balance between professional and personal concerns, and continue to function in a committed, vibrant and authentic fashion' (Klein et al, 2011: 17). These issues have only just begun to be explored in the IAPT context (see 3.6.4 below, Chapters 6 and 11) (Green, 2011; Green et al., 2014; Pereira & Barkham, 2015; Pereira et al., 2017).

3.6.3 Common themes relating to role transition

The findings described above about the negotiated movement therapists undergo to align their inner and outer, personal and professional selves (Rønnestad & Skovholt, 2013: 15), is an example of a psychodynamic view of role transition (see also 1.3.2). There is a close inter-relationship between roles and identities, which applies to therapists as to any other group or individual, managing expectations and negotiating conflicts about what they do (Michalec

& Hafferty, 2015: 183). The degree of contrast between roles, the salience of different role identities to the individual (defined by subjective importance and situational relevance), and the attractiveness (or valence) of the role transition to the transitioner have all been found to affect the quality of the experience (Ashforth, 2001). It has also been shown that distinctive psychological and cultural processes affect both the entry to and exit from roles; for example, role entry may involve adopting a transitional identity and be accompanied by a 'rite of passage' (Ashforth, 2001: 74 after Van Gennep, 1960). 'Normalisation' is another process that may affect the quality and speed of role transition, and refers to how far an individual is immersed in the new social context, and whether they are predisposed to becoming involved in the new role and organisation (Ashforth, 2001: 179). Socialisation practices might also be expected to play a significant enabling or inhibiting effect. Finally, the way the individual responds, their motives, and proactivity are central to how they learn and adjust to a new role (Ashforth, 2001: 189).

It has been suggested that there is a preoccupation with successful transitions in the literature relating to career change, with insufficient attention paid to processes of 'unbecoming' as well as 'becoming' (Fenwick, 2013: 364). It may also be useful to distinguish 'transition shocks' at the start or when completing training, from changes needed to enable a person to stay in role over a sustained period of time. Preconceptions about a role and strength of identification with prior occupations may have a formative influence on therapists when they begin training (Carlsson, 2012). Equally, few seem likely to escape the 'shock' that occurs when moving between classroom-based education and real life clinical practice (Fenwick, 2013). The oscillating dynamic of development across a career lifetime described by Rønnestad and Skovholt (2013) (see 3.6.2 above) is helpful in this regard.

When it comes to staying in role, particularly in the caring professions, the importance of managing emotions has often been stressed (Ashforth & Humphrey, 1993; Obholzer & Roberts, 1994; Abbott & Meerabeau, 1998). These professions are expected to make use of emotions in performing their jobs, and parallels have been made with the work of Hochschild (1983) on service roles, where, in order to fully integrate into their chosen occupational group, individuals have to internalise certain 'display rules,' expected by peers, employing organisations and society in general. They perform 'emotional labour' in order to comply with the expression norms of their field, by 'surface acting, deep acting, and the expression of spontaneous and genuine emotion' (Ashforth & Humphrey, 1993: 89). The emotional costs of such display rules

can be unsettling, leading to dissonance and even self-alienation (Ashforth & Humphrey, 1993; Abbott & Meerabeau, 2003; Obholzer & Roberts, 1994). A lot depends on the context however, as Briner and colleagues have shown in relation to when and whether emotional labour turns into burnout (Briner et al., 2008).

The idea of resilience has also been cited as important in relation to individuals' ability to survive in emotionally demanding occupations. Resilience, in the sense of making positive adjustments in the face of significant adversity (Luthar et al., 2000) may depend upon many factors, such as, the support of friends and colleagues, independent supervision, management culture and policy context (Hoggett, 2010b). However, like the notion of 'recovery' in mental health, the value of 'resilience' is contested, because of the way it can pathologise individuals and be co-opted to promote a neoliberal agenda (Davoudi, 2016; Harper & Speed, 2012) (see Chapter 2).

3.6.4 The attributes of 'effective' therapists

Closely related to the issue of role transition and the factors which enable therapists to stay in role, is the idea that some therapists become more 'effective' than others. The research literature generally defines effectiveness in terms of the therapists' contribution to the outcomes achieved by patients. Considerable variation in outcomes between therapists has been shown, with variability greater between individuals than between different therapy types in this regard (Saxon et al., 2017). The reasons for this are not fully known, although it seems likely that what is a good therapist for some kinds of patients may be quite different from a good therapist for other kinds (Klein et al., 2011: 19). Certain characteristics have generally been considered helpful, such as, ability to understand the experience of others, ability to communicate empathy, ability to recognise and keep in check what is evoked in them (known as countertransference), and ability to find ways of utilising their personas toward therapeutic ends (Klein et al, 2011: 19). The role of the therapeutic alliance has been posited as central to the 'common factors' that make all therapies effective, over and above the 'specific factors' of individual modalities (Castonguay, 2000; Boswell & Castonguay, 2007; Wampold, 2015). There also appears to be a complex relationship between competence, patient outcome, and implementation issues in CBT (Branson et al., 2015: 25).

One characteristic which has been attributed to 'effective therapists' is that of 'psychological flexibility' (Biron & van Veldhoven, 2012). Drawing on ideas

from Acceptance and Commitment Therapy (ACT), psychological flexibility has been defined as the ability to be aware of and accept thoughts and feelings, including difficult or negative ones, whilst basing actions upon positive values and goals (Biron & van Veldhoven, 2012: 1264). It has been suggested that this is a more important means to avoid emotional exhaustion in service roles, than either surface or deep acting as posited by Hochschild (1983) (Biron & van Veldhoven, 2012: 1260). A similar conceptualisation is that of 'negative capability', proposed by French (2001). This suggests that a person's 'capacity to live with and to tolerate ambiguity and paradox, to remain content with half knowledge....and therefore to engage in a non-defensive way with change' is essential to effective practice, in emotionally demanding roles. It is about internal space, the capacity to 'take in' emotions evoked by a situation and 'digest' them on behalf of the whole system (French, 2001: 484). When negative capability fails, or is not 'good enough', it is argued, symptoms occur, such as denial, avoidance and resistance (French, 2001: 485). This suggests that training and professional development need to take account of the whole person, to build negative as well as the positive competences, psychological flexibility and capacity to process emotion (Biron & van Veldhoven, 2012; French, 2001; Rønnestad & Skovholt, 2013).

In the IAPT context, as we shall see, the definitions of competence used in designing the training and assessment procedures for new therapists, have tended to have a narrower and more concrete meaning, based on 'the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects' (Fairburn & Cooper, 2011: 374). In other words, the therapist's ability to implement a specific form of treatment, with competence defined as 'the ability to appropriately apply CBT interventions that reflect the contemporaneous evidence base for the treatment of [a particular] patient's presenting problem' (Rakovshik & McManus, 2010: 498).

3.6.5 IAPT training and competence frameworks

The definition of competences in which IAPT practitioners and therapists should be trained was based on a review of evidence of exemplar trials of CBT interventions to identify those with the strongest efficacy claims, and on 'best practice' as described in the treatment manuals used in these trials (Roth & Pilling, 2008a). In view of the diversity of people (and their professional backgrounds) expected to train, there was a concern to promote the use of competences over qualifications or experience (Roth & Pilling, 2008a). Having an appropriate competency framework which could be used to structure both

training and on-going development and supervision of workers was thought to be essential. From 2007, the Department of Health published work which was designed to meet this need (Roth & Pilling, 2007, 2008a, 2008b). This defined five main domains for practitioners: generic competences in psychological therapy; basic CBT competences; specific CBT competences; problem-specific CBT competences; and, meta-competences (Roth & Pilling, 2008b: 7). Within each of these areas detailed competence 'maps' and curricula were provided.

CBT and non-CBT interventions had to be combined within a single framework (Roth & Pilling, 2008a) and the intention was that LIPs should not be seen as shortened or weakened versions of HIPs, but as treatments in their own right, whose duration and intensity were 'clearly matched to need' (Roth & Pilling, 2007: 4). It was also argued that the best way to close the gap between 'routine' and 'best' practice was to require practitioners to reflect on their own practice (the means as well as the outcomes), provide good supervision, promote collaborative working, and expect practitioners to have an ability to maintain focus in therapy 'even when unplanned clinical or social issues emerge' (Roth & Pilling, 2008b: 142). One of the meta-competences described was that therapists/ practitioners should work flexibly with clients, adapting techniques according to the clients' circumstances, maintaining focus whilst following protocol. This was perhaps the closest, the competence descriptions came to specifying the kind of 'psychological flexibility' and 'negative capability' described in 3.6.4 above.

The national curriculum for PWPs was based on a modular structure delivered over 45 days in total (one day per week) (CSIP, 2008: 3). Modules covered engagement and assessment of patients with CMHPs; evidence-based LIPs (behavioural activation, exposure therapy, cognitive restructuring, medication support, problem solving, panic management and sleep hygiene); values, policies, culture and diversity; and, working with the employment, social and healthcare context (CSIP, 2008). Bespoke learning materials were developed to enable trainees to undertake patient-centred interviews, support use of LIPs, work inclusively and promote recovery, whilst respecting diversity (Richards & Whyte, 2009).

For HITs, training was expected to take place two days a week for a full year with supervised practice in between (IAPT Programme, 2016). It was designed to provide practical intensive and detailed skills training, to increase students' knowledge base of theory and research in CBT, promote a critical approach to

the subject and equip them to be creative and independent practitioners, in accordance with BABCP guidelines (IAPT Programme, 2011a). Trainees were expected to become familiar with the low intensity work provided by PWPs, to use the IAPT national outcomes monitoring system (including session-by-session symptom measures) and to assess employment needs and develop close working relationships with employment coaches, to maximise patients' chances of being able to return to work (IAPT Programme, 2011a). The core modules covered the fundamentals of CBT; CBT for anxiety disorders (including specific phobias, panic disorder, social phobia, OCD, PTSD, GAD and health anxiety); and CBT for depression (cognitive therapy and behavioural activation) (IAPT Programme, 2011b).

3.7 Discussion and implications for my research

This chapter has reviewed the history and background to the IAPT programme as set out in the early policy documents, implementation guidance, outcome reports and evaluations. It has looked at the role of the 'founding fathers', Layard and Clark, as policy actors, and the role of associated institutions, such as NICE, and the 'evidence-based' policy and practice movement (3.2-3). It has identified a number of sources of controversy surrounding the programme and its aims; such as the ambiguity of its purpose in relation to health, welfare and work; its compatibility with a rehabilitative model of recovery and its use of 'colonising' discourses. It has discussed some of the problems and difficulties with evidence-based practice (EBP), both epistemologically and as implemented in practice. It raises questions about the values, ideology and power relations that might be at work, in the policy and in the service design; perhaps most especially where these are presented as being pragmatic and supported by evidence (3.3).

The IAPT service delivery model, centred on stepped care and the use of low- and high-intensity CBT-based interventions, has been described (3.2.3-4). There are questions about the degree of choice these treatments offer, their applicability to patients with a range of needs, and how the use of protocols and manuals support or limit what practitioners are able to do. The progressive roll-out of the programme from 2007, has led to increasing numbers of patients being seen, large numbers of practitioners and therapists being trained in IAPT specific competences, and some new care pathways being introduced. Some of the distinctive aspects of its implementation have been discussed, including the use of systematic outcome monitoring, recovery targets, and time limited treatments. The persistence of inequalities in access to provision have also

been raised, in light of the variation that has emerged in performance, service design and treatment choices, between local IAPT services (despite strong national prescription) (3.4).

The design and purpose of the two new roles introduced by IAPT have been discussed (3.5). I have argued that there are parallels with other types of ‘assistant roles’ used in social work, teaching, health and social care. From looking at these, it would seem important to consider how the IAPT roles may be shaped in specific workplace settings, the extent to which the two roles, PWP and HIT, overlap and interact, and their relationships with adjacent professionals. The literature on assistant roles has also raised questions about the extent to which either or both the IAPT roles might represent a form of degradation or empowerment for those who take them up, how much agency they are able to exercise, and the nature of their tasks.

In the final section of this chapter, I have discussed themes relating to the training and development of psychological therapists (3.6). These raise questions about the different kinds of motivation that may be involved, the role of personal biographies, characteristics, prior occupations, and experiences of therapy, as well as the role of chance and opportunity in starting to train. The possible reasons for choosing a particular modality to train in, such as CBT, have also briefly been raised. A number of different ‘stages’ models of therapist development have been presented, based on a literature which pre-dates IAPT, and which assumes a longer period of formal training than one year. Some of the issues which might be expected to arise for IAPT trainees have been suggested such as the existence of ‘transition shocks’ at certain points in training, the prevalence of anxiety, high needs for supervisory and peer support, and the demands of managing task and self in role. Factors that may contribute towards successful role transition and/ or the ability to stay in role over time have been described as ‘resilience’, ‘psychological flexibility’ and ‘negative capability.’ The IAPT competence frameworks and training curricula have also been described.

In relation to role transition (my first research question), the research presented here suggests that attention needs to be paid to the use and internalisation of language in training and practice, the nature of change experienced by individuals over time, how well equipped they feel to deliver what is expected of them, within the IAPT service and workplace context, and what helps and hinders them in their work. The relationship between the PWP

and HIT roles and their service teams is important, as is their mutual relationship to adjacent groups in the primary care setting. In relation to personal and professional identity (my second research question), the literature reviewed raises questions about what CBT and their respective role identities mean to trainees and qualified practitioners, how far they adhere to prescribed treatment models during and after training, what their experience is of working with patients, and dealing with adversity (either their own, their patient's or the organisation's). In relation to sustainability (the third, and final, research question), this chapter raises questions about the longer-term impacts of IAPT training and working practices on the development of individuals as practitioners and therapists, how far their career trajectories might converge or diverge from those found previously, how they process the emotional demands of the work, and what opportunities for progression and professional development are available. These, and many more issues, will be explored in the chapters which follow, after introducing the research design and describing the main methodologies of investigation in the next chapter.

Chapter 4 - Research Design and Methodology

4.1 Introduction and overview

This chapter sets out the study design and methods, in light of the research rationale described in the previous chapters (see especially, 1.1, 2.6 and 3.7). The first section gives an overview of the design, methodology and analysis methods used (4.1) and summarises some characteristics of the research participants (Table 4.1). The next section describes the study setting (4.2) and the process of gaining access. Section 4.3 provides a detailed account of the methods I deployed (from sample design and selection, through observation and interviewing, to data management and analysis). I look also at ethical issues and my position as a researcher (4.4). Further information on all aspects of the research procedures adopted, including copies of the research instruments, interim outputs from the analysis and ethical approval, is given in Volume 2 (of this thesis).

4.1.1 Design overview

I have addressed the main research aim and questions, as originally defined (see 1.1.1) through an 'experience-near' qualitative longitudinal research (QLR) design (Hollway, 2009; Cooper, 2009; Thomson & Holland, 2003; Thomson, 2007; Thomson et al., 2014). QLR combined with a 'psychoanalytic sensibility,' is particularly well suited to generating 'intensity and insight' and to representing 'psychologically complex, embodied and mobile subjects' (Thomson et al., 2010: 7). For this reason, it is well matched to my research purpose of exploring the psychosocial dynamics of IAPT and the new psychological therapy workforce created by it.

Within this design, I have combined ethnographic and psychoanalytically informed observation (Angrosino, 2007; Hinshelwood & Skogstad, 2000), with biographic narrative interviews with IAPT trainees and qualified practitioners (Hollway & Jefferson, 2000, 2013), over an 18-month period. The research is situated within a local IAPT service setting, during the third and fourth year of the national IAPT programme. The chosen methods provide a holistic 'rich picture' account of IAPT practitioners' experiences of learning, role transition and identity change, between starting out as an IAPT trainee to becoming qualified and beyond, whilst working clinically with patients. The research follows one cohort of eight people (two HITs and six PWP), whom I am calling Cohort A, through their training year and beginning

clinical practice, up until at least six months afterwards. I observed this group in their classroom setting whilst at University, for nine months of the academic year. The research also follows a second group of practitioners (four HITs and three PWPs), whom I have called Cohort XYZ, who trained prior to Cohort A, in the first or second year of IAPT (or before), and who therefore had up to and just over 3 years' experience working in an IAPT service. With these two cohorts, I aimed to capture a range of experiences, from new recruit to established practitioner, and to see what changed for each individual and cohort, over time. Full details of the sample are described in 4.3.1.

Individuals in Cohort A were interviewed three times, using free association narrative interviewing (FANI) (Hollway & Jefferson, 2000, 2013). The first interview took place mid-way through the training year and was biographical in focus. The second interview took place at the end of the training year, and the third six to eight months later. These focussed on their experience of the role and of clinical practice. Individuals in Cohort XYZ were interviewed twice, using FANI, once shortly after recruitment (with a biographical and work-related focus), and again 11-13 months later (looking at developments in their role and clinical practice). In total, there are 15 individual respondents, 9 of whom are PWPs and 6 HITs. The inclusion of both groups of practitioners is important as both roles are IAPT-specific, even though the HIT role is equivalent to that of a (non-IAPT) CBT therapist. Comparison of the two roles, which have a high degree of interdependency in practice, is intended to shed light on what is innovative and distinctive about each, and what may be more generic (as discussed in 2.3, and 3.5 especially).

Interviews with individual participants varied between one and three hours' duration, making in total 38 FANI interviews (and 62 hours of recorded data). In addition, I conducted semi-structured one-off interviews with members of the IAPT workers' role set (whom I called 'Group 5') (see 4.3.1 below). These were the IAPT programme director (PD) and NHS service manager (SM) who were jointly responsible for training and supervision. In addition, within this group, I conducted two focus groups: one with IAPT course teachers (CTs) and the second with supervisors (SUPs) from the IAPT service (see table 4.2 in section 4.3 below, and further details in Volume 2, section A.2, Table A2.4). These provided context to place alongside the trainees' and IAPT workers' experiences (Chamberlain et al., 2011; Smart et al., 2014; Vogl et al., 2018).

All of these data were extensively analysed using a range of different psychosocially informed interpretive methods. These include biographic and free association narrative analysis (Clarke & Hoggett, 2009; Hollway & Jefferson, 2000, 2013; Wengraf, 2001; Thomson, 2011; Rosenthal, 2004), comparison of cross-cutting and case-based themes (Ritchie et al., 2013; Ritchie & Lewis, 2003; Thomson, 2007; Barbour, 2007) and voice-centred relational (VCR)

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analysis (Gilligan et al., 2003; Doucet & Mauthner, 2008; Edwards & Weller, 2012). The details of these methods are outlined below (sections 4.3.6 - 4.3.8), and further explanation and illustrations given in Volume 2 (sections A2-9).

Table 4.1: The main research participants: PWPs

All names are pseudonyms.

PWPs	Status on recruitment to study	Cohort *	Age group	Employment immediately prior to IAPT	Educational background	Parental occupation(s)/ social class+	Status by end of study
Chrissie	PWP trainee	A	20s	Assistant Psychologist	Psychology degree	Education/ established middle class	PWP looking for work elsewhere
Jane	PWP trainee	A	20s	Support Worker	Psychology degree	Healthcare/ Academia/ established middle class	PWP in a different service
Maria	PWP trainee	A	20s	Support Worker	Psychology degree	Admin/ Financial Services/ Technical middle class	PWP on career break
Rachel	PWP trainee	A	20s	Student	Psychology degree (as mature student)	Technical/ Homecare/ emergent service workers	Assistant psychologist
Sarah	PWP trainee	A	20s	Support Worker	Psychology degree	Emergency services/ admin/ emergent service workers	PWP in a different service
Sue	PWP trainee	A	20s	Community trainer/ student	Humanities degree	Business manager/ Homecare/ New affluent workers	PWP (on maternity leave)
Kay	PWP	XYZ	20s	PCMHW	Psychology degree	Established working class	PWP looking to retrain

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PWPs	Status on recruitment to study	Cohort *	Age group	Employment immediately prior to IAPT	Educational background	Parental occupation(s)/ social class+	Status by end of study
Steve	PWP	XYZ	30s	Management Consultant	Psychology degree	Healthcare/Education/ Established middle class	Clinical Psychology trainee
Vicky	PWP	XYZ	20s	Advice Worker	Psychology degree	Healthcare/ Academia/ Established middle class	University researcher

Table 4.1: The main research participants: HITs

All names are pseudonyms.

HITs	Status on recruitment to study	Cohort *	Age group	Employment immediately prior to IAPT	Educational background	Parental occupation(s)/ social class +	Status by end of study
Anna	HIT trainee	A	20s	Nursing assistant	Psychology degree	Healthcare/ Established middle class	HIT
Joanne	HIT trainee	A	50s	CPN	Nursing degree	Manual/ Retail Trades/ Traditional working class	HIT
Andrea	HIT	XYZ	40s	CBP	Psychology degree	Technical/ Homecare/ Emergent service workers	HIT
Jill	HIT	XYZ	50s	Social Work	Social science degree	Armed forces/ Technical middle class	HIT
Martin	HIT	XYZ	30s	Occupational Therapy	Humanities degree	Armed forces/ Technical middle class	HIT
Stephanie	HIT	XYZ	30s	PCMHW	Psychology degree	Manual/ Retail Trades/ Traditional working class	HIT

* Cohort A – trained in 2010/11; cohort XYZ – trained in 2008/9, 2009/10 or prior to this.

+ Social class defined using Savage et al (2013)’s revised seven category classification. For discussion, see Chapter 5 (5.7).

4.1.2 Methodology overview

A number of concerns drove the choice of methodology. The first, following Hollway and Jefferson's critique of more traditional forms of qualitative and narrative research, was to be able to disrupt 'the idea of the transparent, unmediated self...[to] recognise the role of defences against anxiety in mediating our relationship to reality, the importance of unconscious intersubjectivity, and how free associations can give access to a post-rational, post-unitary subject' (Hollway & Jefferson, 2013: 144). By using FANI, I sought to counteract what Hollway and Jefferson (2000, 2013) describe as the 'transparent self-problem,' that is, the assumption that respondents always know what they mean to say, are able to say what they mean, and that their verbal accounts are therefore straightforwardly and literally meant. FANI, it is suggested provides 'a different way of research knowing' (Hollway & Jefferson, 2013: 150). It borrows from psychoanalysis, the ideas of unconscious defences and of free association, and 'allows interviewees to follow the threads of their emotional experience as they transform it into freshly discovered meaning' (Hollway & Jefferson, 2013: 151). It enables interviewees 'to give answers that reflect their own concerns even when these are not immediately consciously accessible' (Hollway & Jefferson, 2013: 151). This is *not* about exposing repressed material, but to help 'access latent meaning through eliciting and focusing on the associations between ideas, as opposed to exclusively on words and word clusters' (Hollway, 2009: 463). It requires sufficient 'containment' (see 1.3 for definition) in the interview to enable participants to think new thoughts, and the use of researcher subjectivity as an instrument of knowing (Hollway & Jefferson, 2013: 151-2).

A second (and linked) concern was to keep 'experience-near' by preserving the 'vitality of meaning' in respondents' accounts, and thus to put the 'actual people' who participated into the findings (Hollway, 2009: 461-462). This required 'drawing on the full range of ways in which people communicate (unconscious, as well as conscious, intersubjectivity)...to retain the vivacity of the way experience is represented' (Hollway, 2009: 472). In other words, broadening out the range of material included for analysis, beyond the written transcripts of interviews, to include the gamut of audio-recordings, fieldwork notes, emotional and embodied responses to the data at the time and subsequently, in the person of the researcher and their relationship with the researched, as moderated through supervision and peer group discussion.

Thirdly, the use of observational methods, combined with FANI, provides an instructive contrast regarding the nature of identity changes over time. As Hollway (2009) suggests, the observational methods capture the 'mundane detail of changes, the particularities of the setting...and help to counter-balance the generalising tendency of interviewees' narratives' (Hollway, 2009: 468). The different timescales and frequencies of the two methods (see Chart 4.1 below), show up what is remembered and what is forgotten in both participants' and researchers' accounts, and raises 'questions about the painful aspects of lived life which would

otherwise have been invisible' (Hollway, 2009: 469). The addition of a small number of 'semi-structured' one-off interviews with service leads and a focus group each with IAPT trainers and supervisors, also enables comparisons in perspective to be made, and some of the more concrete details of the setting to be confirmed (Chamberlain et al., 2011; Smart et al., 2014; Vogl et al., 2017).

To be successful, each of these methods, and especially when they are combined, requires 'a heightened awareness of the inter-relationship of the researcher and the research' (Thomson et al., 2010: 6). They require an extended notion of researcher reflexivity, compared with traditional sociology and qualitative psychology, as '*more than* the product of an array of social identities' (gender, ethnicity, class and so on), that are relevant in relation to participants (Hollway, 2009: 471). This version of reflexivity also considers 'differences produced by power relations, pays attention to the dynamics of the inner world and the way that experience-near understanding contains within it social reality' (Hollway, 2009: 471, after Froggett & Hollway, 2010). In other words, it seeks to avoid a simplistic model of power and identity. The approach is considerably more time-consuming than other, even in-depth, methods, and is premised on 'an endeavour that rewards patience, commitment, dialogue and careful reflection' (Thomson et al., 2010: 9 after Back, 2007).

Furthermore, intensity in these methods comes from their temporal pattern, and the frequency of the research encounter (Thomson et al., 2010: 16). Depth 'comes from noticing the juxtaposition of narratives over time, their repetitions, contradictions and movement, which provides a sense of the connectedness and dynamism of real lives' (Thomson et al., 2010: 16). Insight is generated by 'taking researcher subjectivity seriously, and acknowledging the limits of individual insights due to the researchers own identifications and defences' (Thomson et al., 2010: 16). Juxtaposition of the different types of data aids this insight. Finally, using two different psychoanalytically informed research methods, in a longitudinal design, enables the research to 'go beyond a language-based account to one that includes dynamic, affective, embodied, intersubjective and practical aspects of identity' (Thomson et al., 2010: 19). This approach attempts 'to achieve psychological depth without inflicting symbolic violence on the subject, to document and understand social life without assassinating it!' (Thomson et al., 2010: 9).

4.1.3 Analysis overview

I approached the analysis of my data in multiple overlapping stages (Pope et al., 2000; Simons et al., 2008; in addition to references already cited in 4.1.1-2). In the early stages, I kept a research diary noting key meetings, discussions with supervisors and peers, gatekeeping events, practice interviews, work and study experiences, conferences and workshops that helped to open my eyes and tune my ears, as I prepared for fieldwork. During and after

fieldwork, I continued to keep reflective notes, for each fieldwork appointment, data analysis session or as relevant thoughts and ideas arose. These informed my analysis, by reminding me of the situated, co-constructed and intersubjective nature of the research 'data,' the thoughts and feelings the research process evoked in me. I used this material in discussion with my supervisors (and in peer group discussion), to reflect on my role in the knowledge production process (Jervis, 2012; Elliott et al., 2012) (and see 4.3.7 below).

During fieldwork and for 18 months afterwards, I immersed myself in listening to interview recordings, transcribing, reading, checking and re-reading transcripts and field notes (see 4.3.7). This fulfilled the 'familiarisation' stage of analysis common to most qualitative research methods, but the attention to listening and re-listening to audio-recordings went beyond the need for accurate transcriptions. It gave me the opportunity to hear and note down things that passed me by at the time in the exchanges between myself and the respondent, the hesitations, *non-sequiturs*, omissions, changes of pace, tone and energy that infused both my and their words. Based on these listenings and the fieldwork notes (often before the final transcript was ready), I prepared case summaries and 'pen portraits' for each participant, to help keep the 'whole person' in mind, before moving on to more detailed analysis of themes from the transcripts themselves (Hollway & Jefferson, 2000, 2013) (for examples, see Volume 2, section A9).

Subsequent stages of analysis involved developing low- and high-level themes within and across individual cases, and over time, and interpreting these (Ritchie & Lewis, 2003; Ritchie et al., 2013; Barbour, 2007). A vital step in checking the completeness, accuracy and validity of the themes, was the role played by supervision, and by a group of peers, with whom I shared in psychosocial 'data analytic meetings' (see 4.3.7) (Clarke & Hoggett, 2009). As well as my lead PhD supervisor (a sociologist), I had an external supervisor who was psychoanalytically trained. Throughout the fieldwork period and for eighteen months afterwards, I shared with them the 'raw material' and my responses to it. This helped me to stay in role, as PhD researcher, to separate out my own thoughts and feelings from those of my respondents, and to recognise significant themes and alternative meanings. I also met regularly with a peer group of PhD researchers and staff, at my own and another University, to present and respond to extracts of interview material, in the form of a data analytic discussion group (Hoggett et al., 2010; Elliott et al., 2013; Hollway & Jefferson, 2000, 2013). These meetings served a similar reflective and creative purpose as supervision, providing multiple viewpoints, associations, resonances and observations, with which to compare and adjust my own responses and build interpretations.

On a practical level, I used CAQDAS software (specifically Framework within NVivo) to assist with the day-to-day management and manipulation of my textual data (but not as the

principal means of analysis). I involved my research participants in the analysis and interpretation only in the sense that I revisited some themes from their initial interview with me, in subsequent meetings, where some chose to elaborate and clarify what they had said earlier. I did not offer interpretations, of the kind that occur in clinical practice, directly into the interviews. However, I did often reflect back what I heard them to be saying, and tried to offer a containing presence. Over time, this led to more reflection and revisiting of meanings by respondents, each of us making interpretative suggestions and questions, filling in factual details, and checking gaps in understanding. This was the process I agreed with them in advance, and it was gratifying to experience a strengthening sense of dialogue, mutuality and respect, in the way our conversations unfolded. Towards the end of the fieldwork period, I also invited formal feedback from participants on my draft findings as I presented them at conferences (see Volume 2, section A11 for details). Only two participants responded directly to these invitations, commenting positively that I had represented their experiences accurately. A third participant was in the audience when I presented the findings and spoke to me afterwards, acknowledging what rang true for her. Three (more) also re-contacted me over a year later, to ask how the research was going and to tell me how their own lives were progressing. As part of the 'research bargain' (Cunliffe & Alcadipani, 2016), participants were also offered copies of their interview transcripts if they wished to have them, but only one took this up. A further stage of validation took place when I presented my emerging findings for peer review at in-house and external seminars and conferences (as before, see Volume 2, section A11). The feedback received extended my thinking, and helped build interpretations, in addition to the input from supervisors.

Chart 4.1: Fieldwork and Participant IAPT Journeys by Cohort

++ Not all members trained at the study site.

Year	2008				2009				2010				2011				2012			
Quarter	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Cohort A in training												7* 2*	PW P HIT							
Cohort A first interviews																				
Cohort A second interviews																				
Cohort A third interviews																				
Cohort XYZ joined IAPT service ++				2* PW P			1* 4*	PW P HIT												
Cohort XYZ first interviews																				
Cohort XYZ second interviews																				
PD/SM interviews																				
CT Focus Gp																				
SUP Focus Gp																				

4.2 Study Setting

My study is set in a city in the North of England, within an IAPT service and University-led training programme for IAPT low- and high-intensity therapists. The service is an NHS service, set up during the first wave of IAPT's roll-out, in 2008/09. The training course was in the third year of its delivery at the time I started fieldwork. Both the service and the training course were considered (by the national IAPT team based in DH and DWP at the time) to be well managed and run. They met national service criteria and training standards for IAPT and a number of managers and teachers from the site were involved in helping to develop and promulgate the IAPT national guidelines. For this reason, the site was considered to provide a positive example of what national policy makers intended in relation to IAPT. The University was a training hub for nine IAPT services in the region, at the time of my fieldwork. There was also a history of collaboration for the purposes of research and training between my department and the services and training programmes concerned.

4.2.1 Characteristics of the local IAPT service

The local IAPT service where all but one of my respondents worked operated a devolved 'hub-and-spoke' model of delivery, with both PWP and HITs located for the majority of their time in GP practices. The service manager worked in the city centre, where clinical work could also be conducted and self-referral patients could be seen. The service as a whole was managed through four geographically defined 'sector teams.' Each sector team had its own base which PWP and HITs used for 'admin time', including supervision, line management, and team meetings. PWP and HITs were allocated to a particular sector team on recruitment, and worked across different GP practices in the sector. Most practitioners operated in at least three GP practices or satellite surgery sites, with clinics from one half to several whole day sessions each week. They were constantly on the move, often in a different place on different days of the week, and between morning and afternoon. During their training year, PWP spent one day, and HITs two days per week at the University. Thereafter, each group spent a minimum of four full days in clinical work, and a maximum of one non-clinical day on admin, supervision, team and training activities.

4.2.2 Gaining and maintaining access

The process of gaining access to a research setting requires obtaining formal permission from relevant review bodies and organisational gatekeepers ('primary access') and building effective relationships within the organisation of study through which to gain information and access to relevant people ('secondary access') (Cunliffe & Alcadipani, 2016; Feldman et al., 2003). The things that made a difference in my case were: the good working relationships and contacts of my supervisors and colleagues, the credibility of the research team and the work I was engaged in as my 'day job' whilst working on the PhD, presenting myself in person to key

gatekeepers and providing them with a written proposal, cultivating administrative staff attached to the IAPT training course and service, and responding positively to last minute invitations from gatekeepers, wherever possible. The main hiccoughs related to NHS Research Ethics and local NHS Trust R&D governance procedures and it took two attempts to get through. Due to a change in the national guidelines for NHS RECs (in 2011), my study was later deemed to fall out-of-scope for NHS ethical approval, as it involved NHS staff and not patients. Copies of formal approval letters and correspondence are shown in Volume 2, section A5. In terms of the relational aspects of access to the observation site, it helped when the PD reinforced the non-evaluative nature of what I was doing. Once classroom based observational fieldwork had started, I continued to build secondary access by joining in, in a limited way, on coffee breaks alternating between the CTs, and the trainees; making myself available immediately before and after sessions for anyone wanting to ask questions, and the rest of the time retaining a neutral stance (for more on 'the experience of being an observer', see Volume 2, A9.14). I also attended some professional meetings held in the service setting, to aid interview recruitment.

4.3 Study Methods

4.3.1 Sample selection and recruitment

The sample frame: Individual PWP and HIT trainees and IAPT CTs were identified by the University training course management team soon after the start of the academic year. There were 33 PWP trainees enrolled on the course for the year I observed and ten HIT trainees. Of these, ten PWP trainees and two HIT trainees worked for the IAPT service which was the main study setting. To enable a sufficient sample of trainees in the HIT category, I negotiated access to a second IAPT service, with trainees on the course. This IAPT service was geographically adjacent to the main site, but at an earlier stage of service implementation. With the agreement of the service Clinical Director, three additional HIT trainees were approached to take part in my research. Of these, one agreed to participate. My 'Cohort A' HIT trainee sample therefore consisted of two individuals, one from the main service setting and one from the adjacent service. To protect confidentiality, I do not draw attention to these service differences in my analysis. All other Cohort A sample members came from the main study site.

Qualified PWPs and HITs (Cohort XYZ) were identified by the IAPT service management from employment records, dating back two years. Amongst this group, one HIT was trained as a CBT psychotherapist prior to joining IAPT. One PWP had trained in a different IAPT service and had relocated to the main site after qualifying. The remainder were all recruited to IAPT and trained at the main site, one or two years prior to the Cohort A recruits.

Initial contact and consent to observe: All individuals on the sample lists were contacted initially by the relevant gatekeeper (the PD and/or SM). Trainees and CTs were handed the information sheet about the study and asked to complete a consent form, during the University induction period (see Volume 2, section A4). Until written consent had been received from trainees, I had no contact with participants. I received verbal or email consent from the CTs.

Recruitment of interview respondents: Early in the second term of their IAPT course, all eligible trainees (Cohort A) were contacted by letter at their home address, via the IAPT service management. The letter included a flyer inviting expressions of interest, a letter from the SM and a full participant information sheet and consent form (shown in Volume 2, section A4). Individuals were invited to contact me by email, telephone or in person, to express interest and to ask questions (I was by this point observing classroom teaching sessions regularly). Only at this point was I able to obtain their name and contact details. A similar process was followed for Cohort XYZ individuals. These invitation letters were mailed out by the SM's support team a couple of weeks after Cohort A's, to spread the administrative burden. Copies of all documents used are included in Volume 2, section A4. Each participant was offered a book token for taking part (£15 for each interview).

For the SM and PD interviews, invitations were emailed directly by me towards the end of the training year. I also invited CTs directly (via email) to participate in a focus group at the end of the teaching period. By that point, the CTs were familiar with me and we had been in regular email contact already regarding dates and times for observation. Letters to the SUPS were emailed by the SM, at a similar time point. Expressions of interest were collated by the central support team and passed on to me. I then contacted individuals personally to answer questions, confirm their availability and a date for the focus group meeting. Table 4.2 below gives a breakdown of my target and achieved samples, together with the number of interviews.

Table 4.2: Target vs achieved sample

Sample category	Cohort	Target sample size	Available recruitment pool where known	Actual number of respondents	Number of interviews per respondent	Total number of completed interviews (or focus groups)
Group 1 (PWP trainees observed in training)	A	2-3	10	6	3	18
Group 2 (HIT trainees observed in training)	A	2-3	5	2	3	6
Group 3 (Qualified PWPs, trained in earlier years)	XYZ	2-3	15	3	2	6
Group 4 (Qualified HITs, trained in earlier years)	XYZ	2-3	12	4	2	8
Group 5 (Individual interviews)	-	2	1 (SM) 1 (PD)	1 (SM) 1 (PD)	1 1	1 1
Group 5 (Focus groups)	-	6-8 (across both groups)	n.k. (SUPs) 5 (CTs)	4 3	1 1	1 1
Total	-	16-20	-	24	1-3	40 individual interviews 2 focus groups

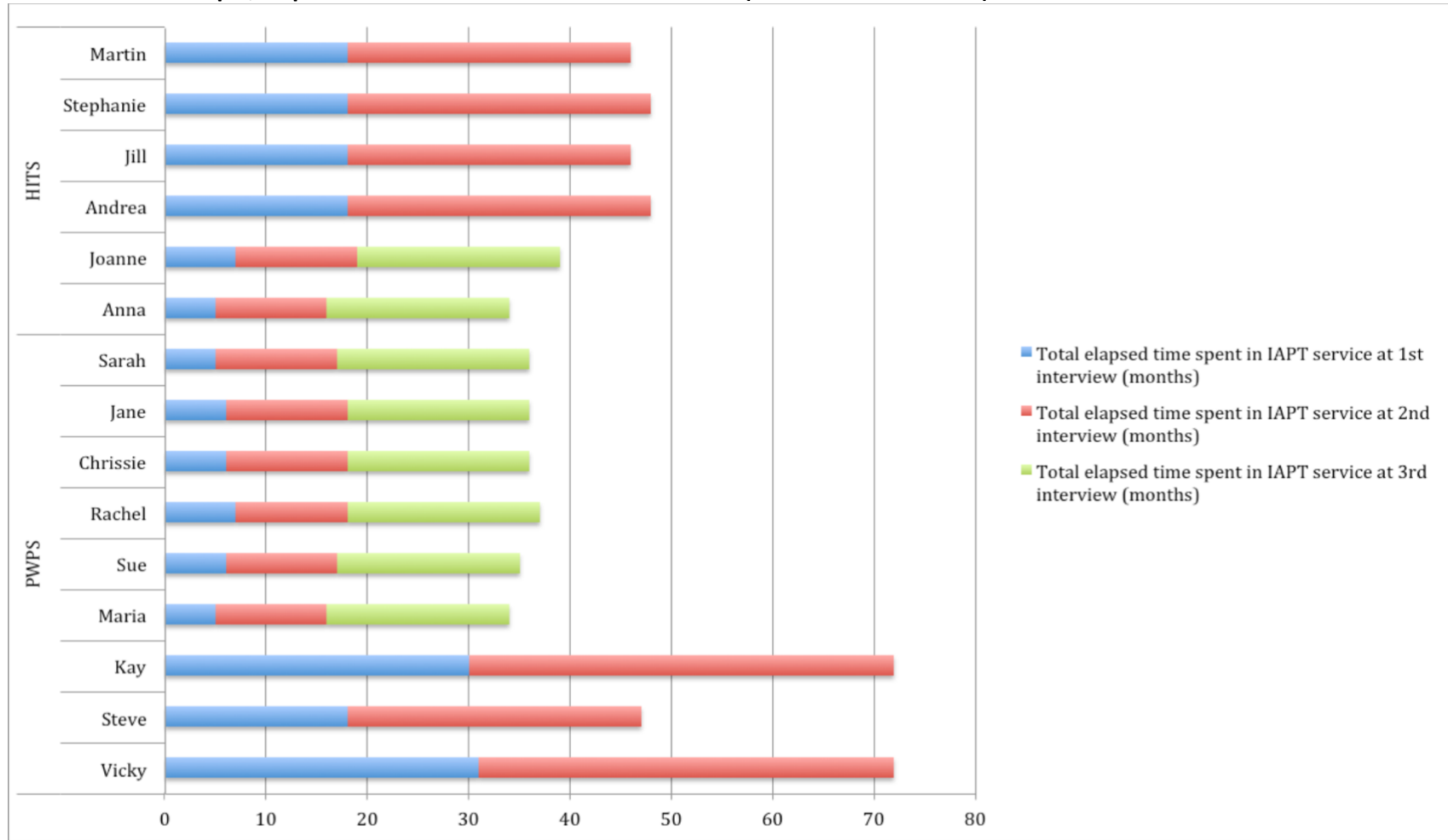
Sample characteristics: Table 4.3 below shows the distribution of interviews for PWPs and HITs at each time period and the total number of interviews. Chart 4.2 illustrates the elapsed time in the IAPT service for each respondent, at each interview date. This demonstrates the difference in ‘IAPT time served’ between Cohort A and Cohort XYZ respondents.

In terms of the workforce as a whole, my sample has a higher ratio of PWPs, than the national average across all services at the time, although it does represent the 60: 40 ratio of PWPs to HITs that was recommended in national guidance for this period (IAPT Programme, 2013). In terms of demographic characteristics, my sample is not atypical, in being young, white and female dominated. The 2015 Census of the IAPT workforce found 79% were women, 83% White British and 66% under the age of 46 years (NHS England and Health Education England, 2016).

Table 4.3: distribution of main sample interviews by time period

Time point since start of IAPT training	Numbers of PWP interviews	Numbers of HIT interviews	Total interview numbers at each time point
Approx. 6 months	6	2	8
Approx. 12 months	6	2	8
Approx. 18 months	7	5	12
24-36 months	3	4	7
Over 3 years	2	1	3
Total Number of Interviews	24	14	38

Chart 4.2: Main sample, elapsed time in IAPT service at each interview (n = number of months)



Observation sampling points: Table A2.1 (in Volume 2, section A2) shows the content of the taught sessions I observed during the training year for each group of trainees. I attended 19 out of a possible 49 taught sessions* for the PWP group, and 20 out of a possible 58 for the HIT trainees. In total, I observed for over 100 classroom hours between October and June. I observed as wide a range of activity types as possible. The only activity type I was unable to observe was the small group supervision sessions which HIT trainees had with CTs, where discussion of identifiable patient data made it inappropriate for me to attend. During six sessions with each of the PWP and the HIT trainee groups, I completed psychoanalytic-style micro-observational notes (12 hours in total), using a schedule developed specifically for this purpose (see Volume 2, section A4). Sessions where I conducted this style of observation are highlighted in Table A2.1, and an anonymised completed pro forma is shown at section A6 (all in Volume 2).

(*Sessions are defined as half-days on a specific topic.)

4.3.2 Data collection: observations

As already described (see 4.1), my main strategy for understanding the experience of IAPT workers as they went through training and into clinical practice combined classroom observation during the training year, and individual FANI interviews with 15 individuals.

For the first five months of my 18-month fieldwork period, observation was the main method of data collection. My first observation session was at the start of the academic year, during the university induction period for both groups of trainees. My last observation session was at the end of the teaching period, nine months later. In-between, I observed in part or in whole, at least one third of the formal teaching sessions for each group (see 4.3.1 above, and Volume 2, Table A2.1 for a precise breakdown). For the first few months of observation I did not know the trainees' names or what services they worked in. I alternated ethnographic style observation (Angrosino, 2007) and a more intensive form adapted from infant observation methodology, attempting to maintain 'evenly hovering attention without premature judgement' (Hinshelwood & Skogstad, 2000: 17) (see Volume 2, section A4.3-A4.4). The experience of being an observer, and how this may have mirrored the experience of trainees, is also described in Volume 2, section A9.14.

4.3.3 FANI interviews

Preparatory phase: I completed a pilot study for this PhD based on secondary analysis of the qualitative interviews I conducted with staff and patients for the IAPT SDO evaluation project, as part of my University contracted employment (see Volume 2, section A10 and A11 for details). I also carried out a couple of pilot FANI interviews with two student peers, who were not part of my target sample, using similar procedures as I had planned for the PhD. I audio-recorded these interviews and re-listened to them with my external supervisor. Amongst other things, this revealed the extent of my 'back-channelling' talk, in particular, the frequent use of the word 'right' after every comment by the respondent, which appeared to inadvertently give a message to them about what I wanted to hear. These practice interviews reduced some of my anxiety about the fieldwork but did not save me from repeating the same errors in my interviews with study respondents.

Differences in interview settings: Nine out of my 15 PWP/HIT respondents opted to be interviewed in their own homes on each of the occasions I met with them. These interviews took place on weekdays, usually at the start or end of the working day, or over an extended lunch-break. The other six interviewees opted for a range of locations; a meeting room at their team base; a consulting room at one of their GP practices; or, in a room booked by me, at the University. These too took place in working hours. Over time, as my relationship with each of the participants became more established, I was invited to meet partners, pets and other family members, to sit in gardens, front and back rooms, and to follow respondents to new homes and locations, in the city and in other parts of the country, following their relocation from the original site. As well as contributing rich 'scenic understanding' (Froggett & Hollway, 2010; Redman et al., 2010; Oleson & Weber, 2012) for my research, these different settings brought out nuances of difference in terms of respondents' outlooks on work and personal life.

Dynamics of interviewing and field notes: When I came to meet respondents in person, I found some I instantly recognised and greeted (and vice versa), and others I had not especially noticed. After each interview, I wrote down my impressions, thoughts and feelings about the interview; I found myself commenting on the relative ease or difficulty of making practical arrangements, the questions (or lack of) asked, our interactions with the setting, the starts and ends of our meetings, and the interruptions that occurred. I also noted when I had a strong emotional or physical response to things that were said (Hollway,

2009; Cooper, 2009). An example of my fieldwork notes is given in Volume 2, section A6 (see also 4.1.1).

The interview schedules incorporated Hollway and Jefferson's advice (2000; 2013) for eliciting respondents' 'meaning-frames' (or *Gestalts*): using open-ended rather than closed questions, eliciting stories with phrases such as, 'tell me about a time when...', avoiding 'why' questions that invite intellectualisation and following the respondents ordering and phrasing (Hollway & Jefferson, 2013: 32-34). Respondents told me they found the interview experience positive; as a space in which to reflect upon their experiences, and where they could learn by hearing themselves think out loud (Elliott, 2011; Birch & Miller, 2000; Gair, 2012) (and see 4.4.2 below).

4.3.4 Data collection: contextual interviews and focus groups

Both the PD and SM respondents, whom I interviewed individually, were willing for their views to be identifiable in the reporting of the research. Both had been with the local service from the outset, and gave me a better understanding of how the course and service were set up, what the local priorities were and how these had changed over time, the challenges of implementation and the influence of the national context. The topic guides for these interviews are shown in Volume 2, section A4.

The CTs' focus group included teachers on both the HIT and PWP trainings. The focus group provided valuable insights into the 'group character' of the current cohort of trainees, the range of backgrounds and learning trajectories seen, common stumbling blocks and successes before, during and after training. The SUPs' focus group included newly appointed 'Senior PWPs' who supervised PWPs, and HIT supervisors. This group made observations on the translatability of classroom learning into the work setting, the on-going process of consolidating skills and using routine outcome data to reflect on practice, the need for on-going professional development and the role of supervision. They also discussed issues of career progression within and beyond IAPT, particularly for PWPs. Copies of the topic guides are shown in Volume 2, section A4.

