The Transition and Transformation process to become an Improving Access to Psychological Therapies Therapist. A study using Interpretative Phenomenological Analysis

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Abbreviations

BABCP: British Association of Behaviour and Cognitive Psychotherapy

BACP: British Association of Counselling and Psychological therapies.

BPS: British Psychological Society

CASP: Critical Appraisal Skills Programme

CBT: Cognitive behaviour therapy

CCGs: Clinical commissioning groups

CINAHL: Cumulative Index to Nursing and Allied Health Literature

CNE: Clinical Nurse Educator

CNL: Clinical Nurse Leader

CNS: Clinical Nurse Specialist

CQC: Care Quality Commission

FNP: Family nurse practitioner

FYFPMH:The Five Year Forward Implementation Plan for Mental Health

FYFVMH: The Five Year Forward View for Mental Health

GP: General Practitioner

HITs: High Intensity Therapists

HRA: Health Research Authority

IAPT: Improving Access to Psychological Therapies

IPA: Interpretative Phenomenological Analysis

IRAS: Integrated Research Application System

JBI: Joanna Briggs Institute

MDS: Minimal Data Set

NCCMH: National Collaborating Centre for Mental Health

NHS: National Health Service

NICE: National Institute for Health and Care Excellence

PEQ: Patient Experience Questionnaire

PICO: Population of the study, Intervention, Comparison group and Outcome

POT: Person- Organisation Trustworthiness

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PWPs: Psychological Wellbeing Practitioners

RCT: Randomized Clinical Trial

RDaSH: Rotherham, Doncaster, and South Humberside NHS Foundation Trust

RN: Registered Nurse

SANE: Sexual Assault Examiner Nurse

SE: Self- Efficacy

UK: United Kingdom

Glossary

Cognitive Behaviour therapy is a talking therapy that aims to reduce symptoms of various mental health conditions, primarily depression and anxiety disorders.

Counselling is a type of talking therapy that allows a person to talk about their problems and feelings in a confidential and dependable environment.

High Intensity Therapists are part of the Improving Access to Psychological Therapies (IAPT) service and provide high intensity interventions – initially cognitive behavioural therapy (CBT). They work with clients who have a range of complex problems related to anxiety and depression.

Improving Access to Psychological Therapies services provide psychological treatment to people with mild to moderate mental health problems mainly depression and anxiety.

Interpretative Phenomenological Analysis is an approach to psychological qualitative research with an idiographic focus, which means that it aims to offer insights into how a given person, in a given context, makes sense of a given phenomenon.

Minimal Data Set is the IAPT Routine Outcome Measuring Tool to collect data in IAPT services in four domains: Health and wellbeing, Inclusion and employment, Choice and Access, and Patient Experience. These outcome measures are collected by the practitioners and provide information for monitoring service effectiveness and the quality of care.

Psychological Well Being Practitioners provide educational and psychological support at step 2 in IAPT services to people with mild to moderate depression and anxiety.

Abstract

Background

Too many practitioners leave Improving Access to Psychological Therapy (IAPT) services roles and this puts IAPT services at risk. In the context of increasing access to IAPT services this creates a deficit which can impact on patient care. Therefore, ways to improve work satisfaction and role adjustment may help people to transition more effectively.

There is a commitment in England to expand the IAPT services so that 1.9 million adults with mental health problems can access treatment every year by 2023/2024. This requires the recruitment of 4500 new therapists by 2021 and an extra 6000 by 2024. However, IAPT services are struggling to recruit and retain its workforce. Therefore, investigating what may improve recruitment and retention is essential. This includes examining the support needed with role transition for IAPT practitioners.

This study investigated the lived experience of psychotherapists who transition to working as High-Intensity Therapists in IAPT services.

Method

The theoretical framework for this inductive qualitative enquiry was Interpretative Phenomenological Analysis. Seven non-IAPT qualified psychotherapists transitioned to IAPT services participated in audio recorded semi-structured interviews. Interviews were transcribed and a case-by-case idiographic analysis was undertaken. This process was followed by a cross-case analysis.

Findings

Four super-ordinate themes were identified through the IPA process '*Transition*' highlighted participants' experiences in their early phase of moving to the IAPT services. '*Learning the ropes'* emphasised participants' endeavour to understand and make sense of IAPT. The super-ordinate theme '*Adjustment'* described the changes participants made to adapt to the new IAPT role and position themselves in the new system. '*Transformation*' described the participants' cognitive and emotional evolution while transitioning to the IAPT system.

Conclusion

This study provides a detailed, phenomenological account of the lived experience of the transition of seven non- IAPT qualified psychotherapists to IAPT services. Transition to IAPT services for this group of therapists presents unique challenges that employers might consider in attracting and retaining experienced therapists. New insights were developed that can inform not only IAPT services but also other mental health services. The role of the organisation in facilitating the transition to IAPT services was explored specifically for experienced therapists. New avenues for future research were also identified, such as empirical studies into IAPT managers' challenges in IAPT with its fast expansion and how they could support newcomers to IAPT.

Chapter 1 Introduction

1.1 Introduction to the Thesis

This thesis aims to explore and critically evaluate the experience of seven non- Improving Access to Psychological Therapies (IAPT) qualified therapists who transitioned into working within IAPT services. This topic is essential to the evidence base because non-IAPT qualified therapists are likely to continue moving to IAPT services to meet the demands for expanding IAPT services and increasing the need for skilled therapists (NHS England, 2020). Furthermore, currently, very little is known about how these individuals adjust to working in IAPT services. Therefore, an understanding of the challenges with the transition is essential. This thesis will inform IAPT therapists, managers, and employers on optimising the transitioning experience and assisting policymakers in planning long-term solutions to IAPT workforce recruitment and retention problems (NHS England, 2018b).

It is crucial to understand transition and adjustment because research has shown that employees who adjust well to their new work role have more job satisfaction (Aziri, 2011; Srivastava, 2002). Job satisfaction has been found to correlate positively with job tenure and intention to stay (Borda and Norman, 1997; Dabke and Patole, 2014; Zaghloul, Al-Hussaini and Al-Bassam, 2008). Moreover, this topic is meaningful to me personally, as I experienced a challenging transition to IAPT services. As such, this was an insider research study, and the influence this insider status had on the conduct and conclusions of this study are critically debated throughout.

1.2 Introduction to the Chapter

This first chapter provides an overview of the structure of the thesis. It begins with justification and rationale for the study and the expected outcomes. It then states the aim and objective of the study and presents the research questions. This chapter also considers the researcher's position in conducting this research. A brief account of the IAPT programme background and its development in the last decade is presented and linked with the study's topic. This is followed by an orientation to the chapters describing each chapter's central tenets and ends with a summary.

1.3 Justification and rationale for the study

The United Kingdom's (UK) healthcare landscape is continuously changing to meet the increasing demands and the new challenges it faces. Over the past decade, there has been a dramatic increase in mental health services in the UK by introducing IAPT services.

The National Health Service (NHS) in England aims to expand and transform the IAPT services, so 1.9 million adults with mental health problems can access treatment every year by 2023/2024 (NHS England, 2020). An extra 11,000 psychotherapists and psychological professionals are required by 2023/2024 to meet this increased demand (NHS England and Health Education England, 2016).

Against this background, NHS England's 2015 census of IAPT services highlighted therapist leaver rates of 31 % per year (NHS England and Health Education England, 2016). This figure gives insight into the volatility of this workforce. Moreover, recruiting and retaining therapists in IAPT services is challenging (NHS England, 2018b). Studying the topic of the transition of this workforce is important because of the impact that their early adjustment and socialisation can have on outcomes such as job performance, job attitudes, organisational

commitment, and turnover (Black and Ashford, 1995). Furthermore, identifying what facilitates therapists' transition experience to IAPT services may help workforce planning for psychological professions. Therefore, the purpose of this thesis is to contribute to an understanding of the transition experience of non- IAPT qualified therapists to IAPT services.

It is perhaps surprising that given the significant issues around retention and the challenging circumstances around transition, there are no empirical studies in the published literature. This study is the first known study investigating the lived experience of transition for non-IAPT qualified therapists into IAPT services. Furthermore, this research is significant because of the need to identify the ways therapists in IAPT services respond and adapt to their new environment.

1.4. Personal interest and motivation for the study

Interest in this topic was first stimulated by my own transition to an IAPT service in England from working in secondary care service in the NHS in Scotland. I found the transition hard, and the experience of adjusting to the new way of working was uncomfortable for me. Although my managers were supportive, I grappled with adapting to the new working model. I found the IAPT service very different from how I worked in secondary care services in Scotland. As an experienced CBT therapist, delivering CBT competency protocols (Roth and Pilling, 2007), did not pose a challenge to me. However, I felt challenged by IAPT's different processes and procedures, such as delivering treatments based only on limited manualised protocols within a limited number of sessions. Professionally, I discovered the IAPT framework to be very prescriptive and restrictive. I also found scrutiny and continual monitoring challenging to cope with and as a result, adjusting to this new system was very challenging. The impact of facing and working through the challenges mentioned above on my own was considerable.

Critically reflecting on this experience, I noticed two groups of High-Intensity Therapists (HITs). HITs who completed an IAPT accredited training programme and another group of therapists such as psychologists, counsellors, and CBT therapists, like me. This group of therapists did not have the IAPT training but were well qualified and experienced and employed as high-intensity therapists when they joined the IAPT services.

Also, it became apparent that turnover amongst practitioners was high within the service I was working with. The high turnover of practitioners created its own problems in terms of pressure on the staff and service delivery. The high turnover of staff in my service made me wonder whether this was a unique problem to my service or a problem that existed in other IAPT services. Subsequently, I carried out a literature search and found several articles which highlighted the problem of the high turnover of IAPT staff, e.g., Binnie (2015); Rizq (2012); Steel et al. (2015); Timimi (2015); Walklet and Percy (2014). I also learned that recruiting therapists to IAPT services was a significant challenge (NHS England, 2018b). Following this, I decided to investigate this problem and the possible solutions. This research was the start of my journey.

1.5 Significance and impact

Research has shown a clear link between staff job satisfaction and patient satisfaction with care (GROL et al., 1985; Laurant et al., 2008). Therefore, if this thesis' findings can develop a more in-depth understanding of transition and make recommendations to improve transition experiences, these may also improve job satisfaction and patient satisfaction with the quality of care.

It is hoped that the information gained from this study will help improve the transition experience of therapists working in IAPT services. IAPT service managers and commissioners, professional bodies, and their members may be interested to understand

psychotherapists' experience and facilitate role transition to help recruitment and retention efforts.

1.6 The aim and objective of the study and research questions

I) The aim was to investigate the lived experience of psychotherapists who transition to working as High-Intensity Therapists in IAPT services.

II) The objective was

To understand and critically evaluate the personal subjective experience and the rewards and challenges posed by the transition and transformation process for non-IAPT qualified psychotherapists within IAPT services.

III) Research questions

1- How do non-IAPT qualified psychotherapists experience their transition to IAPT services?

2- What are the rewards and the challenges posed by the transition and transformation process for non-IAPT qualified psychotherapists within IAPT services?

1.7 Researcher's Position Statement

An insider researcher is a researcher who conducts a research study within a social group, organisation, or culture of which the researcher is also a member (Greene, 2014). Insider positionality refers to "the aspects of an insider researcher's self or identity which is aligned or shared with participants" (Chavez, 2015, p475). As a qualitative researcher, doing a phenomenological study makes it inevitable that my position and experiences influenced interpreting the participants' stories. This is particularly true as an insider researcher. As an insider researcher, I may share the values, perspectives, beliefs, and knowledge of the group under study because I am also a group member. Therefore, because of my insider position, I

engaged with in-depth critical reflection throughout the research process, particularly during data collection and analysis, where I considered both my perception of the participants and their perception of me. A more critical discussion of insider research is presented in Chapter Five.

1.8 Background of IAPT services

In 2007 the UK government announced a large-scale initiative for IAPT for depression and anxiety disorders in the NHS within England (Department of Health, 2008a). The IAPT programme initially focused on recruiting staff from the core mental health professions such as nursing, psychology, and occupational therapy and trained them to become high-intensity CBT therapists (Davidson and Franks, 2010).

However, this extension of practice did not address the increased demand for IAPT services, so in 2008 more diverse groups such as CBT therapists, counsellors, and psychotherapists without IAPT training were recruited to IAPT services (Davidson and Franks, 2010). By 2016 IAPT qualified high-intensity CBT therapists made up 49% of the workforce, and 51% were non-IAPT qualified (NHS England and Health Education England, 2016).[1]

The non-IAPT qualified high-intensity therapists are largely drawn from primary and secondary care services (Davidson and Franks, 2010). They have had to adapt to working in IAPT services where the focus is on clinical recovery rather than personal recovery, on achieving NHS England targets, not patient's targets of treatment, on outcome measures and manualised formulation instead of tailored case formulation (Binnie, 2015; Rizq, 2012; Timimi, 2015). IAPT therapists deliver interventions based on disorder-specific models and

[1]Census data is not yet available post-2015.

treatment protocols based on the CBT Competencies Framework by Roth and Pilling (2007) within a limited number of sessions. Furthermore, IAPT therapists work under scrutiny to achieve specific targets, which can feel challenging for non-IAPT qualified therapists. Especially, this group of therapists may have had more professional freedom and autonomy in their previous role as experienced therapists and supervisors before joining the IAPT services (Binnie, 2015; Rizq, 2012; Timimi, 2015). Therefore, exploring these therapists' lived transition experiences may shed light on the specific issues that may facilitate a more successful transition experience in the future.

1.9 Overview of thesis chapters

This overview briefly describes each chapter and orientates the reader to how the thesis is organised.

Chapter 1 provides the initial introduction to the study and its importance. The aim and objective of the research study and the research questions are presented. This chapter offers a background context to developing the research questions by discussing why the transition experience for non-IAPT qualified therapists to IAPT services might be challenging for this group. A gap in the literature is identified, and therefore the case is made for undertaking a qualitative study of 1) How do non-IAPT qualified psychotherapists experience their transition to IAPT services? 2) What are the rewards and the challenges posed by the transition and transformation process for non-IAPT qualified psychotherapists within IAPT services?

Chapter 2 provides a detailed account of the IAPT programme, its background, and underpinning aims. It also presents the clinical service model of the IAPT programme, the workforce, and the future expansion for IAPT services.

Chapter 3 is an integrative literature review of work-role transition for nurses in healthcare settings. This focus on a nursing population is defended as there was no relevant literature on work role transition for psychotherapists specifically. Therefore, the existing literature concerned with understanding the nurses' subjective experience of transition was reviewed as a suitable alternative to understand role transition in a comparable group of registered professionals. This review's conclusions informed and influenced the current study's design and conduct.

Chapter 4 provides a strong defence for this study's philosophical orientation and critically examines how the Interpretative Phenomenological Analysis (IPA) methodology was congruent with the study's aim and objective. IPA's theoretical position is critically explored in-depth, and the epistemological and ontological basis of inquiry is discussed and clarified. Further to this, the ethical dimensions of investigating and interpreting another's lived experience in qualitative research are discussed.

Chapter 5 defends the methods used in this study while also presenting a critical dialogue and reflexivity around the choices made and how they were operationalised. How the pilot study informed these decisions is also explored. Ethical dilemmas in this study and the

related process and procedures are discussed alongside the insider status of the researcher. Finally, steps taken to ensure the rigour and credibility of the study are evaluated.

Chapter 6 presents the findings of the study within four super-ordinate themes and their associated subordinate themes. Extracts of interview data are used throughout this chapter to support each theme's origin within the raw data.

Chapter 7 discusses, synthesises, and critically evaluates this study's overall findings and identifies their unique contribution to knowledge in this discipline. The chapter evaluates the research design's strengths and limitations and presents the implications for practice. This chapter concludes with recommendations for future research and presents a dissemination strategy.

Chapter 8 emphasises the organisational factors on therapists' experience of transition in facilitating adjustment. It also specifies the main issues in the IAPT system that need to be considered by policymakers, commissioners, and managers to improve recruitment and retention of the IAPT workforce. The conclusion chapter highlights this study's main contributions to the evidence base and the literature on work role-transition.

1.10 Chapter summary

This chapter presented this thesis' topic, which is the transition and transformation process to become an IAPT therapist. The chapter also discussed why the topic of the transition

experience of non-IAPT qualified therapists to IAPT services is important to the evidence base and the researcher. The justification and rationale of the study were critically discussed, and the expected outcomes were clarified. The aim and objective of the study were specified, and the research questions were presented. This chapter also provided an initial statement on the researcher's position as an insider researcher.

The following chapter discusses the IAPT Programme in more detail to help the reader understand its structure and functions and places this study within the context of IAPT expansion and transformation.

Chapter 2

The Improving Access to Psychological Therapies Programme (IAPT)

2.1 Introduction

This chapter provides an overview of the IAPT programme to help the reader understand the aims and the structure of the programme and its service model. The chapter provides a historical background of the development of the IAPT in the last decade and highlights its future expansions.

2.2 What is IAPT?

IAPT services provides evidence-based treatments for people with depression and anxiety disorders. In addition to evidence-based psychological therapies, IAPT services also provide employment support to people, where appropriate.

2.3 The IAPT programme

The IAPT programme was launched as a response to the Depression Report (Layard, 2006), highlighting scarcity in the availability of evidence-based psychological therapies for common mental health problems, namely depression and anxiety (Firth, Barkham and Kellett, 2015). The IAPT programme is underpinned by the clinical and economic agenda. The clinical agenda is based on the evidence that strongly supports specific psychological interventions for depression and anxiety disorders (National Institute for Health and Clinical Excellence, 2005, 2009, 2011) (NICE). The economic agenda was based on the argument that increasing access to psychological therapies would largely pay for itself by reducing welfare benefits and medical costs and increasing revenues from people returning to work (Layard et al., 2006).

2.4 IAPT today and what it offers

Every local health area now has an IAPT service. The number of IAPT services currently in England is 209 (Psychological Professions Network, 2018). Cognitive behavioural therapy is the predominant treatment approach offered in IAPT services. However, other therapies are also offered, such as couples therapy, counselling, interpersonal therapy, and brief psychodynamic therapy (National Collaborating Centre for Mental Health, 2018) (NCCMH).

2.5 IAPT service provision

IAPT services are commissioned by local clinical commissioning groups (CCGs). IAPT is commissioned on the basis that it can prove its effectiveness in delivering evidence-based treatments for common mental health disorders (Richards and Suckling, 2009). Effectiveness is measured in terms of IAPT services achieving the targets of access rates and recovery rates, as discussed below. Referrals to IAPT services come from: self-referrals, general practitioners, secondary care services, and voluntary services (NCCMH, 2018).

2.6 Measuring service effectiveness

2.6.1 Routine outcome monitoring

To monitor IAPT outcomes, detailed information about patients' symptoms, disability, functioning, the treatment offered, and treatment outcome are collected. Collecting outcome measures every session is one of the key characteristics of the IAPT framework (NCCMH, 2018).

2.6.2 Measures of clinical outcome

The Patient Health Questionnaire 9-item (PHQ-9) score10 (clinical cutoff >9) is used to measure symptoms of depression (Kroenke, Spitzer, and Williams, 2001). The Generalised Anxiety Disorder 7-item (GAD-7) score 8 (cutoff >7) is the default measure of anxiety

(Spitzer et al., 2006), but services can also use more specific measures for particular anxiety disorders.

The routine outcome measures collected by all IAPT services automatically flow monthly to NHS Digital for analysis and national reporting. The routine outcome measures include measures of symptoms, disability, and employment. Patients can comment on their experience and the quality of care they received by completing the Patient Experience Questionnaire (PEQ) (NCCMH, 2018). All IAPT workers are responsible for entering timely data that is accurate for each person after each session (NCCMH, 2018).

IAPT services should achieve the minimum national standards in access to the service, waiting time, and recovery rate standards. The access standard in 2015 was 15% for people with anxiety and depression. The Five Year Forward Implementation Plan aims to increase the access rate to 25% by 2023/2024 (NHS England, 2018a).

As for recovery standards, a minimum of 50% of people who entered treatment should move to recovery. Recovery is measured in terms of 'caseness.' Casesness refers to the person's symptoms above the threshold measured by the Minimal Data Set (MDS) outcome questionnaires, mainly PHQ 9 and GAD 7. People who measure below this caseness at the end of treatment are considered recovered (NCCMH, 2018).

2.7 IAPT clinical service model

The IAPT clinical service model is based on the stepped care model advocated by NICE guidelines (NICE, 2011). A fundamental feature of the stepped care model is that the least restrictive treatment available to provide significant health gain should be offered first (Bower and Gilbody, 2005). 'Least restrictive' refers to the impact on the patient's cost and personal inconvenience and the amount of specialist therapist time required, and treatment intensity.

Stepped care offers a range of treatments of differing intensity: Low-intensity and High – intensity (Figure 1, p15). Low-intensity interventions are offered at step 2 and include brief therapies, psychoeducation, guided self-help, bibliotherapy, computerised CBT, group treatments, and signposting to voluntary sector services. Low-intensity interventions are delivered by Psychological Wellbeing Practitioners (PWPs) who undergo a short training period in a manualised version of a specific therapeutic model (Rizk, 2012).

High-intensity interventions are delivered at step 3 and reserved for patients who did not respond or partially responded to low-intensity interventions or deemed unsuitable to low interventions because of the severity of the disorder or risk factors. NICE advocates cognitive behavioural therapy as the primary intervention for stepped care (NCCMH, 2018). However, since 2010 a new range of other therapy models were added, including brief psychodynamic therapy, counselling, interpersonal therapy, and couple therapy (NCCMH, 2018).

Treatments at step 3 are delivered by HITs who have either completed an IAPT accredited programme or non-IAPT qualified therapists who are accredited or eligible for accreditation by their relevant professional bodies (Psychological Professions Network, 2018). Table 1 in page 15 provides a summary of the main features of IAPT services.

Figure 1 Stepped Care Model for Anxiety and Depression Treatment adapted from Stepped Care Model for depression treatment (NICE, 2009)

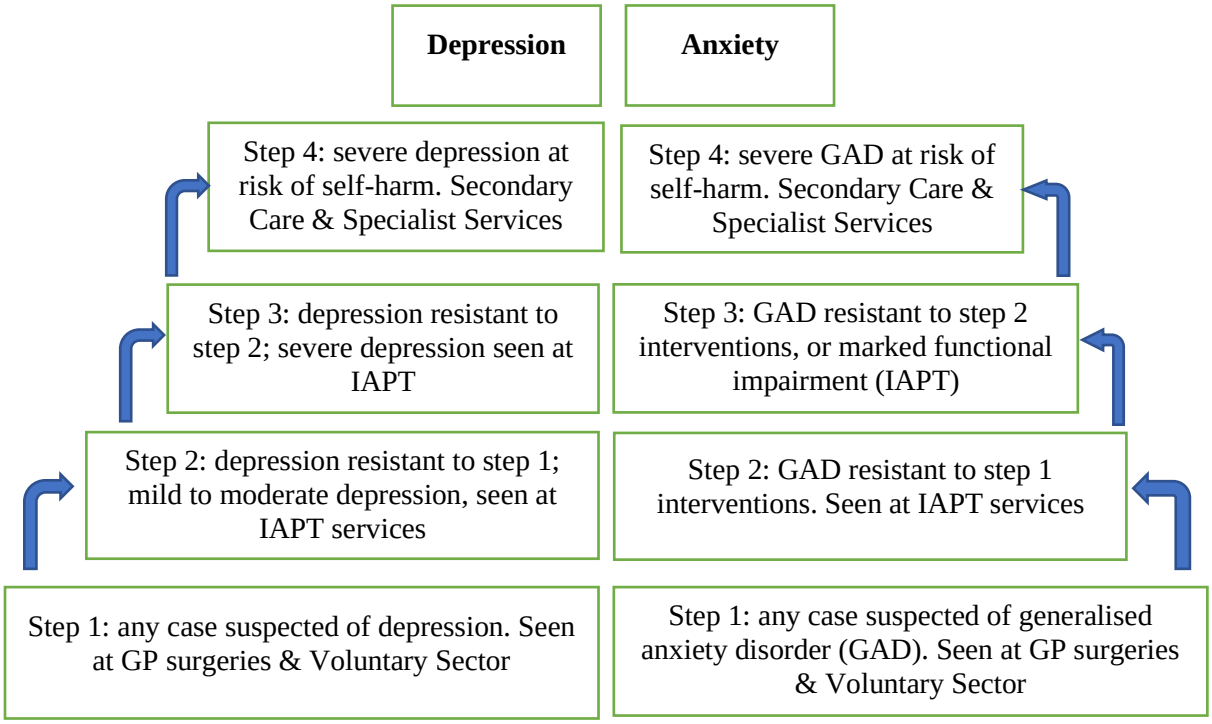


Table 1 Summary of the main features of IAPT services

IAPT main features	**Details**	**Comments**
Stepped care model	Step 2 and Step 3	Based on NICE guidelines
Workforce	PWPs provide treatments at step 2 HITs provide treatment at Step 3	HITs are comprised of: IAPT qualified therapists Non-IAPT qualified therapists
Disorders treated	Anxiety and depression	Other conditions will be treated with the expansion of IAPT, such as learning disabilities, chronic fatigue syndrome, and long-term conditions.
Referrals	Self-referrals, GPs, Secondary services and voluntary sector	
Treatments offered	Mainly evidence-based CBT Manualised protocols by Roth & Pilling (2007) Other therapies	Other therapies such as couples counselling, counselling for depression, brief psychodynamic therapy, and interpersonal therapy.
Number of sessions	Vary according to each disorder	
Recovery	Achieving below caseness on PHQ 9 and GAD 7	These measures are used to monitor the patient's progress, recovery, and to evaluate therapists' competence.

2.8 The required expansion of IAPT psychological professions

The Five Year Forward View for Mental Health (FYFVMH) aims to expand the IAPT services to increase access to evidence-based psychological therapies for adults with anxiety disorders and depression so that 25% of those affected receive psychological therapy each year (NHS England, 2018a). This expansion includes, but is not exclusive to, providing services for people with a learning disability, long-term conditions in the context of anxiety and depression, and chronic fatigue syndrome (NHS England, 2018a). An extra 11,000 psychotherapists and psychological professionals are required by 2023/2024 to meet this increased demand (NHS England and Health Education England, 2016). This additional workforce is anticipated to be recruited from IAPT qualified and non-IAPT qualified therapists (Psychological Professions Network, 2018).

Although non-IAPT qualified therapists possess expertise in their given area, they do not always have the knowledge needed in an IAPT setting. This work-role transition also entails assimilating a new set of values and norms and developing a new identity as IAPT therapists. The sustainability of IAPT services to meet the demands of its expansion means recruiting and retaining the required practitioners. Adapting to the IAPT role may be challenging for non-IAPT qualified therapists because of the unique work-role set up in IAPT, as discussed earlier in this chapter. Therefore, understanding this workforce's subjective experience who took the role in IAPT services will help identify and analyse the factors that aid the recruitment and retention of this group of therapists. It is hoped this study's findings will assist workforce planning for IAPT expansion by identifying what helps transition to IAPT services and hence facilitate newcomers' adjustment into their new role. Literature suggests that smooth adjustment to a new work-role improves job satisfaction and retention (Martin, Jones and Callan, 2005).

2.9 Summary

This chapter provided an overview of the IAPT programme. The chapter described the IAPT system structure, and its clinical service model based on a stepped care model that is advocated by NICE. The chapter provided an insight into the IAPT workforce and their roles. This chapter also discussed how IAPT services' effectiveness is evaluated and the programme's planned further developments. A summary of the main features of the IAPT system was provided.

The following chapter provides a systematic review of the literature on work role transition. Due to the absence of literature on the transition to IAPT services a comparable registered workforce was chosen as the subject of this review.

Chapter 3 Literature Review

3.1 Introduction to the Chapter

This chapter presents an integrative literature review of work role transition in a nursing population. The decision to review the literature on transition in a nursing population stemmed from a scoping search which identified a very small evidence base on health professionals transitioning to IAPT services and no research specifically on work role transition for registered psychotherapists or counsellors transitioning to IAPT services. Whilst there is a large body of literature about pre-registration students transitioning to registered practitioners, this review purposely sought the experiences of experienced professionals transitioning to new roles as this was considered a more comparable experience on which to draw insight and understanding.

3.2 Transition to IAPT

Three studies were identified in search of the literature that examined transition into IAPT roles: Robinson et al. (2012); Hutten (2018); and Hakim, Thompson, and Coleman-Oluwabusola (2019). However, these three studies examined the transition to IAPT by those training to become IAPT practitioners and not experienced counsellors and psychotherapists transitioning to IAPT roles. Robinson et al. (2012) examined the role transition of mental health nurses into the IAPT role after training as HITs. Hutten (2018) explored how practitioners transitioned to the IAPT role managed the transition during and after training to become qualified PWPs and HITs, the dilemmas they faced in practice and their changing identities over time. Finally, Hakim et al. (2019) investigated the transition experience of Black, Asian, and Minority Ethnic (BAME) community mental health workers to become PWPs.

Robinson et al. (2012) used a qualitative design to explore the lived experience of six mental health nurses during their first year of training to become high-intensity therapists in IAPT services. This study showed that transitioning to HIT's role for mental health nurses is challenging, and clinical supervision is crucial in supporting complex psychotherapy role transitions.

Similarly, Hutten (2018) used a qualitative longitudinal research design and recruited two HITs and six PWPs participants (n=8) during their training year and four HITs and three PWPs (n=7) who had three years or more working in IAPT services. The analysis showed that the practitioners who transitioned to IAPT services undergo an uncomfortable and anxiety-provoking process of role transition in many respects, and both groups (HITs and PWPs) struggled to cope with the ambiguity, stress, and role insecurity. Furthermore, personal authority within the role was not cultivated but lay instead with managers, supervision, and a performance surveillance system. The lack of the professional identity of the new job roles was an issue of interest to both PWP and HIT participants. This study made important recommendations, including increased capacity to contain uncertainty, ambiguity, complexity, self-authorisation, and reflexivity. Furthermore, ongoing support and training for qualified practitioners and robust supervision were identified as essential factors for a successful transition.

Hakim, Thompson, and Coleman-Oluwabusola (2019) investigated the transition experience of four BAME community mental health workers to the IAPT PWP role. This study described the specific training needs of BAME groups to become PWPs. The study recommended adaptations during PWP training to deliver low-intensity cognitive behavioural therapy (LICBT) to BAME patients that are culturally sensitive. However, the study also

stated that adaptations were not enough on their own, and the use of language and cultural awareness was necessary.

These studies provided a helpful insight into the demands of the IAPT role, and the difficulty faced when transitioning to the service during training and beyond. However, in-depth analysis and understanding of transition experiences were not possible within this limited evidence base hence the justification to examine the wider evidence base for registered nurses transitioning to new roles within the nursing profession.

3.3 Registered nurses' transition to new roles within the nursing profession

The existing literature that examined nurses' subjective experience was chosen as a suitable alternative to understand role transition in a comparable group of registered professionals. An integrative approach to the review was chosen because, during the scoping exercise, it was noted that research in this area had been approached from both the qualitative and quantitative paradigms. Therefore, the most appropriate approach to use was an integrative review methodology, which allows philosophically opposing studies to be combined. Specifically, in this context, the structured approach described by Whittemore and Knafl (2005) was used as it is both systematic and rigorous. Therefore, this chapter will first discuss Whittemore and Knafl's (2005) integrative review methodology as an appropriate and robust framework to facilitate this review. The steps conducted within this framework will then be discussed sequentially as the method used to conduct a contemporary and in-depth review of work-role transition for experienced registered professionals.

3.4 Review methodology

An integrative review is a specific review method that uses a systematic approach and detailed search strategy of empirical or theoretical literature to provide a more comprehensive

understanding of a phenomenon or healthcare problem (Broome, 1993). While theoretical literature may be sourced in integrative reviews, more commonly, these are restricted to peer-reviewed sources.

An integrative literature review methodology was chosen because it allows for the inclusion of diverse methodologies; hence it can capture the complexity of varying perspectives of a complex phenomenon such as work role transition (Whittemore and Knafl, 2005).

Combining qualitative and quantitative studies in one review provides a holistic and unified understanding of the work-role transition phenomenon and its meaning for the participants. Quantitative data provides the objective measurement needed, and the inclusion of qualitative data provides rich contextual details of participants' experience.

Whittemore and Knafl's (2005) structured framework was used because it provides a robust systematic five-stage method (see box 1).

Box 1 Whittemore and Knafl's (2005) five stages framework

1- Problem identification
2- Literature search (methods and outcomes)
3- Data evaluation
4- Data analysis
5- Presentation

3.4.1 Limitations of the methodology

Although the integrative review methodology allows for integrating qualitative and quantitative research, the combination and complexity of incorporating diverse methodologies can contribute to a lack of rigour, inaccuracy, and bias (Hopia, Latvala and Liimatainen, 2016). Therefore, maintaining scientific integrity while conducting an

integrative literature review is quite challenging as it involves careful consideration of threats to validity. Indeed, there are limitations to an integrative framework, as discussed by Grant and Booth (2009), who argued that the conclusions drawn depend on the availability of resources, the quantity and quality of the literature retrieved, and the expertise or experience of reviewers. The impact of these limitations was mitigated by ensuring retrieval of all published literature, working collaboratively with a librarian with advanced skills in literature acquisition, and extending my skills through additional training in review methodology. However, a limitation remained because of the pragmatic decision to exclude grey literature.

3.5 Review methods

3.5.1 Stage One: Problem identification

Theoretical and empirical research in the past decade related to the concept of work-role transition suggested that successful adjustment to a new work-role was an essential aspect of job satisfaction and tenure (Aziri, 2011; Sullivan-Bentz et al., 2010). Although non-IAPT qualified therapists represent 51% of the HITs workforce and more of them are likely to be employed due to the expansion of IAPT services (NHS England, 2020), nothing in the literature has been written about their transition experience to IAPT services.

Following an extensive search of the relevant databases for this professional group's transition experience (e.g., CBT therapists, counsellors, psychologists, and allied health professionals) to healthcare settings, no literature was found. Therefore, the nursing population's transition experience was searched instead because they were considered a comparable registered professional group in terms of work roles and healthcare settings. Therefore, this integrative review aimed to critically analyse the literature on nurses' transition in healthcare settings.

The first stage of the integrative review framework involved developing a focused review question to a) define the review's scope and b) define the terms. Arguably, this was even more important within the context of work role transition because the definitions of work role transition are so broad.

To develop a good review question, three elements of the PICO tool were incorporated in the question, as illustrated in Table 2 (specifically PIO). PICO is a mnemonic used to describe the four elements of a sound clinical foreground question (Yale University, 2017). The question needs to identify the intended **P**atient or **P**opulation of the study, the **I**ntervention or treatment that will be used, the **C**omparison of one intervention to another (if applicable), and the anticipated **O**utcome (Yale University, 2017).

Table 2 PICO Tool

PICO Elements	Keywords
Population	Nurses
Intervention / Phenomenon of Interest	Work-role transition in healthcare
Comparison group	Not applicable
Outcome/Context	Factors that facilitate or impede their adjustment in healthcare settings.

3.5.1.1 Review question

How do nurses experience work-role transition, and what factors facilitate or impede their adjustment in healthcare settings?

3.5.1.2 Aim and objectives

This review focuses on understanding the work-role transition experience for nurses in healthcare either after a transfer or upon initial entry into the organisation.

a) Aim: to advance an understanding of adjustment following work–role transition for nurses in healthcare settings through a critical review of published literature.

b) Objectives

1. Critically evaluate the current empirical literature regarding adjustment following work-role transition for nurses.

2. Synthesise the findings of research studies to summarise the state of knowledge in adjustment following work-role transition.

3- Identify the factors that facilitate or hinder work-role adjustment for nurses in healthcare settings.

4- Make recommendations for future research concerning adjustment following work-role transition to IAPT services for counsellors, CBT therapists, psychotherapists and psychologists.

3.5.1.3 Inclusion & Exclusion criteria

This review's inclusion criteria centred on the need to focus on work-role transition from the individual's perspective. Therefore, papers that described expatriates' transition to working abroad were excluded because participants were adjusting to a new culture and a new job. Papers on new graduates' transition were also excluded as the study's focus is on work-role transition for experienced therapists. Papers that reported supervisors' perspectives were also excluded because the focus is on the individual's experience of transition. Finally, this review only included peer-reviewed empirical primary research, and thus abstracts, unpublished dissertations, and literature reviews were also excluded.

Table 3 Inclusion and exclusion criteria

Inclusion criteria:	**Exclusion criteria:**
- Aimed to examine work- role transition in healthcare - Nurses - Published in peer-reviewed journals - Empirical primary research - English language - Published 1964 – April 2021	- Aimed to examine work-role transition outside healthcare - Not nurses - Not published in peer-reviewed journals - Not empirical research - Not in the English language - Studies on new graduate nurses entering work as the focus of this review is on work-role transition for people who started their careers

3.5.2 Stage Two: Literature search stage

Whittemore and Knafl (2005) advocate four steps in their stage of literature searching. Each was actioned as follows:

1) Identification of search terms

An initial scope of the literature was conducted to identify appropriate search terms for searching the relevant healthcare databases (Aveyard, 2014). The PICO tool then provided a guide for concept mapping and identification of specific search terms.

Critical concepts for the review were identified as nurse, work-role, transition, and healthcare. Alternative keywords for these concepts were identified through brainstorming and thesaurus mapping (Aveyard, 2014; Wakefield, 2015). The key terms and synonymous, truncation, and all associated spelling variants were used where appropriate to ensure no papers were missed.

Boolean operators enabled the combination of search terms in such a way to optimise results. The use of 'OR' enabled a combination of related searches, truncation, and wildcards to facilitate 'high recall.' The use of 'AND' enabled the combination of the three concepts "transition," "work role," and "healthcare" together to facilitate 'high precision' (Aveyard, 2014).

2) The use of appropriate databases

The following databases were searched: Cumulative Index to Nursing and Allied Health Literature (CINAHL); PsychInfo, Medline, Scopus, AMED, and Psychological and Behavioural Science, as recommended by Aveyard (2014), Cottrell (2011), and Oliver (2012). The search strategy was applied in the same way for each of the databases used. An example of how this was executed specifically is provided for the CINAHL database in Table 4 (p 27). An academic subject librarian confirmed the robustness of the search protocol.

Reference lists from identified papers that were found to meet the inclusion criteria were also hand searched. This hand search was essential to compensate for any deficiencies in retrieval terms and add to the search strategy's thoroughness (Davis, 2016; Harari et al., 2020; Whiffin, 2020).

3) Search limits

Searches were limited to the English language so that all papers could be read, understood, and appraised. The publication limit was set to academic peer-reviewed journals and dates from 1964-2021 because the first formulation of a work adjustment theory was published in January 1964 (Dawis, England and Lofquist, 1964). Therefore, it was sensible to commence searching from this date. The search limit to all adults was included to exclude articles that were for other age groups.

Table 4 CINHAL search strategy

Search ID #	Search terms	Search options	Results
Population	"practitioner*" OR "therapist*" OR "nurse*" OR "clinician*" OR "counsellor*" OR "allied health professional*"	Search modes- Boolean /Phrase Title OR Abstract	**550,870**
Intervention	"tran?ition*" OR "adjustment*" OR "soiali?ation*" OR "adaptation*" OR "transformation*" AND "work*" OR "job*" OR "employment*" OR "occupation*" OR "profession*" OR "business*" OR "career*" Or "service*" AND "Healthcare*"	Title OR Abstract	**43,840**
Outcome	"View*" OR "experience*" OR "opinion*" OR "attitude*" OR "perc*" OR "feel*" OR "know*" OR "understand*"	Title OR Abstract	**1,359,996**
Search history with AND			**3,188**
Limitations	English language Date: 1964-2021 Peer reviewed All adults		**897**

4) Search Results

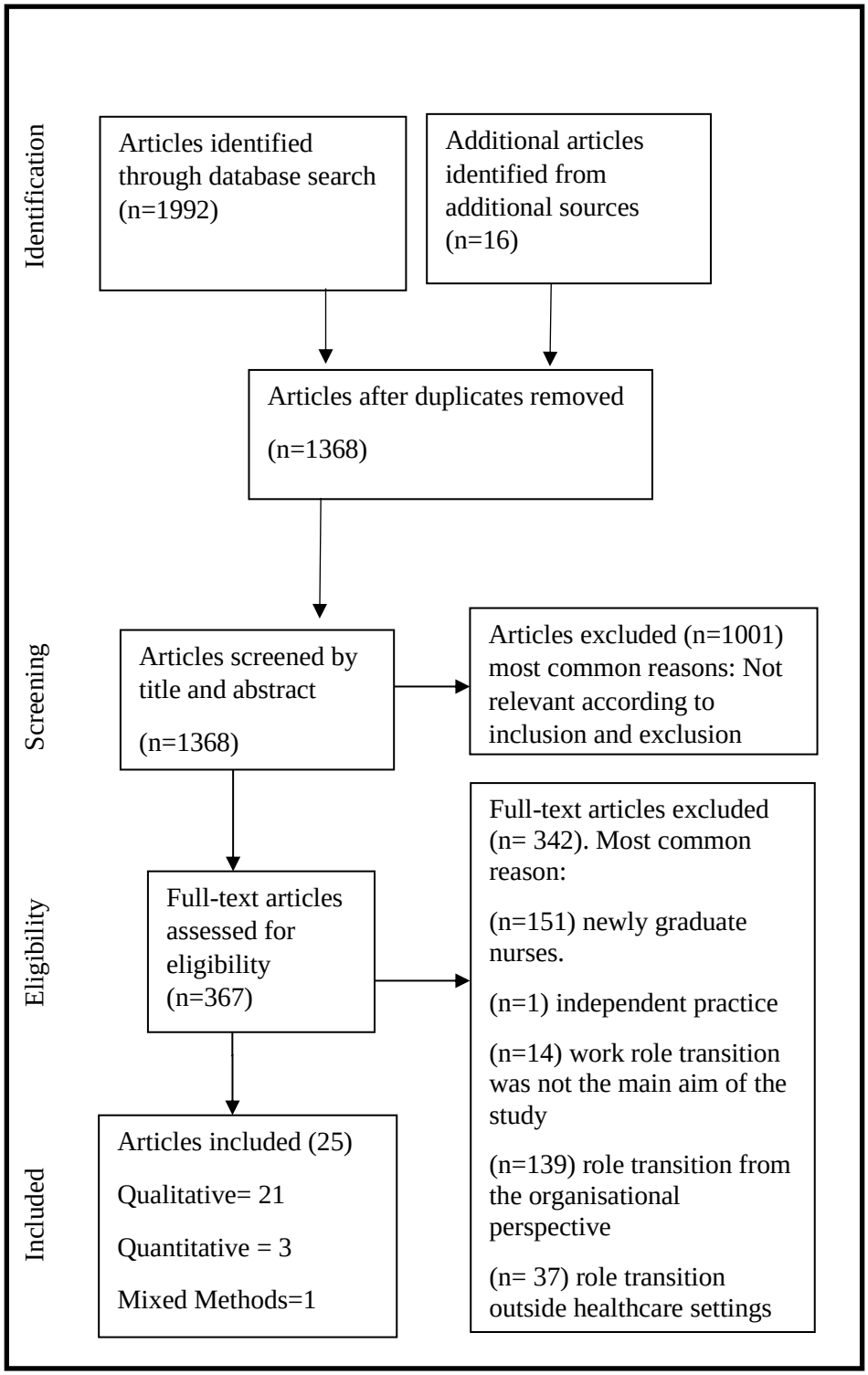
The search yielded 1992 articles across the six databases (Table 5, p28) and 16 articles identified through other sources.

Table 5 Final outcome of searching across the six databases

		Database	**Results**
Limitations	English language Date: 1964-2021 Peer reviewed All adults	CINHAL	897
		Medline	574
		AMED	33
		APA PsycInfo	401
		Psychology and Behavioral Sciences Collection	80
		Scopus	7
		Total articles	**1992**

After excluding duplicates electronically and by hand searching, 1368 papers remained in the next phase to review by title and abstract. In this phase, the title and abstract were assessed against the inclusion and exclusion criteria and discarding any that clearly did not address the topic of interest. When it was not clear from the title or abstract whether an article was relevant, the full text was considered. A total of 1001 articles were excluded, and 367 remained for the next phase, 'review by full text', where a further 342 articles were excluded using the inclusion and exclusion criteria presented in Table 3 (p25). Twenty-five articles then remained for this literature review. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were used and adhered to. A PRISMA flowchart was completed (see Figure 2, p29).

Figure 2: The process of paper selection- PRISMA flowchart



3.5.3 Stage Three: Data evaluation

Data evaluation is important in a systematic review to ensure the evidence base's validity is assessed and to ensure conclusions are based on robust evidence (Aveyard, 2014). However, researchers have no consensus on a generic tool that can be applied across study types (Crowe and Sheppard, 2011; Katrak et al., 2004). Therefore, several appraisal tools were used in this review to ensure papers were appraised appropriately. First, the Critical Appraisal Skills Program (CASP, 2017) tool was used because it is a widely used tool and user-friendly (Aveyard, 2014; Cottrell, 2011; Oliver, 2012) (see Table 6, p32). However, on reflection, it was apparent that the CASP tool was limited in its ability to facilitate the appraisal of evidence of rigour in qualitative research due to their [qualitative research] interpretative nature, their emphasis on meaning of participants' experience, and the impact of the researcher on the research (Aveyard, 2014; Cottrell, 2011). Second, Joanna Briggs Institute (Joanna Briggs Institute, 2018) (JBI) tool was used because it was found to be better than CASP in terms of appraising the descriptive, theoretical and interpretative validity of qualitative research as reported in a study by Hannes, Lockwood and Pearson (2010). Therefore, the CASP tool and JBI tool were used for appraising the quality of all the qualitative studies included in this review.

The studies' rating followed each appraisal tool's key criteria. Table 6 (p32) presents the outcome of the CASP appraisal for each paper, and Box 2 (p34) presents the CASP questions and an explanation of the outcomes following the appraisal.

The appraisal of a study by Glen and Waddington (1998) using the CASP appraisal tool is reported in Table 6 (p32). This study was initially rated as of high quality as the study has met most of the criteria; however, the JBI tool indicated a medium quality when used (Appendix 1). The lack of detail in reporting data collection methods and data analysis made

it difficult to judge the study's robustness and thus was rated as of medium quality. This example illustrates that the studies' rating was dependent on the skills of the reviewer and the criteria of each appraisal tool.