4.3.5 Data management methods

Audio-recordings and transcription: All the individual interviews were digitally recorded and stored securely with an ID reference number. Out of 40

recordings, three had recording errors and couldn't be used. I reconstructed the data from these interviews from memory and my field notes. The focus groups were audio and video-recorded to aid identification of speakers during transcription. I transcribed at least one individual interview from each group of respondents, and transcribed all of the focus group discussions myself. The majority of individual interviews were professionally transcribed and then checked in detail by me. The transcriber was already familiar with the concept of biographic and FANI interviews, and adapted quickly to my suggestions on the format and style. The transcription protocol, template and examples of corrections made are shown in Volume 2, section A7.

Field notes: As described in 4.4.2 above, my notes for the observation work took a variety of written forms (notebook, paper pro forma etc.). For the interviews, over time I developed a set of common headings to use, and wrote up my thoughts and feelings as soon as I could after each one (see Volume 2, section A6).

Use of CAQDAS: Framework in NVivo: I uploaded transcripts and data summaries into this, to make it easier to compare across cases, identify and extract quotations from pre-identified themes for writing up. I also adapted, re-grouped and sub-divided a number of themes in light of this process (see Table 4.4, in section 4.3.7 below) (Woods et al., 2016; Ritchie et al., 2013).

Paper charts: I used hand-written flip charts, mindmaps and diagrams to complete the analysis of the output from NVivo.

4.3.6 Data analysis methods: observations

As described in 4.1 and 4.3 above, my approach to data analysis took as a starting point the importance of using the 'whole context,' keeping the data 'alive,' not losing sight of the person, or moving too quickly to use of 'disembodied' themes (Hollway, 2009, 2010, 2011; Clarke, 2002; Thomson et al., 2010). Equally, I understood the need to make use of theory and reflexivity to make sense of what I found (Finlay, 2002a, 2002b; Finlay & Gough, 2003; Hollway, 2009; Elliott et al., 2012; Frosh, 2010b, 2010c).

Thematic and longitudinal analysis of observational data: With the observational data, I started out by reviewing my notes from the classroom sessions, reading through them and highlighting what stood out (Ritchie & Lewis, 2003; Ritchie et al., 2013; Angrosino, 2007). From these readings I started to write down low-level theme headings, adding page references (from my hand- and type-written notes) to each, so that I could see where and how often the themes recurred. I went through both my ethnographic and psychoanalytic-style observation notes in this way (Ritchie & Lewis, 2003; Ritchie et al., 2013; Angrosino, 2007; Paterson et al., 2003). The notes included both what I saw, what I felt and what I heard in relation to the classroom group as a whole, my sense of how my presence was experienced by the trainees and CTs, and their interactions with me (Hollway, 2009; Angrosino, 2007; Madden, 2017; Bondi, 2014). An example of this first stage of descriptive summarising by low-level theme is shown in Volume 2, section A9. I then aggregated these very low level observational themes into groups, with additional sub-headings, under each of my main research questions. The summary from this intermediate stage of analysis for the two trainee groups, PWPs and HITs is shown in Volume 2, Table A9.2. This provided the base document from which I could compare the experiences of the two groups and select examples for inclusion in my write-up of the training year (Chapter 6). I then made a month-by-month summary of the observational themes for each group, so that I could look at where topics emerged, when themes changed or ended. This helped to identify changes of mood, group dynamic, learning styles and CT-trainee interaction, through the year. I have used these headings in my description of the trainees' progression through the course in Chapter 6. This process also enabled me to compare experiences between the two groups over time (Irwin et al., 2012; Thomson et al., 2010; Neale et al., 2012).

Combining observational methods: There were plusses and minuses from combining two different approaches to observational work (ethnographic and psychoanalytically-informed) (Paterson et al., 2003). I found I was significantly more comfortable with the ethnographic style of observation than the psychoanalytic one. The latter, I found to be intense and draining, even though it was for shorter periods (one hour at a time). However, after the first month, I was better able to relax and let my attention 'hover' over whatever was happening in the room (Hollway, 2009; Froggett & Hollway, 2010; Hinshelwood & Skogstad, 2000). My attempt at this style of observation helped me start to notice what was going on for me internally, as well as the external setting. In practice, over time however, the two styles of classroom observation I adopted merged. This was reflected in the way I recorded the session notes (often running over the hour in the 'psychoanalytic style' observations) and in the way I analysed the notes afterwards. Although there were differences in content, I

found I treated both sources, once written down, in the same way (Paterson et al., 2003).

4.3.7 Data analysis: interview data

Familiarisation stage: listening and responding to the audio-recordings: I re-listened to the audio-recordings of each individual interview repeatedly (see 4.1.3 above). I came to feel intimately connected with my respondents in this process; their voices, the pace, tone and fluency of their narratives became part of my daily existence. I scribbled down comments in the margins as I worked on the transcripts, regarding background noise [dogs barking, phones ringing etc.], the content of any interruptions, hesitations in the participant's narrative or in my own comments and questions during the interview, changes of pitch, tone and emphasis by either one of us, places where the interview speeded up and slowed down, and what I remembered about what was happening between us at the time (following Hollway & Jefferson, 2000, 2013; Hollway, 2009; Clarke, 2006; Clarke & Hoggett, 2009; Hoggett et al., 2010). I noted any mis-hearings on my or their part (or the transcriber's), various *non-sequiturs*, ellipses and omissions of words (Hollway, 2010; Josselson, 2004, 2007; Loubere, 2017). (Hollway, 2010; Josselson, 2004, 2007; Loubere, 2017). I kept revising and annotating the transcripts until I felt I had a reasonably accurate verbatim record of what had been said, some indication of the gaps and hesitations etc., using punctuation marks, and an initial record of my thoughts and feelings as they occurred at the time.

Data analytic meetings/discussion group meetings: The typical format of meetings involved myself (or whichever researcher was presenting), introducing the research context, saying a few words about the specific recording, who was speaking, and where in the interview, or sequence of interviews, the extract occurred. I would then play the recorded extract (no more than 10 minutes' worth at a time). Alternatively, another student and I would read an excerpt from the written transcript, like a play script, whilst other group members listened. At this point, after the extract had been heard and any immediate clarification needs had been addressed, the lead researcher would withdraw from the discussion, literally moving their chair away, turning around and sitting with their back to the rest of the group. The remaining group members would then 'free associate' to what they had heard for 20-30 minutes (or as long as thoughts, images and associations still occurred). In this time, I as presenter listened to the discussion, but did not engage in it, or make eye contact with group members. After the flow of the discussion had slowed, or stopped, the presenter would be invited to rejoin the group, and to respond to what they had

heard. Group members asked questions, linked ideas, and images, and made associations which resonated with my experience of the participant, but which often captured an aspect I had not noticed before, or thought much about (Clarke & Hoggett, 2009).

In one-to-one supervision meetings, particularly with my external (psychoanalytically trained) supervisor, we followed a similar sequence of activities, but moved more quickly through the stages and listened to more extracts in total. My supervisor and I would take it in turns to share our thoughts and feelings about the material, my supervisor would ask me questions which helped me to think about the material in a more psychodynamic way, and to process my feelings about the research experience. Together, our discussions prompted many associations and reflections on the participants, the research process and my role (Jervis, 2012; Elliott et al., 2012).

First steps towards summarising or ‘taming’ the written data: For each participant in my PWP and HIT samples, I developed a biographical case summary (after the first interview), a pen portrait (an initial draft which was then revised on completion of fieldwork) (Hollway & Jefferson, 2000, 2013). These were based primarily on my recollections of the interview experience, and listening to the audio-recordings, rather than on the written transcripts. Examples are given in Volume 2, section A9 (together with very brief, mini-pen portraits for each sample member).

Descriptive analysis: Once all the transcriptions were completed and checked, I developed low-level theme summaries, on an interview by interview basis, for each person (see A9 for an example). These first low-level thematic summaries kept very closely to the textual content of the transcript, kept the same narrative ordering as the interview itself, used the interviewees’ phraseology and included material from the pre- and post-fieldwork notes. These summaries, together with the pen portraits and case summaries, and notes from supervision or data analysis meetings, then became the bedrock of my subsequent analyses (see below). I also used the case summaries to ‘prime’ participants in the data analytic meetings, where appropriate.

Identifying themes: After reading through the low-level theme summaries, and noting down possible headings in the transcript margins, I grouped the low-level themes for each person under higher level headings. I repeated this

process for at least half the members of each group (PWPs and HITs). Quite quickly, I found a similar set of headings could be applied across cases and started to use these to organise the material across all cases. These in effect became my 'data management' or 'descriptive' themes (Ritchie & Lewis, 2003; Ritchie et al., 2013), which I checked out with supervisors and members of the data analytic meetings, to see if they rang true. Examples of this process are shown in Volume 2, section A9, and the examples, cumulatively, fed into how I managed the data using a simplified NVivo Framework (shown at Table 4.4 below). I did not move to use CAQDAS, however, until I had completed further intensive analysis of a small number of cases, to test out a number of different analytic methods and combinations of methods (Chamberlain et al., 2011; Hollway, 2009, 2010; Simons et al., 2008). Nor was this 'data management' or descriptive analytic phase sufficient in itself. Several further analytic stages, searching for explanatory interpretations were also needed.

Comparing themes over time: Drawing on the low-level and grouped 'data management' themes for each case, I compared findings for the same person, across each of their interviews, to see what changed over time (for an example, see Jane's analytic summary in Volume 2, section A9). I did this for each person. These enabled me to see analytic connections within and across themes which had not previously been visible (Thomson, 2007; Barbour, 2007).

Experimenting with analytic methods: I then selected one PWP and one HIT case to analyse in more depth, using I-Poems and the voice-centred relational (VCR) analysis method (Gilligan, 1982; Gilligan et al., 2003; Doucet & Mauthner, 2008; Edwards & Weller, 2012) (and see 4.4.8 below). I added two further cases to this (another PWP and another HIT), to check both the methods and the findings. Finally, I also experimented with analysing the micro-interactions between myself and the participant, in one HIT case (Anna), to see if I could get a handle on the transference and counter-transference dynamics of the interviews (Kvale, 1999; Frosh & Emerson, 2005; Kvale & Brinkmann, 2008; Gemignani, 2011; Hollway & Jefferson, 2013; Redman, 2009; Urwin, 2006). This was a useful exercise to help me look at the fine grain of interaction in the interviews. However, for the reasons described by Frosh (2010a, 2014) and others, and my own lack of psychoanalytic training, the results of this analysis were not especially successful, and after discussion, bearing in mind confidentiality concerns, I omitted them from the writing up.

Framework (in NVivo) analysis: This required me to ‘code’ the thematic and case-based summaries, fieldwork notes, and extracts from the full transcripts, using the ‘data management’ themes identified. I selected extracts from all transcripts to illustrate each of these descriptive themes. For ease of management, I also grouped the themes under five ‘analytic’ headings: managing self in role, opportunities, relationships, threats, working with patients (as shown in Table 4.4). In total, at this point I had 28 themes for Cohort A and 29 for Cohort XYZ, with only three slightly different themes between the two cohorts (Cohort XYZ reflected more on both the PWP and HIT roles, Cohort A only on the viability aspects of the PWP role). The output of this analysis brought together all of the summary material, fieldwork notes and illustrative quotations from the transcripts, for each descriptive theme, with additional ‘analytic’ comments. These outputs then formed the basis for the final ‘explanatory’ stage of my analysis before writing up (Ritchie & Lewis, 2003; Ritchie et al., 2013; Irwin et al., 2012).

Charting the results: I read through the Framework output files, highlighting key points, differences and variations. I extracted from these the analytic headings and links I used to examine and display the findings visually, using circles, boxes, arrows, lists, underlinings and additional annotations, on a large single flip chart sheet of paper. Working again through these, I drew in links between groups of concepts, and re-labelled some of the headings, where it aided understanding. I thus had a one-page diagram, for each descriptive theme, which showed overlap and interconnections between sub-themes, and new analytic headings, which pointed to possible explanations and interpretations. In addition to this, I drew up a simple 2*2 comparison table, for each theme, showing differences and similarities between PWPs and HITs in Cohort A and Cohort XYZ. These two charts (for each theme) formed the route map for the writing up.

Table 4.4: NVivo/Framework themes by cohort

	COHORT A HIT Trainees (Anna, Joanne) PWP Trainees (Chrissie, Rachel, Jane, Maria, Sarah, Sue)	COHORT XYZ HITs (Andrea, Jill, Martin, Stephanie) PWPs (Kay, Steve, Vicky)
THEME GROUP	THEMES	THEMES
Managing self in role	Managing self in role Feelings about the job Interviewer-interviewee relationship Sources of support	Managing self in role Feelings about the job Interviewer-interviewee relationship Sources of support HIT therapist role reflections PWP role reflections
Opportunities	Opportunities Entry routes Belief in IAPT Engagement with CBT Model adherence Theory-practice split Professional identity and development Motivation Reflections on finishing training Transitions and turning points Reflections on own practice	Opportunities Entry routes Belief in IAPT Engagement with CBT Model adherence Theory-practice split Professional identity and development Motivation Reflections on finishing training Transitions and turning points Reflections on own practice
Relationships	Working with others Ecologies of practice IAPT team relationships Supervision and performance management	Working with others Ecologies of practice IAPT team relationships Supervision and performance management
Threats	Threats Atrocity stories Comparison between IAPT services System issues Views on viability of PWP role	Threats Atrocity stories Comparison between IAPT services System issues
Working with patients	Working with patients Case management Clinical dilemmas Social suffering and complexity	Working with patients Case management Clinical dilemmas Social suffering and complexity

4.3.8 Data analysis: I-Poems and VCR analysis

For four individual cases in my sample, I experimented with the Voice-Centred Relational (VCR) method of analysis (also known as ‘the Listening Guide’) to see if I could access a different register of affect than I could from the methods already described (Gilligan et al., 2003; Gilligan, 1982; Doucet & Mauthner, 2008; Edwards & Weller, 2012). Following the Listening Guide involved a series of sequential listenings to ‘tune in’ to particular aspects of the person’s feeling voice, and how these came and went in the context of the interview (Gilligan et al., 2003: 159). The first listening (in fact, a reading) was similar to what I had already done, in that it attended to plot and the landscape in which the stories told were embedded (Squire, 2008; Doucet & Mauthner, 2008; Edwards & Weller, 2012). Doucet and Mauthner (2008) describe this stage as ‘a reflexive reading of narrative’ looking for ‘central story lines’ and bearing in mind the selectiveness of the readers’ observations (Doucet & Mauthner, 2008: 405). Dominant themes, contradictions and absences were also identified at this point (Gilligan et al., 2003: 160). The second reading focussed on the voice of the ‘I’ who was speaking, the participant’s first-person voice, and required construction of an ‘I-Poem.’ Every first-person ‘I’ statement within a selected passage of the interview transcript was pulled out in sequence on to separate lines, like a poem. This helped place the subject, the narrator, at the centre and allowed them to ‘speak about who *they believe they are*’ (Doucet & Mauthner, 2008: 406, italics in original). It highlighted the associative stream of consciousness within the text and moved the narrator’s subjectivity to the foreground (Gilligan et al., 2003: 163). Reading through these, and listening for voice, I found I could ‘hear’ one at a time, starting with the strongest and most obvious. When the ‘loudest’ voice had been exhausted (that is, all relevant lines of the I-Poem identified), I listened again for different or quieter voices. With each person, I ended up with at least five distinct voices that carried across each of their interviews. The next listening was for ‘contrapuntal voices’; that is, the juxtaposition of ways in which the subject expressed their relation to others (‘you’, ‘we’, ‘they’ statements, for example). It identified the voices of the participant’s connection to a social network, to close and intimate others, and was intended to recognise their ‘self-in-relation’ (Doucet & Mauthner, 2008: 406). Gilligan et al (2003) identified voices of resistance and of resilience in their work, an ‘I’ who spoke clearly and directly (‘I think, I feel, I want, I believe’) and one (‘the over-eye’) that observed, judged and was ashamed, thence over-riding or silencing the other ‘I’. Identifying these was an iterative process, over several interviews (Gilligan et al., 2003: 168). The final listening, in Doucet and Mauthner’s (2008) analysis was for ‘structured subjects;’ that is, the power relations and dominant ideologies that framed the subject’s narrative and an attempt to link the micro-level narrative with macro-level processes and structures (Doucet & Mauthner, 2008: 406). In my case, this stage was more about relating the analysis back to the research questions; bringing the separate

listening back into relationship with one another, and, in Gilligan's words, looking at the complexity of the person's expressed experience with fresh insight (Gilligan et al., 2003: 169). A more detailed account, with examples of the various stages, is given in Volume 2 at A9.

The method enabled me to identify a number of different 'voices' in which my participants spoke of themselves, their relations to others and the wider context. Even where the literal meaning of the text was transposed in the process of extraction (for example, negatives in the text, read as positives in the poem and vice versa), the I-Poems spoke with passion and feeling, in ways I had not been able to discern from the full text or even the audio-recordings. The I-Poems highlighted repetitions, reversals, contradictions, and metaphors which I had not noticed before and led me to question what they meant. The 'voices' of my participants, derived from this analysis, are described in Chapter 5. Examples are also given throughout the chapters which follow, where they relate to the themes under discussion.

4.4 Ethical considerations

My overall approach has been informed by a 'duty of care' to the subject, using a positive and relational (rather than prescriptive) approach to ethics (Hollway & Jefferson, 2000, 2013). By relational, I am referring to an approach, 'predicated on establishing ethical, credible, and agentic relationships characterised by mutual respect... discussion with research participants and collaboration around the resolution of problems' (Cunliffe & Alcadipani, 2016: 555). I have adhered to the principles set out in the ESRC (2012) and earlier sets of guidelines (SPA, 2009; SRA, 2003; BPS, 2010), in relation to ensuring voluntary participation, avoidance of harm, provision of appropriate information regarding the research, respect for anonymity, independence and scientific integrity. The research has also been ethically reviewed and approved by the NHS Research Ethics Service (application reference, 10/H1310/89, dated 05.11.2010) (see Volume 2, sections A1-A5 for copies of relevant documentation).

Ethical considerations have been present at every stage in the research, from the development of my research questions (see Chapters 1 to 3), gaining access to the fieldwork site (see 4.2.2), through recruitment, data collection, analysis and reporting (Kvale & Brinkmann, 2008). This section describes how I have dealt with some specific issues in relation to consent, validity, confidentiality

and positioning. Further information from the formal ethical review process is given in Volume 2.

4.4.1 Validity

In terms of the data collection through FANI, I sought to maximise the amount of control the interviewee had over what was talked about during each interview, and to allow them freedom to move away from difficult topics, if they wished to (Hollway & Jefferson, 2013). Having more than one interview, spaced several months apart, gave participants (as well as myself) time to digest each interview experience, to reflect back on the thoughts and feelings evoked, what had been said and what left out, and thus to have a part in interpreting their own data. In terms of my own role, I took an 'attitude of inquiry' (Marshall & Reason, 2007). I checked, questioned and sometimes tentatively, and in a limited way, theorised what I heard, within the interview setting (Kvale & Brinkmann, 2008; Miller et al., 2008). The bulk of the reflection, checking and analysis however took place outside of this context, in the re-listening, the long analysis process, discussions with peers and supervisors, and in the writing up (Kvale & Brinkmann, 2008; Hollway & Jefferson, 2013).

As already specified (see 4.1.3 and 4.3.6-8 above), the main protection against the risks of 'wild analysis' (Hollway & Jefferson, 2013: 154) were the multiple viewpoints in the data, the use of different and overlapping methods of analysis including a long period of data immersion, balancing single case studies with cross-sectional and over-time comparisons, and the use of interpretive panels and supervision (Clarke & Hoggett, 2009). I have sought to protect against the 'knowingness of the researcher' (Thomson, 2010), by recognising my own defences, both as researcher and as a person who has seen a therapist for a CMHP. I have attempted to leave room for doubt, to value the agency of my respondents, and not to over-interpret their responses (Frosh & Emmerson, 2005; Hollway & Jefferson, 2013). I have also involved respondents in the development of the research instruments, the piloting of these, and in dialogue over the emerging findings (see 4.1.1-4.1.3 above).

4.4.2 Consent and confidentiality procedures

A particularly important consideration with psychosocial research, where unconscious dynamics are under investigation (as well as social processes), is how to ensure participants really know what it is they are consenting to, when they agree to take part. As well as being as candid as possible in my introductions and provision of information about the study (see Volume 2, A4),

I had regular conversations with my respondents, about what my interests in the research were, how my perspective may have differed from theirs, and how I hoped to use what they told me. Consent was thus very much a process, which continued for the duration of fieldwork and afterwards, during the analysis and preparation of conference presentations. It was a distinct advantage that the main respondent group for this research were articulate, educated and well disposed towards research. I guaranteed to protect their anonymity and confidentiality in all the standard ways, using pseudonyms, numerical identifiers and 'disguise', where appropriate (Wiles, 2013; Miller et al., 2012). All transcripts and audio-recordings were password protected and labelled with numerical identifiers and pseudonyms, rather than real names. All data summaries and other outputs from the analysis also used pseudonyms, and place names and other clearly identifying details were changed or removed. The audio-recordings were stored securely on a standalone computer in a locked room at the University, and on the University's secure server. No-one who took part in the research was identified to anyone else, and especially not to the IAPT course team or service. However, in practice, several participants chose to talk to each other about the experience of being interviewed. Respondents were also keen that I should feedback my findings to service managers, and were pleased when I told them about my presentation plans, sent them draft conference papers to comment on, and illustrated these with de-identified examples of what they had said.

One further set of considerations related to the 'assessment pressure' that the trainee group, in particular, were under whilst I conducted my observation. To ensure I did not add to this, I consulted regularly with the CTs regarding which sessions I planned to attend; if they felt a particular session was inappropriate, they let me know. I also made it clear in the letter to trainees that at any time they could let me, or a CT know if they felt uncomfortable with my presence, and ask me to leave. This never happened. In fact, trainees tended to ask me where I had been, if I missed a session or date that felt significant for them.

In relation to the time commitment needed to take part, participants chose their own dates, times and venues for interview (see 4.3.3 above). Most opted to meet in their own homes, at the start or end of a working day, or occasionally over an extended lunch-break. As well as having control over the duration of the interview, they repeatedly told me they found it a useful space in which to reflect, for their own well-being, and for their training and clinical practice. During fieldwork, I also offered participants the opportunity to see their

individual interview transcripts. One person took this offer up, but did not comment further after I had sent them; she seemed only to be checking that I would keep my promise.

4.4.3 Positioning the researcher

In relation to my respondents, I was older than the PWP's and some of the HITs, and a similar age to the more experienced HITs and Group 5 members. In my introductions, I presented myself as a professional researcher, and felt recognised as such, although at times, I also felt myself taking on the role of trainee, peer, confidante, friend, supervisor or parent. My university affiliation and employment were important for the gatekeepers and 'group 5' respondents, and some trainees also commented on the prestige of my 'researcher role'. One or two even suggested that it was a privilege to take part, and I was wary of turning anyone down. Two respondents were slightly known to me in advance, and offered to act as 'critical friends' whilst I was developing my proposal, and the research instruments. They volunteered to take part, despite my stressing that they should not feel obligated, and in practice, their interviews felt no less open than other respondents. Over time, I felt enlisted by those whom I observed, to 'bear witness' to how hard they had to work and study, and to share in some of the highs and lows of their experience. As described in Volume 2 (A9.14), the experience of being an observer was a demanding one. Similarly, during the interviews, there were times when I felt pushed and pulled in different directions, and found it difficult to keep in role. Nonetheless, interviewing felt like a mutual and equally engaging process. So, it is to their life stories and experiences as IAPT trainees and workers that I now turn.

Chapter 5: Starting points – the journey into IAPT

5.1 Introduction

This chapter introduces the main study participants, the fifteen individuals (nine PWP and six HIT) who took part in the FANI interviews (see 4.1.1 and 4.3.3) about their experiences prior to and since joining IAPT. It provides background on their life stories, outlook and motivations as context for the findings that follow in Chapters 6 to 10. The focus of this chapter is on what has led participants to become IAPT recruits, following my opening question to them all, to ‘tell me how you got to this stage in your life where you are now training to be (or practicing as) a PWP or HIT.’ It reports participants’ accounts of their immediate entry routes to IAPT (5.3), their social class and educational backgrounds, family dynamics, major life events and exposure to trauma, their role models, aspirations and sources of support (5.4) and their motivations to train (5.5). It provides a narrative to Table 4.1, in the previous chapter, where participant characteristics were summarised, for ease of reference.

I argue the main things participants have in common are: a desire to be part of a new organisation and service; seeing IAPT as a ‘golden opportunity’ not to be missed; and, a fairly uncritical belief in the ‘evidence base’ and efficacy of CBT. They also share a degree of anxiety for themselves about being ‘good enough;’ a determination to have a career in mental health; and, a history of either their own, or a close family member’s physical or mental health difficulties, and being helped through some form of talking therapy. The main differences I identify relate to individuals’ age group and generational position; the security of their prior occupational roles, levels of work experience, mentoring and training; their priorities in terms of work-life balance and mobility; and, their views on IAPT as an end in itself or as a stepping stone, in career terms.

The chapter opens with extracts of the I-Poems from four individuals (5.2) on whose transcripts I conducted VCR analysis (see 4.3.8 for details on this

method). I describe some of the different 'voices' I identified from this work with a view to helping the reader to keep the changing internal voices of my participants in mind, whilst reading the results of the narrative analysis in subsequent chapters.

I have chosen to present the bulk of this chapter thematically and have changed details (e.g. former occupations) to be less specific, to prevent individuals from being identifiable. It should also be noted that the narratives supplied were seldom chronological and sometimes covered the same events and circumstances more than once, with new reflections and layers of detail added each time. The bulk of information was imparted at the first interview, which had a biographical focus, although points of detail were revisited in later meetings. With the I-Poems in this chapter, I have kept extracts from particular individuals intact, but have used extracts from more than one person to illustrate the 'voice descriptions' (in 5.6 below, and Volume 2, A9.12.2).

5.2 In their own voices: extracts from I-Poems

Extract 1: A PWP trainee

I worked
I looked young
I was very, very petite
I looked even younger
I went on this challenge
I worked
I was really up and down
I didn't enjoy working
I really liked that.

I was only an assistant
I was very honest
I wanted to progress
I ran group therapy
I was on a few care teams
I'd have a lot of input

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I got a lot out of it

I really enjoyed it

I wasn't really going anywhere

I had this big debate with myself

I wanted to go

I could have done it

I did like that role

I thought no, I've got my psychology degree

that's what I wanted to do

I did apply

I never got an interview.

=====

I'm one of these people

I won't

I won't

I took a bit of a 'that's it!' attitude

I took it personally

Maybe I shouldn't have done looking back.

=====

I thought I'd go back to basics

I liked the idea

I dropped a hell of a lot

I applied for the job

I got it

that's how I came to be a PWP trainee.

Extract 2: A HIT trainee

I applied for any job

I was able to

I thought

I should have done nursing

I was stuck
I came across a job
I'd never particularly thought about
I did it
I think
The best move I made
I could work
If I needed the support
I got a lot out of that
I worked there for three years
The best job I ever had.

=====

I'd before
I'd got this job
I'd got experience

I'd been doing those
I knew
I knew that IAPT
I knew about IAPT
I knew
I'd read about the stuff
I knew
I knew
If I didn't do it
I would need to get a core profession

=====

I spoke
I pursued the thing
I thought if
I want to stay
I can

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I've had those three options
I can do that
I've not got a qualification
I think a few people thought
I could do it
I could have stayed
I started
I just thought
I'm just going to give it a go

=====

I had this big dilemma
I'd applied three times
How could I not?
If I wasn't sure
I was going to take it
I shouldn't go
I decided
I should just go for it
That's how I ended up here today.

Extract 3: Another PWP trainee

I've always been fascinated by people
I've
when I was a child
I first heard about counselling
I thought
I experienced counselling myself
I was thinking
I could possibly
I
I'm a very caring person
I help my friends out....

=====

I'm stubborn
I'm a stubborn person
I was not going to let them put me back
I was going to
I knew
I could do it
I had
I had such a wonderful group of friends....

I dread to think what would have happened
If I hadn't had that kind of help
I don't know how
I would have climbed out of that hole.

=====

When I applied
I've just been really lucky in the people
I've had round me all along...

=====

I'd got the IAPT interview
I had the IAPT interview
I expected a phone-call
I didn't get one
So, I rang them
I just assumed
I obviously haven't got one
I was disappointed
I had been playing it cool
'yes, yes, I want the post!'
I was writing on my pad
I couldn't hear properly.

Extract 4: Another HIT trainee

I suppose going right back
I'm mental health trained
I, I, I suppose
I worked
I did have an interest in CBT
I was going to start looking
I got a job
I can remember saying
I said
'Well I wouldn't mind doing the CBT training'
I said that all them years ago
I guess
I got doing other things

=====

I needed to do something more
I did a degree
I enjoyed doing that
I could tell really
I was getting a bit fed up
I felt as though
I'd been in it too long
I felt
I was less happy with the job
I was incorporating some CBT
I was doing it

=====

I wasn't thinking IAPT
I wasn't thinking
I don't by the way
I was

I knew
I knew the manager
I also knew some of the others
I did have close links with them
I was team lead there
I was aware of IAPT
I wasn't looking at IAPT
I wasn't looking at CBT
I wasn't looking at doing any further training
I'd said to myself
I don't want to be doing any training
I'm not bothered now
I was very much
that wasn't for me
=====

I applied for the job
I spoke to them
I realised I hadn't
I didn't know until the morning
I was going
I went for this interview
I thought obviously
I'd better do my best
I found out
I'd got the job
I was in disarray
I was in total shock and disbelief
What the bloody hell have I done?
I never wanted to go back to Uni
What am I doing?
I was still in disbelief
I can remember
I had to go

I goes

I talked myself around

I suppose

I had to really.

5.3 Entry routes into IAPT

5.3.1 The HIT therapists and HIT trainees

As might be expected in view of the level of experience required for the role, HITs in my sample mostly had substantial work experience and came to IAPT from a range of occupational backgrounds. All but one had received their HIPI training through IAPT (in either the first, second or third year of IAPT training provision). One had trained prior to IAPT as a cognitive behavioural psychotherapist (CBP) following the traditional part-time Master's degree route and had joined the local IAPT service in the year prior to my fieldwork. One was considerably younger than the rest of the group and had a work history similar to many of the PWP's.

Two HITs came in via Teaching Assistant and PCMHW roles. Those who had worked in 'core' helping professions previously practised mainly in Occupational Therapy (OT), Social Work and Mental Health Nursing. All found the move from their old roles to IAPT a steep learning curve, which created tensions and discomfort in the process. Having a 'core' profession was not necessarily felt to be an advantage.

There is a contrast too between the experiences of the younger entrants relative to their older peers. For Stephanie, the HIT trainee role followed on from her most recent post as a PCMHW. IAPT was the culmination of six years planning and preparation and four years part-time training in CBT, enabling her to gradually build a portfolio of qualifications, with relevant clinical and organisational experience. For Anna, the HIT role was the latest in a series of promotions she had achieved since graduating; she moved quickly from a Support Worker role, into more specialised nursing assistant and therapeutic roles. After gaining a basic CBT training to help with her application for IAPT, she did not struggle to the same extent as others to re-define her practice.

There was also variation in the stability or consistency of individual career trajectories prior to entering IAPT. Jill, for example, had spent 30 years working for the same employer, in a variety of roles, connected to her core training in social work. Martin however had reinvented himself professionally several times, moving between institutions and self-employment. Andrea qualified prior to IAPT and worked privately, following many years working in public health and community work. She joined the IAPT service for improved job security after her partner lost his job.

When looking at reasons for applying for the IAPT role, a number of stark contrasts become apparent. For some, the degree of choice, opportunity and excitement involved in applying was more limited than it was for others. Some felt compelled to apply due to real or threatened redundancy happening within their organisation, forcing them to look for alternative employment. For some, moving to IAPT was the culmination of long held ambition and planning, involving careful preparation, in order to secure a paid training and clinical role. Most saw IAPT as a 'golden opportunity', which could not be missed. Everyone nurtured a desire to work in a helping role, expressed commitment to public sector values, and welcomed the supervision and training available.

Amongst those who had followed a standard educational route straight through from secondary to higher education (and then into the graduate labour market), degree subjects included psychology or a social science followed by some form of professional postgraduate training. Amongst those who left school at 16, the route to IAPT was longer and included periods of relocation, living abroad and/ or not working due to illness and/ or parenthood. For these individuals, a series of chance job opportunities combined with changing personal circumstances preceded their arrival in IAPT and led to a more or less considered decision to apply.

Only the two younger HITs (Anna and Stephanie) had considered (and rejected) Clinical Psychology training. Individuals received varying support for making their IAPT applications. Anna showed great persistence and motivation in applying multiple times, over separate years and different services, before finally being successful at the study site. She had strong support from her family and actively sought feedback on her failed applications to find out what additional training and/ or experience she needed to get shortlisted. Others felt they benefitted from the encouragement and/ or mentorship of particular colleagues and/ or friends, both in telling them about IAPT in the first place

and in helping them to prepare for application and interview. For Joanne, the move to IAPT was unexpected and prompted by the threat of redundancy from her previous role.

5.3.2 The PWP's and PWP trainees

All but one of the PWP's had completed a Psychology Degree. Two completed their degrees as mature students. All but one who previously had a consultancy career, were in their 20s at the time of being accepted into IAPT.

Typical job roles after graduating were Support Worker, Assistant Psychologist, Advice Worker or Nursing Assistant. One trained initially as a PCMHW in another service, before moving to her current PWP role. Those who had taken Support Worker roles worked in secure prisons and on acute psychiatric wards, in services delivered by both public and private sector providers. Unlike the HIT trainees, all the PWP trainees had considered Clinical Psychology as a career route and most were keen to pursue this at some point.

Two came into their PWP roles straight from their first degrees. All arrived with high expectations of the role and the local service, having researched what IAPT was about. They defended their interest in the low intensity role at interview yet saw it as a chance to get their foot on the ladder of a career in mental health, a stepping stone towards Clinical Psychology. Only a couple appeared to be interested in and to enjoy the PWP role in its own right; these individuals looked towards IAPT HIPI training rather than Clinical Psychology as a longer-term option.

The newly recruited trainees were all eager and determined to make a success of the role when I first met them. The PWP's who had trained in earlier years and who had more experience in the service were however ambivalent. Vicky, one of the longest serving PWP's, was jaded and looking for ways out when I first interviewed her. Steve, who was in his post-qualifying year when I first met him, was positive about the role but also determined to move on. He disliked the high volume and wanted to be able to engage in a more therapeutic way with patients. Kay, who trained initially under the PCMHW scheme, was adjusting her practice to meet the requirements of the new IAPT service. She perceived the new service standards to be more rigorous and was pleased to be getting supervision and professional development; however, by

the time of her second interview, she too was looking to get out and feeling that she had reached saturation point with the work and what she could learn in the role.

5.4 Themes from the life histories

I found five themes from the individual life stories which recurred across the whole sample. These themes concern the social class and educational background of my respondents, the dynamics of their early and later family lives, adverse life events they reported, their experience of role models and the aspirations they held when younger, as well as their main sources of support. They give a sense of the factors which may have shaped participants hopes and expectations when they joined IAPT and their motivations to work in mental health. I revisit these themes in relation to the research literature in the final discussion section of this chapter (5.7) and in Chapter 11.

5.4.1 Social class and educational background

Stephanie, Sarah, Kay and Joanne described having 'working class' parents and experiencing significant financial hardship growing up. They talked of their parents as being 'hard working' and as being role models, who were 'intensely proud' of their children's achievements. In Sarah's case, her mum had to work at three different jobs to reduce their debts and to manage financially as a single parent. Joanne's mother longed to live in a semi-detached house, rather than a terrace and for her children to get shop or office jobs rather than to work in the mines. Jill and Martin were the children of armed forces' fathers and moved around frequently when they were young. Jane and Vicky moved a lot too, as the children of professional scientists. Maria, Rachel and Sue had 'stay-at-home' mothers and their fathers worked in financial services. Anna, Vicky, Steve and Jane came from families where one or both parents (and/or step-parents) worked as healthcare professionals.

Joanne, Martin and Rachel left school aged 16 and began their working lives in service industry jobs, returning to study as mature students. Rachel undertook an Access course to gain her full-time University place, whilst Joanne studied part-time whilst working, gradually progressing through different levels of nursing qualification and then specialising in mental health at graduate and postgraduate level. Sue also obtained her degree as a mature student whilst working, after having disrupted schooling due to ill health.

Whilst Joanne and Sue's schooling was disrupted due to periods of illness, Vicky had to repeat a year of school, after moving abroad with her family. For Joanne, Sarah and Rachel, secondary education was a disappointing, even scarring, experience and one they couldn't wait to leave behind them. Anna, Jill, Vicky, Steve and Jane all went straight through from school to University and post-graduate level training.

Amongst my older (30 years plus) participants, all were home-owners currently and had experienced or were still experiencing financial hardship in their own working lives. This was due to relationship breakdown and becoming a single parent; having low-paid or unsatisfactory work, having a non-working partner, or needing to take time off work for children or ill-health reasons. Those who had made previous career changes had also lost out on salary progression. Steve could only make ends meet as a PWP by working part-time and combining his NHS salary with private sector work in his former job role. Amongst my younger and mainly PWP participants, most were living in rented accommodation and only Anna was a home-owner.

5.4.2 Family dynamics

Participants talked about their families of origin in different ways; it was certainly not uncommon to have experienced the break-down of a parental marriage, in some cases, more than once; and for these to be followed by the re-partnering of either or both parents. Some had problematic relationships with their new step-parents, particularly step-fathers, whilst for others it was the arrival of additional siblings which created challenges. Others felt they had adjusted well and reported being close to their new step-parents, as well as being in close contact with both parents. Sarah and Vicky felt their relationships with their fathers had suffered and reported only having intermittent contact. Martin and Chrissie had both lost a parent at a young age. Sarah and Andrea were only children; while Stephanie, Anna, Sue and Jane had three or more siblings. For those who were the oldest child, there sometimes came responsibility for looking after the younger siblings which they described as having a lifelong impact.

At least three of my respondents had become parents themselves at quite a young age and one had a 'second family' in his 40s. Amongst the older respondents, all but one had experienced the break-down of a long-term relationship and/or a period of being a single parent. Amongst the younger

respondents, half were cohabiting with a spouse, friend or partner and half were single.

5.4.3 Life events - experiences of illness and trauma

Most respondents had personal experience of either their own, or a close family member's anxiety and/ or depression which had impacted on their personal relationships and choice of career.

Two participants had life-long physical disabilities, which had a significant impact on them growing up. One HIT's condition was not properly diagnosed until she went to University, by which point she had learned to cope largely by herself. During her training and in her IAPT role, she had 'reasonable adjustments' to take account of what she was not able to do. One PWP's condition required multiple hospitalisations as a child and led to her coming very close to death in her final year at school. Although physically recovered, she experienced PTSD whilst at University and continued to be alert to the impact of trauma on herself and others.

As already described, several respondents had caring responsibilities for younger siblings whilst growing up and/ or continued to feel responsible for their welfare. Several also described experiencing bullying as a child, which had an impact on their self-esteem. Three left home before the age of 18 and two had serious childhood illnesses which interrupted their time at school. A couple described having mothers and/ or other female relatives who were depressed; others had experienced serious physical or mental illness within their immediate families, either a parent, sibling or close cousin. One cared for a sick child. Amongst the older respondents, several reported having experienced periods of debilitating depression in their adult lives, which had required them to seek treatment. Amongst the younger group, three reported having had mental health difficulties in their teenage years and two had received counselling.

5.4.4 Role models and aspirations

When I started interviewing respondents I was struck by the intensity with which the younger group, especially of PWPs, longed to have 'a career.' With so many still in their mid-20s and within a few years of graduating, it was not surprising that they were keen to establish themselves in a career with professional standing.

Another striking feature of respondents' accounts was how often a significant helper or role model at school, University or in early working life appeared to have made the difference in enabling them to achieve what they wanted. For Sarah and Sue it was their mothers who impressed them with their initiative and proactivity; one in paid employment, the other through volunteering. For Anna and Jane it was their step-mothers who offered particularly pertinent advice and support when it came to applying for University places and/or jobs in the mental health field. Sarah was also influenced by a teacher at school, encouraging her to apply for a degree course and both she, Stephanie and Joanne were the first in their families to go into Higher Education. At work, both Anna and Sarah made good alliances with senior colleagues who backed them to do further training and to apply for promotion. Jane, Jill and Anna found out about IAPT and got advice on their applications, from a family member or work colleague, with good 'inside knowledge' of the field.

Amongst the established PWPs and HITs, one NHS Service Director was mentioned as having given specific and meaningful support to help them meet their personal and professional goals. Two PWPs cited their positive experiences of counselling whilst in their teenage years as having influenced their outlooks; and at least two HITs and four PWPs described having had their own psychotherapy or counselling in adult life.

5.4.5 Sources of support

Those who came from traditional working-class backgrounds talked of having strong family support which included a willingness to make sacrifices on behalf of the whole family to meet their needs. Some described work colleagues and supervisors as having provided support or advice at critical junctures and a few had made specific close friendships at work which sustained them through personal crises.

For those who had moved to the city to take up their IAPT posts, peer group friendships which extended beyond the working day, were particularly important. Those who had grown up in or near the city, reported still having contact with school friends and extended family members living in the area.

One HIT opted to undertake her own personal therapy alongside her IAPT post whilst she was training. Others took up counselling or Occupational Health Service support (OHS) after starting work in the service. Two HITs and one PWP described feeling supported by a religious faith and one HIT had experienced this in the past, but no longer identified in this way.

5.5 Motivation to train

Participants' attention was brought to IAPT by parents, family members, colleagues, friends and other mentors as well as by their own research. Most were aware that it would be a time-limited opportunity to gain a paid training and that every effort should be made to get on board, before the funding and political initiative ran out. For the PWPs, starting out on their professional lives, it was simply 'the best opportunity available', one which offered potential to gain clinical experience quickly and to advance ambitions towards a career in Clinical Psychology. For Maria, IAPT was a chance to 'catch up' career wise, after a number of false starts; for Jane, it was a chance to work with a different client group (adults rather than children) and to earn enough money to live away from home. For Sue, as a non-psychology graduate, it was simply a golden ticket to a career path she thought would otherwise be unobtainable and the prestige of being a mental health worker.

For the HIT trainees, IAPT offered the chance to re-train at a salary commensurate with their prior experience, thus enabling them to take the gamble of starting over again, sometimes quite late on in their working lives. It also promised much needed job security - and at the very least, a transportable qualification.

Participants recognised a link between their own and/ or their families' experiences of mental health difficulty and their desire to train. Martin, for example, felt he had a long-term pattern of over-working which could adversely affect his health, until he learnt about CBT in a previous job role and found it helpful in breaking the pattern. For Andrea, on the other hand, training was a way of capitalising on the experience she had gained in community health and volunteering, whilst living abroad. She saw it as a stepping stone to building a career working with people from diverse backgrounds. And for Kay, it was her own experience of struggling as a young adult which changed her view on the importance of talking and what would

make a meaningful career. She described it as ‘a eureka moment’ when she realised that she could help other people, in the way that she had been helped, by talking.

Almost all the HITs expressed a commitment to public sector values, whilst for PWPs this commitment was not so explicit. For Martin, the motivation to re-train came from a desire for job security and structure, but also a strong set of ethical or ‘spiritual’ values. He described wanting to focus on ‘being of value to society,’ to help others to ‘have a good life’ and his own feelings of ‘empathy and compassion’ with those who suffer. He recognised ‘a common thread’ between his former job roles, religious experience and his current desire to create change.

For everyone, IAPT represented a considerable investment of hope and belief, as a new service meeting a population need for talking therapy and using ‘evidence-based’ treatments. Everyone had heard about the ‘evidence base’ and believed in CBT as treatment of choice. Some were aware of the criticisms of CBT but were prepared to suspend disbelief. Others professed wholehearted belief regardless. Most deepened their attachment to CBT as time went on (see Chapter 8). Respondents sometimes expressed doubts about the low intensity ‘variant of CBT’ delivered by PWPs, but most were uncritical about the modality as a whole. Those who had had experience of receiving counselling or CBT previously, valued CBT’s ‘common sense’ approach and sometimes spoke in quasi-religious terms about it having ‘salvational’ qualities. Several felt guilty at ‘jumping ship’ and leaving former team mates behind. All were intent on doing their best and doing well.

5.6 ‘Voice’ descriptions

At different times within and across each interview, different ‘voices’ are identifiable in my respondents’ accounts of themselves (see 4.3.8). Without being an exhaustive list, and based on three complete cases only, I ‘heard’ the following in my participants’ narratives:

- *IAPT champion/ dedicated worker voice*: business like and purposeful, committed to the role, prepared to believe in it, hardworking, responsible, ethical and conscientious. This is the voice of the aspiring

professional. It is practical, good at reasoning and problem-solving (a kind of internalised CBT). It is also suggestive of the model IAPT trainee and research respondent. (See Chapter 8, and Volume 2, A9.12.2, for examples).

- *Voice of belonging*: the energetic 'I' that is knowledgeable, identifies as a professional, has a desire to try new things, and takes pride in team and service achievements. It is relational, drawing strength from interconnectedness with other professionals, friends and family. It tells a story of belonging, collaboration and collegiality, of 'we' and 'us,' as well as 'I.' (See Chapter 8).
- *Voice of nostalgia*: the voice which misses past good times that have now gone; childhood with family and school friends, first jobs, University peers, early role models and supporters. It speaks of love for fellow trainees, and shared hope for a bright fulfilling future. (See Volume 2, A9.12.2, for examples).
- *Epic dramatic voice*: a strong story-telling voice, with a heroic quality to it. It uses graphic metaphors, juxtapositions and imagery to re-enact episodes and moments of high drama from work and personal life. It is animated and engaging, fluent and fast paced. At times, it is excitable and uncontrolled, at other times rueful, and insouciant. Sometimes linked with a '*rebel girl*' voice; the voice of defiance when 'type-cast' as young and inexperienced, as a CBT'er, or 'wannabee'; it is energetic, vital and uncompromising. (See Chapter 8).
- *Combative angry voice*: the voice of defiance against the IAPT system, which erupts in reference to injustice and a lack of care for self and co-workers. It is louder on the inside than on the outside; bitter and corrosive at times. (See Volume 2, A9.12.2, for examples).
- *Voice of resilient determination*: the voice that galvanises the speaker when their energy is flagging; it is quietly determined, helping the speaker move forwards after disappointments and setbacks. It is compassionate, to self and others; recognises the need for support and for independence. It accepts being 'good enough,' whilst striving for the best. (See Chapter 8).

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- *Fragmented, crumbling voice*: expresses self-doubt, weariness and frustration. It is inarticulate, choppy and hesitant, suggestive of undigested affect. It is disjointed, uncertain and cannot stand back and reflect. It is often diffident and self-critical. (See Chapter 9).
- *Reflexive, observing voice*: a contemplative voice which is rueful and self-deprecating, honest, self-aware and self-disciplined, even humorous. Notices mood swings, habits and irrationalities in self and others, and thinks about how to improve things. It conveys a willingness to learn from experience and a capacity to self-soothe; it suggests an internalised supervisor voice. (See Chapter 9).
- *Othering, critical voice*: a self-conscious voice, that speaks of ‘them’ and ‘they’, the others in the IAPT system, those with intractable problems, different ways of working, and/ or who observe, assess and don’t respond in the way expected. It sounds benign, but suggests a defence, a boundary, a wish to withdraw. (See Volume 2, A9.12.2, for examples).

5.7 Discussion and conclusion

This chapter has addressed a number of themes which are relevant to understanding PWP and HIT role transitions, professional identity and orientation to practice. The themes relate to their entry routes and expectations upon joining an IAPT service; their life histories, and their motivation to train in a psychological therapy, such as CBT.