The quantitative studies all used a survey approach and were appraised using the NICE Critical Appraisal Checklist for a questionnaire study (NICE, 2004) (see Appendix 2 for an example). From this appraisal, it was found that two studies were of high quality, and one study was of medium quality. The mixed-method study's quality was assessed as two studies because one study reported the survey data, and the other study reported the results of the qualitative interviews. Therefore, the survey data quality was assessed using NICE Critical Appraisal Checklist for a questionnaire study. The quality of the qualitative study used CASP and JBI tools. No research was excluded based on quality because some answered aspects of the literature question despite poor quality. However, they contributed less to the analytic process, and a comment on their quality was included in the review chapter's main text.

Table 6 CASP appraisal of qualitative studies

Appraisal question	1	2	3	4	5	6	7	8	9	10	11	12 Quality
Lead author												
Anderson (2009) USA	Y	Y	Y	Y	Y	P	P	Y	Y	Y	Y	High quality
Ashley et al. (2017) Australia	Y	Y	Y	Y	Y	P	N	Y	Y	Y	Y	High quality
Azimian, Negarandeh &Movahedi (2014) Iran	Y	Y	Y	Y	P	P	N	Y	P	Y	P	Low quality
Barton (2007) Wales	Y	Y	Y	Y	Y	P	N	N	Y	Y	Y	Medium quality
Bombard et al. (2010) USA	Y	Y	Y	Y	Y	Y	Y	N	P	Y	Y	Medium quality
Boyd & Lawley (2009) UK	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	High quality
Brown & Olshansky (1997) USA	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	High quality
Cubit, Lopez & County (2011) Australia	Y	Y	Y	Y	P	Y	N	Y	P	Y	P	Medium quality
Dearnley (2006) UK	Y	Y	Y	Y	Y	Y	P	Y	Y	Y	Y	High quality
Glen & Waddington (1998) UK	Y	Y	Y	Y	P	Y	Y	N	Y	Y	Y	High quality
Holt (2008) UK	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	High quality

Manning & Neville (2009) New Zealand	**Y**	**Y**	**Y**	**Y**	**P**	**Y**	**N**	**Y**	**Y**	**Y**	**Y**	**High quality**
Melrose & Gordon (2011) Canada	Y	Y	Y	Y	P	P	N	Y	P	Y	Y	Medium quality
Miller, Vivona & Roth (2017) USA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	High quality
Owens (2018) USA	Y	Y	Y	Y	P	Y	N	Y	Y	Y	Y	High quality
Pearson & Care (2002) Canada	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Medium quality
Seng, Sanubol & County (2004) USA	Y	Y	Y	P	Y	Y	N	N	Y	Y	Y	Medium quality
Simpson et al. (2006) Saudi Arabia/Australia	Y	Y	Y	Y	Y	P	N	N	P	Y	P	Low quality
Sullivan-Bentz et al. (2010) Canada	Y	Y	Y	Y	P	Y	N	Y	Y	Y	Y	High quality
Wenner & Hakim (2019) USA	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	P	High quality
Zurmehly (2007) USA	Y	Y	Y	Y	P	Y	N	N	Y	Y	Y	Medium quality

Box 2 CASP appraisal questions for qualitative studies

Appraisal Questions CASP for qualitative studies
1- Was there a clear statement of the aims of the research?
2- Was qualitative methodology appropriate?
3- Is it worth continuing?
4- Was the design appropriate to address the aims of the research?
5- Was the recruitment strategy appropriate?
6- Was the data collected in a way that addressed the research issue?
7- Has the relationship between researcher and participants been addressed?
8- Have ethical issues been taken into consideration?
9- Was the analysis sufficiently rigorous?
10- Is there a clear statement of findings?
11- How valuable is the research?
12- Overall rating, high quality, medium quality, low quality.
Appraisal Questions (CASP, 2017) Y= Yes, N=No, P= Partial
High quality: all/almost all criteria met, any weaknesses cannot change the conclusion of the study.
Medium quality: used if any criteria from the checklist are not met or if the criteria are not satisfactorily described.
Low quality: used if few or no criteria from the checklist are met or not satisfactorily described. The weaknesses may mean the conclusion of the study is wrong.

3.5.4 Stage Four: Data analysis

Whittemore and Knafl's (2005) systematic approach of data analysis, which consists of: data reduction, data display, data comparison, conclusion drawing, and verification, was applied as follows:

3.5.4.1 Data reduction

The first phase of data analysis was data reduction, which involved the classification of articles into groups to facilitate analysis. Papers were first grouped by methodology, then by population, and then by the outcome of quality appraisal to understand initial patterns within the evidence base.

The first stage of grouping the papers was followed by reading and re-reading the papers for familiarisation with the contents and confirming their relevance to the review question, referring to the inclusion and exclusion criteria. Next, each article was read, and its main themes were summarised. High-quality papers that were more relevant to the review question were given more weight during this phase.

Data reduction involved extracting and coding data from primary sources by reading each article several times, analysing findings line by line, and coding the relevant features of the data concerning the review question. The data extracted from primary sources were grouped into different categories: expectations, aspects of adjustment, facilitators, barriers, challenges, emotional experiences, cognitive, emotional, and behavioural adaptations, and other variables such as support.

3.5.4.2 Data display

The extracted data from individual articles was compiled into tables (see Appendix 3). Data was assembled under subheadings, for example, role clarity, mentoring, support, and prior occupational experience.

Displaying the data in tables enhanced the visualization of patterns and relationships within and across primary data sources and served as a starting point for interpretation.

3.5.4.3 Data comparison

Related themes across all included studies were identified. During this phase, several strategies were used to enhance data analysis, such as noticing patterns and themes and the relationships between them and counting and discerning common and unusual patterns (Miles and Huberman, 1994; Sandelowski, 1996). The final phase of data analysis was isolating these patterns, commonalities, and differences and then moving data from description to

higher abstraction levels and moving the particulars into the general (Table 7, p37) demonstrates the identified themes and subthemes in each article).

Table 7 The identified themes and subthemes

Super-ordinate themes		Learning & sense making of the new role within the organisation				Adaptation and change					Facilitators to role transition								
											Organisation						Individual		
	Identified subthemes / **Studies**	Anticipation & Excitement	Learning the role	Expectations	Positioning oneself in the new role	Accepting reality	Enacting & shaping the role	Learning & unlearning	Changing self and role identity	Building support network	Induction & orientation	Role clarity	Mentoring & support	Effective interprofessional relations	Clear career pathway	Appraisal & supervision	Self -efficacy	Prior occupational experiences	Proactivity
1	Anderson, (2009). USA	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓
2	Ashley et al. (2017). Australia		✓		✓		✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
3	Azimian, Negarandeh & Movahedi (2014). Iran		✓		✓			✓		✓	✓		✓	✓	✓				✓
4	Barton, (2007). Wales	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓		✓		✓
5	Bombard et al. (2010). USA	✓	✓		✓		✓	✓	✓				✓	✓	✓	✓			
6	Boyd & Lawley (2009). UK		✓		✓		✓	✓	✓	✓			✓	✓			✓	✓	✓
7	Brown & Olshansky, (1997). USA	✓	✓		✓		✓	✓	✓	✓			✓	✓			✓		✓
8	Cubit & Lopez (2012). Australia	✓	✓	✓		✓		✓				✓						✓	✓
9	Dearnley, (2006). UK	✓	✓		✓		✓	✓	✓				✓	✓	✓		✓	✓	✓

10	Glen & Waddington, (1998).UK	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓			✓	✓	✓
11	Goodrich, (2014). USA		✓	✓									✓	✓			✓		✓
12	Holt, (2008). UK		✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓
13	Khoza, (2005). South Africa									✓	✓	✓	✓	✓	✓				
14	Manning & Neville, (2009). New Zealand	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
15	Melrose & Gordon, (2011). Canada		✓					✓		✓		✓	✓	✓			✓		✓
16	Miller, Vivona & Roth,(2017). USA	✓	✓		✓		✓	✓	✓				✓	✓		✓	✓		✓
17	Owens, (2018). USA	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓		✓	✓	✓	
18	Pearson & Care (2002). Canada			✓			✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
19	Seng & Sanubol (2004). USA	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓	✓		✓
20	Simpson et al. (2006). Saudi Arabia /Australia		✓		✓	✓	✓	✓	✓	✓	✓		✓			✓	✓		✓
21	Smith & Boyd (2012). UK	✓	✓		✓		✓	✓	✓	✓		✓	✓	✓		✓		✓	✓
22	Smith et al. (2017) UK & Australia		✓						✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
23	Sullivan-Benz et al. (2010). Canada	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓		✓		✓	✓	✓
24	Wenner & Hakim, (2019). USA	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓		✓			
25	Zurmehly, (2007). USA	✓	✓		✓	✓	✓	✓	✓			✓	✓	✓			✓	✓	✓

Initially, 18 subthemes were identified, then with further comparison, refinement, and synthesising, this led to 13 subthemes (Table 8), and through a process of developing more abstract categories, three super-ordinate themes were finally identified: (1) Learning and sense-making of the new role within the organisation, (2) Adaptation and change, and (3) Facilitators and barriers of successful transition (see Table 8).

Table 8 Super-ordinate themes and subthemes

Super-ordinate themes	Subthemes
1- Learning & sense-making of the new role within the organisation	1- Anticipation and excitement
	2- Learning about the role and the organization
	3- Expectations versus reality
	4- Positioning oneself in the new work environment
2- Adaptation & change	1- Facing reality/the encounter phase
	2- Enacting and shaping the role
	3- Learning and unlearning
	4- Developing a new role identity
	5- Building a support network
3- Facilitators and barriers to successful transition	1- Induction and mentorship
	2- Proactivity and self-reliance
	3- Prior occupational experiences
	4- Barriers to adjustment

3.5.4.4 Conclusion drawing and verification

As data were conceptualised at higher abstraction levels, each primary source was reviewed to confirm that the new conceptualisation was congruent with the primary source (Smith, Flowers and Larkin, 2009). Following verification of theme identification, the findings were examined within the broader literature to inform a final conclusion. This final stage of

conclusion drawing where the existing research implications for work-role transition and further research are considered follows Stage Five of the framework 'Presentation.'

3.5.5 Stage Five: Presentation

3.5.5.1 Overview of the included papers

The studies included in this integrative review describe transition experiences for three different groups of nurses: those moving from acute care to community care (n=6), those changing from clinical to educational roles (n=7), and those transitioning into specialist nurse roles from more general nursing positions (n=12). Geographically studies originated from the USA (n=9), the UK (n=6), Canada (n=3), New Zealand (n=1), South Africa (n=1), Iran (n=1), Australia (n=3), and one study from both Australia and Saudi Arabia. The study designs varied from descriptive qualitative studies to three quantitative surveys and one interpretative phenomenological study. The commonalities observed between these groups and within each group are discussed below. These studies' appraisal found fifteen to be of high quality, seven medium, and three studies of low quality. Methodological weaknesses were often: the recruitment method was not clearly stated or how the informed consent was obtained. The inclusion/exclusion criteria were not clearly stated and why the participants were appropriate for the study—also, no mention of participants who dropped out and why.

The relationship between the researcher and the research participants was not discussed in most studies and did not indicate a reflective practice. For example, no discussion of potential bias or the researcher's role was not critically discussed for potential influence during the research process. While ethics approval can be assumed, there is no direct mention in one study (Glen and Waddington, 1998). Recruitment methods were not clearly described in Azimian et al. (2014) and Bombard et al. (2010). The study design was not clearly justified in Azimian et al. (2014) and Seng, Sanubol, and County (2004). Most

studies did not provide an example of the interview schedule. The process of data analysis was not transparent in some studies such as Cubit and Lopez (2011) and Simpson et al. (2006), and finally, in a few studies, there was no or little discussion of the contribution of the study to the existing literature see Seng, Sanubol, and County (2004), and Simpson et al. (2006).

3.5.5.2. Identified themes and subthemes

Three super-ordinate themes were identified from the synthesis of the empirical literature. Specifically, these were: Learning and sense-making of the new role within the organisation; Adaptation and change; and Facilitators and barriers to adjustment following work-role transition. Each super-ordinate theme will now be discussed alongside a critical evaluation of the evidence base's strengths and limitations.

3.5.5.2.1-Super-ordinate theme one 'Learning and sense-making of a new role within the organisation'

The first super-ordinate theme*, 'Learning and sense-making of a new role within the organisation,'* critically evaluates participants' experience in the early phase of transition to their new role. This super-ordinate theme included four subthemes**:** anticipation and excitement, learning about the role and the organisation, expectations versus reality, and positioning oneself in the new work environment.

3.5.5.2.1.1 Anticipation and excitement

The findings of the literature review indicated that in the first few months of transition, participants experienced mixed emotions of excitement and anxiety (Bombard et al., 2010; Brown and Olshansky, 1997; Glen and Waddington, 1998; Miller, Vivona and Roth, 2017; Sullivan-Bentz et al., 2010; Wenner and Hakim, 2019; Zurmehly, 2007).

Nurses who moved from acute service to community care service experienced cognitive and emotional transition (Zurmehly, 2007). The cognitive transition was apparent in participants' accounts regarding thinking of the new role and its scope, and the skills required to do the role. The emotional transition was evident in their mixed feelings about losing the security of know-how of their old role and the sense of anticipation and excitement mixed with their new role anxiety.

Participants felt excited about their new role in the community where they worked independently (Zurmehly, 2007) and had more flexibility to manage their work (Sullivan-Bentz et al., 2010). However, they also described anxiety about working autonomously and independently without the level of support they felt in the acute care setting (Simpson et al., 2006). Participants described feelings of anxiety about their performance and feared making mistakes before gaining confidence in their skills and their abilities to do the role (Brown and Olshansky, 1997).

Similar experiences were described by four direct-entry master's students in the first cohort to complete the Clinical Nurse Leader (CNL) curriculum and sit for the pilot CNL certification examination in the USA (Bombard et al., 2010).

Participants described feelings of uncertainty and trepidation mixed with excitement about entering the clinical nurse leader practicum and meeting the challenge of being among the programme's first cohort. The newness and uncertainty raised several questions about the role, the skills they needed to learn, and whether local institutions would accept the role in the long term.

Glen and Waddington (1998), in a case study of two clinical nurse specialists (CNS) and Seng, Sanubol and County (2004) in a descriptive qualitative study of six participants of the Sexual Assault Nurses Examiners team (SANE) in the USA, explored how registered nurses

transitioned to CNS and SANE roles. In both studies, feelings of excitement and motivation mixed with apprehension and anticipation were described by the participants. As experienced nurses, they felt confident in their skills and abilities to do the new role. However, in Glen and Waddington (1998), participants became stressed, overwhelmed, and frustrated by conflicts between the individual CNS's goals and targets and those of the multidisciplinary team. Issues related to organisational power, politics, and inter-professional relationships led to frustration and individual dissatisfaction.

In contrast, Seng, Sanubol and County (2004) found that nurses felt comfortable in their new SANE role. They were experienced nurses who were skilled in working with patients in crisis in their previous occupational roles. The findings of these two studies highlight two critical issues. Firstly, previous occupational experience's role in facilitating adjustment to a new work role as in Seng, Sanubol and County (2004). Secondly, inter-professional conflicts, organisational power, and politics were barriers to successful adjustment (Glen and Waddington, 1998). As for participants who took educator and preceptor roles, they found the role was more challenging and complicated than anticipated (Manning and Neville, 2009) with ill preparation for the role (Wenner and Hakim, 2019) and suboptimal orientation programmes (Miller, Vivona and Roth, 2017). Signs of stress were evident as the enormity of the role became apparent (Anderson, 2009).

3.5.5.2.1.2 Learning about the role and the organisation

Participants in most studies in this review contemplated the change from their previous role to their new role and had expectations of themselves and the role. They wanted to prove themselves and learn more about the role and their organisational culture. This issue was particularly highlighted in Anderson (2009); Barton (2007); Bombard et al. (2010); Boyd and Lawley (2009); Dearnley (2006); Manning and Neville (2009).

Findings of this review suggest that participants expressed a need to learn new skills, knowledge, and roles that were critical for successful transition (Ashley et al.; 2017; Boyd and Lawley, 2009; Brown and Olshansky, 1997; Dearnley, 2006; Glen and Waddington, 1998; Holt, 2008; Melrose and Gordon, 2011; Miller, Vivona, and Roth, 2017; Owens, 2018; Seng, Sanubol and County, 2004; Wenner and Hakim, 2019). In the learning process, participants attempted to make sense of their new role and work environment by seeking information from managers, mentors, co-workers, and documents (Cubit and Lopez, 2011; Manning and Neville, 2009; Miller, Vivona and Roth, 2017).

Participants who moved from acute care to community care settings indicated that the focus of their role in community care was broader than in acute care. They learned that their role extended beyond the individual and included the whole individual within their whole context with the ultimate goal of health and wellbeing of the community at large (Pearson and Care, 2002; Simpson et al., 2006; Sullivan-Bentz et al., 2010; Zurmehly, 2007).

For example, participants learned that community environments were unpredictable and varied from situation to situation (Zurmehly, 2007). Learning about their community culture, the client's culture and integrating this learning in their working with clients was a significant learning curve (Zurmehly, 2007). Although participants were experienced nurses, they expressed their need to upgrade their knowledge, skills, and attitudes when transitioning from an acute care setting to a community care setting. They had to learn to practise independently and think critically to make purposeful clinical judgments to implement effective interventions and provide quality care (Simpson et al., 2006). The nurses cited that preceptors, clinical competencies, clinical assessments, journaling, case studies, and presentations enhanced their learning and effectively met their learning needs (Ashley et al., 2017; Simpson et al., 2006).

In a similar vein, Owens (2018) discusses registered nurses' transition experience to the family nurse practitioner role (FNP) in rural areas. The findings suggest that nurses' prior clinical experience, knowledge, and skills were positively related to their new work role adjustment by transferring knowledge and skills to navigate their new role and tasks. Also, the transitioning nurses expressed the importance of lifelong learning through continued professional development. For example, attending conferences, learning new research and evidence-based practice, and listening to webinars were critical for providing safe and quality patient care. Participants also expressed the vital role of mentors and supervisors as a valuable resource for learning and support during their transition.

Learning about the role involved three stages: firstly, focusing on the role, which implied an active process of identifying what the role entailed in terms of skills, knowledge, and behaviours. Secondly, enacting the role in a given context within available resources. Thirdly, shaping the role through loss or expansion part of the role associated with transition. Shaping the role was considered a complex process that entailed redefining the role itself (Holt, 2008).

Holt (2008) argued that these three learning stages about the new role positively or negatively impact the transition experience. Holt (2008) proposed a role transition model that integrated the above three concepts of focusing, enacting, and shaping the role and centring identity.

The findings of studies on nurses who moved from clinical settings to become educators indicated insufficient preparation in knowledge and skills for clinical nurses specialists and nurse practitioners to enter the academic setting (Anderson, 2009; Boyd and Lawley, 2009; Manning and Neville, 2009; Wenner and Hakim, 2019). Findings suggested that for nurses moving to an academic setting, it was necessary to add new knowledge and skills and integrate a new set of values as they developed their new role identity as educators. For

example, Anderson (2009) reported that participants needed to learn about the role and the organisation by shadowing an expert educator, listening to and observing the educators' behaviours in the class, handling the students, and considering the lesson's important content. Formal and informal guidance provided by full-time educators, instructors, staff at university, and even students themselves were influential in their adaptation and adjustment to their new role as educators (Boyd and Lawley, 2009; Wenner and Hakim, 2019).

Equally, Miller, Vivona, and Roth (2017) described positive preceptorship experiences for 20 experienced nurses who transitioned to new roles as preceptors in allied health work settings through shadowing and observing preceptors. The preceptor is an experienced nurse who provides individual guidance to a less experienced nurse, and their role is a "cross between an educational instructor and a professional mentor" (American Sentinel College of Nursing and Health Science, 2017, no page).

Participants expressed that modelling and observing allowed them to observe more subtle aspects of patient interaction and that their experience was connected to learning and developing new knowledge. Although formal training seemed beneficial, participants voiced their concern regarding the inconsistency regarding the programmes' content as these inconsistencies impacted how they handled their role.

3.5.5.2.1.3 Expectations versus reality

The findings in most studies in this review highlighted an important issue: the discrepancy between participants' expectations and organisations' expectations (e.g., Anderson, 2009; Glen and Waddington, 1998; Manning and Neville, 2009; Sullivan-Bentz et al., 2010).

For example, in Sullivan-Bentz et al. (2010) qualitative study, 23 nurse practitioners who graduated from the Primary Health Care Nurse Practitioner program in Ontario had high

expectations of themselves and their primary health care roles. They had expectations of having adequate orientation to the role and the organisation. However, participants indicated that they had no orientation, and they showed up one day and started to work. Participants stated that the lack of orientation affected their adjustment and made it difficult because it added to their frustration and dissatisfaction with their jobs.

Equally, Glen and Waddington (1998) found that the registered nurses expected in their new role as CNS to act independently of superiors; to set their work targets; to choose the order in which different parts of the job were done and choose with whom to deal in order to carry out job duties. However, team targets took priority over CNS targets. Furthermore, CNS priorities did not always match those of the team, especially when resources were stretched. This discrepancy of priorities was identified as another source for individual dissatisfaction and disillusionment.

Similar experiences were reported by Anderson (2009) in a qualitative study where 18 nurse practitioners described that they had expectations about the role, the workload, students, and themselves. However, their expectations were far from their reality. To give an example, some participants thought they would become expert educators in a few months, others thought students would do what was asked of them, and some expressed their naivety about what to expect. Participants' emotions were linked to their expectations and became considerable during their first year of transition.

In another qualitative study by Manning and Neville (2009), the reality of the new clinical nurse educator (CNE) role exceeded their expectations of what the role entailed. Participants were surprised to find that the role contained numerous extra responsibilities that they had not considered, such as counselling and resolving inter-professional relationship conflicts. The

negative discrepancy of expectations and reality caused anxiety and uncertainty in the first few months of working as educators.

In contrast, in Zurmehly's (2007) qualitative study, many participants entered their roles as community nurse practitioners without knowing what to expect as their transition to their new roles was through unexpected routes. Nonetheless, all of them experienced a successful transition because they found the reality of their new role rewarding. Participants felt they could make a difference in people's lives, which has made them feel satisfied and proud.

In a survey of the injunctive logics (pre-entry beliefs about what institutional practices ought to be) and descriptive logics (experience of these institutional practices) during newcomer socialisation and the impact on organisational identification, trustworthiness, and self-efficacy by Smith, et al. (2017) 63.7 % of 264 participants (doctors, nurses and allied health professionals) experienced a negative discrepancy between what they expected and their reality for both clinical logic and managerial logic.

These discrepancies were related to decreased organisational identification of 50.4% and a perceived trustworthiness of 57.5%. Participants witnessed the priority organisation placed on patient care, and efficiency was less than what they thought it should be. The findings suggested that this negative discrepancy affected the person organisation's trustworthiness (POT) and self-efficacy (SE). In other words, the findings indicated newcomers' pre-existing beliefs about their role and their organisation had a significant impact on the success of adjustment in terms of identification with their organisation and perceiving their organisation as trustworthy. Consequently, their organisation's lack of trust affected their perceived ability to do their new role effectively.

3.5.5.2.1.4 Positioning oneself in the new work environment

The findings suggested that in the initial phase of transition, participants attempted to make the shift from their previous role to the new role (Anderson, 2009; Barton, 2007; Brown and Olshansky, 1997; Cubit and Lopez, 2011; Glen and Waddington, 1998; Holt, 2008; Owens, 2018). Positioning oneself entailed accomplishing specific tasks such as preserving relevant skills and knowledge from the previous role while incorporating skills and knowledge of the new role, developing a new role-identity, and focusing on the role and expectations of them. Furthermore, positioning oneself involved proving themselves as competent workers and developing relationships with colleagues, co-workers, and managers, in other words, "fitting in". It also meant navigating the politics and team dynamics (Boyd and Lawley, 2009; Pearson and Care, 2002; Sullivan-Bentz et al., 2010).

Nurse practitioners working in primary care had to balance their increase in autonomy with working collaboratively with family physicians. This tension between autonomy and collaboration proved challenging as the nurses felt that the physicians and other health professionals were not familiar with their role and did not understand their role or scope. The lack of understanding caused inter-professional conflicts, and as a result, one-third of the participants 9/27 left or changed jobs during the study (Sullivan-Bentz et al., 2010).

Holt (2008) conceptualised identity as a central theme for 11 registered nurses during role transition in primary care settings. Holt (2008) described that the transitioning nurses initially struggled to centre their identity in their new roles, such as sister/manager roles, pain management roles, and a rapid assessment role. Holt (2008) argues that the individual's attempts to centre their identity through their attitudes and actions they engage in depending on their specific role, the work context, and the people they are interacting with. Holt (2008)

also states that the individual's education, physical and mental health, values, and beliefs play an essential role.

Similar themes were identified in two qualitative descriptive studies by Anderson (2009) and Boyd and Lawley (2009) when participants transitioned from clinical nurse experts to novice educators. Participants described their experience of positioning themselves in their new role as educators by establishing relationships, learning and unlearning, facing reality, and questioning. Participants described feelings of insecurity regarding their credentials in academia. They also wanted to establish their credibility as educators as part of developing their new identity.

Participants engaged in a cognitive sense-making process to establish their new identity by questioning their decisions to become educators. They also questioned their competence and ability as educators. The findings suggested that participants struggled to relinquish their previous role identity as expert clinicians and develop their new role identity as educators. Another aspect of participants positioning themselves in their new role was establishing relationships with students, colleagues, staff, and administrators.

Interestingly, Anderson's (2009) study found the novice educators viewed their students like their patients by describing the relationship as "therapeutic." This finding indicated that the shift from a care provider identity to an educator identity was still evolving in the early phase of transition.

Similar findings were described by Manning and Neville (2009), whereby eight registered nurses described adapting to their new role as CNE as chaotic and, at times, overwhelming. Participants coped with the new role demands by working long hours and pushing themselves to do better. They wanted to achieve in their new roles and establish their credibility, which

caused them to feel stressed and affected their self-confidence about being able to do the role competently.

Equally, 20 preceptors in a qualitative interpretive study by Miller, Vivona and Roth (2017) described their experience of positioning themselves as preceptors when they changed roles from expert nurses to become preceptors. Positioning themselves in their new role entailed bringing forth other characteristics such as mastering patience, listening intently, spending more time with preceptees, facilitating their learning, and being a role model for their preceptees.

3.5.5.2.2- Super-ordinate theme two 'Adaptation and change'

In this second super-ordinate theme, *'adaptation and change'* participants described gaining confidence in themselves and their skills and competencies by the end of their first year of transition (Anderson, 2009; Ashley et al., 2017; Barton, 2007; Bombard et al., 2010; Dearnley, 2006; Simpson et al., 2006; Sullivan-Bentz et al., 2010). The growing confidence was manifested in their work by acting on their clinical judgment, implementing complex protocols, and adding new skills in their new roles. This super-ordinate theme incorporates five subthemes: Facing reality / the encounter phase; Enacting and shaping the role; Learning and unlearning; Developing a new role identity and, Building a support network.

3.5.5.2.2.1 Facing reality / the encounter phase

All participants who moved from acute care to primary health care settings realised that the context of working in community care was very different from working in acute care settings. The key differences between the two types of nursing were the focus of care and the level of autonomy (Pearson and Care, 2002). In a hospital setting, the focus was narrow on the patient, whereas in a community care setting, the focus was broader, as discussed earlier.

The other key difference was the level of autonomy. District nursing had a high level of autonomy where nurses did not have easy access to other health professionals, while nurses working in hospitals could consult other staff members on the ward or members of the multidisciplinary team, should they need to (Zurmehly, 2007). Being autonomous and working independently empowered these nurses. Nurses felt they were responsible for making sound clinical judgments and implementing effective treatment without returning to check with a matron or with a colleague (Zurmehly, 2007). In contrast, a study by Ashley et al. (2017) found that some of their 13 participants described feeling less autonomous in small GP surgeries, where the practice owners and the managers took decisions.

Facing the new role and work environment's reality was also noted in Holt's (2008) study findings. The nurses focused on what they should be achieving within their role and what was expected of them. Participants realised that the new role necessitated losing part of their old role and adding parts to their new role. However, in the encounter phase, participants' expectations may clash with the reality of their new role, as in Anderson's (2009) study on nurses who became educators, as discussed earlier. To meet the new role's challenges, participants learned to look for resources, handle technology, navigate the politics, and reflect on their students' experiences. Participants had to learn to resolve any unrealistic expectations. They also learned to renounce their old roles as experienced registered nurses and embrace their new role as novice clinical educators (Manning and Neville, 2009). Considerable adjustments had to be made, such as learning and unlearning, changing self, developing a new identity and work-life balance.

As for nurses who commenced a preceptor role, providing feedback about nurses' progress, assessment, and evaluation, and increased workload were among other challenges participants had to face and overcome in their new roles (Miller, Vivona and Roth, 2017).

3.5.5.2.2.2 Enacting and shaping the role

The subtheme of enacting and shaping the role encompassed three sub-themes 'transition to nursing in the community,' 'transition to educators,' and 'transition to specialists.' These transitions are discussed separately and specifically because the transition experiences differed from one group to the other.

a) Transition to nursing in the community

Participants in the studies investigating nurses' transition in the community (Holt, 2008; Pearson and Care, 2002; Simpson et al., 2006; Sullivan-Bentz et al., 2010; Zurmehly; 2007) described several features that related to their new role working in community care settings. These features were: flexibility, organisation, a vast amount of paperwork, resources, and traveling. Participants embraced their new role and learned how to organise their time and to use the available resources. Productivity was identified as a key outcome of being organised (Simpson et al., 2006). Participants realised that their new role as community nurses encompassed the clinical and social aspects and that the role's social aspect significantly increased in a community context (Pearson and Care, 2002; Zurmehly, 2007).

The nurses enacted their role by interacting with patients and their families, carrying out assessments, and providing treatment. They also educated patients and their families and worked with allied health professionals and physicians to ensure patients' needs were provided (Owens, 2018; Sullivan-Bentz et al., 2010). Participants cited that their frequent meetings and discussions with their preceptors and physicians and constructive feedback had helped their learning and supported their development of the competencies required to enact their new role (Ashley et al., 2017; Simpson et al., 2006).

Enacting the role was a dominant theme in Holt's (2008) study findings. Participating nurses wanted to do the role as anticipated and expected of them by the manager, the team, and their patients but struggled with reduced resources, including time, which sometimes led to feelings of frustration and stress. Shaping the role was evident in 70% of the interviews (Holt, 2008). Participants acknowledged the role loss and experienced grief; they also integrated role expansion and experienced a sense of accomplishment. They shaped their role by delegating part of the role and expanded the role by adding new knowledge and skills.

Participants working in the community reported increasing self-confidence by the end of their first year (Holt, 2008; Sullivan-Bentz et al., 2010). Instead of feeling overwhelmed and anxious, they reported more confidence in their ability and competence (Ashley et al., 2017; Simpson et al., 2006). While nurses worked collaboratively with physicians and other health professionals, they also worked autonomously (Zurmehly, 2007).

Participants looked for opportunities to improve and promote health care in the community (Pearson and Care, 2002). They also learned how to resolve inter-professional conflicts and educate physicians and other health professionals on their role and scope in practice (Sullivan-Bentz et al., 2010). However, a third of the Sullivan-Bentz et al. (2010) study's participants left their new job because of the inter-professional conflicts and lack of support.

b) Transition to educator/preceptor role

The totality of the transition experience of nurses to educators was described by Barton (2007) in a three-stage process of identity loss, transitional role evolution, and subsequent re-socialisation into clinical practice. Similar stages were described by Anderson (2009), whereby participants went through stages from contemplating the change to feeling overwhelmed to finding balance and regaining confidence. The participants identified and

initiated change, reached out and recognised rewards, developed a vision for their new role, integrated expertise, sought answers, and reacted to students in a more meaningful way.

Connecting to preceptees was developed by preceptors in Miller, Vivona and Roth's (2017) study. Participants had to change and modify their teaching style to fit their working relationships as they interacted with various personalities with different learning styles.

These studies provide insight into the process of adaptation of the participants to their new work- role. The findings suggested that newcomers were proactive agents during the process of adjustment. They made sense of their new work-environment and proactively changed aspects of their behaviours to enact their role effectively and fit in. Thus, interpersonal relationships and how newcomers related to others in their new work-role were essential aspects of successful adjustment.

c) Transition to a specialist

Clinical nurse specialists in two qualitative studies by Glen and Waddington (1998) and Seng, Sanubol and County (2004) learned to practise autonomously, set work targets, prioritise different tasks, and balance their skills and targets with team and organisational priorities. They also learned to manage intra-professional conflicts as part of their role.

Participants also found that multiple expectations were placed on them from staff, colleagues, managers, and themselves as they became specialists. They learned to seek support and accept constructive criticism from other professionals. They also were eager to evaluate their performance and continue their professional growth.

3.5.5.2.2.3 Learning and unlearning

The subtheme, 'Learning and unlearning,' emerged from many studies. The participants identified the new environment along with the new responsibilities. Learning to negotiate intra-role conflict and intra-professional relationship conflicts was one of the significant tasks all participants had to do (Anderson, 2009; Ashley et al., 2017; Holt, 2008; Manning and Neville, 2009; Miller, Vivona and Roth, 2017; Pearson and Care, 2002; Simpson et al., 2006; Sullivan-Bentz et al.,2010; Wenner and Hakim, 2019; Zurmehly, 2007). Doing these tasks proved challenging in the transition period, mostly when the role was unclear and participants were eager to please (Ashley et al., 2017; Zurmehly, 2007).

Participants who took their new role as educators realised that they had to learn the language of academia, learn about the new environment, the hierarchical system, the role responsibilities, and the knowledge and skills to enact the new role in the academic community. Academic evaluation and academic advising were common themes that kept emerging from participants' accounts (Anderson, 2009; Manning and Neville, 2009; Wenner and Hakim, 2019).

Keeping up was a theme identified by Anderson (2009) and Boyd and Lawley (2009) in their qualitative studies. Participants expressed their strategies and efforts to keep up, which meant to be ahead of the students and prepare for the lessons. This phase was characterised by adjusting to the new work setting and its demands.

The adjustment included reducing their clinical hours for participants who also maintained clinical practice to accommodate the new workload and establish priorities (Wenner and Hakim, 2019). Participants expressed the need for feedback as important to know whether they were on the right path. Mentors and colleagues were identified as a critical source of

feedback for participants. Feeling more confident in their role was ascribed to gaining knowledge and learning new skills (Anderson, 2009; Boyd and Lawley, 2009).

Participants who became educators recognised the cultural and functional differences between the academic and clinical settings. They had to unlearn their previous ways of being with patients and learn a new way of relating to their students, colleagues, and the academic community (Anderson, 2009; Boyd and Lawley, 2009; Manning and Neville, 2009).

Reacting to students was another characteristic that occurred throughout the transition time. Reacting to students involved in generational differences, working with at-risk students, international students, and students enrolled in the accelerated program (Anderson, 2009). Participants also learned to handle students' feedback, especially negative feedback, which profoundly affected most of them. Positive feedback was also acknowledged and helped participants identify more with their identity as educators (Anderson, 2009; Boyd and Lawley, 2009).

The same theme emerged in Manning and Neville's (2009) study findings as participants had to learn to relate to their colleagues who once were their equal but to whom they now were senior. They learned to communicate and interact in their new role in a new way and develop a new relationship with their colleagues.

Participants also reported in their new role as CNE, they had to learn and understand more about the organisations and how they operated via attending meetings and getting involved at the management level, and learning about the politics of the roles, the organisations and how they were interrelated (Wenner and Hakim, 2019). They also learned that their skills were transferable to other senior roles. Participants felt overwhelmed by learning a new set of skills, developing new relationships, and developing their new role identity as CNE took

time, mental and psychological effort (Anderson, 2009; Boyd and Lawley, 2009; Manning and Neville, 2009; Wenner and Hakim, 2019). For educators who still held their clinical nurse role, they had to learn to balance attending the learning needs of the preceptees and meet the daily needs of work demands of their nursing work (Miller, Vivona and Roth, 2017).

Nurses who moved to work in the community care services realised it was essential to be confident and competent in their skills and knowledge to make sound clinical judgments and implement effective treatment (Pearson and Care, 2002; Zurmehly, 2007). Educating patients and their families was an essential feature of the community nurse role, and nurses realised they had to learn about their client's culture and the environment and respect it (Holt, 2008; Zurmehly, 2007). Participants acknowledged it was a steep learning curve (Ashley et al., 2017; Simpson et al., 2006; Sullivan-Bentz et al., 2010; Zurmehly, 2007). Another challenge of working in the community was to learn to assess and use the available resources, time management, and being organised (Pearson and Care, 2002; Simpson et al., 2006; Sullivan-Bentz et al., 2010; Zurmehly, 2007).

3.5.5.2.2.4 Developing a new role identity

Developing a new role identity was a recurring theme in most studies. Participants had to reconcile and integrate different aspects of their old identity to develop and embrace their new identity, the self, the role, the new group, and the organisation. In the transition phase, participants experienced uncertainties regarding their professional identity (Barton, 2007).

This phase was marked by a sense of identity loss (Bombard et al., 2010) as they shed their old identity and yet struggled to inhabit a new identity associated with their new role (Holt, 2008). This uncertainty phase was followed by evolving their new roles and new identities (Ashley et al., 2017). Barton (2007) described an incorporation phase, where the student nurse practitioners began to reconcile their new role with their clinical world, became more

confident, established their new identity, and positioned themselves within existing workplace hierarchies. Student nurse practitioners began to select role models from the multi-professional context. They observed experienced nursing staff and selected professional traits, behaviours, and attitudes to merge into a new role construct.

Similarly, Holt (2008) suggests that a successful role transition can be facilitated by recognising that transitioning individuals struggle to centre their identity in their new role. The transitioning individuals must reconcile and integrate the different identities and develop them. For example, they lose parts of their old role and gain parts of their new role; the sense of self also becomes unclear. The professional role can be part of the person's identity. Letting go of the previous work-role and embracing a new role is very much affected by a person's identity and what the person is going through during their transition from role loss and role expansion and how this impacts them and their sense of self and identity.

Owens (2018) suggested that participants experienced a role identity transition from registered nurses to nurse practitioners while enrolled in their nurse practitioners' programme, which continued throughout their first year of rural nurse practitioner clinical practice. The change in role identity facilitated them enacting and shaping their new role as nurse practitioners with its broader scope. Nurses saw themselves as care providers to their clients rather than registered nurses treating health problems.

Participants reported that their relationships with their patients, nursing staff, and other health care providers were crucial in defining their new professional identity as nurse practitioners. They also reported that their mentors' and supervisors' support was an essential factor in helping them bridge the gap between their old role and their new role by providing them with encouragement, feedback, knowledge, and support.

In contrast, findings reported by Anderson (2009) and Boyd and Lawley (2009) indicated that participants established their new identity as educators later on by integrating new skills, knowledge, and values of the new role, as well as coping with the loss of the expert status. This could be because the role of an educator was very different from a nurse practitioner role. Participants in their new role as educators moved beyond focusing on themselves to identifying and initiating change such as in course sequencing or plan of study, observation of students' performance, creativity, and changing aspects of the job.

3.5.5.2.2.5 Building a support network

Building a support network was a recurring theme as well in almost all the studies (Anderson, 2009; Glen and Waddington, 1998; Manning and Neville, 2009; Owens, 2018; Seng, Sanubol and County 2004; Simpson et al., 2006; Sullivan-Bentz et al., 2010; Wenner and Hakim, 2019).

For example, in Owens (2018), participants established a good relationship with nursing staff; other healthcare providers in the rural areas, social experiences, and close relationships with their patients made it a successful transition experience. These social interactions between the participants and their new environment facilitated their learning and identity development.

Likewise, Boyd and Lawley (2009) and Manning and Neville (2009) indicated that participants found it challenging to cope with the newness of their role and the loss of their security as expert clinicians that disturbed their professional identity. They reached out for support from other, more experienced CNEs who filled the roles of mentors. With their mentors' support, participants came to terms with being promoted to CNE and grew in their confidence and ability to function appropriately in their new role. These social relationships facilitated participants to embrace their new identity as CNEs.

3.5.5.2.3 Super-ordinate theme three 'Facilitators and barriers of successful transition'

Data analysis of the studies included in this review identified several factors that facilitated or impeded successful adjustment to a new work role. Facilitating factors included: adequate induction and socialisation to the role and the organisation (Ashley et al., 2017; Holt, 2008; Smith et al., 2017), mentoring (Pearson and Care, 2002; Simpson et al., 2006), role clarity (Glen and Waddington, 1998; Khoza, 2005; Owens, 2018), prior occupational experience (Boyd and Lawley, 2009; Miller, Vivona and Roth, 2017; Seng, Sanubol and County, 2004; Wenner and Hakim, 2019), pro-activity (Anderson, 2009; Dearnley, 2006; Manning and Neville, 2009), and self-reliance (Barton, 2007; Seng, Sanubol and County, 2004; Sullivan-Bentz et al., 2010; Wenner and Hakim, 2019).

Barriers included the inadequacy and absence of the facilitating factors as well as resistance to change (Barton, 2007; Bombard et al., 2010; Boyd and Lawley, 2009; Dearnley, 2006; Glen, and Waddington, 1998; Manning and Neville, 2009; Owens, 2018; Seng, Sanubol and County, 2004; Wenner and Hakim, 2019). In this next section, the factors that frequently emerged in the studies as facilitators or barriers are discussed.

3.5.5.2.3.1 Induction and mentorship

Proper and adequate induction, orientation, and mentorship stood out as the most critical factors contributing to successful adjustment following work-role transition (e.g., Ashley et al., 2017; Khoza, 2005; Owens, 2018; Pearson and Care, 2002; Simpson et al., 2006). Mentors served as a valuable resource and support during participants' transition. Good mentorship provided encouragement, support, guidance, modelling, linking theory to practice, and constructive feedback (Simpson et al., 2006; Wenner and Hakim, 2019).

Participants believed in the importance of having a mentor and orientation to the health care facility (Owens, 2018). They cited training and mentoring by preceptors who were knowledgeable and skilled facilitated adjustment to community care services (Simpson et al., 2006). As for nurses who became educators, mentoring was one of the most important factors that facilitated adjustment through interactions, preparation programmes, and face-to-face presentations (Wenner and Hakim, 2019).

3.5.5.2.3.2 Pro-activity and self-reliance

Most participants' accounts suggested that they were proactive during their transition to their new role (e.g., Bombard et al., 2010; Dearnley, 2006; Owens, 2018; Sullivan-Bentz et al., 2010). For example, in Sullivan-Bentz et al. (2010), the transitioning nurses were proactive and designed their practices, and educated other health professionals on their role as nurse practitioners. Participants stated that the familiarity of colleagues, physicians, and employers with the role of nurse practitioner and its scope of practice was an important factor in successful role transition. Furthermore, they identified their own needs and planned their programmes of continuing education.

Likewise, Owens' (2018) participants were self-directed active learners, proactive in their adjustment following their transition by gaining knowledge and skills necessary to enact and shape their new role as family nurse practitioners in rural health care services. Dearnley (2006) described his participants' journey during their transition from second to first level nurse registration. First, they were silent, passive, and dependent, but gradually they gained confidence in themselves and their professional skills. They became proactive and took responsibility for learning, integrating knowledge, and working independently.

3.5.5.2.3.3. Prior occupational experiences

Findings of several studies in this review indicated that prior occupational experience helped nurses adjust to their new roles. Participants recognised that their previous occupational experience mitigated or eliminated the stressors over their first year of transition (Anderson, 2009; Ashley et al., 2017; Boyd and Lawley, 2009; Glen and Waddington, 1998; Seng, Sanubol and County, 2004; Sullivan-Bentz et al., 2010). Seng, Sanubol and County (2004) found nurses in their new SANE role described the contribution of prior experience of observing, assisting examinations, and using their usual coping skills helped them get past the first examination and finding satisfaction.

Nurses in other studies reported having years of prior occupational experience helped them meet the new role's challenges as nurse practitioners, for example, working in an intensive care unit or an accident and emergency department (Ashley et al., 2017; Sullivan-Bentz et al., 2010), medical and surgical wards (Simpson et al., 2006), clinical experience as registered nurses (Owens, 2018). The nurses' clinical expertise provided a base to add on and link past learning experiences and new knowledge, understanding, skills, and competencies. It also made it easier to transfer theory into practice as they felt confident in their new role and felt less stressed.

Similarly, nurses who took an educator or preceptor role indicated that prior clinical experience positively influenced their adjustment to their new roles. It was integrated into the new teaching experience by bringing the reality of practice to the content and skills taught to the students (Anderson, 2009; Boyd and Lawley, 2009; Miller, Vivona and Roth, 2017). Nurses brought with them knowledge, interpersonal skills, and general abilities (Wenner and Hakim, 2019), which laid the foundation for participants' teaching careers.

However, in one study by Cubit and Lopez (2011), previous experience as an enrolled nurse was not helpful in their transition to registered nurse (RN). It caused them anxiety, fear, and worry. The new RNs preferred not to be identified as having previous nursing experience because they feared being perceived by their ward managers as already capable of practising as RNs.

3.5.5.2.3.4 Barriers to adjustment

Several barriers to adjusting to a new work role were identified in this review, such as inadequate or insufficient induction or orientation (Barton, 2007), lack of adequate role modelling (Bombard et al., 2010), or mentoring (Cubit and Lopez, 2011), lack of support from managers (Khoza, 2005), training barriers (Pearson and Care, 2002), inter-professional conflicts (Sullivan-Bentz et al., 2010) and not having a sense of control or authority over ones' role (Ashley et al., 2017; Khoza, 2005).

In Sullivan-Bentz et al.'s (2010) study, most of the 27 participants reported the lack of preparation for integrating nurse practitioners into primary care clinical settings, poor mentorship, non-existent orientation, and their colleagues and employers' lack of awareness of their role made their transition difficult. A third (9/27) of the participants left their role due to interpersonal conflicts and lack of acceptance of their role within the new practice environment.

Participants identified that professional relationships with family physicians were essential in easing their transition experience to a primary health care setting. Sullivan and colleagues (2010) argue that a successful transition for nurse practitioners to primary health care can be facilitated by preparing the health care services to work with and support the nurse practitioners in their work environment. However, the rapid changes in primary health care make it difficult.

A descriptive survey by Khoza (2005) of newly employed nurses revealed that 63% felt that they did not have much authority and freedom to make decisions, and authority was only in seniors' hands. 57% agreed that intra-professional conflicts were poorly managed, 54% felt management was not supportive, and 63% indicated too many rules, regulations, and standard procedures.

Inter-professional conflicts, the existence of workplace bullying, and incivility, negative remarks, and negative feedback were identified as important factors that drive people to leave their jobs (Miller, Vivona and Roth, 2017; Sullivan-Bentz et al., 2010). Other factors also identified as hindrances to successful adjustment, such as lack of communication and lack of information on how to teach (Wenner and Hakim, 2019) and resistance to change (Boyd and Lawley, 2009; Glen and Waddington, 1998).

3.6 Discussion

This review's findings support the seminal works on work role transition (Ashforth, 2001; Bridges, 2004; Nicholson, 1984; West and Rushton, 1989) that adjustment to a new work role is a collaborative process that includes several factors. Specifically, these were organisational socialisation in terms of induction and orientation to the new role, prior occupational experiences, and the individual's motivations.

The transition process's psychological perspective was evident in all the studies, whereas the focus was on coping with transition's emotional aspects. The psychological transition included having expectations, experiencing anxiety at the early phase of transition and then regaining confidence in themselves and their competencies, facing reality and overcoming challenges of the new role and the new work environment (Ashforth, 2001; Bridges, 2004; Nicholson, 1984; West and Rushton, 1989).

This review findings also emphasised the cognitive aspects of transition, encompassing contemplating the change, asking questions, thinking processes such as critical thinking, analysis, drawing conclusions, seeking feedback, weighing alternatives, and making decisions. As described in the literature (Ashforth, 2001), the social aspects of transition were evident in most of the studies that emphasised new role identity development.

The relational elements involved in establishing oneself in a new role were recognised in this review. For example, fitting in and establishing relationships, seeking support, and managing inter-professional conflicts. The learning aspect of the transition was also reported in all the studies including shadowing, observing, seeking knowledge, training, and learning new skills.

The empirical literature on nursing transition is commonly limited to graduate student nurses' transition experience to staff nurses and less often on staff nurses' transition to nurse specialists. In contrast, the integrative review presented here was broader in its focus. It included several recent studies on nurses' transition experience moving from acute care to community care setting, from nurse role to educator role in academia, and from registered nurses to specialist nurses and nurses moving to work in rural areas. The inclusion of various groups in different countries provides a new perspective of nurses' transition experience.

Although the core experiences were similar for the various groups, there were differences in how they dealt with their situation. The results of this review suggest that the majority of participants in all the groups experienced feelings of anxiety and uncertainty in the early phase of transition, which ranged from a few weeks to a few months, such as in Ashley et al. (2017) and in some studies continued for the first year on the job (e.g., Anderson, 2009; Pearson and Care, 2002; Simpson et al., 2006; Zurmehly, 2007). The findings support previous research on emotional upheaval of role transition (Menzies, 1960) and lend support

to Van Maanen and Schein's theory (1979), where they described a culture shock or surprise for newcomers (Louis, 1980).

Several factors have been reported that contributed to participants' feelings of anxiety. Firstly and most significantly was the inadequate socialisation and ill preparation for their new role as it was discussed across the different groups (e.g., Anderson, 2009; Ashley et al., 2017; Barton, 2007; Bombard et al., 2010; Holt, 2008; Manning and Neville, 2009; Miller, Vivona and Roth, 2017; Owens, 2018; Pearson and Care, 2002; Sullivan-Bentz et al., 2010; Wenner and Hakim, 2019; Zurmehly, 2007).

Most participants had little preparation and inadequate socialization to their new work role. Lack of orientation to their new role and the new work environment made the transition feel difficult. The findings of this review support previous studies on the significance of organisational socialisation in reducing anxiety and stress for newcomers during transition and facilitating adjustment (Ashford and Cummings, 1985; Ashforth and Saks, 1996; Black and Ashford, 1995; Feldman, 1976; Feldman and Brett, 1983; Katz, 1985).

The results of this review confirmed that mentorship of nurses in their first year of transitioning to a new role had a positive effect on adjustment to the new role. Preceptors played a crucial role in facilitating nurses' transition experience into specialist roles. Participants reported that having mentors/ preceptors was an important resource for guidance, support, and feedback (Anderson, 2009; Miller, Vivona and Roth, 2017).

Additionally, timely constructive feedback and frequent meetings helped nurses identify practice gaps and apply knowledge, skills, and attitudes competently. Mentors and preceptors encouraged reflective practice, critical thinking, and learning as a means through which to reinforce practical knowledge and skills (Simpson et al., 2006; Sullivan-Bentz et al., 2010; Wenner and Hakim, 2019). Therefore, this review adds weight to calls for effective

induction and orientation programmes, effective mentoring, and effective preceptorship programmes.

Mismatched expectations between participants and their experience of reality was a common theme in this review supporting other studies such as Porter (2013), Siler and Kleiner (2001), West and Rushton (1989). In this review, negative discrepancy of expectations and reality led to disappointment and frustration (Anderson, 2009; Glen and Waddington, 1998; Manning and Neville, 2009; Smith et al., 2017; Sullivan-Bentz et al., 2010). However, positive discrepancy of expectations and reality led to satisfaction and tenure (Zurmehly, 2007).

Striving for a new professional identity was evident in almost all the studies. However, developing a new identity following transition was not always achieved, resulting in an unsuccessful transition (Bombard et al., 2010). Therefore, it is crucial to identify the elements that impede a new identity development.

This review also highlights the barriers to successful work role transition, such as heavy workloads, lack of support, inadequate induction and orientation, and inadequate preparation for the new role. These results support previous studies on the barriers to adjusting to new work-roles in nursing (Freeney and Tiernan, 2009; Siler and Kleiner, 2001; Torrens et al., 2020).

This review identified that the quality of social exchange and interpersonal relationships between nurses and group members moderates for work-role adjustment. These results suggest that the workplace's social dynamics were the most troublesome aspect for some participants, such as in Sullivan-Bentz et al.'s (2010) study.

These study results support previous studies on inter-professional conflicts and their negative impact on newcomers' adjustment and tenure (Cullati et al., 2019; Kinston, 1983). Therefore, organisations should reduce inter-professional conflicts by creating and developing strong communication channels and providing conflict resolution training, especially for team leaders, and educating team members about the new employee's role and scope (Huan and Yazdanifard, 2012).

Prior occupational experience and the transfer of learning in this review have been found to facilitate smooth transition. Several studies suggested that participants could use their prior occupational experiences as anchors to mitigate stress (Glen and Waddington, 1998; Melrose and Gordon, 2011; Miller, Vivona and Roth, 2017; Seng, Sanubol and County, 2004).

Data analysis results confirmed that all participants expressed a need to learn new skills and add knowledge to enact their new role, whether as educators, nurse practitioners, clinical nurse leaders, or nurse specialists. This review supports findings of other studies such as Elliott (2010) and Bain and Moggach (2019) that it is necessary to develop community-based skills to equip nurses to work in the community appropriately. It is also essential to educate and familiarise the community health teams with the nurse practitioner's role to facilitate their integration, provide clear job descriptions, and cater to their educational needs. The context surrounding the responsibilities and roles of community nurses differs significantly from those of nurses in an acute care setting whose previous experiences may not have provided these transitioning nurses with the necessary skills to function in the community (Holt, 2008; Owens, 2018; Pearson and Care, 2002; Simpson et al., 2006; Sullivan-Bentz et al., 2010; Zurmehly, 2007).

All participants who moved to community health care services indicated that CHC nurses had a broader focus of care than acute care nursing and, as such, had different continuing

educational needs. They expressed a need for resource management, training, and better preparation to practise in the community setting. It may be more feasible to focus on distance learning, online discussions with mentors, and practical courses that meet their educational needs (Pearson and Care, 2002).

This review found that transition from urban to rural areas of community nursing was an under-researched area worthy of further investigation. Owens (2018) found nursing in this new environment caused isolation and delayed adjustment.

This review identified that nurses who moved to become educators need training in specific competencies such as assessment, evaluation of students' competencies, and training on adult learning (Anderson, 2009; Manning and Neville; 2009; Miller, Vivona and Roth, 2017; Wenner and Hakim; 2019). The results of these studies provide insight into the process of adjustment as newcomers felt more confident and more secure in their new environment; they became more proactive and took on a wide range of professional, interpersonal, and integrative tasks. This is contrary to the belief that newcomers are passive recipients of organisations' norms and values (Van Maanen and Schein, 1979). Arguably, by creating a work environment for newcomers that is supportive and safe, the newcomers will strive to satisfy their competence, autonomy, and relatedness, positively affecting their job satisfaction and tenure (Borda and Norman, 1997).

3.7 Review conclusion

This integrative review provided an overall view of the literature on work-role transition for nurses from different perspectives. Twenty-five primary research papers were retrieved following a systematic literature search process. Following a detailed appraisal of each paper and subsequent data extraction and analysis, three super-ordinate themes were identified related to this review's aims. Specifically, these were: Learning & sense-making of the new

role within the organisation; Adaptation & change, and Facilitators & barriers to successful transition.

The literature on nurses' transition to primary care focused on developing a new identity, enacting and shaping the role (Holt, 2008), training and educational needs (Pearson and Care, 2002), stages of transitional practice (Simpson et al., 2006), the broader focus of care in community settings (Zurmehly, 2007), the challenges nurses encounter integrating in primary care (Sullivan-Bentz et al., 2010) and the role of nurse practitioner in rural areas (Owens, 2018).

The studies that explored nurses' transition to educator role focused primarily on the different stages of transition from expert nurses to novice educators and the challenges along the way (Anderson, 2009; Boyd and Lawley, 2009; Manning and Neville, 2009; Wenner and Hakim, 2019). In a similar vein, one study on preceptorship (Miller, Vivona and Roth, 2017) focused on the transfer of learning and positioning themselves as facilitators of learning. The third group of studies explored the transition for registered nurses to specialists focusing on autonomy, maintaining clinical competence, transfer of skills and expertise, and role-specific stressors (Glen and Waddington, 1998; Seng, Sanubol and County, 2004).

Three quantitative survey-based studies provided insight into the elements of organisational culture that had an impact on the adaptation of newly employed nurses to the work environment (Khoza, 2005) and the impact of pre-entry beliefs about institutional practices on newcomer socialisation in a healthcare context (Smith et al., 2017). Ashley et al. (2017) identified the difficulties of transition to a new work role in primary health care settings and highlighted the role of support in facilitating adjustment.

This review confirmed that the core experience of transition for the different nursing groups was similar; however, each group had its unique educational needs, orientation programmes,

training and preparation programmes, and support system. Secondly, different nursing groups encountered different challenges according to their specific new roles. Thirdly, while there is a plethora of literature on nurses' transition, there is little or no evidence of similar transition experiences for experienced professionals like psychotherapists, counsellors and allied health professionals.

3.8 Recommendations

Formal induction and orientation were identified as the most critical factors for successfully transitioning to a new work role. Therefore, providing adequate preparation by formal induction and tailored orientation programmes to the new work role and what it entails is essential. Mentors and preceptors are valuable resources to facilitate newcomers' adjustment by modelling, guiding, and enhancing the learning process.

Throughout their first year of transition, supporting the individual is paramount by providing opportunities to discuss and explore role loss and expansion effects upon them. It is also crucial to recognise and utilise skills and knowledge the individuals bring as resources and explore opportunities for learning for further progress and development to enhance role progression. Finally, creating a non-threatening environment characterised by openness, respect, and trust promotes collaboration and reduces inter-professional conflicts.

3.9 Recommendations for future research

While this review provides a critical synthesis of the available literature, it also highlights the need for more research in this area. Research on the transition experience for experienced practitioners and allied health professionals was identified as a significant gap in the literature, and this topic is worthy of future research. Further research is also required to

investigate the causal relationship of perceptions of organisational trustworthiness and organisational identification for newcomers.

This review highlights the variation in the standard of the training programmes for preceptees, which affected their adjustment to their new role. Research on these training programmes and standards would be a valuable addition to the evidence base. Similarly, research into rural nurses' continuing educational needs and ways to facilitate their professional development may help optimise this under-researched group's transition and working experiences.

3.10 Relevance of literature review to research questions

This integrative review synthesised the literature on nurses' transition to a new work role in healthcare settings provided an important backdrop to studying a similar group of registered professionals. Specifically, the transition experience of non-IAPT qualified therapists moving into IAPT services. This literature review provided insight into how nurses experienced their role transition in the healthcare context and what helped or hindered their adjustment. One of the critical findings from this review was the lack of in-depth critical investigation of how the transitioning individuals made sense of their transition experience and what it meant for them.

In addition, this review has confirmed the gap in the evidence base and justifies a study about counsellors, psychotherapists, and psychologists' transition experiences to IAPT services and if these are similar or unique from the nursing profession. Such empirical findings can improve working conditions and job satisfaction in a role that suffers from significant challenges in staff retention.

3.11 Chapter summary

This chapter presented the findings of an integrative literature review about the transition experience of registered nurses moving into new roles, be that specialist, leadership, or academic. While previous reviews have focused on single types of role transition, most notably the transition from student to registrant, this review provides a more advanced understanding of transition for more experienced nurses. Although this integrative review was comprehensive in its review of nurses' transition experience, the lack of evidence for similar transition experiences for counsellors, psychotherapists, and psychologists was stark. More specifically, in the context of a struggling workforce, like IAPT, evidence that would improve work role transition, job satisfaction, and retention is essential. The subsequent chapter will present the methodology used to investigate therapists' transition experience to IAPT services.

Chapter 4 Methodology

4.1 Introduction

The methodology chapter begins with a brief overview and justification for a qualitative approach underpinning the empirical work conducted within this thesis. The suitability of adopting a phenomenological approach for in-depth exploration of therapists' transition experience to IAPT services is discussed. The use of Interpretative Phenomenological Analysis (IPA) in this study as a phenomenological approach to answer the research questions and meet the aim and objective of this thesis is discussed and defended. This chapter discusses the limitations of IPA and how these have been mitigated to enhance this study's rigour.

4.2 Qualitative Research Approach

Qualitative research explores and understands the meanings people assign to their experiences (Tuffour, 2017). It seeks an in-depth understanding of social phenomena within their natural setting (Ashworth, 2015). Qualitative inquiry is inductive as it seeks to understand the phenomenon from the participant's perspective and how they experience it themselves, which means it takes the insider's view (Conrad, 1987).

The common assumptions in qualitative research are that knowledge is subjective rather than objective, and researchers explore and understand detailed, in-depth views of complex processes of human experience (Ashworth, 2015; Smith and Osborn, 2015; Tuffour, 2017). Different qualitative approaches have different but overlapping epistemological underpinnings and theoretical and methodological emphases (Smith, 2004).

4.3 Rationale for choosing a qualitative method in this study

This thesis is interested in exploring and understanding how therapists experience adjustment following transition to IAPT services and the rewards and challenges they encounter during their adjustment. Therefore, the rationale for adopting a qualitative approach in this thesis was to understand the participants' subjective work-role transition experience. Qualitative research is beneficial when little is known about a topic (Austin and Sutton, 2014), and in this case, there is no published literature, making qualitative methodology particularly useful in this context.

Unlike positivist research into work-role transition that focused on measuring the variables said to be factors in work-role adjustment, this study investigated the subjective experience of work-role transition from the therapists' perspective and what it meant to them.

While a descriptive quantitative survey may have offered findings such as opinions and views within objective measurements to collect descriptive data (Borg and Gall, 1989), it may not have allowed exploration of the complex transition phenomenon. However, the absence of an insider's view of the experience of transition to IAPT services of this group of therapists was most compelling. IPA has been specifically selected for this study to allow rigorous exploration of the participants' idiographic subjective experiences. The following section introduces phenomenology, hermeneutics, and idiography as IPA's three theoretical underpinnings before introducing IPA.

4.4 Introducing Phenomenology

Phenomenology and its research methods are a branch of philosophy concerned with the structure of human experience (Langdridge, 2007). The phenomenological approach

originated in Edmund Husserl's writing and was later developed by Martin Heidegger (Husserl, (1970[1936]); Laverty, 2003; Smith and Osborne, 2003).

Phenomenology focuses on the world as encountered from a "first-person" standpoint and is broadly focussed on the "Lived Experience" of a phenomenon. This lived experience could be sense-based, but the focus might be on an encounter with understanding phenomena in the moral, political, and aesthetic domains (Detmer, 2013). It is beyond this thesis's scope to discuss these philosophers' concepts; therefore, this discussion is focused on how their concepts informed IPA.

4.4.1 Husserl

Husserl's work is significant to IPA because he developed a 'phenomenological method,' intended to identify human experience's core qualities and features (Smith et al., 2009). Husserl proposed the epoche` or bracketing, which is suspending our presuppositions, judgments, and previous knowledge 'our natural attitude' to fully understand our conscious experiences' structure and content. However, suspension of the 'natural attitude' does not mean that the taken-for-granted world disappears. IPA's reading of Husserl's suspension of the natural attitude and advocating a phenomenological attitude is summed up by Zahavi (2003:45): "we keep the attitude, but we bracket its validity."

How feasible it is to engage with the epoché as intended by Husserl fully is a matter of debate among different phenomenological traditions (Biggerstaff and Thompson, 2008; Brooks, 2015; Finlay, 2008, 2011). For example, Donalek (2004:516) argued that "research is not truly phenomenological unless the researcher's beliefs are incorporated into the data analysis." Biggerstaff and Thompson (2008) questioned the need for bracketing altogether in an IPA study as IPA is essentially an interpretative process, which means the researcher

draws on their beliefs, knowledge, and values in the interpretative phase as stressed by Heidegger.

Other authors have argued the case for bracketing as it may prevent unacknowledged emotional experiences resurfacing and affect engagement with data (Drew, 2004). Others argued for bracketing as a way of safeguarding against data negatively influenced by the researcher's own emotional experiences and cognitive biases (Beech, 1999; Creswell and Miller, 2000; Starks and Brown Trinidad, 2007).

In contrast to Husserl's pursuit of pure consciousness that he called *transcendental ego,* an IPA researcher would seek to understand participants' personal lived experience and commit to exploring, critically analysing, and interpreting how they make sense of their own experience. While Husserl was concerned with the essence of experience, IPA is concerned with examining in detail participants' lived experience, in its own terms, situating each participant in their own particular context before making general claims (Smith et al., 2009). Regarding this study, as interpreted through IPA, Husserl's work provided a conceptual argument for exploring subjective personal experiences as a means of developing knowledge and understanding of work-role transition.

4.4.2 Heidegger

Heidegger's contribution changed the direction of phenomenology from Husserl's focus on consciousness towards the question of 'Being' with his philosophical masterpiece *Being and Time,* 1962 [1927] (Moran, 2000). Heidegger was more concerned with existence itself and what it means to live in and among a world that each individual experiences it in their own way (Brooks, 2015; Gorner, 2007; Heidegger, 1962; Moran, 2000; Smith et al., 2009).

One of the significant innovations of Heidegger was the turning of phenomenology in the direction of "hermeneutics." Heidegger's hermeneutical turn was primarily motivated by his conviction that phenomena are not fully accessible to a purely descriptive phenomenology; instead, a method is needed for uncovering what had been covered up and hidden (Moran, 2000). Heidegger rejects Husserl's call for pre suppositionlessness and contends that we cannot help but begin where we are, as historically conditioned beings (Detmer, 2013). Furthermore, Husserl's pure experience is elusive and inaccessible because experience is usually witnessed after the event has already happened (Smith, 2007; Tuffour 2017).

Heidegger argues that we live in a meaningful world, and we have a meaningful relationship with it. In short, we are part of a meaningful world, and the meaningful world is also a fundamental part of us. Heidegger's view that the individual is already involved in a fundamentally meaningful world has several interesting implications for IPA researchers. Heidegger argues that it is impossible to remove ourselves from our meaningful world to find out how things really are. Therefore, for an IPA researcher, Husserl's epoche` becomes problematic and impossible to achieve (Larkin, Watts, and Clifton, 2006).

In a Heideggerian sense, the IPA researcher aims to allow the phenomenon under investigation to show itself 'as itself.' In other words, it is to allow maximum opportunity for the subject- matter to reveal itself on its own terms without imposition of any preconceived assumptions or expectations. However, we fully recognise that we cannot entirely escape from our pre-conceptions, but this should not discourage us from attempting.

Given the inherent epistemological and methodological limitations of IPA, the success of the research is not dependent on revealing the 'pure' experience of the participant; but is dependent instead on doing the most sensitive and responsive job that the researcher can (Larkin et al., 2006).

Critically, and of significance to IPA and its aim to understand people and their experiences, Heidegger proposed that existence is not a thing out there in the world; rather, it is always somebody's existence, personal and owned (Becker, 1992; Moran, 2000). IPA readings of Heidegger's ideas should, therefore, carefully consider individuals- in-context and situations with which they are engaged (Becker, 1992; Smith et al., 2009). Thus, Heidegger's work invites IPA researchers to immerse themselves in participants' world through a lens of cultural and socio-historical meanings. Heidegger's work also prompts IPA researchers to be reflexive in their interpretation concerning their fore understanding of the investigated phenomenon (Tuffour, 2017).

Simultaneously, congruent with Heidegger, IPA recognises the exploration of the meaning of personal experience as an interpretative endeavour on the part of both participant and researcher. Hence, IPA operates within a double hermeneutic, as 'the researcher is trying to make sense of the participants trying to make sense of their world' (Smith and Osborn, 2015, p26).

4.4.3 Merleau-Ponty

Merleau-Ponty (1945) has made the most original and enduring contribution to post-Husserlian phenomenology through his radical description of the experience of embodied human existence (Moran, 2000). Merleau-Ponty radically challenged accepted dualist notions prevalent at the time, arguing that as people are embodied beings, we cannot consider human experience meaningfully detach the mind from body or subject from object (Moran, 2000).

Merleau-Ponty emphasises the active engagement in the world by individuals making choices and imposing meaning. This existential subject replaces Husserl's transcendental ego, leading to his departure from Husserl's phenomenology and reconstruction of his

phenomenology (Hammond, Howarth and Keat, 1991). Merleau-Ponty develops a view of the human subject as essentially 'embodied.' For Merleau-Ponty, we have access to the world through our bodies. He argues that all knowledge that we develop is embodied, knowing that the body is a subject-object and can never be understood as one without the other. It is through the body and bodily experiences that the surrounding world becomes meaningful for us. The body and its embodiment in the world are central to Merleau-Ponty phenomenological philosophy (Moran, 2000). IPA's reading of Merleau-Ponty's embodied phenomenology is that to take into account the bodily experiences of a phenomenon as an integral part of the experience as a whole.

4.5 Interpretation (Hermeneutics)

IPA is strongly connected to the hermeneutic or interpretative tradition as it recognises the researcher's central role in making sense of the participant's experience (Smith, 2004). Smith et al. (2009, p37) summed up the relationship between phenomenology and hermeneutics as articulated in IPA "without the phenomenology, there would be nothing to interpret, without the hermeneutics, the phenomenon would not be seen."

IPA draws on four influential philosophers' theoretical perspectives: Schleiermacher, Heidegger, Gadamer, and Ricoeur (Larkin et al., 2006; Smith, 2007; Smith et al., 2009).

Schleiermacher (1768-1834) offers a holistic view of the interpretation process, which involves linguistic and psychological parts. The linguistic part is mainly concerned with what is common or shared in a language, while psychological interpretation is concerned with the person's individuality (Smith et al., 2009). Schleiermacher's views allow analyses to offer meaning to participants' text. They also offer meaningful insights that may exceed the explicit claims of participants. These meaningful insights added value to the participants'

narrative as partly from connections that emerged from a large data set and partly from a dialogue with psychological theories.

For Gadamer (1900-2002), interpretation is a dialogue between past and present. This is an interesting point; for an IPA researcher to make sense of a text that originated in the past; the interpretation will focus on the meaning of the text in the present when the interpretation is made (Smith et al., 2009). Gadamer emphasises the complex relationship between the fore conception of the interpreter and the text that is interpreted as discussed by Heidegger. Gadamer argues that the interpreter projects a meaning of the text as soon as some initial meanings emerge in the text. Gadamer argues to work out these fore projections as the interpreter penetrates the meaning of what is there in the text (Smith et al., 2009).

Ricoeur (1970) linked phenomenology and hermeneutics by explaining that experience and meaning are closely intertwined. Thus, meaning, in his view, is indispensable to experience. Hence, for both Ricoeur and hermeneutics, experience and language are co-emergent. Language is used for descriptive purposes and as an expressive force of experience (Tuffor, 2017). Ricoeur distinguishes between two broad interpretative positions, a hermeneutic of empathy and a hermeneutic of suspicion. The former approach attempts to reconstruct the original experience in its own terms; the latter uses theoretical perspectives from outside to shed light on the phenomenon (Smith et al., 2009).

IPA takes a central position between the two approaches as long as it is informed by the meaning of the experience. In other words, the IPA researcher attempts to combine the two hermeneutic approaches (empathic and questioning). It could be argued that both approaches complement each other as the empathic approach allows the researcher to be in the participant's shoes and see the world through their eyes while the questioning approach illuminates and makes sense of the phenomenon (Smith et al., 2009).

4.6 Idiographic Inquiry

IPA is fundamentally idiographic; it offers detailed, nuanced analyses of particular instances of lived experience. In other words, IPA is mainly concerned with the study of *specific individuals* as they deal with *specific situations or events* in their lives (Smith, 1999). IPA takes the insider's perspective; this is easier said than done as it is challenging to deliver it in a meaningful way (Larkin et al., 2006). It begins with a detailed examination of each case, based on its own merits, before moving to the general cross-cases analysis. IPA researchers cautiously examine the similarities and differences across the cases. However, these individual cases are examined as 'in-relation-to phenomenon,' i.e., to understand the particular in whatever context that is relevant and not as isolated entities (Sandelowski, 1996). It is possible then to produce an account of shared themes between participants' experiences while distinctive voices and variations can be heard (Smith et al., 2009).

4.7 Rationale for choosing IPA methodology in this study

Several possible qualitative approaches were considered, such as grounded theory, discourse analysis, narrative analysis, and IPA, but after careful review of the philosophical position of each of these approaches, IPA was chosen. When deciding on an approach for this study, the following points were needed to be taken into consideration: a) the purpose of the study, b) the potential sample size, and c) the researcher's insider position.

The study's purpose was to explore and understand non-IAPT qualified therapists' transition experience to IAPT services and give them a voice to tell their story and what it meant to them. The potential sample size was a small number of participants, knowing that recruiting participants would be challenging given the study's topic. In addition, the researcher's insider status who shared the same social group, organisation, and culture may be advantageous. Having pre-existing knowledge of the research context could enable the

researcher to project a more, authentic understanding of participants' experience, as discussed earlier in Chapter One. Therefore, with its phenomenological, ideographic, and hermeneutic aspects, the IPA approach was considered the best fit for this study, as illustrated in the Table below.

Table 9 The transition experience of therapists to IAPT services as seen through different qualitative approaches.

Approach	**Features**	**Purpose**	**Research Questions**
Grounded Theory	Combination of positivistic and interpretative elements to give an explanatory account of a particular phenomenon.	To develop theory grounded in the study data.	What factors determine successful adjustment following work-role transition?
Discourse Analysis	Interaction	To understand how language is used in real-life situations.	How does talk facilitate adjustment in work role transition?
Narrative Analysis	Focus on the content or structure of a narrative to create meaning.	To identify the kinds of stories told about the researched phenomenon and the kinds of stories representing the phenomenon in culture and society.	How do the stories that therapists tell about themselves and their experience in IAPT services shape the work-role transition process?
IPA	Emphasis is on the personal meaning of a particular group of people in a particular context.	To explore in detail how participants are making sense of their personal and social world and the meanings of particular experiences, events, and states hold for them.	How do therapists experience and make sense of work-role transition to IAPT services?

Before adopting IPA as a methodology for this study, a literature search for studies that used IPA to investigate work-role transition was carried out. The search aimed to evaluate IPA's strengths and limitations in examining the work role transition phenomenon to equip the researcher to decide about the appropriateness of using IPA for the current study. The literature search outcome indicated that IPA methodology was used to investigate the topic of

work role transition in various contexts. For example, Dyble (2012) investigated the transition experience from being an end-user to becoming a provider in a mental health service. Another example was in a study by Brown et al. (2018) investigating athletes' social support experiences during their transition out of elite sport. It was common among these studies that they provided an in-depth understanding of participants' experience, which was idiographic and gave a voice to the participants. Indeed, through IPA's phenomenological, interpretative and idiographic aspects, these studies provided illuminating, meaningful, and thoughtful insights into specific human experiences and events.

Furthermore, participants' making sense of their transition experience and researchers' interpretations allowed the phenomenological meaning of transition to appear and show itself. Therefore, a conclusion was reached that IPA represents a highly useful methodology in providing a rich and nuanced insight into research participants' experiences. Hence a decision to use IPA for the current study was made.

Appendix 4 provides additional examples of studies that used IPA to investigate the topic of work-role of transition. Having established and justified the methodology adopted for this study, IPA is now introduced as a qualitative methodology.

4.8 Interpretative Phenomenological Analysis

IPA is a qualitative research approach developed within psychology to examine personal lived experiences (Smith, 1996; Smith et al., 2009). IPA aims to explore how participants make sense of their personal and social world and the meanings of particular experiences for them (Smith and Osborn, 2003). Consistent with other phenomenological approaches, IPA understands that human beings are not passive perceivers of an objective reality. However, rather they come to interpret and understand their world by formulating their own biographical stories into a form that makes sense to them (Brooks, 2015).

IPA has three primary theoretical underpinnings: phenomenology, hermeneutics, and idiography (Smith et al., 2009), as discussed earlier. IPA seeks to understand the lived experience by integrating the works of three major phenomenological philosophers: Husserl, Heidegger, and Merleau-Ponty (Smith, 2004, 2007; Tuffour, 2017). These philosophers' works complement each other and collectively contribute to a mature, multifaceted, and holistic approach affiliated with phenomenology but distinctive in its own right (Tuffour, 2017). Although IPA integrates and unifies ideas from these philosophers' work, it identifies more strongly with Heidegger's hermeneutic phenomenology as IPA is from the outset an interpretative process (Smith et al., 2009).

4.8.1 The Epistemological and Ontological Perspective of IPA and this study

IPA's preferred ontological position is minimal hermeneutic realism (Larkin et al., 2006). IPA aligns itself with Heideggerian realism that accepts things exist and are real even if humans are not aware of their existence. Minimal realism means people may not be aware of the independent existence of things (experience, phenomenon, situation) until they ask the question. When they ask the question, it brings their experience into their awareness to make sense of it.

Heidegger's position of reality is interpretative, in the sense that things exist in the world, and they are real. However, the meaning of things (objects, events, and encounters) is made by people through their engagement with the "thing," in other words, through their experience and how they make sense of it (Smith et al., 2009).

This study's ontological position is that understanding being in the world is based on connectedness and mutuality. This position is profoundly against the dualistic separation of the ego from the world; in other words, the separation of subject and object as argued by Husserl (1970) and Heidegger (1962).

It could be argued that inter-subjectivity, which means our relationship with others, is part of the entire horizon that makes our world meaningful. This inter-subjectivity affects our being in the world and our self-awareness as we see ourselves through others' eyes.

Phenomenology takes an epistemological position between realism and idealism and can function as a link between the two. Husserl lays the ground for an epistemology that cuts through this dichotomy and instead focuses on the relationship between the thing and the subject (Dahlberg, Dahlberg and Nyström, 2008). IPA positions itself in the middle ground between two opposing paradigms; social cognition and discourse analysis. Social cognition is concerned with cognition and quantitative measurement that transforms words into numbers to produce numerical data based on reliable, standardised procedures (Smith, 1996).

As presented by Potter and Wetherell (1987), discourse analysis challenges the assumptions of social cognition premise that verbal reports represent or can easily reflect underlying cognitions. They argue that what people say is largely contingent upon their situation. Thus, discourse analysis is concerned with verbal statements' interactive tasks and how they are completed (Smith, 1996). Discourse analysis is critical of the social-cognitive paradigm for its privileging of cognitive entities such as attitudes, beliefs, and intentions. Therefore, in discourse analysis, the analyst does not have to go beyond verbal statements to seek their relationships with underlying cognitions or other behaviours (Smith, 1996).

IPA takes an epistemological position that mediates between the opposed positions of social cognition and discourse analysis. The IPA epistemological position is through careful and explicit interpretative methodology; it becomes possible to access an individual's cognitive inner world. Through exploring how people ascribe *meaning* to their experiences in their interaction with the environment (Smith, 2004). This epistemological openness and flexibility may enrich the literature for areas previously only studied quantitatively, such as

health psychology (Smith, 1996). IPA shares cognitive psychology and social cognition approaches in recognising the centrality of mentalization, in other words, their concern with sense-making on the part of the participant and the researchers (Fiske and Taylor, 1991). However, IPA differs from mainstream cognitive psychology and social cognition in how such mental processes are examined; while the former uses quantitative methods, IPA employs in-depth qualitative analysis (Smith, 2004).

This study's epistemological position is connected to IPA's theoretical perspective that seeks to develop knowledge inductively by empathically exploring and understanding a person's experience-in context. IPA's orientation fits more with the aims of this study of learning in-depth and in detail about the participants' experience of transition to IAPT services and how they made sense of their transition experience.

In conclusion, the epistemological position based on phenomenology, hermeneutics, and idiography with the ontological position of embodiment and inter-subjectivity of this study could offer the most in-depth understanding of the transition experience for the participants.

4.8.2 The Ethical Dimension of Phenomenological Hermeneutics

There is no doubt that there is an inherent power in interpreting another's experience. As discussed earlier, in IPA, phenomenology and hermeneutics are intertwined (Smith et al., 2009). The ethical issues of hermeneutic research have been highlighted by several authors such as Tappan (1997), who raises the issue of defining the "right" interpretation and urges researchers to be attentive to this issue and not unintentionally distort participants' accounts. Packer (1985) suggested that the hermeneutic/interpretative data analysis be "subtle and complex and intellectually satisfying." Levinas's work (1961) is characterised by the endeavour to preserve the Other as Other, to avoid its reduction to the familiar and the already known. For Levinas (1961), respect and responsibility for the Other become the

ethical principles at the source of nonviolent human relations and a just social organisation. Though less explicitly concerned with ethics, Gadamer's thought revolves around a similar respect for the Other.

4.8.3 Critique of IPA

IPA's methodology has been criticised for being mostly descriptive and not sufficiently interpretative (Giorgi, 2010; Van Manen, 2017). For example, Giorgi (2010) dismisses IPA's claim to have roots in contemporary phenomenological philosophy as seriously deficient. He (Giorgi, 2010) argues that IPA's claim that it has a basis in hermeneutics is superficial. Smith (2010) dismisses this critique, affirming that IPA clearly has theoretical underpinnings in phenomenology and hermeneutics, and IPA research provides genuine phenomenological understandings and insights.

Giorgi (2010) also argues that IPA's hesitation in proclaiming fixed methods makes the possibility of replication of IPA studies impossible, and thus it lacks standardisation. Smith (2010) rebuffed the above critique, stating that qualitative research processes are not equivalent to the carefully prescribed procedures in quantitative research. Furthermore, in qualitative research, the intellectual and intuitive work and the complex skills involved influence the research quality more than the conscientious following of procedures.

Van Manen (2017) argues that IPA is a psychological "therapy-oriented" research methodology rather than a phenomenological approach. Van Manen's premise is based on the view that IPA is concerned with the person themselves and their lived experience rather than the phenomenon itself. Van Manen (2017) also claims that IPA studies offer descriptions of a phenomenon in superficial, cliché, or shallow outcomes and do not contain phenomenological insights and understandings.

Thirdly, Van Manen (2017) argued that it must include the pre-reflective and reflective domains for a study to be phenomenological. Smith (2018) rebuffed Van Manen's critique by stating IPA's particular focus on the reflective domain is at odds with Van Manen's claim. Smith (2018) aligns IPA's fluid and graded set of positions adopted by participants on the pre-reflective–reflective spectrum with Husserl's interest in these shifting levels of reflectiveness. Smith (2018) highlights the importance of examining the pre-reflective in phenomenological inquiry, but it is also a legitimate part of phenomenological research to examine the reflective. Smith (2018) further describes Van Manen's criticism of IPA focusing on the person's lived experience rather than the phenomenon itself as dualistic and splitting. Smith (2018) believes that the person's interpretations and reflections on their experience become part of the phenomenon itself.

Willig (2008) argues four specific conceptual and methodological limitations of IPA. Firstly, its emphasis on meaning-making takes the place of context, narrative, discourse, and metaphors, and only people who are eloquent and with good communication skills can describe their experience. While IPA researcher's primary aim is to gain insight into participants' experience and its meaning, it is always intertwined with language. Presumably, any form of language-based investigation – not just IPA – implies the same limitations. Moreover, any good interviewer is aware of the spoken language and what is said and how it is said, picking on subtle cues such as body language, silences, and hesitations to capture the meaning of what is said.

Secondly, Willig (2008) argues IPA is more descriptive and does not capture the experience but describes opinions of it. It is argued that it is not the IPA approach per se; it is the level of interpretation that is incumbent on the researcher's skills and experience.

Thirdly, Willig (2008) continues the IPA critique, arguing it focuses on understanding and describing the experience and does not explain why it occurs. The IPA aims to understand and describe the experience; it is not interested in explaining its causes. However, it is argued that IPA uses hermeneutic, idiographic, and contextual analysis to understand the cultural position of the people's experiences. Therefore, IPA, through describing people's personal experiences, explains them.

Finally, IPA's focus on cognition is a limitation as some aspects of phenomenology are not compatible with the role of cognition (Willig, 2008). However, Smith et al. (2009) rebuff this by arguing that the IPA's prerequisite of sense-making and meaning-making, encompassing formal reflection, clearly resonates with cognitive psychology.

Taking these opposing positions, it could be concluded that the critique of IPA is pivoted on the definition of the phenomenological approach. Georgi, Van Manen, and Willig are affiliated with the Husserlian phenomenology that is based on the editic reduction and the essence of the phenomenon (Finlay, 2009). IPA, on the other hand, is more aligned with the Heideggerian phenomenology that is not as concerned with the pure essence of experience but instead prioritises the provision of a rich and dense description of the lived experience and how the participant is making sense of their experience (Smith et al., 2009). Therefore, like Heideggerian phenomenology, IPA works within the double hermeneutic cycle and can be accurately classified as a phenomenological approach.

4.9 Summary

This chapter presented IPA as an appropriate methodology for addressing the research questions. The ontological and epistemological positions of the current study were clarified and explained concerning IPA. The reasons for choosing IPA and not other phenomenological approaches of inquiry were stated.

The ethical issues pertinent to interpreting another's lived experience were highlighted and discussed, and the criticism of IPA as a methodology was discussed. The following chapter will now describe the detailed methods used to undertake this study.

Chapter 5 Method

5.1 Introduction

This chapter details and justifies the methods used in this research, which were guided by IPA principles. This chapter's structure follows the research process: sample and recruitment, pilot interview, data collection, data transcription, and data analysis. The chapter then presents a section on the ethical approval of this study. This chapter also discusses the pertinent ethical issues associated with insider research and ends with the rigour and quality assurance for this study.

5.2 Methods

5.2.1 Sample

A purposive homogenous sample of seven participants was used in this study. A purposeful sample is defined by Patton (1999) as selecting information-rich cases from which one can learn a great deal about issues of central importance to the purpose of the research. Purposive sampling is relevant to qualitative studies that seek to explore and understand the meanings people assign to their experiences (Tuffour, 2017). Unlike quantitative studies, whereby a random or representative sample is necessary for meaningful statistical analysis (Mays and Pope, 1995).

Sampling procedures in qualitative research are not rigidly prescribed. However, an appropriate sample must be theoretically consistent with the qualitative paradigm and answer the research questions (Marshall, 1994; Smith et al., 2009). Thus, the sample was intentionally selected according to this study's needs and was informed by the existing knowledge or theory about the field of study (Ritchie, Lewis and Elam, 2003).

Small samples are commonly used in IPA studies because it is only possible to do in-depth exploration and detailed analysis of human lived experience on accounts from a small number of participants (Smith et al., 2009). How small is small is a matter of debate among scholars. For example, some stipulated a sample size between four and ten is appropriate for professional doctorates (Clarke, 2010; Coyle, 2014; Smith and Osborne, 2003). Others suggested a broader scale of one-fifteen (Pietkiewicz and Smith, 2014). Therefore, the sample size was discussed in supervision, and following deliberation, a sample size of ten was agreed. It was envisaged that a sample size of ten would allow the researcher to penetrate deep under the surface to understand each participant's experience without being overwhelmed by the large amount of data generated. Although a sample size of ten was agreed upon, only seven people participated in this study, as discussed in detail under the recruitment subheading.

5.2.2 Participants

Specific psychotherapists and counsellors had to be recruited to the purposive and homogenous sample. Several inclusion and exclusion criteria were identified to ensure psychotherapists had access to the phenomenon under investigation.

5.2.2.1 Inclusion criteria: non-IAPT qualified, experienced psychotherapists and counsellors who provide High-Intensity Therapy in IAPT services. 'Experienced' psychotherapists comprise qualified and registered with British Association of Behaviour and Cognitive Psychotherapy (BABCP), British Association of Counselling and Psychotherapy (BACP) or British Psychological Society (BPS), accredited or eligible for accreditation with these bodies.

5.2.2.2 Exclusion criteria: IAPT qualified HIT therapists, PWPs and therapists who are not accredited or eligible for accreditation with BABCP, BACP, and BPS are excluded as the focus of this study is on experienced therapists who moved to IAPT services.

5.2.3 Recruitment

A summary of the research study, its aims, and objectives were presented to the researcher's service manager and the team managers at the three sites of Rotherham, Doncaster, and South Humber NHS Foundation Trust (RDaSH).

Following the Health Research Authority (HRA) approval and the favourable opinion from the research office at the University of Derby and RDaSH, potential participants were first approached by their team manager, who introduced the research project. People who were interested in participating contacted the researcher by email or phone.

Potential participants were then sent an Information Sheet (Appendix 5), the Interview Schedule (Appendix 6), and a Consent Form (Appendix 7) via NHS secure email (nhs.net). As the response rate was low, only three people expressed an interest in participating in the study; the researcher sought help from her service manager for recruiting more participants. It was suggested to put an advertisement on the RDaSH website, which did not yield any results. Similar advertisements were put on the BACP website and BABCP website; however, these did not result in any more recruits. Therefore, the team managers of other IAPT services in the NHS in England were contacted by the researcher to enlist their help in recruiting participants. As a result, six more potential participants contacted the researcher and expressed an interest in participating in the study. The recruitment phase took twelve months in total, which was longer than expected.

Although the literature suggests that the researcher's insider status can help identify and recruit participants (Blythe et al., 2013; Griffith, 1998) in this study, my insider status proved disadvantageous in that respect. IAPT therapists in the researcher's service and other IAPT services were reluctant to participate in this study. The reluctance could be because they felt uncomfortable talking to an insider because of the study's topic. After all, any negative findings could be viewed as a criticism of their employer. Therefore, recruitment for this study proved challenging.

Two consenting participants could subsequently not be contacted. Email follow-up took place, but no response was received. This matter was not pursued further on the assumption they no longer wished to participate in the study. Therefore, the study proceeded with seven participants.

5.2.4 Qualitative interviewing

Qualitative interviewing was indicated as the topic of investigations was contextual and idiographic. Choosing a suitable method for interviewing participants in qualitative research is crucially important because the quality of the collected data depends on the interviewer's skills in gathering data that reflects the participant's experience to answer the research questions (Whiting, 2008).

Highly structured interviews are not usually used in qualitative interviews because of the nature of closed questions, which do not allow participants to talk freely about their experience (Polit and Beck, 2010). Therefore, semi-structured and unstructured interviews were considered. Although an unstructured interview would have allowed the participants to talk openly on areas of concern, these require advanced skills from the interviewer to manage the interview process (Smith et al., 2009). For a novice researcher, a semi-structured interview seemed more appropriate. This style granted the participants the opportunity to talk

candidly about their experience while also providing a structure aligned to the research questions in this study (Smith et al., 2009). Therefore, a semi-structured one-to-one interview method was chosen.

5.2.5 Developing the semi-structured interview schedule

The areas that needed to be explored were mapped out to uncover the lived experience of the participants' transition, as suggested by Rose (1993). This mapping process was informed by the literature review that highlighted the main areas of inquiry. These areas included: previous roles, roles in IAPT services, similarities and differences, their experience in IAPT service compared to other work role experiences, and the challenges they faced to adapt to the IAPT framework. The questions were developed from the general to the particular and included prompts to ensure the key issues were addressed, and the flow of the interview was maintained (Polit and Beck, 2010; Whiting, 2008).

Developing the interview schedule was a complicated process but essential as this would be vital to gaining the right data to answer the research questions. The whole process of developing the interview schedule took a couple of months. The interview schedule was developed and discussed with the researcher's supervisors. A second draft was developed in response to supervisors' comments regarding re-wording some of the questions and their order in the schedule. The revised interview schedule was discussed with peers, and minor changes were added (Appendix 6).

5.2.6 The pilot interview

Before the main study, a pilot study was developed and approved by the University of Derby College of Health and Social Care Research Ethics Committee. This pilot study enabled the interview schedule and the process of qualitative interviewing to be tested out. The pilot

interview aimed to ensure the correct questions were asked to gather the research study's data. It was also to refine the researcher's interview skills and a familiarisation process to the semi-structured interview style.

5.2.6.1 The participant

The first person who responded to the recruitment material and consented to participate was interviewed for the pilot interview, David (a pseudonym given to the participant to maintain anonymity and confidentiality). David was an experienced CBT therapist who moved from secondary care service to IAPT service 18 months prior to the pilot study.

5.2.6.2 The interview

David was informed about the study's purpose, objectives, and what to expect from the interview. The broad scope of the interview and the inclusion of verbatim extracts in published reports were discussed. Confidentiality and anonymity were confirmed, and the right of withdrawal from the study at any point was established. A brief description of the IPA methodology and methods used in the study were explained. Questions from the participant were answered. Informed consent was taken after reading the information sheet and the interview schedule.

The interview schedule (Appendix 6) was used flexibly to allow the participant to talk freely about his own experience of transition to IAPT service while still allowing the researcher to probe further about the research study's aims. The interview was conducted over one session, lasted 90 minutes, and was audio recorded. It took place at the participant's IAPT service site.

A good contact was established with David by attentive listening. The researcher showed interest, understanding, and respect for David's narrative, and the researcher at ease and clear about what she wanted to know (Kvale and Brinkmann, 2009).