With regard to their entry routes, differences were found between PWPs and HITs, of the kind specified in selection guidance (IAPT, 2009). PWPs were generally younger graduates with a couple of years’ relevant work experience, whilst HITs were generally older, with a variety of prior qualifications, job roles and occupational trainings behind them (see also, Table 4.1, in chapter 4). There were differences between those individuals who had planned for and prepared their moves in the direction of IAPT for a long time, and those who felt driven to apply by circumstances connected with their existing employment. Everyone however recognised that IAPT was a time-limited ‘golden’ opportunity that was important not to miss, as described by Norcross

and Farber (2005) (see 3.6.1). All had high expectations of the training, work and rewards offered by the new roles, even where they had already been on the receiving end of an earlier government initiative directed at primary care mental health, which had not been sustained (for example, the PCMHWs programme). The majority of PWPs also had clear intentions of positioning themselves to pursue Clinical Psychology careers in the longer term.

In terms of their life histories, a major difference to emerge was that of the occupational and social class background of sample members' parents. Whilst I did not set out to systematically collect this information, participants sometimes talked about their backgrounds in class terms, and described their educational experiences in ways which seemed to be closely linked. For example, several had negative experiences of schooling, entered the labour market relatively young (aged sixteen) and spent several years working in jobs that did not satisfy them, before returning to study and trying out new careers. This matches the kind of trajectory described by Walkerdine et al (2001), in their study of young girls growing up against a back drop of deindustrialisation, high male unemployment and an increasingly feminised labour market. By contrast, others appeared to follow a more straightforward path through compulsory education, into higher education and entering graduate careers. Savage et al (2013) describe these kinds of differences as combining economic, cultural and social capital components, which define and differentiate seven main groupings, in contemporary Britain (Savage et al., 2013: 230). These include a small elite social class (with high economic, social and cultural capital), an established middle and technical middle class, a new group of 'affluent workers', a much smaller group of 'traditional working class', emergent service workers and a 'precariat' (with minimal capital of any kind) (Savage et al., 2013: 230). I have ascribed these categories to the information given me by respondents (see Table 4.1, in chapter 4). Whilst the dividing lines between these groupings are in many cases quite fluid, they do broadly appear to connect with the different career trajectories described by my respondents.

In terms of motivation to train, the theme of early losses is prevalent amongst my participants, as predicted in the literature (Farber et al., 2005; Wheeler, 2007; Barnett, 2007) (see 3.6.1). There are thus some signs that amongst my sample, several could be described as having the potential to be 'wounded healers,' having had troubling childhood experiences, a desire for self-healing and experience of personal therapy or counselling of some kind (Gilbert & Stickley, 2012; Wheeler, 2007). Another feature which comes out of the life histories is the importance of role models in the family and at work, in

shaping individuals' aspirations and choices. This accords with the literature on the importance of role models (Safi et al., 2017) (see 3.6.1), and points to the continuing relevance of class and social capital in the way expectations are formed as young women grow up (Walkerline et al., 2001). There are also individuals in the sample (not necessarily defined by age) who present as the 'current' generation in terms of attitude (Farber et al., 2005); that is, they show a strong research orientation and desire to develop cognitive skills. Others appear to be driven mainly by intellectual curiosity and psychological mindedness (Denollet & Nyklíček, 2005; Farber et al., 2005). Several of the PWPs and HITs, appear to have strong intrinsic and prosocial motivations for joining IAPT (Dill et al., 2016), in that they believe in IAPT's goals, want to help others, and have a determination to work in mental health. The HITs in particular appear to value the extrinsic rewards promised by IAPT, in making the decision to apply (Dill et al., 2016). This is understandable given that for the most part, they have more to lose (than PWPs) from giving up their former careers and job roles, although one or two PWPs also described having difficulty leaving their old jobs behind.

The IAPT recruits in my sample shared anxiety and excitement about what lay ahead, in ways that would suggest they were making a substantial emotional investment in their future roles and training (Stronach et al., 2002) (see 2.3.4). They were all enthusiastic, relatively uncritical about the 'evidence base' for IAPT and CBT, and willing to believe in CBT's efficacy (Plchová et al., 2016). In their desire to see improvement, they had much in common with what Cooper and Lousada (2005) describe as frontline workers' belief in 'newness' when faced with longstanding difficulties of unequal service provision (see 2.5.3). One or two admitted to having an interest in other modalities (particularly psychodynamic), and did not feel they were yet 'settled' in their theoretical orientation (Arthur, 2001). As described by Rønnestad and Skovholt (2013), all entered their training as cultural participants, with 'more of less consciously, elaborated conceptions of helping practices' (Rønnestad & Skovholt, 2013: 43).

Chapter 6 - The IAPT training year

6.1 Introduction

This chapter locates the trainees in the classroom setting and follows them through the course of the year. In Chapter 7, I look beyond the classroom, at what trainees experienced as they entered the world of GP practices and started their clinical practice. There are three main themes in this chapter: the process of getting into and staying in a new role; the distinctiveness of the training language used; and, how an IAPT attitude and set of practices are cultivated.

The chapter is based on my observations of Cohort A participants and their peers during their training year. Through the process of classroom observation, I attempt to 'render the familiar strange' (van Maanen, 1995), in the teaching and learning of core CBT skills for IAPT purposes. The chapter includes retrospective views of some Cohort XYZ participants regarding their training experience and views of the six PWP and two HITs in Cohort A, whom I interviewed for the first time mid-way through the training year. I also cover 'Group 5' respondents in this chapter. These are the IAPT Programme Director (PD), course teachers (CTs), NHS Service Director (SD) and service managers and supervisors (SUPs), who took part in focus group discussions and/or individual interviews.

In this chapter I report on the trainees coming together as a group for the first time, their induction and first few weeks of learning (6.2). I describe some of the topics covered and how the teaching and learning took place (6.3), the distinctiveness of CBT and the IAPT training discourse and how trainees felt juggling the competing requirements of service and University (6.4). In this chapter, I also look at how trainees prepared for their end of year assessment, the last teaching sessions and end of year planning (6.5). The perspective of CTs and SUPs on what makes a good trainee, the strengths and limitations of the training course and the challenges posed by the IAPT service model are covered at Section 6.6. I conclude with some reflections on what I observed

and heard, in relation to the literature reviewed in Chapters 2 and 3, and my research objectives (6.7).

Unless otherwise stated all non-italic indented quotations are edited extracts from my observation notes. Quotations in *italics* are verbatim, either overheard during an observation session or recorded at interview. I also use abbreviated terms as listed at the start of the thesis, to indicate who is speaking and combine roles (for example, referring to the PD as a CT, and the SD as a SUP), to protect confidentiality. Where quotations are used, I indicate which interview (1st, 2nd or 3rd etc.) it came from and the pseudonym of the respondent in brackets.

Although staff and trainees used several different terms to describe the recipients of IAPT services, such as 'client,' 'service user' or 'patient' (which I have kept in the quotations), I have chosen to use a single term 'patient' in the main text for stylistic consistency.

6.2 Getting started

After a short period of induction in their respective services, both groups of trainees began their formal training with an intensive immersion week (or two for HITs) at University. These week(s) included a combination of lectures, taught sessions and skills' practices. The two groups trained in adjacent rooms, with overlapping break times. My first encounter with the trainees was in advance of an introductory joint lecture on the development of IAPT and its competency frameworks.

Waiting outside the lecture theatre, I was struck by the predominance of young women, erupting into laughter and exchanging mobile phone numbers. Slightly later than scheduled we all filed into the lecture theatre and the CT introduced the lecturer, who invited the trainees to call out what their professional backgrounds and/ or degree subjects were. A high proportion indicated they had psychology first degrees; other common backgrounds were nursing, social work, occupational therapy and drugs/substance misuse services. Counselling training was mentioned, but more as an afterthought.
(14th October)

The lecture thus provided an insight into the composition of the trainee group. It also introduced the rationale for the new IAPT roles and how they were meant to inter-relate. The PWPs were described as ‘enabling communities, helping people psychosocially, whereas CBT therapists are all about treating symptoms.’ Within a stepped care model, it was said PWPs were ‘not inferior’ and the main difference between LIPI and HIPI work was the duration of treatment (i.e. number of sessions offered) and the complexity of care. It was argued PWPs had to be able to do ‘first contact and assessment’ work with suitable supervision, if the system as a whole was not to become bottle-necked at the entry point.

Even at this early stage, I observed, some instances of resistance to the official IAPT discourse:

The trainees became quite engaged with what the lecturer was saying and wanted to know more about the social context of the work. One asked ‘if depression is so common, like a common cold, does it mean depression is *normal*, given the society we live in?’ Another asked about the interchangeability of the terms ‘mental ill health,’ ‘mental disorder’ and ‘mental illness.’ They asked too about the use of other (non-CBT based) modalities in IAPT and the long-term recovery rates, acknowledging some of the policy critique.

The lecturer acknowledged these points and agreed it was important to think about the 50% of IAPT patients who ‘don’t recover’ at the end of treatment. He commented on how the evidence base used to develop the competency frameworks for the IAPT roles, linked directly to the NICE guidelines. He observed that these guidelines and frameworks were intended to protect against the ‘known concern’ of variability in individual therapist effectiveness and advised the trainees to stick as closely as possible to the specified interventions, to maximise their clinical outcomes. The trainees continued to raise questions, which were more often than not met with further questions from the lecturer, until the session had run beyond its scheduled finish time.

6.2.1 Musical chairs vs mass education

My first observation with just the HIT group felt like a game of musical chairs. It was held in a small room relative to the number of people in it and the amount of equipment: a DVD player, projector, desktop computer and

Chapter 6: The IAPT training year

screen. As well as two CTs, ten trainees and myself, the course administrator and a technician crowded in. It was uncomfortable and cramped and I felt awkward, although the two CTs also had stools and very little room. They spent most of the time on their feet. It felt like all of us were new and didn't quite fit together, as a group or within the wider institution.

The session began with a rapid round of introductions and I struggled to catch the trainees' names. I was not included in the introductions, although my presence was acknowledged. With little room to write and feeling constrained by my visibility at the front of the room, I became less of an observer and more like a student.

By contrast, my first experience of observing the PWP group took place in an exceptionally large meeting hall. It had space for thirty plus trainees to work in small groups and for me to sit and observe at one side. The most junior of the CTs was running the session on her own. It was a 'skills practice' following on from a teaching session on the subject of 'risk assessment.' As this was the first time I had encountered the group in person, I was invited to introduce myself and did so. I was also asked by the CT if I wanted to join in with the trainees to complete a role-playing exercise. I declined in the interests of keeping to my role as observer.

The CT introduced the session and admitting to feeling nervous herself in front of such a large group, offered to role-model the skills she wanted the trainees to practice. The group were then invited to take turns with each other and to provide constructive feedback. They chatted and laughed whilst repositioning chairs and then got on with the task. I tuned in and out of conversations whilst the CT hovered near by. There were loud eruptions of laughter as role players swapped over and gave feedback on each other's performances. I was impressed by what I saw; the caring and compassionate behaviour of the trainees towards their 'patients'. My gaze kept wandering around the room and I gradually started to notice individual differences.
(October 29th)

6.2.2 First teaching sessions: concepts and conceptualising

Over the first few observation sessions, I was impressed with how confidently and quickly trainees made use of phrases which sounded baffling to me: 'ABC model,' 'five areas approach,' 'guided discovery,' 'funnelling,' 'the four Ws,' 'behavioural activation,' 'triggers,' 'cognitions,' 'OSCEs' and 'empathy

dots.' I noted too how the CTs highlighted issues *not* on the national IAPT curriculum, encouraging trainees to think about strengths and resilience, rather than a 'deficit model' of illness. They suggested that where an individual could not identify strengths and resilience of their own, the therapist needed to ask whether IAPT was the right service for them. In the words of one CT,

IAPT is designed for a primary not secondary care population and people [should] only have strayed a little way off the tracks of their life, they shouldn't be completely off the rails. (CT, 4 November)

New concepts were introduced every session, often with vivid metaphors and imagery. 'Formulation' I learned, could be at different levels, was built collaboratively with the patient, and not delivered by the therapist 'like a rabbit out of a hat!' The 'main treatment level' was described as 'IAPT disorder-specific,' the place where the bulk of an eight-week contract with a patient should be spent. Differences between standard CBT approaches to formulation and the IAPT competencies were pointed out. Each formulation was to be seen as a framework to which 'change tools' were linked. One purpose of treatment was to come up with a new formulation by the end; revisiting it along the way would foster engagement, and help the patient understand what maintained their difficulties.

HIT trainees learned about 'suitability screening', and how the patient must be 'ready to contract' for treatment, or the treatment wouldn't work. CBT was described as 'not a panacea,' but an 'antibiotic,' to be given at a fixed dose, where the patient must finish the course. The importance of 'throughput' and 'help-ability' were also stressed. When a patient was considered 'unsuitable' for IAPT, the therapists' duty was to make 'a good referral'. They could 'step up' or 'step down' within the service (between PWP and HIT, or 'sideways' to counselling), or discharge, if the patient was not suitable for psychological therapy at this stage. The CTs suggested that 'clinical uncertainty' was normal in these decisions and supervision essential to ensure they made the right choices. PWPs were taught early on that assessment, involving 'information gathering', 'risk assessment' and 'creating a problem statement,' was central to their role. They were encouraged to use a 'five areas approach' to guide discussion with the patient, to identify risk by asking about suicidal thoughts or intentions, look for evidence of self-harm or neglect and risks to others, and ask about the patient's access to support. They were told not to diagnose, but to offer a choice of treatment options and to signpost patients on where

appropriate. Developing the 'problem statement', was an activity for the first meeting intended to list and prioritise the patient's difficulties. PWPs were advised to define conservative goals, with opportunities for early success. Their interventions had to be designed to be completed within 4-6 weeks, and to 'nail the right here, right now' (rather than 'historical causes').

The term 'OSCE,' borrowed from medical education, was also introduced early on. These structured clinical exams were the main method by which trainees' skills were tested, prior to starting each new aspect of their clinical role. They were spread across the year, and for the HITs, were combined with requirements to submit 'tapes' (or DVDs) of themselves in session with a patient, and for both groups, written reflections on their practice.

6.3 The first semester

Following the induction period, the first semester saw both groups rapidly covering ground: they learned the rationale and expectations of their roles, what IAPT offered to patients, assessment skills and clinical interventions (for example, behavioural activation (BA)). They were instructed on the use of clinical outcome measures, aspects of the therapeutic relationship and the HITs were invited to deliver clinical case presentations. This section looks at some of the metaphors and comparisons used to convey these lessons, and at interactions in the classroom. These conveyed the particular ways in which CBT, LIPIs and HIPIs were positioned in relation to other therapeutic practices and modalities.

6.3.1 What the trainees were taught about their role

PWPs were taught to assess new patients at step 2 (the stage of least treatment intensity) (see 3.2.3), and to focus on risk assessment, whether to caseload at step 2, or refer the patient on. It was stressed to PWPs that they needed to work within their remit and not get drawn into a counselling role. Their role was described variously as being about 'assessment', 'facilitating patient choice' and 'promoting self-help'. They were taught to 'reconnect' people with what they were good at and their support, and to use their 'common factors' skills (a language taken from psychotherapy research, which differentiates skills generic to all modalities, such as listening, empathy and curiosity and those which are specific to particular modalities, such as 'Socratic questioning' and 'guided discovery' in the case of CBT). Diversity awareness

was a strong theme, with trainees reminded that it could be ‘easier to talk about suicide than diversity’ with some patients. Opportunities were given to practise these skills.

HITs were also taught to be mindful of the boundaries to their role, to screen patients referred to them by PWP or GPs and to direct people who could not be helped within the recommended IAPT time limits to secondary care. Common injunctions from teachers included: ‘don’t follow the patient too much’ and ‘remember focus is the cornerstone of CBT.’ From the outset, trainees questioned how they should respond to patients with more than one difficulty and were told ‘avoid swimming in a co-morbid soup.’ Their job, it was said, was to help prioritise and to ‘do enough for the patient’s quality of life to improve.’ They were asked to manage the patient’s expectations from the outset, so that both parties were clear about the goals and prospects for treatment. Their task was described as a collaborative one, requiring openness and transparency and a clear ‘contract’ with the patient. Trainees were told to work with the end of therapy in mind from the outset and to manage the treatment process through the ‘change cycle’ with the agreed aims in mind.

6.3.2 Core skills: PWPs Learning about ‘behavioural activation’ (BA)

Over the course of a full training day, PWP trainees would typically have a taught session in the morning on the theory and principles behind a particular intervention, followed by an extended role-playing exercise and review session in the afternoon. I observed one whole day, along these lines, when the PWP trainees were taught about BA (for a full account, see Volume 2, A6.2). They quickly began to ask questions and to demonstrate their familiarity with how BA could help.

The CT suggested trainees practice the approach on themselves, using their reflective diaries. He reiterated how useful the category system was for patients and reminded the group that it was important to watch their own levels of pleasurable activity as they trained. Two CTs then presented a series of slides on the principles of BA. They talked about it being crucial to reduce the negative cycle of avoidance and inactivity and to lift the patients’ mood before attempting ‘cognitive’ work.

The next part of the morning was devoted to a role-modelling exercise, with the CTs showing how BA could be done. The trainees watched attentively

as one CT played the part of a patient and the other, the PWP. Their interaction became quite involved as they listed, discussed and categorised different activities, then put them into order and made a detailed plan for the coming week. An anonymised patient vignette was passed round, which the trainees were invited to use for their own role-plays. The CTs provided reassurance. A couple of videos were then shown of 'real life' PWPs doing BA with a patient, one 'face-to-face' and one by telephone. I noted the trainees' reaction and the CTs response to this:

The trainees watched and when invited to, raised 'learning points' from what they had seen, commenting critically on the language and tone used by the second PWP, who did the telephone work, on the video. The CTs agreed that 'you need to be very careful with language on the phone...'. They seemed a little concerned that the video was being dismissed too quickly and asked for any good points. The only point in favour the trainees could think of was that the process was 'very quick!'

This moment seemed to encapsulate a recurring dilemma for trainees, evident throughout the observation period and in participants' interview material, between the need to be pragmatic to get the job done and the desire to focus on relating well to the patient (see 6.7, and Chapter 11 for further discussion).

In the afternoon the trainees divided themselves up into three separate groups, each with their own CT. They organised into pairs or threes, negotiated over time allocation and started to role-play, taking it in turns to act the part of the patient, the PWP or to observe. As the afternoon progressed, I was struck by how fluent the trainees were. Their main concern appeared to be about keeping to time. I sensed they invested a lot in acting well. No-one was overly self-conscious and the group members were at ease with one another. The day ended with a 'review session' where trainees commented positively on how useful the practice had been. The CTs summed up by commenting on what they had seen; good examples of 'moving people on' and 'section-by-section' summarising.

6.3.3 HITS on 'understanding therapeutic relationships'

The HITS' taught sessions also included teacher-led presentations and role-playing or groupwork exercises. One such session in the first semester focussed on the place of relationship building in CBT, contrasting the *doing* nature of

CBT with the *interpretive* work of psychodynamic therapies. The minute by minute notes of this session are shown in Volume 2, section A6.4 and are summarised here.

The CT tells trainees.... it's really important to ask the patient regularly how he/she feels the relationship is going, to clarify with them what is and what is not helpful about it. In CBT, he suggests, there is a real sense of teamwork between the therapist and the client, 'a key difference from other therapies.' He stresses that despite CBT relying on technical and structured skills, there is still room for relationship development. An important point to remember he says, is 'that this person isn't going to get any other help other than from me, so I have to make it work.' He advises trainees to 'think about the alliance all the time.....and remember that your 9 o'clock person is very different from your 10 o'clock person.....' He expands, 'some people really want to tell a story....so it's important to listen to them; but others are more autonomous or reluctant to engage....so you need a different response.' (13th January)

In their responses to this session, trainees revealed their awareness of being under scrutiny; they talked about 'working to the camera', for the benefit of the supervisor who would watch the tape back afterwards, rather than the relationship in the room. They again raised the issue of managing time, and were concerned about 'leading' the patient and setting a realistic agenda for each session. The CT reassured them that listening to the patient and letting them talk was important, 'like putting money in the bank' for later on.

This led on to another common discussion theme, regarding what makes 'an effective therapist.' The CT stressed the difference individuals could make to clinical outcomes. He argued that even in IAPT, where the trainees were delivering 'protocol-based care', the evidence showed that 'therapist effects' would be strong. For this reason, it really mattered what they did. He suggested a lot of the difference between therapists could be attributed to the therapeutic relationship and that trainees needed to understand what it was that the 'more effective' therapists were doing.

The taught part of the session was followed by a discussion using written clinical 'scenarios' which were handed round. The CT asked trainees to consider how they would 'operationalise warmth', in the selected example. They responded that the patient needed to 'own' their 'core pain,' and that both patient and therapist needed to discover what had led to the patient's 'fall

from grace.’ The discussion moved on to think about differences between empathy and sympathy, the role of eye contact and allowing ‘space to let off steam.’

6.3.4 Classroom interactions

The way trainees and teachers interacted with each other conveyed the challenge of the learning process. Both teachers and trainees displayed occasional nervousness and discomfort at having to perform in front of others, hesitating to get started on role-plays and looking for reassurance and feedback after presenting. Sitting for too long and listening resulted in small outbreaks of irritation amongst the trainees. They and the CTs would withdraw from these moments of tension at break-times, to let off steam in separate informal refreshment spaces. There always followed a conciliatory joint discussion, upon resumption of the session.

With both groups, the CTs listened to trainees’ contributions, answered questions and provided constructive feedback. Over time, particularly in the younger PWP group, the relationship between trainees and staff became quite intimate and trusting. Humour also predominated, particularly when CTs admitted to times they too ‘got it wrong’ with patients. With both sets, the CTs worked as a team, taking it in turns to lead sessions and facilitate skills practices. They modelled the collaborative and democratic approach they encouraged trainees to take with patients.

6.4 Mid-year

The turn of the year and the second semester saw the trainees gaining further immersion into the language and concepts of CBT and the IAPT competency framework. During this period there were strong admonitions to both groups to ‘maintain focus’ and not treat everything, to avoid creating dependency and to help the patient ‘become their own therapist,’ to understand what CBT is not, and to appreciate the role of ‘simple solutions for complex problems.’ Alongside these messages about the nature of the interventions and their roles, trainees juggled coursework, practical exams and competing pressures arising from the service, GP practice and University.

6.4.1 CBT and the IAPT training discourse

The CTs warned against the ‘medicalisation of sadness,’ used metaphors from medicine, philosophy and business, in their teaching. The trainees were taught about the ‘phenomenology and aetiology’ of depression, about ‘symptoms, triggers, cognitions’ and conditions, what CBT does and does not work for. It was suggested the trainees’ roles were not about ‘cure’ but about strengthening the patient’s ‘coping strategies,’ and helping them to overcome their ‘intolerance’ of uncertainty, in the same way as an allergy might be managed. Psychoanalytic language was also used to explain and illustrate particular techniques. Trainees were advised to notice when ‘acting out,’ ‘splitting and projection’ occurred in their interactions with patients and to use their formulations as means of ‘containment.’ The terms ‘transference’ and ‘counter-transference’ were also indicated as a potential resource in treatment; and, the aim of being ‘good enough’ was repeatedly espoused, in speaking to trainees’ anxieties (see Chapter 5). In relation to patient complexity and socioeconomic deprivation, trainees were told that working with ‘co-morbidity’ was ‘like plaiting fog,’ but could be amenable to the ‘Heineken effect’ (i.e., if you improve one part of the problem, other parts will follow). They were told to use the psychometric measures wisely, and not to ‘torture’ the patient with them. At the same time, resistances and ‘hot spots’ in sessions were to be worked closely with.

From an early stage, trainees were familiarised with how to express and demonstrate their skills and how to use supervision. They were encouraged to increase their own emotional vocabularies, to turn challenges into ‘learning points’ and to value the psycho-educational aspects of their work. In turn, the trainees questioned what they heard, asked about future developments, and were sceptical about the role of ‘homework’ in CBT, and the meaning of ‘recovery rates’ in the IAPT setting. They talked of their concerns about working with ‘difficult’ patients, their own and their patient’s feelings. They challenged some of the treatment prescriptions, but welcomed the idea of providing ‘simple solutions for complex problems.’

6.4.2 Simple solutions for complex problems

In a PWP role-playing practice session on assessment, trainees were told:

Remember people can come with complex problems but it doesn't mean you have to do complex interventions....(CT, 29th October)

This phrase and ones like it came up repeatedly. PWPs were told they were 'not looking for the historical causes' of patients' problems, but 'to keep it simple'. They were advised to avoid 'boom and bust' behaviour in themselves and their patients and to work towards agreed goals. They were especially warned against 'medium intensity drift', the process by which individual practitioners risked departing from protocol, by extending from LIPs to HIPs, without sufficient training. Instead, through outreach and signposting, PWPs were encouraged to exercise 'ecological power' to influence the patient's interactions with their community, helping them to engage better with it. Their role was described as 'teaching the patient to become their own therapist', alongside educating GPs and the practice community. They were urged to be realistic however, about their expectations of GPs and secondary care services.

HITs were taught about doing 'good enough' assessment and knowing 'when to stop' with complex patients in primary care. They were told to 'make things obvious' when negotiating a contract with the patient, to provide 'a menu of options' and let the patient set their own priorities for treatment. Their task was described as 'to do enough for the patient's quality of life to improve' and to take things slowly and steadily, breaking down treatment activities into manageable parts. Whilst 'chipping away at core beliefs' trainees were recommended to 'think about sequencing' and 'know your limits.'

We will see how trainees and qualified practitioners applied these ideas in practice in Chapter 8 (especially 8.4.4).

6.4.3 Mid-year blues and three way pulls

All of the trainees described having ups and downs over the course of the year. The experience of training imposed demands which were new and different in kind from those they had encountered before. The challenges were felt on a personal as well as intellectual level,

...it's very up and down, I have really good days and really bad days, it is a mixture of emotions and it's quite difficult, not academically difficult, I can't really describe why it's difficult, it's just a totally new way of thinking... (Sarah 1)

The PWP described the importance of peer support, as each person had weeks or months where they found it difficult to cope with the work, the course or personal life. Breaks and gaps between teaching sessions provided valuable 'bonding time' which often extended into out-of-hours social contact. For some PWPs, the demands made them feel like they wanted to leave and that they had made a mistake in taking the IAPT training route. Sarah, for example, found the transition into clinical practice very tough; it coincided with first semester deadlines for coursework. She doubted herself and her capacity to do the job and started to look elsewhere for work.

This was also true for the HIT trainees, who on the whole, faced a greater challenge in redefining themselves professionally in a short time, through the IAPT course. Joanne, for example, felt disorientated finding her way around a new city, keeping up with coursework and OSCE exams. She felt frustrated with what she perceived as conflicting advice from CTs, supervisors and managers and described the course as one of the most stressful years of her life,

... they all say and it's common knowledge amongst everybody you ever talk to, that this course will be one of hardest things you've ever done, and it is just totally stressful all the time. (Joanne 1)

For both groups of trainees, the combination of preparing for OSCEs, having written exams and assignments to complete and building up to a clinical caseload was hard going. PWPs who contemplated leaving, slowly regained their balance by getting into a routine and taking the course advice, to organise 'pleasurable activities' for themselves. They commented on the similarities between themselves and their patients in this regard.

I think we've all been the same really, finding it [hard], especially when you've had exams and things, you've got to study for it, but then you are working, so you've got to do it in your own time and there's no other way around it.... so I have tried to plan things..., 'cos I was getting quite down... I had some real low points in January and after the OSCE, so I made, I've booked things in, to do on a weekend, fun things just to make sure that I am doing that now. (Rachel 1)

Chapter 6: The IAPT training year

Achieving a work-life balance, whilst meeting assessment deadlines and preparing sessions with patients, was a strong theme amongst both groups. For Martin, the training year was 'hugely demanding,'

....because of the combination of doing clinical work and having to prepare for clinical work with very little experience and knowledge, having to do a lot of reading,... whilst also having to do two days a week of study and all the writing up of assignments, it was a huge number of demands all at once and lots of parties wanting a bit of you [LAUGHS]... (Martin 1)

The trainees had a lot invested in achieving the qualification at the end of the year that would equip them to work as an IAPT practitioner. It was not unusual to find they needed to re-evaluate their own standards in the process. Sue, for example, found she had to change her approach as the demands of the course began to bite,

I [thought] I'm going to do my absolute best, I really want to excel at this...[but] that has, that flew out the window sometime in January I think. So now it is very much, just get through it one bit at a time, plug on with it, have a chinwag with my colleagues, you know whenever we're in the office together....and you know, just I suppose, trying to feel like I'm connected to the people I'm with when I'm there... (Sue 1)

However, it was the juggling of expectations between the University, the GPs and the service which were hardest to manage,

...you feel like you're jumping between spinning plates; we've got the GPs and their expectations, the University and their expectations and the job and their expectations. And two of them you might be able to balance but all three? (Sue 2)

HIT trainees felt the pressure too, with an added burden of feeling they should take the lead in managing expectations at micro-local level (see Chapter 8),

We've got to establish the service and get numbers through and get recovery...You've got University, you've got the practices, with waiting times and...there's this massive waiting list now, [with GPs saying] 'we've got loads of people to refer to you,' so feeling pressure about how many people are waiting, expectations of GPs, expectations from the University, expectations from managers of the service... (Martin 1)

6.5 Coming to the end

This section looks at the assessment process, the last teaching sessions and presentations, and trainees' views about what lay ahead after the end of the course.

6.5.1 Assessment

A frequent topic of conversation amongst trainees was the issue of recording clinical sessions for assessment and supervision. PWPs were expected to share recordings with their service supervisors and also had their OSCEs recorded as a starting point for a reflective writing task. HIT trainees recorded sessions for weekly supervision at the University and for service supervisors responsible for reporting on their progress. Assessed recordings were marked against measures of quality in professional practice, such as the CTS-R scale (Blackburn et al., 2001). A minimum score would be required to pass, along with a detailed record of all their clinical activities; the different disorders seen, supervision hours, patient and caseload volumes and outcomes. Trainees were hence highly conscious of being part of an evaluative process and a lot of time and effort went into collecting and reviewing evidence, to meet these requirements. They were understood as important in their own right, and as a step along the road to formal accreditation with the BABCP as either a CBT therapist or PWP.

The outcome of OSCEs and assignments were anxiously awaited by trainees, and it was not uncommon to overhear trainees talking of having to resit or resubmit. When things went well, the trainees appeared relaxed and to take the deadlines in their stride. At other times, I observed individuals anxiously 'prepping' for role-plays, prior to assessment, and looking distinctly uncomfortable. PWPs sometimes expressed concern about their qualification being less transferable than that of the HITs, and told me they disliked not having recognition as a 'core' profession. HITs knew their qualification was recognised and transferable, but were also anxious, correctly anticipating that

they had further to fall than PWPs if they failed. The threat of redundancy or redeployment in their employing organisations was very real. HIT trainees therefore kept focussed to ensure the accumulated the right caseload mix and number of clinical hours. As Jill explained,

...we had to do the hours and that was quite a pressure all the time, because if you hadn't done your hours then you couldn't qualify, so.... I was very organised about it, I quickly realised, especially as it was very slow to get started..., working in [Sector 1] there were a lot of DNAs, a lot of systems not working properly in the practices and it came as a bit of a shock... half way through, [feeling] you're only just getting started and nowhere near having half of the hours. I worked out how many weeks and how many people on average I needed to be seeing. I was lucky that I could expand one of my surgeries because they had space.... (Jill 1)

In practice, HIT trainees often found they were collecting evidence and clinical hours after the end of the course,

...we had to have a portfolio that had to have.... eight assessment reports, eight treatment plans, eight formulations, eight discharge reports, I think it was four or six reflections on pieces of literature that had made a difference to your practice. Another four tapes, with four reflections, your reflective journal....it was a hell of a lot of pieces of work...(Stephanie 1)

HITs also worried about selecting the right session tapes to submit for assessment,

...most sessions were not good enough to pass because that's just the nature of developing the skills and it's quite demanding using the CTS-R to measure your competence. It's quite a demanding set of criteria... and... so one of the pressures was trying to engineer sessions where you knew it would be good enough, because you could keep it simple enough to be focused on being able to deliver everything [required] in that session. (Martin 1)

Meeting the course demands meant making sacrifices in ways which had personal knock-on effects. Jill, for example, spoke of adjusting her standards to get through.

...I kept very organised, I kept on top of all my records and...I knew one of my down things was my perfectionism streak, which a lot of us had on the course... So yeah, I did learn much more that 'good enough' is good enough. (Jill 1)

The PWP's also experienced these pressures although their preoccupations were slightly different. Rachel liked 'to plan, to plan, to plan' as a way of managing the demands of preparing for OSCEs and class presentations alongside clinical work. She, like others, worried about her effectiveness as a PWP, about how to internalise the learning from the course. Maria told me she felt anxious most of the time and thought it was hard to live up to the messages from the course about what makes an 'effective therapist',

... I do want to be really good, I don't want to just be mediocre and just give all the techniques and all the skills and things, 'cause I think it does rely on the personality but I just don't know quite how to get to be that really good person, or maybe, I'm just not confident enough in myself...? (Maria, 1)

6.5.2 Final teaching sessions

The last semester saw the PWP's looking at their wider social role in preparing people for employment, managing the impact of physical health conditions and pain. They prepared group and individual clinical presentations, as part of their end-of-year assessment and had tutorials and Q&A sessions on these and their clinical practice portfolios. The HITs continued with core topics and techniques started in earlier sessions and covered new ones (see Volume 2, Table A2.1, for timetable). Both groups were encouraged to think about self-care, and about planning ahead for accreditation after qualifying. The HITs informally discussed their 'neophyte' status with each other, and complained about how hard it was 'to get it right' with patients when training. The CTs acknowledged trainees' comments about how tough the year had been, and noted how self-confidence in the group had grown.

PWP's too showed signs of anxiety and stress, talking to each other about 'lack of sleep' and performance nerves, during assessment tasks. Their Q&A sessions with the CTs took on an added intensity, as the end of semester deadlines loomed. The CTs had endless patience and provided reassurance, reminding trainees to 'think about the bits of the PWP method you *can* apply

here...help [the patient] maintain progress and cope with setbacks.’ They were taught to help patients manage and accept pain, rather than recover from it. They were also told it was inevitable that they would disappoint people.

6.5.3 End of year presentations

Whole days of the final semester were set aside in both training groups for individuals to present an aspect of their clinical work to their peers and the CT assessors. These days were marked by high drama and spontaneous celebration. PWP’s talked fluently about how they adapted an approach to the needs of their patient, how they engaged with issues of diversity and communication, making use of community, service and supervisory resources. They often faltered when it came to answering questions ‘from the floor’ they had not anticipated.

HIT trainees laughed and joked, and were deadly serious when presenting their clinical work. They spoke of their love for some ‘change methods’ and dread of others, their doubts about the use of CBT and/ or outcome measures in every case, and the times when their knowledge was insufficient and they did not know what to do. They talked about the value of sticking to protocol, and of finding that planned treatments did not work. Once again, the CTs expressed their satisfaction with the trainees and commented on how far they had come.

6.5.4 Wrapping up the year

Formal teaching for both groups ended in June/ July, and was followed by a three month period of self-managed time to complete coursework and clinical portfolios. The last day of teaching was marked by intimate sharing of reflections on personal learning journeys across the year for CTs and students. It meant saying goodbye to peers from other services in the region, who had attended the course, with whom there would no longer be a routine reason to meet. It signalled the beginning-of-the-end of ‘trainee status.’ All seemed to enjoy a brief few weeks respite, before their diaries were filled to capacity again with a new clinical caseload. Most remained intensely busy. HIT trainees in particular had a long tail end to their studies, with assignments being submitted well into the following calendar year to complete requirements.

Trainees anticipated the end of year with a mixture of excitement, trepidation and relief. Celebrations were eagerly planned. PWP’s like Sarah

looked forward to adding new activities into her clinical sessions, when the number of clinical days rose from 3 to 4 per week,

...once I'm qualified I might look into widening [my experience], maybe doing some groups and things like that. I think it would be good to have a mix of things because if you're just doing one [thing]..., obviously after I've qualified, I'll be doing the same thing for four days a week...and it's the working on your own I think is the biggest obstacle... (Sarah 1)

Rachel wanted to focus on developing her CBT skills, with a view to positioning herself for future job and training opportunities. Maria worried about the pass and failure rates for PWPs and if she had made the right decision in going down the PWP route. Sue was determined to stick with it in the interests of having a career in mental health. Sarah looked forward to a period of consolidation and getting to a point where she could really enjoy the job.

Amongst the HITs, Joanne continued to feel ambivalent, wondering if it was expecting too much from a one-year course to achieve the required competence level. She felt rushed into making poor decisions about her assignments and longed for more time to reflect on what she was doing. At times, for her, the experience of training put her off the job and made her worry about her job security. For Anna, however the course boosted her self-confidence, and helped her to change as a person, in ways she felt benefitted both her work and personal relationships.

I've learnt to have my own confidence, rather than always relying on someone else saying, 'oh, you've done a good job'...Some of the skills that they teach you to use on patients, you can use them on yourself and... it's a whole new skill set which just helps you grow up and develop in a different way I guess. (Anna 2)

HITs looked forward to trying out new clinical activities (such as, running a group), to vary their week; they also wanted to broaden their professional networks.

6.6 Teacher, supervisor and manager perspectives on the training task

This section introduces the views of the people working most closely with the trainees during the training year: the CTs, managers and supervisors (SUPs), who coached and played a part in their assessment. It looks at their views on what makes a good trainee, the strengths and limitations of the IAPT course and the challenges posed by the IAPT service model for translating the course learning into practice.

6.6.1 What makes a good trainee

Whatever their role, CTs and SUPs were aware of how demanding the training year could be for trainees. CTs commented on the differences between trainees and how prior experience did not accurately predict who did well on the course. Some SUPs felt that having a background in mental health was beneficial for the PWP role whilst others noted that those who had counselling or other experience, where their practice was freer, struggled to adjust and had to unlearn what they had done before. There was consensus that those with less prior experience found it easier to fit in. CTs made similar comments about HITs who had previously worked in a nursing or a PCMHW role; these trainees were described as finding the role boundaries restrictive, and missing the team-based approaches of their former roles. SUPs felt that some, not all, HIT trainees struggled to leave their previous roles behind, to shift into a formulation focused way of doing things. SUPs also recognised how de-skilling and anxiety provoking the training could feel.

SUPs commented on the difficulty of choosing between older, more experienced recruits, who were more 'entrenched' in their way of working and younger, less experienced ones who were passionate and easier to mould. They noted how the foreshortened nature of the IAPT training (compared with other types of clinical training), meant trainees had to let go quickly and allow themselves to experience uncertainty. A few years into the programme, they felt the most important selection criterion for CBT training was the person's 'self-reflective skills' and their ability 'to critically evaluate what they're doing.' They commented too on the desire of PWPs to progress to HIPI training, sometimes sooner than was realistic.

CTs acknowledged that trainees needed ‘a lot of resilience’ to get through the HIPI course and to learn quickly. The approach had to ‘click’ early on or they would end up in difficulties (as described by Branson et al., 2015, see 3.6.4). With LIPIs, the trainees who did well were the ones who valued the PWP role and were not trying to be something else or to overcomplicate the work. CTs also observed that the best HIT trainees used CBT as a ‘life philosophy,’ they ‘walked the talk,’ and incorporated CBT into every aspect of their lives, as the CTs themselves did. These trainees were effective because they were curious, reflective and interested in improving their practice.

6.6.2 Strengths and weaknesses of the training and assessment process

CTs and SUPs all commented on the challenges of delivering a role-specific training within a one-year timescale, compared with longer duration training routes in CBT. They agreed on the importance of the clinical interventions trainees were taught and the value of having a continuous work-placement which provided clinical exposure from the start. CTs recognised that in the time available, teaching could only focus on a few main areas and could not do justice to complex ‘co-morbid’ conditions. They were happy that they could cover the prescribed disorder-led and problem-solving approaches in some depth, beyond what was required. They also felt it important not to make assumptions about trainees’ prior knowledge, and to teach CBT from first principles. SUPs and CTs were unanimous in the view that the training was high quality, thorough and appropriate to the needs of the service, even if for HITs it was, of necessity, less comprehensive than a traditional CBT training. They commented on the importance of induction at the start of training and on consolidation afterwards. They observed the pressure trainees were under in relation to numbers and outcomes, and how this delivering against these could be at the expense of really learning how to reflect. They felt that all trainees would need time after the course to gain experience with patients and conditions not previously seen during training.

All were confident however that what the trainees were being taught was practical and usable. CTs felt trainees could better appreciate the specific treatment models and strategies, after they had tried them out in practice. To this end, the supervision (for HIT trainees) built into the course was essential. CTs felt that the defining moment of transition for HITs was when they started to ask questions of each other rather than the CTs, when the trainees worked out formulations together with minimal intervention. Where the PWPs were concerned, CTs felt the main difficulties were not to do with applying what was taught in practice, but with the pressure trainees were under to turn patients

away who were not suitable, and for whom there was no alternative service available. SUPs felt that their task was to make sure that each person was comfortable working in their role, despite these service gaps. They were keen to ensure that trainees used only the interventions they were trained in and acted on the cut-off points for treatment, stepping patients with social phobia and PTSD, for example, quickly up to Step 3 (the high intensity provision). As we shall see in subsequent chapters these concerns were borne out in practice.

SUPs also felt that the safest way to ensure the distinction between PWP and HIT tasks was kept clear, was by having separate supervision models. PWPs were supervised by PWPs or existing PCMHWs, not by CBT therapists. This reinforced the idea that their interventions were different in kind and not just a 'watered down' version of CBT. CTs felt torn in the knowledge that the CBT they themselves had trained in was not what was being asked for in the IAPT roles. They felt they were teaching trainees 'to use boxes' matching service requirements, rather than any diagnostic purpose.

6.6.3 Challenges arising from the IAPT service model

SUPs shared a concern about the blurring of the boundary between the PWP and HIT roles and interventions. They noted incidences of trainee impatience with what they were taught and a tendency to confuse treatment models with service delivery ones (see 6.6.2),

[IAPT] is a good effective model of service delivery...[not] a treatment model. It's a model of service delivery based on stepped care.... that's where people get confused sometimes.... stepped care is meant to work like collaborative care, but sometimes the steps get a bit confused. I know that we teach step 2 interventions for PWP and step 3 for high intensity, but I readily can feel when I'm teaching that the PWPs are pushing to do something else. (CT 1)

They felt that in the patient group seen, there was a large grey area, which made a fallacy of the idea that PWPs worked only with patients who had 'mild-moderate' CMHPs. All had supervised PWPs who worked with severely depressed and/ or anxious patients. They described the challenge of helping PWPs to use the tools at their disposal, and how they should know when to work with a patient whose needs were 'complex' and when to step them up to high intensity. They felt the main risk of therapeutic 'drift' occurred during the first year after training, in part because of a misperception that the PWP role was lower in status than HIT and a tendency to treat both types of intervention

as synonymous with CBT. In circumstances where the patient presented with complex difficulties, SUPs stressed the importance of careful contracting up front and not assuming that 'more is better' in every case.

6.7 Discussion and conclusions

This chapter has focussed on the making of IAPT psychological therapists through formal teaching and assessment during the initial training year. In the next chapter (Chapter 7) I look beyond the classroom, at trainees' experiences in clinical practice, their encounters with other professionals, and their learning from supervision on the course and in service. There were three main themes in this chapter: the process of getting into and staying in a new role; the distinctiveness of the training language used; and, how an IAPT attitude and set of practices were cultivated.

At the start of the year, I found trainees, from a range of backgrounds, quickly picking up on IAPT and CBT-specific expectations, regarding ways to approach problem definition and response (6.2). The nature of 'recovery' within the IAPT system was briefly discussed, and trainees left to draw their own conclusions as to why only half reached this benchmark outcome. The discourse of surveillance medicine (Armstrong, 1995) (see 2.2.2) was present in the teaching on risk assessment, the use of categories to help prioritise activities and treatment plans (or to diagnose and formulate, in the case of HITs), the emphasis on improving 'life chances' by 'reconnecting' people to their communities, and 'preventing relapse' (see also, Chapter 8). The 'necessary, but not sufficient' view of the therapeutic relationship (Neuhaus, 2011) was promoted to both groups, alongside references to the significance of 'therapist effects' in determining patient outcomes. Trainees in turn appeared uncertain at times about the role their own personalities should play, in their development towards being a competent practitioner or therapist.

The relationship between the two roles, PWP and HIT, was explained in terms of each having equal but different contributions to make in a stepped care system (6.2). It was made clear, as described in Chapter 3 (see 3.5.1) that PWPs were expected to draw on the official 'Reach Out' manual (Richards & Whyte, 2009) and interventions, rather than use clinical discretion. The CTs tried to prepare the trainees for the modesty of what was actually achievable, within the IAPT service model. Their injunctions to 'focus' and not follow the

patient too much (6.3), anticipated the tension trainees felt between policy and practice reality, in their questions, jokes and conversations with each other, in the classroom.

As the year went on, the trainees became ‘cognitively entrenched’ in the CBT/ IAPT habitus (Anteby et al., 2016) (see 2.3.4), and gradually took on the ‘language-games, activities and practices’ indicative of an ecological process of learning, as described by Kemmis et al (2012: 47) (see 2.4.2). They learnt the common ‘doings and sayings’ (Schatzki, 2012) of IAPT practice, such as the requirement to offer choice, not diagnosis; and, to keep things simple, in the face of complexity (6.4). There was little questioning of the value of choice, or the idea of enabling individuals to do ‘self-help’ for themselves, rather than have their needs met directly (Fotaki & Hyde, 2015). There was a clear focus on results, in the way described by Steger and Roy (2010) as characteristic of NPM (see 2.2.5). Trainees were also encouraged to make use of the tools and interventions they were learning about to help themselves as well as their patients, to monitor their own reactions and reflect on their practice. They were introduced to the ‘knacks, feels and know-how’ of doing time-limited interventions, the kinds of IAPT ‘internal goods of practice’ (Hager 2012: 23), such as ‘suitability’, ‘throughput’ and ‘help-ability’, which would enable them to become competent practitioners.

This socialisation process had many ‘ups and downs’ for the trainees, with the tension between course, service and GP practice to manage, alongside starting clinical work, and meeting coursework and assessment deadlines. There appeared to be moments of ‘unbecoming’ as well as ‘becoming’ (Fenwick, 2013), in the transition between aspirant psychological therapist trainee to fully fledged IAPT practitioner (Reich & Girdwood, 2012). An ‘oscillating dynamic’ (Rønnestad & Skovholt, 2013) was in evidence as individuals struggled at times to leave their previous job roles and identities behind (see 3.6.3). In the classroom, there were changes of mood and atmosphere between ‘work group’ mentality, where concentration and focus were high, and a more combustible, ‘basic assumption’ atmosphere (as defined by Bion, 1961), where trainees let off steam in a kind of collective hysteria (see 2.5.1). The pervasive anxiety which typically accompanies therapeutic training and career transition (Skovholt & Rønnestad, 1992) appeared to focus particularly around the issue of time-keeping, in the role-playing sessions, the OSCE practices and exams, the management of self-in-role and the time limits on treatment. There was also a striking degree of ‘busy-ness’ about the training programme, especially amongst the CTs, which made me wonder about what ‘social defences’ might

be at work in the training (Hoggett, 2010a) (see 2.5.1). I was regularly caught out in my observations by sessions beginning or ending earlier or later than scheduled, as extra mini-sessions or tutorials were crammed in, to meet trainees' requests. The trainees expended considerable emotional labour, in role playing, groupwork activities, interim and end-of-year presentations (see 2.4.3). Overall, there were clear signs, to me, of a culture of performativity being instilled (Hoggett, 2010a), a belief in the value of being business-like, time-conscious, and results-focussed even when the tension between this and the messy reality of frontline service were spoken about.