The researcher had over twenty years of clinical experience as a psychotherapist; therefore, she was not questioning or challenging but carefully probing to generate more knowledge about the participant's transition experience. There is a fundamental difference between the therapeutic interview and qualitative research interview. In qualitative research interviews, the emphasis is on knowledge production to understand the interviewee's lived experience as they experienced it. On the other hand, in therapeutic interviews, the focus is on knowledge construction to help personal change (Kvale and Brinkmann, 2009). This ambiguity has been reflected in the researcher's diary:

"*Sometimes, I feel like I have probed more than I should or should I have challenged the contradiction of his narrative. Should I have pursued this line of inquiry or just stopped here and moved to the next question"?*

In this interview, David opened-up about profoundly personal and emotional experiences that had been suppressed for a long time. To dispel any anxiety David might have experienced giving too much information about his life, he was asked about his interview experience. David was genuinely comfortable as he said:

"*I enjoyed talking to you and gained much more insight into important themes in my life. I've never told anybody about these things before."* p35

As much as I felt privileged to have been trusted by David to open-up and share deeply personal experiences, I was unsure whether that was necessary in a research interview. Following the review of the transcript from the pilot interview, it was possible that in this

first interview, I was struggling to find a 'comfortable research persona' (Smith et al., 2009:67), and this was evident in the following diary extract:

"*David has opened up in the second half of the interview. I think he felt safe, listened to, and respected. I am wondering how David will feel afterward. He may regret disclosing too much information, especially that we work together. Should I have been more detached in my interview? Should I have probed less?"*

I took field notes straight away after the interview of my impressions of the interview, the emotional tone of the interaction, the conversation's mood, and David's body language and facial expressions. Also, I noted down when David was holding back and when he opened up. These notes provided valuable context for the later analysis of the transcript.

Box 3 An extract from field notes following the pilot interview

I think the pilot interview went really well. Although David was reserved in the first half of the interview, he seemed more relaxed in the second half. In the first half of the interview, David was still wearing a professional persona. This professional self was apparent in his body language, good answers, and attitude to protect the service and the organisation. All his answers were positive, implying that everything at the service is fantastic. In the second half of the interview, David started to open up more, and his narrative felt more congruent and not superficial. I think David did not want to appear critical of the service if he voiced any opposing views. I believe the turning point was when I asked David about his competitive nature when he opened up about his upbringing. From this point onwards, David seemed to shed off the professional persona and became himself. David talked about his childhood, relationship with his father, and how his father instilled in him that he must win in sport.

The interview schedule yielded rich and in-depth data on David's transition to IAPT service, making it appropriate to use in the main research study. Feedback from the participant indicated that the questions were straightforward, and the interview process was comfortable for him. Therefore, no changes were needed to be made to the interview schedule, and it was administered in the main research study in the same way as in the pilot study. Relevant and

essential features unique to David's experience emerged. The later developed themes from this interview foreshadowed some of those to appear in the interviews with other participants. Therefore, the pilot interview data was incorporated into the main study (Appendix 8).

5.2.6.3 Learning and development

After the pilot interview, the interview technique was modified in the subsequent interviews. For example: summarising, paraphrasing, reflecting to the client, and challenge are necessary skills in therapy but not always in qualitative interviewing (Kvale and Brinkmann, 2009). After the pilot study, I learned to balance using my therapy skills and experience to understand participants' lived experiences and sticking to the phenomenon's boundaries under investigation. Moreover, I became aware of some logistical difficulties. One interview for 90 minutes was not long enough to collect the data required; therefore, two interviews for 60 minutes were conducted in the main study. In addition, two recording devices were used in the subsequent interviews to overcome any potential problems in recording.

5.2.7 Data collection

Following the pilot interview, other participants who had consented to join the study were interviewed between January and April 2018. Box 4 (p102) provides an extract from the reflective diary during recruiting participants. The reflective diary proved an invaluable resource throughout conducting this study. For example, in Box 4 extract, the researcher reflects on the nature of a problematic situation. As a result, the researcher gained insight into the problem, and the alternatives considered, facilitating recruiting more participants (Kottkamp 1990).

Box 4 extracts from field notes during the recruitment phase

Two months have passed now with no interest in participating in the research. I feel anxious about recruiting enough participants for my study and do not understand the discrepancy between management's enthusiasm and therapists' reluctance to participate in the study.

One of the things that helped recruitment was a sudden insight into my insider status is what stopped participants in my organisation from taking part. There is a culture of gossip, which may be a factor that therapists are not keen on opening up to an insider, no matter how much confidentiality was assured. The process of opening up and talking to an insider about issues that are still ongoing may be threatening. It is like when you have a problem, as a therapist, I would not go to my colleague, and I would go to an outsider. Maybe my best bet is to seek more recruitments of other IAPT services outside my organisation.

I contacted the managers of five IAPT services in England. Again, most managers seemed willing to help. While feeling disappointed about the lack of response, I am still enthusiastic about my project and talking to non-IAPT qualified therapists about the issues we usually discuss in our chats.

5.2.7.1 The interview process

Husserl's (1970) concept that subjective personal experience is a first-order knowledge influenced the interviews' conduct. Therefore, the focus was on understanding the participants' transition experience without using any theoretical lens during the interview. Striking a balance between striving for a reductive focus and reflexive self-awareness; between bracketing-pre-understanding and exploiting them as a source of insight was sought as suggested by Finlay (2011). Finlay described this as something like a dance, in which the researcher glides through a series of improvised steps (Finlay, 2011). The IPA's idiographic aspect that emphasises each participant's unique personal experience influenced the researcher significantly during the interview process. Thus, the details of each participant's experience were given great attention to interpret their meaning.

In order to get as close as possible to the participants, rapport was utilised throughout the interviews. Rapport was not just employed to make the interview process as comfortable as possible to the interviewees but also to facilitate in-depth interviews. Therefore, the affiliative and empathic concepts of rapport were specific foci for the interviewer (Prior, 2018).

Elements of the hermeneutic cycle were apparent during the interview as the researcher tried to make sense of each participant trying to make sense of their story (Smith et al., 2009). Therefore, the attention was focused on how the participants spoke of their experiences, body language, tone of voice, silences, the unspoken, the hidden, and the avoided. Prompts were used when appropriate to go deep. Similarly, Heidegger's (1962) phenomenology of seeing the "person in context" characterised the interview. For example, participants were given the space to talk about other important things, such as their family life, their prior occupational roles, their country of origin, and other struggles in their lives. The interview spirit, which is characterised by spontaneity, trust, and light-heartedness, yielded rich material about them as individuals.

Finally, the interview was followed up with a debriefing by asking the participants if they wanted to add anything and asked them about their interview experience. All participants reported they felt comfortable with the interview with no specific issues that required intervention.

5.2.8 Transcription

Transcription is constructing the interviews from a conversation to a written text (Bailey, 2008). Transcriptions were made as soon after the interview as possible to capture the interview atmosphere's many details. Although computerised transcription methods (e.g., voice recognition software) help reduce the transcription process's intensity, errors could

arise, impacting transcript comprehensibility (Brooks, 2010; Johnson, 2011; Perrier and Kirkby, 2013). Besides, there is evidence of the importance of listening to the recordings to secure the many details relevant to the analysis, such as the interview situation's social and emotional aspects present during transcription (Rodhama, Fox and Doran, 2013). Therefore, the researcher chose to transcribe all the interview recordings, which, although at times felt stressful and time-intensive, immersion in the data in this way was of significant benefit.

The first transcript included everything audible: verbatim, the narrative, part words, interjections, and a note of notable non-verbal utterances such as laughter, significant pauses, and hesitations. These non-verbal communications accompany spoken messages, convey a great deal of meaning (Wertheim, 2008). (...) was used to indicate silence, [pause] to show a long silence, and { } to indicate a definite break. […….] was used to indicate words uttered that were not relevant to the transition experience. A cleaner version was then produced of the first transcript by removing frequent repetitions, noting "uhm"s and the like, and completing half uttered words. Pauses, hesitations, emphasis on intonation, and emotional expressions were kept making the interview conversation in a form amenable to closer analysis.

The cleaned version (second transcript) was sent to the participants to confirm the content's authenticity and accuracy. Once this was established, a third transcript was made that included the participants' minimal alterations.

5.2.9 Data Analysis and interpretations

To prepare the text for analysis, one margin on the left-hand side was left for the initial comments and a right-hand side margin for emergent themes as suggested by Smith et al. (2009) (Appendix 9).

5.2.9.1 IPA data analysis

IPA can be differentiated from other forms of qualitative research such as discourse analysis because at its core is its emphasis on the experiential claims and concerns of the person taking part in the study (Pietkiewicz and Smith, 2014). Therefore, data analysis was approached with two aims in mind: the first aim was to access the participant's experience of transition to the IAPT role as closely as possible, and secondly to interpret it and produce a coherent, third person and psychologically informed description.

Data analysis is challenging as access to another's experience is both partial and complex (Smith, 1996). Thus, in IPA, the researcher endeavours to get as 'close' to the participant's experience as is possible (Larkin et al., 2006). Getting 'close' to the participant was a process that started during the interview process, continued throughout the transcription phase, data analysis, and interpretations.

The second aim was to develop an interpretative analysis that positions the descriptive narrative in a broader social, cultural, and perhaps theoretical context. That is what is referred to as a second-order account (Larkin et al., 2006). Thus, interpretative analysis allowed the researcher to think about the participant's meaning ascribed to his/her experience. This interpretation was also informed by existing theoretical constructs, which distinguishes IPA from grounded theory approaches (Larkin et al., 2006).

The essence of data analysis in IPA is to focus on how each participant attempted to make sense of their experience (Smith et al., 2009). Thus, analysis in IPA focuses on personal meaning-making in particular contexts, in other words, commitment to understanding the participant's point of view. The analysis moved from the particular to the shared and from the descriptive to the interpretative.

Data analysis was a complex process that was both challenging and interesting. This process was informed by the heuristic framework set out by Smith et al. (2009). This process was overwhelming at the beginning, but it got more comfortable with experience. The first analysis focused on the parts, and then the text looked at again in the context of the whole transcript. This process has been described by Smith et al. (2009) as flexible engagement between the researcher and the transcript, like having a dialogue with the text asking questions, and being curious.

Accessing the 'experience' of individual persons is a complex pursuit that required caution and careful reflexivity. For Heidegger (1962), our subjective world is not primarily mental or 'hidden inside'; it is in the very nature of our being, out in the world relating to the world in a meaningful context. Therefore, during data analysis, several concepts were utilised, such as the Heideggerian concept that the 'individual in context' is always accessible to analysis as a reflection of their current intentionality and directness. According to Heidegger, if we are sensitive and responsive to the subject and adjust our ideas and assumptions accordingly, then a third-person account can potentially reveal the participant's experience as they experienced it themselves (Larkin et al., 2006). In IPA analysis, the focus was on understanding the person-in-context, for example, how the participant related to their colleagues in the new service, what support they needed, and how they went about meeting their needs. Each participant's transition experience was analysed within the participant's context, not as an isolated experience.

For Merleau-Ponty (1945), our personal experiences have a structure that extends across space and time that can be communicated to others through appropriate expressions (Giorgi, 1995). Therefore, in the data analysis phase, close attention was given to the linguistic account, and the field notes described participants' facial expressions, body language, and

tone of voice. Field notes were a rich source for accessing and recording the participant's embodied transition experience.

Box 5 Extracts from field notes following the interviews

Val's facial expression in the interview today when she talked about how disappointed she found the IAPT culture in the service where she worked very different from her expectations. She looked like a vulnerable child who was very disappointed in her family. I wonder why Val had this expectation of working in the NHS will be like a family of care and compassion? Again, I am wondering how having these expectations affected her adjustment.

Heather seems to be philosophical in her attitude towards life. In the interview, she took a long time to answer a question. Heather also tends to look at the issue of question from different perspectives, how interesting. She always expressed her views and then expressed the other perspective. For example, when she talked about some of the ethical dilemmas for her, which was discharging clients after a limited number of sessions even though she believed they needed more sessions. Heather then looked at the issue from the managers' and IAPT service's perspective. I noticed she was very calm and reflective throughout the interviews. No matter how she felt about the issue she was talking about, her calm stance prevailed.

For choosing the IPA approach, the researcher's commitment was to explore, understand, analyse, interpret, and reveal how each participant made sense of their experience. The aim was to produce an insider's perspective (Conrad, 1987). However, the IPA approach does not state a single theoretical assumption about generating the 'insider's perspective.' This open epistemological approach is a great strength of IPA, provided the phenomenological account is central and contextualised. This epistemological flexibility is unique to IPA because richness of data analysis was possible (Smith, 1996).

Moreover, when choosing IPA as an approach for this study, it was clear that the research questions' objects could be accommodated by IPA, such as experiences, understandings, sense-making, meaning, and within the epistemological limits of IPA such as causality or correlation. A well-structured analysis is offered in this thesis that drew upon those

conventional qualitative analysis aspects: cumulative and integrative coding to produce a plausible thematic account (Larkin et al., 2006). Also, existing theoretical concepts were drawn upon to assist in the development of these themes.

The IPA analysis aims to produce an 'insider's perspective' (Conrad, 1987), but it goes beyond that point to seek meaning, commonality, and interpretation. At the interpretative stage of IPA, a range of analytical strategies was applied to help manage some 'balancing acts.' In other words, balancing description against interpretation and contextualisation (Larkin et al., 2006).

5.2.9.2 Strategies used for data analysis

Data analysis proceeded on a case-by-case basis using the three-step approach common to IPA; description, use of language, and concepts (Shaw, 2010; Smith et al., 2009). Data analysis was underpinned by coding, organising, integrating, and interpreting data (Smith, Jarman and Osborn, 1999).

1-Reading and re-reading and making notes

This step involved a close reading of the transcript several times and listening to the interview's audio recording. Listening to the recording helped the researcher become immersed in the data and recall the interview atmosphere. After listening to the recordings, a line-by-line analysis of the narrative was done at a descriptive level. This free textual analysis process helped engage with the text and get close to the participant's experience by identifying the objects of concern for each participant (Smith et al., 2009). Exploratory comments were made on the content, the use of language such as metaphors, repetitions, pauses, and intonations that provided context to the spoken words. Some comments highlighted the researcher's reflections on the process using the research diary (in italics).

At this stage, different colours were used to highlight the descriptive, linguistic, and conceptual aspects of the participant's narrative, as illustrated in Table.10 (p110).

During the immersion process in the data, participants were each given a pseudonym. Pseudonyms were chosen in place of numerical codes to help maintain the visceral connection between myself and them and bring each participant alive through the text when others read the findings. In my mind, each participant was given a name that reflected their personality as it was perceived. For example, the name 'David' was given to a participant who came across as confident and competitive. Similarly, the name 'Heather' was given to a participant who came across as philosophical, contemplative, and calm. The name 'Dorothy' was given to a participant who appeared self-determined, knew her own path and was willing to follow it. While these assumptions could be challenged, naming participants in this way helped facilitate analysis and stay connected to the individual's lived experiences.

Table 10 demonstrates an example of free textual analysis for an interview with Val

	Exploratory notes
I: did you do anything to adapt to IAPT? V: [long pause]..... yes, definitely with recovery, we already touched on that, I remember thinking rather than what does the patient need; to what I need to do to get him to recovery. Uhm, it felt very pressured, and sometimes it does still I think. I know where I'd like to go with this but it might take a bit longer than we've got, so sometimes,….. so we're not going to touch that let's stick with this and not always knowing this is the best for them.	Val started to change the way she works, i.e. her professional self to adapt to the new role requirements as defined by the IAPT model. *Val was very reflective at this point, her demeanour changed as if she was looking at a picture in her mind. I wonder what is going on with her. Is she visualizing the two routes of treatment? The use of the word "go" implies walking along with the client but the road is long. Using the past (felt) and the present (does still) to emphasize the continuity and persistence of this feeling.*
I: Does that cause any conflict or problems for you? V: yeah, I think over the years a lot of conflicts, I've often thought I'd say, I discussed it in supervision this person needs this but as a service, we can't give them this. As a therapist, I feel I could but as a service, we don't and then knowing they're possibly going to be left without their needs met because possibly no one else will give them either.	Val here is talking about her inner conflict regarding meeting patients' needs. Therapist versus service Needs versus resources No one else a strong statement which might indicate abandonment of

2- Identification of the emergent themes

Step 2 involved identifying the emergent themes and nuances, first case by case and then across multiple cases (Appendix 10). At this stage, the detailed notes and comments that had been produced earlier were used to identify the emerging themes. These themes were discussed in supervision, and the feedback highlighted that more in-depth analysis was required, and a suggestion was made in supervision to go back to the transcriptions. The themes were then examined against the source material, which indicated congruence between the developed themes and participants' accounts. However, this time the researcher engaged

in more in-depth analysis and more profound interpretations of participants' narratives. For example, the first time, the interpretations focused on line-by-line analysis of the transcript's parts, which produced fragmented interpretations. This chronological interpretation of the different parts of the transcript provided a limited understanding of the experience's totality. Looking again at the part after interpreting the whole transcript illuminated aspects of participants' experience that was not noticed the first time. The data analysis and interpretations could be described as an iterative process that involved reflecting, refining, and revising the work to get as close to the participant's experience as possible.

Through the iterative process of zooming in and out, looking at the part within the whole and the whole concerning the parts, a lot about the participants was learned. The data then became alive, not just words that tell a story but something more significant that was full of movement, emotions, and even colour. Grasping what Smith (2004) meant by the part explains the whole and the whole explains the parts was a key learning point at this stage. This new understanding facilitated interpreting each participant's account as part of their entire personal story. Table 11(p112) shows examples of the emergent themes and related codes for the same interview extract with Val.

Table 11 Coded themes from Val's interview

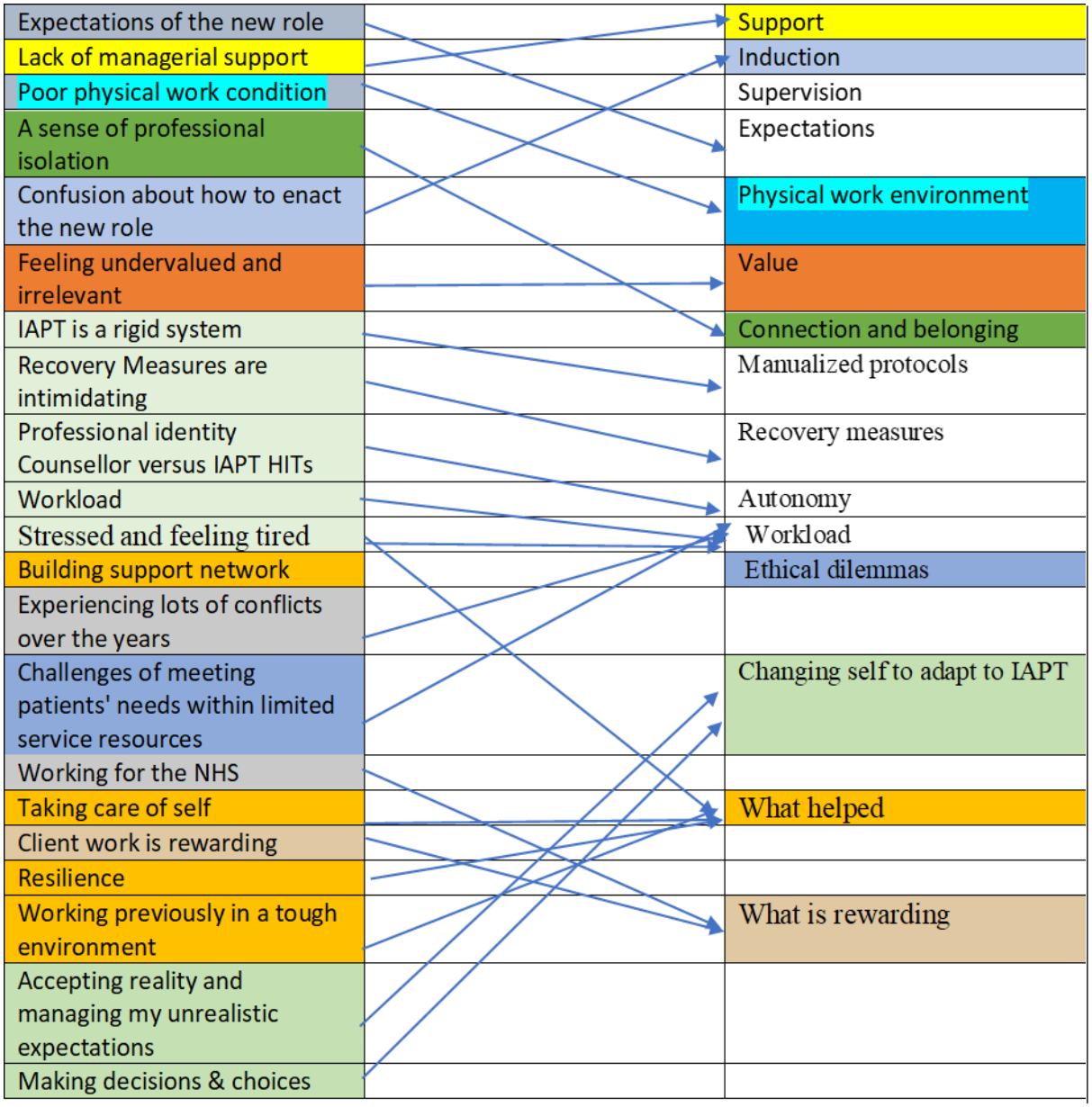
Extracts from the interview	Themes
I: did you do anything to adapt to IAPT? V:[long pause] yes definitely with recovery, we already touched on that, I remember thinking rather than what does the patient needs; to what I need to do to get him to recovery. Uhm, it felt very pressured, and sometimes it does still I think. I know where I'd like to go with this but it might take a bit longer than we've got, so sometimes,….. so we're not going to touch that let's stick with this and not always knowing this is the best for them.	**Changing self to adapt to IAPT** Polarized thinking. Inner pressure of going against the grain. Evaluating and weighing options Not completing the sentence which might be interpreted as the rush to make a choice or she might have reached a conclusion based on previous experiences. Made a decision but not sure of the outcome for the patient.
I: Does that cause any conflict or problems for you? V: yeah, I think over the years a lot of conflicts, I've often thought I'd say, I discussed it in supervision this person needs this but as a service, we can't give them this. As a therapist, I feel I could but as a service, we don't and then knowing they're possibly going to be left without their needs met because possibly no one else will give them either.	**Ethical dilemma** Experiencing lots of conflicts over the years. Attempts at resolving these conflicts. Challenges of meeting patients' needs within limited service resources. Knowing from experience. A sense of abandoning the patient.

3- Searching for relationships and clustering themes

The next step was listing all the transcripts' emerging themes using a table on the computer. This step was followed by looking for connections across the themes and moving the themes across the list to form clusters of related themes (Appendix 11). To look for connections across the themes, contextualisation or organising the emergent themes in terms of the temporal moment where they were located was done as suggested by Smith et al. (2009). For example, within the interview with Val, there were a series of significant events of her transition experience: expectations of IAPT, feeling unsupported, struggling with the new system, reaching out for support, getting to know the new system, and change to adapt to the

new system. The emergent themes' frequency was looked at as well, not from a quantitative perspective but a qualitative view. For example, the theme of the need for connection to others was repeated several times in Val's narrative and in every transcription that indicated this theme's relative importance to the participants. Table 12 represents a structure of the emergent themes for Val.

Table 12 Emergent themes for Val



4- The next step in data analysis was moving to the next case and then looking for patterns across cases. This step was followed by moving themes around that shared higher-order qualities. For example, the theme of support represented idiosyncratic instances but also shared higher-order qualities (see Table 13).

Table 13 An example of patterns of the theme support

Participant	Theme Support	Line
Val	"*I remember feeling like I was expected to know everything and there wasn't, it wasn't taken into account that I hadn't come from NHS or IAPT service. In the meantime, I was just left. No not in the beginning [support]. The management weren't supportive*".	Page 7 Page 9
Heather	"*Yes, before anything else I needed to find somewhere to have clinics, and that actually is not done for you unless you have stepped into someone else's role and I was a newcomer and I wasn't taking over from someone else. You have to basically, you have to make to amend, and you have to do it yourself".*	Page 11
Dorothy	"*No, I didn't, support was really poor. It got better over time but I think I just adjusted my expectations. I'd moved, it was a new county, I knew nobody, and I was on my own. And I was put in the most remote surgeries where three of the surgeries were very unfriendly*".	Page 4

5- Identifying recurring themes

The identified themes were laid in a table and checked again against each participant's account to identify the patterns of themes across participants. Table 14 (p115) illustrates some of the recurring sub-themes for the participants (Appendix 12 for all themes).

Table 14 Recurring sub-themes for the participants

Themes	Val	David	Dorothy	Heather	Cathy	Shirley	Julie
Support	Y	Y	Y	Y	Y	Y	Y
Orientation & supervision	Y	Y	Y	Y	Y	Y	Y
Physical work environment	Y	N	Y	Y	Y	N	Y
Professional isolation	Y	N	Y	Y	Y	Y	Y
Value	Y	N	Y	N	Y	Y	N
Connection & belonging	Y	Y	Y	Y	Y	Y	Y

6- Moving to super-ordinate themes

This step involved identifying patterns between sub-themes and clustering them under a theme that was given a label that represented these themes at an abstraction level. For example, the sub-themes of support, orientation & supervision, professional isolation, physical work environment, value, and connection & belonging described the participants' early experience of transition to IAPT services. Therefore, the super-ordinate theme '*Transition*' was identified, encompassing all these sub-ordinate themes (Appendix 13).

5.3 Ethics

5.3.1 Ethical approval

First approval from the Rotherham Doncaster and South Humber NHS Foundation Trust research office was sought in March 2017 and granted on the provision of appropriate favourable ethical opinion from the University and the HRA (Appendix 14).

The Local Research Ethics Committee confirmed this study did not need review (Appendix 15). However, review by the HRA was still required, and therefore an IRAS form was completed. The HRA provided a favourable opinion in June 2017 (Appendix 16).

With these approvals in place, the University of Derby College of Health and Social Care Research Ethics committee issued their final approval in July 2017, at which time data collection could proceed (Appendix 17).

5.3.2 Considerations within insider research

My position as an insider researcher who shares a similar background and professional socialisation to that of the participants enabled me to identify with participants' experiences, ethical dilemmas, and sometimes 'reading between the lines' of what they said. In contrast, an outsider researcher unfamiliar with the IAPT service may experience difficulties in understanding the participants' meanings within IAPT context. Nevertheless, my position as an insider researcher was not without caveats, as discussed below.

During the research process, I found that it was hard not to influence and be influenced by the participants, no matter how detached I tried to be. As a qualitative researcher, I acknowledge that this research study's findings are the product of my interpretations of participants' experience, as Finlay (1998) suggested that any qualitative results are co-constructed.

As a qualitative researcher, I view subjectivity as an advantage. While striving to understand participants' transition experiences from their perspective, I valued my connection to their world. I could construct meaning that may not be apparent to an outsider detached and unfamiliar with the IAPT programme.

The quality of the relationship that unfolded from this study, characterised by trust, openness, shared background, and values, enriched the collected data. The ongoing process of

producing, confirming, and adapting the data helped construct a more authentic and original account of participants' transition experience. This originality makes the phenomenon of 'transition to IAPT services' more explicit, and this knowledge helps improve understanding and action for all those involved in IAPT services.

Nonetheless, it is argued that the risk of bias increases for insider research as personal beliefs, values, and experiences influence the study methodology, design or/ and results (Aguiler, 1981; DeLyser, 2001; Greene, 2014). Therefore, as an insider researcher, I worked through the following challenges to increase this study's rigour and trustworthiness.

1)**Power issues**

Although power issues are not exclusive for insider research, they warranted more consideration as an insider researcher. Some of the participants were my colleagues, and hence this issue presented some challenges in managing it. The qualitative paradigm departs from the quantitative paradigm, whereby the researcher is the ultimate source of authority (Heron and Reason, 1997). It is argued that the power balance between the researcher and participants encourages disclosure and authenticity (Karnieli-Miller, Strier and Pessach, 2008). As a qualitative researcher, I was aware of the tensions between the commitment to power redistribution and the ethical and methodological complexity inherent in qualitative research.

I endeavoured to be transparent about the study's process and what is involved in the initial recruitment stage. The explanation of the interpretative nature of IPA was part of the initial discussions with participants. At this stage, I felt the power was in the participants' hands as they chose to participate in the research or drop out during the study.

During the data collection phase, I was keen to make the interviews as natural as possible to help the participants feel comfortable. Therefore, the interview was conducted like a conversation with a purpose, as suggested by Smith et al. (2009). As the research interview situation is saturated with moral and ethical issues, I was aware of the power asymmetry (Kvale and Brinkmann, 2009) inherent in the research interview; I set the stage for the interview, asked the questions, and chose what to follow up on from their answers and what not to. However, I am an experienced psychotherapist and my practical skills enabled me to understand the concrete powers and vulnerabilities in play in situations and dealt with them ethically and morally.

During the data analysis and interpretation phase, I became the "storyteller" of participants' stories re-cast into a "new" theoretical, political, and cultural context (Karnieli-Miller et al., 2008). During this stage, my power over the data was absolute (Kvale and Brinkmann, 2009; Marcus and Fischer, 1986). Therefore, data analysis and interpretations were extensively discussed in supervision, and verbatim extracts were provided to support interpretations. Patton (2002) describes this process as one where qualitative analysts return to their data "over and over again to see if the constructs, categories, explanations, and interpretations make sense" (p339).

2) Shifting position

Positionality is determined by "where one stands in relation to the other" (Merriam et al., 2001: 411). The researcher's positionality concerning the participants has been debated extensively in qualitative research (Gair, 2012; Lee et al., 2012; Savvides et al., 2014). This debate is because positionality influences the co-constructed knowledge between the interviewer and the participants (Griffith, 1998).

As an insider researcher, I was always aware of my social identity in relation to the participants throughout conducting this study. For example, during the interview, I endeavoured to be close to the participants to feel comfortable talking freely about their experiences and meanings. Dwyer and Buckle (2009) suggested that participants might be more willing to share their experiences with an insider because there is an assumption of shared understanding. It is as if "you are one of us and it is us versus them (those on the outside who do not understand)" (Dwyer and Buckle, 2009, p58). However, I was also aware that their experiences are different as they are similar through other personal, social, and situational characteristics that outweigh the shared positions (Bridges, 2002).

Reflexivity and self-awareness facilitated position shifting from a colleague to a researcher to an interviewer to analyst throughout the different stages of this study, as suggested by Savvides et al. (2014).

Several authors highlighted the associated challenge of assumed understanding or presumptions with insider research, such as Blythe et al. (2013), Couture, Zaidi and Maticka-Tyndale (2012) and Davies (2005). The study topic's familiarity with the insider researcher and the participants can cause presumptions (Couture et al., 2012). To ensure clarity and understanding, probing questions were used such as 'what do you mean by .....?' or 'can you give me an example?' or 'can you elaborate more on ....'. Being aware of cues that presumptions are happening led me to shift my position. For example, during the interviews, participants say, 'you work in IAPT, and you know what I mean by that.' This statement indicates shared experiences and understanding. However, such comments prompted me to shift my position to become more detached to create a distance to enable me to probe, explore, and enquire about the meaning of their own experience.

There were multiple opportunities to check out my understanding and interpret participants' accounts using a reflexive approach.

3) Objectivity

Closeness to the topic and the investigation subjects posed a threat to objectivity due to a high level of subjective involvement and familiarity with IAPT culture, which may compromise the ability to engage critically with the data (Drake, 2010). To manage the influence of my closeness to the field, I followed the suggestions of Chavez (2015) by collecting reflective personal data and Van Heugten (2004), who suggests a "stream of consciousness writing," which gave me the freedom to voice my internal feelings when writing. This writing technique allowed my thoughts to move between the past and the present, the participant and the researcher, giving me an insight into the complex nature of investigating this transition topic.

Furthermore, objectivity may be affected during data analysis and presenting findings unless specific strategies are implemented to ensure the study's credibility (Rooney, 2005). Therefore, to ensure analytic objectivity, a concerted effort to focus solely on participants' experience during data collection and data analysis was made. During the interpretation phase, I used bracketing to put aside what I knew about the participants, such as their personality, interactions with colleagues, aspiration, and motivation to focus on the data itself. Similarly, during data interpretation, a process of continuous internal dialogue and constant scrutiny of 'what I know' and 'how I know it' was employed as suggested by Hertz (1996). Besides, ongoing reflection and reflective journal aided this process. Moreover, discussing the findings with my supervisors and sometimes challenged made me go back to the transcripts to check objectivity in analytic interpretations of participants' accounts.

5.4 Rigour and trustworthiness of the method

To ensure this study's rigour and reliability, the researcher adhered to Yardley's (2000) four principles of evaluating qualitative research quality. These fundamental four principles are sensitivity to context; commitment and rigor; transparency and coherence; and impact and importance (Yardley, 2000, 2017). This study demonstrated sensitivity to context by showing awareness of the participants' perspectives and setting, the research's socio-cultural and linguistic context. For example, this study's recruitment was done through a third party (IAPT team managers) and published advertisements on the Intranet, BABCP and BACP, websites. Recruitment through these avenues was preferred because of the study's context and not to impose any direct or indirect pressure on colleagues to participate. Interviews were offered when and where participants felt comfortable. During the interview process, awareness of the participants' perspective was given the utmost attention by attending to the spoken verbal and non-verbal messages, body language, and noticing participants' demeanour. Psychological space was provided when needed when one of the participants became distressed during the interview.

Sensitivity to context was observed during data analysis by immersing oneself and through the disciplined attention to each participant's account and how they were trying to make sense of their experience of transition. During data analysis, sensitivity to the raw material was attended to, and the interpretations of participants' accounts fitted their socio-cultural context. The use of verbatim extracts from the interviews helped give participants a voice and supported this study's findings.

Commitment and rigour have been demonstrated by recruiting a purposive, homogenous sample appropriate to answer the research questions. Inclusion and exclusion criteria for sampling were rigorously applied. The semi-structured interview allowed the participants to

talk freely about matters that were of concern to them. During the transcription phase, the researcher transcribed the interviews herself, as discussed earlier, to capture the interview atmosphere and ensure the collected data's accuracy. It was taking fieldnotes straight after the interviews secured the many details of the interview and the researcher's observations of the participants' interactions and body language. Data analysis was conducted thoroughly and systematically, as illustrated earlier in this chapter. Close and rigorous supervision ensured that the interpretations of participants' accounts are congruent with their stories.

Transparency was ensured by clearly describing the research process to the potential participants during the recruitment. Each stage of this study has been clearly explained in this thesis and supported by relevant evidence such as Tables, appendices, verbatim extracts, and elements of the analysis process.

This study has enriched the literature on understanding work role transition in IAPT services, which an area that has not been researched before. The current study also provides important insights that will impact socio-cultural practices for IAPT policymakers, IAPT therapists, and CCGs.

This thesis presents a coherent account of the research and the principles of IPA. Coherence is evident in the phenomenological and hermeneutic aspects of this thesis and the commitment to interpreting the experiential accounts of individual participants.

5.5 Summary

This Method Chapter discussed and defended the design and conduct of this study. To be as transparent as possible, a detailed account of each stage of the research method was explained; the ethics approval, the development of the interview schedule, data collection, transcription, and analysis were presented and thoroughly discussed. The researcher's insider

status and how the associated challenges were mitigated were discussed. The steps taken to ensure the rigour and credibility of the research study were demonstrated. The next chapter presents the findings of this study.

Chapter 6 Findings

Introduction to the chapter

This chapter presents the analysis findings, which critically discuss non -IAPT qualified HITs' experiences as they transitioned from other services to IAPT services. Four super-ordinate themes were identified and are discussed in detail below. Specifically, these were:

1) Transition, 2) Learning the ropes, 3) Adjustment, 4) Transformation

These super-ordinate themes are presented to answer the research questions, and best represent the participants' experience. Several sub-themes associated with each super-ordinate theme will also be discussed, and these are summarised in Table15 (p125). Each sub-theme is evidenced through extracts of raw data using quotes from participants; each has been italicised for ease of identification with relevant page numbers from the original transcripts cited as p1, p2, etc. In addition, each participant is referred to by the pseudonym chosen during the analytical process explained in Chapter Five. The chapter closes by examining the thematic map developed in this study, explaining how the super-ordinate and sub-themes relate.

Table 15 Super-ordinate themes and sub-themes

Super-ordinate Themes	Sub-themes
6.1 Transition	6.1.1. Support
	6.1.2 Orientation & supervision
	6.1.3 Expectations
	6.1.4 Physical work environment
	6.1.5 Value
	6.1.6 Connection & belonging
6.2 Learning the ropes	6.2.1 Manualized protocols
	6.2.2 Recovery Measures
	6.2.3 Professional autonomy
	6.2.4 Work pressure
	6.2.5 Ethical dilemmas
6.3 Adjustment	6.3.1 Accepting reality & lowering expectations
	6.3.2 Fitting in
	6.3.3 Professional identity
	6.3.4 Facilitators of adjustment 6.3.4.1 Focusing on clients' work 6.3.4.2 Building support network 6.3.4.3 Prior occupational experience 6.3.4.4 Personality traits 6.3.4.5 Taking care of self
6.4 Transformation	

6.1 Super-ordinate theme one '*Transition*'

The first super-ordinate theme to be discussed is *'Transition*.' Transition was identified from participants' accounts and for many, this was depicted as a challenging experience. One of the main overarching themes that manifested throughout the data analysis was how difficult the transition was for the participants in their first year in IAPT services. Although participants worked at different IAPT services in three different counties, they described their early experience in IAPT services as "*difficult*." This super-ordinate theme incorporates six sub-themes: 1. Support 2. Orientation and supervision 3. Expectations 4. Physical environment 5. Value 6. Connection and belonging

6.1.1 Support

Support was identified as a sub-theme within the transition experience as participants spoke about their own needs for support, their perceived lack of support from managers, and their personal ability to offer support to others. However, for many, it was the lack of support that dominated their accounts. Phrases such as *"On my own," "I am lonely," "it is not friendly," "I do not feel supported"* were common and reflected the need for connection with others.

The theme of having friendly people around in the workplace came up several times in participants' accounts, which indicated the importance of social and relational support for facilitating the transition. Five participants discussed the lack of support from their managers and its impact on them during their first year of transition to IAPT services. Participants described their transition as difficult, chaotic, and solitary. Participants cited that they expected managers to be supportive and take their circumstances into account, such as allocating them to GP surgeries or supporting them with work issues. These expectations were based on their previous work experiences when managers supported their circumstances that required support. Some participants sought support from their managers but felt their managers were not available or themselves [managers] too stressed to offer support. Participants reported that they felt they were just seen as doing a job rather than individuals within their whole context and described their employers as uncaring and unsupportive.

Dorothy, *"I found it a difficult transition. It was chaotic, and they were not doing it the way I expected it as they did it in [County]". "Support was really poor I'd moved, it was a new county, I knew nobody, and I was on my own, and I was put in the most remote surgeries where three of the surgeries were very unfriendly."* p4 "*I am lonely, it is not friendly, I don't feel supported."* p4

In the above excerpt, Dorothy described her transition in the past tense, which conveys a sense of detachment from the past and moving on. However, in the last sentence, Dorothy described her feelings of loneliness in the present tense, which indicates these feelings still lingered. Dorothy revealed a sense of being lonely several times in the interview by talking extensively about how her being single affected her transition experience. For example, Dorothy expected understanding from her managers by not placing her in remote surgeries where she was working alone. Dorothy felt her managers could have been more understanding and placed her in areas where she might have made more friends. This lack of understanding of her circumstances made her question her decision to work in the service.

Dorothy, *"they wouldn't have cared because I was new in [County] and I didn't have a partner. I don't understand why they put me in such remote surgeries. They could have put me in an area where there is another colleague sometimes, so I was close to people; so, I could have made friends. It was very solitary because the driving conditions were challenging, the computers didn't work so I was living on my own, so it was not a happy phase, six months on and I thought I made such a mistake I am gonna find something else."* p6

Dorothy expressed her need for connection and closeness to people, and these needs were left unmet in her new role, which further complicated her transition experience. Also, Dorothy reflected on other causes of her challenging transition experience, such as driving conditions and IT problems. Dorothy then made sense of her experience by talking about how unhappy she felt in her new role and regretting moving to the IAPT service. Dorothy thought of resolving this issue by finding somewhere else. Perceived lack of support from the managers evoked feelings of anger, resentment, and anxiety. These feelings triggered a cognitive sense-making process; participants doubted themselves and questioned their decisions about

moving to IAPT services. Similarly, Julie, in the following quote, expressed her regret about moving to IAPT.

Julie, *"No, I wasn't supported, I remember [……..] thinking, oh have I done the wrong thing coming here; should I stayed nearer to home… yeah... I had very very little support at that time."* p7 *"No, no actually thinking back, it was rubbish, [Laughter]."* p13

Heather's transition was also challenging; the lack of organisational support of finding a place to see her clients was left entirely for Heather.

Heather, *"yes, before anything else, I needed to find somewhere to have clinics, and that actually is not done for you unless you have stepped into someone else's role and I was a newcomer, and I wasn't taking over from someone else. You have to basically, you have to make to amend, and you have to do it yourself*." p11

Heather spoke of losing the support she had with her colleagues in her previous role and reflected on the nature of their relationship: support, care, stability, and sharing. In the following quote, Heather reflects on the loss of social and relational attachment with her old colleagues, which contrasted sharply with her experience in her new role.

"oh, (pause) I had lost a lot of informal support because I had been in an office with good colleagues whom I'd become fond of and was friendly with and we knew each other within the work setting quite well, and it was a stable setup. We knew whatever was going on, and you're kind of letting a bit of steam, and you pick yourself up, and you carry on, and there were some quite caring people there. And so, (….) I completely lost that and uhm, so yeah, I mean I think that that combined with the fact that IAPT work is quite isolated, it certainly is in [County]." p10

In the above excerpt, Heather reflected on her previous role, the development, and the evolution of her relationship with her colleagues, who became more than just colleagues. Heather's use of '*fond of'* is indicative of a warm and close relationship. The social self is intertwined in the above quote with the professional self, where employees knew each other quite well, shared information, and felt safe to express strong emotions, which helped them keep going. Heather then sums it all up by saying, "*caring people*." Heather ruefully reflected on the past as if recalling a dear memory and a time of happiness that had gone by. Heather then returned to the present and affirmed the lack of support in her current role.

Val reported a similar experience to the others discussed above. Val said she felt her managers were not there to provide psychological support, mentoring, guidance, and feedback. Val felt unsafe when she was a newcomer and had to carry the risk or the uncertainty about what to do**.**

Val, *"I think staff, including myself, need to know they are not just out to see themselves; they are not just left. Managers never go in that room, never, ever, so they are never present, so there isn't how one is today there isn't. So, if the staff don't feel they have the structure to keep them safe. They don't have support; they don't have managers that they can approach.*" p18

Participants tried to make sense of why they felt so unsupported, and they did this by talking about the manager's competing demands and struggles to keep up with the speed of change in IAPT services (Heather and Julie). In contrast, Dorothy and David perceived their managers as lacking the skills and competencies to be in a management role, and others felt managers were only concerned with statistics and figures (Cathy and Val). Participants explained that they felt the lack of support from their managers was the norm within their services.

Participants turned to their colleagues and co-workers for support and as a learning source when they felt unsupported by their managers.

On the other hand, when managers were supportive, participants postulated that managers' support facilitated their transition. For Shirley, the support indicated that her employer cared about her wellbeing, which made her feel valued by her employer.

Shirley, *"we had a team lead who is a lovely woman and very supportive and encouraging, and I found, you know if I need something, they do their best to get it within reason such when I moved, they found surgeries, and I am a bit out of the area they found surgeries as near as possible to where I live*." p10

Shirley's quote highlights a positive experience of support within the IAPT services, which were instrumental in the transition process. To feel supported by her manager meant for Shirley that her employer cared about their staff. Therefore, the manager for Shirley represented the attitude of the service as a whole where she worked. The use of "*they*" repeatedly in the above quote indicated a collective meaning of "the service."

In contrast to other participants, David described a much smoother transition to IAPT services despite still reporting a lack of support from his manager.

David, *"It felt fine, absolutely fine because I'd always held positions that were very different, so, uhm when I think back to what I have done in the past, [……..] you know that was a walk in the park for me*." p8

In summary, participants felt support was a crucial part of their transition experience and directly impacted their ability to work well within the role.

6.1.2 Orientation and supervision

Participants saw the provision of proper and adequate orientation about the structure and functioning of the IAPT system and the IAPT therapist's intended responsibilities as paramount to successful transition.

Participants' accounts implied that non-IAPT qualified therapists felt they were just thrown into their new roles in IAPT services without proper induction or orientation to the IAPT system and were left to fend for themselves. Although participants were inducted into their organisation, they were not orientated to the IAPT service and their role. While induction and orientation are often used synonymously, they are different. Induction refers to the newcomer being introduced to the new organisation and its work environment. In comparison, orientation aims at aligning the newcomer with the new role, responsibilities, and work culture (Human Resources Dictionary, 2013). The lack of orientation to the IAPT system made participants struggle to figure out the "rules." All participants in this study stated that their orientation to IAPT service was at best inadequate and at worst non-existent:

Cathy, "*No, we did it on our own. We were given the IAPT forms and were told to get on with it"* p17. *"I 've had the feeling of being a new girl [laughter] and when I haven't been really and not feeling as safe and secure at work. You know."* p18

David, "*No, I have done it all. No, turned up on a Monday morning, here is your caseload, get on with it, and that was it."* p15

Similarly, Julie, Dorothy, and Shirley described their experience of lack of orientation.

Shirley, "the orientation at the beginning was very brief, but as a result of speaking up about that, our new staff are getting much better orientation." p10

In this quote, therapists were able to voice their concerns and have improved the situation for new starters. The participants expected their managers to provide orientation to the IAPT role and the intricacies of the service. However, many felt the managers themselves lacked knowledge and understanding of the service and, as a result, were probably unable to provide a good orientation. Orientation to the service was considered problematic when the managers themselves did not understand the service. Heather felt that managers were not sure about the rules, and hence they could not explain them to her.