In the next chapter, we will find out how far these different emotions extended beyond the University classroom, and what other new challenges these beginner 'worker-learners' (Reich & Girdwood, 2012) encountered in their training year.

Chapter 7 - beyond the classroom: becoming IAPT

7.1 Introduction

This chapter looks at the experience of trainees beyond the classroom during the training year and is based mainly on the first FANI interview with each individual, whether in the observation cohort (Cohort A) or trained in an earlier year (Cohort XYZ). It includes the narrative analysis from these data and extracts from I-Poems, where relevant.

The main themes found in this chapter concern the challenges trainees faced in adapting to the people and practices they encountered in their GP practice and sector team settings. Challenges included: key role relationships; first experiences of clinical work and case management; the impact of working predominantly alone; different supervision practices; and, the mismatch between training and practice.

In the first section (7.2) I look at the practical and psychological aspects of positioning in role, through the making of IAPT 'mini-teams'; next, I explore the different dimensions of the clinical and case management task trainees have to get to grips with (7.3); the main difficulties identified by them in translating learning from the classroom into the work setting (7.4) and their views on the strengths and weaknesses of University and service supervision (7.5). I end with a discussion about the 'ecological' aspects of practice in the local setting, the particularities of the transition anxieties experienced, and how these were affected by relationships with colleagues and patients, at this point (7.6).

7.2 Entering the world of GP practices

7.2.1 The weekly rota

It was not unusual for PWPs or HITs to be working across four or more GP surgeries each week, and to not overlap with their IAPT co-workers or meet with their team mates, other than occasionally at the sector office base. This system was challenging both for the trainees and their managers. It was a major scheduling task for managers to match the supply of workers and trainees, in each role with the demand for sessions at each surgery and the availability of consulting rooms. The largest surgeries had satellite practices attached at different sites, each with their own, often part-time, reception and clinical staff to get to know. The smallest were single site, but varied considerably in size and referral rates. None had purpose-designed counselling rooms. It was a running joke within the service that everyone had to have at least one practice where they worked out of a 'broom cupboard.' Most workers and trainees were required to travel to different sites every day and sometimes to two sites in the same day. Those that were allocated to larger GP practices tended to count themselves lucky in only having one waiting list to manage and not having to move about so frequently. All felt their days went better when they worked a full day in one place, compared with the sites where they had just half a day to fit everything in.

There were a number of practical consequences from having such complicated weekly rotas. Both groups had to be very organised to keep on top of their record keeping, when moving from site to site in quick succession,

It's really hard working in so many different places; you have to be really organised to keep on top of the admin and to remember everything you need...I found it really hard when I first started... I just couldn't keep up with the admin and I felt like I'm not organised enough for this job, 'cos you have to remember to do all these things and if you don't get it all done when you're in the surgery, then you're not there [for another week], so I don't know. It's much easier now, but I think that was the hardest thing at the beginning. (Vicky 1)

Over time, most trainees collected and stored self-help and related materials they needed electronically. It was not unusual for trainees to have to re-arrange furniture on arrival at each site, to make very 'clinical' rooms friendlier and to set up recording equipment to enable sessions to be video-taped, for assessment purposes.

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...carting round lots of stuff... arriving at the start of the day when you'd booked in several sessions and you'd got someone coming in early, you'd arrive there, unpack all your stuff and set up shop, re-arrange the furniture....It's not right for you, it's very clinical and you have to cart these chairs out, sort the bed out [LAUGHS]. So, there's ... getting into those routines, the pressure of having to get recordings and knowing that people are going to watch those, that you've got to get recordings that are assessable and passable to get through the course, was a huge pressure. (Martin 1)

The weekly rota was such that HITs would not necessarily overlap with the PWP's at each practice, nor the counsellors, let alone with one another. The constraints of room availability meant IAPT team members could only be present in sequence, rather than at the same time, on each site. As described in Chapter 4 (4.2), everyone was allocated to one of four 'sector' teams within the city and in theory, was restricted to practices within their geographical sector. However, staff turnover, especially amongst the PWP's, created gaps in service coverage, which meant it was not unusual for individuals, even as trainees, to end up working across more than one sector.

Peer supervision was encouraged, but more often than not could only happen virtually, via telephone and e-mail. Opportunities for meeting up with peers during work time were constrained by the daily schedule of appointments and the need to travel. For all of the trainees, it was a shock to find themselves working alone so much of the time; they often commented on the sense of isolation, even when things were going well.

If you're only going in one day a week, that's one of the downsides of the job, that sense of isolation in different places. It's very very difficult (Jill 1)

In an extract from her first interview I-Poem, Sarah in her 'reflexive, observing voice' also described this,

I do miss being part of a team

I work on my own

I don't really see anyone

I do miss that

I do think of myself

I think
I found this job hard
I think
I used to try and cheer everyone up
I used to like having a laugh
I definitely used humour a lot
I used to try and boost morale. (Sarah 1)

The impact of staff turnover and lone working is a theme which recurred throughout the study (see 7.6 below). I return to this in my thesis conclusions (chapter 11).

7.2.2 Working with GPs and GP Practice Staff

Both the PWP and HIT trainees described the task of integrating themselves into GP practices as a concern. On the practical side, Martin found he had to write down pages of passwords and login details for the different IT systems in use. For Jill, the challenge was that each workplace required getting to know a new set of people and to sell the service, when she was still wasn't feeling confident about what she was doing. For Rachel, it was about being marginal in the practice setting, with so little time in each place - 'you're just the drop-in that comes in once a week'. Being one of many new faces and growing waiting lists would add to the pressure trainees felt, as Anna explained.

In every surgery I've been in, they seem to have had lots of different PWPs in the last three years. The surgeries get pissed off with IAPT 'cos they're not having the same staff... they're building a relationship for a year and then that person's pulled out to go to another clinic or new group or whatever, or they leave or they're on maternity leave or sick leave, so... that has its challenges as well.
(Anna 1)

A major challenge for all the trainees was to establish credibility. Both groups had to work at making themselves known to the different professionals working in the practice. The most common misapprehension experienced by both PWP and HITs, was that GPs treated them as if they were the practice 'counsellor.' They tended not to distinguish in their referrals between the PWP,

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the HIT and the counsellor or to explain the difference to patients. Referral methods would vary across and within practices,

...it's different in different practices, but [the GPs] tend to write a letter to the IAPT team. Or to whoever they've decided they're going to write it to, but they don't usually have a concept of who does what, they don't really understand the difference between PWP or CBT or counselling...And they'll often write 'Dear Anna, please see this person for counselling'. So you know then, they don't know the difference! (Anna 1)

Service policy was that all referrals should go through the PWP (Step 2) in the first place, but adherence to this approach varied. For the PWP, it was a case of taking 'all comers' and working with the HIT to educate the GPs to better understand the IAPT roles,

I've had some surgeries where they still think I'm a counsellor...I get all sorts sent to me, so it's just trying to get them to speak to me about what my role is. We've done some flowcharts for the surgery, so the GPs can have them in their own room, which explains a bit more about our roles... I suppose time will tell as to whether that's effective or not! (Rachel 1)

PWPs were also sometimes seen as Social Workers, able to deal directly with patients' wider social, financial and health concerns. Sue described where this misconception came from in one of her practices and the impact it had on her:

The waiting list is 70 odd people, the previous person in my surgery who did my role, he had a background in social work...so the expectation from the GPs is that I will manage the wider issues that people come to me with....and that I will manage more intense mental health problems. And I'm having to draw that line and say 'this isn't an appropriate IAPT referral, I can't work with that aspect of this person's problems at the moment, we're going to have to signpost and you know, you're going to have to pick up some of the slack here and that's been very difficult. I'm not a confident person anyway, I'm not a very assertive person, I've got a lot of confidence in certain areas, but I'm not an assertive person, by nature and so I'm having to pick that set of skills up very quickly... (Sue 1)

One difficulty for both groups associated with their part-time presence in each practice, was that of asking for help. Rachel, for example, was concerned to appear capable in front of others and hesitated to ask for back up with potentially 'difficult' patients (for example, asking another staff member to sit in on a session), even though she knew this was encouraged. On the course and in supervision, trainees were encouraged to integrate themselves by getting to know the practice reception team. Trainees did work at this, but had a mixed reception, especially where there was a history of previous IAPT staff moving on in quick succession. As Maria explained, 'you just feel as though you've got big boots to fill.' For most, the IAPT sector team and not the GP practice was where they felt most at home.

Another difficulty arising from being a part-timer in GP practices was communication. Anna commented on how she could not rely on being able to come into the practice the morning after a busy day in clinic to send messages to colleagues regarding cases (unlike in her previous, team-based job). This was important when seeing people for the first time and assessing whether they were appropriate for Step 3 CBT or if they needed to go elsewhere. There was also very little time to get in touch with patients themselves outside of the session, if needed.

.... [when] you're not overlapping with the PWP, or the counsellor, bearing in mind some of the counsellors aren't writing on the system and some of the GP's referrals aren't straightforward; some GPs refer one way, another GP refers another way...Some people are booking through clinics and you've no idea who they are. So, admin-wise, there's all that stuff that you've got to deal with, that you can only deal with on that day and then you've got to wait a week. (Anna 1)

7.2.3 Relationships between IAPT Co-workers

In each GP practice, trainees were part of an IAPT 'mini-team' comprising themselves, possibly one other (qualified) PWP, a HIT trainee or qualified therapist and in theory, an IAPT counsellor. As we've seen above, individual workers seldom coincided face-to-face with their 'mini-team' colleagues. The IAPT counsellors, for the most part, pre-dated the PWPs and HITs and were used to working independently. They kept their own patient records and tended not to 'convert' to the IAPT automated case management system, on grounds of professional ethics. Relationship building and referrals between team members thus relied heavily on electronic messaging, supplemented by handwritten notes, phone calls, occasional meetings on admin days at the team

headquarters or snatching a conversation with colleagues during in-service training sessions.

On the other hand, even the 'invisible' presence of a co-worker in the same practice made life easier on a number of fronts. PWPs talked about their sense of relief at being able to share responsibility for managing the waiting list with a fellow PWP or HIT. Co-workers were an important source of support for making changes in admin systems, for example, winning support from GPs and reception staff for using 'direct booking' (where the patient is responsible for booking themselves a first appointment, via reception, rather than the GP or anyone else). On the odd occasions when they did overlap, PWPs valued the reassurance of having another PWP or HIT colleague nearby, to talk to, if needed. Comparisons with previous experiences of teamwork were often made, with IAPT initially coming out less favourably. Both PWP and HIT trainees noticed the different atmospheres of GP practices, the time it took to get to know what everyone did and the variation in working practices. For a PWP, getting to know the HITs working in the service, sector team and individual practices, could open up avenues of support. Other PWPs could also be relied upon for informal advice at any time, such as when preparing for OSCEs. For the HIT trainees, the PWPs also played a vital role in determining the quality of their experience in the GP practice. Without a PWP in post, too often, waiting lists would rocket and the HITs would find themselves carrying out an unhappy mixture of the two roles - screening, assessing and case loading new cases from the waiting list, whilst also attempting to make the right decisions about referrals and worrying about treating people at the appropriate level of care. Jill, for example, commented on what a difference it made when there was a PWP in post that she could develop a useful working relationship with.

...where it works best is, in the very big practice I'm in....the PWP and I overlap on half a day, so.... we check in with each other and talk about what is going on... So, when we do overlap it's absolutely great...(Jill 1)

Relationships with counsellors were perhaps the hardest for trainees to develop within their respective GP practices. Anna told me about one GP surgery where the counsellor was employed directly by the practice and not the IAPT service. It made co-working hard as she had little or no contact with this colleague. She felt there was 'a lot of politics' involved, which she did not really understand. She knew the counsellors as a group felt under-valued in the new system, regardless of whether they were employed directly within IAPT or not; 'they're really experienced and skilled professionals and they don't get paid

anywhere near as much [as we do].’ She sensed resentment of her youth and scepticism due to her inexperience and commented on the very different cultures of practice and information sharing that existed between these ‘old’ and the IAPT ‘new’ hands. I return to this theme in the final chapter of this thesis.

7.3 Starting in clinical practice

7.3.1 Starting clinical work

As soon as the induction period was over, the trainees’ time in service was spent shadowing previously trained practitioners and therapists, whilst they waited to pass their first OSCE exam – on clinical assessment. Passing this exam provided the green light for them to start assessing patients and assembling a caseload, in their allocated GP practices. Following a period of doing assessments only, trainees were expected to begin working with patients, in line with the course teaching. For most, this meant first seeing patients around November or early December, following the September start to the training year. Trainees were encouraged to build up a caseload gradually over the next few months, to the required level whilst in training. In the service studied, this was eight people per clinical day (four days a week) for the PWPs and four per day for the HITs. Once qualified, it was ten people per day for PWPs and five for HITs.

Notwithstanding their prior experience, the start of one-to-one clinical work was a daunting prospect for most of the trainees. Maria described the start of her clinical work as a fraught time, dependent on the support of her supervisor,

I was nearly crying... I didn't sleep the night before 'cos I was so nervous and...nothing I could say to myself; none of my sleep hygiene techniques were working. I felt awful and everything went wrong and I rang [my supervisor] and said, 'I just don't know what to do, it's all going wrong and I'm having a meltdown' (LAUGHS). (Maria 1)

For the HITs it could equally be an unnerving experience. Even though they were more likely to have worked one-to-one with patients or vulnerable people before, this wasn't always the case. Jill and Joanne had both specialised in

training and groupwork roles in their previous jobs and felt thrown by the experience of providing therapy for the first time. Joanne felt out of practice at doing assessments and for Jill, the anxiety was compounded by having a supervisor who was new to the IAPT service,

I don't think she understood that she wasn't really my supervisor, she was teaching me what I had to do next! And I remember being in tears at one point because I felt so stupid, because she was assuming I knew things I didn't know, and I remember having to say to her, 'I don't think you know how much I don't know!'...And that was so de-skilling, so de-skilling, feeling really stupid all the time ... (Jill 1)

7.3.2 The assessment task

The bulk of initial patient assessment work was carried out by PWP's (see Chapter 6 and 7.2.2 above). PWP's were responsible for gauging which level of care a patient needed; whether they could benefit from LIPs or needed to be stepped straight to Step 3 CBT or alternatively, to counselling if appropriate. They were also responsible for 'sign-posting' patients on to alternative services in the community where they thought these might be better placed to help, for example, referring people to benefit and employment advice services, bereavement counselling, drug and alcohol misuse services or debt counselling organisations.

The assessment task for HITs was different. They could generally expect their patients to have been pre-assessed as suitable for CBT and thence to focus their efforts on formulating a collaborative 'case conceptualisation' and treatment plan which was deliverable within the session limit for Step 3. Whilst PWP's might have 'caseloaded' less than half the people they assessed each week, the HITs worked with the majority of their new appointments. The experience and impact of the assessment task was keenly felt by the PWP group and by trainees in particular. As Sue explained, assessment was the task most likely to fall to the least experienced practitioner in the IAPT mini-team,

...because the qualified PWP is only in there one day a week and I'm in there four days a week, so I do the majority of assessments at that surgery. So, between us we've got 13 assessment slots over the week, she's got three, I've got ten. So, the chances are...as a low intensity worker, we get all the referrals. (Sue 1)

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For some trainees, assessment took up the majority of their time and contributed to a feeling of overload which the training course did not prepare them for.

I've done back-to-back assessments; on Wednesday, I think I did about five assessments and then a couple of treatments and that was difficult because it's trying to get your head around all the information from an assessment and it is a lot more than you get when you're role playing, because people come with baggage, they don't just come with a mild-moderate mental health problem and that's the only thing they want to tell you about. (Rachel 1)

Few PWP trainees felt that the people they were being asked to assess fitted neatly into the eligibility criteria for IAPT.

I don't think you could find a single person in this sector who matches that very clean cut appropriate referral kind of thing. There's always something else going on, in my experience... (Sue 1)

And what is more, patients frequently arrived with misconceptions about the PWP role as being more akin to counselling,

... they get told by their GP that they're going to see a counsellor and they then sit there and as soon as their bottom hits the seat, they start to talk about their childhood abuse or their current partner is hitting them or taking drugs or whatever the problem is. (Sue 1)

The challenge was to find ways of keeping the patients 'focussed' on what was troubling them most. As Rachel suggested, it helped if you asked the right questions and didn't leave things too open,

The one thing I did learn 'cos I always used to say, 'what's brought you to the surgery today?' and wow, does that open a kettle of fish, 'well, when I was four this happened and when I was six...' And... so now I just say, 'what do you feel is the main problem for you at the moment?' (Rachel 1)

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An added pressure for trainees was to fit the assessment into the allocated time. In training, PWPs in this cohort were taught to do a 35-minute assessment and in the service, were allowed 45-minute appointment slots. The throughput of patients each day, however, meant they were constantly up against the clock. Trainees found it particularly challenging to gather all the information they needed to make a decision on next steps, in one go. A common problem for all PWP trainees when they started was to find they needed more than one assessment appointment, before they could reach a decision about referral or caseloading, discuss the case with their supervisor and communicate a decision back to the patient. This tendency, which was counter to the IAPT service model, was exacerbated by trainees' sense of guilt about not immediately offering a follow-up appointment, particularly when patients had waited a long time to be seen.

The PWPs worried about getting their assessment wrong and the volume of inappropriate cases sent to them by GPs. Where GPs treated IAPT as their 'one stop shop' for all things mental health related, it was not uncommon for PWPs to find themselves assessing people with severe and enduring mental health conditions, who were already involved with secondary care services. PWPs were very conscious that they lacked diagnostic skills. Throughout their training (see 6.3.1 above), it was stressed that Step 2 was about 'patient choice, not diagnosis' and yet, in practice, it was hard to separate the two things. Inappropriate referrals thus contributed to the anxiety trainees felt. As one of the CTs explained,

Step 2 have not been trained at the university to see everything that comes in, they've been trained to assess for depression or anxiety... they have to screen them or do an assessment and if we've not taught them how to do that, how can they do it? And if they do it and they get it right, that's excellent. And if they do it and they get it wrong, then what happens? [CT1]

For HIT trainees, there were also feelings of guilt associated with the assessment process. These were less to do with the volume of inappropriate cases than with uncertainty about their own skills, especially at the assessment and formulation stage,

... it's slightly confusing to put everything together, when you need it, confusing to know exactly what they want, confusing about the models and how you use them and just how you put it all together. [It's hard to] do the assignments, be

prepared for your patients and feel as though the patients are getting a good deal...Sometimes you do think to yourself...are they getting the best deal?
(Joanne 1)

Supervision made a huge difference to trainees' confidence, as we shall see (7.5 below). Where supervision was supportive and available as planned, trainees like Anna felt encouraged to take on even the more unlikely cases.

7.3.3 Engaging and maintaining patients in treatment

The theme of managing patient's expectations and engaging them in treatment was one which featured strongly in PWP accounts of their early clinical practice. One issue was motivating patients with what the PWP had to offer, as Sarah observed,

...it's quite difficult when you're armed with all these tools and they don't really want to do any of them (Sarah 1).

And Sue learnt that she couldn't assume even a basic level of information literacy,

...this is a very difficult area to work in, there are a lot of other issues going on, people don't keep appointments, they don't necessarily absorb information very well, because of their educational background and you're working with a whole different set of issues and [we can't] fix it all, we just do the best we can within it... (Sue 1)

Both Rachel and Jane commented on the struggles their patients had to engage with the self-help materials and 'homework' tasks assigned to them; they found even the well-tested booklets were too challenging for some patients. In these cases, Jane found herself abandoning the booklets and preparing her own versions of the exercises to share with the patient (see 7.6 for discussion of this point).

PWPs also worked hard at preparing patients for more intensive intervention at Step 3. Sarah, for example, talked about 'knowing the

boundaries and limitations' and 'being honest with people' about what she could and could not offer. She focussed on the sign-posting aspect of her role and attributed some of her early successes to her ability to identify and locate the right follow-on service for patients. She felt this was an area where she went 'above and beyond' so that her colleagues looked to her for advice and recommendations about what was available locally. However, for Kay, always moving people on entailed an element of guilt, which she had to check in herself,

...I keep that in my mind, making sure that they know it's not about rejection, it's just about me not having the resources or knowledge to work on that for them and they're better off...speaking to somebody else that can. (Kay 1)

The temptation was there for PWP's and endorsed by service managers, to offer the patient *something* rather than nothing, if moving them on would entail a further waiting list, either for Step 3 CBT or an alternative service. For HITs, having the PWP's work with a patient prior to sending them on for CBT was valuable,

...it works far better to have [the patient] at least have a screening with the PWP and you know, the PWP doesn't have to offer a course of treatment they can step up directly [if it's social phobia or PTSD]...and even if people do end up being stepped up for CBT, it's really helpful for them to have gone to low intensity first because it socialises them into the idea of helping themselves, doing homework, make sure they're going to attend...(Stephanie 2)

However, Andrea felt this was a mixed blessing because it sometimes led to patients inadvertently gaining the impression that Step 2 interventions were CBT,

...[The PWP] has to decide where that patient will go and they've got a number of options with step 2; so they've got one-to-one self-help with a PWP, they've got computerised CBT, they've got the workshops they can go to, they've got Stress Control groups, so there's lots of different interventions there, but what's happening increasingly is that they come in and they're sat at step 2 for up to 8 sessions, more sometimes and then if that doesn't seem to work they're booted up to step 3 to CBT, but thinking that they've had CBT already. (Andrea 1)

Where this happened, it could be hard for the HIT to disentangle the patient's preconceptions. Another issue for both groups was finding ways to remember individuals and their treatment plans, before each session. HITs felt the electronic notes system was insufficient and that hand-written supplementary notes were needed, to keep track.

When you're itinerant... you can't hold it all in your head, it's there, but you need something to just bring it to mind...when there are that many people that you are working with... (Martin 1)

7.3.4 Managing a caseload

Case management refers to the multiple tasks of assessing new referrals (mainly PWP), stepping people up/ down/ or sideways, caseloading for LIPI or HIPI and managing patients through treatment with or without input from others. It requires handling non-attendance, treatment endings, outcome measurement, re-referrals and follow-ups. It is supported electronically through the automated supervision and MIS system where details of every practitioner's activity rates, caseload size and patient outcomes are recorded, where patient throughput is monitored, active cases flagged for review and inactive ones 'discharged' or left on hold for future review. HITs used the same system as PWPs, but were predominantly assessing for specific treatment rather than for IAPT suitability *per se*. They also saw far fewer patients, had longer sessions and treatment durations than PWPs.

All new patients were seen by PWPs at Step 2. Keeping up with the volume of new referrals was a major challenge, and at times, it could feel like there weren't enough hours in the day to fit everyone in. The pressure could be such that conscientious trainees found it difficult to take time off, for fear of the backlog of appointments they'd face on their return.

For the PWPs, it was common to need to book in back-to-back assessment sessions, which could feel like a bombardment of new faces, each with their own complicated set of circumstances and needs. It was this, more than anything else, which affected PWP trainees' views of the job,

I just really under estimated how tough this job actually is, it really is a hard wearing job! I've never experienced stress like this before and I do sometimes find

myself getting quite stressed out.... We're meant to see ten people a day and I do feel like that that's too much. I know they say the evidence shows half hour sessions are fine, but it's hard to just stick to that strict 30 minutes. (Sarah 1)

The pressure on HIT trainees in terms of volume of new cases was less. Where there was a PWP in the practice, trainees could generally be assured that the people waiting to see them were suitable and appropriate for Step 3 CBT. However, it was not uncommon for HITs and trainees to find themselves working in practices where there was no PWP, or where the PWP was a trainee and/ or completely overstretched, with a long waiting list. In these practices, HIT trainees tended to feel they had little option than to help out with assessing new cases, making referrals and generally trying to get patients seen as quickly as possible. For Anna, the hardest part of managing a caseload was the DNAs. She regularly booked in an additional appointment slot each day, to compensate for these. PWP's faced this too, often struggling to manage drop-out over the first few sessions. If they took too long over the assessment process (for example, more than one session) or didn't get the assessment right, patients would quickly become disillusioned and not come back. Sue commented on the impact of the DNA rate in her sector,

....people just don't attend their appointments, or they cancel at the last moment, so it makes it hard to....to keep the treatment going. For the first two or three weeks definitely, I feel it's important to get into a pattern of coming to the appointments, getting your head around the work, but a lot of people haven't done that. So, I've got one gentleman... he's having his appointments three weeks' apart and it's very difficult to keep the work rolling, with intervals like that. (Sue 1)

The diversity of the patient caseload was an issue for HIT trainees. They too could find themselves working with patients who had severe and complex needs, beyond the remit of IAPT. For Anna, these could be amongst her most rewarding cases to work with, as they were the ones where she felt CBT had the greatest potential to effect change. Joanne too liked sticking with the more difficult cases, in anticipation of helping to turn things around for patients, even where this meant long gaps in treatment (for example, where patients had spells in hospital).

7.3.5 Discharging people

The first cases to be discharged by trainees were those that had failed to attend their initial appointment or had dropped out after one meeting. This was a relatively frequent experience for PWP, less so for HIT. The earliest cases that PWP saw to completion were typically the users of cCBT self-help packages. PWP, still part way through the course, talked about not knowing how to end treatment, despite knowing the recommended durations. Maria, for example, felt uncomfortable stepping up a patient, for whom English was not his first language, simply because communication had been such a struggle she had run out of time to explain to him. Rachel found the booklets and materials available for working through the end of treatment and helping patients to plan ahead were useful, especially if combined with a session reviewing outcome scores, with a graph, which demonstrated the patient's progress.

I've found it a bit difficult you know when it's coming to the end of treatment...we've got the Chris William's 'Planning For The Future' book and I go through that with people, and...we'll print the graph off for them, so they can see how their scores have gone and... a lot of people, they are really pleased with how they've done. So that's nice, but it is difficult when it's coming to an end, I guess after you've worked with people they keep [wanting to] come back...(Rachel 1)

For HITs ending treatment involved recognising the fact that patients might need further help down the line.

It's okay to discharge people when they're not fully well, because you get to a point where all you're doing is checking in, then it's fine to discharge them and they know where you are if they need to come back, but I think that requires a certain amount of confidence...(Stephanie 1)

7.4 The training - practice mismatch

As suggested in the previous chapter (see 6.6), the sequencing of teaching and learning was inevitably at variance with what trainees needed in their clinical practice. PWP regularly felt they wanted to run, before they could walk. Jane had to assert her right to be a novice, to remind herself and her manager she was a trainee, when expectations of her role diverged between the

University and service. Maria, mid-way through the year, struggled with a kind of 'stage fright' about the gap between theory and practice and felt impatient to get past the point where she simply didn't know or hadn't done things before.

...I'm not so nervous about assessments anymore, but follow-ups I get really nervous about and I know it's just because I'm not as practised at those. I just hate having to trudge through all the unpractised stuff and feeling like I don't know. I guess that's what knocks your confidence and I guess as a person I'm too impatient, I just don't like it (LAUGHS). So I try and avoid it! I prepare by just prepping so much, prepping little speeches in my head, that kind of thing... 'cos it's like acting a lot of it and that's what I try and prepare for in the follow-ups, just try and act my way through it. (Maria 1)

Trainees also found it challenging to apply what they had learnt in the classroom to the work environment, even where it was relevant and timely. All commented on the experience of being faced with a patient they did not know how to respond to and feeling out of their depth, during the training year. Martin, for example, looking back six months after completing the course, recalled his worry about not having the basic skills to help patients,

...if you'd not done the teaching on a particular condition because that's in January You're seeing someone with health anxiety or GAD now, you're like, 'what's GAD?' [LAUGHS] Yeah, so just being able to diagnose people and know what to do, so I assume my first patients took a lot longer and didn't get anything like the service they would get today,...so, knowing that you're not doing a very good job and you're going round the houses a bit and you don't know what you're talking about [LAUGHS] and don't have the skills....just basic things. (Martin 1)

For HITs, with their greater responsibility for diagnosis and formulation, the mismatch between teaching and practice led them to worry when they hadn't seen certain conditions which they were meant to provide evidence of treating, to meet the course requirements:

...sometimes, you're doing about a particular condition and you haven't got anybody with that condition, you're trying to work on some other people with other conditions, so of course, you know, you focus on it while you're in the lecture, while you're in the session, you know, but then once you've come out of

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there, it's hard..., because really you want to be focusing on the ones you're trying to do for your [assessment], that you haven't already had a session on you know... but there's no way around that... (Joanne 1)

Sue felt the course was a bit 'ivory tower' in the way it presented things and that the distance between training and clinical practice was too large,

...after the first few weeks, especially those first few weeks out in practice, my view of the University course changed quite drastically. At first, I expected that I would be applying everything in exactly the way stated in the course, but now I see it as quite removed from reality... Important to have it there as a kind of lodestone to keep us on track, but not something that relates in any way to reality... (Sue 1)

Sarah, on the other hand, accepted that what she had to offer patients was not going to work for everyone and that there would be people for whom the interventions taught on the course, such as BA, wouldn't be suitable. For her, the frustration was that the written case examples used in training didn't reflect messy reality.

Most of the trainees in both groups worried about whether they were applying what they learned correctly, but PWP's were most likely to have difficulties with the materials they were expected to use. For example, Sue described struggling with the PWP 'bible' (the 'Reach Out' Manual) as guide to how long different activities should take. Her patients didn't seem to get the materials at the pace the Reach Out guide suggested they should.

In practice, I'm not structuring my sessions the way the University wants. A lot of the interventions, I try to use the Reach Out worksheets but...there's a really minimal amount that's going to apply.... a lot of my patients pick things up slowly. So I'm having to do in three sessions what the course says to do in one session. (Sue 1)

Sarah too found doing 'follow-ups' with patients who couldn't read or write, rendered many of the tools they were encouraged to use at University redundant. She became good at adapting the materials in these circumstances,

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using pictures, relaxation techniques and talking through the principles of the interventions with patients instead. She was keen to get past the stage where nothing seemed to ‘click’ at assessment and felt frustrated by the mismatch when working out how to help patients:

...because a lot of what we're taught at university like it's good, and I do try and stick to them interventions where possible, but sometimes people just don't fit into the boxes neatly, none of us do really. (Sarah 1)

Steve felt that patients could sense when he was unsure about what he was doing and was concerned about the impact his uncertainty could have on the session. Joanne too, worried about her knowledge from the course lagging behind her need to make clinical decisions and plan sessions with patients,

...You can have read things up but then you think, well, how do I plan this? You know, how do I put this into a plan? ...When somebody brings something up you haven't got quite enough knowledge about the models to know whether you're actually doing [the right thing], but if you follow something up, [you ask yourself] should I have followed that up? Is that right for the model, or not? That, that's the feelings I'm getting. (Joanne 1)

The overall intensity of the training year and lack of time to absorb what they had been taught was also difficult for HITs. Like the PWP, they struggled with fitting the IAPT treatment ‘models’ to individuals, with different needs and preferences,

I'm unsure when to stick with what seems important and when to stick with the model. (HIT trainee, observation session, 3 Feb)

Even where things started to make sense during teaching days, it was easy to feel uncertain again when working on your own, back in the service, with little time to think.

7.5 Supervision during training

The IAPT service model provided high levels of supervision to trainees during and after the course. The HIT trainees had weekly group supervision at the University throughout the year. They also received one-to-one clinical supervision from a senior member of staff in the service, on a less frequent (typically fortnightly) basis. The service supervisors were the trainees' first port of call for day-to-day clinical concerns and were usually qualified CBT therapists or clinical psychologists, who had undertaken additional IAPT supervision training. The CTs' supervision on the course was focussed on helping the HIT trainees to develop their skills to meet the assessment criteria for the OSCE exams and end of year portfolio.

The PWPs, by contrast, did not receive supervision (other than informal peer supervision) as part of the training course, but did have case management supervision within their services. For most PWP trainees, the case management supervision was combined with clinical supervision and could be provided either by an established therapist or counsellor, or 'Senior PWP' (see 3.5.1) or their team manager. All supervisors were meant to undertake specific IAPT supervision training, enabling them to give role-specific advice. At the time of my research however, this requirement had yet to be fully implemented and the level of clinical (but not caseload) supervision provided to PWPs varied. It is only since 2015, that weekly case management supervision and fortnightly clinical skills supervision has been a national requirement (PWP Training Review Team, 2015: 2).

7.5.1 HIT trainees' views on supervision during training

HIT trainees were extremely positive about both the amount and type of supervision they received whilst training. Anna, for example, described it as the best and most intense form of learning and a great improvement on the supervision she had experienced in her previous post. She told me it was uncomfortable at times, as supervision involved watching back videotapes of sessions that could be exposing. It confronted her with intimate details of her practice and showed up areas of weakness, which might previously have been glossed over. She felt well supported by both University and service supervisors however.

For Jill, the supervisory relationship in the service took longer to develop. She attributed this to the fact that her supervisor was not specifically IAPT trained at the time she started. She found the University supervision to be more supportive and easier to make use of,

...the university supervisor was much more clued into what we didn't know...and I'm not blaming [the service supervisor] now, because I think some of that was the fact that she was new to IAPT and new as a supervisor... (Jill 1)

For Joanne, however, her in-service supervision conflicted at times with what her University supervisors were telling her. She resented what she perceived to be a more relaxed style of supervision in the service, which didn't help prepare her for the exacting standards expected by the University. She felt disadvantaged relative to her training peers and attributed failing some of her clinical assessments to the discrepancy between the two sources of supervision.

7.5.2 PWP trainees' views on supervision during training

Amongst the PWPs, those who were supervised by 'Senior PWPs' were the happiest. Trainees felt these individuals had the best grasp of the PWP role and the most recent, directly relevant experience to share. Sue, for example, contrasted the position of trainees who were supervised by experienced PWPs with those supervised by co-workers from different, non-IAPT backgrounds,

I'm fortunate in that I'm being supervised by a PWP, who's done the supervision training course and it's all very clear cut for me... My colleagues aren't so fortunate in that they've got these experienced workers with different backgrounds, usually it's Social Work, they don't adhere to the PWP model and method and that creates a whole other set of issues to contend with as well. (Sue 1)

During and after training, the bulk of supervision time was spent on case management, using the electronic MIS. All new patients had to be discussed and assessment decisions reviewed. Thereafter, cases would be flagged up by the system following a traffic light system; for example, if the patient DNA'd or refused treatment, if their outcome scores worsened, if they were nearing the end of their six-session treatment or needed another referral intervention or if they were to be discharged early. The supervision task was to discuss all active cases - new and/ or flagged as needing review - and to look at the overall caseload size and waiting times for each GP practice list. For the PWP trainees, there was also a component of clinical supervision, in that they would be helped to plan and implement suitable LIPI treatment plans from the PWP manual. For Rachel, case management and clinical supervision worked well when done together,

...when you're in the notes and in the throes of doing case management, to ask the clinical stuff does I think naturally come into it and it's difficult to say, 'this is case management and that's clinical.' I think there is overlap, definitely....
(Rachel 1)

PWPs universally welcomed the supervision they received and found it reassuring and helpful,

It's really helpful to have someone there that you can just say if you're not sure of what to do, 'cos there's nothing worse than thinking you've got a follow-up session and not knowing what to do. (Sarah 1)

7.6 Discussion and conclusions

This chapter has sought to locate trainees within the wider setting of the GP practice and IAPT sector team, during training. It has looked at some of the practical and emotional challenges of being itinerant, starting clinical work for the first time and establishing themselves in role, in the context of multiple pre-existing roles and practices at this level. A number of different factors appeared to have helped and/ or hindered the transition process for individuals, as anticipated in Chapter 3 (3.6.3).

First of all, administrative systems, people and practices, varied considerably in each workplace setting, often in ways which complicated the process of learning. There was no static back-drop against which the trainees could position themselves in their new roles, as discussed by Fenwick (2013) (see 3.6.3). Instead, they had to adapt their own practices on a daily basis to fit in with pre-existing, and sometimes inconsistent systems at each site. Trainees had to work at correcting misconceptions, particularly about the PWP role, whilst cultivating good will and support for handling cases outside of IAPT's remit. Individual differences in referral practice (between GPs), combined with the variation in population characteristics between GP practices, added a random component to planning and preparation for clinical work (this is discussed further, in Chapters 9 and 10).

Secondly, their 'transition shock' (Hoare, 2016) was exacerbated by the lack of co-workers and supervisory support on site, to whom the trainees could look for role modelling or advice. Individuals had to work at making connections and keeping in touch with 'virtual' colleagues (separated by time and/or space), when delivering their core tasks of screening, assessment and referring new patients on. As advised during training, most were proactive and made use of informal contact opportunities to overcome the obstacles. The GPs and practice-based staff however were not all equally prepared for or amenable towards IAPT, and itinerant 'mini-team' members were very conscious of their part-time presence and newness. Trainees thus felt they were uncomfortably positioned as 'hero innovators' (Grant et al., 2008: 38), with a case to prove, whilst still very much at the novice stage of learning (see 3.6.2). In this context, it is not surprising that trainees valued peer support highly, especially when able to be given in person. There was however, a strong theme of isolation and loss (from staff turnover), connected with these arrangements (I return to this theme in Chapter 9).

Starting in clinical work was another aspect of transition that evoked strong feelings in trainees (7.3.1). Whilst a certain level of anxiety was to be expected (Rønnestad & Skovholt, 2013), given their beginner status, there were also tensions between the 'discipline specific' requirements of the IAPT training course and the 'context specific' and team aspects of their roles, which required considerable adaptability (Michalec & Hafferty, 2015). It was hard to know when information gathering at assessment was sufficient to facilitate the process of choice-making with the patient, and individuals varied in how confident they felt about adapting materials, to increase engagement. A consistent message from training was that trainees should stick with protocols and 'best practice', yet it was not unusual for individuals to find things looked very different from these formal roadmaps (Neuhaus, 2011).

The problem of knowledge translation worked in two directions; from classroom learning into workplace practice, and from practice back into the assessment process. HITs in particular, had to work hard at accumulating the right kinds of cases to practice on and to show competence for their clinical portfolio. Having their clinical sessions video-taped and scrutinised throughout the year by University and in-service supervisors was exposing and a new experience, even for the established professionals in this group. For PWP and HITs, knowing that their employment contracts were contingent upon their passing the course, intensified the pressure and stress felt at times (Walklet & Percy, 2014). On the other hand, the introduction of senior PWP roles and their

presence, in IAPT sector teams, whether in supervisory capacity or not, helped instil confidence in PWP trainees.

In Chapters 8 and 9 we will see how these challenges looked to former trainees once they had qualified, what new difficulties and dilemmas emerged and what they left behind.

Chapter 8 - Post-training transitions: role consolidation and clinical practice

8.1 Introduction

This chapter and Chapter 9 look at the first year after completing IAPT training for both PWPs and HITs. The focus of this chapter is on consolidation of role and clinical skills, the growth of case management pressures, dilemmas in practice and related transition challenges. In the next chapter, the focus is on working relationships within and beyond the IAPT mini-team, the impact of supervision and performance management, and both groups' thoughts and feelings about the future. The findings are based mainly on the analysis of the second and third FANI interviews with Cohort A participants and the first interviews with Cohort XYZ. In both chapters, I also include extracts from I-Poems to illustrate particular points.

In this chapter, I argue there is evidence of practitioners changing in ways which are likely to strengthen their effectiveness; for example, coming to terms with being 'good enough', developing treatment likes and dislikes, making use of peer support, internalising supervision and applying CBT to themselves. There is also evidence however of change occurring which has the potential to have adverse consequences, such as 'therapeutic drift'. I argue the theory-practice gap persists and changes shape, as the course assessment strictures are lifted and practitioners feel encouraged to work more flexibly. This and the contradictions of patient-centred care contribute to some loss of faith and disowning of the PWP model. We also see increasing differentiation between the HIT and PWP roles at this stage in terms of their capacity to exercise choice and control over daily tasks.

The first section below looks at former (Cohort A) trainees' reflections on the training once they had finished, compared with those (Cohort XYZ) who trained earlier (8.2). It explores the process by which individuals sought to

consolidate their role and clinical practices, how they incorporated CBT into their work and world views, and dealt with the challenges of self-care and keeping to task (8.3). In Section 8.4 I look specifically at their work with patients; the challenges of working at high volume and low intensity, the success stories and dilemmas posed by clinical work within the IAPT service model. I again compare views between the later and earlier cohorts of practitioners. I conclude (8.5) by reviewing the main gains and losses entailed in moving on from the training year, the helping and hindering factors and risks to patients' and practitioners' well-being that surfaced at this point.

8.2 Reflections on finishing training

Those trainees from the observation cohort (Cohort A) who submitted all their work on time at the end of the second semester received their final results in the Autumn just over twelve months after they started, whilst those who had extensions, or had to resubmit work, heard their results at different times. For the HITs, passing the course was overshadowed by knowing a small number of their peer group had failed to qualify and faced job change and/ or redundancy as a consequence.

All of the trainees valued the learning they had gained from the course. Completing and passing all the assessed work was a source of pride and improved self-confidence for PWP's and HITs alike. Jane, for example, felt she had learned new skills and could be discerning in how she used them,

I've learnt loads from the course... lots of skills..., things that I can use....things that I think work well and things that I think don't...I've developed confidence in being able to treat and assess people, I think that's got better and better. (Jane 2)

None of my respondents were under any illusions that their learning was complete however. As Anna commented,

I feel confident in what I've learnt, I definitely wouldn't say I feel competent (Anna 2)

Chapter 8: Post-training transitions: role consolidation and clinical practice

For the PWPs and younger HITs, there was a feeling of still being at the beginning of a clinical career, with much to learn, a need to consolidate and practice the rudiments learned on their courses. One of the things the PWPs reported feeling most pleased about was how they'd learned to understand the boundaries of their role and to stand up for themselves at work,

Since the course finished I've been able to say, 'I know what my job is, I know what my skills are, this patient does or does not have an issue I can work with' and being able to say that to the GPs, to [the CMHT] and to the patients ... (Sue 2)

For the HITs, being able to let go of the perfectionism they struggled with during the training year and accept 'good enough' was an important benefit of the course. Some attributed their improved self-confidence to a greater degree of self-acceptance, which was hard won. Joanne found her self-belief badly shaken in the assessment process, but felt it was slowly reappearing after she got through the qualifying hurdles.

All the former trainees felt relief and for a while, a greater sense of control over their time once the course had finished. HITs in particular welcomed the chance to take more time to think, read and prepare for patient sessions. PWPs tended to spend more time doing the research necessary to signpost patients on to appropriate services as part of their assessment role. All felt it was good to have more freedom to decide what they wanted to learn, when and how to do it. Some quickly took up opportunities to work with new colleagues, for example, Anna co-facilitated a BA group with one of her HIT colleagues. Sarah shadowed and then co-led a Stress Control psycho-educational course as part of a sector-team initiative - something which she described as hard work, but valuable for her own development. Six months after qualifying, former trainees also talked of varying their treatment plans and taking a more flexible approach to working with patients, which they enjoyed following the 'straitjacket' of the course. All commented too, on aspects of their practice, which had changed; for example, getting better at 'goal setting' and keeping sessions focussed, or learning to trust the interventions more.

Other important positive aspects of finishing the course mentioned were the friendships gained, the pay rise, recovering social and personal life from a year of evening and weekend working and returning to physical activity and

leisure pursuits abandoned during training. For some, finishing training meant having time to get to know the wider IAPT team (see Chapter 9). For the first time, they attended team meetings, took part in service CPD activities, met and shared information with colleagues. A final major benefit of finishing was the reduction in 'surveillance' activity. Trainees were no longer monitoring and recording their performance in search of examples to use for assessment purposes.

There were losses too in finishing the course. All missed the regular time away from clinic, with their fellow trainees. The PWPs formed tight friendship bonds and missed the shared week day activity. Both groups felt the loss of their University teachers and supervisors, the helpful back-up when problems arose during the training year (see 7.5). Another aspect was the loss of 'trainee' status; despite the vulnerability felt whilst training, individuals described feeling less 'protected' as qualified practitioners. As Sue observed,

I think that step up from trainee to qualified practitioner was, there were expectations as to how many people you were seeing, how many clinical hours you're doing. So we all knew it was coming and we'd all been building up to it, but I think a big factor has been....that we're in effect fielding everything that the GPs throw at us (LAUGHS)... (Sue 3)

Clinical caseloads increased more steadily for HITs than they did for PWPs. New GP practices were added to each person's rota and sessions given over to new patient contacts, on what had been their training day. For HITs, this was valued as an opportunity to broaden their experience with different patient groups, whereas for the PWPs it was an uncomfortable step change in their workload. HIT and PWP pairings in GP practice 'mini-teams' became increasingly important as a means to support (or not) PWPs to cope with wait list management.

Learning by doing was also a continuing necessity. All former trainees encountered new patient 'conditions' they had not treated during the training year. HITs welcomed this as an opportunity to continue learning. For PWPs, it was a source of stress when they felt unequipped to deal with the severity of patient conditions. Problems arising from inappropriate referrals continued unabated after training. Another continuity from the training year was the discomfort of the theory-practice gap; a learning opportunity for some, a

source of stress for others. As Jane commented, it was hard to know how this gap could ever be completely filled, in relation to assessment skills,

...in terms of the training course, it is really good, and you're guided well in the treatments you learn a lot, but I still think there's maybe something around assessing that we could have more on. Whether that's about how should we be seeing people with complex needs, or is it that we shouldn't be assessing those people? I don't know. But [the teaching] doesn't quite fit with the practice side of it... (Jane 2)

For HITs, assembling all the necessary evidence for course and service assessors was arduous, whilst for the PWP, lack of time to consolidate learning was keenly felt. Their accounts at this point, are gritty and determined, as in Sarah's 2nd and 3rd interview voice of 'resilient determination':

I think I've just sort of
I've come round to it
I'm not a quitter
I would never leave
I always stick at things
I would never leave this job (Sarah 2).

=====

I'm quite a strong person
I'm a resilient person
I'm independent
I'm saying that
I don't
I let
I do let things get on top of me
I said
I just at work
I'm, yeah
I just get on with my job
I do my job (Sarah 3).

The PWPs, more than the HITs, saw all comers including those with more severe conditions, such as psychosis or PTSD, and anxiety conditions, such as GAD. PWPs felt they had not been prepared enough to know how to respond (see 8.4 below). They also wanted to know more about how to end treatment. Some wanted 'personal supervision' or personal therapy to be included in the training.

A number of new(er) preoccupations came to the fore for both groups after they finished the course, whilst others that were not new, intensified. Paying attention to recovery rates and what they might mean became more prominent in reflections on practice for both groups. Both talked about adjusting as their centre of gravity switched to the service team rather than University. Some practitioners saw the wider service teams as an opportunity for alliance building and professional development. The PWPs continued to rely heavily on their training peers for emotional and social support outside of work. HITs tended to look more quickly to new colleagues to connect with, because their training peers were less in number and they didn't cross paths any more. As time went on, former trainees in both groups spoke of adapting treatment models, 'mixing and matching' to suit their patients. The links between this and concerns about model adherence are considered in 8.4.6 below.

Participants (from Cohort XYZ) who trained in the first two years of the IAPT programme (or before) echoed many of the experiences described above, but raised different and sometimes more critical comments about the quality of training they had received. These included: teething problems in assessment due to the newness of the courses; frustration with the fact the training did not take into account the diversity and richness of trainees' own personal and professional backgrounds; and at times, resistance to embracing the IAPT way of doing things. There was also a suggestion that the training could be more 'recovery focussed' if trainees were encouraged to reflect more on their own experiences and if patient experience had a greater place in the curriculum.