Heather *"Uhm, so I arrived in this setup, which was in turmoil, near turmoil with few fixed points. (……). So, in terms of grasp socialisation into IAPT, the people in IAPT [the managers] actually in a way have been, what can I tell you "we don't know from week to week, this is how we used to do things." That is in transition anyway. NHS combined with modern life setup really, and there wasn't something happening all over the place really. You know this is the new normal in a way. This has made things a bit more difficult. You know I wasn't moving to somewhere where people knew the rules and could explain them to me*." p9

In the above excerpt, Heather portrayed a picture of chaos, with contradictory statements such as "*turmoil*" and then "*there wasn't something happening*." Heather's narrative is inconsistent and chaotic, which reflects how turbulent that time was for her. Heather was trying to make sense of the chaos by drawing on her wisdom. In the end, Heather made sense of the whole thing by concluding that managers did not know the rules to explain them to her. She then reflected on how she felt at that time, "*feeling of being alone and completely responsible for learning the rules."* p9

Due to poor orientation, most participants described their initial experience in IAPT services as confusing. Participants described a sense of chaos, dissatisfaction, uncertainty, and

anxiety due to not knowing what was required of them, and these feelings occupied them for the first few months on the job.

Although the therapy competencies were precise, how to achieve them, given the newness of the role/service, was less clear. For example, participants found the lack of standardisation of the IAPT system across England confusing, such as criteria for referrals, number of treatment episodes people can have, disorders treated in IAPT services, criteria on accepting people with alcohol and substance misuse, and the level of complexity of patients can vary within the individual IAPT service and amongst different IAPT services. Also, "the back to work agenda" (Department of Health, 2008) was confusing as some IAPT services provided employment support, whereas others did not offer this service. The lack of orientation to the IAPT system and its diverse workforce, like PWPs, was confusing for Heather, who moved from secondary services and never heard of PWPs before. Julie was confused about all the models and manualised treatments.

Dorothy, *"I kept saying why we haven't got an employment advisor? Why we're working with these old people? They didn't understand, and they'd said well we do it the way we do it in [county]."* p3

Because of the lack of proper orientation to the IAPT role, participants sought information from managers, colleagues, and co-workers. Participants learned how to do the job by trial and error and were proactive in finding out about the different aspects of their new work environment. Participants recommended proper orientation, mentoring, shadowing, and buddying options for transitioning therapists to prepare them for the distinct and different structure and function of the IAPT system.

Shirley, *"I'd have liked to observe and shadowed some people, but it never kind of came around."* p11

Heather, *"Uhm, I think I could've done with maybe uhm a couple of days just on, you know, this is the IAPT stuff you need to know because I've had to sort find that myself uhm. I think that would have been helpful*." p36

Only one participant reported receiving mentoring during their transition to the role. Val moved from the prison service and was given a chance to shadow a HIT therapist for a week. Nonetheless, she felt that was not enough to get to grips with the IAPT system's complexity, particularly it was her first post in the NHS.

In addition to lack of orientation to the new IAPT role, this study's findings suggest that inadequate clinical supervision had a significant impact on three participants who felt unsupported, clinically insecure, and worried about their practice. They described their supervision as '*lousy*,' *'non-existent,'* and '*inadequate*.' Two participants Heather and Cathy, whose services were in transition to become pure IAPT services, felt the impact of lack of supervision. Although things got better and supervision improved, it took a long time. Participants felt that the balance between autonomy and safety was not ideal as they felt on their own and doubted their professional self and competence. Participants talked about feeling insecure, less confident about their clinical work, and unsafe when working with clients. Participants felt very resentful about that.

Heather was left without adequate clinical supervision for more than a year. She felt very resentful and expressed a sense of anger for not supporting her accreditation by not getting adequate supervision.

Heather, *"Well, the clinical supervision situation was actually lousy, and it was recognised to be lousy."* p36 *"resentful, resentful uhm uneasy, insecure, you know. I felt it was absolutely not good enough. And it wasn't good enough on so many levels. It wasn't good enough from the patients' safety point of view; it wasn't good enough from my clinician's safety point of*

view. It wasn't good enough because you know we all supposed to be working towards accreditation, and how can we do that without adequate supervision. Uhm, it was rubbish on many levels. So, although I was getting very good managerial supervision, none of us were getting adequate clinical supervision." p22 & 23

The inadequacy of clinical supervision was problematic for Cathy and Dorothy as well. Both felt they were more experienced than the persons allocated to be their supervisors.

Dorothy, *"So, I had to have to be supervised with someone who is not working with my modality, she was very sweet, as a person I am not disputing, but I couldn't discuss difficult cases. I was concerned about all my cases because she didn't want to hear about cases from that area [where the supervisor used to work]. To me, so [pause] but she was totally from the person-centred brigade, and she said that. So, I'd be talking for 50 minutes, and then she gave me one sentence. That is not my style at all, and I wasn't allowed to change her*." p15

Cathy, ***"****Uhm, I think it had an impact on the team because we don't have a choice of supervisor. Now I don't have a supervisor at the moment which is not very good [.....] There is no choice whereas we had choice before. If somebody has an issue with somebody so you can change, and we're all human, and things happen. So, I think this has been taken away*." p2 & 3

In essence, participants reported a lack of induction and orientation to the IAPT role, which has negatively impacted them doing their new role. Three participants reported inadequate clinical supervision, making them feel clinically insecure and unsupported when working with complex clients.

6.1.3 Expectations

All seven participants came to IAPT services with certain expectations of the role, organisation, and themselves. Val and Dorothy came to the IAPT services with positive expectations about the role and the service. However, the negative discrepancy between their expectations and the reality of their new work environment made their early transition challenging. Both described feelings of frustration, disappointment, confusion, and even anger in the first few months of their transition to IAPT. The intensity of their emotions correlated with the negative discrepancy of what they expected the role would be and the reality of what it was.

Val, "*Not sure that I had specific expectations about IAPT; it was more about the NHS. That it would be supportive, like a family, like a culture of care, uhm just compassionate. I think I had this idealistic view that we all be doing it for the same reason because we all want to get people well, get people back to their normal life."* p12

Val's expectations reflected her values, morals, and professional code of practice. They also reflected her need for connection, warmth, and belonging. Val believed these expectations ought to be the case rather than expecting them to be the case. She had assumptions about the NHS that contrasted with the reality of her job in the prison service, where the culture was characterised by violence, hostility, and separateness. Val imagined and then expected the NHS culture to be like a compassionate, warm, and supportive family. Family used in this context meant for Val connection, support, understanding, and shared values.

For Dorothy, her expectations of the new IAPT service were based on knowledge she derived from a previous IAPT team she worked alongside in secondary care. Dorothy expected the new IAPT service would operate in the same way as it had in her previous employment. Therefore, for Dorothy, her assumed expectations about the new service clashed with reality.

She felt confused and bewildered by the new IAPT service as it was quite different from what she had expected. Moreover, Dorothy was confident of her skills and capabilities; she expected that these skills be acknowledged, valued, and utilised by her new employer, and this would open the way to advance in her career. Dorothy's expectations were based on her logic and her employer's promise to support her career advancement. However, the reality was different; she felt obstructed and struggled to advance her career in IAPT service. Unmet expectations made Dorothy feel betrayed, resentful, and angry.

Dorothy, *"I couldn't understand why they were not doing it the way it should be done. It was chaotic, and they weren't doing it the way I expected it as they did it [County]"* P3. *"I could use Eye Movement Desensitization and Processing (EMDR) which I was already experienced at, and I was working towards my consultant level in EMDR*." p3

Similarly, Cathy expected her role stays the same after her service became a pure IAPT service as promised by her employer. Cathy felt betrayed and let down by the service when these expectations were not met. Val, Dorothy, and Cathy subsequently had to go through a process of self-negotiation and adjustment to address the cognitive dissonance created by the discrepancy of their expectations and the reality of their role. For example, these two contradictory statements by Val show the apparent conflict experienced by participants questioning the value of IAPT "*what is the point of IAPT; are we doing any good*?" then endorsing the service as a means of enabling recovery *"of course, we do, people get well.*" p15

About unmet expectations, these study findings suggest that when expectations were based on promises by the employer to the newcomers, they had a severe impact when these promises were not fulfilled. For example, Dorothy and Cathy felt betrayed by their employer and lost trust because their employers did not fulfil their promises. Both left IAPT services

while conducting this study. Therefore, it could be surmised that the loss of trust of their employer substantially impacted them.

On the other hand, having expectations based on knowledge or experience seemed to facilitate transition. Four participants felt that their expectations of the IAPT role matched the reality of the role; however, their expectations of the organisation were not met. David, Shirley, Heather, and Julie knew what they were taking on through learning about the role and what it entailed. These four participants reported less frustration or disappointment during their transition as they found the role matched their expectations; therefore, there were no surprises or shocks.

David seemed to understand how the IAPT system operated, which met his personal and professional expectations. David prepared well for his move to IAPT services. He learned about the new role in detail from trustworthy sources, spoke to people, and checked how the new service operates against NICE guidelines and the IAPT framework.

David, "*Yes, very much so. I think talking to people who work in other IAPT services [.....] Yes, it has met my expectations both personally and professionally*." p4

David described how he prepared well for his move to IAPT service and developed expectations based on reality. This preparation was recognised as core to his character, which from a young age, he was required to prepare appropriately for competitive sport. These internal drivers supported a more positive transition experience.

This study suggests that a negative discrepancy between participants' expectations and the reality of their new work role negatively affected their transition, job satisfaction, and tenure.

6.1.4 Physical work environment

One of the significant factors contributing to participants' transition difficulty to IAPT services was an inadequate physical work environment. Participants pluralistically described their physical work environment as "*inadequate*," "*inappropriate*," and "*not conducive to wellbeing*." As a result, participants felt physically and emotionally uncomfortable in their new work environment. Participants talked about what the physical work environment meant for them. Dissatisfaction with this environment stretched beyond concerns about the physical environment to the psychological impact it had on them. Participants described how the inadequate work environment affected their sense of self as being valued by their employers.

Six participants described their physical work environment without being asked directly about it in the interview, which may indicate this topic's importance. The physical work environment meant for them more than just a place of work. Dorothy went into detail in describing her room, the desk, the printer, and the chair. She was portraying an image of a place that was uncomfortable both physically and emotionally.

Dorothy, "It was just you came, you went to a room, it was very basic, the chair was the wrong height you know you had just to make do with the situation, you can't find a space with a very small desk with a big printer, you do work while you eat, you know while you're putting your notes." p12

While describing her office, Dorothy's body language conveyed a sense of discomfort; she was wriggling in her chair as if her body recalled the memory of physical discomfort. Heather's account echoed Dorothy's in terms of the importance of having a good physical work environment. Heather used emotive language to describe the building as "*horrible*," "*poky*," "*ill-lit*," and the usage of "*suffering*," "*enduring*," and "*painful*" indicate the psychological impact of poor physical environment.

The working environment's importance was also evident in Julie's positive appraisal that demonstrated a good working environment was conducive to positive feelings. In the following excerpt, the feelings of happiness, involvement, and pride are noticeable.

Julie, *"they [service users] love the building which I was very involved in, choosing the colour scheme, and was very much involved in that right from the beginning and is a nice building, has a nice feel to it."* p4

Participants' accounts of the work environment indicate the powerful emotional impact of the physical work environment on their wellbeing and transition. Indeed, participants who felt uncomfortable in their work buildings found it challenging to transition to their new work role.

6.1.5 Value

The importance of recognition and feeling valued by the employer came up several times in participants' accounts during the interview, and some participants specifically talked about feeling undervalued in IAPT services. Several factors were mentioned that contributed to this feeling of being undervalued. For example, not being listened to, lack of autonomy, and not participating in decision-making about their jobs. These study findings suggest that not being listened to and the lack of therapists' involvement in decision-making in IAPT services contributed to feeling discontented and apathetic. Phrases such as "*like it or lump it*" (Shirley) "*this is the way things are*" (Cathy), "*you can kick and scream, but nothing changes*" (Heather), indicate a sense of apathy and powerlessness. Not being part of the decision-making process, given IAPT's hierarchical structure, made participants feel irrelevant and that their views did not matter, which fed their feelings of not being valued by their employer.

Val, *"uhm it is difficult I think it can sometimes feel for me it doesn't matter what the patient needs, it doesn't matter about you and your style of practice, what it matters is how many sessions have you had, are you getting recovery? Sometimes, it can feel like the patient or me is irrelevant; that is how it feels, and I don't know if it is how it is."* p11

Cathy, *"I don't feel as fulfilled, uhm, I do with the client work but the organisation and the feeling undervalued, I don't feel fulfilled anymore."* p6

Four participants, all counsellors, revealed they felt unappreciated by their employer and inferior to their CBT colleagues and other psychological therapy therapists. Counsellors spoke of feeling disadvantaged and treated less favourably than their CBT colleagues regarding professional development opportunities. In this study, the counsellors felt that their experiences, training, and qualifications were not utilised to the fullest, and their skills were not used sufficiently, such as offering EMDR and other various treatment modalities. Some counsellors stated that their role shrunk in IAPT services in terms of clinical and supervisory responsibilities. Counsellors perceived the loss of role and responsibilities as a mark of devaluation of their status.

Dorothy, "*Yes, and what I also struggled with is knowing how the CBT was treated compared to the counselling team. They were getting a lot of CPD, they got training days, they've got speakers but for the counselling team if you wanted that you pay for it yourself and I belong to UKCP, so you have to get 50 hours of CPD, and I have to pay for it all."* p20

Shirley expressed some resentment about feeling undervalued, but at the same time, she played it down. However, Shirley's feelings of resentment resurfaced now and again.

"*Well, I feel undervalued within the larger workforce; because there are still a lot of people who think that counselling is such a kindly vicars wife intervention."* p12 *"it is not good is it?*

This one of those things that doesn't keep me awake at night, but occasionally it'll bug me." p13

Lack of autonomy further engendered feelings of being undervalued, and this made the transition experience more protracted because skills and knowledge were not recognised in this new role. However, lack of autonomy was also a vital part of learning the ropes and is therefore discussed in more detail in 6.2.3

6.1.6 Connection and belonging

Five participants described their transition experience as 'solitary' and viewed isolation as a barrier to their transition. Isolation was a feeling they frequently commented on. The isolation here is both physical and psychological. Data revealed that therapists who worked in GP surgeries [n=4] experienced isolation more than others who worked at their IAPT base. The physical isolation was caused by working in GP surgeries where participants had no chance to meet up with colleagues and the rest of the team except once a month in team meetings. Psychological isolation because of workload; staff had no time to communicate and interact with each other or engage in proper clinical supervision. Shirley commented on her need to belong and to connect with other people in her work environment.

Shirley, *"there is not that sense of camaraderie, having a chat about the client. I think it makes us better therapists. It is not there, and that is quite hard."* p16

Participants found the isolation very hard because they felt disconnected from camaraderie with other people in the team. They often felt they were on their own. Participants described the adverse consequences of professional isolation on them both emotionally and clinically. They described feelings of loneliness, lack of feelings of togetherness or camaraderie, loss of laughter and lustre, and not having an outlet to their stress by chatting with colleagues or

laughing. Participants also believed that interacting more often with colleagues and informally discussing complex cases made them better therapists. These brief encounters allow them to share information, knowledge, and experiences.

Cathy, *"not many people come in here if they don't have to. I see my colleagues once a month usually, and I feel there is a sense of loss really with the belonging."* p18

Psychotherapy is emotionally demanding because of the amount of distress therapists hear and absorb and having an emotional connection with colleagues is essential for their wellbeing, as reported by the participants in this study. Professional isolation, among other factors, may cause stress and emotional exhaustion. All participants seemed to value feeling part of a team and having a sense of belonging.

Shirley, "*We are so busy that I don't see them. So that sense of..., I mean one of the reasons I decided to stop my private practice was because I wanted to belong to something bigger."* p16

Dorothy, *"the transition, I found it very solitary because I only saw my own team once a month very briefly."* p7

On the other hand, Val worked with colleagues at a base, yet she also described isolation. It was not physical isolation she described but psychological isolation. Val attributed that to the workload.

Val, "*everybody is overly busy and has no time to have a laugh or a chat."* p10

Heather's comment confirmed the sense of isolation *"Uhm, uhm [long pause], yeah, it has been a mixture. Sometimes it's felt like quite an isolated role, and I think it is a common experience in IAPT services and although some of them now have developed so that may change. The therapist kind of isolated"* p12. Heather shifted the focus from herself to talk

about "*the therapist*" perhaps to emphasise this experience was not unique to her and instead was a common experience in IAPT.

6.1.7 Summary

The super-ordinate theme "*Transition*" described seven non-IAPT qualified therapists' experiences in their early few months in IAPT services. This super-ordinate theme highlighted the expectations participants had of their new role and the organisation, and their physical and emotional experiences in their new work environment.

All participants but one described their early experience of transition to IAPT services as "*difficult*." The difficulties stemmed from lack of support from managers, lack of orientation and poor supervision, inadequate work environment, unmet expectations, and a sense of isolation. Support extended beyond performing their role to the relational and social aspect. Participants expected their managers to be more supportive, empathic, and take their circumstances into account. The lack of support made the transition more challenging for the participants. The lack of orientation to the IAPT role complicated the matter as participants felt confused about enacting their new role. Three participants described inadequate clinical supervision's impact on their sense of professional competence, making them feel insecure and practising unsafely. Participants talked about the impact of unmet expectations on them and the sense of disappointment and frustration they experienced as a result. A sense of satisfaction contrasted these feelings by participants whose expectations of the role were met. The meaning of the physical environment extended to the psychological domain, and the feeling of being physically uncomfortable made participants feel psychologically uncomfortable, which negatively affected their early transition. Four participants, all counsellors, felt undervalued by their employers and inferior to their CBT colleagues. The

impact of professional isolation was felt by five participants and was identified as a barrier to their transition.

6.2 Super-ordinate theme two '*Learning the ropes'*

This next super-ordinate theme, '*Learning the ropes,'* explores how participants made sense of their new role and worked within this system. New ways of working were encountered that had to be adjusted away from more familiar practices they were used to as counsellors or CBT therapists. For many, these adjustments were uncomfortable as they challenged the roots of their professional identity and preferred ways of working with clients. These issues are explored under the following sub-themes 1) Manualised Protocols 2) Recovery Measures 3) Autonomy, 4) Work pressure, and 5) Ethical dilemmas.

6.2.1 Manualised protocols

Participants described conflicted feelings and thoughts about delivering therapy within the IAPT manualised protocols. On the one hand, therapists expressed feelings like being "*a cog in a machine,*" "*pigeonholed,*" "*boxed in,*" "*impotenc*e," "*one size fits it all*" due to the system being overly descriptive and manualised. They described the IAPT system as rigid because they were forced to rigidly adhere to the limited specific manualised protocols for treating specific disorders as per Roth and Pilling (2007). Participants described the IAPT system as restrictive because it did not allow them to use other therapy modalities that are not specified in the IAPT manualised protocols.

Val, "*so we work with anxiety and depression, and sometimes we get a referral for someone who may have a complex journey before they got here, so we're told to work on the symptoms of anxiety and depression, but that is really difficult when they've got the complexities, so I find that really challenging.*" p23

Some participants believed that they were trained, skilled, and experienced in a wide range of treatment modalities outside the manualised protocols described by Roth and Pilling (2007), and they should be able to use them based on their clinical judgment and idiosyncratic case formulation. Therefore, they felt frustrated for not being able to use these modalities as they see clinically appropriate. Hence, phrases like "*had to dumb down a bit*," "*shelf a lot of knowledge and experience*," "*underused skills and experience*," "*my experience is not utilised to the full*" were expressed.

For example, Dorothy wanted to take the initiative and apply the broad range of skills she brought to IAPT; for example, using EMDR. However, she was obstructed and prevented from using EMDR. Dorothy was also obstructed when she suggested groups for older people.

Dorothy, *"And I was told, "where did you read about that in NICE guidelines?" Obviously, I haven't, but instead of spending eight hours with these people every week, we can spend one and half hours [……..]. Uhm, it was absolutely unacceptable. I got put in my place; you just don't go there. They wanted you just to do the job and not question it"* p6. Dorothy inferred that *"quality does not matter, innovation is not encouraged or wanted, and you just do as you are told."* p6

On the other hand, most participants found working within the boundaries of the manualised protocols of the IAPT framework reassuring. They felt protected and practising safely. They felt backed up in their clinical decisions and safe following NICE guidelines. Participants used phrases like "*feel in control*," "*feel safe*," "*protected by following evidence-based practice*." Besides, working within a limited number of sessions provided them with safety and the authority to end treatment when there was no evidence of progress without fearing the repercussions if the client complained. Participants compared working in secondary care

services when treatment would go on and on for months and even years without evidence to suggest progress. Participants' prior experience in secondary care made them more appreciative of the IAPT boundaries and feeling backed up in their clinical decisions.

Another critical point the participants mentioned was following the protocols, documenting their therapy session's content and linking it with the recommended protocols made them feel protected if these clinical notes were legally requested.

David, "*Uhm, initially I was very annoyed because it feels like the experience you have got and the qualifications you have got are being undermined. How dare they tell me what I can do yeah, and I think part of you is that I'll show them, I'll show them I can better treat this person. Uhm, but I realised it is just a process, you know, if I had to stand up and defend myself in court, then for me it would then be able to demonstrate why I did what I did."* p19

The meaning of working within the boundaries of the manualised protocols was unique and varied from participant to participant. For example, for David and Julie, it meant being in control. For Heather, it meant learning and enhancing her therapy skills. However, it also meant she could hide behind the protocols and did not have to take risks in therapy.

David, "*it makes me feel in control, it makes me feel at peace, yeah, and this is how I run my sessions now. I am in control, and I think with the benefit of experience, I don't care what the person throws at me and I can work with it."* p23

For some participants, it meant and indicated a lack of trust and respect for their experience and professionalism. Hence it felt for them like an attack on their professional self (Shirley and Cathy).

Shirley, *"I think it is awful; I mean, you know, we're trained, interviewed, assessed, and all the rest of it. There should be a level of trust in your judgment. It seems to be fear of trust, so I think a lot of that; there is a sense, sometimes, a bit of impotency around that."* p8

Val, *"It felt scary to have treatment plans laid out, this is what you going to do, in this amount of time uhm that was completely new, and I think it was scary because it was something was completely different to me, but that was also a good feeling because I felt protected.... I felt like I had [long pause] I don't know what the word is ... it felt safe, safe way of practising."* p2

In conclusion, all seven participants expressed positive and negative views and feelings about working within the IAPT manualised protocols. The above quote from Val exemplifies this contradiction. On the one hand, participants felt restricted by delivering treatment through manualised protocols rather than idiosyncratic formulation and tailored treatment plans. On the other hand, they felt protected within the IAPT system's boundaries, meaning working within disorders-specific protocols guided by NICE guidelines and within a certain number of sessions. This contradiction required them to learn how to work within the system and be more flexible in delivering therapy.

6.2.2 Recovery Measures

All participants expressed mixed feelings about the recovery measures as a tool for monitoring therapists' performance. On the positive side, participants believed measures could stimulate some reflective and constructive thinking to improve performance. However, they [the measures] could be misused in the wrong hands, and as they stood, taken by themselves out of context and without considering other variables was biased. Participants believed the measures were a blunt tool, an inaccurate measure for their competence, and did

not reflect their clinical practice in its entirety. Recovery measures were cited as a constant source of stress.

Participants reported experiencing anxiety, feeling stressed, and doubting their competence when their recovery rates went down below 50%, which is the minimum acceptable recovery rate therapists should achieve. Some participants feared their monthly management supervision, as these were uncomfortable encounters with their managers. One participant, David, reported feeling like "*a naughty schoolchild"* when his manager reprimanded him because he did not achieve 50% recovery. Central to David's self-esteem was the significance of "*being the best*." For David having less than 50% meant he was not good enough, and when his recovery rate once dropped to 0%, he felt he was "*a complete right off*." p17

Val reported that she felt utterly incompetent when her manager described her recovery rates as unsatisfactory, and her performance would be closely monitored.

Val, *"intimidated, yeah by all of the systems and the rules and the guidelines and the need for recovery and you have to do this and the question why this person hasn't improved. I remember that feeling quite intimidating."* p5

Despite feeling threatened by the recovery measures to monitor their performance, participants expressed some positive views about having some performance evaluative tool. For example, they expressed their understanding of the importance of monitoring and assessing staff performance, and some participants indicated recovery measures make them reflect on their practice.

Heather, "*Yes, it is a pressure, and I've mixed feelings about it. I think it is probably good to be kept on my toes and be stimulated to do some constructive thinking, but it is also a bit scary.*" p32

David, *"it took some adjusting to. I think there is good and bad. The good I think it makes you.... very aware of your own practice, but also it makes you highly susceptible to criticism and scrutiny when things could go wrong and not necessarily your fault."* p11

In particular, in this study, counsellors reported feeling very anxious and threatened by their recovery rate, especially in the early phase of their transition. They were made to believe they were the first to go if they did not achieve reasonable recovery rates. The threat of losing their jobs made them feel insecure and extremely worried. Therefore, they worked extra hard to secure their jobs.

Dorothy, "*They use statistics in a very threatening way, they kept telling us we're the counselling team, so we were not as important as CBT therapists, and if we didn't reach our target we'd be out, we lose our jobs. It was very threatening from the starting point. They actually didn't do that to anyone, but I ended up over-performing because I was so concerned, and I'd better be ahead [.....]it was a very threatening style of management if you don't achieve you will be out."* p16

In essence, participants in this study expressed mixed feelings and views about the recovery measures. On the one hand, participants believed recovery measures made them reflect on their practice. On the other hand, it was a blunt tool to assess their competence as clinicians and could be abused in the wrong hands. So, participants had to learn how to achieve the minimum recovery rate, justify to their managers any drop in the recovery rates below 50%, and balance the demands of doing their job.

6.2.3 Professional Autonomy

One of the central challenges that participants had to face during their adjustment to their new role was asserting their autonomy. These study findings suggest that these IAPT therapists valued autonomy, creativity, and independence and considered it crucial to enhance their morale in IAPT services. Participants felt disempowered by the lack of autonomy within the IAPT framework. Autonomy meant for them to be empowered to apply their skills, knowledge, and expertise to their client's best advantage. Asserting their autonomy posed a specific challenge for five participants.

The lack of autonomy has led to feelings of disempowerment amongst participants, affecting their job satisfaction and sense of professional identity. Participants used phrases like *"you[r] just a person that provides statistics you know"* (Cathy, p14), "*you really [do] not have a say"* (Dorothy, p8), "*dismissed, I am just a person here to deliver a very prescribed treatment"* (Val, p17); to express their feelings of disempowerment.

Shirley was very proud of her work experience in her home country, where she felt more autonomy and flexibility. In contrast, working in this country, she felt constrained and restricted and believed this was across the NHS.

Shirley *"I had a lot more freedom and autonomy as a clinician than I do in IAPT, but to be fair, I looked at other roles within the NHS and found in fact in any service it is very limited."* p7

Shirley expressed feelings of powerlessness and hopelessness about a fundamental change happening in the NHS. She believed the NHS is plagued by bureaucracy; it is not only the IAPT system and its structure but the whole of the NHS.

"I think that is true, but I think it is true about anything in the NHS. I suppose I feel a bit protective of IAPT (laughter). It is a pain in the neck, but a pain in the neck you see it right across the board but on a smaller scale, but how the system is set up is basically like it or lump it." p17

Non-IAPT qualified therapists come to IAPT with knowledge and experience from a broad range of disciplines, bringing a diverse set of skills and perspectives to the profession. However, some participants felt their skills, clinical experience, and knowledge were underutilised in IAPT services. Some said that they had to dumb down a little bit by working in IAPT as they had to shelf some of their resources because it was not in IAPT manuals. Another participant commented, "*it is a waste of professionalism*." Some participants felt they did not matter; what the patient wanted did not matter, but what mattered was achieving recovery and hitting targets.

Cathy, *"it is a waste of professionalism, and it is kind of, I feel like people being told we can't help you go elsewhere and the cherry-picking, so, I don't feel they are utilising the profession and the experience."* p22

Some participants defended their therapy style and their convictions based on their learning, experience, values as therapists, and their value in their work.

Heather, "*I am not just using such and such models because the IAPT training says*." p19 Heather was asserting her autonomy *"So as far as I am concerned, the IAPT training may say this and that but if something seems to my experience worked better so that I'd use."* p19

Julie, *"Uhm, the autonomy comes from my previous training. It doesn't matter what IAPT is saying outside. When I am in there with that person, I'd use whatever works for the client. I am not hung up on recovery; I may when I was younger but not now."* p24

In the above quotes, the professional confidence and flexibility that came with experience and professional maturity were evident. Heather and Julie were able to maintain their autonomy within the IAPT system. They felt it was incumbent on them to select the best treatment approach for their clients based on their clinical judgment and formulation. Although both felt restricted by the IAPT manualised protocols, they still maintained their sense of professional autonomy. It is unclear why some participants struggled to feel autonomous in their IAPT role, and some did not. It appears that therapists who were willing to take clinical risks and provide treatments based on formulation did so. It also seems that participants who had lots of experience and worked in different NHS settings were able to balance complying with the IAPT framework and using their initiative. This could be explained that these therapists felt more professionally confident. Another explanation could be it depended on how participants and managers interpreted the IAPT framework.

6.2.4. Work pressure

All participants reported that the workload in IAPT services was heavy, very pressured, and fast-paced. Participants stated that the number of contacts and the endless need to input data is another pressure in the IAPT system. Furthermore, participants reported experiencing stress because of the high workload. Also, participants stated that the way the IAPT system ran was unsustainable in the long run as this demand was affecting their wellbeing. Heather expressed this point of workload repeatedly throughout the interviews.

Heather, *"Uhm, so sort of seeing people back-to-back it's always had its own challenges. I did that in secondary care as well, but it is faster and more consistent in IAPT, so that is quite hard."* p15 *"Uhm, [pause], yeah, think about whether you can stand the pace with that sort of number of contacts and the endless, the endless need to put in data."* p37 *"Uhm, as I said, it's been fast and furious in IAPT."* p28

Shirley, *"Because we get a lot of referrals and the team is expanding so sometimes, I feel sort of pressured to get someone going and say come back when you are ready."* p15

Julie, *"When I was working in secondary care, the pace wasn't fast enough, and it needed to change, but in IAPT it is always something coming out* as *you alluded this 25% access. You know; how?"* p26

The fast pace of change in IAPT puts more demands on the staff, and without an increase in resources, managers and staff are struggling to keep up with the pace of change and increase in demands. Participants reported that they were under constant pressure to provide the briefest possible treatment, often to reduce symptoms. As their recovery rate measures therapists' competence, so they had to absorb the pressure of working in a fast pace environment with complex clients to hit the access rate targets and at the same time achieve good outcomes to hit the recovery rate targets. All the participants expressed their frustration with the incompatible demands from the organisation. Dorothy described the intensity of work in an emotive statement.

Dorothy, "*The PWPs the turnover was very high, and of course, we had to do assessment too to help out because of the waiting list. So, it really felt like you just couldn't breathe, because if you have a gap, they spotted it and they filled or the pressure to fill it, and meanwhile you really think I've got to get things done, so the intensity is part of the problem in IAPT."* p23

The above excerpt gives the impression that staff are suffocated by the load they are carrying. Staff are under constant pressure to reach targets, and they are overworked. A huge learning curve for the participants following moving to IAPT services was how to manage these competing demands.

Moreover, participants reported getting inappropriate referrals outside the remit of the IAPT framework was challenging and added to work pressures. Participants believed IAPT that started with a clear mandate became a dumping ground for people who did not fit other services.

Julie, "*as a therapist is getting inappropriate people into the service. Mental health has never been able to deal with them. It is always this middle band of people with disordered personality; they don't function well, they don't hold, they don't manage emotions well. We end up seeing them in IAPT. They don't fit with secondary services, but they don't fit with IAPT either."* p20

Furthermore, seeing unsuitable referrals to IAPT services such as patients with complex clinical presentations or severe pathology added to workload pressure. Three out of seven participants reported that working with complex clients beyond their competence was a source of stress. Participants explained they were forced to see them because they [the patients] did not fit the secondary care service criteria, and they were under pressure to achieve the access targets.

Dorothy, *"More and more conditions, you have to, all the challenges you have to work with, away from the area of your expertise."* p14

Participants described the endless need to input data concerning work pressure as another burden in the IAPT system. Participants explained that data was of significant importance in IAPT services, and it took a long time to input this data into the system. Participants realise the importance of data in healthcare; however, they believed the amount of data input could be reduced to give them more time with their clients and reflect on their practice. Participants commented that they needed to think of the data as well as their clinical work.

Julie, *"absolutely, yes, the data is a huge thing in IAPT nowadays."* p11

Shirley, *"by the time I ticked all the boxes and the benefits and all of this and all of that, my energy drained. I have to really think, what did that person really say? So, it is a bit of a pain."* p8

Shirley's quote portrays a picture of a person who is overwhelmed with the administrative tasks and has no energy left to focus on the clinical work.

In summary, the participants felt under strain to manage the workload in IAPT. They were learning to manage the competing demands in terms of working fast enough to hit the access rates and competent enough to hit the recovery rates. They also were learning to manage the considerable data input and to working with complex cases outside their area of expertise. All these new learnings were stressful for most of them and made their early experience in IAPT unenjoyable. Hence, several participants expressed their regret at moving to IAPT.

6.2.5 Ethical dilemmas

The findings indicate that some participants experienced discomfort about some of the work processes and procedures in IAPT services. These issues were expressed by participants as ethical dilemmas. On the one hand, therapists had to conform to IAPT rules and processes. On the other hand, participants knew that these were real people with human suffering and not only figures and statistics. This sub-theme sheds light on some of the ethical dilemmas the participants struggled with within IAPT services: turning people away who were below caseness [scored less than 9 on PHQ 9 questionnaire and less than 7 on GAD questionnaire]. Also, seeing people with complex clinical presentations outside the IAPT remit to boost access rates, tactically holding on to patients unnecessarily to boost recovery rates, and IAPT 'back to work agenda'.

Shirley, "*Uhm in [County] we don't have much step 4 service, so very often I see somebody who is assessed by PWPs, which is more of a ticking box exercise. It is more of a call centre really, and when you actually see them realise, they are really far more complex, and that is a dilemma because I will be told we don't do that they need to be discharged, and I struggle with that, I got nowhere else to send them to*." p4

Val, *"I discussed it in supervision; this person needs this, but as a service, we can't give them this. As a therapist, I feel I could, but as a service, we don't and then knowing they're possibly going to be left without their needs met because possibly no one else will give them either."* p14

Similarly, discharging patients or holding on to them in a tactical way to boost access rate and recovery rate figures caused an ethical issue for some participants. Heather expressed mixed feelings about this issue and felt conflicted about what to do.

Heather*, "I feel very conflicted about it, and it is a mix. Sometimes I think I may have gone too far working with somebody when, ideally, I should've stopped sooner or said no, to begin with. I mean other people; I feel IAPT has forced me to abandon them when I actually think they might have been quite promising."* p27

"*IAPT forced me to abandon them*" manifests a sense of connection, responsibility, and powerlessness. Heather expressed strong emotions of pain, anger, and powerlessness in the interview. Heather wanted to help everyone who came to the service; however, she quickly looked at the issue from the organisation's perspective. In the next excerpt, Heather was trying to reconcile two conflicting perspectives.

"*I can see we are constantly trying to find a balance, and there are a lot of conflicting demands and expectations, so in a way, this is just another episode in working life. You have to tiptoe through the minefields (laughing).''* p27

Heather depicted an emotive picture of how she walked through the psychological dangers in IAPT while trying to keep herself safe. Heather, in the above quote, touched upon several points. Firstly, in IAPT services, therapists have to make difficult clinical decisions and choices to balance conflicting demands. Secondly, this process was emotionally and psychologically taxing and could be detrimental for therapists if they were not careful. The use of '*tiptoe through the minefields'* suggests there is very little room for manoeuvre, and a single misstep can have serious consequences. Heather then rounded it all up with a note of impotence instead of feeling effective and useful in IAPT.

Heather, *''We can only do the bit we are hired to do, and we're capable of doing it as well. So that is quite painful. There is human suffering out there, and I am not doing as much as I'd like to help, yeah or I can't alleviate.''* p28

Heather was reflective throughout the interview; she tended to see things from different perspectives, and she seemed to accept that life was not perfect. She was also willing to compromise and work through challenges. Heather was able to see the bigger picture, and that gave her a different perspective on things.

Shirley struggled with the IAPT 'return to work agenda' (Department of Health, 2007). She believed it was not her role as a counsellor, and it should not be one of her goals in working with clients.

Shirley*, ''the only thing that I struggle with a little bit, there has been a lot of add on. I mean, we have an employment team; I don't care what somebody does for a living, I don't*

care if they are on benefits. If NICE wants to get them well to get to work, you know what, that is not what I do, it is just irritating." p19

The sense of irritation and defiance is apparent in the above quote. Getting people back to work was not one of Shirley's goals in therapy with her clients. Therefore, these ethical dilemmas added to the stress and anxiety the participants experienced in working in IAPT. The participants had to work through these ethical issues to find a place where they felt comfortable, and this theme will be discussed under adjustment 6.3

6.2.6 Summary

In conclusion, the super-ordinate theme of '*Learning the ropes'* critically evaluated participants' endeavour to make sense of their new role and the system. Participants' accounts revealed mixed emotions and sometimes contradictory views. They described the new role in IAPT services as restrictive, reassuring, threatening, empowering, and disempowering. However, what was consistent in all the accounts was the IAPT system's rigidity and their struggle to cope with the workload. Participants also raised some ethical issues, which were important in this super-ordinate theme as they conveyed a sense of anxiety and discomfort. The next super-ordinate theme is about how participants adjusted to their new role in IAPT and what facilitated their adjustment.

6.3 Super-ordinate theme three '*Adjustment*'

The super-ordinate theme '*adjustment*' discusses the processes participants went through to adjust to working in IAPT. Participants' accounts are discussed under the following sub-themes: 1) Accepting reality and lowering expectations, 2) Fitting in, 3) Professional identity, 4) Facilitators of adjustment.

6.3.1 Accepting reality and lowering expectations

Participants' accounts indicated overtime that they accepted the reality of working within the constraints of an IAPT service and adjusted their expectations to align with the way the service functioned. Participants stated that they realised they were expected to work the way they were told and not to initiate or question. All participants reflected this by saying, "*it is how it is done in IAPT*." Participants cited that gradually and over time, things got better, and they learned to live with the rigidity of IAPT. "*Learning to live with it*" involved a learning process about finding out, reflecting, and taking in how things were done in IAPT. "*Learning to live with it*" for the participants entailed accepting reality, observing others, and changing self, regarding expectations, cognitions, and behaviours.

Shirley, *"I've come to accept that. It doesn't bother me as much as it did (pause) Uhm, but really I don't like it."* p31

Val, *"I still feel the same [laughter], but it doesn't bother me now, and I just have to respect that is the way it is [……..] Uhm now it just feels like the norm, it is what we do."* p29

A reasonable interpretation of these responses would be that both Shirley and Val had resorted to compartmentalize their cognitions, feelings, and behaviours. Both indicated that they still believed that IAPT was a rigid and restrictive system, which they did not like. However, they learned to reduce the impact of these conflicts on themselves. This emotional acceptance seemed to be related to their acceptance and respect for the IAPT system, and soon this became the norm:

Val, "*it is what we do*." p29

Acceptance and positive appraisal of their experience enabled some participants to feel a sense of acceptance to the IAPT system. Viewing their expectations more realistically helped

some participants to express a feeling of reconciliation and admission of the rewards of working in IAPT. For example, they valued what IAPT services offered to increase access to psychological therapies, seeing more people with mental health problems than ever before, using evidence-based practice. For a couple of participants, they felt they were clinically stretched and became better therapists.

Julie, *"I think I am more effective as a practitioner, definitely, maybe not as likable, but then we are not here to be liked."* p19

Participants were also appreciative of the attention mental health services were given due to launching IAPT services a decade ago. They compared how mental health services were neglected in the past in terms of budgeting, training, and development to where it was now.

Heather, *"I suppose because I've been around for a long time, I can remember when there were no primary care mental health services. So, I have this perspective as well, so I actually what we are offering is very considerable even if it has its limitations and it is a heck of improvement, from not having primary mental health care. So, I can remember when some GP practices were hiring a counsellor, and that was it. There wasn't anything else uhm. So yes, I suppose a bit of experience gives a perspective."* p15

It could be postulated that these therapists managed to appreciate some of IAPT values and goals, and some of their ethical dilemmas, such as rejecting clients below caseness or working within a limited number of sessions, were actually for the good of society as a whole. They took a more comprehensive view and developed different perspectives to understand and learn more about the service and its structure. Also, participants expressed their pride in working for the NHS that they valued and held in high esteem.

Dorothy, "*I really like to work for the health service."* p9

Julie, "*there was something about working for the NHS, it made me feel quite proud, to be working in that way uhm and in a team uhm and it still does, working with people who are similar minded. I always had that pride in working within a Trust."* p10

6.3.2 Fitting in

Following participants' cognitive acceptance of IAPT as a rigid system, they went through a process to fit the role. Participants learned to change themselves in terms of expectations, cognitions, and behaviours to fit in the new work-role. Participants changed their expectations from how they perceived things should be done to how they were required to be. Participants realised they could not change the IAPT system. Participants described how they adjusted their thinking to reconcile the cognitive dissonance of working for two opposing agendas and conflicted demands. IAPT agenda focused on data regarding outcome measures and target rates and their agenda of working therapeutically and relationally with clients based on an idiosyncratic formulation. Participants also adjusted their behaviours; they learned to censor what they said and edit themselves to appear to be conforming to the IAPT framework. These strategies allowed them to keep their jobs. However, it indicated incongruence between participants and their organisation.

Val, *"I remember thinking rather than what does the patient need; to what I need to do to get him to recovery. Uhm, it felt very pressured, and sometimes it does still. I think. I know where I'd like to go with this, but it might take a bit longer than we've got, so sometimes, [.....] so, we're not going to touch that let's stick with this and not always knowing this is the best for them."* p14

The above quote illustrates Val's attempts to reconcile two opposing agendas the patient's needs and the organisation's demands.

Similarly, Dorothy changed aspects of herself to fit in with the organisation's norms. She learned to adjust her behaviours and how she came across to fit in with the new environment. Dorothy learned to censor what she said. This change was a strategic adaptation and was done consciously.

Dorothy, *"So, I think within myself I started to learn what I could say and what not to bother with [laughter]. I really learned how to edit my- self to a great extent,"* p11. *"I didn't offer groups anymore, I didn't show much initiative, I did the job and did the best I could, but I accepted it was a very restrictive way of going about things."* p12

Interestingly, David went in the other direction. When David first moved to the IAPT service, he was too keen to follow the IAPT manualised protocols. It caused him anxiety if he deviated from the model. Furthermore, David felt obliged to justify in the client's clinical notes why he deviated from the model. David felt safe and in control within the IAPT framework and within its boundaries and rules. However, after a while, David realised this was not healthy for him. In the next excerpt, David reclaimed his professional autonomy; he was more flexible in his thinking and treatment approach. David used his clinical judgment to run his therapy sessions according to the client's needs.

David, *"What I used to do I must stick to the model, I must stick to the model, I must stick to the model, but actually now you can step away from the model. (Interviewer: so, you are more flexible now in your approach), yeah yeah because it was drummed into you that these are the models that are used for these disorders. I don't do that now. If there is a model that fits that person, I don't do one. If not, I do an idiosyncratic formulation."* p12

What is interesting here is that when David was gently challenged by the interviewer that 'sticking to the models' is an integral part of the IAPT system, he defended the change in him

"It doesn't necessarily fit that well but what it does fit well with me. It also fits well with my results; it also fits well with my sustainability to keep well and be able to do it. Yeah yeah." p13

All participants talked about how they changed, having transitioned to the IAPT role. For some, the change was at a subconscious level, and for others, it was a conscious process that involved thinking, weighing pros and cons and making a concerted effort to change.

Julie, *"I did have to make changes because in IAPT it is more structure [.....] I had to think differently. So, in IAPT, I have to make up my mind what I am working with, and actually, I think it suited me very well."* p19

In the above quote, Julie made conscious decisions to change. She knew why she needed to change and adjusted her thinking to align it with working in IAPT. Julie cited she was happy with the change, and hence she embraced it. On the other hand, for Shirley, the changes were happening at a subconscious level. Shirley was not aware of the change until she suddenly realised that she had changed in her new IAPT role.

Shirley, *"I think I have changed and when it came sort of hit me I suppose was when I was supervising a counsellor who was relatively new to the field, and I found myself mirroring what my supervisor said to me, "what is the goal, why are you working so hard, maybe they need to be discharged and come back when they're ready to work hard" and all that sorts of things that actually weren't necessarily my philosophy. When I actually realised, I started to sound like them."* p18

Shirley spoke of her shock when she realised that she was mirroring her supervisors and has become '*like them*.' This quote illustrates a subconscious process, whereas Shirley has

internalised the organisation's "norms" and adopted their philosophy without being aware of this process and was shocked by this.

Cathy also had to change, but for a different reason. Cathy was lamenting the loss in her role due to reducing her supervisory and leadership responsibilities when her service became a pure IAPT service. Cathy explained that she used to be vocal and express her views, however, as she felt insignificant due to the changes in her role and reducing her responsibilities, she learned to keep quiet.

Cathy, "*[long silence] I think I've had to become less vocal. I felt suppressed by what's happened and the changes. I feel I have always got a voice, and because of the feeling of not being important, so, I kept quiet; I kept things inside, I believe. Yeah."* p17

The following quote illustrates how suppressing her feelings affected Cathy.

"I've lacked the feelings of lustre and excitement at work. I'd go to a meeting and have things to say, and uhm, I occasionally do, but I tend to keep quiet. And just listen, not really feel part of it." p18

The above quote represents a fractured sense of self that no longer wishes to be present and active, preferring to be withdrawn and distant from the organisation. It also highlights several changes that happened to Cathy during her adjustment: emotional, cognitive, and behavioural. Cathy talked about losing the sense of lustre and excitement at work.

"[pause] some avoidance, I think. Avoidance to come to the office unless I have to because I don't need to. I am quite a gregarious person and like people, and I like fun and because there isn't any, so I avoid coming in if I don't have to." p18

Cathy's mode was subdued with a sense of powerlessness in the interview. Cathy also felt she did not belong to the organisation, and hence she felt detached. Cathy used avoidance as a strategy to affirm her detachment.

6.3.3 Professional identity

All participants reported they could not fully identify with the IAPT system. They expressed that the gap between their values and IAPT values and goals is too wide to reconcile. Participants' accounts strongly affirm their pride in who they were as counsellors or CBT therapists and valued their experience, skills, and therapy style. All Participants valued their autonomy and did not like to be dictated to about how to do their job. They expressed that the way the IAPT framework was implemented was undermining their skills and experiences. Phrases like "*I am a CBT therapist, counsellor; not an IAPT therapist*" indicated participants who had held onto their professional identity and did not readily embrace the new IAPT identity. Subsequently, these participants felt that their sense of professional identity was under threat. Although accepting the "organisation's norms" about how things should be done, they found a way to keep their sense of self -respect and professional identity.

Cathy, "*I was employed for being a person-centred counsellor, and that is kind of who I am and if they want to change me, if they make me change if I had to say you can't talk about your bereavement that is the day I go, yeah. If it is too far removed from what I believe in, I can't work like that. And, it is quite good having the respect; no one really can tell you how you can work."* p16

The sense of pride and defiance is almost palpable in the above quote. It is also noted the oneness between the professional self and Cathy's personal self. For Cathy, being a person-centred counsellor is not just a job she does, but it is part of who she is; that is why the sense of pride and the need to protect this part of her identity was powerful.

David, "*Well, my job title is Cognitive Behaviour Therapist, and that is one of the things I was keen to hang on to when I started because I am not High-Intensity Therapist and had not done the High-Intensity training [Pause] I have done the CBT training and for me there is a bit of a personal pride, in that my training was very different to High-Intensity training and I wanted this distinction made clear in my job title."* p18

In the above quote, David expressed his pride in being a CBT therapist and his rejection to be identified as a HIT. David's comment was infused with a sense of superiority of his training and his title as a CBT therapist.

6.3.4- Facilitators of adjustment

Participants in this study mentioned several factors that facilitated their adjustment. These factors were: focusing on clients' work, building support networks, prior occupational experience, personality traits, and taking care of self.

6.3.4.1 Focusing on clients' work

This study's findings suggest that clients' work was a source of satisfaction for participants and motivated them to do their job to the best of their ability. All participants stated that they loved what they did despite all the challenges they faced in IAPT services. They valued working for the NHS and felt proud. They found client work gratifying and enriching. Despite the challenges in IAPT services, participants reported that they were making more difference for more people in a constructive way in IAPT services than in secondary care services. There is a better match between what they could offer and what clients can get, and they believed they were making a difference.

Julie, *"I think there is always a reward in working with people on a one-to-one level, and I've always enjoyed the therapeutic aspect, no matter what therapy I am using, what patients I see. I've always got a reward from it."* p10

Shirley, *"I really like seeing people get better."* P4 *"I can't stress how much I love what I am doing. I can't imagine not doing what I do, and that's helped.*" p24

6.3.4.2 Building a support network

Reaching out for support from colleagues and forging strong relationships with colleagues and peers was rewarding and empowering for participants because it helped them manage the ups and downs of adjustment. Family support was also cited as a significant factor that kept them going. The support from colleagues, in particular, compensated for the lack of belonging to the organisation. Participants felt they belonged to a group that shared the same values, beliefs, and views regarding psychological therapy. They also shared similar experiences of frustration, disempowerment, and feeling like they were not being heard. Some described having a supportive group as their secure base; they went back to when they felt shaky and insecure. They described a sense of camaraderie "*we are all in it, under the same pressures, and dealing with the same challenges*."

Dorothy, "*I think from my experience of coming over to IAPT that I think that kind helps people to form strong relationships and to bond. Peer support is very good and can be rewarding."* p26

Julie, *"I think it did help because it is like having a secure base, I can go back to I can feel comfortable. I think this did really help because I think if I'd had it wholly on to IAPT and had not known people. I think I might have been a bit shaky."* p31

6.3.4.3 Prior occupational experience

Participants stated that their prior occupational experience mitigated the stressors of working in IAPT services. As experienced therapists, they drew on their knowledge, skills, expertise, and previously working with complex clients. Participants also indicated that working in various services, sometimes in difficult working conditions such as the prison service or managing an acute ward, provided them with resilience. Prior work experience enabled them to use their usual coping strategies to deal with the challenges of working in IAPT.

Heather, *"where I've come from, I was kind of used to some of the stuff they considered deterioration."* p14 *"Some IAPT staff oh my God, what is going on, this is terrible and uhm, so yeah some of the stuff. Some IAPT staff may have perceived it is deterioration; I saw as normal; I am accustomed to that anyway."* p34

Val, *"So I think what helped me was working in the prison service was tough. I saw a lot of violence, and there were a lot of changes, so I think being able to manage difficult working conditions helped me to be a bit more tough."* p31

6.3.4.4 Personality traits

Participants described their own understanding of how their character influenced their process of adjustment. Other data alluded to character traits that enabled them to adjust to their new role. For example, they utilised their positive personality traits to help their adjustment. Qualities such as self-awareness, flexibility, resilience, and acceptance were reported that helped participants withstand the challenges of adjustment and moderated the stress they experienced.

Julie, "*Yeah, I think I am resilient, and I think that helped me*." p32

Dorothy, *"Well, you know I had to be very resilient over the years, and again I attribute some of it to my culture. I grew up in* [redacted] *[Country of origin redacted to maintain anonymity] during the time when it was very isolated internationally, and there were sanctions and everything, you know, and I haven't done anything wrong. It was the country I was born in, and you grow up with the mentality no one was going to be there for you, you have to do it yourself. So, I think I just work hard, work hard, be responsible, and do my best and have a go at it."* p27

6.3.4.5 Taking care of self

Participants cited that taking care of oneself was crucial in coping with the stresses of adjustment to their new work role in IAPT services. Participants identified that self-awareness and reflexivity helped them take care of themselves better and change some aspects of their cognitions and beliefs and change their unhelpful behaviours. Several participants realised that they were putting many demands on themselves because of their beliefs. For example, David realised that his competitiveness and desire to be the best were coming from himself, not from the IAPT service.

David, "*it was really positive at first because I wanted to go out there and show look how fantastic my therapy is, look at the wonderful results I can generate (Interviewer: yeah) kind of die-hard. But obviously, the longer I have been in it (Interviewer: yeah), the more flexibility comes to my thinking. Yeah, for me now, with all honesty, I do the best I can each month, and once my time up, I say bye*-bye." p22

David indicated that he was now more comfortable with his role and has more freedom in doing his role within the IAPT framework's constraints.

In the next excerpt, David reflected on the process of change and compared his earlier attitudes and behaviours to his newly evolved ones. The quote suggests that David was still in control, but he was more compassionate to himself now.

"When I was in secondary services, I was just drifting, and then when I came back into primary care, it was all about really upping your game, really sticking to all the models doing what you need to do (Interviewer: yeah yeah), that worked, but I realised it [long pause] was unhealthy (Interviewer: in what way) because you can't sustain that personal recovery rate. It is just impossible, so what I have done I just tapered it down. When I came to IAPT, I said I'd turn my volume control to 10, and everything was full-on, I'm getting it back where it should be." p24

Participants provided several examples of taking care of their wellbeing; having a work/life balance helped to ameliorate the stress of adjusting to a new work role and a new system. Exercising and focusing on a healthy lifestyle was an effective strategy for releasing stress after a long day at work. For example, Val used Mindfulness and self-compassion when she doubted herself and her competencies when managers closely monitored her performance. She reported that using Mindfulness and self-compassion increased her resilience and wellbeing and enabled her to see things from a different perspective to improve her performance.

Cathy, *"Yeah, self-care really, walking and swimming, yeah family, I got a supportive husband, and he is good you know."* p10

Investing in spending quality time with family and friends, developing new hobbies and interests outside work were identified as ways participants employed to take care of themselves.

In conclusion, the super-ordinate theme '*adjustment'* discussed the participants' cognitive and behavioural changes in their Adjustment to their role in IAPT services. Participants accepted that the IAPT system was rigid and realised they were unable to change it so, they had to change themselves to fit in with their new role. Participants changed their behaviour to be in line with how the system functioned. An attitude of acceptance to the new way of working helped participants acknowledge the new role's rewards. Although participants learned to align themselves to how the service functioned, they did not fully identify with the IAPT role. Participants held on to their professional identity as CBT therapists or counsellors and did not fully embrace the IAPT role's identity.

Participants drew on their coping strategies to manage the stress of the new work role. They learned to take care of themselves and cultivate other interests outside work.

6.4 Super-ordinate theme four '*Transformation*'

Having examined the experiences of adjusting to the IAPT system, this super-ordinate theme '*Transformation'* evaluates the process of transformation as participants moved to a position that embedded them within the IAPT services as confident and competent therapists and what was important in facilitating this process. This super-ordinate theme has no sub-themes because every participant's transformation was unique, and no common themes have been identified. The participants' transformation processes involved a structural change in how they saw themselves and their relationships with their organisations. Their values underpinned this structural change.

All participants in this study implied, directly or indirectly, how their experience in IAPT services had transformed them to some extent. The transformation was a result of an increase in self-awareness and the demands of the role.

It appears that the transition experience led to both professional and personal growth. Therefore, the super-ordinate theme '*Transformation'* critically discusses how the changes participants made to adapt to the IAPT system resulted in their transformation.

For example, self-awareness helped David to re-examine his beliefs and values and make conscious changes. David realised that he could not sustain his high recovery rates and accepted that he needed to lower his expectations. He realised the negative impact of his attitude on his physical and mental health. David challenged his core beliefs and his perception of self as a performing self. He became more aware of the issues that stemmed from his upbringing and their impact on him. It appeared that David evolved both personally and professionally. Personally, David seemed to have renounced the performing self and has become more authentic with who he is. The following quote suggests that David did not need the audience [managers and colleagues] or the recovery measures to bolster his once, was a fragile sense of self "*yeah like a naughty school child… yeah [pause] initially it is not nice, …but excuse my language sod them I did the best I can."* p8

David, *"some from the role [the pressure to be the best] some from the people who see you in that role and a substantial part comes from my stuff about needing to prove (……) about needing to demonstrate (……,) certainly there were early stages that went on for(.....) for a long period whereas now(.....) went on for a few months, and I thought actually it is ridiculous [pause]. Uhm, I realised how unhelpful for me to maintain it, um because some of the pressures and some of the demands were internal, um certainly there were demands and pressures from colleagues, um basically what I started to do is deflect it back, rather than assuming that it is my responsibility to make it right and solve it which has always been my experience in the past."* p22

It is noted in the above quote, David did not utter the phrase "*to be the best*," although one can surmise it was what he meant when he said, "*needing to prove…… about needing to demonstrate……..*" Not mentioning *'to be the best*' contrasts with his earlier account when he first joined the IAPT service, where '*to be the best*' was repeatedly mentioned. It could be interpreted as his desire now was to distance himself from his earlier rule of '*I must be the best.'*

The above quote illustrates the transformation in David. David started his IAPT role keen to show everybody how good he was and compete with everyone and against himself. The performing self was at the forefront and took centre stage. Gradually and over time, the authentic self was more evident in his comments, with the performing self, receded to the background.

In contrast, Val came to the IAPT with expectations that her team and manager would be like a family of care and compassion. Val thought she would be supported and taken care of. Val felt professionally vulnerable when she moved to the IAPT service due to not having worked before in the NHS. Over time, Val realised it was not what she expected, and she needed to see the reality for what it was. Val showed insight by acknowledging this was how she saw things, but things, in reality, may be different. This insight helped Val change her attitude from 'what the system should be' to 'this is the way the IAPT system is.' The next excerpt reflects Val's increased confidence.

Val, "*I think for me it is about staying grounded and keeping with the client work and just being aware of all of that going in the background but not allowing it to get in the way, but this can sometimes be challenging."* p22

The confident professional self has replaced the fragile self in the early phase of transition. This transformation was the result of seeking information, learning, and observing colleagues.

Dorothy's transformation is another example. Dorothy's early lonely self has evolved into a socially connected self. When Dorothy talked of her early experience of moving to IAPT service, the lonely self was evident. As the interview progressed, Dorothy's social and a happier self has shone through. The following quote illustrates this example of seeking connections and investing in relationships and social activities. Dorothy also explored new opportunities to progress in her career and decided to leave IAPT.

Dorothy, "*We all got on well, and it was four of them [colleagues], and we kept in touch as friends and so invited them at lunchtime for a meal at my place, and it was so much fun*." p29

This study suggests adapting to the new role in IAPT services was both a challenging and rewarding experience. Participants found the work with clients rewarding; however, the IAPT framework's rigidity and the management left them feeling dejected and disillusioned. The results also highlighted participants' resilience and resourcefulness and their determination to stay faithful to their values and ethics of the profession and true to themselves. Participants went through significant reassessment and growth phases in which familiar assumptions were challenged, and new directions and commitments were charted. This perspective transformation reformulated the criteria for valuing and for taking action. Behaviour change was a function of such transformation. The participants in this study appeared to have moved through a gradient that involved a sequential restructuring of their frame of reference for making and understanding meanings (Mezirow, 1978). They

[participants]were not only reacting to their new IAPT culture but doing it critically by analysing and creatively integrating the new work role experience in IAPT.

6.5 Summary of the findings

This chapter examined the four super-ordinate themes identified in the data. The first super-ordinate theme, '*transition,'* discussed participants' struggle throughout the first year of moving to IAPT services. The difficulties stemmed from a perceived lack of support from managers, poor orientation to the IAPT system, poor clinical supervision, inadequate physical work environment, and not feeling valued by the organisation. Participants could not identify with their organisation, which negatively correlated with their sense of belonging and resulted in feelings of alienation.

The second super-ordinate theme, '*learning the ropes,'* described participants' endeavour to understand and make sense of the IAPT system. Participants described feelings of confusion, a sense of disempowerment, anxiety, work pressure, isolation, and ethical dilemmas. These feelings resulted in more alienation because of divergent goals and values, which were difficult to reconcile.

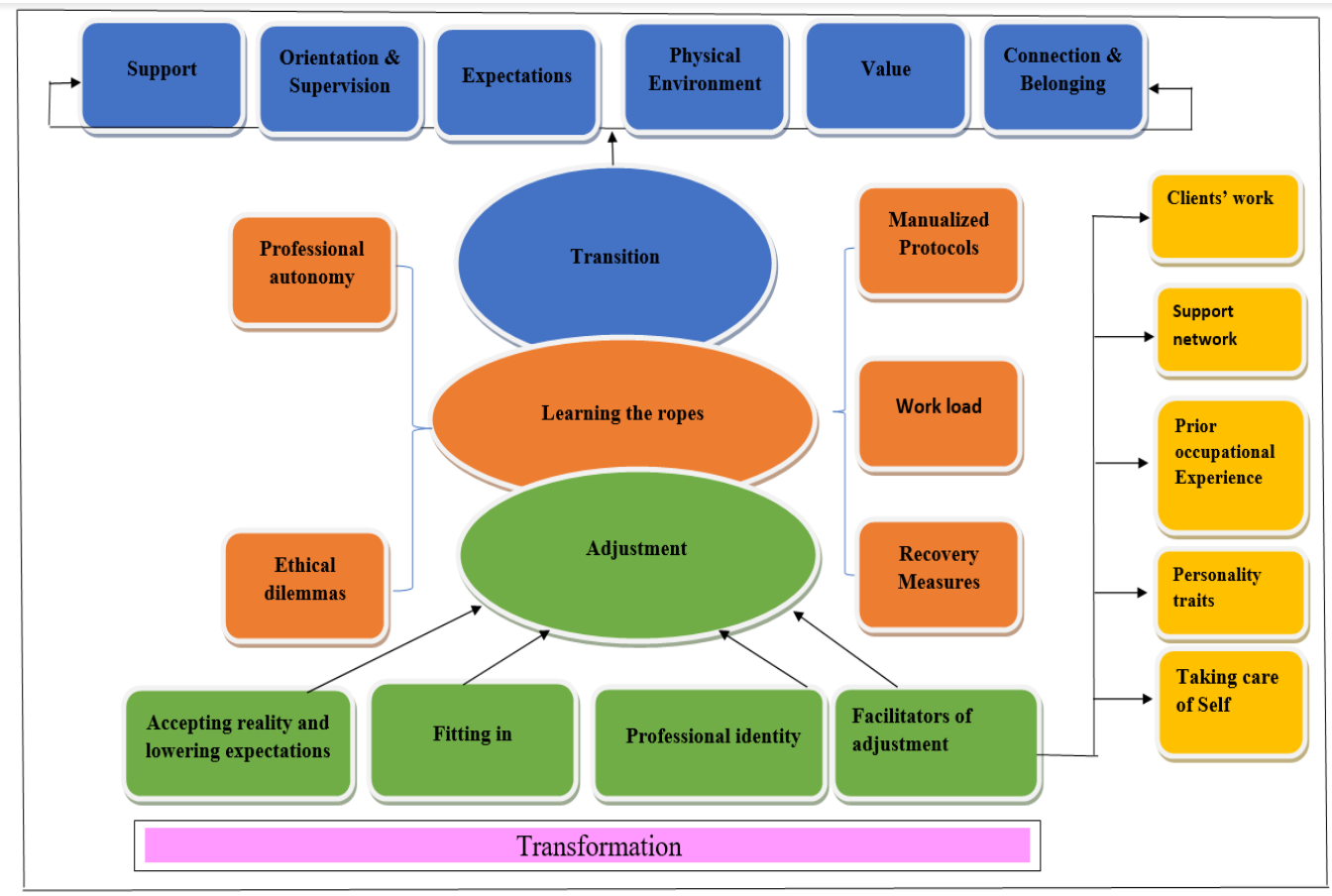
The third super-ordinate theme, '*adjustment,'* critically discussed the emotional, cognitive, and behavioural changes participants experienced to adjust to the new work environment. Two participants felt IAPT was not the right service for them and chose to leave. Others who stayed found a way to work within the IAPT system's boundaries; however, they failed to identify with IAPT and were still critical of its implementation. Two participants were looking forward to transitioning into retirement very soon.

The fourth super-ordinate theme, '*transformation*,' discussed the personal and professional growth participants experienced due to working in IAPT. It was surprising that all participants, including those who left IAPT services, wanted the IAPT programme to continue evolving. They acknowledged the IAPT programme's positives in mental health services, such as increasing access to psychological therapies and using evidence-based practice. Participants acknowledged that the mental health services before IAPT were not given the due attention in training, budgeting, and development. Therefore, although there were challenges in providing this service, IAPT was seen as a significant improvement in the care available for people with mental health problems before this service being available.

6.6 Discussing the thematic map

This thematic map below represents the processes participants went through during their adjustment following their transition to IAPT services. Each colour represents a super-ordinate theme and its sub-themes.

Figure 3 Thematic map of super-ordinate themes and sub-themes



Although these processes are represented individually and overlapping, they do not represent a phased transition. On the contrary, the process itself was not clear cut, and some of the feelings and issues were consistent throughout the transition from start to the end in the participants' accounts.

For example, some of the issues that participants struggled with within the early stage of their transition such as poor orientation and lack of support, were resolved as time went by. Participants found ways to seek support and make connections. However, the sense of professional isolation, feeling undervalued and disempowered persisted throughout their transition and long after, which had a lasting impact on the participants.

The other two super-ordinate themes, '*learning the ropes* and *adjustment,'* could be viewed as feedback cycles. The more the participants learned about their new work role and environment the smoother the adjustment has become. The more they felt secure in their new role, the more they became interested to learn about the new environment. However, the challenges and dilemmas participants encountered in their transition to IAPT services could not be resolved by simply learning more about the role or adjusting effectively. Transformation occurred as a result of working through the discrepancies and anomalies they [the participants] encountered by critically analysing and examining their assumptions and values against the IAPT organisation's frame of reference. In the next chapter Discussion these study findings will be critically discussed and evaluated within the broader literature in the field.

Chapter 7 Discussion

7.1 Introduction to the chapter

This chapter discusses the main themes derived from the data analysis; and offers a synthesis and critical discussion of the overall findings directed by the IPA methodology and its double hermeneutic interpretation process (Smith et al., 2009). These findings will then be placed within the theoretical framework of work role transition to advance the understanding of this topic. This discussion also focuses on how the knowledge on the work role transition has been extended by this research and highlights the implications in practice. The chapter concludes by identifying areas for future research and recommendations for practice. A complete dissemination strategy is also included at the end of the chapter.

The findings of this original study are important for two main reasons. Firstly, this work is focused on the transition experiences of non-IAPT qualified therapists as they adjust to their new role within IAPT services. The specific issue of role transition for therapists working within IAPT has received minimal research attention despite its importance. Given the expansion and transformation of IAPT services as stipulated in the Five Year Forward Planning for Mental Health (NHS England, 2018a), the need to recruit and retain experienced practitioners is essential (NHS England, 2018b). This research can now be used by policymakers, managers, and IAPT commissioners to facilitate this workforce's adjustment following their transition to IAPT services. Secondly, this study adds to, deepens, and advances the general understanding of work-role transition's psychological processes.

It is hoped that the findings of this study may prompt policymakers, managers, and commissioners to improve aspects of the processes and procedures in IAPT services

to facilitate the transition, which in turn may support recruitment and retention efforts. The findings also provide an essential insight into the potential rewards and challenges in the IAPT role to non-IAPT qualified therapists who are contemplating moving to IAPT services.

7.2 Super-ordinate themes

The research findings can be understood within the context of four overarching super-ordinate themes:

1) Transition 2) Learning the Ropes, 3) Adjustment 4) Transformation

Together these super-ordinate themes reflect the different processes participants experienced during their transition to IAPT services. Although these processes are discussed separately under each super-ordinate theme, in reality, they were more nuanced and interrelated. Some of these processes took longer than others to end or to evolve into a different process. As in IPA, these super-ordinate themes represented different parts of the overall hermeneutic cycle, and the totality of participants' experiences could only be grasped by looking at the parts to understand the whole and the whole to understand the parts (Smith et al., 2009).

Each super-ordinate theme will now be critically debated within the literature in the field to deepen the participants' experience and contextualise the findings into the broader evidence-base.

7.2.1 Super-ordinate theme one '*Transition*'

The super-ordinate theme '*Transition*' discusses participants' experience in the early phase of working in IAPT. Participants' accounts revealed novel ways of understanding their experience following the transition to a new work role as an emotional and cognitive experience. Generally, newcomers come to their new work role with expectations of

themselves, the role, and the organisation (Feldman and Brett, 1983; West and Rushton, 1989). In this context, schema theory explains that one's past experiences inform one's expectations of future experiences (Biddle, 1986; Miller and Turnbull, 1986). Schema theory indicates that their beliefs inform one's expectations of themselves, others, and the world (Young, Klosko, and Weishaar, 2003).

The participants in this study moved to IAPT services believing in the IAPT ethos and wanted to be part of it. CBT therapists believed there was a better match by what they can offer in terms of their CBT skills and clients in IAPT.

These study findings provide a new perspective on newcomers' expectations based on assumptions, reality checking, or a psychological contract between newcomers and their employers (Robinson, 1996). Participants whose expectations were based on assumptions as part of their schema of how things should be, experienced more frustration, disappointment, confusion, and even anger. The intensity of their emotions correlated with the negative discrepancy of what they assumed the role would be and the reality of what it was. They experienced what Van Maanen (1979) described as 'culture shock,' and Louis (1980) described it as a 'surprise.' On the other hand, participants whose expectations were based on formal information about the new role from trustworthy sources had better transition experiences and were less disappointed or frustrated with their new role. By contrast, participants whose expectations were based on their employer's promises felt betrayed and let down by the service when these promises were not fulfilled. Subsequently, these participants lost trust in their employer. In this population of experienced therapists, services perhaps need to be more aware of the impact of prior employment experiences on therapists and their expectations. Working with these to explore what is possible within IAPT may positively support the transition.

This study suggests that a negative discrepancy between participants' expectations and the reality of their new work role and work environment negatively affected their adjustment, job satisfaction, and tenure. These results support the literature on the importance of matched expectations between the newcomer and the organisation. Dawis, England and Lofoquist (1964) used the correspondence theory to explain the relationship between expectations and job satisfaction. Such theoretical expectations were investigated by Smith et al. (2017) in a population of nurses and other health professionals such as doctors and allied health professionals transitioning to a new healthcare environment. Much like this study's findings, Smith et al. (2017) concluded that the newcomers who felt their expectations were incongruous with the role's reality were more likely to be unsatisfied and perceive the organisation as untrustworthy. Therefore, organisations need to be more transparent and honest about applicants' roles to support the role's transition (Wanous, 1980).

This study's findings raise an important theoretical and practical issue, which is "unmet expectations." A few studies of socialisation have investigated the notion of the "unmet expectations" for newcomers and its potential problems for job satisfaction and retention (Carr et al., 2006; Wanous et al., 1992). Generally, unmet expectations were attributed to the organisation for not providing enough information to the newcomers as discussed above (Wanous, 1980), or ascribed to the newcomers for not learning about their new job (Louis, 1980; Wanous, 1992). Nevertheless, it is not clear from the literature on how and why these expectations differed between newcomers. Furthermore, while the literature focuses on organisational socialisations (Van Maanen and Schein, 1979), very little research was found on newcomers' intended expectations in the socialisation process.

In this idiographic study, it was possible to identify what informed each participant's expectations. A better understanding of the divergence between newcomers' expectations

and the reality of their experiences can help work role preparation for newcomers to IAPT services. This understanding, in turn, may improve the transition and, therefore, retention of this workforce. Moreover, this study's results assert individuals' responsibility in finding information about the new role and the organisation and reality check before taking a new role.

All participants expected that their new organisation would provide them with guidance and clear instructions on enacting their role. Participants' prior occupational experiences informed these expectations. However, participants' accounts indicated that these expectations were unmet for most of them due to poor induction and lack of orientation to their new role. Consequently, participants experienced confusion and anxiety in the early phase of their transition and felt utterly responsible for learning the rules.

This study's findings support other studies on the importance of newcomers' socialisation to the new role and work environment. Studies on organisational socialisation established the causal influence of socialisation on job satisfaction and career effectiveness. These studies indicated that people who are well socialised are more adjusted than people who are not well socialised (e.g., Allen and Meyer, 1990; Anakwe and Greenhaus, 1999; Asforth and Saks, 1996; Chao et al., 1994; Feldman and Brett, 1983; Jones, 1986; Klein and Weaver, 2000; Morrison, 1993; Ostroff and Kozlowski, 1992). However, Billett (2004) describes an emerging trend for less formal inductions in the workplace, emphasising that newcomers actively take responsibility for learning about their new role. This current study's findings stress the importance of formal induction and orientation to the new role and work environment in support of Van Maanen and Schein's (1979) seminal work on the role of organisational socialisation for facilitating adjustment to a new work role. Organisational socialisation allows newcomers to move from being an outsider to becoming an insider by

learning the knowledge, skills, and behaviours they need to succeed in their new organisation (Van Maanen and Schein, 1979).

In addition, to be adequately inducted and orientated to their new IAPT role, participants expected to be provided with adequate clinical supervision. This study's findings demonstrate that supervision experiences were inferior in terms of access to and quality supervision for some participants. For example, one participant was left without clinical supervision at all for almost a year. Consequently, participants felt unsupported, clinically insecure, and perceived that they were at risk of practising unsafely.

Clinical supervision is vital as it provides a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work (CQC, 2013). Furthermore, supervision is considered a key element in developing therapists' skills to ensure effective and safe practice in IAPT services (Turpin and Wheeler, 2011). Literature has highlighted that inadequate supervision has a profound negative effect on therapists' confidence, competence, and safe practice (Ellis et al., 2013).

This study's findings emphasise the importance of adequate supervision while transitioning into the IAPT role and the ramifications of not having adequate clinical supervision. Adequacy of supervision was assessed in terms of timely availability of supervisors, experience, and perceived knowledge.

Participants viewed the quality of the interaction between managers and newcomers as critical to being seen as individuals, not just as job holders (Korte, 2009; Sluss and Thompson, 2012). In addition, participants felt managers were not empathetic or understanding when they failed to accommodate their circumstances, which brought great stress and anxiety, further complicating their transition to the role.

Heidegger's phenomenology provides insight into this issue. Heidegger (1969) argues that we live in a meaningful world, and we have a meaningful relationship with it and views the individual as always, a 'person-in-context.' Therapists and counsellors transitioning to IAPT services may benefit from managers taking account of their personal and social circumstances to help them feel supported.

Organisational support has been identified as one of the top ways to support nurses in transitioning into their new roles (Lindeke and Block, 1998). Studies confirm this assertion and have found satisfaction and wellbeing are enhanced in nursing populations when managers provide a supportive environment (Pearson and Care, 2002), when employees have a chance to interact with them (Simpson et al., 2006) and when they can speak about work or personal issues that may impact on their work (Sullivan-Bentz et al., 2010; Zurmehly, 2007).

In addition to unmet expectations, one of the significant factors contributing to the difficulty of participants' transition to IAPT services was the inadequate physical work environment. Although this study did not explicitly seek to examine the work environment, participants chose to speak extensively about this to demonstrate how important it was within their transition experience. The physical environment is a significant factor but understudied and under-researched in the literature. This study is the first to highlight this issue for therapists working in IAPT services and its negative impact on their transition.

Several important issues arise from the current study concerning the work environment. Firstly, it appears there is a positive relationship between the physical environment and employees' job satisfaction. These results confirm the findings of previous research that favourable working conditions whereby employees feel physically comfortable report increased job satisfaction (Greenberger et al., 1989; Holman, 2002, 2003), work performance, and employee psychological wellbeing (McGuire and McLaren, 2009; Sargent and Terry,

1998; Stellman et al., 1987). Secondly, participants stated that working in inadequate buildings affected them emotionally, as was evident in their accounts. Feeling physically uncomfortable made participants feel emotionally uncomfortable. The inadequate work environment made them feel unwelcome and unvalued. This theme refers to Merleau Ponty's phenomenology (1945), which argues that the surrounding world becomes meaningful for us through bodily experiences. Thirdly, these findings provide insight into the physical work environment's psychological meaning, making people feel welcomed and valued. These findings deepen the understanding of the importance of the physical work environment on employees' physical and psychological wellbeing.

The feeling of being undervalued because of the inadequate physical work environment was compounded by the perception of not being heard and not being involved in decisions that affected their jobs. Participants did not like what they experienced as excessive oversight and direction to do their jobs. Empirical research emphasised the adverse effects on employees for not being involved in the decision-making process (low commitment) and organisation (adverse effect on productivity and performance) (Asiedu-Appiah and Addai, 2014; Zin and Talet, 2016).

Connected to the subtheme of '*Value,*' four participants, all counsellors, felt undervalued by their employer and felt inferior to their CBT colleagues and other psychological therapy therapists. Feeling undervalued and inferior to their colleagues led to resentment and feeling unfulfilled. Consequently, counsellors felt alienated and affected their sense of belonging to the organisation.

Counsellors who provide high-intensity therapies at step 3 in IAPT services come with a wealth of experience, knowledge, and practical skills. It is argued here that IAPT is not using this resource [counsellors] to its best potential. However, because IAPT services are heavy

on CBT (Jackson, 2019; NHS England, 2019), counsellors feel disadvantaged, and like they were treated less favourably than their CBT colleagues in terms of opportunities for professional development. In this study, the counsellors felt that their experiences, training, and qualifications were not utilised to the fullest, and their skills were not used sufficiently, such as offering EMDR and other various treatment modalities. Two counsellors reported that their role had shrunk in IAPT services in terms of clinical and supervisory responsibilities.

The views of these four participants support previously published qualitative research by Altson et al. (2014) on the perceived implications for counsellors and psychotherapists working in IAPT services. The study found that non IAPT therapists and counsellors felt excluded from the IAPT and like outsiders. A thematic qualitative study by Mason and Reeves (2018) on the effect of working in IAPT services on the personal and professional developments of counsellors found that many counsellors feel vulnerable and threatened by the IAPT system and feel like they lost their validity as counsellors.

An unexpected finding that added to the difficulty of the participants' transition was that most participants described their transition experience as '*solitary*.' The isolation here was both physical and psychological. Working in GP surgeries where participants had no chance to meet up with colleagues and the rest of the team except once a month in team meetings resulted in physical isolation. Also, agile working from home increased the sense of social isolation. The psychological isolation was caused by excessive workload when staff had no time to communicate and interact.

The findings of this study highlighted the adverse consequences of professional isolation on the participants. They described feelings of loneliness, lack of feelings of togetherness or

camaraderie, and increased stress. Participants also believed that interacting more often with colleagues and informally discussing complex cases made them better therapists.

Diekema (1992) defined professional isolation as a belief that one is not connected with others in the workplace. In effect, one's fundamental needs to feel socially connected in the workplace have been blocked (Baumeister and Leary, 1995). IAPT therapists usually work in isolation, and this area is overlooked in the literature; hence, it deserves more research. This is the first study to identify the feeling of physical and psychological isolation that IAPT therapists experience and its negative impact on their transition and wellbeing. These results support the limited research on professional isolation; a study by O'Donnel, Jabareen and Watt (2010) found a strong association of professional isolation with intentions to leave practice nursing.

In addition, it could be debated that professional isolation may affect job performance as participants pointed out that interaction with colleagues and discussing complex clinical cases make them better therapists. Furthermore, professional isolation, among other factors, may cause stress and emotional exhaustion. Emotional exhaustion and burn out is common among mental health professionals (Maslach et al., 2001, Steel et al., 2015) and has severe personal and professional consequences; decreases therapists' job satisfaction and increases turn over (Lim et al., 2010; Maslach and Leiter, 2016; Wilkerson and Bellini, 2006). Several studies showed that the emotional exhaustion and burnout among staff in IAPT services are high and increasing (Jackson, 2019; Marzouk, 2019; Scott, 2018; Steel et al., 2015; Westwood et al., 2017). As a result, some IAPT services have taken steps to improve staff wellbeing, such as introducing IAPT sports days and social gatherings, forums to promote sharing of best practices and networking with colleagues (NHS England, 2018c). Also, the provision of IAPT Masterclasses for continuing professional development to enhance

learning and expertise (NHS England, 2018c). These are examples of the positive steps taken by several IAPT services and commissioners to promote staff wellbeing (NHS England, 2018c). These measures highlight that some of the transition and wellbeing in the workplace concerns identified in this study are recognised as being important and that some steps are being taken to address these at a variety of levels within the system.

In conclusion, the '*Transition'* super-ordinate theme highlights several important factors that facilitate employees' transition to a new work role. These factors specifically are organisational support, formal induction and orientation to the new role, good physical work environment, valuing employees, and reducing professional isolation. While the organisation determines many transition experiences, this study also highlights the importance of taking ownership and learning before moving into a new role.

7.2.2 Super-ordinate theme two '*Learning the Ropes'*

The super-ordinate theme '*learning the ropes*' discussed participants' learning about their new role and how to enact it. This discussion focuses on how participants experienced the different processes and procedures characteristic of and unique to the IAPT system. Furthermore, this section discusses how the participants felt about delivering therapy within the IAPT manualised protocols and the impact on their sense of professional autonomy. The discussion also focuses on participants' experience of their performance being monitored and evaluated by the Recovery Measures. In addition, the impact of workload on the participants' wellbeing is discussed, and the ethical dilemmas participants struggled with during their transition are highlighted.

Strict adherence to the manualised protocols by Roth and Pilling (2007) is considered an essential feature of IAPT services (Turpin and Wheeler, 2011). It is argued that fidelity to the evidence-base ensures quality and effective delivered care (Clark, 2011; Turpin and Wheeler,

2011). However, in this study participants argued that the highly descriptive and manualised IAPT protocols were potentially causing a disservice to patients and therapists alike. Participants pointed out that the clients' complexity at step 3 required a more tailored and idiosyncratic treatment approach, which directly conflicted with the rigidity in IAPT. Perhaps this point was best expressed by the participants as "*one size fits all*" due to the system being perceived as overly descriptive and manualised.

Therapists are forced to formulate patients' problems based on their symptoms and deliver CBT protocol specific for the diagnosis. For example, if the patient describes anxiety symptoms, he/she will receive treatment based on one of two models specific for anxiety. Participants in this study stated that there was no exploration of deeper issues such as traumas, loss, or childhood abuse within the manualised protocols' strict boundaries, which may be the root cause of patients' anxiety symptoms.

Arguably, the complexity of therapy is minimized when there is a focus on diagnosis and subsequent training in technique and manualised treatments (Woolfe, Dryden and Strawbridge, 2012). Indeed, by adopting a diagnosis-manualised treatment attitude, clinicians can lose perspective and fail to see the client as a whole person within a context. Broader social issues like poverty, social exclusion, alienation, loss of hope, purpose, and meaning are outside IAPT services' remit (Binnie, 2015).

Furthermore, the participants expressed their concern that the IAPT rigidity does not encourage therapists to take initiatives or clinical risks in therapy and tempt therapists to hide behind the protocols as a safer option, which was not always the best for clients. Literature suggests that highly standardised and formalized work blunts creativity, initiative, and achievement (Ashforth, 1989). Many participants felt the complexities of some clients seen within IAPT services, and their needs were often poorly understood within the IAPT

manualised driven protocols and IAPT managers. For example, participants found it challenging to extend therapy beyond the limited number of sessions when they asked their managers. Consequently, participants often felt they "short-changed" clients resulting in ethical dilemmas.

Participants expressed needing more flexibility in delivering therapy and extending sessions when working with complex clients. Participants felt that compartmentalising treatment was not a valid clinical option for those with complex mental health problems. These findings support the literature that described the IAPT system as highly prescriptive, which does not take account of the idiosyncratic formulation of client's problems and delivered by therapists who work within closely defined clinical parameters (e.g., Binnie, 2015; Greene, 2019; Pickersgill; 2019; Timimi, 2015). Participants called for considering flexible implementation of NICE guidelines and valuing a more comprehensive range of evidence-based therapy approaches.

Arguably, using a couple of models for each disorder may lead to deskilling IAPT therapists in the long run. Pickersgill (2019) confirms this issue and stated by reducing psychological therapy to pre-packaged manualised protocols which can be delivered in specific, pre-determined ways; IAPT is deskilling therapists.

Several participants expressed reservations about how effective the one-year HIT programme with its emphasis on manualised protocols was for atypical, complex, and clients with comorbid problems. This is not a new issue with arguments for formulation versus manualised protocols having a long history of debate within the CBT literature (Barlow et al., 2017; Eifert et al., 1997; Iwamasa and Orsillo, 1997; Waltman and Sokol, 2017). This issue perhaps needs to be revisited with empirical investigation within the IAPT context, given the concerns raised by the participants in this study.

Even though the literature previously highlighted the drawbacks of the tightly regulated and highly standardised culture of IAPT services, e.g., Binnie (2015), Hogget (2010), Jackson (2019), Pickersgill (2019), and Rizk (2012), this is the first study to discuss the psychological impact of IAPT inflexibility on the therapists themselves. Several impacts on the therapists have been identified, such as feeling disempowered by IAPT rigidity. This rigidity indicated a lack of trust and respect for therapists' experience and professionalism. This study demonstrates that therapists value autonomy, fostering independence, confidence, competence, and responsibility (Ulrich et al., 2010). Prior studies have also shown that therapists appreciate being autonomous clinicians, which gives them the freedom to make decisions based on clinical management and professional judgment to the best advantage for their clients (Holt, 2008; Pearson and Care, 2002; Simpson et al., 2006; Zurmehly, 2007).

Some of the issues that emerged from this study relate specifically to empowering therapists by giving them more autonomy. The positive correlation between professional autonomy and job satisfaction has been empirically established in nursing literature (Blegen, 1993; Finn, 2000; Taylor, 2008; Varjus, Kilpi, and Suominen, 2011; Weisman et al., 1980).

Job satisfaction is empirically linked with improved patient care and tenure (Grol et al., 1985; Laurant et al., 2011; Tzeng, Ketefian, and Redman, 2002). In contrast, lack of autonomy has been shown as a significant cause for job dissatisfaction (Carr et al, 2006; Crose, 1999). Job dissatisfaction is linked with poor performance and high turnover (Brooks and Anderson, 2005; Judge et al., 2001; Nayeri, Salehi and Noghabi, 2011). Lastly, dissatisfaction at work is problematic to high-quality patient care (Brooks and Anderson, 2005; Williams, 1997). Also, disempowerment could generate reactiveness, helplessness, and work alienation, and if it becomes salient, it could impact the staff's sense of belonging to the organisation

(Ashforth, 1989). The findings indicate the need to enable IAPT clinicians to feel empowered, control their practice, and enhance their professional autonomy.

Another essential characteristic that is unique to the IAPT system is the IAPT MDS or Recovery Measures. These study results demonstrate that all participants felt anxious by the constant emphasis on numbers and targets. Participants reported that the pressure to achieve targets in terms of recovery rates and access rates has intensified over the years. This study established that participants felt threatened by the Recovery Measures currently used to measure their competence. Participants believed it was a blunt instrument, an inaccurate measure for their competence, and did not reflect their clinical practice in its entirety. It was a constant source of stress, especially for counsellors who felt insecure about keeping their jobs in IAPT as their managers told them they would be the first to go if they did not achieve their targets.

This study's findings highlighted how participants perceived Recovery Measures to be inadequate as an evaluative tool for assessing therapists' clinical competence in IAPT services. Furthermore, the results shed light on the potential misuse of the Recovery Measures in IAPT services through a threatening management style to boost recovery rates for the service, as was evident in three of the participants' accounts.

Previous research highlighted the issues around IAPT Recovery Measures; these studies focused on their usefulness, reliability, and validity to monitor patient's progress in treatment in IAPT services (Binnie, 2015; Hogget, 2010; Jackson, 2019; Rizk, 2012). While this study did not set out to examine the impact of the use of Recovery Measures, the experience of using these impacted the way the therapists learned about how to develop the skills of IAPT.

While this suggests Recovery Measures may not be used effectively, further research is required to understand how these are being used and their impact on the therapists. Hogget (2010) has called attention to the weight given to performance management, where practitioners are subject to intensified surveillance of their work. This is specifically true for NHS staff working within a firmly managed and highly monitored culture of IAPT service.

This study has identified the primary stress sources in IAPT; the high turnover of clients, the high volume, and the complex cases outside the remit of IAPT. The participants believed workload in IAPT is unsustainable in the long run, especially with the ambitious plans to expand the IAPT services. The description of IAPT as a conveyer belt is indicative of its emphasis on high output.

The high volume of data input in the IAPT system was also a factor in increased feelings of stress. Work stress was identified in the literature as a predictor of emotional exhaustion and burnout for practitioners working in mental health services (Sciberras and Pilkington, 2018) and particularly in IAPT services (Jackson, 2019; Steel et al., 2015; Walklet and Percy 2014; Westwood et al., 2017). Therefore, the working practices in IAPT may warrant further consideration by the IAPT services and how data input exacerbates these feelings.

Even though many of the stressors that participants reported in this study are commonly found in the nursing literature (e.g., heavy workload, fast pacing activity, unsupportive management) Khoza (2005); McVicar (2003) and Lim et al. (2010), several issues reported here have not previously been raised through research, which are very specific to working in IAPT services. These work stressors are the fast pace of change and expansions in IAPT, the huge data input, and the inappropriate referrals to IAPT services of patients with complex needs or severe pathology who are clearly outside the remit of IAPT services. These challenges are compounded by IAPT inflexibility that is limiting therapists' clinical freedom

of applying their skills and experiences to the best for their clients. Furthermore, the organisation's incompatible demands and the overly monitored and scrutinised therapists have added stress sources.

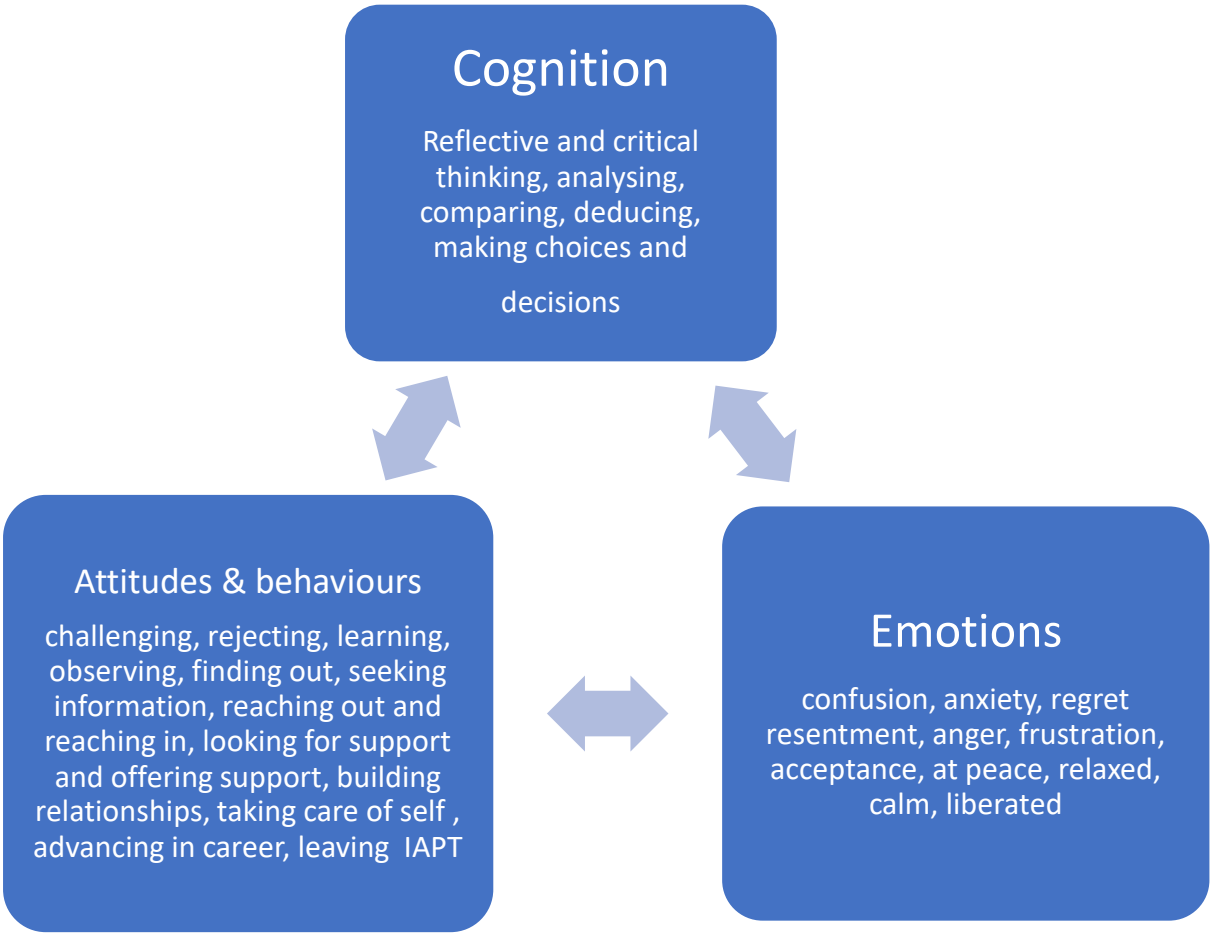
These factors mentioned above not only were sources of frustration and stress to the participants in their own right; they also caused an added pressure by bringing about some ethical dilemmas. The IAPT system focuses on symptom reduction in the briefest time to hit recovery and access rates, and these aims may be divergent from therapists' values. For example, discharging clients prematurely because they have not "recovered" within the IAPT specified time frame, rejecting clients because they were below "caseness," working with inappropriate referrals, and 'back to work agenda.' When therapists work in an environment with oppositional views to those congruent with their professional beliefs, it is argued that it creates conflicts (Jackson, 2019). The potential for these issues to cause anxiety to therapists in IAPT has not been discussed in the literature; therefore, this study presents these issues for consideration not only by IAPT services but also by other mental health services.