On the other hand, positive and appreciative views of the training were also expressed. For Steve, the PWP training was a way of rapidly gaining clinical experience which increased his confidence in pursuing a career in mental health. For Jill, the HIPI training enabled her to make the transition into clinical work from her former non-clinical job role, but she would have liked

more help with the expectation that she contribute to running the service. She, like others, described struggling with stepped care not working as intended, and felt that CPD opportunities, after qualifying, could be better. Former trainees continued to feel their practice benefitted most from supervision. Both HITs and PWPs were pragmatic, however,

...supervision helps, and I suppose the experience is now beginning to tell that those are the [patients] who may well make some improvements but at the end of the day, I never really feel that I get to grips with what is going on, but if they stick with [the interventions], most of them take something from it. (Jill 2)

8.3 Developing into the role of qualified practitioner/therapist

8.3.1 Consolidating skills and practices

As already suggested, former trainees were acutely aware of their need to continue learning after the IAPT course. HITs were on the whole better able to protect space to consolidate in than PWPs,

I thought I'd find it difficult being in surgeries all the time, but it's been quite nice actually. You can really concentrate on your patients rather than, like if I had five minutes between patients before I was quickly doing pieces of Uni work whereas now it's like I can work on the waiting list, I can research something I'm not sure about. I can look this up or I can look that up. (Anna 2)

PWPs valued the skills they had learned in managing expectations. Sue, for example, commented:

I'm a lot clearer on what treatment goes with what disorder. I think I'm getting a lot tighter in assessment on setting goals with the patient, what is it you actually want to work on? (Sue 3)

And accumulating case experience helped PWPs in knowing what questions to ask, to tailor treatment plans. Both groups found themselves experimenting too, in light of the patient's responses, as time went on,

With my clinics now, I don't have to prep as much because everything's a bit more familiar. So, sometimes, if you go a bit off topic then you can bring it round or you can do a bit of a mixture...If you're doing behavioural activation, then you might be able to bring in one of the theories about exposure and it might overlap a bit.....it's easier for me to pull different bits ...from all the different interventions and sessions that I've used or done before...(Maria 2)

Activities which all the trainees found useful and which they were encouraged in by their supervisors and managers, included using management information to better understand recovery rates, reflecting on their own practice and applying CBT methods to themselves. Not everyone was comfortable with this process (see 8.3.4).

All the former trainees, by the time they finished, had developed treatment likes and dislikes. Anna was an enthusiastic advocate for BA; Jane preferred cognitive restructuring. Several were developing their administrative practices and finding themselves getting faster at routine tasks. All were concerned to do what felt right for the patient,

Some of the work, you can see how it works through the [IAPT] model...but some... it don't seem to fit right, or you fit the model to the person, rather than fit the person to the model, but obviously have a model to work with. (Joanne 3)

Individuals altered the pace of sessions to make the content more manageable for patients. They broke tasks down, and supported patients to follow them through. In this way, practitioners' progress was deliberate and purposeful. Sue, for example, voiced how things had improved, using her 'rational, determined voice':

I'm much clearer now
I've spotted the things
I can work with
I've highlighted most of the patients
I'm more likely to offer to work with

I've got a lot of confidence in my skills

I've had a lot of very good feedback from patients

I want to do the supervisor's course

I need to make sure

I talk to my manager about that

actually I do feel very confident in this role

I think it must be

I think practice makes perfect

I think

I'm still introducing myself to patients

I feel more like a practitioner than a learner now (Sue 2).

Trainees spoke of developing an ethical position in relation to their work (as predicted in Chapter 5). For those HITs who trained in earlier cohorts, this period after qualifying was also marked by job satisfaction and willingness to share what they learned in professional meetings. Martin, for example, described how presenting in front of others had improved his sense of belonging,

I'm making increasing use of things like [the CBT Forum]. I think it's a brilliant forum and I really like that about the IAPT service.... It's full of very dynamic, enthusiastic people, who are all of the same, early in their CBT career and still in their honeymoon, which is the best thing and starting to improve and really open to sharing stuff. (Martin 1)

8.3.2 Developing allegiance to CBT

HITs and PWPs talked about feeling a strengthened allegiance to CBT in the post-training year. They described themselves as 'believers' able to articulate its benefits, even when they had started out with reservations. Jill, for example, noted she could easily have gone down a different modality training route, but was glad she had opted for CBT,

without a shadow of a doubt I am absolutely delighted that I've done CBT. I mean I see it working, I see it working daily and you can't, you can't argue with that really. If people take it on board and really do it, then things happen. (Jill 1)

Anna, welcomed the use of evidence and the discipline of protocol in CBT,

...the evidence is [to] stick to the model, stick to the model, stick to the model!
(Anna 2)

HITs agreed that the ‘doing’ aspect of CBT was distinctive and something for which patients needed to be well prepared.

...there’s something about the homework dimension, the very active aspect of CBT...which...requires a lot of engagement and an intellectual underpinning of how this might help me, a willingness to engage with the process of putting myself through some painful stuff or making the effort to keep a thought record or do an experiment and write that down. That’s quite, that’s a concept that isn’t going to be familiar to people of some backgrounds. (Martin 1)

For Kay, the focus on the ‘here and now’ in CBT had initially caused her some concern, wondering if it would be sufficient to address patients’ longer-standing concerns and ‘underlying issues.’ She gradually changed her view on this, however, and felt she could work on ‘core beliefs.’ Martin cited several cases of people with phobias, who were hard to engage, but where he had successively better results. Few in this cohort (XYZ) expressed any doubts about the value of CBT, although several, like Andrea, questioned its political popularity,

I think the future is going to be very challenging. I think in five years’ time CBT won’t be the flavour of the month I think counselling will... (Andrea 1)

Some of the former trainees felt there was a strong compatibility between CBT and their own values. Martin, for example, commented

.... just cognitively, logically, [CBT] makes perfect sense to me. I like putting things in boxes and making sense of things and then you can deal with it [LAUGHS]...and so I feel, you know, committed to that as a concept. I do believe that it’s something that is valuable for everybody... (Martin 1)

However, doubts were still expressed about the LIPs, particularly by PWPs who wanted to believe in them, but found the evidence was contradicted by their experience,

I need to believe in the treatment I'm offering people and believe in the model and get really stuck into it. If I believe I'm not helping people or not doing a good job, it's awful. (Maria 3)

The recently qualified HITs on the whole found it easier to be convinced about what they were doing, than the PWPs.

8.3.3 Self-care and keeping to task

Practitioners developed a range of strategies to manage themselves and the work whilst adapting to their new roles after training. Positive strategies adopted by PWPs included: being very well-organised and assertive; using the support and friendship of their peers (see 3.6.2), help from supervisors and managers to police the boundaries of the role. They also included keeping engaged with learning activity where feasible and actively working to improve their own practice. Both Sue and Steve, for example, negotiated changes to their work patterns, to reduce the amount of travelling they needed to do. Sue spoke of ringing into the office to confer with colleagues or supervisors after difficult sessions, 'ranting and raving' at times. Learning to understand the service limits and links with secondary care was also important. Kay, for example, talked about the need to come to terms with the wider system when negotiating patient care,

It does take time, but I think once you get to grips with it, it makes you, it unburdens you, it almost makes you feel okay with the fact that you're turning patients away, almost, 'cause that's how it felt before, it felt as though I were rejecting people, whereas now I know it's not about that, it's about.... I'm giving them the opportunity, the best opportunity, it's just that that's not with me. (Kay 1)

Becoming a resource and source of expertise for others helped Sarah feel more in control of her work.

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Getting early agreement from patients about what to prioritise was also important,

You have to be quite strict and just say, 'this is the option, this is what you need to be doing and in order to do that we need a goal, we need you to say what you want to get from it for us to work towards it.' (Jane 2)

Reflecting on how her own practice had changed since moving services, Kay felt she had become more comfortable by adhering to a structured approach,

...when I came here I made the conscious decision that as a clinician I needed to be more boundaried with patients, I needed to be more structured in the sessions and I thought I'll see how that works. And I've done it and I get so much better results! My road to recovery rates are a lot better...It's guided self-help... we're not psychotherapists, we're not there to do everything for them, it's them doing things for themselves, promoting independence... (Kay 1)

Helping each other out and using the support of co-workers in the same premises was also important. Nonetheless, even the most resourceful PWPs struggled at times,

You do have to look after yourself 'cos listening to other people's problems all day, especially if you're not feeling the best yourself, can be really hard. Sometimes you think 'oh, I just can't do it today,' but you can and it's fine. It's almost always the days you don't look forward to, that are never as bad as you think. (Sarah 2)

Or, as Sue says in her 'epic, dramatic voice'

I was living... I was ill

I was booming and busting (Sue 1).

Supervisors and managers played a big part in helping practitioners not to internalise their own high expectations of themselves,

I think it's taking on board that the pressure I feel sometimes doesn't actually come from my manager, it comes from me trying to do my best. So when I see a waiting list I think I don't want that, I don't like it, I want to be good, efficient and I take that to my manager, my manager will say, 'you can only do what you can do,' and then, I [realise] okay, this pressure isn't coming from you, it's coming from me. (Kay 1)

By contrast, all of the PWP's reported periods of sickness, intense stress and inability to sleep, affecting their ability to do the job. A few took time off, but others kept going for fear of what they would have to come back to and the perceived stigma from not being able to cope. Chrissie admitted to losing sleep and having nightmares worrying about waiting lists and patients she had seen. She didn't want to be seen as someone who couldn't cope or who became overly stressed and refused to take time off. She, and others in my sample, in part blamed 'poor managers' in the service for turning PWP stress back on to the individual who raised it. A number of PWP's cited lack of management understanding as a reason for people leaving the service prematurely, or for being on long-term sickness absence. Over-working and not taking time off, even legitimate holiday entitlement, was thus an issue for some respondents.

The final self-management strategy adopted by the PWP's was to leave. Participants who trained in earlier cohorts were already a minority amongst their peers by the time my research took place (see 5.3.2). Amongst the most recent (Cohort A) trainees, Jane was the first to leave for a new job, immediately upon completing the taught course. By the end of fieldwork, Rachel, Sue, and Maria were all developing exit strategies, and just over two years from when they started on their IAPT training, all but Chrissie, Maria and Sue had permanently left the service. Jane and Sarah moved to different IAPT services elsewhere in the country, still in a PWP role. Rachel left to become an Assistant Psychologist and Maria and Sue were both taking 'career breaks' (see 3.4.1, for national statistics on PWP turnover rates, and 8.5 below, for discussion).

The HITs also adopted a range of strategies in relation to self-care and keeping in role. The main strategy was to use supervision, the next, to gain

control over the weekly diary by negotiating 'reasonable adjustments' where they could. Other strategies, as for the PWP, included being well organised, and working on self-acceptance (see Chapter 6). Jill, for example, learned to reassure herself, along these lines,

I think I'm much better at saying that to myself now, you know, okay what I'm doing is going to be good enough and for some people it's very good and I'm probably not making anyone worse. (Jill 1)

Former HIT trainees worked on their relationships with colleagues in the GP practice, IAPT sector team and beyond. With patients, they stuck to the prescribed treatment models and made sure they didn't see too many patients who were highly distressed back-to-back, a luxury not afforded to the PWP,

I try and plan not to do too much trauma in one day and to do it at the end of the day so you're going home, you're not going to see other patients straight after. (Anna 2)

HITs benefitted from the greater control and discretion they had over their weekly schedule compared with PWP. Martin actively managed new appointments, so as to avoid becoming 'overloaded.'

I tend not to book too many assessments. I never do too many assessments on the same day... I can't process all that information and absorb it. Once I'm up and running and working with somebody I've got a handle on who they are, and developed a formulation in my head...[know] what the problem is and what their history is and where we're going, then that's alright, you can work with five people a day if I'm up and running....it's managing your time to not be overloaded and make sure you've got enough time to process, put it in the right boxes. (Martin 1)

HITs also leaned on their family and friends for support and, where feasible, kept in touch intermittently with training peers, if they lived nearby (see 8.2). Engaging with CPD activity was felt to be another way of keeping on top of the job. The biggest danger for HITs, as already indicated, was finding themselves falling back into their former job roles, especially when under pressure. Once qualified, HITs spoke of being more open with supervisors regarding struggles and personal difficulties affecting work. One or two spoke of needing

supervision to help them take a more positive approach to their physical health and self-care.

8.4 Working with patients

8.4.1 Case management

For the PWP's in my sample (as during the training year, see 7.3.4), assessing and handling new referrals absorbed a lot of time. It was not unusual to have 4-5 'assessments' and 4-5 'follow-up' appointments a day, although in practice, it was rare for all patients to turn up and an average of 7-8 a day was common. The volume of new cases posed significant challenges for the PWP's, including: how to keep patients focussed and stop them 'talking too much'; the struggle to complete baseline outcome measures; and, educating the patient about what to expect from treatment (see 7.3.3).

Some of them just come and sit and sob for a whole hour and want to tell you their life story but generally I think I'm getting them all down to forty, forty-five minutes...(Chrissie 2)

Screening new referrals and deciding what to do was onerous and had corrosive effects over time. PWP's had to repeatedly listen to people in distress and accept having a limited range of things to offer in response to longstanding and comprehensive difficulties. We hear something of the impact of this in Sue's 'epic dramatic voice',

I assessed her this morning
I had to work very hard
I was
I knew
I was walking into a situation
I just had no idea (Sue 2)

=====

I've tried booking ten people a day in

I'll work non-stop

I'll try to do four or five assessments

I had one day where

I had to ring social services

I had to make two referrals

I didn't feel like that was manageable

I took annual leave

I just turned around went up to the bathroom and sobbed my heart out

I couldn't quite comprehend what was happening there

I've treated one patient with a personality disorder

I'm handling all these bizarre situations

I never imagined in a hundred years

I'd end up in (Sue 2).

Chrissie described reeling at times from what she heard and felt she didn't know where to go to process the experience. She was most frustrated by the lack of obvious alternative services to signpost people to (discussed further in Chapter 9). In practice, she felt a lot depended on the individual GP practice and her co-workers, to move people on. PWPs felt there were times when they became de-sensitised to protect themselves from what they were hearing. Sue noticed, for example, her relief when a patient did not attend (DNA'd), as this meant one less person's upsetting story to listen to. She accepted relatively few people on to her caseload and engaged GPs in managing risky patients.

Managing treatment duration was also an issue. Learning how to pace activity within and across sessions was something which everyone grappled with. The PWPs were more likely than the HITs to find themselves up against the clock, with shorter treatment times and a high proportion of non-English speaking patients needing the services of a translator. As shown in 7.3.2, assessment involved quickly recognising and negotiating options. Over time, PWPs became better at referring patients on, caseloading where appropriate and reviewing progress, every few sessions.

Most continued to feel frustrated and wished they could spend more time working with patients,

It would be nice to be able to do longer work with people and really have time to explore a lot more with them, because you feel like you're only touching the surface sometimes. (Rachel 2)

Despite this desire, discharging patients was a necessity in order to keep up with the volume of new referrals and to minimise waiting times for those not yet seen (see also 7.3.5). As Sue observed, the ending of treatment could feel abrupt, with little time to absorb the impact before new cases were ready to be seen,

It's very strange... you've been working quite intensely with somebody, it's a half hour session but you pack a lot into a half an hour...you do build a strong rapport... and if someone gets to the end of the treatment you wrap things up...acknowledge everything they've achieved.... and it is just 'goodbye!' And it's good, I'm always very glad to see the back of a patient (LAUGHS)... (Sue 2)

Waiting lists were an ever-present source of pressure for PWP's, testing their initiative and organisational skills.

For HITs, by contrast, the decision-making process at assessment was primarily about understanding the patient's difficulty and working out a suitable treatment plan, rather than moving the patient on. It couldn't be assumed that every patient they saw would engage with the process and this sometimes meant taking a bit of a gamble, with regard to the possible outcome,

I like to give everybody a chance and if they don't take to therapy, then they don't, but at least we've done a bit of a trial. But once they're on your caseload and they don't get better, even if it's just two or three sessions, then that counts on your recovery rate...So, you're thinking ahead much more quickly, you know, 'do I want to work with this person?' (Anna 3)

Even with their smaller caseload size, longer average session time and overall treatment duration, the HITs felt under pressure to keep to time and task. Only after qualifying, did the issue of volume and session management really strike home for Martin,

I'm finding it hard to keep sessions to time, I do a bit of 'let's have another five minutes just to make sure we've really done what we need to do,' I do have that tendency! [LAUGHS]... It was really acute [just after qualifying]. It was going to those five sessions a day and carrying around a lot of people in my head and suddenly you've got 17 plus people's stories in your head and formulations and treatment plans and that's all flowing around up there... (Martin 1)

At times, HITs would need to make a further referral after working with a patient, either back down to a PWP for guided self-help as a way of finishing off treatment started, or to counselling, for more specific work, such as grief or relationship advice. Referrals to counselling could mean putting patients back on to a waiting list however - which was a further source of frustration. Some of the HITs felt particularly uncomfortable about handing patients back to a PWP after HIPI treatment,

I found it quite difficult to know how to present to the patient that actually seeing a PWP was more appropriate than seeing me....I saw someone with health anxiety and he was particularly tuned into who was seeing him and I found it quite difficult to say to him, 'well, have a go with this person and if it doesn't work you can come back and see me'...(Jill 1)

In general however, the HITs were aware of the large burden on PWPs of having to assess all new referrals and were relieved not to have to share it. In a system where everyone has to be seen initially at step 2, they recognised PWPs might be tempted to refer people on to step 3 quickly, even where there were things that they could do to help first. Where the PWP had worked with the patient prior to stepping up, the HIT valued the priming for CBT that this provided (as suggested in 7.6). In practice however, the HITs also found themselves having to negotiate and accept difficult cases due to pressures above and below them, at the boundary with secondary care and step 2 (see 8.5 for discussion of this point).

8.4.2 'Success' stories

A year after beginning in clinical practice, former trainees told me about a range of people they had worked with that they felt they had genuinely helped. This was sometimes in response to a prompt from me, sometimes raised spontaneously by them. Usually, the cases described were people that the practitioner felt was an unlikely candidate for IAPT treatment. Anna, for example, in her 'voice of belonging,' says,

I'm getting to the point
I'm doing something right
I've got
I've nailed that now

=====

I'm persevering with people
I just feel
I want to give them a chance
I am seeing people that are technically not appropriate
I've seen her for seven or eight sessions now
'I don't know if this person's appropriate'
I did
I can't even tell you
Everything I said
When I passed her the PHQ9
I just completely ignored it
I mean
I couldn't say
I wouldn't see her on that basis

=====

I'm a big talker
I'm just really lucky (Anna 3).

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In this extract, she is describing working with a female patient, that her supervisor thought she would be unlikely to make any progress with. The patient was aggressive, and had a traumatic history, but presented with 'loneliness and a lack of friends'. Anna worked with her on her social skills, conducting 'behavioural experiments' both in session and out in the community. She managed to make the patient laugh and understand better how she came across to others. Together they identified different ways of coping and the patient 'moved towards recovery.' In Anna's words, 'that was a really nice piece of work.' By the end of treatment, the patient was,

not hugely different... but starting to look, starting to learn how to interact with people differently. She's got a partner now and it wouldn't surprise me if she ended up going back to work eventually, well she's never been to work but getting a job at some point...(Anna 3)

For Sarah, the greatest satisfaction came from finding people the right support and services, in the local area. We hear about this in her 'IAPT champion/ dedicated worker voice':

I'm doing lots of extra little bits
I've been doing my first course of Stress Control
I book out a little bit of time in the afternoon
I still do a clinic in the morning
=====

I saw him
I've worked
I felt
I could
I'm going to send him
I've gone above and beyond
I've sent him some information
I've also spent some time looking
I'm aware of
I've done that for him today
I think

I'm not taking this off
I think
What I've done
I've referred
I've given him the information

=====

I took it seriously
I went through all those things
I can see why
I felt like
I'd done a good piece of work (Sarah 3).

The rest of the time, when describing clinical work, participants tended to differentiate between 'good' and 'bad' cases they had seen. For PWP, 'good' cases were those where it was possible to make an appropriate onward referral, compared with having no obvious place for the patient to go. Both HITs and PWP described how much easier it was to work with patients who were willing and motivated, engaged with the activities and gave things a go.

Another distinction drawn by participants was that between patients with high 'caseness' compared with low. Practitioners generally found it easier to have an impact with people at the higher end of the symptom scale and struggled with those who had either got better by themselves whilst waiting or who had been in and out of mental health services over a long period of time.

There are sometimes people that have waited to be seen, referred by others, for over a year... And when they come...they've not really been scoring that bad, they're under case-ness... They have recovered to a certain extent but... they're keen and they want something from you...I find it hard to work with people like that. It's easier to work with people that are scoring threes and eights on everything than with the under-scorers... It can be difficult... I feel that I've got to do something with them, after they've waited all this time. (Joanne 3)

Practitioners described being surprised at their own successes some of the time. For Martin, it was down to how well he and the patient engaged with

each other. With his successful cases he was able to work collaboratively on understanding the problem and breaking down what was needed into manageable pieces. Although there were times when cases didn't progress well, it was a triumphant experience for all concerned when the treatment did work,

...when people engage with it really well, and you're not struggling, banging your head against a wall...., [when you can] get a handle on a problem and put things into boxes for people, enabling them to see it and to see it as a manageable problem, something that was life consuming a few weeks ago, that has got a name on it.... I think that's the beauty of CBT. When people engage with that and are very pro-active, their locus of control shifts quite quickly and then yeah, it boosts your confidence that you're doing a not bad job...(Martin 1)

In her third year, Jill described continuing to find 'depressed' patients less enjoyable to work with than others, but felt she could express her sense of humour and sometimes 'have a giggle' with those who were anxious. She felt the people she saw who had made the most 'miraculous' recoveries were those with OCD or PTSD who had not previously had any input from psychological services and who had experienced their difficulties for a long time. She also enjoyed working with women, using CBT treatment models, not included in the IAPT protocols, such as those relating self-esteem. The satisfaction she felt from seeing these women improve was immense.

8.4.3 Clinical dilemmas

The first year post-training saw all the former trainees grappling with the complexity of patients' lives. None could really turn a blind eye to the challenging environments their patients came from. Rachel gave one example,

[There are] different pockets of areas. I've got one area where it's quite socially deprived and the amount of problems with neighbours can massively affect what [patients] are doing. It really does make a difference where people live. Because if you're getting all that hassle from your neighbours in, what's supposed to be your area, your home, that's supposed to be where you feel safe... And if you don't feel safe in your home... It makes a massive difference. (Rachel 2)

For the HITs, the long-term and chronic nature of patient difficulties, was often reported, alongside various 'co-morbidities.' Stephanie, for example, felt it was rare to see someone for whom the current episode of depression was the

first or the only difficulty. For the PWP, working with patients from different cultures, who had different expectations regarding treatment and communication, was a common challenge, whether or not interpreters were involved.

Where I see a lot of different cultures it's so frustrating because... you can't pinpoint what it is that's difficult... People don't come with a 'this is what I need to work on,' you get a lot of barriers and boundaries to break down and people drop out and then come back. I'm not sure why they come back. If it's just for a chat or if you had to end treatment because they were not getting anywhere, then they're coming back and wanting an appointment. I'm so full up and it's like 'arrgh!' - that's hard. (Sarah 3)

Some PWP and HITs took pride in researching resources to help manage in cases like these, whilst others wished to do this, but didn't feel they had the time. Patients with histories of severe trauma were felt to be especially hard to help. As Anna explained, the people she saw with a substantial history of trauma and/ or abuse, were least likely to fit the stepped care model,

I get a lot of women who've had really horrific childhood abuse, domestic abuse as adults, multiple rapes and all the rest, who have been risky, have overdosed and done lots of self-harming. But in their forties and fifties, they've settled down and... they're dealing with it in a different way... They're not risky enough to send to other services but equally their trauma is so complex that I don't know if I've got time to do deal with it in twelve sessions... They fall between the gap a bit, they're the hardest ones. (Anna 3)

The omnipresence of these 'gap' patients was keenly felt. This group included people whose needs were more complex or more chronic than could be managed within IAPT, but whose symptoms weren't severe or acute enough to meet the criteria for secondary care. The 'bouncing' of patients between referrers was thus a daily occurrence. Chrissie found the most common group she and her HIT co-workers had difficulties with were women, 'who are impulsive and high risk one minute and perfectly okay the next.' She commented on how differently the same patient could present from one day to the next. Vicky said she tended to send these patients to counselling. Kay put the onus back onto the patient to decide and used supervision to confirm what to offer and when to recommend that 'it's not the right time [for treatment].'

8.4.4 Fitting simple solutions to complex problems

Following the training year (see 6.4), everyone could see value in keeping things simple for patients and focussing on a defined set of problems as a starting point. For Kay, the best moments in the job were when, as taught, simple things led to major changes,

People getting better, people moving to recovery, feels good. Those kind of 'eureka' moments where you can see the penny drop. The really simple things that just people acknowledging certain aspects of their thinking just makes them think, 'oh,' and it changes their lives completely almost. The changes that you see in some people are incredible. (Kay 1)

However, it was also common to feel resistance to doing so, either in themselves or their patients. For Rachel, the time limits on assessment and treatment duration grated most. For Jane, the content of the interventions and how these could be perceived,

I do feel that a lot of what we do is quite simple. Patients look at you as though, you know, 'I could have thought of that,' or like, '[if] it's literally that simple, that's not going to work,' so you really have to sell it to them that actually it does sound really simple, but it is effective. (Jane 3)

For Maria, not being convinced herself of the value of what she was offering, made the task of persuading the patient impossible at times. Like many of her peers, she hated not being able to see things through with people and feared disappointing patients,

That message is drummed into you, 'simple solutions to complex problems,' which generally means you'll have to step somebody up in a couple of sessions because [your work] won't have done anything, or else the person will drop out because they'll be so disappointed because it isn't what they expected at all. (Maria 3)

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At times, the signposting aspect of the PWP role could be experienced as 'letter-boxing' - that is, endlessly posting patients through different referral channels in the search for a suitable (and available) service,

I know signposting's part of our role, but when the doctor just sends anybody to you, you can't just shove them back. You have to say, 'okay, so they're more appropriate for Anger Management, I'll get you a form and I'll tell you what it is, and I'll book you a place and then send it across and you need to sign this.' And so you're doing a lot of paperwork, running in between and it doesn't feel very mental health based. (Maria 2)

Service closures made the problem worse. Sue, for example, commented on the instances where referral to sexual abuse services was equivalent to sending the people into a 'black hole' in the light of recent funding cuts. Anna too, found juggling the needs of a patient with complex problems was problematic, in a system with unequal waiting times,

Lots of people have personality issues that make it very difficult in therapy. Doesn't mean that they can't have CBT, but it might be that they need longer term stuff. So the CMHT will be able to offer that. But they've got a year's waiting list and they might bounce them back and then they're left between services....(Anna 2)

The emotional toll of repeatedly having to come up with 'a simple solution' for patients told on the newly qualified PWPs in a way that they had not felt before. Maria, for example, experienced the need to keep moving people on, whilst not addressing the full complexity of their needs, as a clear ethical dilemma,

They all come through us at step 2 and we've got no prior warning. So, you know, somebody's divulged all this information [to you] and you just have to work [with it] on the spot. You can't..., how on earth can you protect yourself emotionally from that? How on earth can you give a decent service? You can't just say, 'oh wait, stop talking, because I'm not going to treat you anyway, you're going to have to go somewhere else'. Ethically, it feels horrible to have to tell people 'I know you've disclosed all this but you need to go elsewhere.' (Maria 3)

Joanne also felt the time limits on HIPI treatment curtailed its value:

It's a hard task in 16 sessions to make an impact. (Joanne 3)

Both PWP and HITs felt the discontinuities in stepped care rendered the idea of simple solutions meaningless at times (see previous sub-section). However, it was the PWPs who were most likely to feel fraudulent in attempting to persuade patients of the case.

I feel awful that this patient's had five different appointments with a psychiatrist, a PWP, a CBT therapist, the doctor and a CPN and they've just told them exactly the same story all the time and you're going, 'no, it doesn't fit for me...' And then we're told 'well, I'll offer you a simple solution for your complex problem,' it just sounds ridiculous (LAUGHS)... 'oh maybe they've never tried this before' that's what I get told sometimes... (Maria 3)

8.4.5 How to be patient-centred?

There was a recurring tension in participants accounts between the idea of being patient-centred and that of managing patient expectations (as described in Chapters 6 and 7), so that the practitioner could stay within role. The tension was particularly acute for PWPs, who found it difficult to know how far to go in meeting patients' needs and wishes. Knowing what was on offer within IAPT (see 6.3) was one thing and going beyond this was another, as Jane explained,

I suppose in terms of what we know we can offer within our service it would be the patient's choice, but it's whether we know enough about the other services to make it completely patient-centred. And whether that's our role or whether it's the GP's? (Jane 2)

Maria also found it onerous to cover all bases sufficiently,

There's a massive responsibility, if somebody comes and you need to know everything about every service, you need to pick up everything, because you'll step them to something and they'll get rejected back. Or, you'll refer them to

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something and they'll come back. You have to do loads in just that one assessment time, because you are responsible for where they go next. (Maria 3)

PWPs felt they were good at getting patients to open up to them at assessment, but this could also cause difficulties. Patients would prefer to talk in an open-ended way, whilst the PWP's task was to get them to focus rapidly and agree a referral route or treatment goal before the end of the session. As Sarah explained, the concept of being patient-centred was hard to implement when patients confused their mental health difficulties with physical symptoms. Jane felt strongly that flexibility was needed and to focus more on the person, than the model,

You've got the theoretical side of what you do which is very clear cut, but in actual practice it's not like that with patients. It's a bit give and take, but I think as long as I've got a general structure - either BA or problem solving or, I don't know, anxiety work, exposure - then it's alright if we end up talking about something else for a bit of the session... (Jane 2)

The limited repertoire of interventions and places to signpost people at times belied the philosophy that it was always better to do something at Step 2, than to leave people waiting,

it's only better to see them if you've got a clear treatment programme and a clear beginning, middle and outcome. Otherwise they drift. So you know a PWP can do six sessions of excellent behavioural activation and then a relapse prevention, they might do seven sessions in all, that's brilliant. But if they're just cherry-picking bits from CBT manuals ...and sticking them on the patient that's not good. (CT 1)

For Kay, it was less about the patient achieving full recovery after 'treatment', than getting started on something they could continue by themselves. All too often however, the search to accommodate patients' needs, through sign-posting or LIPs, meant PWPs felt drawn to experiment and borrow from the HIPI repertoire. By being patient-centred, they risked working beyond their role and training. This risk was increased when PWPs felt frustrated and that they were stagnating in their clinical skills.

For the HITs, the tension over being patient-centred was strongest for those with 'multi-morbidity', as Joanne explained:

There are people that go round the system. The idea is... that you treat one problem at a time. And if you treat that problem within six weeks then basically you're done. You've done your job. They [have to] go back on the waiting list and wait again... if they want to look at another thing...But who's going to do that? I don't think anybody does that. You're not going to discharge somebody after six weeks when you've solved one problem...You're going to work on the others aren't you? Up to 16 weeks. (Joanne 3)

HITs were only too aware of the ironies of promoting patient choice in a system with waiting lists. Even if people did manage to pass through to the appropriate step relatively quickly, it was at the cost of having to tell their story over again each time. In addition to all this, being patient-centred meant balancing patients' need to progress at their own pace and the system's need to keep people moving and hitting targets.

There's this contradiction that IAPT is patient-centred, but then there's performance reports and targets that show somebody where they are in numbers and where they are on the conveyor belt and the need to fulfil contracts. (Andrea 1)

8.4.6 Model adherence

For the HITs, there could be tensions arising from the expectation that they use only the IAPT-specific treatment models, rather than the full repertoire of CBT tools. For example, Joanne felt she had to obtain 'permission' to use a self-esteem model which was not IAPT recommended, with one of her patients. Discussion with supervisors would resolve concerns and there was comfort in knowing that the IAPT-specific models helped individuals to stay within role,

There's certain times that you can see CBT, by following specific models within IAPT, the ones that they recommend, you can see how that works..., it can work well with people...If people have got complex problems you don't have to take the lot on...(Joanne 3)

Chapter 8: Post-training transitions: role consolidation and clinical practice

However, different practitioners interpreted their roles and the use of models differently, and changed their views over time; Anna, for example, initially took the view that ‘mixing models’ was not appropriate, but six months later, preferred an integrative approach. For her, a more important distinction was to manage the boundary between her role as CBT therapist and that of a social work professional,

...by default now I'm more settled into my role... I'm very much doing CBT rather than working on benefits. I'm very clear now if anyone brings benefits up... there's nothing I can do... So, although I might not be sticking to the model for generalised anxiety and I might be doing some depression as well at some point, I'm still very much sticking to CBT rather than addressing multiple social and economic problems. (Anna 3)

For Joanne, the complexity of patient presentations meant looking to more advanced ‘trans-diagnostic’ models as a way forward,

I can't split people up into [separate] diagnoses, I just can't do that because they're all interrelated...that's what's hard sometimes to put people into a model and that's why that trans-diagnostic model is quite an interesting concept and one that I'll work with...(Joanne 3)

For the PWP, the risks of going beyond strict model adherence were reinforced by national policy changes regarding the conditions it was appropriate to work with at step 2.

We know the basics, now it's about fine tuning into what it is you can do at step 2 and I suppose seeing the difference between them but also the fact that now we're allowed to see OCD [patients] and do behavioural experiments. It's almost like the boundaries of the PWP are getting pushed up and up and up. (Jane 3)

8.4.7 Comparison with earlier cohorts: medium intensity drift?

More experienced HITs and PWP recognised ‘medium intensity drift’ as a concern (see Chapter 6 and 8.4.5 above). The mismatch between practitioners’ and supervisors’ trainings was noted as a possible contributing factor. Where supervisors were trained prior to IAPT, either in a different modality or in traditional CBT, struggles could arise over interpretation of the IAPT

competencies and treatment models. The more experienced the supervisor, the more helpful they could be in terms of demonstrating alternative approaches to treatment problems, but in so doing, the more likely they were to lead PWPs away from strict adherence to the IAPT models. Judgement was always needed as to whether this should be seen as a risk or a benefit. For Andrea, who trained in CBT prior to IAPT, it was a badge of professional integrity to always do what was right for the patient, regardless of fit with the IAPT model. For Kay, who trained in the first year of IAPT, it was important to recognise and revisit what she was doing when she found that she had inadvertently moved away from using the IAPT models.

The discipline of recording sessions and submitting them for supervision was felt by CTs to be less well instilled in PWPs than HITs, after qualifying. The onus was on managers and supervisors to keep tabs on what the PWPs were doing. One concern was that separating out the tasks of case management from clinical supervision, could make the task more difficult,

because the assumption is that the two supervisors will talk to each other. Sometimes they're busy themselves and they don't, so these PWPs kind of fall through the net, as to what they're doing..., and I think the crunch is with the managers and the supervisors [to notice]...(Andrea 1)

HITs were on the whole more confident that where they deviated from the prescribed norms they could justify it in terms of building upon best practice,

I would say that I'm still... I'm totally rooted in the CBT model and all of my practice is formulation-driven and goal-focused. I come up with a treatment plan which is full of cognitive and behavioural tools and where I'm drifting out and using other things like 'mindfulness' it is the latest addition to my tool box. I don't see that as a departure from CBT in any way... it's a branch within CBT, under 'tool'... (Martin 2)

The desire to 'dip in and out' of models could be strong, but the reassurance of supervision was always there, along with the individual's own clinical judgement,

I do check what I'm doing and haven't had too many tapes with that. I'm just in the process of getting more tapes so will get more direct feedback on those. So yeah, I think I work around [the models] rather than rigidly to them, which I think will probably have some strengths in it and some, you know, some drawbacks, but I think we all develop our own way of doing it... (Jill 2)

In addition, the more experienced HITs described using performance data as a means of reflecting on and modifying their own practice,

I'm trying this year to self-consciously, it's one of my mental goals, to get a bit more streamlined and find ways of cutting a session or two down. 30 percent of the people I see are over twelve sessions...so I set a goal for me that is to reduce that figure. Maybe get down to, I think the average for the service is 15 percent seen for more than twelve sessions, something like that...so I would like to be a bit closer to the average. (Martin 2)

8.5 Discussion and conclusions

This chapter has reviewed some of the main gains, losses and continuities for PWPs and HITs from completing the IAPT training year and identified new preoccupations in both groups (8.2). The gains included: self-confidence in what they had learnt, feeling more able to assert themselves at work, freedom to flex interventions and treatment plans, course friendships and new team connections. Former trainees took pleasure in diversifying their activities where feasible; for example, trying out interventions they hadn't used before, particularly group-based work (mainly HITs) and/ or running psycho-educational classes on their own (mainly PWPs) for the first time. They saw people with conditions they had not met before. Some actively built alliances with colleagues from whom they could learn new clinical methods and/or organisational 'top tips.' In all of these ways, the former trainees demonstrated that they were not passive recipients of tasks, but able to marshal resources, as is characteristic of people in assistant roles (Bach et al., 2012) (see Chapter 3, 3.5.4). Both groups also used aspects of the methods or materials they used with patients on themselves as self-practice, when feeling under pressure; a habit which has been shown to be important in the development of psychotherapists (Neuhaus, 2011; Bennett-Levy & Beedie, 2007), and which has been argued to be the 'equivalent to personal therapy' in CBT, when combined with self-reflection (Groom, 2010). Individuals developed particular treatment likes and dislikes and enjoyed feeling they had got on top of at least one of the

'change methods' (see also, Chapter 6, 6.5.3). HITs reported feeling more able to let go of perfectionist tendencies (as advised in training, see Chapter 6). PWP reported feeling they had got better at communicating with patients, sometimes without realising it. The degree of reflexivity involved in these changes, so important to processes of professionalisation in general, was however, not obvious at this point (see Chapter 2, 2.3.2).

The losses included: missing the University days away from the job, feeling less protected without 'trainee' status and having less or no contact with University supervisors. The challenges of learning by doing and the discomforts of the theory-practice gap continued and intensified for both groups. Worrying about evidence needed to meet the course requirements was replaced by concerns about not having enough experience or knowledge to tackle all aspects of the work as caseloads increased in volume and complexity. As has been shown with Clinical Psychology trainees, encountering patients with sometimes severe symptoms, and distressing personal circumstances, whilst attempting to follow protocol-based clinical methods was challenging (Neuhaus, 2011) (see Chapter 3, 3.3.5). Even when they felt proficient with depressed or anxious patients, HITs could find themselves working with patients with multiple diagnoses, and PWP with patients who did not fit their intervention categories. This could lead some to become stressed and to feel they were failing, in the way that has been found amongst other practitioner groups, making the transition from academic environment to clinical (Neuhaus, 2011: 227). What was different for these former PWP trainees, was the step change in caseload size and being the first point of assessment and sign-posting for all referrals. Most described feeling the flow of new patients was relentless and difficult to manage. For HITs, the loss of competence compared with former job roles (see also Chapter 6) when formulating and working through treatment plans was still felt. They were aware of the pressure on PWP, felt the difference when PWP left and their posts were not filled (an aspect of their emotional labour (see Chapter 3, 3.5.4 and 3.6.3 in particular)). With turnover rates amongst PWP estimated at over one in five nationally in 2015 (see 3.4.1), it is likely that these concerns expressed by respondents, have been experienced more widely (see, for example, Walklet & Percy, 2014; Steel et al., 2015; Delgadillo et al., 2018).

Both PWP and HITs were concerned to do what felt right for the patient, but it wasn't easy to know when 'mixing and matching' their approach was appropriate and when it was moving away from protocol. The discourse of patient-centred care thus created a dilemma, of the 'type 1' variety (value

conflict), described by Hoggett (2009b) (see 2.5.3). Even with supervision in place, the search for variety and to continue learning and developing clinical skills, encouraged individuals to put experimentation and flexibility ahead of strict adherence to protocol. They perceived the cultural diversity of the local community, and issues of multiple deprivation added an incentive to do this (8.4.3). This tendency 'to drift away from evidence-based practice' has been described, in the CBT training literature, as 'the product of very human experiences and characteristics' (Waller & Turner, 2016: 133). Indeed, HITs struggled with balancing control and collaboration in their work with patients; PWP's with new assessments overtaking follow-up work. All felt the limitations of the wider service system within which IAPT was embedded when they tried to find appropriate referral routes for patients they could not help directly. The tension experienced in negotiating referrals with secondary care providers (8.4.1) had an unresolvable flavour (or 'type 2' dilemma), and seemed suggestive of a 'paranoid-schizoid' position dominating the healthcare boundary (Walsh et al., 2016). The legacy of anxiety and disappointment ('the remainder') (Hoggett et al., 2007) left by patients for whom no service could be found or only ones with long waits, told on both groups, but especially PWP's. In a very real sense, they felt the emotional labour of service work (again, see Chapter 3).

In this period differences in agency and reflexivity, which were hinted at between the two groups during the training year, become more clearly evident (see 3.7). Both groups contained individuals who were more and less reflective (see also 6.6.1), and who expressed conviction (or lack of it) about what they were doing, as might be predicted for this stage (Skovholt & Rønnestad 1992) (see 3.6.2). The HITs however had markedly more opportunity to control their diaries and to manage the pace and place where they worked, suggesting a degree of 'institutional agency,' as found amongst professionals (Muzio et al., 2013) (2.3.2). PWP's were more likely to feel their personal and professional needs went unrecognised; either in terms of what they brought to the job or whilst tackling the demands of the role. Being young, some worried about how they would be seen by managers and others if they spoke up about their difficulties. Whilst there was a strong component of pragmatism in individuals' views of the tools they had been taught to use, doubts about the merits of the LIPs were expressed. Both recently qualified and established PWP's appeared to lack conviction at times in what they were doing. As shown in Chapter 2, ambivalence of this kind and how it is managed, is significant for the development of professional selfhood (Stronach et al., 2002) (see 2.3.4, and 2.5.3). Similarly, the existence of strong emotions such as hope, shame, resentment and guilt, in organisation members, are likely to be defended against at the organisational level (Hoggett, 2015; Armstrong & Rustin, 2015)

(see Chapter 2, 2.5.1). Finally, also as discussed in Chapter 2, if the link between care actions and decision-making is absent, mistrust and disempowerment of practitioners follows (Halton, 2015) (see 2.5.1).

We will find out more about how working conditions, team relationships and supervision, in the year following training, impacted on practitioners' thoughts and feelings about their jobs, the IAPT service and their future careers, in the next chapter.

Chapter 9 - The first year post-training: team, organisation and system

9.1 Introduction

This chapter looks more closely at the organisational embeddedness of recently qualified practitioners and therapists; in particular, their relationships with team members and others within the professional system of primary care (9.2). It looks at what has changed in participants' experiences of supervision (9.3) compared with when they were training (see chapter 7); their motivations at this point, occupational identity and plans for the future (9.4). The micro-politics of IAPT service organisation and delivery are explored alongside individuals' search for personal and professional development.

The findings, like Chapter 8, are based on analysis of the second and third FANI interviews with Cohort A participants and mainly first interviews with Cohort XYZ. I have included some extracts from I-Poems to illustrate particular aspects of voice at this stage. I have also drawn on the VCR analysis of Sarah's transcripts to give an example of a PWPs' network of relationships (Table 9.1, in section 9.2 below).

I end with a discussion of the continuities and changes in relationships, identifications and attitudes expressed, by PWPs and HITs, and how these connect with the literatures reviewed in Chapters 2 and 3 (9.5).

9.2 Working with others

A continuing theme for both groups from the training year (see Chapter 7) was the isolation they felt at work. Whilst not all IAPT services were delivered in this way, at the study site, PWPs and HITs were out-stationed in GP practices for most of the week and felt the need for more contact with colleagues.

That is still the hardest part of the job, the lone working, 'cos sometimes you're so busy, you're trapped in a room all day, you don't really get to see or speak to anyone. (Sarah 2)

How well the pairing of PWPs and HIT in the IAPT 'mini-team' worked played a big part in their experience of the role. Many other relationships were present however in the way they thought about themselves and the work. These relationships were spoken about directly, but also came across via switches in articulation, in participants' narratives, from 'I' to 'you', 'I' to 'we,' from 'us' to 'them' and so on. Quite often the person or persons referred to could be inferred, without being named; the relationship appeared sufficiently alive and internalised in the participant's mind, to not need spelling out. Table 9.1 illustrates this 'self-in-relation' set of voices from the analysis of one practitioner's interviews over time.

Table 9.1: Who does an IAPT practitioner relate to?

	INTERVIEW 1	INTERVIEW 2	INTERVIEW 3
Me (the researcher)	✓	✓	✓
Other graduates , especially psychology graduates	✓	✓	✓
Her work group – co-workers, team-mates, specialists	✓ (in former job role)	✓ (IAPT service)	✓ (IAPT service)
Her generation	✓ (in terms of age and gender)	✓ (People younger than her)	✓
The client group	✓ (in former job role)	✓ (IAPT patients, as individuals and as caseload)	✓ (IAPT patients, as individuals, as caseload, and groupwork participants)
Employer(s)/ managers	✓ (former, and current)	✓ (current)	✓ (current and prospective)

	INTERVIEW 1	INTERVIEW 2	INTERVIEW 3
Her fellow IAPT trainees (‘the girls’)	✓	✓	✓
Mental health professionals	✓ (includes practitioners of other modalities)	✓	✓ (includes practitioners of other modalities)
Parents/ family members – mum, dad, step-mum, step-dad	✓	✗	✗
Peer group competitors	✓ (at school and at University during undergraduate degree)	✓ (fellow PWP)	✓ (fellow PWP)
Teachers/ mentors	✓ (at school and in first job; plus the IAPT training CTs)	✓ (IAPT training CTs)	✗
Friends/ flat mates	✓	✗	✓
Other working people	✓ (part-time or shift workers)	✗	✓ (financially ‘hard-up’ workers)
Visiting speakers on IAPT course / Programme Director	✓	✗	✗
Assessors/ administrators for IAPT course	✓	✓	✓
HIT colleagues in IAPT sector team	✓	✓	✓
Supervisor(s)	✓	✓	✓
GPs at her practices	✓	✓	✓
Other sector teams in IAPT service	✓	✗	✓
Counsellors in GP practices	✓	✓	✓

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	INTERVIEW 1	INTERVIEW 2	INTERVIEW 3
Other cohorts of trainees/ IAPT workers	✓ (previous IAPT cohorts)	✓ (previous IAPT workers at her GP practices)	✓ (newly recruited IAPT trainees)
Other PWPs she works with/ groupwork co-facilitators	✓	✓ (Stress Control/ Healthy Living)	✓
PWPs in other services	✓ (trainees from her IAPT course)	✓	✓ (other qualifying PWPs)
Prospective employers/ promotion panels	X	✓ (selectors for HIT training and Senior PWP roles)	✓ (promotion panels)
Specific 'paired' CBT therapist (in GP practice)	✓ (not by name)	✓ (named)	✓ (named)
Former colleagues / colleagues suffering from stress	✓ (in former job role)	✓ (IAPT team mates who have left/ are about to leave)	✓ (people she perceives as 'crumbling in the role')
Organisations to whom she refers patients	X	✓ (Local advocacy and support agencies)	✓ (Secondary care teams)
Communities of IAPT patients	✓ (‘deprived communities’)	✓ (‘minority ethnic’ groups)	✓
Her IAPT sector team	X	✓	✓
Interpreters	X	✓	✓
Reception staff at GP practices	X	✓	✓
Co-supervisees	X	✓ (generic)	✓

	INTERVIEW 1	INTERVIEW 2	INTERVIEW 3
			(specifically, in same supervision group)
Other interviewees in my research	X	✓	✓
IAPT Service management/ leadership	X	✓	✓

(Based on VCR analysis of Sarah's interview transcripts/ I-Poems)

This 'self-in-relation' conveys gradual movement in the range of identifications felt by this individual, from pre-IAPT to IAPT. The 'I' becomes more organisationally embedded over time, and the connection to an IAPT work community appears to become internalised.

9.2.1 The IAPT 'mini-team'

PWPs and HITs at the study site were allocated by managers to surgeries on the basis of service demand. Being co-located at the same GP practice provided a source of mutual support and peer supervision. Anna and Sarah, for example, felt it ensured better handovers for their patients.