In conclusion, the super-ordinate theme '*Learning the ropes'* critically discussed participants' endeavour to enact their role within the strict boundaries of IAPT. This discussion highlighted the drawbacks of IAPT rigidity on patients and therapists. The discussion also brought attention to Recovery Measures in evaluating therapists' performance and their unsuitability as an evaluative tool. The discussion highlighted the impact of workload in IAPT on therapists' wellbeing and discussed the specific stressors unique to the IAPT system. The discussion also illuminated some ethical dilemmas therapists experienced working within the IAPT, such as working relationally with clients and at the same time adhering to the target-driven manualised protocols.

7.2.3 Super-ordinate theme three '*Adjustment*'

The super-ordinate theme '*Adjustment'* discusses the changes participants made to adapt to the IAPT system and what facilitated their adjustment. The diagram below illustrates the cognitive and emotional processes and the behavioural changes for the participants.

Figure 4 The adjustment processes for the participants



Participants' endeavour to adjust to the new role was interpreted through accepting reality and lowering expectations as depicted in their comments. These findings suggest that participants engaged in a reflective process to examine their expectations against the reality of the role they had experienced. This cognitive process involved reflecting, critical thinking, identifying, and analysing their assumptions and beliefs about their roles and values. The

acceptance included a thinking process to evaluate options and make decisions about whether to stay in IAPT. In addition, accepting reality was conducive to learning and gaining knowledge about the IAPT service and comprehending its structure and processes.

Within the adjustment process came the need to accept the IAPT system's rigidity, which then obligated participants to focus on fitting into the new role despite these constraints. Nicholson's theory of Work Role Transition (1984) postulates that when newcomers transition to a new work role, they either change the role to fit them or change themselves to fit the role. This theory reflects this study's findings, which showed that when participants realised, they could not change the IAPT role to fit them, they changed themselves to fit the role—these included changes in self in terms of expectations, cognitions, and behaviours. Participants reported adjusting their thinking to resolve the cognitive dissonance they experienced earlier because of working for two opposing agendas. The IAPT agenda focuses on reducing symptoms in the briefest treatment versus therapists' agenda of working relationally with clients and understanding the person in their own context.

Participants also changed their behaviours to be compatible with the nuances of the IAPT culture. For example, they censored what they said and did not express views or opinions different from the IAPT conventions. They enacted the role within the IAPT parameters and learned to edit themselves to appear compliant to the organisation. Even though participants learned to be creative in doing their role within the limitations of IAPT, they were limited in shaping their role. For example, they did not show much initiative and accepted it was a very restrictive way of working. Thus, we can deduce that the burden of adjustment in IAPT was borne almost exclusively by the therapists (Nicholson, 1984). These results support evidence from previous observations in the literature on nurses' transition, which involves cognitive,

emotional, and behavioural changes (e.g., Anderson, 2009; Barton, 2007; Bombard et al., 2010; Glen and Waddington, 1998; Zurmehly, 2007).

The incongruity between participants' values and IAPT requirements made it difficult for them to fully embrace the IAPT role identity. Therapists expressed their pride in who they were, be that counsellors or CBT therapists. In this research study, all participants were mature adults above 45, except one participant in her mid-thirties. They all have been well established in their professional career for so many years. They expressed pride and confidence in their professional identity that became part of who they were. Possibly, they were not prepared to relinquish their identity to embrace and develop a new role identity. Therefore, some resistance could be presumed on the participants' part to embrace the new IAPT role identity, especially when the goals and values seemed incongruent with their own.

This study's findings are consistent with nursing literature that suggests newcomers develop their new identity by identifying with the organisation's values and goals and trusting the organisation (Anderson, 2009; Barton, 2007; Holt, 2008; Owens, 2018). However, this study's results do not support what Pearson and Care (2002) described as the implications of ineffective role transitions on nurses when they accommodate to the role but are unable to influence positive outcomes or experience role conflict. This ineffective transition can result in a nurse becoming task-oriented, displaying dependency, and exhibiting burnout (Pearson and Care, 2002).

Although they did not fully take on the new IAPT role identity, participants in this study still managed to adjust successfully to their roles in IAPT. Furthermore, they did not exhibit any of these features Pearson and Care (2002) referred to, such as dependency and burnout. Conversely, they focused on clients' work, which was a source of satisfaction for participants and motivated them to do their job to the best of their ability. Doing good and affecting

change in people's lives and feeling appreciated by clients offset some of the frustration participants experienced by working in IAPT, as was evident in their narrative. Participants' accounts conveyed a sense of pride to be working for the NHS and making a difference. These results add to the limited literature on clients' work as a source of satisfaction and motivation. A study by Sciberras and Pilkington (2018) examined the challenges experienced by psychologists working in Malta mental health services compared to their colleagues working in other settings. They found that client work was one of the main rewarding experiences for all psychologists. This was attributed to seeing improvements in treatment, clients' appreciation, and learning experience for exposure to different mental health illnesses.

7.2.3.1 Facilitators of adjustment

This next section in the discussion focuses on what factors facilitated participants' adjustment following the transition to IAPT. Building a support network was one of the elements that facilitated participants' transition to their new role. These findings are consistent with other studies on nurses' transition that a support network is an essential contributing factor in facilitating the transition to a new work environment. The social interactions and support facilitated learning about the new environment (Owens, 2018), provided a sense of identification with the IAPT staff (Manning and Neville,2009), and compensated for lack of mentoring and support from the organisation as the group became a resource for learning through shared experiences (Sciberras and Pilkington, 2018).

In addition to the role of social and relational support in facilitating adjustment, this study's results indicate that prior occupational experience mitigated the stressors of working in IAPT services. Participants' confidence in their skills and competence appeared instrumental in facilitating their adjustment. Participants drew on their knowledge and expertise when

dealing with complex cases. They also used their usual coping skills to tolerate the uncertainty and anxiety of adjusting to a new job, reaching out for support, and taking care of themselves. Past experiences of adjustment to work role transitions provided them with insight into the psychological demands of adapting to a new work role. These results are comparable with nursing literature on work role transition that prior occupational experiences facilitate a smooth transition through the transfer of learning and linking past learning experiences and new knowledge and skills (Anderson, 2009; Glen and Waddington, 1998; Miller, Vivona and Roth, 2017; Seng, Sanubol and County, 2004; Sullivan-Bentz et al., 2010).

In addition to prior occupational experiences, it appears that participants' high self-efficacy helped their adjustment. Resilience, positivity, flexibility, and accepting different perspectives have been identified as personality traits that helped participants withstand the challenges of adjustment and moderated the stress they experienced. Participants reached in to cultivate their positive personality traits to help them adapt to the new system. High self-efficacy seemed to have protected participants from feeling distressed by negative experiences during their adjustment. High self-efficacy also appears to have resulted in more active and effective coping and increased motivation in the face of stress for these therapists (Abel, 1996).

Several empirical studies indicated a positive and linear correlation between self-efficacy and adjustment (Brief and Aldag, 1981; Gist and Mitchell, 1992; Sherer et al., 1982). These studies found that self-efficacy plays a critical role in influencing newcomers' work effectiveness, perceived productivity, job satisfaction, and ability to cope. Jones (1986) found that self-efficacy moderates organisational socialisation's learning process and affects how individuals perform their role and adjust to the role requirements.

Interestingly, this study's findings support the literature on general self-efficacy rather than task-specific self-efficacy was found to be potentially a crucial dispositional factor in predicting newcomers' adjustment to work during the new and highly uncertain period of organisational entry (Eden and Kinnar, 1991; Eden and Zuk, 1995; Sherer et al., 1982). In this study, the participants did not know much about the different procedures in IAPT; however, their general self-efficacy facilitated their adjustment.

Although there is strong empirical support for the role of personality traits in adjusting to a new work role (Nicholson, 1984; Saks and Ashforth, 2000), it is claimed that the role of dispositions or personality traits might be highly restricted during the early period of transition (Feldman and Brett, 1983; Saks and Ashforth, 2000; Zahrly and Tosi, 1989). Indeed, this research study's findings indicate that participants in the first six months of their transition to IAPT were preoccupied with learning the work rules and getting to grips with the structure and processes of the IAPT system. However, once they learned the ropes (Van Maanen, 1979) and made sense (Maitlis and Christianson, 2014) of their new environment, their disposition and individual characteristics began to play a more prominent role in the adjustment including taking care of oneself.

Comparison of the findings with those of other studies confirms that 'Taking care of Self' helps workers cope better with negative work environment (Kriger and Hanson, 1999; Sciberras and Pilkington, 2018; Yarnell and Neff, 2012). Therefore, it is imperative for newcomers to IAPT services to take care of themselves by implementing specific strategies to facilitate their adjustment to the new work role. Furthermore, taking care of oneself signified a transformative process for the participants.

7.2.4 Super-ordinate theme four *'Transformation'*

All participants in this study directly or indirectly implied that their experience of transition to IAPT had transformed them in some way. Although participants did not appear to fully embrace the IAPT identity, they indicated a change in themselves at a cognitive and emotional level resulting from working in IAPT. Therefore, '*transformation*' here is defined as "learning that transforms problematic frames of reference to make them more inclusive, discriminating, reflective, open, and emotionally able to change" (Mezirow, 2009, p22).

The participants took proactive actions and evaluated the potential consequences of choices. Identifying patterns of thinking, perceiving, and flawed assumptions helped participants evolve cognitively and facilitated their cognitive transformation. At a cognitive level, participants engaged in critical reflection and dialogue among themselves and other IAPT colleagues to orient themselves toward being open and receptive to others' views. Through learning how to do their role within IAPT strict boundaries, they learned a great deal about themselves, their beliefs, assumptions, and values. Consequently, participants embodied new ways of being after they experienced a period where their old ways of being stopped working. Old patterns driven by fear, need, ego, and control ceased to work, and they embodied more authentic and value-driven ways of being. Research supports the notion that cognitive development helps people focus their attention on meaningful cues, detect patterns, and pattern shifts in understanding their implications (Bransford, Brown, and Cocking, 2001; Ericsson and Ward, 2007).

Along with cognitive development and perspective transformation, emotional self-efficacy has been evident in this study. Emotional self-efficacy is a perceived familiarised capacity to compact with the negative affect (Muris, 2002). Furthermore, emotional self-efficacy could be understood as a hierarchical process through which individuals first recognise their

emotions and then understand them. Once these emotions are understood, only then is the individual able to describe them. This stepped process helps individuals gain control over their emotions and their underpinning thoughts (Kirk, Schutte and Hine, 2008). Similarly, Kluemper and Sauly (2012) depict emotional self-efficacy as a concept representing how successfully individuals control or transform their emotional lives.

This study indicates that emotional transformation took place with variable degrees to all participants due to their transition experience. Several examples were evident in this study, such as the lonely self that was clamouring to be noticed in some participants' earlier accounts, became muffled, and secured more social self. Reaching out and building their support network was a theme that highlighted participants taking responsibility for their wellbeing and responding to their emotional needs for connection. Also, the feelings of vulnerability have been replaced with feelings of confidence and competence in their role.

Feeling liberated and choosing to leave IAPT to pursue a career in other services outside IAPT was another choice for some participants. Two participants, both counsellors decided to leave IAPT because they felt their expertise was not appreciated, and their aspirations would not be fulfilled if they stayed. Two other participants decided it was time for another transition. This time a transition to retirement.

In conclusion, the super-ordinate theme "*Transformation*" discussed how their experience of working in IAPT had transformed participants. Participants accepted that IAPT was a rigid system and realised they had to change to fit in with their new role. Participants engaged in a cognitive process that involved reflection, examining their beliefs and values, and making choices and decisions. This cognitive process also involved weighing the challenges against the rewards of working in IAPT. Participants changed their behaviours to be in line with how the system functions. Therefore, we could infer that those therapists endeavoured to adapt to

their new role, and during this process of adaptation, another process at a deeper level was taking place, which was transformation. The transformation here did not mean changing their professional identity, but it meant therapists evolved at a cognitive and emotional level to effect change within themselves. This transformation led to new ways of thinking and behaving and new choices that were congruent with their goals and values.

7.3 Strengths and limitations of the study

7.3.1 Strengths

This research study's main strength is that it was carried out within the framework of the guidelines for '*Assessing Validity and Quality in Qualitative Research'* by Yardley (2000), as discussed in detail in Chapter Five. Within Yardley's framework, the quality of analysis was ensured through the iterative process and going back to the transcription, the rigour of methods applied, and the depth of interpretation. Also, the potential for transferability is a particular strength for this study.

Another factor contributing to this study's strength is reflexivity as an instrument to achieve quality, as suggested by Benjumea (2015). Using the qualitative research assessment tool JBI to review the work was invaluable in identifying strengths and weaknesses and as an educational process to improve this research. Close rigorous supervision by two competent supervisors is another strength of this study as their scrutiny of the work ensured thoroughness at every stage of executing this study (Nicholls, 2017).

This research extends our knowledge of work role transition by investigating how non-IAPT qualified therapists experienced their role transition in IAPT services and how they coped with the challenges they encountered. Conducting this research in three IAPT services in three different counties is a strength of this study (Trochim, 2020). Obtaining samples from three different areas in England facilitated recruiting and retaining enough participants to

provide a valid answer to the research questions and learn about a diverse range of experiences and increased rigour.

The researcher conducted the interviews at the three IAPT services to ensure consistent processes and high-quality data. Also, the inclusion of counsellors and CBT therapists is a strength of this study as this gives different perspectives on how each group experienced their transition. Another important strength of this study is that two of the participants had worked in mental health services in different countries, which enabled them to compare their working experiences in IAPT services in England.

7.3.2 Limitations

When interpreting this research, one must be cautious in generalizing as IPA research represents participants' perspective and their stories without claiming this is everyone's story (Smith et al., 2009). Qualitative studies favour exploration of transferability instead of generalizability (Amankwaa, 2016). The nature of transferability, the extent to which findings are helpful to persons in other settings, is different from other research aspects in that readers determine how applicable the findings are to their situations (Polit and Beck, 2014). Although this is considered analogous to generalization in quantitative research, it is different from statistical generalization (Connelly, 2016). Despite this study's rigour and trustworthiness, a few limitations must be considered—each of these highlights opportunities for further research. First, the data is limited to a small number of participants; therefore, the generalizability of participants' experience cannot be claimed. However, this type of sampling is often seen to be sufficient in IPA; as Smith et al. (2009) point out, the purpose of the interpretative phenomenological analysis is not to discover universal truths but to identify the meaning in a given phenomenon.

Second, possibly therapists who had negative experiences of transition were more likely to participate, given the strength of their experiences. However, the aim and the details of the research study were sent to several IAPT services and participation in the study was open to therapists with various experiences. For example, one participant with a positive experience of transition was the first to come forward.

Third, participants' retrospective nature reflecting on their transition experience is problematic as much as current cognitions and affect may have affected the recall of their experience. Future research could explore the transition experience for IAPT therapists at different stages during their first year.

Fourth, being an insider had the potential to affect participants' accounts; however, I was mindful of mitigating any potential impact from my insider status, as discussed in Chapter Five. Despite these limitations, I am confident in the results' authenticity and trustworthiness because of my strict adherence to the guidelines proposed by Yardley (2000), which was fully discussed in reference to rigour in the research process in Chapter Five. I do claim credibility by undertaking techniques such as prolonged engagement with participants by conducting two interviews 60 minutes each, persistent monitoring of this study by my supervisors, peer-debriefing, and reflective journaling. The iterative questioning of the data and returning to examine it several times as established in the Method Chapter supports this study's credibility (Polit and Beck, 2014).

7.4 Implications for practice and recommendations

Therapists in IAPT services valued working in the NHS and reported feeling proud. They derived most of their satisfaction from their therapeutic work with clients. Especially when there was some positive therapy outcome and when they felt appreciated by clients. Stressful

and negative feelings seemed to arise from the IAPT system's rigidity, workload, and unmet expectations.

The workload was cited by participants in this study as one of the main reasons for stress. Participants reported the high volume of clients; the complexity and severe pathology of some clients, with the fast pace of work, and data inputting, were the primary sources of stress. Heavy workload compounded with lack of training and inadequate clinical supervision has led to emotional exhaustion and anxiety. This study shows the substantial impact of high workload on therapists working in IAPT. It may be helpful for services to adopt practices that mitigate the stress of high workload. However, within the context of political and professional drivers for increased service delivery, a reduction in workload may be difficult to achieve, although much needed. Therefore, strategies such as robust clinical supervision and a formal period of induction and orientation to the new role become even more essential to ensure therapists' safety and retention within the workforce.

The high demand for data input is another pressure for therapists in IAPT services, which negatively affected their transition because it increased workload. Participants struggled with managing the considerable data input and learning about their new role. No one could argue that accurate data collection and analysis are essential for developing the healthcare system as it builds up a foundation for decision making (Lloyd, 2019). However, participants felt that the seemingly endless data gathering, and recording were done more for political reasons to present their IAPT services to CCGs successfully to secure funding. Therefore, this study endorses recognition and understanding of how the high demand and pressure for continual data input has on IAPT practitioners and how this reduces satisfaction in working within IAPT services.

This study has raised important questions about some clients' complexity that therapists see in IAPT services, necessitating adequate support, supervision, and training for therapists transitioning to IAPT. Support includes direct communication with managers and colleagues, allowing therapists more flexibility in treatment approaches and extending therapy sessions when requested by therapists if deemed clinically appropriate.

Training for therapists to be adequately prepared for the complexity of patients accessing IAPT may be useful for experienced practitioners transitioning to IAPT and those in formal programmes of counselling and psychotherapy where they learn about IAPT interventions. Recommending that High Education Institutions (HEIs)' programmes include the provision of insight into the demands of IAPT services may go some way to reduce attrition from this essential service further.

Adequate clinical supervision is paramount in IAPT services to ensure that therapists are supported and practising safely. In addition, continuing training programmes should be available and easily accessible, including using the internet to enhance therapists' skills training (Fairburn and Cooper, 2011). Arguably, IAPT was created for people with straightforward, mild to moderate common mental health problems. However, helping those with more complex and severe problems requires step 4 to be incorporated into the IAPT system. Expanding IAPT to help this group is problematic within its current framework, which sets limits on the kind of therapy used; the number of sessions offered includes recovery targets that do not suit more complex patients. Hence, the participants' recommendations are to integrate step 4 in the IAPT system for people with an elaborate socio-psychological presentation. Furthermore, developing a specific framework suitable for this group of people allows therapists to develop idiosyncratic treatment plans that consider the individual's social-psychological complexities. Therefore, it will be beneficial for

therapists and patients to integrate step 4 into IAPT and develop a specific framework to allow therapists to individually tailor interventions for the patient's best interest.

Working in IAPT services brought about several ethical dilemmas**.** The findings indicated divergent goals and values for therapists and the IAPT system. The IAPT system focuses on reducing symptoms in the briefest treatment, often with concrete behaviour modification, whereas participants described a more holistic approach, incorporating multiple dimensions. Therapists believe in working relationally with clients to understand the person in their context and a tailored treatment approach informed by an idiosyncratic formulation.

Therefore, this study calls for consideration of the flexible implementation of the IAPT framework and valuing a more inclusive range of evidence alongside Randomized Clinical Trials (RCTs) in developing future guidelines to broaden the evidence-base for psychological therapies.

These findings have significant implications for understanding how therapists value autonomy, creativity, flexibility, and feeling empowered. It is recommended that IAPT therapists' views are sought on matters that affect their work. Furthermore, empowering therapists to make decisions through which they will have a sense of self-worth and belonging will facilitate their best in the organisation.

This study showed that those who transition to IAPT services could easily become professionally isolated, either physically or psychologically. This is important in the service delivery as isolation can negatively affect feelings of competence from a lack of opportunity to discuss care strategies with colleagues. Strategies to increase socialisation within services may address some of these concerns.

Initiatives such as restructuring work schedules so therapists can often meet and structuring activities to ensure a sufficient contact level may be helpful. Also, allocating focused sessions for therapists to share knowledge and information for professional development and encourage informal activities that help integration and building cohesion.

Counsellors should be a valuable resource in IAPT services with all their experience and skills. Besides their clinical role, they could offer advice, help with job instructions, answer questions for newcomers to IAPT services, and take clinical leadership and staff management roles. Acknowledging them as an essential asset within IAPT services could enhance their job satisfaction and the sense of being needed in a team, which in turn may increase retention.

IAPT services can help applicants learn about the organisation and therapist's role by presenting its vision and mission on its website. Prospective employees could be invited to spend some time in IAPT services, getting a sense of what it is like to work there and have a chance to talk with workers and staff. Mentors can help manage newcomers' expectations by providing information, answering questions, and offering support.

Working in the NHS before moving to IAPT probably provided participants with valuable skills and strategies to adjust to their new IAPT role. This may raise special considerations for the IAPT workforce who come from outside the NHS, and as such, their need for support and mentoring may be even greater.

In this study, some participants questioned the usefulness of the current Recovery Measures with the changing population who access IAPT services. Therefore, new tools and criteria could be in place to monitor and evaluate therapists' competencies, which can capture the entirety of their clinical work and the effectiveness of treatments. Also, participants raised concern about abusing the current Recovery Measures for punishing therapists as these had

the potential to be misused in the wrong hands. Therefore, this study's findings call for developing more appropriate tools for measuring therapists' competencies and monitoring how these are used to assess therapists.

Participants identified the lack of support from their managers as an essential factor that affected their transition. Therefore, this study recommends that managers provide moral support to newcomers and consider their sociological circumstances.

Finally, it is suggested here that the wealth of previous experiences, knowledge, and skills non-IAPT qualified therapists bring to IAPT services should contribute more to the development and evolution of the IAPT culture. Instead, it is discounted and not used effectively because of the system setup. There is a general issue about recognising that those with extensive prior experience as counsellors may need more support to transition because they are less likely to shed their previous professional identity.

7.5 Recommendations for future research

While this study has examined the experience of transition of non-IAPT qualified therapists to IAPT services, there remain gaps within the evidence base that warrant further investigation to improve work role transition experiences of IAPT therapists. First, studies could explore IAPT managers' experience in IAPT services and their challenges to support these managers. Also, how the managers could help and support those new to IAPT during the transition to the service. Second, using quantitative research to provide the statistical data in support of the main challenges identified in this study might prompt policy makers and the commissioning groups to implement much needed changes in IAPT services. Third, empirically investigating the efficacy of the one-year HIT training programme might be a valuable addition to the evidence base, given participants' reservations on its efficacy in atypical and complex presentations. Fourth, investigating the newcomers' expectations and

attitudes in facilitating transition would help identify the impact of their expectations of the IAPT role on adjustment following the transition. Knowledge gained through such investigations will improve IAPT and help identify that therapist experiences and clients' care can continue to improve.

7.6 Summary of discussion

This chapter discussed the processes participants went through during their adjustment following their transition to IAPT services. These processes were interlinked and changeable over time. These processes were discussed under four super-ordinate themes. The first super-ordinate theme, "*Transition,*" the discussion focused on participants' early experience of transition and the challenges they faced. The second super-ordinate theme, "*Learning the Ropes*," discussed participants' endeavour to make sense of the IAPT system and learn to enact their role. The third super-ordinate theme, "*Adjustment,"* centred on the cognitive, emotional, and behavioural changes participants made to reconcile different goals and values. The fourth super-ordinate theme, "*Transformation,"* discussed the participants' cognitive and emotional transformation during their transition to IAPT.

These super-ordinate themes shed light on the factors that facilitated participants' transition to IAPT. These factors specifically were support, formal induction and orientation to their new role and work environment, adequate clinical supervision provided by well-experienced supervisors and timely delivered, good physical work environment and workload that is balanced with available resources.

Following the transition to a new work role, participants focused on learning about the role and how to do it. At this stage, managers and co-workers play an essential part in facilitating this learning process. The tension between letting go of old ways of working and embracing a new way is heightened at this stage. People who learn about the role and develop

expectations based on accurate knowledge find it easier to embrace the new role. While people learn to adapt to their new role and working environment, a process at a deeper level occurs where people change at a cognitive and emotional level, which in many cases leads to their transformation which results in new ways of being.

7.7 Dissemination

Dissemination is the process of sharing information and knowledge. Transfer of research-based knowledge into routine clinical practice is high on the policy agenda both in the UK and internationally (Agency of Healthcare Research and Quality, 2016). Indeed, dissemination is an intrinsic element of all good research practices. Dissemination prevents knowledge from becoming lost. Furthermore, it provides added value to research projects, as the impact of research can be potentially broader than the original focus (Brownson, Colditz and Procter, 2012).

This section outlines the dissemination strategy of this research project. Because dissemination and implementation are complex processes involving many disciplines and players within an organisation, multiple methods were used in developing this dissemination plan. The Knowledge Transfer of Patient Safety Research Framework informed the dissemination plan (Agency of Healthcare Research and Quality, 2005). The framework prompted thinking about the process used to disseminate the research findings beyond publishing and presenting in conferences. Moreover, the framework aided in identifying the different aspects of the research and who could benefit from the findings, and in what way. The framework also encouraged considering various ways to reach and communicate the findings to the target audience and tap into existing networks.

7.7.1 Study findings

These study findings added to the evidence base on work-role transition specifically to IAPT services. The findings highlighted the specific facilitators and barriers to a smooth adjustment following the transition to IAPT services. These findings revealed that smooth adjustment following transition is an essential factor in newcomers' job satisfaction and wish to stay. These findings will help policymakers, IAPT steering group, CCGs, and IAPT managers to implement more appropriate ways to support those who transition to IATP services, and hence retention of the IAPT staff.

These research findings are also invaluable for psychological therapists who are contemplating moving to IAPT services as they shed light on the IAPT working environment and highlight the challenges and rewards of working in IAPT.

7.7.2. Identifying the target audience

Dissemination of findings has already started at a local level through discussions with professional colleagues and management. These discussions have provoked a positive response and an interest in reading this study. This dissemination plan is designed to get the research results to as many of the following as possible, IAPT managers and therapists, policymakers, GPs, CCGs, and NHS England. It is hoped the results will have a maximum impact and reach as many target audiences as possible. It has been found that the traditional ways of getting the research results out, such as peer-review publications and conference presentations, are far less effective than social influencing interventions, such as having respected opinion leaders promote the results (Carpenter et al., 2005). Despite this, these modes of dissemination are still important in the wider success of implementing the recommendations of this study.

National dissemination will be through: First, publishing the literature review in a nursing journal such as journal of advanced nursing. Second, will be a findings paper in high impact journals such as Qualitative Health Research. In addition, the aim is to publish a translation of the findings to a professional audience and communicate this in professional journals such as 'Behavioural and Cognitive Psychotherapy' and 'Therapy today.' These are professional journals for CBT therapists and counsellors. Also, BPS Journals such as the British Journal of Psychology, Psychology, and Psychotherapy: Theory, Research and Practice would be appropriate peer review journals to publish this research and disseminate its findings.

To compliment these papers additional opportunities to disseminate this study and its findings will be explored through abstract submission and poster presentations at the annual conferences of BABCP and BACP. Also, submission of the findings of the study in chapters, books, clinical practice guidelines and grey literature are other means of disseminating the knowledge gained from this study.

7.7.3 Stakeholder engagement

The research findings will be presented in meetings and disseminated to the relevant bodies such as BABCP, BACP, and IAPT steering group. I will contact the previous employer and ask if they would welcome a presentation on the findings. In addition, I will contact IAPT services in the East of England and the Midlands and ask if they would like an informal presentation on transition experiences. The research findings and their significance will be published in academic journals and newsletters to reach academics and researchers. BABCP and BACP conferences and events are suitable venues for disseminating these research findings.

7.8 Chapter summary

This chapter discussed and critically evaluated this study's overall findings and identified their unique contribution to knowledge in this discipline. The chapter also evaluated the strengths and limitations of the research design and presented the implications for practice. This chapter also provided recommendations for future research. Finally, the chapter concluded with a complete dissemination strategy. The next chapter provides a final conclusion to this thesis.

Chapter 8 Conclusion

This thesis has presented an interpretative phenomenological analysis of non-IAPT qualified therapists' transition experience to IAPT services. Adjustment to the new IAPT role and the IAPT framework was a complex process that involved cognitive, emotional, and behavioural adaptation. This study identified several factors that facilitated adjustment to the new role, such as clients' work as a source of satisfaction and pride in working for the NHS and helping people get better. The prior occupational experience was another factor that facilitated adjustment to the new work role following the transition. Self-efficacy was experienced in this study as a pivotal factor in adjustment as it mitigated stress. Reaching out for support and connection was another factor that helped adjustment. Finally, taking care of oneself appeared to play an essential role in adjusting by reducing stress, setting boundaries, and being compassionate towards oneself.

Transformation at a cognitive and emotional level was a parallel process that underpinned the whole transition experience. Transformation entailed changing the participants' frame of reference and develop a broader and more inclusive perspective. Transformation is a process that occurred as the standard procedures of learning about the role and the new environment, and efforts to adapt did not solve these participants' ethical dilemmas. The divergent goals between the participants and their organisations evoked inner conflicts. On the one hand, therapists needed their jobs and to do them as required. On the other hand, therapists felt they needed to be true to themselves and their values. Resolving inner conflicts necessitated re-examining their beliefs, assumptions, and values. Realising inner harmony meant considering the challenges and rewards of working in IAPT services, resulting in new

choices. Participants developed new perspectives that were reflective and inclusive, and authentic ways of being informed these choices.

The findings of this study make four contributions to research and practice in adjustment following work role transition: Firstly, it identified the gap between theory and practice. Although the work role transition topic has been extensively researched and scholars emphasised the significance of facilitating newcomers' transition to their new work role, the findings of this study showed that the implementation of research recommendations is still problematic as nothing changes. Secondly, it extended the evidence base by identifying additional factors that can facilitate therapists' adjustment to work roles in IAPT services. For example, flexible implementation of the IAPT framework, utilising therapists' skills and experiences to the full, empowering therapists to feel autonomous in their role and engaging therapists in the decision-making process regarding their jobs. Thirdly, it provided recommendations to improve adjustment following the transition to IAPT services, including adequate induction and orientation to the IAPT system, reducing workload, and balancing data input with clinical work. Fourthly, this study identified areas for future research to improve adjustment following work role transition. For example, investigating the newcomers' expectations and attitudes in facilitating transition would be helpful because almost no data exists on the importance of newcomers' attitudes and expectations on transition. Also, quantitatively investigating the facilitators and barriers to adjustment following the transition to IAPT services would help quantify the prevalence of the issues identified in the study, which may add weight to the evidence calling for change.

The conclusions reached from this study provided insights into the rewards and challenges non-IAPT qualified therapists experience following the transition to IAPT services. The

findings have emphasised the potential significance of organisational factors on therapists' experience of adjusting to a new work role in IAPT services. Therapists value working in the NHS and feel proud. Moreover, they appreciate the enormous benefits the IAPT services brought to people with mental health problems. However, some therapists found the rapid turnover of client work, stringent adherence to the manualised protocols, and the limited number of sessions offered, a challenging process to manage.

In conclusion, this study has provided a detailed, phenomenological account of the lived experience of the transition of seven non-IAPT qualified psychotherapists to IAPT services. Transition to IAPT services for this group of therapists presented unique challenges that employers might consider in attracting and retaining experienced therapists. New insights were developed that can inform not only IAPT services but potentially also other mental health services. The role of the organisation in facilitating the transition to IAPT services was explored specifically for experienced therapists. New avenues for future research were also identified, such as empirical studies into IAPT managers' challenges in IAPT with its fast expansion and how they could support newcomers to IAPT.

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Appendix 1

Critical appraisal of Glen and Waddington, (1998) article using JBI tool (2020).

	There is congruity between	
1. 1	Philosophical perspective and the research methodology	The stated philosophical perspective and the research methodology. There was no stated philosophical perspective.
2.	Theoretical framework	The research methodology and the research question or objectives There is no research question; however, there is congruity between the theoretical framework and the aims of the study. The study used the framework of Nicholson's model of work role transition (1984) and Wanous (1992) model of organisational socialization.
3.	Appropriateness of research design and data collection	The research methodology and the methods used to collect data The research study was exploratory descriptive case study, which was appropriate to the research aims, however sample size was very small (2) and in one organization. The methods used for data collection were appropriate: taped individual supervision sessions, semi structured group interviews and written reflective accounts from the participants. However, there was no interview schedule attached or a sample of the questions. The semi-structured group interview didn't specify who was in these groups, how many interviews were held, for how long etc. There was not enough details about how the data was collected.
4.	Data analysis	The research methodology and the representation and analysis of data No details of the method used for data analysis
5.	Findings	The research methodology and interpretation of results. Yes, there is a congruence as several themes were identified and presented that reflected aspects of the two theoretical frameworks.
6.	Context	There is a declaration of the researcher's cultural or theoretical orientation.

		Yes
7.	Impact of investigator	The influence of the researcher on the research and vice versa is clear. No
8.	Believability	Participants and their voices are heard To some extent from the comments, however the voice of the researcher was dominating, therefore it felt like the participants' voice was in the background.
9.	Ethics	The research is ethical according to the current criteria or there is evidence of ethical approval by an appropriate body. No mention of ethical approval
10.	Evaluation/Outcome	Conclusions drawn in the research report do appear to flow from analysis or interpretation of the data. Yes, there is a congruity between the conclusions and the themes that were derived from the data analysis.

Appendix 2 Appraisal of survey-based studies

NICE questionnaire appraisal tool (2004)

Critical appraisal checklist for a questionnaire study Ashley, Halcomb, Brown & Peters, (2017). Australia

Research question and study design	
Was a questionnaire the most appropriate method?	Yes, a survey was purposefully designed to answer the research question.
Validity and reliability	
Have claims for validity been made, and are they justified? (Is there evidence that the instrument measures what it sets out to measure?)	Yes, claims for validity has been made and justification was provided as follow: The questionnaire was circulated to experienced PHC nurses and two research experts, seeking feedback regarding content, design, time required to complete and ease of comprehension. The revised tool was then loaded onto SurveyMonkey© (2015) and piloted by the same group. Further feedback was used to make minor modifications to the wording and layout of the survey prior to final dissemination.
Have claims for reliability been made, and are they justified? (Is there evidence that the questionnaire provides stable responses over time and between researchers?)	Yes, descriptive statistics were used to summarise the data
Format	
Are example questions provided?	Yes
Did the questions make sense, and could the participants in the sample understand them? Were any questions ambiguous or overly complicated?	Yes No
Piloting	
	Yes

Are details given about the piloting undertaken	
Was the questionnaire adequately piloted in terms of the method and means of administration, on people who were representative of the study population?	The questionnaire was piloted first, and feedback was obtained. Minor modifications took place.
Sampling	
Was the sampling frame for the definitive study sufficiently large and representative?	Yes, 111 registered nurses transitioned from acute care to PHC within the last 5 years. Recruitment techniques were clearly explained.
Distribution, administration and response	
Was the method of distribution and administration reported	Yes
Were the response rates reported, including details of participants who were unsuitable for the research or refused to take part?	Yes
Have any potential response biases been discussed?	Yes
Coding and analysis	
What sort of analysis was carried out and was this appropriate? (e.g. correct statistical tests for quantitative	Descriptive statistics were used to summarise the data for both categorical (using frequencies and percentages) and continuous variables (mean, standard deviations and ranges. Relationships between variables were explored using the independent-sample t test and Pearson's chi-square test. Statistical significance was attributed to results where $p < .05$. Thematic analysis was used to analyse responses to open-ended items

Results	
Were all relevant data reported?	Yes
Are quantitative results definitive (significant), and are relevant non-significant results also reported?	Yes
Have qualitative results been adequately interpreted (e.g. using an explicit theoretical framework), and have any quotes been properly justified and contextualised?	Yes, Role theory was adopted as a theoretical lens to explore the transition (Hardy & Conway, 1988). Quotations were used to support the identified themes.
Conclusions and discussion	
Have the researchers drawn an appropriate link between the data and their conclusions?	Yes
Have the findings been placed within the wider body of knowledge in the field (e.g. via a comprehensive literature review), and are any recommendations justified?	Yes, the study provided evidence that orientation and ongoing professional support for experienced nurses transitioning to PHC roles should be purpose-designed to address individual gaps in knowledge and skills of the new employees.

Appendix 3 Data Extraction Table

Table 6 Data extraction Table Nurses' perceptions and experiences of work role transitions: summary of findings (n = 25).

	Author, Publication year, Country	Role change	Design & methods	Study Sample	Findings Themes and subthemes	Quality & significance
1	Anderson, (2009). USA	Experienced nurse to nurse educators.	Qualitative descriptive study. Semi-structured interviews 1 x 45-90 minutes	18 participants from 14 nursing education programs.	Contemplating the change Transition to the new role Feeling overwhelmed From surviving to thriving Finding Balance.	High Identified the different stages participants went through during their transition to academia and the different psychological processes.
2	Ashley, Halcomb, Brown & Peters, (2017). Australia	Acute care nurse to community care	A sequential mixed methods study, a survey, and semi-structured interviews.	Phase 1 111 registered Nurses transitioned from acute services to PHC within the last 5 years. Phase 2). 13 participants phone (n=12), face-to-face (n=1).	**Survey Results** **Support:** Orientation 81.1%, preceptorship 72%, encouragement 63.9%, time for PPD 58.5%, physical learning resources 48.6%, supernumerary period, 49.5 % funding for external PPD 45% **Difficulties in transitioning**: 56.4%, orientation difficulties, 42.7%, unclear role expectations, 34.1% a lack of confidence, 28.2% workload concerns, and 15.5% safety issues. **Adjusting to PHC** 33.9 % "neither difficult nor easy": organisational knowledge and information overload 25.4 %"difficult" or "very difficult.": new technology and workplace familiarisation. 55% "easy" or "very easy.": autonomy, prioritizing work, change of responsibility **Qualitative part results** "Role learning: the new environment"	High It is the only mixed methods study that investigated the transition experience for nurses from acute to community care. The survey provided the statistics and the numerical data in support of the qualitative data

					"Role socialisation: transition validation."	
3	Azimian, Negarandeh &Moyahedi. (2014). Iran	Factors affecting nurses' coping with transitions in different nursing roles	Qualitative semi-structured interviews 1 x 28- 87 minutes	16 nurses in Medical wards in 4 hospitals	**Inadequate preparation for transition** "staff training and development", "professional relationships", "perceived level of support", "professional accountability and commitment", "welfare services", and "nursing staff shortage".	Low It is not clear how the participants were recruited. No examples of the interview questions. Data analysis was not clearly described. The participants' voice was not strongly represented. The relationship between the researcher and the participants was not mentioned. No evidence of reflective practice. Identified the factors that facilitated nurses' transition which can inform health authorities and managers.
4	Barton, (2007) Wales	Experienced to specialist nurse	Qualitative Ethnographic study Data collected: x 2 semi-structured interviews over two years + field notes	Sample size N=21 10 Student Nurse Practitioners. 5 Medical Mentors. 3 Educators. 3 Senior nurse academic Staff.	**Five transition themes:** social, professional, clinical authority, clinical knowledge & clinical skills. **Three-staged process:** **The separation phase:** identity loss, mixed feelings of anxiety and excitement. **The transition phase:** learning new practice, skills **The incorporation phase:** returning to practice.	High It enhanced the understanding of the complexity of the transition of the student nurse practitioners with its social, cultural and professional aspects. Indicated that Van Gennep (1960) model had a universal application. Revealed the fundamental importance of the theory of rite of passage to individual and group transitional

						experience and educationalists.
5	Bombard et al., (2010). USA	Experienced to clinical nurse leader.	7	Sample: 4 direct-entry master's students	**What is a Clinical nurse leader (CNL)** **Coming to the edge**: mixed emotions of excitement and anxiety, vulnerability **Trusting the process** **Rounding the corner:** confidence and action, **Valuing becoming:** continuing to grow professionally ,	Medium Answered the question of what a CNL is? Highlighted the processes of transition to becoming a CNL.
6	Boyd & Lawley, (2009). UK	Experienced to academic educators	Qualitative- Case study semi-structured interviews, analysis of institutional documents related to the appointment, induction and continuing professional development of academic staff	9 nurse lecturers in the first 4 years of their appointment. + 3 line-managers	'Feeling new and in at the deep end' 'learning the language of academia, procedures, responsibilities and level of autonomy within higher education' 'seeking credibility through knowing' 'valuing practice sessions than spending time on scholarship and research activity' 'time management' 'marking' 'formal and informal support' 'mentoring' Managers value the prior clinical experience of newcomers and view postgraduate course for newcomers as useful. Managers experience a tension between providing time for measured induction and the pressure to covering teaching.	High This study identified the need to enhance the academic workplace as a learning environment for lecturers in professional education fields such as nursing.
7	Brown and Olshansky (1997) USA	Experienced to specialist	Grounded theory. Interviews-individual at 1,6,12 months (n = 11)	Seven focus groups (n = 24)	Laying the foundation; launching, meeting the challenge, broadening the perspective. Model of transition presented	High Deepened the understanding of the transition experience of experienced nurses to

						specialists which was conceptualized as "moving from limbo to legitimacy" Presented a model of transition that could be applicable in similar services.
8	Cubit & Lopez, (2011). Australia	Enrolled practical Nurse to RN	Descriptive, qualitative study using focus group interviews x 3 for one hour Week one (n = 8); 6 months (n = 5); 12 months (n = 4)	Eight graduate nurses (GN) in one hospital in Australia	**Stepping out of comfort zone** Different scope of practice, Delegating work to ENs **Being taken advantage of** Knowing more than others, Concealing previous work as ENs, Fear and anxiety **Needing support as much as others**	Low It was not clear how the participants were recruited. No statement on how data saturation was reached. There is no clear statement on how the themes were derived. No discussion of why half the participants dropped out. RNs with enrolled qualifications need the same level of support like any new qualified RNs to foster job satisfaction and retention.
9	Dearnley, (2006). UK.	Enrolled practical Nurse to RN	Phenomenology, qualitative study 5 semi-structured interviews over 2 years.	18 second level registered nurses converting to first level registration in a two-year, part-time open learning programme.	**Finding the professional voice.** **Hesitant:** silence & passivity **Liberated:** self-confidence & professional autonomy. **Dynamic:** learning and integrating knowledge A model of transition was proposed.	High The study showed how ways of knowing can directly impact on ways of nursing and being. Provided a model of transition which is useful in understanding the relationship between ways

						of knowing, learning and continued professional development which is vital in achieving quality in higher education and care delivery settings.
10	Glen & Waddington, (1998). UK.	Experienced nurses to specialist	Case study. Data sources: recorded individual supervision sessions, semi-structured group interviews and written reflective accounts of both CNSs	Two CNSs employed in a National Health Service (NHS) Trust	Professional autonomy Acting independently of superiors, Inter-professional relationship conflicts Role clarity, conflicting targets, personal dissatisfaction, role overload Organizational socialization Learning the rules, norms, and values, expectations. Support from peers and preceptors Maintaining clinical competence	Medium Identified the facilitators and barriers of successful transition from experienced to specialist.
11	Goodrich, (2014). USA	Expert nurses to academic educators	Four self-report electronic Descriptive, quantitative Survey measuring the relationship between readiness, confidence, personal control, support, decision independence, general self-esteem and locus of control in work settings	N = 541 registered nurses Recruitment via electronic mail and answered an on-line survey.	confidence, support, independence, self-esteem, work locus of control Significant positive relationships existed among all the Subscales except readiness and personal control. For these two subscales participants scored low, which indicated the extent to which individuals feel they have personal control and their readiness for the role.	High Identified the psychological factors that facilitate role transition.
12	Holt, (2008). UK	Registered nurse (RN) to primary health care. RN clinical role change.	Exploratory research semi-structured interviews, focus groups, observations	Sample: 11 registered nurses in 2 community NHS Trusts	Centring identity Focusing roles Enacting roles Shaping roles	High Model was proposed could have relevance to other

			and content analysis of job descriptions .			settings and other health professionals
13	Khoza, (2005). South Africa	Identify the elements of organizational culture that have an impact on the adaptation of newly employed nurses to the work environment.	Descriptive quantitative survey	49 newly employed nurses all nursing categories within a period of less than 18 months, working in one particular hospital.	Feeling valued by the organization 56% disagreed Identification with the organization 51% Management style empowering 34% Locus of control (inner) 43% Conflict resolution 49% Employee participation 50% Goal clarity 65%	Medium It identified the various constructs of organizational culture had a positive or a negative impact on the participants' adjustment to work setting.
14	Manning & Neville, (2009). New Zealand	Experienced nurse to academic educator	Qualitative description Using Bridges (2003) framework One individual semi-structured interview for an hour	Eight CNEs who were RNs and employed as senior nurses for the first time.	Ending their previous role Early phase of transition working hard Adjustment	High Discussed the importance of the support, mentoring and preparing the newcomers for their new role as CNE. Emphasized that leaders who have knowledge of transition theory and the commitment to applying it can improve the journey for staff nurses moving into the CNE roles
15	Melrose & Gordon, (2011) Canada	LPNs to RNs Licensed practical nurse (LPN)	Descriptive qualitative study 3 interviews beginning, middle & end of the of 3 years programme	10 Post LPN to BN students Bachelor Nursing (BN)	Mentors helped Post LPN to BN students apply their learning Professional growth and development Isolation was a barrier Time management Competence, skills, stress	Medium This research extended the knowledge of how LPNs and ENs experienced their transition to become registered nurses with a bachelor's degree.
16	Miller, Vivona & Roth, (2017) USA	Staff nurse to a preceptor	Interpretive qualitative research	20 preceptors	**Transfer of learning** **Clinical expert to novice again**	High

			face-to-face interviews,45-90 minutes + written Field notes		Deconstruction. Construction	It extends the literature on informal learning and training for preceptors. Identified several areas of improvement for preceptorships such as additional administrative support, guidelines and standards for preceptor training and preparation.
17	Owens, (2018) USA	Staff nurse to FNP in rural areas	Moustakas' qualitative phenomenology approach Semi-structured interviews x 2 at 6 and 12 months after beginning their new role + field notes	10 Participants lived in 3 states and worked at 10 rural health care settings	Learning new skills, knowledge and roles. Interactions and relationships with others. Desire to practice in rural health. Role Transition to NP Professional Identity.	High Extended the knowledge on transition for nurses in rural areas. A model was proposed for rural nurse practitioner transition and professional identity development.
18	Pearson & Care, (2002). Canada	Acute care to PHC	Qualitative descriptive study Semi-structured interviews 10 telephone and one face to face interviews 90 minutes each + Detailed notes	11 subject experts were selected from three provinces based on their representation of key stakeholder groups involved in the strategic planning and implementation of CHCs	A broader focus of care in CHC, different continuing education needs Involvement of stakeholders in the planning Phased transitional approach at systemic & individual level. Educational programs, mentoring Systemic Support from the organization	Medium Identified the education needs for nurses transitioning to PHC. Informing regional health authorities to improve nurses' transition experience.
19	Seng, Sanubol, & County, (2004) USA	Experienced to specialist	Ethnography Semi-structured interviews x3 30- 60 minutes each over 1 year	6 participants one SANE centre in semirural area	**Transition to a SANE role wasn't as stressful as anticipated**. Previous occupational experience, transfer of skills and expertise, usual coping strategies, growing confidence finding satisfaction. **Role specific stressors**	Medium Provided an insight into what it was like for members of a new Sexual Assault Nurse Examiner (SANE) team in a semirural

					getting over the first examination; overcoming fears and anxiety, doing it right; testifying in court	area to go through their first year in practice as a SANE. This study could be helpful for nurses considering the role.
20	Simpson et al., (2006). Saudi Arabia/Australia	From acute care to PHC	Qualitative descriptive study Focus group interviews	Two experienced acute care nurses + head nurse + education coordinator	**Stages of transitional practice** Model consists of three components: dimensions, domains and evaluation. **Growth & development** **Facilitators** Preceptors, reflective practice, past occupational experience, mentoring and supervision, supportive environment.	Low Discussion of any researcher or participant bias was not included. The credibility of the findings has not been discussed in detail. The Transitional Practice Model, adapted from Benner's (1984) research described the professional development for nurses from acute care to PHC. It also identified the facilitating factors for successful transition.
21	Smith & Boyd (2012) UK	Clinical nurses to academic educators	online quantitative survey	146 participants Had 1-5 years experience in higher education	**Managing self:** exciting and stimulating, autonomy and learning. heavy workload, learning organisational procedures, learning to teach, and marking students **Activity** Teaching, maintaining links with their clinical role, and research activity **Support** Most participants felt well supported: 54% reported colleagues as an important source for support. line managers, mentors, formal programmes, external clinical	High Identified the need for departments in nursing, midwifery, physiotherapy, radiography, and occupational therapy to provide a guide for new lecturers in their reconstruction of identity. To strengthen the essential characteristic of university teaching, that it is underpinned by engagement with research.

					colleagues, and informal support groups.	
22	Smith et al., (2017). UK & Australia	Investigating the impact of pre-entry beliefs about institutional practices on newcomer socialization in a healthcare context.	Survey based longitudinal study	264 participants 77% medical doctors, nurses and physiotherapists, 23% administrators and operations staff	**Organizational identification** Solidarity, satisfaction, centrality, similarities with others. **Perceived organizational trustworthiness** ability, benevolence and integrity **Self- efficacy** participants experienced negative injunctive–descriptive logic discrepancies for both the clinical logic and the managerial logic, and these discrepancies were related to decreases in organizational identification and perceived trustworthiness. Organization placed less priority on patient care and efficiency than the priority that newcomers thought should be placed on.	High Provided a conceptual model that extended the knowledge on work role socialization. Provided new concepts of injunctive logics and injunctive–descriptive logics discrepancies, explaining how they are different from job expectations. Highlighted the newcomers' moral map to evaluate the procedures and practices of the participants new organization for understanding where the development of identification and POT lie in relation to newcomers' broader understanding of their professions and organizational field
23	Sullivan-Bentz et al., (2010). Canada	Experienced to specialist	Descriptive qualitative. Semi-structured Qualitative interviews x 3 over one year.	Sample (N= 23) nurse practitioners + (N= 21) co-participants including: family physicians, NPs and managers. + analysing organisational documents (job description and charts)	Transition to the NP role Contextual factors Inter-professional relationship conflicts, Policy & politics Educational preparation for role transition	High Lack of preparation for integrating NPs into clinical settings and lack of infrastructure, orientation, mentorship, and awareness of the NP role and needs were .barriers for successful transition. Provided

						recommendations to overcome these barriers.
24	Wenner & Hakim, (2019) USA	Clinical to academic educators	Qualitative phenomenological study Online video conferencing interviews 60 minutes semi-structured interview	14 RNs & part time educators in academia	Different background-different experiences Guidance & support Challenges along the way Two work roles Prior occupational experience Personal attributes Recommendations for optimal role transition	High This study extended the knowledge of the transition experience of part time clinical nursing to academia, highlighted the potential benefits for both these involved with nursing education and society. The results may be beneficial in future administrative decision-making.
25	Zurmehly, (2007). USA	Nurses transitioned from acute care to PHC.	Qualitative case study Individual, semi-structured interviews for 30-60 minutes.	48 participants	Autonomy Client and family Education Community as nursing work	Medium Highlighted a need for additional supportive preparation strategies incorporated into nursing orientation and continuing education programmes.

Appendix 4

Examples of studies using IPA for the topic of work-role transition

Authors	Research topic	Sample size
Dyble, G. (2012)	"Going through the transition from being an end user to sort of the provider": Making sense of becoming a mental health peer support worker using Interpretative Phenomenological Analysis	7
Oakland, (2010).	'Giving voice': Exploring Enforced Occupational Change in Opera Choristers	7
Wood, Farmer & Goodall (2016)	Changing professional identity in the transition from practitioner to lecturer in higher education: an interpretive phenomenological analysis	5
Brown, Webb, Robinson & Cotgreave (2018)	Athletes' experiences of social support during their transition out of elite sport: An interpretive phenomenological analysis	8
Wilson-Smith & Bates (2014)	Military reserve service and post-tour work adjustment: Exploring lived experiences to inform applied practice.	10
Reynolds (2011)	Exploring the meaning of coaching for newly appointed senior leaders in their first twelve to eighteen months in role	6

Appendix 5

IRAS Project ID: 225283

17 May 2017 Version V02

Participant Information Sheet

Study title: The Transition and Transformation process to become an Improving Access to Psychological Therapies Therapist: A study using Interpretative Phenomenological Analysis.

You are invited to take part in the above research study. The study is being carried out by Reda Hamam of the University of Derby as part of the award of a Doctor in Health and Social Care Practice. Before you decide whether to participate, we would like you to understand why the research is being done, how it is being done, and what it will involve for you. Please take time to read the following information carefully. Please feel free to ask questions if there is anything that is not clear or if you would like more information.

This study aims to understand how experienced psychotherapists experience and make the role transition to working as High-Intensity Therapists (HITs) in an Improving Access to Psychological Therapy Services (IAPT).

The objectives are: To describe and understand the personal subjective experience and challenges of the transition and transformation process for psychotherapists within IAPT services.

Changing jobs or work-role involves a psychological process called transition. Coping with change is a fundamental survival issue. Small changes can be overcome by learning; larger changes may challenge our identity.
Work-role transition can be a positive experience that offers opportunities for personal and career development. But it also has its own hazards that can cause stress, unhappiness, and impacts negatively on personal and work life.

This research will provide a greater understanding of what constitutes a successful work-role transition into IAPT services enabling therapists to develop at a personal and a professional level. Uncovering the lived experience of transitioning into this role as (non-IAPT qualified) experienced psychotherapist will identify the main hazards that lead to stress, job dissatisfaction, poor performance and sometimes leaving the profession. Raising the profile of role transition and increasing awareness among staff and managers at all levels in IAPT services will reduce attrition and increase staff wellbeing. This in turn will improve patient care as research has shown a correlation between staff job satisfaction and patient satisfaction with quality of care.

Why have I been invited?

You have been invited as an experienced therapist who moved into IAPT- based Primary Care Service. We would like to understand your experience of transition into IAPT.

If you decide to take part, you will be given this information sheet to keep and be asked to sign a Consent Form agreeing to be a participant in the study. If you decided to take part, you are still free to withdraw at any time without giving a reason.

You will then be invited to attend an individual interview. The interview will take place at your base and will be conducted by the researcher Reda Hamam.

Interviews will last between 60 to 90 minutes. At the interview, you will be asked to discuss your experience of transition into the IAPT service and highlight issues, which you think have either helped or hindered you in the process of transition. The interviewer will help you to discuss this by asking questions. Please find attached a copy of the interview questions.

The interviews will be audio-recorded and later typed up for analysis in the study. The transcript will be shared with you for confirmation and accuracy. Verbatim quotations will be used in the published reports. Written research notes of the interview proceedings may also be taken during the interview. At the end of the interview session, the interviewer will discuss whether you need to meet again to continue the interview and you may be invited back. If you agree with the interviewer that you do not need to continue further, your involvement in the study will then end. The decision to extend your interview into one more session will be agreed upon between you and the interviewer, as necessary.

What are the possible disadvantages and risks of taking part? The study Involves discussion of some potentially difficult issues to your lived experience in the IAPT service. This may cause you minor anxiety. You will be provided with the opportunity to discuss any concerns you have as a result of your involvement in the research and gain further support, if necessary, after the interview.

If you feel the need to talk about the issues in a therapeutic context, please contact the Occupational Health at Rotherham Doncaster and South Humber (RDaSH) NHS Foundation Trust at the following address: Occupational Health Service, Tickhill Road, Balby, Doncaster, DN4 8QN Telephone: 01302230600.

What are the possible benefits of taking part?

By participating in this research, you may gain insights into your transition and transformation as a therapist working in IAPT. We also hope the information gained during this study will help improve the transition experience of therapists working in IAPT and develop IAPT services. IAPT service managers and commissioners, professional bodies, and their members may be interested to understand psychotherapists' experience and facilitate role transition. This may help positive transition, job satisfaction, and staff wellbeing.

Will my taking part in the study be kept confidential and anonymous? Yes.

All information that is collected about you during the course of the study will be kept strictly confidential. We will replace your name with a pseudo name to ensure that individual participants cannot be identified. Researcher Reda Hamam will be responsible for the security of personal data and will hold the information on a secure, encrypted, and password protected NHS computer. Interviews will be audio-recorded and will be transcribed for analysis. Recording equipment will be locked up in a filing cabinet at the researcher's base. Only the researcher will have access to information that can identify participants. Relevant sections of your data collected during the study may be looked at by the researcher's supervisors at the University of Derby, where it is relevant to you taking part in this research. The researcher will ensure that you will not be identified from this data. Your data will be kept securely for 3 years (duration of the study). After this time, your data will be disposed of securely. During this time, all precautions will be taken by the researcher to maintain your confidentiality.

The researcher understands and complies with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk) and the Data Protection Act (1998), BACP http://www.bacp.co.uk, and BABCP http://www.babcp.com Code of Practice.

What will happen if I do not want to carry on with the study? If you choose to withdraw from the study, you can decide what happens to any data that you have provided up to three months after the interview when data analysis begins.

What if there is a problem? If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions; contact Reda Hamam on [redacted] or by email: reda.hamam@rdash.nhs.uk. If you remain unhappy and wish to complain you can do this by contacting the Team manager [redacted] or email: [redacted]@[redacted] If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the Service Liaison Department at RDaSH NHS Foundation Trust.

What will happen to the results of the research study? The research is being conducted as part of a doctorate in Health and Social Care Practice and will eventually be published as a thesis as part of the doctorate study. The research may be published in journals. A brief report on the study will be made available electronically to participants. You will be asked at the interview whether you wish to receive a copy of the report.

Who is organising and funding the research? The research is being conducted through the University of Derby and the study is self-funded by the researcher.

Contact for further information:

Contact Reda Hamam via email reda.hamam@rdash.nhs.uk Telephone: 01724 867297

Opt IN SLIP: Please Detach Here.....

Study Title: The Transition and Transformation process to become an Improving Access to Psychological Therapies Therapist: A study using Interpretative Phenomenological Analysis.

I am interested in taking part in the study and agree to be contacted by the researcher to discuss my participation in the study. Please return the Opt-In Slip to Reda Hamam using the Stamped Addressed Envelope.

Name:.....

Signed:.....

Date: .....

Appendix 6

IRAS Project ID: 225283

17 May 2017 Version V02

Interview Schedule V02

1) Where did you work before moving into IAPT?
[Prompts: what service? how long? what was your role, why did you leave?]

2) Can you tell me about how you came from your previous job to IAPT services?
[Why did you move to IAPT? What attracted you to IAPT? What were your expectations before moving to IAPT? How did you find it after moving to IAPT?]

3) How long have you been working in IAPT? And what is your role?
[Prompts: describe a typical day at work, how do you feel about this, when doing this? What does this mean to you?]

4) If you were to compare how you did your role in your previous job and your role in IAPT-what might you remark on?

5) What are the main similarities? What are the main differences?

6) How did you find the transition to IAPT services?
[Experiences you would like to share, feelings at the time, things you had to work through, how did you make sense of the transition professionally and fitting into your life generally?]

7) Your personal and home life can often impact the way transition into a new role-What was going on in your personal life at the time of transition?
[Prompts: how did it impact your transition? Life-work boundary? Was the employer aware of this/ did you share it with your employer? What was their attitude? What is the meaning of this to you?]

8) Thinking back when you made the move to IAPT, what was the organisation's attitude and management style during your transition period?

9) What changes, if any, did you have to make to adapt to working in IAPT?

[Prompts: cognitions, behaviours, personal, professional, and how do you feel about these changes, and what is the meaning of these changes to you?]

10) What have you found challenging about working in IAPT?
[Prompts: what was challenging? why was it challenging and in what way? how did you cope or deal with the challenges?]

11) What have you found rewarding about working in IAPT?
[Prompts: what was rewarding? and why? In what way? What is the meaning of it to you personally and professionally?]

12) How does the IAPT model fit in with you?
[Prompts: professionally and ethically]

13) What impact if any has working in IAPT had on you?
[Prompts: as a therapist, professionally, personal life and how do you feel about this?]

14) What do you like about working in IAPT?
[Prompts: why, and what does this mean to you as a therapist and as a person]

15) What don't you like about working in IAPT?

[Prompts: why, and what does this mean to you as a therapist and as a person]

16) What of your previous experience helped or hindered the transition?

[Prompts: how and in what way?]

17) How do you compare this experience to other work transition experiences?

18) Based on your experience, in your view what makes it a successful transition?

[Factors enabled you or would have enabled you and were missing]

19) What recommendations would you make for others experiencing the move to IAPT Services?

Appendix 7

UNIVERSITY *of* DERBY

IRAS Project ID: 225283

17 May 2017

Participant Consent Form Version V02

Research title: The Transition and Transformation process to become an Improving Access Psychological Therapies Therapist: A study using Interpretative Phenomenological Analysis.

Name of Researcher: Reda Hamam

Please initial box

1- I confirm that I have read the information sheet dated 17 May 2017 (version V02) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. If I choose to withdraw, I can decide what happens to any data that I have provided up to three months after the interview when data analysis begins. ☐

3- I understand that the interviews will be audio-recorded and subsequently transcribed. ☐

4- I understand that relevant sections of my data collected during the study may be looked at by the researcher's supervisors at the University of Derby, where it is relevant to me taking part in this research. I permit these individuals to have access to my data. No information that identifies me will be used from these data. ☐

5-I consent to my data being used in the study. I understand that I will not be Identified from these data. ☐

6- I agree to take part in the above-named study. ☐

Participant's Name..... Date..... Signature.....

Researcher’s Name ..... Date..... Signature.....

1 copy for participant; 1 copy for researcher

Appendix 8 Super-ordinate themes and sub-themes from the pilot interview

Keywords	Page	Line	Themes
Secondary Care			
I'd had an absolute belly full of secondary care Patients	P 1	L 28	Had enough in secondary care
Many of them were unsuitable to psychological therapy	P2	L 38	Patients' suitability to psychological therapy
Secondary care service is so disorganised	P3	L 65	Lack of structure and organization
IAPT			
Well, my job title is Cognitive behaviour therapist, and that is one of the things I was keen to hang on.	P4	L 86	Holding on to his CBT identity
I wanted this distinction made clear in my job title.	P 4	L91	CBT identity
You are dancing to two masters in IAPT	P 6	L 167	Conflicting demands
uhm… I wish I had done it earlier [moving to IAPT]	p 7	L189	Positive experience in IAPT
I think the IAPT framework can be a little bit overly prescriptive	p 9	L 251	IAPT framework
Expectations			
and this very much fits my personality	P6	L195	IAPT framework fits his personality
I now know with absolute clarity	P12	L425	Need for clarity and certainty
it makes you very aware of your own practice	P9	L313	Aware of own practice
um .....Yes it has met my expectations both personally and professionally	P4	L 82	IAPT has met his expectations
The performing self			
Yes, for me it is about being the best	P 10	L327	highly competitive
0% it makes me right off,	P10	L 335	self-worth is based on being the best
I wanted to go out there and show,	P10	L352	putting on a good performance
look how fantastic my therapy is,	P10	L352 & 353	
look at the wonderful results I can generate	P10	L353, 354	
die hard,	P10	L354	highly competitive
Prior occupational experiences			
I'd always held positions that were very different	P11	L373	prior occupational experiences
more difficult to what I do now	P11	L374	helped his transition
this time around, transitioning into IAPT	P11	L374	
is a lot shorter, , I saw the light earlier	P 11	L375	
Adaptation & Transformation			
the longer I have been in it the more flexibility is coming back to my thinking	P10	L355	more flexible in his thinking
I realised it was unhealthy Because	P10	L365	more self-aware of the
you can't sustain that personal recovery rate	P10	L366	impact of his attitude on his health
it fits well with my sustainability to keep well and be able to do it	P12	L398, 399	taking care of self

Appendix 9

Data analysis from the interview with Cathy

Loss of belonging to the team.	173 174 175 176 177	I: you talked about a sense of belonging and a sense of identity, and these have changed and not the same since the transition, can you tell me more about that?	successful. To achieve IAPT recovery rates they need the right people who are likely to get better with treatment offered in IAPT.
The importance of having connection and belonging to the staff and GPs.	178 179 180 181 182 183 184	C: yes these seem to have changed now. [long pause] yes I feel it's become more serious, it seemed light hearted before and we were busier, laughter yes busier before and more in demand uhm and I feel there is a sense of loss really with the belonging. I noticed one of the	This divergent views of Cathy and the IAPT system is causing an ethical issue for Cathy. It makes her feel uneasy about it. Using negation four times in a sentence of 15 words indicates how strongly she feels about it.
Changes in the IAPT service has led to feelings of disconnection and being left behind.	185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206	surgeries where I worked quite a while,.....none of the IAPT staff have been asked on the Christmas do and I find that really interesting. They haven't mentioned it so they haven't said why, so they might be cutting back, but I suppose and I don't have a suspicious mind but I wonder if they are not very happy with us now, I wonder [laughter]. And I've stayed there it is where I've been for 12 years and I know the GPs really well and the manager, but everyone else has come and gone Well Being Practitioners, CBT therapists , it's all changing, changes so often and I just think we're left behind. They, the GPS are encouraged now to give the patients a leaflet to refer themselves in so they don't have the contact with us where they sending the referrals. They used to come through to me and I would send an opt in letter out.	A sense of loss of belonging, it has become more serious. No laughter and connection with the team as it used to be despite they were busier. None of the IAPT staff have been invited to one of the GP's Christmas do. Cathy thought of several explanations but the one explanation that seemed to resonate with her feelings was that the GPs are not happy with them (the IAPT staff). Why did she infer that? Cathy is making sense of the changes in the service and its impact on relationships with staff and GPs. Cathy attributes the changes in inter-professional dynamic to the speed of change in IAPT services and provided an example of when GPs used to refer patients to her and the team and now it is self referral prompted by a lefleat from the GP. "We are left behind" again conveys a sense of disconnection and lack of belonging.

Appendix 10 Initial themes from David's transcript

	Themes	Frequency	Page number
1	It was a walk in the park	II	2, 8
2	I have done a lot of different jobs	II	2, 8
3	No induction or orientation to the job	I	15
4	Turned up one morning and was handed my caseload	I	15
5	Lack of support	II	19, 20
6	A belly full of secondary care patients	I	1
7	Reached a saturation point	I	1
8	Ploughing through the trenches in secondary care	I	18
9	Appropriateness of people to CBT interventions in secondary care is an issue	IV	1, 8, 9
10	Using CBT skills in IAPT	I	1,2
11	Needing clarity & structure and certainty Guidance and framework	VIIII	1,2,2, 3, 6, 7,7, 10, 19
12	Work to fit around being a single parent	I	2,
13	Not happy when worked in secondary care	I	2,
14	Lack of structure, organization, and direction in secondary care	IV	2, 6, 9
15	IAPT suits my personality	V	2, 3, 9,
16	Expectation of IAPT have been met	I	4
17	Appropriateness of people for psychological therapy	I	3
18	No appreciation of psychological therapies in secondary care	I	3
19	Comprehensiveness of CBT training compared to HIT	I	3
20	Pride in having the CBT training and being a CBT therapist	I	18
21	Seeing self as more competent because of his CBT training	I	18
22	Impact of personal stuff on work	I	4
23	I am a good supervisor; people want to be supervised by me	II	4,5
24	Work demands, formally and informally because people seek his advice and knowledge	II	4,5
25	Taking the role of mentor and supervisor	I	4
26	Setting boundaries and taking care of self	I	5
27	Being part of a team is important	II	5, 6
28	Developing compassion fatigue	III	5,5, 6
29	Self as a slave dancing for two masters in IAPT	II	6,6
30	A sense of responsibility and feeling the pressure	I	6
31	Competitiveness to be the best	II	6,12
32	A sense of regret for staying in secondary care as long as he did	I	7
33	Working in mental health services is challenging	I	7
34	Working within the IAPT boundaries makes me feel in control	V	3, 7,8, 10,15
35	Role transition was easy	II	7,8
36	Did more difficult in the past	I	8

37	Working in IAPT versus secondary care	I	7
38	Confidence in his abilities and skills as a therapist	II	7,8
39	HITs get flustered and anxious when they see patients who do not fit into the protocols	II	8, 8
40	Working within the models	III	3, 9, 19,
41	Positive experience in IAPT compared to secondary services	II	8,16
42	Negative side of IAPT framework, too prescriptive Limiting and lack of diversity	II	9,9
43	Had to relearn how to do CBT	I	9
44	IT was a challenge in IAPT	II	9, 18
45	Higher level of suitability of people to psychotherapy in IAPT	II	8, 9
46	Adhering to the manualised protocols is fine as it makes his job less complicated	II	9,10
47	Able to defend himself if things go wrong	I	19
48	More autonomy in secondary care	II	10,10
49	Lack of autonomy in IAPT	II	10,11
50	Flexibility in secondary care	I	10
51	Takes some adjustment to the new system	I	11
52	Recovery measures make you more reflective on your practice	I	11
53	Recovery measures make you more susceptible to criticism& scrutiny	I	11
54	Recovery measures are not accurate measures of therapists' competence	IV	11,11,11,12
55	Pride in achieving 75% Recovery	I	12
56	Recovery rates you have to justify yourself and undermines your self-confidence	I	12
57	Feeling like a child when reprimanded by his manager for not good recovery rates	I	8
58	Sod them I did the best I can	I	8
59	IAPT inflexibility sometimes is causing a disservice to patients and therapists	I	19
60	Drifting in secondary care	I	13
61	Upping his game in IAPT at the beginning of his transition	II	13, 24
62	Turning the volume down where it should be	I	24
63	Increase self-awareness and the impact of his attitude on his wellbeing	III	13,14, 24
64	Developing a more flexible attitude towards working within the IAPT protocols	I	12
65	Not feeling anxious when stepping away from the protocols	I	14
66	Caring for self	II	14,19
67	Having disorders specific protocols can potentially disservice the patients and therapists alike	I	14

68	Recovery measures cause me stress	I	13
69	More flexible in his thinking and practice	I	15
70	Boundaries are clearer in IAPT than secondary care	I	15
71	Resentment for having more experience than his superiors	I	16
72	Valuing his role as a single parent	I	16
73	Pride in his skills and status and being headhunted for the job in IAPT	I	16
74	Wanted by both teams; in IAPT and secondary care	I	17
75	Feeling proud	I	17
76	Meeting 80-90% of my targets in IAPT	I	17
77	Describing the change in his attitude through his transition	I	18
78	Relearning CBT	I	18
79	Getting used to scrutiny in IAPT	II	18,18
80	Felt like a child	I	18
81	Lowering expectations of himself and moving from perfection to good enough	I	18
82	Working really hard to get the manager's approval	I	19
83	Awareness of the limitations of the IAPT protocols	I	19
84	Recovery measures are not fair	VI	17,19,
85	Relinquishing the competitive self I do not have to be the best in the team	I	19
86	Accepting the system	II	19,19
87	Recovery measures makes you accountable	III	19
88	Accepting his own limitations	I	19
89	Reviewing his old assumptions and rules and changing them for his own well being	I	19
90	Practising more flexibly within the IAPT boundaries	I	19
91	Feeling more comfortable within himself A sense of peace and inner tranquillity	II	19, 20
92	His hard work should be acknowledged by the managers	II	20, 20
93	IAPT will do with more flexibility in using the models	I	20
94	IAPT is overly monitored and scrutinized	I	20
95	Staff burn out in IAPT	I	20
96	It is only a job; it was my world when I started in IAPT	I	21
97	The pressure of my employer's expectations of me	I	21
98	Previous work role transitions helped me in this transition	I	21
99	Transition to retirement in a few years	I	21
100	Identifying the sources of stress for him	I	21
101	Identifying and acknowledging his need to prove himself to others and demonstrate his knowledge	I	22
102	Deciding to change his attitude of proving himself	I	22
103	Self-awareness and realizing his internal demands that stem from his up bringing	I	22
104	Not taking responsibility for things that are not mine	I	22
105	Self-awareness helped his transition and helped him to change	I	22

106	Work pressures and demands outside work affected my health	I	22
107	I am not taking it anymore It was easier to accept more demands rather than say no	I	22
108	I needed to change	I	22
109	Helping everybody and the demands kept piling up	I	23
110	Stubbornness hinders transition	I	23
111	You need to be seen as coping	I	23
112	Realizing unless I look after myself no one does	I	23
113	People keep knocking on my door asking for advice	I	23
114	People assume I know everything	I	23
115	People should take their share	I	23
116	People asking for me to be their supervisor	I	23
117	Successful transition to IAPT	III	2, 23, 24
118	Caseload and frequency of people you see in IAPT causes fatigue	I	24

Appendix 11

Collapsed themes, sub-themes, and super-ordinate themes for individual participants

	Clusters of themes	Sub-themes	Higher-order themes
	David		
1	A walk in the park	Smooth transition	The early experience of transition to IAPT
2	Lack of support	Support	
3	Lack of induction & orientation	Induction & orientation	
4	Working in secondary care	Prior occupational experience	
5	Positive experience in IAPT	Positive experience in IAPT	
6	Expectations	Expectations	
7	The performing self	Personality	
8	Competitiveness	Personality	
9	IAPT boundaries	Structure and direction of IAPT	Learning about the processes and procedures of IAPT
10	Early phase of transition	Relearning how to work within the new system	
11	Resentment for being overly monitored	Negative feelings	
12	Manualised protocols keep me safe in my clinical practice. Restrictive, and could cause disservice to patients and therapists alike	Manualised protocols	
13	Recovery Measures make me very conscious of my practice	Recovery Measures	
14	Workload stress	Workload stress	
15	Professional autonomy	Professional autonomy	
16	HITs therapists panic if it is outside the protocol	HIT one-year training programme	
17	Fitting in	Adapting to the system	Adaptation & transformation
18	Professional identity	Identity	
19	Changing self	Transformation	
20	Taking care of self	Taking care of self	
	Cathy		
1	Loss of supervisory and leadership role	Loss and sadness	Early experience of transition to IAPT
2	A sense of loss of belonging	Belonging	
3	Lack of support from the organization	Support	

4	Lack of induction and orientation to the role	Induction & orientations	
5	Poor supervision	Supervision	
6	Feeling betrayed by the organization & loss of trust	Expectations versus reality	
7	Inadequate physical work environment	Physical work environment	
8	Feeling undervalued and unfulfilled	Value	
9	Lack of connection to colleagues and GPs	Connection	
10	IAPT rigidity	IAPT inflexibility	Learning to work within the strict IAPT boundaries
11	Manualised protocols	Manualised protocols	
12	Recovery Measures	Recovery measures	
13	Workload is too heavy and stressful	Workload	
14	Autonomy within IAPT boundaries	Professional autonomy	
15	Uncomfortable issues in IAPT	Ethical dilemmas	
16	Becoming quiet and not involved	Fitting in	Adaptation & transformation
17	Client work is rewarding	What is rewarding	
18	Peer support	Building support network	
19	Family support	Support	
20	Taking care of self	Taking care of self	
21	Pride in her professional identity, qualifications, and skills	Professional identity	
22	Did various jobs and has been around for a long time	Prior occupational experience	
23	Contemplating leaving IAPT	Future plans	
	Val		
1	A family of care and compassion Supported and valued	Expectations	Expectations versus reality
2	Lack of managerial support	Support	
3	Poor physical work environment	Physical work environment	
4	Poor induction and orientation to the role	Induction & orientation	
5	Confusion about how to enact her role	Guidance & support	
6	Seeking support from colleagues	Support	
7	Feeling undervalued and irrelevant	Value	

8	Need for connection and belonging	Connection and belonging	
9	IAPT manuals and protocols	Manualised protocols	Learning how to enact her role
10	Recovery Measures	Recovery Measures	
11	Workload is too much	Workload	
12	Autonomy within the inflexible IAPT boundaries	Professional autonomy	
13	Patients' needs versus service resources	Ethical dilemmas	
14	Accepting that the IAPT system will not change	Accepting reality and lowering expectations	Adaptation & transformation
15	Changed my expectations to the reality of the role & the service	Changing expectations to fit in the new role	
16	Reached out for support from friends and colleagues	Building support network	
17	Changed attitudes and behaviours to fit in	Fitting in	
18	Learned to work within the system but to keep an eye on the client	Fitting in	
19	Client work is rewarding	What is rewarding	
20	It feels normal, that is what we do	Embracing the new role	
21	Resilience	Personality traits	
22	Prior occupational experience in the prison service	Prior occupational experience	
	Dorothy		
1	Expectations that all IAPT operate in the same way	Expectations	Early experience in IAPT following transition
2	My personal circumstances were not considered by the manager.	Support	
3	Poor induction and orientation to the role	Induction & orientation	
4	Poor supervision	Supervision	
5	Feeling lonely & isolated	Isolation	
6	Need for connection to colleagues and belong to the team	Connection & belonging	
7	Feeling undervalued	Value	
8	Manualised protocols	Manualised protocols	Enacting the role within the boundaries of the IAPT system

9	Recovery measures are an inappropriate tool for measuring Therapists' competence	Recovery measures	
10	Professional autonomy within IAPT boundaries	Professional autonomy	
11	Workload is stressful	Workload	
12	Complex cases beyond our expertise	Inappropriate referrals	
13	Lowered expectations to be in line with how the service functions	Lowered expectations	Adaptation & Transformation
14	Accepting the service will not change	Accepting reality	
15	Changed my attitude to be in line with the IAPT culture nuances	Fitting in	
16	Prior occupational experience	What helped	
17	Clients' work is rewarding	What helped	
18	Resilience	What helped/ personality traits	
19	Seeking a different career outside IAPT	Making decisions and choices	
20	I am a counsellor, not a HITs	Professional identity	
	Heather		
1	Expectations were based on basic knowledge of IAPT	Expectations	Early experience of transition to IAPT services
2	You have to do it yourself No one does it for you Lost the support of my old team	Support	
3	Lack of induction and orientation to the role	Induction & orientation	
4	Supervision was lousy	Supervision	
5	Horrible building	Physical work environment	
6	Very isolated in GP surgeries	Professional isolation	
7	Working within manualised protocols.	Manualised protocols	Learning to work within the processes and procedures of IAPT
8	I do what fits the client regardless of what IAPT models say	Professional autonomy	
9	Recovery measures are a source of stress and	Recovery Measures	

	potentially threatening in the wrong hands		
10	Having to relearn how to do CBT	Learning / Fitting in	
11	Complex patients in secondary care is the norm	Prior occupational experience	
12	HITs get anxious when they see patients who do not fit in the manualised protocols	CBT training versus HITs training	
13	Workload is fast and furious	Workload	
14	Ethical dilemmas about some processes in IAPT service.	Ethical dilemmas	
15	Accepting that the system cannot change	Accepting reality	Adaptation & transformation
16	I am a CBT therapist	Professional identity	
17	Relearned	Learning	
18	Working within the boundaries of IAPT	Fitting in	
19	Becoming a better therapist	Enhanced skills	
20	Being around for a long time gives you a perspective	Prior occupational experience	
21	I am a team player Seeing the bigger picture I am accommodating	Personality traits	
22	Client work is rewarding	Client work/ rewards	
	Julie		
1	Support was really poor	Support	Early experience of transition to IAPT
2	Inappropriate building Involved in the colour scheme of the new building Feeling very proud	Physical work environment	
3	Like to work with likeminded people Working in a team	Connection and belonging	
4	Manualised protocols make me feel in control IAPT frame is inflexible	Manualised protocols	Working within the limitations of IAPT
5	IAPT services are the most scrutinised and monitored service in the NHS.	Recovery Measures	
6	In the therapy room, I am in control of therapy	Autonomy	
7	HITs feel anxious with complex cases	CBT training versus HIT training	
8	Workload is very high in IAPT	Workload	

	IAPT is the dumping ground for people who do not fit other services	Inappropriate referrals to IAPT	
9	Rejecting people below caseness is an issue for me	Ethical dilemma	
10	You cannot change the system	Accepting reality	Adaptation & transformation
11	Working within the system	Fitting in	
12	I am a CBT therapist	Professional identity	
13	Previous work experience	What helped	
14	Clients' work is rewarding	Client work/ rewards	
15	Resilience	Personality traits	
16	Support from colleagues	Support network	
17	Taking care of self	Taking care of self	
18	Looking forward to retirement	Another transition	
1	**Shirley**		Early phase of transition
2	Did not like previous job	Job alienation	
3	Know what I am taking on	Expectations of the new role	
4	Manager was very supportive	Support	
5	Orientation to the role was very brief	Orientation	
6	Like to be part of a team	Connection and belonging	
7	Feels of loneliness and isolation	Professional isolation	
8	IAPT system is very rigid & restrictive	IAPT system	Learning about the new role and the new work environment
9	Lack of trust in the clinicians and their competence	Resentment and lack of identification with the organisation	
10	Workload is heavy and draining	Workload	
11	Feeling undervalued	Value	
12	I don't care about 'back to work agenda' I am not here for that.	Divergent goals Ethical dilemma	
13	Endless need for data input	Huge data input	
14	IAPT is a mini version of the NHS bureaucracy	NHS bureaucracy	
15	Recovery Measures are pain in the neck	Recovery Measures	
16	Inappropriate referrals to IAPT	Inappropriate referrals	

17	I am a counsellor not an IAPT therapist	Identity	Adaptation & Transformation
18	I had more professional autonomy in [country]	autonomy	
19	I keep my head down and not voice my opinions	Change in behaviours	
20	Lost hope of a real change in the NHS	Loss of hope and resignation	
21	I have a year to retirement, so what is the point	A new transition	
22	My family is very supportive	Support	
23	I am quite resilient and put a positive spin on things	Personality traits	

Appendix 12 - Recurring themes for all the participants

Super-ordinate themes	Subthemes	David	Cathy	Dorothy	Julie	Heather	Shirley	Val	No
Transition	Support	Y	Y	Y	Y	Y	Y	Y	7
	Induction, orientation & supervision	Y	Y	Y	Y	Y	Y	Y	7
	Expectations	Y	Y	Y	Y	Y	Y	Y	7
	Physical environment	N	Y	Y	Y	Y	N	Y	5
	Value	N	Y	N	N	Y	Y	Y	4
	Connection & belonging	Y	Y	Y	Y	Y	Y	Y	7
Learning the ropes	Manualised protocols	Y	Y	N	Y	Y	Y	Y	6
	Recovery measures	Y	Y	Y	Y	Y	Y	Y	7
	workload	Y	Y	Y	Y	Y	Y	Y	7
	autonomy	Y	Y	Y	Y	Y	Y	Y	7
	Ethical dilemma	N	Y	N	Y	Y	Y	Y	5
Adaptation and Transformation	Accepting reality & lowering expectations	Y	Y	Y	Y	Y	Y	Y	7
	Professional identity	Y	Y	Y	Y	Y	Y	Y	7
	Fitting in	Y	Y	Y	N	Y	Y	Y	6
	Client's work	N	Y	Y	Y	Y	Y	Y	6
	Support network	N	Y	Y	Y	N	Y	Y	5
	Prior occupational experience	Y	Y	Y	Y	Y	Y	Y	7
	Taking care of self	Y	Y	Y	Y	N	Y	Y	6
	Personality traits	Y	Y	Y	Y	Y	Y	Y	7

Appendix 13 Initial themes, sub-themes and super-ordinate themes

Super-ordinate Themes	**Sub-themes**	**Initial themes**	**Frequency No of participants**
Transition	Expectations	• The NHS is a family of care and compassion. • Experiences and skills will be appreciated. • Meeting patients' needs of treatment based on idiosyncratic formulation and tailored treatment plans. • Supported in the new role. • Personal circumstances will be considered. • Develop and progress career • Empowered • Inducted and orientated to the new role. • Adequate clinical supervision • Knowing what is taking on • Expectations are based on information from trustworthy sources. • Expectations based on prior work experiences. • Expectations were met.	I VI VI V III I II V VI III I V I
	Support	• Poor managerial support • Personal circumstances were not taken into considerations. • Reaching out for colleagues for support • Not supported to progress in career • Managers are busy and have no time • Mangers lack understanding of the system • No support in finding a place to see patients • Good managerial support	VI II IV II III I I I

	Induction & supervision	• Poor induction • No orientation to the role • Poor clinical supervision • Feeling unsupported and clinically unsafe • Improving supervision as time went by.	VII VII IV IV III
	Physical work environment	• Inappropriate buildings • Not conducive to wellbeing • Impacting on feeling valued • Nice building • Feeling good • Feeling proud for being involved in choosing the colour scheme	V V IV I I I
	Value	• Loss of supervisory & leadership role • Underused Skills & expertise • Loss of professionalism • Not appreciated • Feeling inferior to CBT colleagues • Hard work is not appreciated	II IV IV IV IV I
	Connection & belonging	• Professional isolation • Feeling lonely • Lost a feeling of belonging and connection to GPs • Need for belonging	V III I VII
Learning the ropes	Manualised protocols	• Manualised protocols are rigid and inflexible • Some benefits for manualised protocols • Learning about different models • Better therapists • A sense of boundaries and structure • Makes therapy less complicated	VII VII III II I I
	Recovery Measures	• Pressure on therapists and causes stress. • Not an accurate way for assessing therapists' competence. • Could be threatening in the wrong hands. • A need for better and more adequate tools for assessing therapists' competencies.	VII VII II VII V

		• Are done to secure funding.	
	Workload	• No of clients • Fast pace • Complex patients • Inappropriate referrals outside the IAPT remit. • Feeling challenged by the complexity of clients. • Causing work stress and tiredness • Compassion fatigue	VII VII VII VII I VII I
	Professional autonomy	• Struggling to keep professional autonomy. • No change of professional autonomy. • Doing what is appropriate for the patient regardless of IAPT. • Stick to the IAPT boundaries.	V I II II II
	Ethical dilemmas	• Patients' needs versus limited resources. • Discharging patients prematurely. • Not accepting patients below caseness. • Back to work agenda. • Not adhering to the models.	II III II I I
Adaptation	Accepting reality & lowering expectations	• You cannot change the system • You can kick and scream but nothing changes • Accepting reality • Lowering expectations	VII V VII VII
	Professional identity	• I am a counsellor, not a HIT • I am a CBT therapist, not a HIT • Holding on to who I am • Resistance to embrace the new IAPT identity	IV II VII VII
	Fitting in	• Censoring what to say. • Not criticizing the system. • Keeping quiet and not speaking up in meetings. • Working within the IAPT boundaries. • Keeping to the nuances of the IAPT culture.	II III III V V
	Facilitators of adjustment	• Family support. • Taking care of self. • Previous work experience.	II V VII

		• Personality traits (resilience, putting a positive spin, acceptance, team player, seeing the bigger picture). • Clients' work.	VII VI
Transformation	Transformation	• Professional growth • Work/life balance • Social self • Feeling liberated • Pursuing a new career • From a vulnerable self to a confident self • Letting go of the performing self and connecting to the authentic self • Setting priorities based on values	VII II I IV I I I VI

Appendix 14 Approval from RDaSH (All names redacted to maintain anonymity)

From: [redacted]
Sent: 30 March 2017 16:48
To: [redacted]
Hamam, Reda
cc: [redacted]
Subject: RE: Research

Hi Reda and [redacted]

In light of [redacted] approval of your work Reda, I can also issue you with approval from the research office subject to

1. REC approval
2. Confirmation from the University of Derby

You will not be able to begin your work prior to receipt of your ethics approval but once you have that it would be helpful for you to issue that to both [redacted] and to me and then you will be able to begin.

Good to speak to you the other day and keep in touch with us if you need further support.

Best wishes

[redacted]
Assistant Director Research
Grounded Research
Rotherham Doncaster & South Humber NHS Trust
Tickhill Road
Balby, Doncaster
DN4 8QN
Tel 01302
798456 Mob
07767
647596

From: [redacted]
Sent: 30 March 2017 15:04
To: Hamam, Reda
Cc: [redacted]
Subject: RE: Research

Hi Reda

Yes I will approve for 2017-2018.

Kind Regards

[redacted]
Team Manager
Poiesis IAPT Team
19, Market Hill

Scunthorpe

DN15 6SS

Tel: 01724 867297

[redacted]

Appendix 15 REC approval is not required for this study

From: SOUTHBIRMINGHAM, NRES Committee.West Midlands- (HEALTH RESEARCH AUTHORITY) Sent:ll /05/2017 15:32:21 To: Hamam, Reda
Subject: FW: IRAS 225283. Request for Missing Documentation for HRA Approval

Attachments may contain viruses that are harmful to your computer. Attachments may not display correctly.

image002.jpg (1Kb) image003.jpg (1Kb)

Message

Dear Reda,

As we have decided that your application does not require ethical review, the study has now been withdrawn.

In regards to the email below, you may still require HRA Approval, but that is separate to the REC.

Kind regards

[redacted]

cid:i Health Research Authority mag The Old Chapel,
Royal Standard Place, Nottingham, NGI 6FS eOO
E: nrescommittee.westmidlands-southbirmingham@nhs.net

T: 0207 104 8106 | T: 0207 104 8238
www.hra.nhs.uk

Would you like to receive the latest updates on HRA work? Sign up here

For more information on the HRA Approval process Click here

From: [redacted] (HEALTH RESEARCH AUTHORITY) Sent: 09 May 2017 17:33
To: SOUTHBIRMINGHAM, NRESCommittee.WestMidlands- (HEALTH RESEARCH AUTHORITY) Subject: RE: IRAS 225283. Request for Missing Documentation for HRA Approval

Dear [redacted]

Thank you for your email. Part C of the IRAS form lists an NHS site as a research site, so this would normally automatically mean that it should come under HRA Approval. I note from your correspondence with the applicant that the study does involve NHS staff, so again that would mean the application should be under HRA Approval.

It might be that an assessor looks at the application in detail and decides that it does not require HRA Approval, but in the meantime, our position would have to be that it does. If you are not proceeding with REC review, please could you transfer the study on HARP to the Non-REC committee meeting? I think the PR flag needs to be removed on HARP first, before a transfer to Non-REC can work.

I also note that there is an e-submission pending on this study, and I don't know if I can accept it from the Non-REC side after transfer (sorry, I am not as familiar with transfers as REC staff). Could you possibly accept that before any transfer, if necessary? Many thanks.

Best wishes,
[redacted]

cid:i [redacted]I Application Administrator mag Health Research Authority eOO
HRA NRES Centre Manchester
3rd Floor, Barlow House, 4 Minshull Street, Manchester, Ml 3DZ E: x[redacted] T: [redacted]
www.hra.nhs.uk

Appendix 16

Mrs Reda Hamam
Psychotherapist
Rotherham, Doncaster and South Humber NHS Foundation
Trust Poiesis
19 Market Hill
Scunthorpe
DN15 6SS

05 June2017

Dear Mrs Hamam

Letter of HRA Approval

Study title:	**The Transition and Transformation Process to Become an Improving Access Psychological Therapies Therapist: A Study Using Interpretative Phenomenological Analysis.**
IRAS project ID:	**225283**
REC reference:	**17/WM/0190**
Sponsor	**The University of Derby**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal

confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.

- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

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

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

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

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **225283**. Please quote this on all correspondence.

Yours sincerely

[redacted]
Senior Assessor

Email: hra.approval@nhs.net

Copy to: [redacted] *Derby University [Sponsor]*
[redacted] *Rotherham, Doncaster and South Humber NHS Foundation Trust [Lead NHS R&D]*

Appendix 17

The University of Derby Approval
Dr [redacted]
Dean

Kedleston Road, Derby
DE22 1GB, UK
Approved

31/07/2017
Name: Reda Haman

Dear Reda
Topic:
The Transition and Transformation process to become an Improving Access to Psychological Therapies Therapist. A study using interpretative phenomenological analysis.

Thank you for submitting your application to the Health and Social Care Research Ethics Committee.
Your study has been approved by chairs action. Feedback from the reviewers highlighted that excellent consideration had been given to possible methods of dissemination and publication which is commended.
If any change to the study described in the application or to the supporting documentation is necessary you are required to make a resubmission to the Health and Social Care Research Ethics Committee.
We will also require an annual review of the progress of the study and notification of completion of the study for our records.

All the best with the study

Yours sincerely,

[redacted]

[redacted]

Chair, Health and Social Care Rese

College of Health and Social Care