It's nice because otherwise you don't really get to see anyone and also what we like is, that it's, it's good for the surgeries as well because we both know how each other work and we work very similar.... so if I need to step up someone... it's a seamless link into CBT which is really good (Sarah 3).

Where the rota entailed a different pairing every day of the week, Chrissie found she got on better with some HITs than others; she preferred those who shared responsibility with her for the waiting list; she disliked those who would 'sit back and wait' for her to identify appropriate referrals. All the PWPs felt there were benefits to be gained from having a good relationship with the HIT and practice counsellor. Failing this, PWPs welcomed the odd occasions when they found themselves working with other PWPs on the same site, in larger practices, or as a temporary measure. Maria, for example, described how she and another PWP would help each other to 'offload' after difficult sessions and would notice if the other one was struggling,

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Just to have that comfort that somebody else in the same building and also knowing that somebody else has got your back when we work together... (Maria 3)

There was strong agreement from both PWP and HITs that their relationship determined the quality and timing of stepping up and/ or down decisions for patients. The HITs acknowledged the need to nurture the relationship with the PWP in their practices, with tact and concern, given their caseload sizes,

...supporting the PWPs in our practices...I think their job's definitely a lot harder than ours. They're like the gatekeepers and deal with the GPs a lot more than we do, screening referrals and dealing with the people that are completely inappropriate and that's why... I think it is really important to spend time supporting them. (Anna 3)

In some cases, this extended to shared treatment planning, with the PWP providing input prior to stepping the patient up for HIPs. HITs could thus provide useful feedback and learning for the PWPs, regarding their clinical practice and vice versa.

Some PWPs couldn't help, however, feeling envious at times of their HIT colleagues. When comparing assessment profiles, Chrissie was shocked to find that over a three-month period she had completed 100 new assessments, whereas her HIT colleague had done just nine. The closer they worked together, the easier it was for her to question what it was that separated them, in terms of pay and grading. She, like other PWPs, felt that her colleagues' lot was infinitely preferable, given that the HITs had their patients 'hand-picked' for them by the PWPs. The HITs' patients would be 'appropriate' and prepared for treatment, whereas for the PWPs, it was impossible to predict who was going to walk through the door or what they would be faced with.

HITs recognised that they were fortunate and would take time to shadow a PWP to learn about the role. They helped manage GP expectations, led negotiations over referral criteria and explained the difference in IAPT roles, at practice meetings.

...there's [HITs] that have been doing the job for three years now that are getting to the point where they'll just say what they think. They'll make the case for the rest of us, you know... [it] makes a big difference to our role. (Sue 2)

The HITs were less likely than the PWPs to find themselves working directly with a peer in a GP practice. Their main frustration was the relative invisibility of the IAPT counselling staff (on which, more at 9.2.3 below).

9.2.2 GPs

As suggested above (and in Chapter 7), the GP practice was a hub for many visiting clinicians' practices. Within this context, it was important to ensure GPs understood what IAPT provided, and when the service started, efforts to educate GPs were organised centrally. Thereafter however, it fell to the local team to raise awareness, which wasn't always easy;

...the feeling you get with this job is, you're in these random surgeries, no-one knows who you are, GPs have no idea whether you're doing a good job or not. You don't interact with anyone. (Anna 2)

Lack of understanding and time pressures could lead to GPs effectively 'dumping' patients at the PWP's door, resulting in a lot of unnecessary to'ing and fro'ing,

I had one lady who was referred, but I just knew straightaway she was inappropriate. I thought it was bipolar and asked the GP to sort it out... She tried to kill herself a few weeks after, but luckily I had already passed her back and it turned out it was bipolar. Does make you wonder a bit how it's not picked up sooner, whether because the GPs only get 5-10 minute appointment slots, that's not enough time to talk through it? (Chrissie 2)

The perception of risk in relation to primary care patients differed between GPs and PWPs and could cause friction. Mismatches in risk assessment only diminished once both parties got to know each other. PWPs had to negotiate referrals to secondary care, and slowly got more confident at asking GPs to back them up. Individual GPs in the same practice would respond differently at times and practitioners perceived that some GPs had 'issues' with IAPT, which

made things more difficult (see also, 7.6). The main complaint from GPs was that they felt IAPT screened out too many patients on grounds of unsuitability,

There's so many GPs in each practice. One GP might say [positive things] about me and another one, who I've bounced one of her people back, might say 'oh, Anna won't see anyone...!' (Anna 3)

The more GPs were open to and supportive of the IAPT service, the easier it was for practitioners. The task of establishing professional credibility with GPs, thus had to be worked at. GP turnover also affected the quality of referrals received,

...you might get on board with some GPs, but you've always got new registrars coming in, new locums. It's impossible to pin down a locum, so you're never going to win that battle. (Sarah 3)

Reception and administrative staff also played a vital role (see 7.2.2). They controlled 'direct bookings' and were a source of feedback about appointments, GP likes and dislikes, accommodation, ICT and general procedures. They took time and some creativity to get to know. Where GP practices had several IAPT workers in quick succession, it also took time to rebuild trust in the service. Differences in staff outlook across sites affected outcomes too, in Rachel's view,

Different surgeries and how they view things can have a big impact. Because in one surgery I've managed to get the waiting list down - they're really listening and it's going really well there, and their recovery rates are about 56 percent. Whereas I've tried the same in another surgery that I started with at Christmas and the recovery rate's only around 20 percent. (Rachel 3)

9.2.3 IAPT Counsellors

As observed in Chapter 7 (see 7.2.3) both PWPs and HITs felt they had to tread carefully around counsellor colleagues in the GP practice, given their different background, contract types, working practices, pay and conditions. In particular, there was a perception that counsellors subscribed reluctantly to the standardised outcome measures and MIS recording system. It was hardly surprising therefore that tensions arose at times.

There are difficulties with people who were in post before IAPT, accepting IAPT and that's still a real tension in our teams... the counsellors were very much a law unto themselves I think and resented the changes, perhaps didn't quite understand them all. And of course [IAPT outcome measurement system] came as a real shock to them, [there was] a lot of resistance and [they were] not happy with the new IT. They still feel they're slaving over computers all the time... so there are tensions within the teams...(Jill 1)

PWPs and HITs remarked on feeling 'ignored' by practice counsellors, and were aware of parallel disagreements and tensions at national level between professional bodies. Where counsellors worked on a fee-paying basis, PWPs felt under pressure to ensure a flow of new business for them. It could be intimidating, for newly qualified PWPs like Maria to manage expectations, in this regard,

Recently the counsellors approached me and the CBT therapist there. Luckily I wasn't on my own and I didn't really say anything in the meeting because I was too, I was too nervous, I felt like I was being shouted at and we'd said, 'well, what we do in our service is everybody comes to step 2 and then I can talk about what the different options are, if they want counselling,' but I've not sent anyone to counselling because everybody's opted to see me... (Maria 2)

Whether borne out in practice or not, PWPs feared they might provoke envious attacks, if they did not make referrals. At the same time, both PWPs and HITs tended to feel critical of counsellors for 'hoarding' patients (keeping them in treatment for longer than eight sessions) and for tolerating long waiting times. Having different professional codes of conduct impacted on record keeping practices and how things were communicated with and about patients. HITs also felt an expectation on them to make sideways referrals to counselling to show good will and build collaboration. However, they were wary of doing so, where there was a sense of IAPT having unfairly 'taken over,'

...[The counsellors] obviously feel that they're in this delivery model that they don't want to be in and they're used to not keeping notes and record systems, they're used to seeing people when they want to see them, so they're finding ways around it, to still do that, but... that's a bit messy I think. (Andrea 1)

An additional group that were perceived as having been displaced by the advent of IAPT, were the former 'PCMHWs' who were now co-opted into a PWP role,

I think there are some primary care mental health workers who are extremely experienced, and they are now step 2 workers and I think they are probably over qualified for their role compared to the new PWPs... (Jill 1)

Differing practices between professionals caused bottlenecks and confusions, which had to be constantly worked around. Issues of accommodation could encapsulate these differences, as Maria explained,

I have been complaining to the manager about the room because it's not safe, because it's downstairs, it's not got a fire exit, nobody can hear you, it's not got a panic alarm, all this stuff. And the counsellors go, 'the room's wonderful,' it's an old staff room, so it's not clinical at all, you can sit on the sofa and there's a sink in the corner where you can boil a kettle and to me, I think, 'oh no, health and safety,' and it's doesn't really fit with what I do, I don't feel comfortable there...(Maria 2)

9.2.4 IAPT sector team and service relationships

After qualifying, most practitioners continued in the same sector team they had trained in and also provided 'cover' in other sectors, where there were staff shortages. Turnover of managers and supervisors was not uncommon (as well as more junior staff) and practitioners found they had to work at building new hierarchical relationships. They spoke of the micro-politics of their local team, the difference between 'good' and 'bad' teams and times when it paid to 'stay under the radar.' It was not unusual in some teams for PWPs, in their post-training year, to find themselves becoming the longest serving staff member. They regretted the loss of their former colleagues and struggled at times, to support new trainees who followed behind them. There was also excitement and pride in engaging with new activities and a sense of shared ownership of team achievements, in spite of difficulties. Sarah was pleased that her sector team was the first in the city to implement new practices; they engaged in research activity and carried out additional training for GPs. Group supervision was also organised at sector team level and was seen by former trainees as a useful addition (see 9.3 below).

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An important role of the sector team was to provide access to senior and experienced colleagues to learn from. Senior PWP's were especially appreciated in this regard. Anna described jumping at the opportunity to deliver a new service for patients with one colleague who had a particularly good reputation,

Me and another therapist ran a behavioural activation group for depression just after I qualified. That was really nice, 'cos I got to know another therapist and she was the "golden girl" in the [Sector]...She obviously knew her stuffand she's a fantastic therapist that was really nice to work with. (Anna 3)

For PWP's, staying in the same team as former training peers was valued. Seeing new trainees start made them realise how far they had travelled and how much their mutual support counted. Sue, for instance, described the experience of being co-trainees as being like 'squaddies, going through a war together.' Yet, with the training over and opportunities for further professional development and progression limited, PWP's began to feel some rivalry and competition too.

The only thing now is I wonder what will happen to us in the future because we're all at a similar level, so if we all apply for similar jobs we'll be competing against each other and that's awful. (Sarah 3)

As PWP's like Jane quickly moved on to opportunities elsewhere, the flow of information about how other IAPT services did things differently increased. Service wide CPD meetings helped to reinforce a sense of belonging, but tended to be appreciated better by HITs than PWP's. For the HITs, working with others at sector and service level helped alleviate isolation. Anna was particularly enthusiastic about IAPT's 'learning culture,'

IAPT's fantastic at training you and doing things, you know, even though we've finished. I think it's once every six weeks we have a CBT master class where everybody goes, and my supervisor will teach us something new about something, you know. They're always updating your training and we have a CBT forum where all the CBT therapists meet up once every six weeks to, share any training that you've done, to teach everybody else the training.... You just wouldn't get that unless you were working in a team of psychological therapists... (Anna 3)

For the PWP, the existence of senior PWP roles provided hope and the promise of career progression (see 7.5.2 and 7.6). However, the benefits of these collective activities were outweighed by the adverse effects felt by some from staff sickness and turnover.

I'm getting to grips with my new role, I'm also having to help other people because none of them know how to use the surgery systems, [the IT system], all the rest of it. So I'm getting my head around a new role whilst doing all of that as well...My supervisor's left, gone for a senior post somewhere else and then three people who were quite close [to me] have left our team as well so there's been a big turnover...So many people have been off with stress and really suffering and struggling...I think the general atmosphere in our office is a negative one, so I don't think that helps really. (Rachel 3)

9.3 Supervision and performance management

Before and after qualifying, supervision and performance management were linked through the outcome measurement and reporting system (see 7.5). Practitioners generally had a separate supervisor and line-manager but their functions intersected, and respondents frequently mentioned the two roles together. On the whole supervisors were liked and respected and were seen as a resource by PWP and HITs alike. Practitioners valued supervisors for helping to make the PWP job 'do-able', for offering advice, sharing evidence, knowledge and skills and because they enhanced the practitioners' development in their role. Kay was clear that supervision had enabled her to adapt and improve upon her own practice over time,

I think my skills have progressed...through practice and using the materials and just through looking at what's worked with one patient, could work with another patient, what went good and bad..., reflecting back on what I've done in the past, to use it to get better. Supervision really helps, it brings things up that I wouldn't have thought of, so when I go back to the session, I'll go like, 'have you thought about this?' (Kay 1)

HITs rated both the level and quality of supervision on offer highly, describing it as 'the only thing that counts' in terms of their learning.

I do feel blessed in having a very good supervision structure. Good supervision every week...We watch videos or they talk about shared experiences. I've learnt from other therapists in group supervision, learnt from my individual supervisor, gone away and read stuff, gone on courses.... (Martin 1)

Supervision of PWP's was felt to be more problematic. Steve, for example, felt the lack of clinical supervision stifled his development in the role. Both PWP's and HIT's found supervisors' advice hard to follow at times, but respected that they had the 'final say' in relation to clinical decisions. When supervisors left the service, or changed jobs, they left a big hole; practitioners mourned their loss and felt the discontinuity acutely. Former trainees, such as Jane, who had a number of different supervisors in quick succession, commented on the difference between those who were IAPT and pre-IAPT trained,

there was a month where I just had people who were available, so I had someone who was a PWP and I found that the most useful...I think even though I learnt a lot from my first supervisor, they hadn't done the [IAPT] course specifically, which I do feel... since I've had someone different I can see that, but when my manager took over as my supervisor, they also haven't done the course...I think that's what I've learnt, that it's so important for the person that is your supervisor to have done the course and be doing what you are doing. (Jane 2)

Where group supervision was offered as an addition to individual supervision, PWP's felt hopeful that it would offer the kind of in-depth clinical input their case management supervision lacked. They hoped it would provide emotional support too,

I'm really hopeful that the supervision group will just normalise things a little bit. I know it's the same with most of the girls that I trained with, I know that we're all having a pretty tough time and that makes me feel better a little bit...(Maria 3)

Praise for supervision was not universal however. Some found the advice they received unhelpful, or insufficient and there were incidents where practitioners felt the advice given was inconsistent. The biggest complaint was

from PWPs, who felt there was insufficient time to discuss cases, or to recall individuals in detail (as also shown in the training year, see 7.5).

You might have about 50 people on your caseload. You get normally about an hour, but you need to find the time to discuss about 20 people, so I might, I try and be very [quick], I know people might take their time and go through things and they might discuss about 5 or 6 cases, I always try and discuss about 20, because otherwise you're always playing catch up. (Sarah 3)

Everyone found the supervisory relationship changed over time. Sarah felt she became more confident in using supervision to check what she was doing, rather than relying on it to tell her exactly what to do. Jill felt the difficulties she had with her supervisor when she was a trainee (see 7.5.1) resolved with the passage of time. To cover for staff turnover, or other contingencies, supervisors and line-managers would sometimes swap roles. Practitioners had to adjust to people they had previously regarded as managers becoming their supervisors and vice versa. It brought into focus the difference between the roles; as Sue explained, managers were preoccupied, above all, with 'moving the numbers.'

On the positive side, managers were felt to be useful in providing back up in sorting out difficulties with local practices. Both PWPs and HITs spoke of having trust in local managers, although HITs felt closer to service leaders than PWPs did. HITs, in particular, felt supported and valued by managers, as Martin described,

Everyone has a few gripes depending on who their manager is. I think some people have had harder experiences than others. My experience within the sector that I work in is it is a great place to work and, you know, I've felt facilitated, pushed along and kept on track and focused, but not to the detriment of my health or stress levels. Yeah, I feel valued, really valued and well respected professionally here by colleagues in my team. (Martin 1)

Less positive comments related mainly to perceived variability in management attitudes and approach. PWPs sometimes did not feel recognised for how stressful and difficult the PWP job was. In Sue's view, an epidemic of stress took hold of the service at this time,

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A lot of my colleagues are getting physical health problems like migraines and chronic fatigue and things, or getting frequent infections, so it's an under-the-radar problem. I think... the service provision probably is being affected but in an unacknowledged way. It doesn't feel like it is just an individual problem. I think some of the people who have been strongly affected by it have left the service, so you get a rotation of new staff which keeps things going... (Sue 3)

For her, being a PWP was a painful experience, leading her to feel critical of the lack of support,

I think I feel that we need to be cared for more. I think that's the word I'm looking for, is that we need to be cared for more and that's not happening...It does feel like we're in a very vulnerable position. We're isolated and quite junior. A lot of us, not so much myself, but a lot of us do look very young, [we're] physically small people, you know. It's things like that...we don't have a lot of support or back up day-to-day from people who are more senior in the service like we should. We should have more care and we don't get it. (Sue 3)

This view was echoed by others, although Sarah, notably, did not share it. She, by contrast, felt that by not having any expectation of being cared for by managers, she was able to cope with the demands of the job on her own terms.

PWPs acknowledged that managers were under pressure themselves. Chrissie, for example, felt managers had their hearts in the right place, but were basically 'operating a business' and had to deliver to keep being funded. They had a 'bottom line' as Sue observed,

They need us just, it is literally, we've got to get the numbers from that column into that column and that's what our role is. If anything reduces the numbers going from that column into that column, then that would be a problem for the service. (Sue 3)

Managers also had the pressure of needing to ensure service coverage across the city. However, PWPs, like Chrissie, continued to worry that raising issues of 'burnout' would be seen as 'not professional.' As the youngest and least experienced member of a team, she recognised she could be taking too much

on herself but feared asking for help. Rachel, on the other hand, did ask for help and was disappointed with the response she received.

When I do go and ask for support, I have been told various things like, I'm a perfectionist, that it's the way I'm looking at it, that's the problem, not the actual workload that's a problem! I've been told that I also need CBT therapy myself, which was an interesting one and maybe, 'I'm just not cut out to do this job!' (Rachel 3)

She and several other PWP's opted to go to the Occupational Health Service (OHS) for support, but with mixed feelings. She described it as a compromise, that would not offer any real solution.

Individual and collective performance monitoring was an ubiquitous aspect of life in the service. PWP's and HIT's commented on how wildly 'recovery rates' could vary across time and place. Most raised questions about how meaningful the statistics were, but felt they provided useful prompts for asking questions on DNA rates, step up rates, contact rates, waiting times and so on. Despite being sceptical about their value, practitioners told me they felt good when their recovery scores improved and they wanted to find out more when they dropped. Martin was proud of matching the service and national average for recovery rates, and felt the remainder of his caseload patients at least 'went away with tools and were more able to manage.'

The HIT's were disappointed however that improvements 'within case-ness' were not counted in the system (see 8.4.2). They felt that the measurement approach discouraged them from taking on difficult or borderline 'inappropriate' cases, as these patients wouldn't be likely to meet the criteria for recovery. Anna felt inclined to take the gamble on a more inclusive approach, as it sometimes paid off,

My supervisor's saying that some of those cases, 'great, it's good you're doing that,' but sometimes, I'm persevering with people who clearly aren't suited to CBT. I just feel I want to give them a chance....to give it a go really. So, I am seeing people that are technically not appropriate.... but who are getting better and are moving to recovery (Anna 2)

Thus she and others felt there was a learning curve to using the data effectively to reflect on their performance. Sarah, in her 'reflexive, observing voice' says:

I've been comparing the recovery rates
I was feeling
I was just not getting anywhere
I was feeling
I thought
I'd be more informed
I'd develop a way of working
I was feeling the opposite
I was feeling 'oh God'
I completely didn't realise how much
I underestimated the amount that culture does play
I was thinking
I can't work with people from different cultures
I talked about it
I looked into it. (Sarah 3)

Whilst some undertook the task defensively or because their supervisors called for it, others proactively set about making sense of the figures to contribute to team discussions on how they were judged. How punitive or constructive these discussions were varied considerably. Over time, each sector team tended to have a different atmosphere or culture ascribed to it, linked with team members' perceptions of managers' communication style. Sue, in particular, reflected on what she felt to be a 'culture of anxiety' prevailing in her sector,

if the managers are very anxious and feel like they might be attacked for any sort of perceived lack in the team, then, it creates a culture of anxiety which is very unhelpful to work in... with the kind of absences we've had and the rate of turnover, I don't imagine that that can reflect well on the managers. (Sue 2)

9.4 Looking ahead - uncertain futures

9.4.1 Occupational identity and ambivalence

One of the most striking aspects of PWP's accounts of their work and professional development over time was the ambivalence they expressed about the PWP role itself. Frequent criticisms of the role, the range of interventions available to use and the impossibility of managing cases at such high volume were mixed with reports of loving the job, the work with patients and belief in the value of the IAPT service. Sue summed this up, in her third interview, after many hours on this and earlier occasions, telling me about the 'horrors' of the job,

There are some people that can be helped, things can get better...You have to find a way to deal with each person individually and that's challenging and it's tiring. There are some patients you wish would never ever darken your door again, but you know they will! (LAUGHS)... But mostly you feel like you're doing something worthwhile. You're doing something that's very effective, you're part of something that is a good thing, the bottom line is it's good that we're there and it's good that we're doing what we're doing, even if we're a tiny cog in the wheel...it is still exciting. (Sue 3)

A typical frustration, expressed by Maria, was with the PWP role not having enough to offer and providing only 'sticking plaster' solutions,

I think a lot of patients feel quite let down when they come along... because it's this idea 'oh go and talk to Maria, our therapist from IAPT and she'll sort you out,' and then you go, 'no, this is really complex, there is nothing I can do..., you've got years of abuse and trauma, I can give you some information on panic attacks...' It's a massive let down for people...it's like this horrible conveyor belt of just chucking people a leaflet and things. (Maria 3)

For her, and most of the other PWPs, the role was caught in-between that of care co-ordinator and being 'therapeutic,'

The PWP role is a bit of a mish- mash... it's a bit of a dog's body role (LAUGHS)... (Maria 2)

PWPs felt that they were disadvantaged by being members of a new occupation. They envied the HITs their more recognisable professional identity, as therapists. Overall, there was little confidence in the 'professional' status of the role or its potential to develop as such in the near future. The advent of 'Senior PWP' roles (see 7.6) did not appear to help in this regard, nor the attempts to gain accreditation and recognition from HCPC.

It does feel very fluid, very up in the air, quite insecure I think... I don't define myself by it in any way. It's an exciting role but it feels like a role rather than a profession... It's so brand new, kind of a baby profession. (Sue 3)

The HITs by contrast tended to be much more confident about their role and identity. For Anna, there was no doubt at all about labelling what she was doing as 'proper psychotherapy.' In fact, this was one of the main satisfactions she felt from completing the training, especially as she did not have a former 'core' profession to fall back on.

I'm a therapist, a psychotherapist, definitely. I can't imagine going back to my old role now. (Anna 2)

For other HITs, their core profession continued to be a source of identity, made stronger by the addition of a recognised CBT qualification. As long as they passed the course, they were confident that their jobs would be secure and their skills transferable beyond primary care. For those who passed the qualifying assessments first time there was satisfaction in knowing that they had made a good career choice. For others there were continuing minor regrets about having missed opportunities to train in the past.

Being trained in CBT, with the opportunity to gain accreditation, was highly valued by all former trainees. Even those who had chosen CBT opportunistically, admitted feeling surprised at what they got out of it,

I do feel like I'm getting as much satisfaction out of this therapy as I'd hoped for from other therapies...I'm getting more than I expected out of CBT. (Anna 2)

Subsequently, Anna also commented on the way working in deprived areas of the city, had exceeded her expectations,

When I was applying for IAPT and CBT, I was thinking about the 'here and now' and working with basic anxiety and depression and that being a bit boring. I didn't know I was going to be in the [name of deprived district]... I thought I was going to end up in [name of affluent district], you know. (Anna 3)

For Stephanie, the role of therapist within IAPT was a source of loyalty and commitment,

I don't ever envisage not being a CBT therapist, I might not be in this service or in this primary care role necessarily, but this is what I want to do...for the moment, I don't have any plans to go anywhere else, I think the service has put an awful lot of money into training me and you owe them a certain amount of time really. (Stephanie 1)

Having opportunities to try out new activities, such as groupwork and supervision training, were important sources of satisfaction. Former trainees appreciated having time to develop their therapeutic style and to explore specialisms for the first time.

9.4.2 Looking ahead, changing motivations

Looking ahead, six months after finishing training, the outlook for PWPs and HITs was rather different from when they started. For the PWPs, there was more uncertainty than for the HITs. We can hear this in Sarah's third interview 'fragmented, crumbling' voice:

I'm not really

I get stressed

I get stroppy

I'm fine

I don't

I wasn't

I was feeling really tired

=====

I've been trying to do
I'm going to
I'm going to
I keep getting a lot
I'm getting this bad feeling
I'm coming up against all the time
I get that feeling
I've not got it
I've not had it yet
I'm just thinking
I'm saying that
I want to do
I get a bit stressed
I'm not ready

=====

I do
I do get bogged down
I do think
I do think
I don't think
I think
I think
I get stressed
I don't have the time
I saw them
I've not done it
I think that side of it is
I think
I feel
I said
I don't think people do

I am guilty (Sarah 3)

Amongst the PWP's, motivations at this point varied. As seen in Chapter 5, there were those who continued to view IAPT as a 'stepping stone' to Clinical Psychology or another mental health profession. They felt the PWP role was relevant to meeting their future ambitions, as long as they didn't have to stay too long in the role. In some cases, individuals felt the PWP route was the only realistic option, for getting on to their desired career path,

I don't know what other route I would have gone. I really did need these experiences working within primary care, knowing how to do an assessment, getting these interventions and definitely working on my own, knowing how to manage my time and admin and that kind of thing... (Sarah 2)

As suggested above (9.4.1), a new perspective was also evident at this point; that of ambivalence at the prospect of progression and further training within IAPT. PWP's, such as Sue, who did not have a psychology first degree, were more likely to look toward further CBT training for their next move. However, there were question marks in her mind over the value of the HIPI training in IAPT. She had heard that it was not regarded as equivalent to a full CBT training by secondary care providers and wondered therefore whether she might not be better off training in CBT independently from the service,

I'm hopeful if I sit it out there will be some progression maybe into a senior post or CBT. Personally, I would like to do some more CBT training in the future but not necessarily on the IAPT training course. I'm not sure it sets you up for anything outside of IAPT... (Sue 3)

A third viewpoint was to look for opportunities to progress within the current service. PWP's such as Rachel said she would consider a senior PWP post, or applying for a HIT training post in the same service. However, the prospect made her feel anxious about having to compete with her peers, or wait a long time before a suitable opportunity came up.

I just worry about what progression there is in IAPT. I've seen the PWP's, like the ones who've been going for, because there's a post come up for high intensity worker in [local Service]... but there's only one post....I do think it's difficult in

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IAPT in terms of progression....The senior PWP posts have only just come up.
(Rachel 2)

Fourthly, there was what could be described as a survivalist mentality amongst some PWPs. This group were intent on making a go of the role and taking something positive from it,

I need to take something positive from it before I burn out. I've got lots of good things... all my friends who I've trained with... that's all been amazing, and I wouldn't change that for the world. So I need to manage it... while I can see there are still positives, before all the rubbish takes over... (Maria 3)

I won't leave until I'm brilliant at this job, until I've done it and I think I'm getting to that stage. (Sarah 3)

The fifth and final group were keeping their eyes peeled for opportunities elsewhere. Jane applied for a PWP post in another service as soon as she finished training. She was attracted to a newer and smaller-scale IAPT service, in a rural setting, where working conditions appeared easier to manage. For her, the grass was definitely greener elsewhere. Her experience, reported to me both directly and indirectly (via the other PWPs in my sample) six months after she had left, reverberated around the cohort. Most felt, as she did, that the comparison showed how much better the PWP role could be, if it was relieved of the burden of constantly assessing new cases and handling huge numbers of people. It provided a different model of the PWP role, which those who aspired to work more intensively with fewer people looked towards, as offering a better way. Managers in the new service were perceived as placing 'hard' boundaries around the service (strict referral acceptance criteria), which helped to protect PWPs from 'inappropriate' cases. At the same time, Jane recognised that the service could be criticised for not seeing the volumes of patients needed. She agreed with me that there was a risk that having supervision provided by HITs, might hasten the temptation towards 'medium-intensity drift' amongst PWPs (see 8.4.6).

The HITs, as already mentioned, were more content with their prospects than the PWPs. On the whole, they tended to have modest ambitions and to seek satisfaction and reward from work via different means. Joanne, for

example, kept her eyes firmly set on consolidation and become properly confident in the role. She had no ambition to progress upwards, in career terms and was more interested in planning for retirement.

I just say to myself when I get to 55, whatever happens I know that I can [retire] if I want to... (Joanne 3)

HITs who were not so close to retirement age, did look for opportunities to develop professionally within the role and for the most part, felt like they had these opportunities, without needing to move service. Supervision training, small group facilitation and the chance to add particular niche specialisms to their CBT training were all mentioned as welcome developments. One or two felt some on-going anxiety about the prospect of 'failing' in the job, after the experience of training (see 8.2). However, most HITs were extremely positive, committed to the IAPT service in general and felt ownership of its achievements. These HITs saw IAPT as providing something unique, for them personally and for their patients. They welcomed the chance to work alongside other therapists in a psychological therapy service of IAPT's scale,

There's no way I'd leave IAPT now... Just because I think it's good to stick at like something for a while and make the most of it. (Anna 2)

I think until you're really confident about who you're going to see, what you're capable of, all that stuff, I'd want to stay in a team so you can learn from each other... I don't feel like I'm ready to work independently. (Anna 3)

For them, investment in the IAPT opportunity and vision was rewarded by their experiences at this point.

9.4.3 Comparison with earlier cohorts

Amongst the PWP's trained in earlier years, the range of responses narrowed either as a determination to stay and achieve progression by training as a PWP supervisor or as a decision to leave the service and to retrain in a different role altogether. Kay, for example, joined the service as an already qualified PWP and felt there was still scope for her to grow and develop in the PWP role.

I want to carry on progressing obviously and just building my skills. I want to do the supervisor training 'cos I've been doing the job long enough now to do the supervisor training. I'd like to do that. And in the medium term, not long term, I'd like to look at progression to either the CBT training or management. (Kay 1)

The possibility of undertaking HIPI training was appealing, although it was hard not to be ambivalent when the availability of training places was so limited. Vicky was actively looking for jobs that would take her away from clinical work and back to doing research, which she perceived as less emotionally demanding. She had not ruled out the possibility of applying for Clinical Psychology at some point in the future. She had doubts however about her therapeutic competence, in light of her IAPT experience. Indeed, as Andrea commented, doubts and uncertainties about PWP progression routes were pervasive, even at national level,

I think the way IAPT was portrayed in the beginning was that if [the PWPs] were accredited as a group, then it would open up a career structure for them, but of course it hasn't. And yes, they're supervising, as they go up their pay, you know, spine points, but the future isn't quite clear, nobody knows... what's going to happen to IAPT. (Andrea 1)

By contrast, HITs enjoyed the prospect of feeling more settled in their roles than they had done at earlier stages in their career. The worst that the HITs could see happening was funding cuts threatening their jobs. None were unduly worried however and most were prepared to consider working privately if the need arose.

There was muted concern about becoming 'bored' or not continuing to develop in the role. However, at this stage after training, HITs generally felt doors were open to them and there was no need to hurry to diversify, specialise or seek upward promotion.

9.4.4 Internalising values and beliefs

Working in IAPT meant more than simply doing a job for my respondents. All were touched to a greater or lesser degree by public perceptions regarding what the initiative and CBT were about. They also had their own, often

passionately held, convictions about IAPT's rationale and purpose and the value of CBT in the IAPT context. These views fluctuated, sometimes wildly, from black to white within the space of a single interview with shades of grey in-between.

HITs on the whole moved in the direction of strengthening their belief in what they and the service were doing, whilst PWP's for the most part, expressed a loss of conviction in their own and IAPT's role, which gathered pace over time (see also, Chapter 8). Stephanie for example, was enthusiastic about the IAPT project and became more so,

I think the service is the right development, it wasn't just an opportunity for career progression, I think it was what the NHS needed, what the mental health services needed... the service is blossoming and it's great to be a part of a service that's working. (Stephanie 1)

Jill was initially sceptical about aspects of the service, such as, the way in which outcome measurement was used. She felt there was too much emphasis on global measures and not enough on condition-specific change.

The condition-specific measures usually come hugely down and we're not even recording those at the moment. We have to get people to define their problem and then rate it and we have to get them to set goals and rate that... [and] my biggest thing is that everyone uses them differently. They're all assessment measures, not continuing progress measures and of course people get used to them, so a lot of people just go 'yeah, yeah'... which is another issue about how they're filled in. (Jill 1)

She recognised however that use of the measures could have therapeutic value,

I do talk to people now more than I used to and say... 'are you giving yourself credit for how much work you've put in? And how much you've changed over this time?' because it's hard work for people. They're doing things that are really difficult and when I do show people their scores and they're coming down, you can see it on the nice little graphs...I think it is a real motivator. (Jill 1)

For Martin, working in the IAPT service was about job security and public-sector values,

I've found something permanent that gives me security and where I can switch off. So, I guess part of the reason I'm still [here], in the public sector and in the NHS, is that the job gives me the ability to switch off when I get home. I don't have to worry about the stability of the company. (Martin 1)

The most marked shifts in view were amongst PWP's, from the point where they started in training, with high hopes and expectations (see Chapter 5), to a point of much lower optimism 18 months on. There was a sense amongst this group of great hope and investment in the IAPT project being eroded, as time went on. For Chrissie this translated into a feeling that patients didn't appreciate how lucky they were in being seen, compared with the long waiting times they would have had prior to IAPT. Being able to offer a service which was reasonably quick to access and effective was thus a source of pride for PWP's and HIT's alike.

I think it's a fantastic job. The PWP role is really making a difference. People can be seen, in most of my surgeries [with]in a week or two, get some effective interventions for the things that are making life difficult at the moment and I think that's fantastic.... It's a really vital role. (Sue 3)

Anna was pleased to discover by the end of the training year, that she was ready to defend CBT in the face of others' scepticism.

As their experience increased, some PWP's and HIT's, unlike Anna, narrowed their view of CBT's applicability. Jane, for example, felt that the people who benefitted most from CBT were 'first-timers' or those who needed a 'top up' following a previous treatment,

I do think the people that have never been introduced to CBT are probably the ones that are grabbed by it more.... It works especially well with people that have never experienced anxiety or depression. So the psycho-education and the understanding can be powerful when they don't know what it is that's happening. I think that can be really powerful. (Jane 3)

There was more scepticism about LIPIs than about CBT itself. Andrea, for example, felt there was 'no such thing as low intensity CBT.' Jane had concerns about only scratching the surface of patients' difficulties,

I understand there's a place for low intensity stuff but I'm still a bit sceptical. I feel like you're just treating symptoms and they'll come back because there's still some deeper issue... I think if it's someone that might have had something in the past, you're only teaching them the way to manage it, so it's not gone...If there is something that's a bit more deep- rooted, then they'll be the person that comes back in a year or two, because the actual issue hasn't changed...(Jane 3)

At the same time, PWPs wanted to deliver on IAPT's promise and worried about not living up to patients' expectations, possibly making things worse for them rather than better.

They'll come along and you'll go 'let's try a bit of this, let's try a bit of that,' and they'll go 'no, I don't really fancy it'... and then you get people swapping and changing appointments all the time... and you're chasing around after people and you're not necessarily making them better, you're almost worried that you're going to be making them worse. (Maria 3)

They also recognised that in the eyes of commissioners and others looking in on the service from outside, IAPT was delivering well against its remit. For them, this hid an uncomfortable reality, of success being achieved at the cost of IAPT's human resources.

It looks successful from the outside, but I think at some point there's going to be a big burn out. ...It might look like a thriving service but actually a lot of the staff are struggling. (Rachel 3)

IAPT is this machine that's been built from theory...so theoretically, it's a perfect machine and then you start feeding people into it and eventually get mincemeat out.... (Sue 2)

9.5 Discussion and conclusions

This chapter has shown continuity in a number of themes from the training year, in particular the sense of isolation felt, the desire to build relationships and to 'fit in' within a complex ecology of practices at each workplace, and the need to manage oneself in role, in relation to others. New themes which became much more apparent in this post-training year related to the risks of role blurring between PWP and HIT, mismatches in perception of risk between different members of the primary care team, and variability in the degree of trust in supervision and management. As shown in Chapter 8, there were also clear signs of a loss of faith in aspects of the IAPT roles and models.

In relation to the isolation felt, there was better scope during the post-training year, for individuals to build relationships with their co-workers, and to enjoy discovering more about what their colleagues had to offer, once their time was freed up by the ending of course commitments. Those who proactively negotiated opportunities for co-location, or to take part in group supervision, new groupwork activities and the service-wide 'masterclasses' with more experienced colleagues, felt the benefit from doing so (as predicted in the role transition literature, for example, Ashforth (2001), see 3.6.3). HITs in particular developed an enthusiastic appreciation for IAPTs' 'learning culture' at this point in their training journey.

Within the GP practice, individuals worked at fitting in with pre-existing administrative and clinical practices where they could, whilst still adhering to IAPT management and reporting requirements. Newly qualified practitioners were sensitive to upsetting established appointment booking and waitlist management systems, and worked with their sector team managers to achieve changes where necessary. One positive example was the use of 'direct bookings' for first appointments, an innovation which was felt to improve patient attendance. However, differences in procedures between IAPT and counselling staff, within the same practice, led to bottlenecks in referrals developing. Even at this base level, a clash of cultures was evident, between the 'old' and 'new' hands of primary care mental health (as discussed by Swidler, 2001, see Chapter 2, section 2.4.1). This was exacerbated at sites where PWPs felt responsible for ensuring a flow of trade for the counsellors, even though in practice, HITS were just as likely to make a 'sideways' referral of this kind. As discussed by Nancarrow and Borthwick (2005), the insertion of new workforce roles, by

horizontal substitution (see 2.3.1), created tension between adjacent occupational groups, at the micro-local level. These mirrored the national struggles between professional bodies, discussed in Chapters 2 and 3 (see 2.3.6 and 3.3.4).

In part because of their enthusiasm for learning, each practitioner's relationship with their IAPT pair (PWP or HIT) was important, varying as it did between workplace and day of the week, and when people joined or left the service. Where the pairing worked well, PWPs valued the input of HITs into the process of managing new referrals and treatment planning. HITs valued the PWP's role in screening and preparing patients for more intensive CBT. Interdependence at this level was helpful but could also lead to blurring of role boundaries (as suggested by CTs in Chapter 6), where PWPs were ambitious and eager to develop their clinical skills, or where vacant posts were left unfilled and HITs stepped in, to attend to the ever-present waiting list. This phenomenon had both positive and negative aspects, as described by Michalec & Hafferty (2015). On the one hand, it facilitated continuity of care, knowledge sharing and the learning of new skills, and on the other, it confused the specificity of each role. Practitioners had to be both 'static and fluid' to adapt to the tension 'between the pull of discipline-specific role distinctions and the push of team-based role blurring' (Michalec & Hafferty, 2015: 186). Whilst some overlap in tasks might be expected between workers in adjacent roles, interchangeability is generally less common (Bach et al., 2012). 'Safe role blurring,' it has been argued, requires individuals to have strong 'role security', and to have developed an inter-professional, as well as a professional identity (Michalec & Hafferty, 2015: 187-8).

GP dominance within the primary care professional hierarchy was not changed by IAPT, and may have contributed to practitioners' unconscious feelings of insecurity about their role (Andersen, 2012). Trust in supervision and management was variable; where relationships were good, they contributed to practitioners' confidence and helped sustain their motivation. Where they were not, they added to the stress and uncertainty practitioners felt, the likelihood of starting to look for opportunities to work or train elsewhere. HITs rated their IAPT supervision particularly highly. Turnover of supervisors was problematic for both groups and required periods of adjustment with each change. Group supervision was felt to be a useful addition to case management supervision for PWPs, although it did not offer the kind of clinical skills' development and help to process the emotional impact of the work which individuals wanted. Once again, there was a

mismatch in perception regarding the level of support needed, with the younger age profile of PWP's perhaps heightening their need for formal supervision, as described by Orlinsky and Rønnestad (2005) (see 3.6.3). What seemed notably lacking was any widespread endorsement for practitioners to have personal therapy, alongside their work roles, to reduce the impact of their stressful involvement in therapeutic work with patients (as suggested in 3.6.2). Individuals appeared to be referred to OHS services almost as a punishment, for taking up too much of their managers' or supervisors' time.

As suggested in Chapter 8, the loss of former colleagues at every level also led to grieving and anxiety. Participants missed their peers and supervisors when they left and needed time to re-build relationships. Similarly, it was not always easy to get 'on side' with GPs and GP practice staff who had seen a succession of IAPT workers come and go. Within the sector and IAPT mini-teams, examples were given where recently qualified PWP's had quickly become the most experienced staff member in post, expected to take responsibility for developing newer recruits, but without formal recognition of their role. This kind of contradictory outcome has been described as typical amongst assistant roles (Bach et al., 2007). However, these kinds of outcome are also affect laden; for example, some but not all, PWP's appeared to develop a sense of grievance, or 'ressentiment,' which gave rise to an almost perverse enjoyment of complaint (Crociani-Windland & Hoggett: 2012: 167). These individuals were perhaps particularly attuned to the oscillating dynamic between grief and grievance that is found everywhere, in politics, the media and in institutions (Crociani-Windland & Hoggett, 2012) (see Chapter 11, for further discussion).

Overall, at this stage, the most marked change from the training year was in PWP motivation and outlook. As Fenwick (2013) has pointed out, there was no single linear development of an occupational identity, but rather a more unpredictable 'unfolding' with several different paths being followed. Whilst some accepted the job for what it was, and got on with it, others, as described above, felt uncared for (by managers in particular) and thought that their contribution to the service was not valued. HITs were far more likely to talk of being appreciated in their role, to feel ownership of and pride in the service, and safe in pursuing their (relatively modest) career ambitions. They could be described, on the whole, as 'steady staters' (Bach et al., 2006). PWP's by contrast were often ambivalent, expressing strong contradictory feelings of love and hate for the work, uncertainty about the value of the LIPs, and confusion about whether their work was therapeutic or not. They longed to do more in-

depth CBT and to have the chance to obtain a more widely recognised qualification. They worried about the competition for training posts and opportunities, and some quickly moved on, believing the grass would be greener in IAPT services elsewhere. Whilst the HITs too wanted more from CBT than they had been taught at times, it was the PWPs who showed the clearest signs of losing faith in the IAPT model and training at this point.

I look more closely at how these differences between the two roles evolved, and what they continued to experience in common, in the next chapter.

Chapter 10 - Two years on: identity, practice and survival

10.1 Introduction

This chapter looks at how IAPT workers view their roles and practices two or more years into service; their search to develop as practitioners and to improve their career prospects; the hardening of their enthusiasms and doubts about the work; their survival tactics and dilemmas of identity in the face of wider system pressures. It is based mainly on the analysis of second interviews with Cohort XYZ participants, who, by definition, had been in post at least 12 months longer than those in Cohort A (and for between 2 and 3 and a half years in total) (see Table 4.2 and Chart 4.2 in Chapter 4). There is a strong continuity here in some themes, especially the impact of working at 'high volume and low intensity' and managing 'gap' patients (see Chapter 8). For this reason, a few quotations from third interviews with Cohort A participants are also included.

In this chapter, I show how 'managing the statistics' starts to become an end in itself for both groups at this stage (10.3); individuals are focussed on ensuring movement of patients through the system and feel frustrated by 'returners' and those for whom there is no suitable service, who slow things down. For PWP, there is increasing reporting of caseload fatigue and personal 'tipping points' as well as anxieties about career prospects and patient care (10.4). I report on how feelings about IAPT and the new job roles intensify (in both positive and negative directions) over time (10.5); knowledge practices continue to develop, with some aspects becoming more fixed and others remaining fluid (10.2). I show that both PWP and HIT continue to struggle with issues of self-care and managing themselves in role, within a wider system, increasingly perceived as having difficult unintended consequences for both patients and staff (10.7). HITs are shown to have more confidence than PWP in their professional identity, as suggested in chapter 9, but attitudes vary by age group (10.6). Finally, I conclude by reviewing the main positive and negative developments for practitioner and therapist identity and effectiveness at this stage, in relation to the literature (10.8).

10.2 Development of skills and practices

Qualified PWPs and HITs in their third year of clinical practice shared a number of positive achievements. Both groups felt they had had time to consolidate their clinical skills and, in some cases, to develop new ones. They felt they were better at engaging patients during assessment and responding to them appropriately when treatment planning.

I feel like I'm doing the best now that I've ever done...in terms of therapy. I feel like the way I relate to patients now is a lot better than it ever has been. (Kay 2)

For Martin, 18 months on from finishing training, there were tangible benefits from having had this period of consolidation.

...the more you work with the problem, the more the pieces fit in. Now I understand the problem, I can be a lot more flexible. I'm not relying on the book telling me I have to do things this way. I can actually listen to what this person's telling me. I'm not thinking about what I need to be doing, I'm listening to what this person's telling me and how that fits into my understanding of the problem and what might be helpful at this point. (Martin 2)

He took pleasure in finding that he no longer had to struggle as much as when he first finished training. For him, this period marked a move towards 'unconscious competence' in the way predicted in the training literature (see 10.8 for discussion).

Alongside developments like these, a number of individuals felt they had got to grips with specific aspects of the job which they had struggled with in earlier periods. Kay, for example, felt she was more comfortable showing patients how to use self-help materials and to work with computerised provision. Stephanie felt her understanding of disorders and their treatment had improved. The only downside from this growing sense of competence was the guilt that practitioners and therapists felt from knowing that their practice at earlier periods might have been less than helpful to patients.

For the very few PWPs who were still in their original posts 18 months after completing training, increased confidence about their skills and practice was not something they could take for granted. As Vicky explained, after surviving the worst period of 'burn out' at the 12 months post-training point, she still had plenty of good, bad and indifferent days.

I'm more confident, everything becomes a lot more natural, you feel that you are able to help the patients a lot better than... when you first started. But there's times, depending on, I think it really depends on how you feel personally ...what else is going on for you, because there's been times when I've just hated it and felt like I can't cope with (LAUGHS) hearing people's problems anymore. It's been really overwhelming. And other times, when it's just been alright and I've been fine about it. And then times when like it's not been terrible, but I can't really be bothered. (Vicky 1)

As in the first post-training year, HITs continued to develop their therapeutic style, treatment preferences and specialisms. Martin, for example, attended a course to introduce 'mindfulness' and ACT into his practice, on the back of a specific request for this type of help from one of his patients.

The PWPs, in so far as they were able, also adopted a more personal philosophy of practice at this stage. Kay would proactively contact patients on the 'waiting list' at regular intervals to make sure that only those who really needed the service were kept on it. In her view, this was kinder than leaving people to wait without knowing whether or not the service was going to offer anything suitable. Steve, by contrast, continued to disregard the waiting list pressures and to focus his energy on giving time to caseloaded patients. He steadfastly stuck to his guns about doing longer assessment and follow-up appointments than he was technically allowed to do and to his practice of writing up each session in detail.

...because when you've got 70 people on your caseload at a time, it's hard to remember that Fred Blogs' brother died two years ago and he told you in session three and if you haven't got it in the notes and if you don't quickly read the notes before the follow-up session, you wouldn't know that and those little details might seem quite trivial, but to the individual they're not trivial at all. (Steve 2)

Both groups of practitioners also felt they had learned to use supervision better as time went on. For Jill, this continued to be one of the best things about the job,

I do feel I've got a better idea and the supervision is brilliant. I mean I cannot fault the organisation for that. I get weekly supervision and so I feel very well supported in that. (Jill 2)

Kay too felt that she was becoming more consistent in her practice over time, better able to learn from experience and taking on suggestions from supervision.

I guess, reflecting back on what I've done in the past, [I can] use it to get better. Supervision really helps, it brings things up that I wouldn't have thought of, so that when I go back to the session, I'll go like, 'have you thought about this?' (Kay 2)

As well as supervision, practitioners continued to draw on their own and the service performance reports in order to understand outcome patterns and their own 'recovery rates' (as described in Chapter 8).

10.3 Performance management and fatigue

Both HITs and PWPs were conscious of needing to demonstrate consistency of performance with service averages. Stephanie, for example, took pride in having few 'unplanned disengagements' from treatment amongst her caseloaded patients. She made keeping an eye on the statistics a priority in supervision, to spot when her practice was becoming out of line. PWPs also quickly learned when their actions were deleterious to their perceived performance in the job. Kay described this as a process of 'learning by doing,' in the best interests of patients who DNA'd,

Now I know better and I'm not, I wouldn't say stricter, but I think if after a month you've tried contacting them and sending letters and they're not getting back to you, then they don't want to do it and I think hassling them is probably not the best way to go about it. But you learn don't you, as you go along? But that's probably the biggest improvement I've seen. (Kay 2)

HITs also acknowledged that having PWP's work with patients was an important way of reducing waiting times for CBT and improving retention.

If you look at the interventions we offer, CBT and PWP work are equally effective in terms of recovery rate.... it's about finding an intervention that's the least intrusive for the patient that's likely to benefit their problem. And actually, it's not ethical for someone to be stepped up and then to wait six months....
(Stephanie 2)

Referrals to secondary or specialist mental health services continued to be treated with caution, with only the most severe cases of 'multiple trauma' getting through. Working with time limits was treated as part of the job by this point and ensured practitioners did not hold on to people with chronic difficulties. Jill, for example, came to feel that sticking with the time limits worked best for patients,

I don't tend to hang onto people. I mean what I've found was that people tend to drop out if you do that because they've lost, they've lost the impetus to come if they've got everything out, they are feeling better and I might think there's one or two other things to do, but knowing when to stop is actually [important] I think... (Jill 2)

She also commented on patients who went 'round and round and round' the system, seen by different professionals each time, until eventually they became 'heart-drop' cases.

I'd heard the counsellors who'd been there for a long long time talking about those patients and it's only now that I've been here for a significant time that I'm starting to see it. I'm seeing someone today who I saw this time last year, or maybe a bit later. She dropped out, but even then, she was my heart-drop patient.... She had a huge amount of input by [the CMHT].... Came to see me, wasn't making much progress, she dropped out and then she's been referred to me again and if I looked back through all the GP's notes, she's someone who turns up two or three times a month to see the GP.... (Jill 2)

PWPs however felt it was difficult to challenge the system, to make suggestions for organising the work in a way which would make it more manageable, as managers were so driven by targets and contractual/ funding issues.

10.3.1 Clinical and safety concerns

As time went on, practitioners became more precise in their accounts of people who didn't do well out of IAPT. Jill felt that 'younger' people were hard to engage in general and were best managed by working closely with the GP. Steve commented that he felt people with self-esteem issues needed more than IAPT could offer, not just because of the limited range of interventions at step 2,

I found clients with really poor self-esteem, the interventions weren't really helping them and it was usually stuff stemming back to childhood and not feeling loved or valued by their parents and I think for those people, even high intensity wouldn't be that appropriate really. There are probably other things that might be more helpful.... (Steve 2)

He felt those with relationship problems would do better at a 'relationship type' service, or with counselling. He was frustrated that he couldn't work with these kinds of people and had to pass them on.

Everyone perceived variation in patient motivation as an on-going challenge and having a negative impact on recovery rates. Examples were given of patients being 'pushed' into coming along, by carers, partners or family members, with inevitable consequences for outcomes. Patients whose condition fluctuated also often left practitioners feeling uneasy and uncertain about where to send them,

...if they don't meet criteria for us and they don't meet the criteria for secondary care, I hope they go to external services and seek out other forms of psychotherapy, but I don't know. Some people don't and they just continue to struggle I suppose. It's hard to think that's the gap, the gap is notoriously the hardest bit of the job.... I think a lot of it is people who are a compulsive risk of suicide. So they're fine and plod on and you'll do some work with them on depression, and then they might have an argument with their partner and suddenly they're [suicidal again] ... (Kay 2)

Vicky was distressed recalling a patient she had seen over a year previously, who had deteriorated markedly after being kept waiting by secondary care, discharged and eventually re-referred back to IAPT. Others cited examples of patients who had got worse after treatment or who couldn't work within the treatment parameters (for example, being able to identify a 'main problem'). As shown in Chapter 8 (see 8.4.4 and 8.5), and forewarned about in training (see 6.5.2), PWP's regularly had the experience of disappointing their patients,

... people have problems that we can't [help], we have got nothing to fix them with... situational problems are my biggest bugbear really. People come in and they've got really bad money troubles and they'll be saying 'I'm in debt,' 'my boyfriend's in prison,' just really bad life problems that you'd be depressed about if that was your life. (Kay 2)

For HITs, the performance management system served as a constant reminder that they should think twice before taking 'difficult cases' on. These patients were frequently the ones who had a long history of mental health difficulties and unsatisfactory contact with services.

Anxieties persisted too regarding how well equipped PWP's were to decide about everyone who came through the door at Step 2. In larger GP practices, the number and type of new referrals to IAPT could feel very uncontrolled. PWP's bore the brunt of this and occasionally, found themselves having very difficult encounters with new patients, for whom, in hindsight, they could and should have received prior warning. Rachel, at her third interview, reported one such incident, in which she felt her personal safety was threatened. She attributed this to discrepancies in recording practices,

It was unfortunate that I saw him really and it was not picked up. I think the record keeping was the main problem, because there was actually not any record of the fact that he shouldn't be with female workers on his own and that he had all this history, partly because his name had been changed. And just because the general consistency of record keeping... can sometimes cause problems, with all the different systems that people use and what not, you don't ever have a clear picture before someone comes in... (Rachel 3)

Hearsay reports of patients wielding knives and/ or guns cropped up several times in my interviewees' accounts. These hints of violence in the system impacted PWP's sense of safety. One or two reported feeling unsafe whilst out in the community, out-of-hours. Living and working in the same area meant it was not unusual to encounter patients in the street and this was one way in which the diversity of the population fed into the IAPT system at local level.

One of the CTs felt that with the growth of IAPT, different public and private sector providers each adopting different accreditation routes, there was no longer sufficient control being exerted over who did what at each 'step'. She cited differences between 'home-grown' PWP's, those coming in via 'top-up' routes or trained under previous initiatives and those with more significant 'core' training, such as in CBT or Clinical Psychology. These differences in training combined with the challenges of population diversity, made it difficult for managers and supervisors to ensure consistency in delivery and practitioner adherence to treatment protocols (as discussed in earlier chapters and in 10.8 below).

10.3.2 High volume, low intensity pain

The most immediate threat for PWP's (and indirectly for HITs) was the processing pain that accompanied work in a high volume, low intensity service. PWP's spoke of feeling overwhelmed by the pressure of waiting lists, the sense that they were working on a conveyor belt, with a constant risk of cases 'backing up' and becoming unmanageable (see also 8.4.1, 8.4.5, 9.4.1). Sue described the act of thinking about individual patient needs (or even her own bodily needs), in an average working day, as risking the equivalent of an industrial accident,

It's difficult to pin down... but it does feel like you're in something metal and rigid and if it's not this way, it's no way... there's so much work that could be done with adapting to people with pain, with brain injury, with learning difficulty, with language barriers, with chronic fatigue, you know. If someone doesn't sit on the tray and get processed the machine cuts them basically... Yeah. Spits them out... Yeah, and that's the workers as well as the patients. (Sue 2)

The challenges brought by patients changed from week to week,

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They keep coming in waves...you'll have a week where you get a lot of people who are very risky, lots of thoughts of self-harm or suicide, not very good protective factors, and lots of referrals to [the CMHT]. And you'll get another week where everyone is suffering domestic abuse and violence... and another where nearly everyone had been raped at one point in their life... Just, it just seems to come in waves, it's really odd. (Sue 2)

The management regime in IAPT, with its concentration on numbers, was felt to be oppressive at times. For Sue, there was a contradiction between the ambitious vision PWP's were expected to deliver and the reality of how they themselves were treated,

there's big choppers inside IAPT that will get you if you're not careful. If you don't tow the line...there's no acknowledgement of us as people with, we've all got our insecurities (LAUGHS) we get anxious, we get low, you know... And there's no acknowledgement of that for the workforce. We're pouring it out to the population but there's no reciprocation, you know. (Sue 2)

The service was described as 'bottom heavy', with PWP's insufficiently recognised for 'carrying the weight' of the work,

I do generally think that we don't get paid enough for the work that we do. You know sometimes I'll come home and I'll just be like absolutely shattered...having to deal with people who are suicidal can be emotionally draining... (Chrissie 2)

As shown in earlier chapters, PWP's feared becoming de-sensitized to their patients in the face of relentless volumes. It was as if, for them, the only way to deal with the volume was to partially switch off feelings about what they were seeing. Small individual successes with patients were not enough to relieve the cumulative impact on PWP's of caring, trying not to care too much and simply keeping up with the volume and complexity of new cases,

.... sometimes, people's stories are awful, and it is going to affect you, you can't help it, people will project on you how they're feeling and I'm not immune to that... (Sarah 3)

I think you can enjoy a brief euphoria, can't you, when you have a success...? But it's the day-to-day reality of the job. It eats you up basically! (LAUGHS) So you get home at night and unless you really force yourself, you just collapse at evenings and weekends, there's nothing left really. (Sue 3)

Both PWP's and HIT's thus had concerns about the sustainability of the PWP role if PWP's continued to work at the volume and intensity intended,

I suppose I've not felt that I've, I suppose, enjoyed working here as much as I thought I would...I just think seeing ten people a day, it's far too much. (Chrissie 2)

Accounts of stress and 'burnout' came to the fore during the post-training year and feelings associated with them were talked about openly, as if they were a commonplace occurrence, thereafter. As suggested in Chapter 8, this is borne out in some recent studies of IAPT workers, across a number of sites (Walklet & Percy, 2014; Steel et al., 2015). PWP's who had started out full of enthusiasm and vigour described themselves as beleaguered and looking for work elsewhere. Battle metaphors were rife in descriptions of the work and of co-workers, as 'squaddies' in the 'firing line' (see also 9.2.4).

10.4 Self-care and survival skills

Almost all the PWP's in my sample who stayed in the service for a second or third year found themselves seeking professional help for their own mental health. With so many of their peers and contemporaries leaving the service soon after training, they were no longer able to count on peer support in the way they had before. Individuals felt that their problems had reached a stage where they could not be ignored; for example, after breaking down at work, Vicky plucked up the courage to speak to her manager about her 'burn out' and was referred for CBT herself. She found this helpful, although it did not prevent her from deciding to leave. Whilst acknowledging her own contribution to her difficulties, Vicky felt there was something about the nature of PWP work that made it hard to escape from. She talked about the 'pull' to therapeutic engagement and the 'drain' on her personal resources (in a way reminiscent of Hochschild's account of 'emotional labour' (see 3.6.3-4). I return to this, and related points, in the chapter discussion (10.8).

By contrast with the earlier period, HITs and PWP's still in post after two or more years had developed assertiveness in managing the boundaries of their work roles, were exercising discretion over their weekly schedule where it was possible to do so and were taking a number of initiatives to overcome the isolation and pressures of the job (see Chapter 9). Andrea made sure she took back 'time in lieu' when she had to work beyond her normal hours. Stephanie started to take a more proactive approach towards planning her leisure time so that work did not invade everything, even her dreams. For Kay, it was important to protect her private space for recovering from the working day, by choosing to live alone rather than flat-share. HITs reported using supervision to support their self-care, self-consciously practicing 'mindfulness' on themselves and taking regular time off. They also found it useful to 'mix up the week' by taking on voluntary activities such as, offering workshops to external organisations. Martin, for instance, managed to ease the pressure he felt from the work by taking on fewer cases,

I've engineered it at the moment to see slightly less [people] some of the time and that's alright. The days when I do see 5, it's hard and it can be emotionally draining at times if, you know, the amount of emotional energy expended varies enormously from one session to the next and if you get a lot of emotional sessions on the run, it's a lot to deal with. Five sessions in a day is too much, by a long way (LAUGHS)... (Martin 2)

Assessments continued to be the most emotionally demanding aspect of the work. Unlike the PWP's, Martin felt supported by the service to preserve his own capacity in this area,

It's [about] managing your time to not be overloaded and making sure you've got enough time to process, put [all the information] in the right boxes...there's limits to what you can do, what your brain and your emotions, emotional resilience, can cope with in a day. (Martin 2)

Jill too felt confident enough at this point to work from home for a few hours each week, preferring this to working alone in the GP practice all the time. Kay's strategy for combatting isolation was to actively take an interest in others' work at the GP practice.

I don't feel the isolation I felt when I first started, but I think you have to seek it

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out. A lot of PWPs will go in, sit and do their job in their office, they won't go into the reception, they won't speak to anybody unless they need something, whereas I'll intentionally go in and say 'oh, I've heard about what you are doing?' (Kay 2)

Kay sensed quite keenly when her caseload was becoming too large. She would use her performance data report to discuss cutting back with managers and supervisors, before she reached 'tipping point.'

PWPs who had been in post for this length of time therefore did have some success in controlling the work flow, something which PWPs at early stages in their career struggled to do. Individual differences in outlook, age and self-confidence made a difference. Steve, an older PWP, who had an established career prior to joining IAPT, felt better able than his contemporaries to resist the pressures of the IAPT supervision system for a while. He used supervision time intended for case management to discuss clinical issues, even whilst in training. Afterwards however, he found himself under pressure to be more 'case led' and felt this was detrimental to his patients' interests.

...gradually I had to, I was told that I had to up my volume of patients in supervision and turn it more into case led supervision. I just didn't get any value from that. And not just me - my clients too didn't get any value from case led supervision, but they did get a lot of value from the stuff that I gleaned from my excellent supervisor when it was more of a clinical supervision. (Steve 2)

He conformed reluctantly but felt he stopped learning at this point and became hardened in his intention to leave. He, like Martin, found himself at odds with the IAPT model of care in wanting to slow things down and look after himself,

... when you're a therapist, when you're a skilled craftsman, you need your tools to do the job and you need to keep your tools well maintained and well looked after, but when you're a therapist you are the tool and you've got to keep yourself well maintained and sharp. And if there is, if you look at the IAPT role, well nothing's going to change and all you see in weeks, months and years, it's just a constant stream of clients coming into see you at PWP surgeries. It can feel a bit daunting and a bit overwhelming. (Steve 2)

PWPs still in post at this point resigned themselves in different ways to the requirements of the job. Kay vowed not to be a 'superhero PWP' and to work on communication with GPs, as a way of easing the relentless self-imposed and external demands of the job.

When I notice myself getting really really busy, I just have to take a step back and cut down because I didn't need to do that. Nobody had asked me to do that, but...I think it's knowing what pressure I'm putting on myself.... you've got your patients, they're all wanting to be seen, GPs are at you, so yeah, it's no one person at any particular surgery, just when you're in there, you feel like you need to do your best... (Kay 2)

Vicky continued to feel responsible for her patients and to feel disheartened when what she was offering wasn't working. For her, it was a 'wicked' combination of her own internal expectations of helping and the mixed messages from management. She wanted to engage in a meaningful way with patients and felt this would secure the best therapeutic outcomes, but was extremely wary of taking on too much, in light of the 'burn out' she had experienced.

I did actually get that feedback that I was taking on too much. And so, from that point on I did try and just with people that I did find a bit difficult, sort of just say, 'right, I'm trained to do this intervention,' give them the intervention, show them how it works, and if it still doesn't work, it's not your fault, because that is what you're trained to do. So I just have to remember that, 'cos I was starting to feel that it was something wrong with me. But I think that you do get a very mixed message when you're being trained about what your role is, because it's very easy to get drawn into.... the whole thing about the therapeutic relationship. (Vicky 2)

10.5 Changing perspectives and IAPT beliefs

Views about the IAPT project became more polarised in later periods. Practitioners who were strong believers in the service were, if anything, more evangelical in their support and those who were doubtful, described their misgivings graphically. Almost all the enthusiasts were HITs, or PWPs who had progressed from the service to new career opportunities elsewhere. The detractors came from both groups.

As seen in Chapter 9 (see 9.4.4), the main positive beliefs about IAPT were that it benefitted patients, had delivered on the access agenda and created 'golden' career opportunities for its workforce. For Stephanie, the pioneering spirit was still strong,

...what we're doing in this country with IAPT is so ground breaking...we forget how innovative and how ground breaking it is...we're used to it now, how things work and we forget that this isn't something that's happening in every country. (Stephanie 2)

She and others were aware however that many challenges remained in terms of achieving equality of access to the service across all parts of the city. Jill was proud of the service achievements and attributed its success to the quality of service leadership,

I think it's great people don't have to wait a long time to see someone now and it's a huge achievement and I feel proud to be part of that... I have really enjoyed working in IAPT. I think some of that is to do with personalities ... [the Service Director]. I have felt genuinely cared for and appreciated and she was able to manage that balance between delivering a good service, and caring for the people working in it...

Martin shared this view and felt confident that the service was valued more widely within the Trust. Steve was aware of the criticisms of IAPT being 'one size fits all' but felt that 'the world is a better place for having IAPT in it,' not least because of the career opportunities it afforded. The main benefit of IAPT, he felt, was the shortening of waiting times, enabling a more preventative approach to be taken and reducing the risks of people getting worse or not being able to recover at all. For Jill, it was the use of CBT to get patients to actually do things, something which she felt she could have benefitted from herself during her own experience of personal therapy.

I think the big difference is we get people to do things and to change what they're doing and for me that's been the real great thing about CBT and it works...I think sometimes having a really good understanding about why you might be as you are is actually helpful, but on a personal level, I think after years and years when I've had therapy, you know, I'm still doing the same thing. Maybe it's about time to change... (Jill 2)

Chapter 10: Two years on: identity, practice and survival

Experienced PWP's like Vicky continued to be ambivalent however, feeling that IAPT put processes and procedures before practitioners' experience, skills and ability to relate to others,

... [IAPT is] being made into this bureaucratic thing, it's like a big machine, 'cos it's national, it's got all these targets and guidelines and it seems very rigid. I think [some] struggle with that and that's a shame, because I think that those people even though they might not meet their targets, are actually very experienced at connecting with people and helping them and it's put them off.
(Vicky 2)

She also doubted that IAPT could live up to the expectations of younger recruits, that it would be a stepping stone to HIPI training or Clinical Psychology, given that they weren't allowed an employer reference until at least two years after qualifying. There was a continuing sense of regret, even amongst the IAPT enthusiasts, about the way in which IAPT had initially been introduced - 'coming in and super-imposing itself over a pre-existing service' - and making formerly skilled and valued colleagues redundant. There was less confidence about the future of the service at this point too, in light of perceived funding threats. The encroachment of private providers, the widening gap between primary and secondary care, the tension between different occupational groups, all created 'undercurrents' which affected the organisational climate,

I think people who are in jobs are happy on the whole, but I think for the long-term, a lot of people are just going on day-to-day, waiting to see. If you asked them about the future they all wouldn't be able to answer, or they wouldn't be as optimistic as they would have been two years ago... (Andrea 2)

There was a sense of there being a time limit on the 'good times' for IAPT and a realisation that the future may not be as certain or as positive as when people started,

... it's an exciting time to be in the service right now because it's new, it's fresh and it's expanding, but it's going to have a lifecycle. There is going to come a time when it's contracting and it's feeling stale and old and under pressure and potentially there might be a point where I'm pushed out by necessity... (Martin 2)

The main concern was for the future of the PWP role, the contradiction between the economic necessity of operating a high volume, low intensity service and the 'hidden costs' of staff sickness and turnover. Participants were wary of the national trumpeting of IAPT's success and sometimes felt themselves to be casualties, hidden from the official statistics. For service supervisors, too much was focussed on new starters in the service, who were perceived as accepting the system as it was. They felt not enough attention was given to those who had prior training and experience and who had more of a struggle to accept the IAPT way of doing things. They felt the service would benefit from having a wider range of therapies on offer and more psychologists trained in working across different modalities.

10.6 CPD and professional identity

Within the service, from the second year onwards, opportunities for continuing development and progression did arise (see previous chapter). Former trainees in both groups put themselves forward for supervision training for the first time. Those who did this welcomed the variety supervising others brought to their role. For PWP's there was the chance to develop specialist interests, such as working with sensory impaired patients, people with long-term physical health conditions or MUS. For the HITs, the service-wide 'masterclasses' were a chance to showcase their own work in front of others.

PWP's who stayed two years or more wished to make good their investment in the training and compared the quantity of clinical experience they gained favourably with their peers in different clinical roles. Most felt the experience enhanced their 'employability.' Those who were selected to do supervisory training, felt it enabled them to appreciate better what they had learned,

...it's interesting being on the other end. I think I've learnt that actually I'm not as bad as I think I am... I find myself sounding like my supervisor, thinking, 'I'm quite alright with this.' And I get positive feedback from [supervisee] that the suggestions are helpful, so that's nice... (Kay 2)

The development of newer IAPT services in neighbouring districts also meant that job opportunities opened up and fuelled the turnover of PWP's on level transfer and promotion.

We were one of the first IAPT sites, so we've attracted people from quite a broad area and as other sites developed people have been able to find posts closer to home... A lot of the PWP's we've had, one has gone on to the CBT training in another sector... quite a few into senior PWP posts. (Stephanie 2)

Those who had left the service had no regrets about doing so. Steve, for example, was accepted onto a Clinical Psychology programme. Vicky obtained a research post and was relieved that she could leave her clinical role behind.

With all but one of the PWP's in my sample being psychology graduates, it was clear that the majority would look to Clinical Psychology as a preferred route on (see Chapters 5 and 9). There were exceptions however; Kay felt she still enjoyed clinical work at this stage, and described weighing up her options, whilst knowing that she could not stay on indefinitely in the PWP role:

...as I get older and as I've been doing this role for longer, I do think there's a time limit on it... I don't know whether the Senior [PWP] role [will work for me], it depends how that changes by the time that I want to progress. I mean if that could develop into a more managerial type role... [but] the thing is that everything is changing so much... So, it depends. (Kay 2)

As Stephanie pointed out, PWP's really had to look beyond their own geographical area to have any hope of improving their career prospects,

We have a really good workforce, our PWP's are incredibly competent, incredibly good at what they do and they, you know, there's not going to be a senior PWP role for every single one of them within our service and so we're going to lose really experienced high calibre staff to other services... (Stephanie 2)

The frustration felt when PWP's weren't able to move on, led Kay to put a lot of time and energy into researching alternative ways of gaining an affordable CBT qualification without having to compete for scarce HIPI training places.

At the moment I can't retrain and that doesn't look like it's going to change for the foreseeable future, unless they suddenly start doing the course for free. So what, what am I going to do? (Kay 2)

The Making of Psychological Therapists: Towards a Psychosocial Understanding

Some HITs also felt constrained in terms of professional development. Andrea, for instance, felt the system limited the range of people she could work with and the complexity of conditions she could treat, even though she had appropriate competence and skills. She compared this unfavourably with her experience in previous job roles, where she could work more flexibly across the primary/ secondary care boundary and according to what the patient needed.

[Now] if somebody is in secondary care, you know they can't be seen for CBT in IAPT, unless the service is changed. That's not something that I can just go and do myself.... people just have to wait for the structure....in my last job actually there was a system set up where it didn't matter where I sat, I could still see people. (Andrea 2)

None of the PWP's felt they had a clear professional identity. They mourned the LIPI qualification's perceived lack of transferability and worried about how to progress.

I think I would feel better about my profession if it was recognised as a core profession. While ever it's not, I feel that they down play the role that we do. (Kay 2)

The possibility of formal accreditation, opened up by the BABCP during this period, did not do much to address the lack of confidence in PWP career progression.

I think the way it was portrayed in the beginning was that if they were accredited as a group as PWP's, then it would open up a career structure for them, but of course it hasn't. (CT)

We hear more of this doubt and uncertainty in Sue's 'depressed, anxious' I-poem voice, where she reflects on her fluctuating feelings about the job:

I don't trust this
I don't think
I'm not going to trust it as a profession
I'll see
Ask me again in two years!

Yeah, I think
I think
I don't know
I'd probably
I'd be probably happier
I feel
I've said a lot
I do
I really value the job
I think it's important
I hope
I'm not just
I have been quite angry
I've been told
I'm assertive
I try to be
I do
I think
I have hit stages where
I've just actually
I've always confronted situations
I've been faced with
I think
I feel
I think that's the word
I'm looking for (Sue 3).

By contrast, HITs had a much stronger sense of identification, both with the psychotherapy profession and with the IAPT service. Martin, like Anna (see 9.4.1), felt happy to own the title 'psychotherapist':

I describe myself as a psychotherapist... I quite deliberately choose 'psychotherapist' as opposed to 'CBT therapist' ... it sounds a bit better when people say 'psychotherapist,' that's a very professional job, people understand what a psychotherapist is... It feels like a highly skilled thing to do and I like being recognised as such, as having a professional, highly skilled job. (Martin 2)

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Both he and other HITs had applied for 'provisional' status as a CBT therapist in their post-qualifying year and planned to convert this to full accreditation as soon as possible. They welcomed having a portable qualification which would also give them the option of working in private practice. They valued the IAPT experience for its commitment to training and workforce development,

There are loads of opportunities in IAPT... IAPT is set up for young career people I think...They're really good at supporting your professional development. (Anna 2)

HITs showed commitment to giving back some of what they had received by staying in post. Several described feeling more comfortable in their own skins after completing their second year, confident that what they were doing built on prior experience and gave them a role they could positively enjoy.

I do feel like I've landed in something that fits quite nicely and draws on stuff that's come from all my previous experiences in one way or another. It's comfortable and the more that I'm getting the experience and the understanding of things, the more competent I'm feeling, flexible about things, it's a good place to be. (Martin 2)

They looked to add specialist roles or new work activities to keep themselves marketable and to prepare for promotion opportunities. One became a staff governor in the Trust, several took on running groups and/ or 'special projects':

I've got to a point within the last six months where I've delivered training and I'm about to start heading up a project on introducing exercise as an intervention. So, I've added on a step above my individual responsibilities. I am taking on some clinical leadership. (Martin 2)

The most experienced also wanted access to research opportunities. Andrea, for example, was keen to pursue a clinical doctorate. Most HITs wanted to keep learning in the job but did not feel driven to search for other things in the way that PWPs did. Stephanie wanted to learn more about mindfulness and EMDR but was not ambitious in other ways. Several were

content to focus on improving their job-specific skills whilst also planning for retirement. These multiple issues of professional identity are discussed further in 10.8 and Chapter 11.

10.7 System issues

As time passed, PWPs and HITs increasingly spoke of their concerns about the wider system they worked in. All felt affected to a greater or lesser degree by the context, both organisationally, socially and politically.

Gaps in service provision have already been described (see 6.6, 8.4.3, 8.5 and 10.3 above). Lack of provision for patients who did not 'fit' the service design (i.e. meet the suitability criteria for IAPT) was compounded by service closures elsewhere in the community, often as a result of Local Authority funding cuts (see 10.7.1 below, and 10.8 for discussion of this theme). Strict referral criteria and/ or long waiting lists acted as a disincentive to pass people on to alternative provision. PWPs and HITs spoke of their reluctance to make 'black hole' referrals, when patients had already waited a long time to be seen in IAPT.

If people do come in hearing voices, with housing problems, there's very little I can do to help them and trying to help them in my service would be very inappropriate. I wouldn't know how to treat them well, I wouldn't know what the issues were... it creates more problems than it solves. So, the GP might feel better that they've got this patient an appointment with somebody, but it doesn't help the patient to get bounced from one service to another until they find something where they can get suitable help. (Sue 2)

This was especially the case where IAPT was not the patient's first attempt at finding help and he or she had a history of previous service contact, or of difficulties in obtaining appropriate treatment.

For the HITs, waiting times within IAPT were a major concern. Waiting for PWPs to screen and assess new referrals, when they were new in post, or covering for an absent colleague, was frustrating. Equally, HITs were only too aware of the impact it could have on their own stress levels if patients had to wait to be seen for CBT after assessment by the PWP. The tendency was to try

and get people into treatment quickly, rather than be too precious about referral criteria,

You're getting people that maybe never would have come in... People struggle with things, most people do anyway, they struggle for years before they come for help, and there's a lot of avoidance involved...So, when they come for help you need to be able to offer it, otherwise the avoidance takes over again. (Joanne 3)

The situation was compounded by discrepancies between national guidance and local interpretations of what the ratio of HITs to PWPs should be (see 3.4.2). In a devolved service, such as the one my participants worked in, managing demand at each level of care, across diverse localities and GP practice units was a real challenge. The PWPs were attuned to times when national expectations in relation to their individual caseloads were interpreted differently by local managers. For Sarah, the tendency was for local managers to adopt a more stringent approach in terms of meeting caseload size expectations than was nationally required. However, for Jane, local managers also showed a willingness to take a more gradual approach to implementing changes in PWP workload, despite pressure from the centre to increase numbers of people seen,

I do get bogged down, I think sometimes there's too much.... I don't think that there should be that pressure to see 10 people in a day and I think that that's not a national requirement, so much as a service target.... (Sarah 3)

Nationally they're advocating that we see more...I don't think our service pushes us into that but I think nationally, it's being pushed, they're just upping and upping the limits... (Jane 3)

Where caseload expectations for PWPs were resisted, other changes in their role and/ or in the type of interventions they could offer were welcomed, especially where they were accompanied by some investment in PWP training,

The step 2 interventions are developing nationally. We're doing more as PWPs. They're making sure that actually you've done the training so that you can do them [interventions], whereas before they might have said 'you've not had the

training, so step it up.' It's not like [former service] when it was 'just have a go'!
(Jane 3)

Neither group felt there was any real escape from the individualising pressure of reporting against targets,

there's a message that there's no targets under IAPT, it's just a way of managing the system... but each person, um, they have on [MIS] there's a performance report for each individual and that's checked on a regular basis, so it's about numbers, it's a conveyor belt...that's the bit that doesn't sit easily with me...
(Andrea 1)

10.7.1 The impact of staff turnover and uncertain funding

The reported reasons for people leaving the service weren't always negative; for example, PWPs left to relocate to a service nearer to where they lived, to gain different experience with a view to progression, and/ or to take up a HIPI training place. However, the fact that so many left in quick succession or took long-term sickness absence led to concerns about how an effective service could be maintained. Those who were left behind were anxious about what would happen if funding for the service was cut.

We mainly get trainees to replace qualified workers, obviously that means for a year they're seeing fewer patients, but we have been able to replace the staff. I think my worry would be whether it comes to a point where we're not able to fill vacancies 'cos that's something a lot of Trusts do in order to save money.... they use the natural wastage of the service and don't [back] fill... (Stephanie 2)

There was a sense of loss too, as discussed in previous chapters, with the most experienced practitioners being replaced by younger trainees, whilst they themselves were still in the early stages of their working life.

It's sad it's not retaining the staff. I think that's a real, 'cos all we're doing is, again no disrespect to the younger trainees, we're getting a lot of younger people in that have just qualified, they're very young and lack that experience.... I'm not old, I'm 29... but, you know, to be 29 and to be one of the most experienced IAPT workers they've got is ...says a lot... (Kay 2)

For some workers, the constant turnover had benefits in terms of providing 'new blood' and new ideas in the system, however all acknowledged the disruptive effects, and the loss of pioneer spirit that had enthused the service in the early days (as captured in Grant et al's (2008) description of IAPT 'hero innovators'; see 7.6).

Practitioners also reported for the first time feeling that the balance of provision within the service as a whole was wrong. For example, Jill felt very aware of the demand and long waiting times for counselling amongst patients, in most of her practices. Kay also felt that the service would have to move away from its exclusive focus on anxiety and depression, to start to integrate 'evidence-based' CBT treatments for more severe conditions, such as psychosis and eating disorders, if it was to survive.

I think even if they dropped the IAPT service... downsized it, I think they'd have to mould us into a primary care mental health service, as opposed to a specific anxiety and depression service. I have a feeling we're going to move that way anyway, because I wonder how much time we've got left as a service that purely treats anxiety and depression.... There's evidence that CBT is successful with psychosis, you know, the NICE guidelines are changing. There's evidence that CBT is good for eating disorders so.... I think that's going to change... (Kay 2)

Alongside the pressures to fit everyone in, HITs also expressed awareness of service 'reconfigurations' impacting on their own and the PWP's job roles. Inter-professional rivalries and resentments fuelled by the advent of IAPT were not helped by requiring staff in adjacent roles to reapply for their jobs under new terms, job titles and conditions.

10.8 Discussion and conclusions

This chapter has looked at IAPT workers' changing views and practices two years into service, based on their own accounts and the views of service managers and supervisors. Both groups - the PWPs and HITs - felt established in their roles by this point, and no longer looked backwards to previous job roles and competencies as much as before. The HITs felt valued in their professional capacity by managers in the service and increasingly exercised control over their diaries, to ensure a manageable workload and variety in their

clinical activities. Individuals in both groups, used discretion at times, in session time-management and note-taking (10.2), suggesting a degree of professional autonomy. However, discretion was also exercised ‘under the radar’ (see 9.2.4), away from supervisory or management eyes, in the manner of Lipsky’s ‘street level bureaucrats’ - not so much to ration interventions or materials, but to save the human resources of the practitioners themselves. For most (HITs and PWPs), there was a sense of having internalised the learning from the course, as might be expected at this stage (see 3.6.2, Skovholt & Rønnestad 1992). They could focus their efforts on developing specialist skills and incorporating newer treatment models, once they were comfortable with the main repertoire of IAPT interventions and had discovered their own personal likes and dislikes. In this way, individuals maintained their interest in the work, continued learning and edged from ‘conscious incompetence’ towards ‘unconscious competence’ (Robinson et al., 2011; Crandall et al., 2003; after Howell, 1982). However, these learnings were not all that was internalised (see below).

PWPs also benefitted from having had time to develop their skills. On the whole, at the two years plus point, they were more at ease with the task of explaining the PWP offer to patients, conducting assessments and working out treatment plans and referral routes. As in the year after training (see Chapters 8-9), it was a relief for them to look back and realise that their skills had improved. Both they and the HITs felt helped by supervision and the use of performance data to reflect on their practice and to improve patient attendance and outcomes (as argued for, by the IAPT founding fathers) (Chapter 3). Individuals also articulated a clearer ethical position in relation to practice (8.3.1); they had definite views about how waiting lists should be managed, how best to handle new assessments and handovers between practitioners, and when to seek advice. This was achieved in spite of difficult experiences and times when the job, particularly for PWPs, felt overwhelming. I would suggest that, in these developments, IAPT practitioners were inhabiting their ‘worker-learner’ identities (Reich & Girdwood, 2012); using performance data to ‘audit’ themselves, in the way described in the governmentality literature (Reich & Girdwood, 2012; and Chapter 2), and to know when their practices were becoming out of line (10.2-10.3). They had internalised the expectations and standards of government, and IAPT policy, and the ‘display rules’ (Hochschild, 1983) required to enable them to perform as ‘evidence-based’ psychological therapists. Furthermore, those who stayed in post for this length of time, were better able to align their individual defences with those of the organisation, so as not to experience the full emotional force of the work (in the way described by Menzies-Lyth (1959) and Halton (2015), see 2.5.1).

Practitioners in both groups continued to value the clinical experience they were gaining from IAPT. They recognised that they were in a position to learn a lot very quickly, because of the level of exposure to patients with very different needs, on a daily basis. Both HITs and PWPs continued to express gratitude for the 'IAPT opportunity' and felt pride in the service achievements. In this way, they showed their investment in the 'prized collective identity' of being a new kind of mental health worker (Anteby et al., 2016: 185), with professional status aspirations. This was however, somewhat surprising when the more negative experiences (discussed below) of many PWPs are considered. Individual PWPs expressed conflicting feelings and ambivalence about the work by spending time working out 'escape' routes and/ or creative progression opportunities, inside and outside of IAPT. Supervision training was welcomed by both groups and taken up by a few at this point. Top-up training in new conditions was valued by the PWPs where it was offered. Individuals continued to work hard at negotiating between their inner and outer, personal and professional selves (Rønnestad & Skovholt, 2013; see 3.6.3).

The cumulative impact of working at high volume and low intensity was however very apparent for PWPs, and to a lesser extent HITs. As has been shown in other IAPT samples (see Steel et al., 2015; Delgadillo et al., 2018), there was ample evidence at this stage of practitioners becoming de-sensitised to patient distress and exhausted from the experience of not being able to make much impact on patients' multiple inter-locking psychological, interpersonal and socio-economic difficulties. PWPs struggled with signposting patients who did not fit the criteria for IAPT nor alternative services. They struggled with their own and their patients' disappointment and, like the HITs, dreaded seeing the same people come round to the service again after they had passed them on in good faith, thinking that they would be seen elsewhere. This raises questions about the sufficiency of the IAPT training and what can be delivered within the confines of a one-year course. Even though practitioners at this point in their IAPT journey were technically proficient, they regularly found themselves un-equipped to deal with all their patients, and worried about letting them down. As Neuhaus (2011) has shown, the degree to which individuals felt able to be open about this struggle and supported in managing their anxiety, through supervision, made a difference to their ability to accept these challenges and think of solutions (Neuhaus, 2011: 228). However, there was also a very real sense in which the reality of 'social suffering' (Bourdieu et al., 1999) (see 1.3 for definition), NHS service reconfigurations and funding cuts to alternative provision in the community, were denied in the IAPT service design. Seeing everyone at Step 2 first, then

referring and 'sign-posting' people on, with only a minority being 'stepped up' to high intensity (Step 3) or more (Richards et al., 2012), did not work as smoothly as intended. Practitioners felt they were at fault if they were unable to find an adequate solution, given that supervision was in place to help them, and they were meant to be able to cope. It was as if they internalised some of the feelings associated with the social suffering of their patients' environments (Frost & Hoggett, 2008), but could not voice these, given the emphasis on throughput, and patient 'help-ability.' The continuous everyday exposure to trauma, pain and distress in patients, however unsolicited (in terms of the prescribed clinical methods), left an undigested residue of toxic feelings which could affect the health of practitioners.

Whilst individuals took steps to get themselves out of states where they felt their functioning was impaired, they feared being stigmatised for not being able to cope (as in earlier years, see 8.3.4) and felt they had experienced negative or uncaring responses from managers. There was little time or space to think or to grieve the loss of those who walked, or got left behind (staff or patients). Anxiety and stress were also prevalent amongst managers (in respondents' accounts), suggesting an incapacity at this level, to absorb the fall-out whilst also meeting targets, the demand to improve outcomes, and to ensure service contract renewal (Rizq, 2014a).

Amidst the conveyor belt type pressures, working within prescribed time limits for treatment interventions became second nature to both PWP and HITs. PWPs quickly learnt to spot the warning signs of disturbance in their patients, but did not on the whole feel they should be in the position of having to decide what was best, when patients were unclear themselves as to what they needed. HITs found it took a lot of work to find and/ or adapt treatment models to match each patient's needs. Where they could, they worked with PWPs to identify intermediate steps the PWP could take to keep a patient engaged whilst they waited for high intensity CBT or another service. PWPs valued this input, but risked overstepping their role at times (as seen in Chapter 8), leading to service wide concerns about 'therapeutic drift.' The reasons for drift occurring were generally attributed to individual practitioner's attitudes and motivation, by service and training managers. During training, HITs in particular were advised to be wary of 'clinician safety behaviours' which might lead them to hold back from challenging patients in distressing circumstances, with the various CBT 'change methods.' By the two-year point, it seems many PWPs and HITs were still struggling to 'balance firmness and empathy' in the context of a purely 'functional therapeutic alliance' (Waller &

Turner, 2016: 131). The assumption that drift was mainly one-way (from LIPIs to HIPIs) belied the complex ecologies of practices that were actually occurring, and the backwards and forwards of role transition for both groups (Fenwick, 2013). There was also evidence at this point of 'organisational adversity' (Hoggett, 2010b) challenging staff throughout the service, from the unpredictable and short-lived disruptions presented by disturbed patients, to the more enduring, day-to-day effects of working with distressed people in a high-volume production line system (see 3.6.3) (Loewenthal, 2015c).

HITs for the most part however, were happy and intended to stay in post; they felt pride in the IAPT service and were willing to repay the investment in their training through remaining loyal to their present employer. They also felt confident in their 'psychotherapist' professional identity. For them at least, the promise of IAPT had delivered. PWPs by contrast lacked such a clear identity and had become hardened in their intentions to leave the service. They, for the most part, had lost faith in the IAPT opportunity, and were biding their time, to find the right way to move on. Both PWPs and HITs talked about not wanting to become 'pigeon-holed' professionally by their training in the IAPT versions of CBT. PWPs had more concerns than HITs however about the immediate transferability and relevance of their qualification to other sectors.

The theme of keeping faith, and of its loss, is one to which I shall return in the next and final chapter - where I also review what has been learned, from these empirical chapters, in relation to the research objectives, and literature reviewed at the outset.

Chapter 11 - Thesis conclusions

11.1 Introduction

The overall aim of the research, on which this thesis is based, was to ‘gain a greater understanding of the psychosocial dynamics of current initiatives to improve access to psychological therapies, and the implications of these for the sustainability of new occupational roles within primary care mental health’ (see Chapter 1). The key questions that motivated the research design and methods at the beginning, were:

1. How do individual PWP and HITs manage transitions in their role, during and after training?
2. What challenges to personal identity and professional competence do they face whilst working in these new occupational roles?
3. What are the implications for future service development, and the sustainability of new occupational roles within primary care mental health?

This chapter brings together what I found in relation to each of these questions (11.2) and the connected themes, derived from the literature (see chapters 2 and 3) and the overall research aim. I discuss my contribution to knowledge (11.3), and the limitations of the research (11.4). I end by considering the implications for future research, for IAPT services and training providers (11.5).

11.2 Overview and discussion of findings

11.2.1 The management of role transitions

The preceding chapters have shown that, in many respects, IAPT recruits undergo a similarly uncomfortable, anxiety-provoking and uneven process of role transition as other trainees in health professions. They have to tolerate the

loss of former job roles and the uncertainty of not knowing enough, whilst immersing themselves in new ways of thinking and navigating a new set of relationships and practices with patients, peers and colleagues, often without on-site support (see 7.6). It is neither a linear nor completely predictable process (Fenwick, 2013). What is different about their experience as psychological therapists, is the relative brevity of the training period compared with more traditional psychotherapies, and its linking with a defined set of IAPT specific treatment protocols (as well as competencies). What Rønnestad and Skovholt (2013) describe as the chronologically distinct and sequential stages of 'novice' and 'apprentice' in their model of professional development (from nought to five years), gets abbreviated into half the time for IAPT recruits. There is little time, in the IAPT training, to focus on the more subtle intrapersonal aspects of role development, the internal self-monitoring and emotion regulation, suggested by Reed and Armstrong's (1988) definition of 'role' (see Chapter 1). This sub-section therefore focusses on the tensions around adherence to protocol, the relevance of psychological flexibility (Biron & van Veldhoven, 2012), managing 'burn-out' and role boundaries.

The use of protocols and formal competency frameworks provides an 'evidence-based' framework for interventions and clear boundaries around what practitioners are expected to do, but translating these into practice is shaped by each individual's characteristics, their work and personal biographies, the work context, amount and type of support available. As suggested in the literature, adherence to treatment models is strongest during training (Skovholt & Rønnestad, 1992), but as I have shown, there are signs of 'drift' occurring once the strictures of training are lifted. This transition point coincides with practitioners having to negotiate larger caseloads, waiting lists and gaps in service coverage or provision. These pressures interact in complex ways with the personal preferences, interests, learning and coping styles of individuals (Steel et al., 2015). Some, my analysis shows, feel motivated by the challenges, develop a proactive approach to organising their work, draw on the peer support and supervision available and thus continue to develop in positive ways (as shown by Green et al., 2014, in relation to PWP). Others, particularly amongst the PWP group, find it hard to resist the pull to therapeutic engagement, and may become over-involved with their patients, in ways which increase their susceptibility to burnout (Rønnestad & Skovholt, 2013). It is important to remember, in this context, that being able to identify with the patient populations that IAPT serves was an important motivator for most participants, and had deep roots in their own life histories; for many, there was a 'reparative' aspect to their desire to work in mental health, and their IAPT role was consequently 'more than just a job,' it was also an expression of who they were, or hoped to be (Hoggett et al., 2006b: 762). Even though for both

HITs and PWP's there was a degree of instrumentality in their choice, a recognition of the IAPT 'opportunity,' as a means-to-an-end career-wise, most were strongly committed to IAPT's public mental health aims. Their feelings and 'passionate commitment' toward the project helped them to engage empathically with patients - a characteristic considered important in the psychotherapy training literature (see Rønnestad and Skovholt, 2013: 50). However, it may also have increased their vulnerability to suffering, as has been found historically amongst 'semi-professionals' (Nottingham, 2007) and others working in public welfare roles (Hoggett et al., 2006a, 2006b; Miller et al., 2006).

Two sets of arguments are common around the issue of 'burnout' and its association with an increased tendency to drift between LIPs and HIPs in IAPT services. On the one hand, lack of 'psychological flexibility' and having high levels of 'prosocial' motivation (Dill et al., 2016) has been associated with burnout; on the other, the needs of patients and the existence of 'social suffering' (Frost & Hoggett, 2008) are viewed as making demands, which practitioners have not been sufficiently trained to manage (see 8.4.3). In the CBT literature, it has been suggested, negative attitudes towards the use of manuals, holding over-inflated views of their own abilities, being female, depressed and experiencing high levels of anxiety, are the main explanations for drift occurring (Waller & Turner, 2016). The role of intrinsic motivations (Dill et al., 2016), such as the desire to learn, do meaningful work, and to develop personally and professionally have not been explored, although these motivations were important amongst this study's sample. Psychological flexibility, including the capacity to experience negative thoughts and emotions, without acting upon them, has been mooted as a key to avoiding emotional exhaustion, and to enhancing employees' ability to handle work strain (Biron & van Veldhoven, 2012). The evidence from this study would support this, and the related assertion that training courses often do not pay enough attention to the exertion required to engage empathically with patients (Rønnestad & Skovholt, 2013: 49-50). There is also good evidence of the investment of hope in IAPT, which is compatible with Nottingham's (2007) thesis regarding semi-professionals; that is, that a susceptibility to the ideology of promise, leads to a permanent sense of 'legitimate aspiration denied' (Nottingham, 2007: 446). I suggest that the frustration of hope in IAPT, the denial of feelings and legitimate aspirations, is one important explanation for 'drift' occurring. Another is the difficulty of leaving, especially for those later on in their careers, who cannot afford to lose out on a permanent employment contract or who are unable to relocate for family reasons. For these individuals, 'investing-in-role, retaining-commitment' and passionately defending what the IAPT service is about (Miller et al., 2006: 373), becomes a necessary survival

tactic, together with experimentation and attempts at personalising or 'job crafting' their roles (Kessler et al., 2013).

Thus, despite the rhetoric of role specificity in IAPT, there is also some evidence of role blurring occurring (Michalec & Hafferty, 2015), where waiting lists are high, or vacancies not yet filled, and each member of the 'mini-team' PWP-HIT pairing helps the other out (see Chapter 9). The interdependence of their practices, as well as their feelings of isolation, work together to strengthen the search for on-the-job learning and support from those in adjacent roles, and can leave a residue (of role behaviours) which cannot always be kept in check (Michalec & Hafferty, 2015). It is a struggle for both groups to manage the tensions between task, teamwork, inter-collegiality and self-care, across the different learning and practice settings. After a one-year training course, they have acquired the theoretical background, conceptual and practical tools to facilitate change, and have a good understanding of how they should position themselves within a stepped care system. They do not necessarily have the knowledge or skills to cope with the ambiguity, stress and personal uncertainty of the work (Schermer, 2011: 73). In other words, as shown in 9.5, there is little time for trainees to establish role security, before the interprofessional aspects of their work have to be negotiated (Michalec & Hafferty, 2015).

There is an emphasis, in IAPT training, on developing reflective skills, yet the role of the person is not explored in the way required in many 'professional' trainings (Klein et al., 2011) (see 3.3.5). Nor are the emotional demands placed on the worker attended to in the IAPT system. As Kraemer (2015) suggests, there is an implicit assumption, as with other frontline service roles (and the military), that once a person has been trained, they are equipped to do the job, as they have the protocols (and supervision) to fall back on (Kraemer, 2015: 144). As discussed in Chapter 3, individuals in these roles are treated as equal and interchangeable, with the interventions, rather than the person or the relationship with the patient, being deemed critical in producing change (Klein et al., 2011: 10). Once again, the role of psychological therapist appears to differ markedly from that of psychotherapist, as traditionally understood. The development of personal authority within role is not cultivated, but lies instead with managers, and the semi-automated supervision, case management and performance measurement systems (Kraemer, 2015). The pride of the service in, for the first time, 'embedding' supervision, as an organisational requirement in the NHS, underlines how far trust in IAPT is displaced from the individual practitioner onto the systems and technologies of surveillance. Whereas, traditionally, psychotherapists have been expected to use their own personality

as ‘a catalyst, tool or a resonating instrument’ in the conduct of therapeutic work (Heinonen & Orlinsky, 2013: 727), this is not part of IAPT role designs. There is an acknowledgement of the importance of countertransference reactions, as a source of information for learning about their patients, in the HIT training (see 6.4.1), yet the emotional labour required is assumed to be marginal and the responsibility of the individual. For PWPs, judging by the experiences of participants in this study, there may be insufficient clinical supervision to manage these kinds of inter- and intrapersonal responses. Practitioners are instead encouraged to develop ‘resilience’ by doing ‘self-practice’ of CBT, or by finding help through personal therapy elsewhere (see chapters 8 and 9). Personal development, as a strategy to support role transition and improve patient outcomes (as discussed in 3.6.4), is therefore a by-product, not an aim in the IAPT workforce. Whilst its role in CBT training more generally is also much debated (Neuhaus, 2011), there is evidence from my respondents’ accounts that more time and support to process their experiences could help with the preparation for clinical practice and to withstand the strong emotions aroused in them when relating to a wide range of patients at Steps 2 and 3 (Neuhaus, 2011: 231).

11.2.2 The systemic and dilemmatic challenges of practice

In tracing practitioners’ journeys through training, into clinical practice and beyond, I have shown IAPT practitioners facing numerous challenges to their identity and competence; such as, the dilemma of being both ‘hero innovators’ (Grant et al., 2008) and ‘cogs-in-the-machine’ (Hutten, 2012, and see 9.4.1); ‘patient-centred’ and deliverers of the right kinds of numbers; providing choice, not diagnosis; and, managing complex problems, with simple solutions (see chapters 6 and 8 especially). These dilemmas and the responses to them reveal a number of things about the IAPT system, which I reflect on here.

First, IAPT practitioners operate in a contested space and are subject to powerful collective ideals. The mission of improving access and revolutionising mental healthcare is a seductive one, made more powerful by the paternalistic invoking of ‘evidence’ by the founding fathers, and the offer of a paid training and job role which can provide a rehearsal space for their later professional selves (Scanlon, 2011). When the reality conflicts with these ideals, their roles do not meet their own, or their patients’ expectations, stress is one result (see, for example, PWP views on ‘learning by doing’ at 8.2). Not being able to offer meaningful choices to patients, when the wider system capacity does not match demand, creates anxiety, as suggested by Simpson (2016). Practitioners

have to be 'patient-centred' in a system that is driven by efficiency demands (see chapters 8 and 10). Their lived experience reveals the 'inherent contradictions in policy formation,' predicted in the psychoanalytic and psychosocial literatures reviewed in Chapter 2; PWPs in particular, in their sign-posting role, have been shown, in this study, to become bridge-builders between and within services which are intended to be 'integrated and seamless,' but in practice, are far from being so (McBride et al., 2005: 38). This study has also shown that there is a discontinuity between the IAPT rhetoric and the containment of anxiety on the ground, which is so important to quality of care (Walsh et al., 2016). As shown (see especially 7.5, 9.3 and Chapter 10), there is no space for IAPT practitioners to express or explore their individual or collective unconscious desires and fears about the work (Walsh et al., 2016: 2) (and see, 8.4.1). They must develop their skills to meet patient need at the same time as constraining what patients expect from them, in the interests of optimising system outputs and performance (McBride et al., 2005). There is a commodification of the care process (especially in terms of quality and timeliness) which overrides individual managers or practitioners' own dispositions, motivations, and philosophies of care in this context (see chapters 9 and 10).

The role of the patient in the IAPT system is also ambiguous. As discussed in chapter 2, the relationship with clients for people working in 'semi-professional' roles, tends to be 'imposed' rather than chosen (Nottingham, 2007) (see 2.3.5). Rather than being wholly 'free to choose' as clients of full professionals would normally be (Nottingham, 2007), IAPT patients' options are regulated by service rules and norms. Indeed, earlier chapters have shown there is a disjuncture between the ethos of democratic collaboration as taught in CBT, and the rather rigid and hierarchical structure in which IAPT 'stepped care' is delivered. Practitioners must be mindful of their position as employees (see 7.6 and 8.2), meet managerialist requirements for activity rates and throughput, and enable patients to determine their own priorities, as if fulfilling 'customer requirements'. As shown in Chapter 8, patients who have longstanding or chronic difficulties, of multiple kinds (including social and economic), are like grit in this system (see 8.4.2-3); they slow progression from step to step, and demand more time and thought than either PWPs or HITs can consistently afford to provide. This results in a constant tension for practitioners, in managing referrals (see 7.3.2), between what Miller et al (2006) describe as 'enabling' and 'empowering' patients to choose and providing 'tough love' (Miller et al., 2006: 369). In IAPT, the equivalent is between helping the patient to learn self-care and self-management, 'to become their own therapist' (see 6.4-6.4.2) and ensuring they 'move towards recovery' (see 3.2.1; Layard & Clark, 2014) by completing treatment goals within a specified

time, even when there are waiting lists for the next appropriate step or service (see 8.4.5). I have shown, like Fotaki and Hyde (2015), that patients do not necessarily value the 'choices' they are asked to make, but prefer to defer to practitioners' suggestions (including for example, their definition of the patient's 'main problem', see 7.3.2 and 8.4.3). As has been argued elsewhere (McBride et al., 2005; Fotaki & Hyde, 2015), patients do not always want to be consumers in healthcare; 'they [may] prefer to delegate clinical decisions to a knowledgeable and trusted medical professional' instead (Fotaki & Hyde, 2015: 450). Thus, getting patients to play their part, in the IAPT system, is not just a pragmatic, menu-driven task; it requires relational and assessment skills which do not neatly divide between the roles of 'coach' and 'therapist,' as PWPs and HITs are meant to do (see 3.4.2). It also requires a wider offering within IAPT services (as argued by Perfect et al., 2016), and the existence of viable alternative provision, if patients are to be both consumers, and 'goals' or targets for intervention (Michalec & Hafferty, 2015). Practitioners must deliver managers' and supervisors' perceptions of what a particular patient needs (McBride et al., 2005), personalise and tailor pre-defined interventions, whilst also working in a collaborative way with the patient, as if he or she were a 'team member' (Michalec & Hafferty, 2015) (see 8.5).

The use of outcome measures, performance and case management reporting systems in IAPT, also control the relationship between practitioner, supervisor and patient, in ways which are intended to ensure patient safety, and support learning (see 3.4.2), but at times have the opposite effect (see Chapter 10). There is an obsessional quality to the search for 'improvements within caseness' described by HITs (9.3), and the investigation of performance variation over time, in their own and team statistics by PWPs (9.3). No-one wants their MIS outcomes profile to be out of line with service norms (see 10.3), and HITs think twice about taking on 'difficult cases' (10.3.1). As described by Halton (2015), the measurement-based protocols for risk assessment and quality assurance, are devoid of empathy, and can be experienced punitively, by both practitioner and patient (10.7). A lot depends on local management, site and team cultures (see 9.3). Practitioners are caught between an 'economy of performance' and 'ecologies of practice', as suggested by Stronach et al (2001: 109 and see 2.3.4). In this, and other studies, local interpretation of national IAPT guidance regarding things like staffing ratios, individual's caseload size and expected activity rates, has been found to vary considerably (10.7) (Richards et al., 2012). At the same time, there is an emphasis on governance and 'remote control' in IAPT, which makes individual reflexivity difficult to achieve. As shown by Miller et al (2006), when the focus of a service is on outputs and ends, rather than inputs and means, it creates low-trust

relationships. IAPT managers are perceived to place their faith in numbers, and to lack understanding of the real reasons for people leaving the service (8.3.3).

This is also one of the central characteristics of NPM in healthcare systems where ‘separation of purchaser and provider roles,’ is accompanied by ‘dis-aggregation of large organisations, use of competition to enable user “exit” or “choice” and decentralisation of budgets and supervision to line managers’ (Miller et al., 2006: 369, after Clarke et al., 2000). After the first three years of ring-fenced funding, IAPT service budgets are determined by local CCG decisions, access and throughput are closely monitored. Yet IAPT services, as shown in this study, consist of multiple micro-sites, each with their own dominant players and practices, which also have to be negotiated with. Practitioners have to draw on their own resources, their strongly felt commitments to the work and to patients (stemming from their own early identifications), and find a position which they can sustain, either keeping with, or going against, ‘the grain of managerialisation’ (Miller et al., 2006). This requires ‘emotion work’ and an ethical capacity to negotiate ‘dilemmatic spaces’ (Hoggett et al., 2006a, 2007; Miller et al., 2006). Situations where there is no obvious ‘right thing to do’, and where there is ambivalence about the choices available occur everyday in the IAPT setting. Patients who have been referred on ‘in good faith’ turn up again, having not received the help they needed elsewhere (10.3.1). HITs feel uncomfortable about handing patients back to PWP after HIPI treatment (8.4.1), and PWPs doubt their capacity to manage high volumes well, with LIPI interventions alone (9.4.1, 9.4.4). Practitioners must contain a sense of loss and disappointment, felt by those they work with and for, or else internalise the sense of failure and become demoralised, when outcomes are not achieved (see 8.4.1 and 10.4). This is similar to the experience of community development workers, described by Hoggett et al (2007). Whilst ‘acting for the best’, IAPT practitioners have to contend with the anxiety of knowing they may get it wrong, and not live up to their own personal values and standards (see 8.2, 8.4.1, 8.5). Like development workers, they are often left with ‘lingering feelings of doubt, regret and sometimes guilt’ (Hoggett et al., 2007: 100) (7.3.2-7.3.3). These feelings in IAPT practitioners relate as much to their co-workers as to their patients; for example, both PWPs and HITs expressed regret about members of the primary care team, such as counsellors and PCMHWs, who had been in post before IAPT came along, and who were given little option but to accommodate them as newcomers (see 7.2.3 and 10.5).

These dilemmas, experienced by IAPT workers, have been found amongst other welfare service professions, caught between their own good intentions and wish to care for others, and the modesty of what is achievable (as discussed in Chapter 2; Cooper & Lousada, 2005). They are emblematic of the dilemmas and complexities of contemporary modernity and, I argue, following Hoggett et al's (2007) account, they are 'particularly acute' because IAPT exists 'in the contested space between government and civil society' (Hoggett et al., 2007: 100-101). High ideals, morals and expectations conflict with the unpredictability and pain of really knowing, accurately assessing and then helping anyone and everyone who walks through the door (7.3.2 and 10.3.1). Practitioners cope with the feelings aroused by these dilemmas in different ways. Some become desensitised to what they hear and see (8.4.1). Some suppress their anger and guilt by using humour and irony (7.2.1, 8.4.2). Just like development workers (Miller et al., 2006: 375), this study has shown how IAPT workers seize opportunities to off-load emotions with colleagues and friends, swap notes with one another, accept supervision when it is perceived as valuable, and use self-selected benchmarks to assess how well they are doing in relation to the values it is possible for them to apply (see, for example, 9.2.1 and 9.3). They also refer dilemmas back to the organisation through line managers, and publicly declare the challenges of the job to colleagues, through 'masterclasses' and group learning events (see 8.3.1 and 10.6). For some, as discussed in Chapter 2 (2.5.4), there is a degree of 'compliance without conviction' (Wastell et al., 2010) in relation to case management supervision (see 10.4), the specificity of the IAPT treatment models (for HITs) and the use of LIPI materials (for PWP).

11.2.3 What kind of professionals are IAPT practitioners?

This study has explored the values, interests and identifications of IAPT workers over time. The professional status (or lack of it) of their new job roles was an issue of interest to both PWP and HIT participants. Although HITs appeared to be more secure in their professional identity, and chose to describe themselves as 'psychotherapists', they recognised that their skills would need development if they were to move on and put them to the test in a different, non-IAPT, service context. PWPs on the whole strongly regretted the lack of a clear professional or occupational identity, and did not feel their role was sufficiently recognised, within or beyond the IAPT service. In this sub-section, I contend that the two IAPT roles do not neatly divide between that of 'professional' and 'semi-professional' as suggested by an initial reading of the role requirements and accreditation routes (see Chapters 2 and 3). Rather, they both share semi-professional characteristics, as described by Nottingham (2007) and Etzioni (1969), and have an organisational and service identity which overrides their individual occupational identity (Evetts, 2009, 2013). This is because, like semi-professionals, they have discretion, but this is subject to

'periodic adjustment' by the state (Nottingham, 2007: 365), via the medium of service design, workforce and training reviews (for example, PWP Training Review Team, 2015). There are grounds to argue, from the evidence presented in previous chapters (and see 11.2.1 above), that the IAPT roles 'lack sustained authority,' in that they need the state to act as 'guarantor of basics' in relation to their clinical work, and require 'Olympian supervision' (Nottingham, 2007: 460-461). I would suggest, therefore, that the PWP and HIT roles in fact have more in common with each other, than either do with full occupational 'professionals' of the kind described by Evetts (2009, 2013) (see 2.3.3). Both roles are subjected to rational-legal forms of authority (the existence of NICE-approved 'evidence-based' guidelines), operate within a hierarchical structure of responsibility and decision-making, and involve standardised work procedures and practices, which are consistent with managerialist and NPM forms of control (Evetts, 2009: 248). Their performance is monitored, subject to organisational target setting, regular and frequent reviews (see 7.5 and 9.3). Although individuals work hard at collegiality, building trust between team members, exercising authority and discretion at times, and delivering effective assessments, they are accountable first and foremost to their organisational managers, rather than the relevant professional bodies (Chapter 9). This matches exactly the 'ideal type' of organisational professionalism, described by Evetts (2009, 2011, 2013). This seems likely to contribute to the tensions, uncertainties and stresses felt by PWPs and HITs. This is because their aspirations towards occupational professionalism (see 9.4.2), where they can exercise autonomy, focus on relationship building, adhere to a code of ethics and professional values, and have confidence in their assessment skills, are redirected, all the time, towards the requirements of the organisation structure and its accountability measures. IAPT practitioners are thus 'psychological therapists' first and foremost, and their individual claims to professional 'psychotherapist' status are, in my view, best seen as acts of resistance to the imposed discourse; acts which also demonstrate the strength of IAPT's 'ideal image' (Watts, 2016).

This clarification, and the findings from this study, shed some light on the debate regarding the parallels between the PWP and other kinds of 'assistant roles' in the public sector (see 3.5.4). Although designed to be 'self-standing,' and not assistants to anyone, PWPs do appear to vary in the degree of agency, empowerment or degradation they feel, depending on their specific workplace setting, just as TA, HCA and other kinds of assistant do (Bach et al., 2007, 2012). In chapter 8 I showed that PWPs were not passive recipients of tasks, handed down from HITs (or anyone else); they made good use of their own resources, including mentors, peers, and supervisors and exercised some limited discretion, in managing the pressures of the job, day-to-day. In this

sense, they were not mere ‘relief’ workers, ‘substitutes’ or ‘apprentices’ for the HITs (Kessler et al., 2013: 1650) as teaching, social work and healthcare assistants, have been described (see 3.5.4). They were, if anything, closer to being ‘co-producers’ with HITs, of the IAPT service, in that their interventions were intended to be complementary. As discussed above (11.2.1), however, there were numerous occasions when this complementarity became blurred, and a significant group of PWP had clear intentions of using the role as a moving off point for higher training in a related field (whether Clinical Psychology, HIPIs or CBT). PWP also experienced a greater lack of control over their core tasks and diaries (see 8.3.4, 8.5), than those they worked alongside of (HITs and others), and felt burdened by the volume of patients they were expected to manage. In this respect, they differed from the HITs, and shared some of the experience of others in assistant roles (see 8.5 and 10.3); that is, there were times when, like Bach et al (2012)’s HCAs, they resented differences in pay and status in relation to HITs (see 9.4.1), were dissatisfied with the allocation of work, and felt ‘invisible’ to the organisation hierarchy (see 3.5.4).

What is missing from the analysis of assistant roles in the literature however is consideration of the role of identifications and motivations rooted in individuals’ early life history. This study has shown that PWP commitments to the work and their disillusionments with it, were deeply felt, and impacted in different ways upon their responses to training as well as to clinical practice. Their feelings varied considerably over time, as evidenced in the ‘voice’ characterisations, and sometimes alternated in rapid succession. There was no single downward (‘degradation’) or upward (‘empowerment’) trajectory in these roles. However, cumulatively, the negative aspects of the work did appear to outweigh the positive ones, for PWP, in this study, leading all but three (of nine) to leave the IAPT service permanently.

From the evidence in this study, there are also good grounds for suggesting that new recruits to IAPT services are ‘worker-learners’ in the sense defined by Reich and Girdwood (2012), from a governmentality perspective (see 2.2.4). Over the course of the training year, practitioners learned how to conduct themselves, and took on the task of governing themselves through the use of clinical outcome measures, skills-related rating scales and related auditing systems (chapters 6 and 7). They ‘translated’ learning from the training course into their different workplaces, by reference to the protocols and practices developed ‘at a distance’ (by IAPT central) (Reich & Girdwood, 2012: 154). They became enmeshed in multiple interrelated regimes of practices which had the characteristics of living systems (Hager et al., 2012, see 2.4.2), but which were

linked, inextricably, with government-imposed bureaucracy, political and policy rationales (see 2.4). They used the technologies of self-help and the IAPT-specific CBT interventions not just on their patients but on themselves (see 8.5); as time went on, they increasingly professed their loyalty to CBT (8.3.2). They worked at improving their individual, team and service performance by reference to recovery measures which were constructed 'scientifically,' by government, rather than being user-led. Their training followed a national curriculum, and their CTs had to make a point of justifying it, when they presented anything different or additional (chapter 6). Trainees were challenged to be 'proactive' and creative, whilst also being watched over in ways that suggested a lack of professional trust and a real or imagined culture of blame (Reich & Girdwood, 2012: 159). This was only mitigated where trust in local managers and service leaders was high (see 9.3 and 10.5), and where practitioners' developmental and emotional needs were sufficiently met. As shown in this study, even where the service was considered to be well-led and effective overall, by staff and external observers, internal team and micro-team dynamics, could vary considerably, and affect individuals differently.

11.2.4 The IAPT identity and culture of practice

The IAPT identity may thus best be viewed as an organisational rather than a professional identity. It has a distinctive, but not unique (or even uniform), culture of practice. There are grounds for viewing it as more than a workforce development programme (as originally specified), but as a professionalisation and institutionalisation project, which has yet to achieve its full aims. As described in chapters 9-10 (and above), there is a tension within IAPT over the professional status and identity that can be ascribed to the two new roles, and concerted efforts are being made nationally, to increase recognition, via formal accreditation processes, promotional activities, CPD and registration with the professional bodies, BABCP, BPS and HCPC. If, as argued by Callaghan (2014), professionalisation viewed from a governmentality perspective, comprises ideological practices as well as processes of 'professionalism' (see 2.3.2), then it is to the culture of practice in IAPT that we need to look for evidence.

Previous chapters have shown how individual IAPT practitioners have to negotiate continuously between their professional and personal selves, and to balance values-based discretion in clinical work against bureaucratically-derived rules and norms of practice (Ellis, 2011). This is about more than the issue of adherence to or drift away from protocol, it is about the system within which practitioners operate, and how this is governed through intersecting regimes and ecologies of practice (see 2.4.2). Individuals portray their practices as

neutral and depoliticised (derived from the ‘evidence’), whilst at the same time, they experience them as evoking strong emotions and political affiliations (to IAPT and CBT), which cannot fully be acknowledged or thought about. There is a polarisation of identities and practices within the IAPT system which results in the feeling realm being relegated to that of the nonprofessional, as suggested by Callaghan (2014). Competence in delivering the prescribed IAPT models and interventions, requires particular forms of problematisation, reasoning, ethos and technique (see Chapter 6), which eventually become part of IAPT workers’ identities and subjectivities, as described by Reich and Girdwood (2012), following Foucault’s view of governmentality (see 2.4.2). Furthermore, within each workplace setting, IAPT practitioners act as ‘institutional agents’ when they encounter colleagues from different clinical and administrative disciplines, with whom they vie for control over available organisational resources (Muzio et al., 2013) (see 2.3.2). The juxtaposition of ‘old’ and ‘new’ hands in this context brings into focus the competitive pressures involved, within and at the boundaries of the IAPT service (see 9.2.3).

There is a gender- and age-related dimension to IAPT’s identity and culture of practice too. Young women are the life-blood of the system, with older recruits, in this study, reporting a harder transition into role. As described by one of the CTs (6.6), IAPT does not value the prior ‘experience’ of its PWPs, or even the ‘core’ professional training of its HITs, on entry. It relies on institutionalised forms of expertise, delivered via the one-year training, performance measurement and supervision systems, and their attendant discourses of professionalism (chapter 9). By looking at their journeys over two or more years, I have shown how the energy and ambition of its young ‘wannabe’ (mainly PWP) recruits becomes dissipated as they grow up in the service. The constructive metaphors of business and engineering, during training, (for example, of structured interventions, toolkits, contracts and ‘change cycles’) are turned into metaphors of military and industrial destruction as time goes on (‘meat processing’, ‘decimation’, ‘trench warfare’, and ‘cannon fodder’). For some (mainly HITs), the team ethos successfully holds their aspirations, and provides learning opportunities. A sense of privilege amongst this group runs in parallel with the pain felt by PWPs (and those HITs whose motivations to join the service were mixed). There is a hollow and mournful quality to the experience of lone working for both groups. The IAPT experience is thus fulfilling so long as you have the internal resources and external support to withstand its uncompromising aspects; the relentless time pressures, the ‘othering’ of patients, co-workers and services who don’t ‘fit’ the delivery model. The ‘antibiotic’ metaphor used in training (see chapter 6) to describe the value of time-limited HI and LI interventions, applies also to the IAPT service as a whole. What it provides can be shown to be effective in the short-term; it can

also be over-used creating resistance (in patients and staff), and used inappropriately (e.g. when the problem is relational).

11.2.5 The psychosocial dynamics of IAPT

In this thesis, I set out to explore the subjective experience of being an IAPT worker, the emotional dimensions of the work and what these could reveal about the social and organisational contexts that contribute to them (see 2.6). I also wanted to question what IAPT might represent as a system of care, in light of some of the critiques that have been made of its aims (see 3.3). In this subsection, I review what has been learned about the 'emotional habitus' (Hoggett, 2009c) of IAPT, the social defences and anxieties at work, and the impact of managed care on the minds, bodies and actions of IAPT practitioners.

Kane (2001) adapted Bourdieu's concept of 'habitus' to describe the 'socially constituted, prevailing ways of feeling and emoting...the embodied, axiomatic understandings and norms about emotion' that characterise social and political movements (Hoggett, 2009c: 124). These ways of feeling tend to be embodied in practices, especially those that are implicit. 'Emotional habitus' refers to 'the everyday, taken for granted, and sometimes far from conscious nature of rules and practices' (Hoggett, 2009c: 124). In the IAPT context studied here, I would suggest feelings became embodied in a number of different ways. Optimism and hope were embodied in the maxims, knacks and routines of training, the ongoing CPD and team-building activities, which trainees and practitioners for the most part imbibed with enthusiasm (chapter 6). The LIPIs and HIPIs embodied a pragmatic, rather than relational, view of the world, and were useful but not always sufficient, for practitioners or patients. Feelings of loss and mourning were however also present, in the sense of isolation felt by practitioners at times, their search for role models, and informal support. Seeing more experienced co-workers and supervisors leave the service, having to give up their former job roles and identities were one source of these feelings. Lack of return on the emotional investments made in the work, the training, and in CBT, were also sources of ambivalence and disappointment. Loss of faith in the PWP model was particularly marked.

Drawing on the social defences against anxiety literature, several aspects from practitioners' accounts of working in IAPT come to mind. In this study setting, practitioners' working week was split up across multiple sites (different GP practices and the IAPT sector team base), with relatively little time spent in each place for the majority. Like Menzies-Lyth's student nurses, this posed

obstacles to building collegial relationships, and increased the likelihood of disruptions in interprofessional and IAPT 'mini-team' work occurring. Trainees also found adapting to the requirements and preferences of team and service managers, different supervisors and university teachers, and having a full clinical caseload, painful during and immediately after the training year (see 2.5.1). These were not the only contributing factors leading to relatively high rates of staff turnover, as suggested by Menzies-Lyth (1959). The splitting up of the work into discrete time limited tasks, including assessment, risk and case management, with high volume throughput and unpredictable waiting times, created difficulties for some, in remembering patient details, negotiating appropriate care steps, and engaging patients effectively in treatment. Practitioners became demoralised when they perceived that their interventions were not helping significantly, patients DNA'd or left treatment without achieving 'recovery.' They had to cope with what at times felt to be overwhelming feelings, compounded by the experiences of 'social suffering' regularly communicated to them through their patients. The result, as described by Hoggett (2010a), was for the organisational and social defences of depersonalisation and hyperactivity to become the norm. Recognising and accepting negative emotions did not appear to be a routine part of the management role in the study IAPT site (see 10.8), and practitioners had to look elsewhere for support or risk draining their own internal and social capital resources to the point of illness. Suppression of anger and resentment was a factor in people leaving, possibly affecting managers (see 10.8), as well as PWP, along with the denial of 'legitimate aspirations' for meaningful work and professional development, as described in 11.2.1 above.

However, it is important to remember that HITs, and some PWP, did not leave the service. Although some were looking for opportunities elsewhere or towards retirement, most described working in IAPT as a positive experience. For HITs, the throughput of patients was not as intense or uncontrolled as for PWP, and they benefitted from having PWP prepare people for what was involved in a 'doing' therapy. Being at a different life stage, compared with most PWP, they tended to appreciate what they gained through IAPT in terms of job security, supervision, pay and recognition. Although their transition adjustments were, if anything, more keenly felt, HITs also had more time to consolidate learning after the course, and could exercise more diary control. For the PWP who stayed, it is less clear, however, that this was due solely to having greater resilience (Green et al., 2014; Pereira et al., 2016), less risky patients (Saxon et al., 2012) or better organisational skills (Robinson et al., 2011), although these were clearly important. The possibility has also to be considered that these individuals had found a way of aligning their own defences with that of the organisation and service, and that for them, the use of performance indicators,

structured interventions and stepped care, offered sufficient containment to sustain their faith in the work. They may too have had more amenable managers, and been able to make more use of the support that was available. For some however, the messianic quality of collective beliefs in IAPT and CBT connected with their own histories of overcoming adversity and seeking change. For them, their faith in the new was more unshakeable and was matched by the discourse of progress, recovery and success emanating centrally. Just as the organisations have been found to have 'blind spots' (Fotaki & Hyde, 2015), individuals too could be capable of deceiving themselves without lying or being disingenuous.

As we saw in chapter 2, targets and indicators in the IAPT system, have a performative aspect, which can confuse reality with its representation; they may in fact serve as a 'perverse defence' (against the consequences of social and economic failure), by fostering an '*as if*' relationship between government and reality' (Hoggett, 2010a: 202). There seems little doubt from the evidence of this study that IAPT workers inhabit a space where values and purposes are contested (Hoggett, 2006). Practices such as 'suitability screening' (see 6.2.2) implicitly categorise people's eligibility for help, in the way earlier social policies differentiated between the deserving and undeserving poor. Once in the door, patients must also go along with IAPT's instrumental purpose (complying with sessional measures, 'homework' requirements, problem definitions and simple solutions etc), be passed on or discharged. Practitioners must comply with the managerialist agenda, downplay their own feelings and ethics of care, in the interests of 'transparency' and efficiency. Very real societal anxieties are indexed and expelled, in what Rizq (2016) describes as a state of 'abjection' affecting mental health services generally, and IAPT in particular. In these services, 'individuals deemed to be psychologically distressed are cast out as monstrous or "other" by society' (Rizq, 2016: 71). They become dehumanised (Rizq, 2014: 217) where lack of containment is the norm, and there is too little acknowledgement of the intensity of feelings at the heart of work (Rizq, 2016: 74, after Cooper & Lousada, 2005). This seems to apply as much to practitioners as to patients, in the IAPT context. It is also one explanation for the incongruity of the message and my respondents' demeanour, all those years ago, when I was first interviewing case managers, in the IAPT demonstration site (see 1.1.3).

11.2.6 Implications for sustainability

In this final sub-section, I comment on the tension between organisational and individual sustainability in relation to the IAPT roles. In policy terms, the present government is committed to maintaining IAPT services, as a visible

contribution to public mental health. The results of routine outcome measurement, and several evaluations, suggest IAPT is probably as effective and cost-effective as other mental health services (Mukuria et al., 2013; de Lusignan et al., 2013; Parry et al., 2011; Clark et al., 2009), and is seeing more people than have ever been seen before by NHS psychological services. As this study has shown, there is also a strong compatibility between the IAPT service design, and the culture, values and practices of contemporary government. As a workforce development programme, IAPT is here to stay. The two workforce roles fit within the service design, and complement each other in their rationale, training regime and culture of practice. For individuals, however, it is much less clear that the roles are sustainable for the majority of a career. The PWP role to date has not been one that many individuals can inhabit for very long. At the basic grade, this and other recent studies have shown, burnout in the PWP role happens faster and more frequently than amongst other groups of mental health professionals (Walklet & Percy, 2014; Steel et al., 2015; NHS England and Health Education England, 2016; Delgadillo et al., 2018). The addition of Senior PWP, supervisory and specialist PWP roles provides opportunities for progression and a degree of variation in the pace and type of work, for those who can last beyond the three-year point of high volume, low intensity case management. These kinds of service development provide a form of 'stepped care' for staff, parallel to that intended for patients. However, as with patients, only a very small minority will be stepped up and the difference in kind between the roles at each step, may not be as great as practitioners first hoped for on entering the service.

Importantly, these kinds of measures, do not address the lack of containment for the emotional impacts of the PWP role, the mourning for what is lost, personally and collectively by practitioners at low and high intensity, in the IAPT system. Individuals are expected to be resilient and to cope, regardless of the contradictions and pressures impinging on them from the wider organisational system and from the social suffering of their patients. Their capacity to negotiate dilemmatic space is not explicitly cultivated, and may require a different kind of supervision and/or training than that currently provided. If, as Hoggett and colleagues (2007) suggest, navigating dilemmatic space requires an individual to be self-authorising (that is, they have a sense of authority about their own agency, a personal authority that is embodied and corresponds to trust and belief in themselves), then it is important to pay attention to the internal voice of IAPT practitioners and where they construct their authority from (Hoggett et al., 2007: 105). Personal authority is very different from reputational or positional authority. It is about more than being the author or producer of one's own life story, and cannot simply be 'borrowed' or unreflectively mimicked from supervisors and teachers (Hoggett et al., 2007: 105). In my view, individuals require more space and time to reflect on their life

stories, their identifications with significant others, inside and outside the family and how these are mediated by class, gender and race amongst other factors, than is available within the current programme. Although some will prosper, practitioners, like their patients, do not all 'fit' the IAPT prescription of 'what works' and the cost for those for whom the system does not work, can be very high. Whilst this cost in terms of human resources may not be unique to IAPT, there is something perverse (as Hoggett, 2010a, 2015) about a service designed to alleviate anxiety and depression which makes patients of its own staff.

At the same time, for HITs in particular, and some PWPs, the IAPT programme continues to have a strong hold for the reasons explored in this thesis; the power of collective belief in the IAPT mission, the strength of organisational defences against really knowing about the distress and causes of patient's difficulties, and the disavowal of relational needs at work. Wider institutionalisation processes create a sense of movement and direction which bolster individuals' allegiances to CBT as a profession, even where there is resistance to single short-term psychological interventions of the kind used in IAPT. Local contexts, management and leadership matter too, in how far individuals are able to mobilise their own capacities, work alongside other professionals, and be both flexible and resilient. It is not enough to focus on any one of these levels - the organisational and intra-psychic, the institutional or the inter-personal. Each is affected by the social context and keeping this complexity and multi-layered perspective in mind is necessary to counteract unthinking pragmatism in service practice and design.

11.3 Contribution to knowledge

This thesis has contributed to knowledge in a number of ways. In terms of what I did, the focus on practitioner narratives provides a new perspective on service experience, and contrasts with the focus on patient narratives in other qualitative mental health research studies. This study is also unique in terms of the depth and variety of analyses completed, drawing on a psychosocial framework, to examine the experiences of IAPT practitioners. By combining different data collection methods, with a longitudinal perspective, this study provides a richer picture of individual role transitions, organisational culture and working practices than that provided by any cross-sectional interview-based study. It describes the reported experience of both PWP and HIT practitioners on entering, learning and developing their work and skills over several years, whereas previous research has tended to focus solely on one or

other group, the experience of trainees (Robinson et al., 2012; Branson & Shafran, 2015), or specific issues regarding the development of already qualified IAPT staff (Akhtar, 2016; Waller et al., 2013; Liness et al., 2017; Jones et al., 2013). I have also considered the wider implications of the IAPT roles, as new occupations, each with their own dynamics, inter-relationships, organisational and professional antecedents. By bringing together perspectives from social theory, sociology of the professions, theories of practice and applied psychoanalysis, I have created a theoretical framework in this research which contrasts with the atheoretical and instrumental approaches which have been common in Health Services' and Public Mental Health-related research. I have suggested ways in which a psychosocial perspective, in particular, may add value within these trans-disciplinary fields of study (see individual chapter discussions). My approach counter-balances some of the critiques of IAPT's aims which are purely professionally and politically motivated. It adds a social dimension to complement the applied psychoanalytic critiques of IAPT (such as Rizq 2011, 2012a, 2012b, 2014a, 2014b, 2016). Unlike previous studies published by practitioner-researchers, based on their clinical and supervisory experience, this study has been purposely-designed to address the study objectives, as a standalone piece of research. I have been more of an outsider than an insider, in that my own profession (as social scientist) is not a clinical one; as such, it offers a complementary perspective to that of practising clinicians. The methods I have used have enabled me to build an holistic view of what I observed and heard in practitioners' accounts of learning and working in an IAPT service, which contrasts with the pragmatic and narrowly focussed purposes of most implementation studies.

In terms of what I found, this study has shown unequivocally that the professional status of both IAPT roles, is uncertain. Each has distinctive aspects, but neither is wholly secure in professional terms. Both PWP and HIT roles have things in common with the historical characteristics of semi-professions, especially in their susceptibility to the ideology of promise and sense of having their 'legitimate aspirations denied' (Nottingham, 2007). There are parallels too between PWP job roles and some aspects of other assistant roles in the public sector, despite the fact that PWPs are practitioners in their own right, and are not formally assistants to anyone. They have in common the frequency with which they engage in 'hidden' work, or emotional labour, have boundary issues with adjacent professionals, and ambivalent feelings about the allocation of tasks (see 3.5.4). The two roles, PWPs and HITs, both provide organisational rather than occupational identities to those who take them up. Practitioners 'become IAPT' before they become cognitive behaviouralists. Their work is dominated by a discourse of control, with regulation, accountability, targets and performance review part of their everyday existence. Their professionalism is

defined primarily by the work organisation, not by professional codes of conduct (see 2.3.3). IAPT practitioners are thus 'psychological therapists' first and foremost, not psychotherapists as traditionally understood.

I have described what is distinctive (but not unique) about the IAPT workforce development programme, compared with other government workforce initiatives and different psychotherapy trainings (see 11.2.4). I have found evidence of the contradictions and competing paradigms of policy being internalised by IAPT trainees and practitioners, in the way they speak, the aphorisms, teachings, knacks and feels of practice observed in the classroom and in their accounts of lived experience over time. I have captured something of the changing voices, assertions and denials of practitioner narratives, through my own and others' felt and heard responses to the material gathered during and after fieldwork.

I have also shown the relevance of connecting individuals' accounts of work and training, with their life stories. These accounts have helped to situate the range of different responses to IAPT training and clinical experience, in both organisational and biographical context. By drawing on the full range of my data collection instruments and outputs (audio-recording data, as well as transcripts, different types of observation notes, pre- and post- fieldwork reflections, pen portraits and thematic summaries etc) I have provided rich 'scenic understanding' of the classroom-based parts of IAPT training, and the individual work and home settings of each practitioner included in the study. Changes in the expression of experience, thought and feeling, have been traced over the course of a single interview or observation session and across repeated interviews and observations and, in the context of a specific researcher-researched set of relationships. This attention to the dynamics of intersubjectivity and co-construction in research, makes it easier for others to examine my findings, and to draw different interpretations.

I have shown the links between the different levels of practice in a local IAPT service, the way collective ideals and governmental thinking are transmitted and resisted, how trust or 'faith' in the delivery model is eroded and 'worker-learners' created out of IAPT trainees. I have argued that these developments have had very mixed effects for individuals and have created patients out of some. I suggest, like Anteby et al (2016) that it is important to apply different lenses to the study of occupational change, in order to better understand novel forms of control, especially emotional control, in work. Because of the legacy of

new public management, the increasing institutionalisation of medicine and evidence-based practice, and the competition between rival professional groups, there are risks that members of new welfare occupations surrender part of their autonomy to the collective, and unintentionally, become part of a coercive order (the 'therapy' and 'psy-welfare' industry). Whilst individuals may knowingly or unknowingly 'consent' to the process of being controlled at work (Anteby et al, 2016: 194), many pay a price in terms of burnout and over-commitment. Others survive, even thrive, for a while where local conditions are conducive, progression routes are in place, and good social support and learning opportunities are in place.

11.4 Limitations

The limitations of this study relate to what it has covered, and what it has left out that is relevant to the research objectives; the amount of data collected, and my difficulties in implementing the chosen methods of analysis within a psychosocial theoretical framework.

In terms of study coverage, the focus has been on practitioners' narratives and classroom observations, supplemented by supervisors, service managers, training director and course teachers' perspectives on their work and learning. I have not looked directly at other important actors in the IAPT system, such as the patients, GPs, counsellors and other co-workers, referrers and partner organisations within and beyond the NHS. For the observational work, during the training year, I was not able to sit in on HIT supervision sessions, to see how supervisors worked with trainees on their skills and personal development in role, or with issues of emotional well-being. Nor was I able to observe directly any clinical sessions between practitioners and their patients, or in-service supervisors. These would undoubtedly have shed more light on the learning process, the development of authority in role, and how the IAPT culture of practice is enacted over time.

Despite restricting my coverage to practitioner perspectives, the volume of data collected for this study has been difficult to process and manage. I slightly exceeded the upper limit of my sample design, and did not have the confidence to turn potential respondents away, or to drop anyone's completed interviews from the analysis. This reflects the anxiety of myself, and to an extent, my supervisors, when working with a relatively new set of research practices, and in

an unfamiliar theoretical framework. It always seemed sensible to err on the side of over-sampling, to have more, rather than less, data to work with. In hindsight, I would have more confidence that the range of analytic methods I used would yield usable results with as few as six to eight cases, rather than fifteen. In the event, a number of thematic findings were over-saturated through repetition across the sample, and the individuality and uniqueness of each person's life story under-explored, because of the time required to do this in a meaningful way whilst also safeguarding anonymity. The larger sample and repetition of themes has enabled me to be confident that my findings are representative of the particular cohorts of IAPT trainees and practitioners I studied, and about the relationship of these themes to the service context.

Besides the sample size and the quantity of data collected, the frequency of observations and interviews, and the combination of different data collection methods, has been a strength of this study. As described in Chapter 4, the temporal pattern of the research, and the juxtaposition of different types of encounter, provides a sense of the connections and interactions of real lives in progress. The sequential access (from observation only to observations and interviews, and then interviews only) brought into focus the differences between group and individual practices, the difficulties of knowledge translation from classroom to workplace and vice versa, and the selectiveness of my own and respondents' recall. Each of these aspects contributed to the intensity of insights generated, and to understanding the dynamics of role transition. Equally, the use of case histories and pen portraits before moving to multiple forms of thematic summary helped to keep the data manageable, to remember the whole person, and the overall structure of each person's narrative. I would have liked, however, to get further with the VCR analysis and reporting, to help trace the changes in identification over time of individual PWPs and HITs.

It might legitimately be asked too, how my own identifications as a researcher, might have interfered with or helped the research. I was aware of times when my professional background appeared to arouse mixed feelings in my respondents; several expressed pleasure and surprise at the fact that I had deemed their experiences worthy of investigation. Others enjoyed challenging me on my credentials, and asking questions to check my integrity and knowledge. Feelings of admiration, and occasionally, light-hearted envy, were also expressed. Most often however, during the classroom observation periods, I felt I was treated with benign indifference. I take this as a sign that my presence was not unduly intrusive, and that those observed were comfortable with what I

was doing. The main difficulty for me, which I kept in check through supervision and personal therapy, was not to over-identify as a student and potential psychotherapy trainee myself, or as a patient. Neither of these latter identities were disclosed to my participants, nor was I asked directly about my personal motivation for doing the research. At first during the interviews, I was surprised how seldom respondents ventured to probe me on my interests or my therapeutic allegiance. I do not think this was out of deference or any power inequality, but rather because participants took it as 'read' that I would operate as they did, with integrity, discretion and impartiality, respecting any differences. They no doubt relied too on the fact that I had the blessing of key gatekeepers, and worked with a prestigious group of colleagues. Over time, our meetings became more engaged, and took on the character of mutual discovery and shared interest in the work. It is likely that I was recognised as being similar to people they knew, perhaps members of their own families, or friends, who were also University-educated, white, middle-class and curious. My independence from the IAPT service and the University teaching team was commented upon as a source of reassurance. Over repeated meetings, respondents also had time to assess for themselves the quality of my attention, how I responded to what they said, and what I took away from our conversations. If they felt I had misunderstood a point, or if they had omitted something they felt was important, they didn't hesitate to tell me. Sometimes, this led to interviews going on for longer than was strictly useful; at other times, it proved invaluable in correcting a misapprehension on my part. At times, I felt I was being asked to play the role of advocate, particularly for the PWP, who wanted their concerns voiced, to speak 'truth to power.' However, all recognised that I had my own timescales, supervision arrangements and role responsibilities to fulfil, and wanted me to succeed with the research for my own sake.

Finally, with regard to implementing the different analytical methods implied by my choice of data collection instruments and psychosocial theoretical framework, I like the IAPT trainees, did find myself resorting back to what I knew previously, from earlier research trainings, and my professional work, as a qualitative researcher. I switched over to using Framework within NVivo at the point at which I was becoming exhausted with constructing individual analytic summaries, and wanted to get further, quicker. This did make the task of data management easier. However, in the process, I lost some of the detail of the research encounter and interview dynamics. The incorporation of themes and comments from my fieldwork notes, and reflections on the different research settings, were an important antidote to this. Allowing respondents to choose the interview setting was helpful, and gave me additional insights into their world, which changed over time. Without this, or with a constant setting, I

would have lost a lot. Overall, it was a learning process, made very much easier by supportive supervision, access to a peer group of research students with similar interests in psychosocial research, and regular opportunities to test out my approach and analysis with colleagues, in seminars and conference talks. Each of these provided important sources of validation, improved the analysis and my interpretation.

11.5 Areas for future research, IAPT training and service development

11.5.1 Areas for further research

As suggested in earlier sections of this chapter, there would be value, in my view, in exploring issues of inner voice, personal authority and identifications in practitioners' narratives further, using VCR and related forms of analysis to track how these change over time. It would also, undoubtedly, be useful to look at the longer-term outcomes and experiences of IAPT practitioners, who stay and/ or progress in the service to find out why they do not leave. Given that the IAPT service is now in the tenth year of national operation, it can of course be argued, that things have changed. A more up-to-date sample may reveal new issues and dilemmas, improvements as well as difficulties for those in PWP and HIT roles.

11.5.2 Recommendations for IAPT training

It is difficult to make suggestions for improving IAPT training which preserve the existing service delivery model and ethos, and its reliance on a one-year intensive training. I have suggested in this thesis, that greater attention overall needs to be paid to the development of personal authority in role, managing the emotional impacts of the work, and working alongside others in a system that creates a constant tension between local ecologies of practice and service-wide economies of performance. This might entail a closer integration of training for therapists in different IAPT-compatible modalities (CfD, CBT, IPT and so on), so that trainees developed an understanding of and respect for different approaches, whilst remaining within their own model. This would not however address the need for theoretical breadth in training to make experimentation in practice more effective (Orlinsky & Rønnestad, 2005), particularly in the early post-training period, when the risks of therapeutic drift are greatest. If role adjustment strategies and the tensions with regard to role specificity and role blurring were more clearly acknowledged and explored, this

might help (Michalec & Hafferty, 2015). Following the initial training, on-going support and training for qualified practitioners, should allow for the sharing of personal experiences and reflections on the dilemmas of practice, and acknowledge the time and effort needed to build individual and collective resilience and 'productive uncertainty' (Mintz, 2014). As suggested by Miller et al (2006), a greater focus on upholding service inputs (training course staff as well as IAPT practitioners), as well as outcomes, would benefit those who are most at risk within the IAPT system, the patients themselves.

11.5.3 Recommendations for IAPT services

The importance of focussing on service inputs as well as outcomes is even more relevant for IAPT service commissioners and managers than it is for training providers. To reduce staff turnover, attention needs to be paid to supervision, ongoing personal development of practitioners and their career progression. However, I agree with Walsh et al (2016) that 'a better understanding of unconscious forces at work' would also help 'deliver policy that is more coherent, inclusive and aligned with its purpose' and that 'failing to explore these forces will see [IAPT services] repeating the same mistakes, and becoming locked into a vicious cycle from which it is difficult to escape' (Walsh et al, 2016: 13) (after Fotaki, 2006). Offering staff access to a 'safe setting' – perhaps through wider organisational Schwartz rounds and/or voluntary participation in independently run Balint Groups – would help to foster horizontal relationships between staff affected by similar psychosocial dynamics (Kraemer, 2015; Simpson, 2016). As Hoggett (2010b) has argued, the resilience of frontline practitioners may best be supported by recognising the importance of friends and colleagues, independent supervision, management culture and policy context, and reinvesting in a rather different set of 'professional virtues' than those currently promoted. These would include:

- the **capacity to contain uncertainty, ambiguity and complexity** without resort to simplistic splitting into good/bad, black/white, us/them,
- the **capacity for self-authorisation**, that is, the capacity to find the courage to act in situations where there is no obvious right thing to do
- the **capacity for reflexivity**, that is, to take oneself as an object of inquiry and curiosity and hence to be able to suspend belief about oneself; all this as a way of sustaining a critical approach to oneself, one's

values and beliefs, one's strengths and weaknesses, the nature of one's power and authority

- the **capacity to contain emotions** such as anger, resentment, hope and cynicism without suppressing them and hence to be both passionate and thoughtful (Hoggett 2010b: 14).

None of these options are likely to be cheap or quick, but drawing on the evidence presented in this thesis, I would suggest IAPT service managers, policy-makers and commissioners, need to consider the wider and deeper influences on staff and patients of the psychosocial context. Without looking critically at how societal, organisational and individual hopes and expectations interact in everyday practices, alongside practical implementation concerns, the conundrum of individual versus organisational sustainability in local services will not be resolved.

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